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# Managing social awkwardness when caring for morbidly obese patients in intensive care: A focused ethnography

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ABSTRACT

*Background:* Critically ill morbidly obese patients pose considerable healthcare delivery and resource utilisation challenges in the intensive care setting. These are resultant from specific physiological responses to critical illness in this population and the nature of the interventional therapies used in the intensive care environment. An additional challenge arises for this population when considering the social stigma that is attached to being obese. Intensive care staff therefore not only attend to the physical and care needs of the critically ill morbidly obese patient but also navigate, both personally and professionally, the social terrain of stigma when providing care.
*Aim:* To explore the culture and influences on doctors and nurses within the intensive care setting when caring for critically ill morbidly obese patients.
*Design and methods:* A focused ethnographic approach was adopted to elicit the 'situated' experiences of caring for critically ill morbidly obese patients from the perspectives of intensive care staff. Participant observation of care practices and interviews with intensive care staff were undertaken over a four month period. Analysis was conducted using constant comparison technique to compare incidents applicable to each theme.
*Setting:* An 18 bedded tertiary intensive care unit in New Zealand.
*Participants:* Sixty-seven intensive care nurses and 13 intensive care doctors involved with the care and management of seven critically ill patients with a body mass index $\geq$40 kg/m$^2$.
*Findings:* Interactions between intensive care staff and morbidly obese patients were challenging due to the social stigma surrounding obesity. Social awkwardness and managing socially awkward moments were evident when caring for morbidly obese patients. Intensive care staff used strategies of face-work and mutual pretence to alleviate feelings of discomfort when engaged in aspects of care and caring. This was a strategy used to prevent embarrassment and distress for both the patients and staff.
*Conclusions:* This study has brought new understandings about intensive care situations where social awkwardness occurs in the context of obesity and care practices, and of the performances and behaviours of staff in managing the social awkwardness of fat-stigma during care situations.



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**What is already known about the topic?**

- Obesity is a highly stigmatised condition.
- Caring for morbidly obese patients is both physically and socially challenging for health professionals.
- Weight-bias and fat-stigma have been reported as an issue in health care provision.
- Research has focused on self-reported attitudes and behaviours.

**What this paper adds**

- Interactions between intensive care staff and morbidly obese patients are socially challenging due to the social stigma surrounding obesity.
- When intensive care staff interact with morbidly obese patients feelings of anxiety and discomfort arise.
- As a result health professionals experience social awkwardness when providing care to morbidly obese patients.
- Managing socially awkward moments is an emergent dimension of caring for morbidly obese patients.

## 1. Introduction

Obesity has become a common condition in many countries, and a major concern for public health (Ministry of Health, 2004; Sassi, 2010). The World Health Organisation (2000) identified obesity as one of the most significant world-wide health problems of today, affecting three times more people than 20 years ago. Obesity is a particular concern in New Zealand where, since the late 1980s the prevalence of New Zealand adults who are obese has increased from 10% (Ministry of Health, 2004) to 31% over eleven years (Ministry of Health, 2015). Obesity rates are significantly higher among New Zealanders who are living in socio-economically deprived areas and are of Māori or Pacific ethnicity (Ministry of Health, 2015).

Morbid obesity, a BMI greater or equal to 40 kg/m$^2$ is the fastest growing category of obesity in developed countries (Bromley and Given, 2011; Grieve et al., 2013; Ministry of Health, 2004). Between 1977 and 2003, morbid obesity in New Zealand increased from 0.32% in males and 1.17% in females to 2.15% and 2.95%, respectively, with the most rapid growth occurring after 1997 (Ministry of Health, 2004). This is consistent with other developed Organisation for Economic Co-operation Development countries where morbid obesity prevalence has tripled over the last three decades and affects approximately 3% of the population (Bromley and Given, 2011; Shields et al., 2011; Tjepkema, 2008).

Morbidly obese patients who are critically ill place unique demands on intensive care services as they are more likely to require prolonged mechanical ventilation and tracheostomy tube placement (Villavicencio et al., 2007; Westerly and Dabbagh, 2011); have increased length of intensive care stay (Martino et al., 2011; Oliveros and Villamor, 2008; Sakr et al., 2012; Westerly and Dabbagh, 2011) increased respiratory and wound complications (Villavicencio et al., 2007; Yaegashi et al., 2005) and require significantly increased staffing support and specialist bariatric equipment (Winkelman and Maloney, 2005).

Challenges in the care of morbidly obese patients in the intensive care unit (ICU) are not limited to physiological and resource-based problems. There is concern that the attitudes and beliefs of healthcare professionals about obesity may impact on relationships between healthcare professionals and morbidly obese patients, and on the quality of care that these patients receive (Merrill and Grassley, 2008; Mold and Forbes, 2013). Although there is self-reported evidence that healthcare professionals hold more negative attitudes towards morbidly obese patients compared with normal weight patients (Schwartz et al., 2003), little is known about how doctors and nurses engage and interact with morbidly obese patients during care provision within hospital settings. The nature and quality of interactions during actual care practices remains mainly unexplored. This paper reports on findings of a study that explored the culture and influences on doctors and nurses within the intensive care setting when caring for critically ill morbidly obese patients.

## 2. Methods

### 2.1. Study design

A focused ethnographic approach was adopted as the design for this study enabling the exploration of a distinct issue or shared experience within a culture and in specific settings, rather than throughout entire communities (Cruz and Higginbotton, 2013; Fetterman, 2010; Higginbottom et al., 2013). This approach enabled the study's aim of understanding 'situated' experiences in the professional culture of intensive care staff caring for a subgroup of patients that were morbidly obese, to be met. Ethnographic methodological principles and methods guided data collection, analysis and the written representation of the social group researched.

This study adopted an insider perspective as the ICU was the primary researcher's (CH) place of work, and had been for the previous seven years. The insider position is usually adopted by nurse researchers who are not only researching their own specialty practice areas of nursing but also their own workplace and colleagues (Asselin, 2003; Cudmore and Sondermeyer, 2007; Griffiths, 2008; Simmons, 2007). In these instances, nurse researchers are familiar with the setting and specialty knowledge of the daily routines of the place, and of the research participants prior to engaging in the study. This knowledge and pre-existing relationships are used to inform fieldwork.

### 2.2. Sampling and recruitment

The setting for this study was an 18 bedded tertiary ICU in New Zealand. Participants were ICU staff who cared for morbidly obese patients in this unit. All ICU staff within the unit were involved in the study unless they chose not to consent to participate. Staff caring for patients with a BMI $\geq$40 kg/m$^2$ (i.e. were morbidly obese), who were not undergoing weight loss (bariatric) surgery and expected to remain in the unit for more than 12 h were observed. Staff

were consented prior to the data collection period whilst patients were consented to be observed at the time of data collection. The consent of patient participants occurred through two processes. Patients were consented for the study the night before surgery and admission to ICU or, identified on admission to the unit and consented following confirmation of the inclusion criteria. If the patient was unconscious and ventilated, a family assent form was completed and retrospective consent sought from the patient. All patients were cognitive of their surroundings at the time of consent and deemed to be mentally competent by the intensivist on duty.

### 2.3. Data collection

Over a period of four months in 2009 and 2010, commonly accepted fieldwork techniques were employed to collect cultural data from numerous sources. All data collection was undertaken by the primary author. Methods of data collection were participant observation, ethnographic interviews and review of cultural documents and artefacts. The data collected provided information on behaviours, interpersonal relationships, verbalised thoughts and feelings, and written accounts of care provision. Sixty-seven nurses, 13 doctors and seven patients participated in the study. Of the nursing staff, 25 nurses were observed in practice and interviewed, 28 nurses were observed in practice only, and 14 nurses were interviewed only. All 13 doctors were observed in practice and five of them were subsequently interviewed. Overall 167 h of patient observation was undertaken over 21 days with an average of 12–16 h per day. During observational sessions, frequent 10–15 min 'comfort breaks' were taken (McCrea et al., 1998). Interviews lasted for 20–80 min with a total of 30 h of data.

The 'observer as participant' role (Gold, 1958), was the role adopted during fieldwork, whereby observation was favoured over participation (Hammersley and Atkinson, 2007) and is a role adopted in other nursing ethnographies (Arber, 2006; Asselin, 2003; Coombs, 2004; Page, 2006). Observations of staff occurred in all clinically designated areas of the unit, the staff room, and the seminar room where nursing and medical handovers were conducted. The primary focus of the observations was processes that directly related to the care of morbidly obese patients. Observations were made of all daily routines ranging from handovers and ward rounds, personal cares, and conversations between staff, and staff and patients.

Interviews were developed using an ethnographic framework of questioning and focused on four areas: nurses' and doctors' experiences of caring for morbidly obese patients in the study unit and in prior employment; personal thoughts and beliefs about obesity as influenced by society; resources and education opportunities for nurses and doctors in the care and management of morbidly obese patients; and specific questions in regards to the rich points of social interaction observed in the field. Thus, the latter section was specifically used as a means to clarify certain practices, beliefs and values that would support the interpretations of the observations of care. All interviews were audio taped and transcribed. Participants were offered the opportunity to verify their transcripts.

### 2.4. Ethical considerations

Support was given by the medical and nursing leads at the hospital and the ICU for the study. To maintain patient safety principles were agreed in advance of commencing the study as to how and when the researcher would intervene if a patient's welfare and safety were threatened. Informed written consent was obtained from all participants. All participant data was anonymised and any distinguishing participant features removed from the data. The use of pseudonyms has been used in the presentation of the data. Ethical approval was given by Health and Disability Ethics Committee of New Zealand.

### 2.5. Data analysis

Analysis of the data was conducted in three stages by the primary author and interpretation was verified by the second and third authors. The first stage of analysis was 'deconstruction' where the data was systematically broken down into distinct 'first order' concepts (Strauss and Corbin, 1990). The main objective of this stage was to break up the events and actions into a series of concepts which allowed for new ways of making sense of the data (Gobo, 2008). The second stage of analysis was 'construction', where the concepts previously developed were reassembled into a new pattern to explain the facts of the data (Strauss and Corbin, 1990) that became "second-order" concepts (Van Maanen, 1979). A constant comparison technique was carried out to compare incidents applicable to each theme that emerged from the data (Glaser and Strauss, 1967). The third stage of analysis was 'confirmation' where the conceptualisation of the central phenomenon was constructed into a short story or descriptive narrative using the second-order concepts (Strauss and Corbin, 1990).

Qualitative approaches to ensure credibility and transferability were used in this study (Lincoln and Guba, 1985; Shenton, 2004). Credibility was addressed through adopting a method and sample that was informed and derived from previous comparable studies (Shenton, 2004; Thomson, 2011), familiarisation with the culture of the participants before the data collection commenced, thereby increasing the 'prolonged engagement' with the participants (Lincoln and Guba, 1985; Shenton, 2004), and triangulation of data sources (Fetterman, 2010; Silverman, 2013; Walsh, 1998).

Transferability of the research to other ICU's and clinical practice was addressed by ensuring sufficient contextual information regarding the fieldwork site and study methodology had been given, enabling the reader to make accurate inferences to their own situation (Firestone, 1993; Lincoln and Guba, 1985). Thus, determining transferability to the wider research and clinical communities resides with the reader to assess if they could confidently transfer the results and conclusions of the research to other situations (Shenton, 2004).

## 3. Findings

### 3.1. Overview

Findings from this study describe how morbidly obese patients were cared for during a period of critical illness where social interactions that took place during care were socially challenging for staff. Social awkwardness was evident in the observations of practice and in what staff reported during interviews. It was particularly noticeable during periods of field observation that staff experienced social awkwardness through displaying signs of discomfort and anxiety when interacting with morbidly obese patients and morbidly obese staff. Social awkwardness resulted from pre-existing social attitudes about obesity and how these might be displayed and managed within the professional caring role. These study findings are explored through the three developed themes of 'social awkwardness', 'managing social awkwardness' and 'mutual pretence'.

### 3.2. Social awkwardness

Social awkwardness was observed to occur when staff interacted with morbidly obese patients in the clinical environment and with morbidly obese staff within staff only spaces such as the staff room, offices and seminar room. Staff were consciously aware of the awkwardness that existed between them and the morbidly obese patient during the act of providing care: "*We do tread on eggshells about everything*" (Phillippe-nurse, interview), "*society has made us treat them* [morbidly obese people/patients] *differently*" (Milly-nurse, interview).

Awkward situations caused staff to feel uncertain and uneasy about how obesity could be spoken about, and acknowledged, in the presence of morbidly obese patients: "*I don't think I would really be comfortable talking to a patient about their weight... I would really struggle to have that conversation with a patient*" (Cathryn-nurse, interview)..."*we battle with our own feelings about the fact that we're not comfortable*" (Ruth-nurse, interview). This awkwardness resulted from the awareness of social tensions surrounding obesity and speaking about obesity where personal prejudices could be exposed: "*I don't want them to think that I've got some prejudice against them that's going to influence my care*" (Glenda-nurse, interview), the concern of being associated with mainstream societal views: "*We're part of society. We're not above it*" (John-doctor, interview),..."[the] *hospital's a reflection of society*" (Bob-nurse, interview), and acknowledging the patient's own sensitivities about obesity: "*people assume that the patient will have a degree of sensitivity about the word* [obese] *or about themselves being overweight*" (Rebecca-nurse, interview)..."*They're very embarrassed of their size so you don't really want to accentuate that*" (Helen-nurse, interview).

### 3.3. Managing social awkwardness with patients

Staff were observed to engage in different strategies to alleviate their feelings of discomfort and to prevent any unnecessary embarrassment and distress for the patient. During clinical bedside handovers, many nurses consciously chose to ignore the patient's weight or to not directly disclose information related to the patient's obesity: "*If you're at the bed space and can see the patient it's pretty self-explanatory*" (Jane-nurse, interview). Alternatively, staff engaged in a culture of communicating in undertones: "*We sort of might whisper and go 'they're rather large'...*[I] *don't want to be saying things out loud even if they're sedated*" (Jackie-nurse, interview).

When it was necessary to discuss the patient's obesity in the patient's presence staff used euphemisms, secret codes and gestures: "*We have all those codes* [euphemisms] *don't we for obesity or high BMI or bariatric*" (David-doctor, interview), and non-verbal gestures: "*With a wake patient I'd get the ICU admission note where they list the past medical history... I'd be pointing at it* [morbidly obese] *without saying anything*" (Ella-nurse, interview). This practice was observed regularly: *During the bedside hand over of Emiri, Hayley had read off the ICU admission notes. As she read the report Hayley paused when she got to the list of co-morbidities and carefully selected some to verbally mention. At the same time she tapped the words 'increased BMI' with her index finger. Ella nodded in acknowledgement and Hayley moved on with the rest of the handover* (Emiri-patient, field notes). This type of behaviour of subtly drawing attention to the patient's obesity was observed in the care of other obese patients.

### 3.4. Managing social awkwardness amongst staff

In the ICU culture, one aspect of social awkwardness in the data was how the body size of the staff member influenced interactions with others when talking about the care of morbidly obese patients. Social awkwardness was observed to be present in the staff room when staff of different sizes were engaged in conversations about morbidly obese patients. There was often no apparent social rule of how to behave or proceed with the conversation which often increased the awkwardness present. Consequently, morbidly obese staff often felt uneasy about the situation: "*Sometimes people look at me and they will be quite quiet. Other times people would just look at me and expect me to join in. It's very uncomfortable*" (Rita-nurse, interview).

Morbidly obese staff responded in different ways to the social awkwardness that was present when other staff discussed morbidly obese patients. One strategy morbidly obese staff used to manage social awkwardness between staff was through directly addressing the issue of their own obesity by making jokes about themselves "*I'm actually bigger than them so what does that make me?*" (Shirley-nurse, interview). Observations of this behaviour by morbidly obese staff was common: *Rose, a nurse would often say 'I have to be careful of my rolls, it's taken me years to perfect these'* (Fieldnotes). This approach was observed on numerous occasions and appeared to redress the interpersonal tensions present and restore social unity amongst the ICU staff. Alternatively, morbidly obese staff chose not to take any notice of the conversations of other staff members: "*I think that, they've probably got some issues*

*as well and I tend just to step back and just ignore it*" (Julian-doctor, interview).

Likewise 'normal' weight staff were aware of the awkwardness of discussing morbidly obese patients in the present of morbidly obese staff in the staff room and were conscious of the language they used: "*I'm aware that several of the staff are actually very sensitive about their weight and I'm trying not to use these phrases* [derogative words] *in their earshot*" (David-doctor, interview).

During a clinical intervention, in order to alleviate social awkwardness between staff, 'normal' weight staff changed their behaviours if a morbidly obese staff member was present: "*When we are turning a big person, and there's other nurses helping me who are really big that's when I really feel uncomfortable and you know really want to watch what I'm saying*" (Stella-nurse, interview).

### 3.5. Mutual pretence

A specific strategy used by both staff and morbidly obese patients to manage the social awkwardness surrounding care was mutual pretence. In the context of this study mutual pretence was conceptualised as an awareness of the fact that everyone knew the patient was morbidly obese, including the patient: "*They know that you know that they are overweight*" (Sophie-nurse, interview), but direct communication about their obesity was avoided: "*No one wants to talk about the elephant in the room. There's something huge happening but no one wants to talk about it*" (Vicki-nurse, interview),. . ."*You're all faced with an obese patient but no one wants to say but this patient's obese*" (John-doctor, interview). By not acknowledging the patient's obesity, staff entered into a pretence that the patient's obesity did not exist. Consequently, everyone acted to maintain the illusion that the patient was not morbidly obese and that they fitted comfortably within the space of the ICU. This mutual pretence meant that staff could avoid conversations about obesity, which might expose staff prejudice or the patients' own embarrassment and insecurities about their bodies.

During this pretence staff pretended not to notice the patient was morbidly obese: "*I don't acknowledge to the patient that they're obese*" (Stella-nurse, interview), or that they were difficult to move around the bed or into a chair: "*I would not say the reason we can't move you is because you're obese I would say because you're really sick we need more of us to move you*" (Bob-nurse, interview). On the many occasions when morbidly obese patients did not fit into the equipment properly neither staff or patient acknowledged this fact and both continued on as if nothing was amiss (Fieldnotes).

If the patient did mention their weight or size, staff responded by pretending not to hear the comment, minimalised their weight issue by suggesting they weren't that big, or re-directed conversations to other topics: "*if someone goes 'oh I'm fat', you go 'oh no you're not'. . .you don't want to say that they're fat*" (Kate-nurse, interview). . ."*I work harder to act like it's all normal*" (Stella-nurse, interview). . ."*I would probably try and minimise it* [the conversation]. *I don't want to deal with it*" (Stella-nurse, interview). By engaging in these strategies staff attempted to re-establish the pretence.

The delicate balancing act of pretence between the staff and patient was always being threatened by the negative attitudes of staff about morbidly obese patients. When under intense physical strain or pressure during care provision, this pretence failed and negative feelings and behaviours seeped into the clinical spaces of the unit with retaliations to patients about being obese: "*They'd certainly know in my tone if I was frustrated if I felt that the attitude was unhelpful and if I felt they could be helping and weren't*" (Sophie-nurse, interview), and inappropriate comments and jokes made about their obesity: "*If you're struggling to hold a patient because they're so big and heavy you're going to make a joke about it*" (Shirley-nurse, interview).

Mostly this seepage of negative feelings was observed to occur in the clinical areas that were not involved in direct patient care such as the nursing station, drug room, and computer spaces (Fieldnotes). Incidents involved joking on the telephone or making a joke about a patient who was at the other end of unit, or discussing the prospect of a new patient being admitted: "*If I take a referral from another hospital. . .often both doctors will laugh in a very dark way about somebody being obese. . . We're very happy to say oh you know the 'big unit' and make a sort of judgement on it*" (David-doctor, interview). In these instances these expressions of negative attitudes were not directed at the morbidly obese patient.

## 4. Discussion

Social awkwardness for ICU staff was a significant issue in the management of morbidly obese patients. Findings from this study have provided insight into the face-work and mutual pretence performances of ICU staff when managing embarrassment experienced by staff and morbidly obese patients. Face-work describes a theory of ritual interaction in human-to-human encounters whereby individuals interpret and act accordingly to maintain the face of self and other (Goffman, 1967). Primarily, the purpose of face-work is to manage the impressions, or face, of both self and other. Social awkwardness was managed by ICU staff through specific types of face-work to address potential issues of embarrassment, humiliation or shame.

Avoidant face-work action was one strategy that assisted in preventing a threat to 'face' occurring and included avoidance of conversations related to the patient's obesity either during staff handovers in the patient's presence or directly with the morbidly obese patient. These avoidance face-work acts align themselves with the principles of Goffman's (1967) avoidance processes. However, unlike Goffman's (1967) avoidance strategies, which were instigated by the individual with the potential threat to 'face' (the morbidly obese patient), these strategies were employed by the other person (staff member) to prevent the threat to the 'face' of the patient.

These types of avoidance behaviours shared similarities with those exhibited during interactions between health-care professionals and patients with other socially stigmatised 'conditions' for example, dying patients

(Butow et al., 2008; Tay et al., 2011; Wilkinson, 1991). In the above studies, healthcare professionals used blocking or inhibiting behaviours, such as making normalising or stereotyped comments, changing the topic, ignoring or being selective about addressing patient cues and jollying along the patient. These actions allowed staff to be able to distance themselves from uncomfortable and emotionally loaded areas of conversation by preventing patients from discussing their problems, worries and emotional concerns. The reasons for these behaviours were often related to personal fears of dying (Wilkinson, 1991), being overly task-orientated (Tay et al., 2011; Wilkinson, 1991), having negative attitudes (Tay et al., 2011), and providing care that was perfunctionary (Tay et al., 2011). In contrast, staff caring for morbidly obese patients in ICU used avoidance or blocking behaviours due to the fear of upsetting or offending the patient, or unintentionally revealing personal prejudicial attitudes.

The use of secrets codes, such as euphemisms, indirect speech, and non-verbal gestures were used as face-saving acts during staff-to-staff conversations about a patient's obesity when in the presence of morbidly obese patients. These types of communication tactics have been identified in other health studies where sensitive topics of conversation were broached (Brown and Thompson, 2007; Costello, 2001; Main, 2002; Zuzelo and Seminara, 2006).

Many of the communication tactics used by ICU staff resembled behaviours exhibited by primary care nurses when specifically discussing weight management with clients (Brown and Thompson, 2007). These strategies included softening the terms used to describe obesity, generally avoiding the term 'obesity' due to its negative connotation, avoiding directness by talking around the related issues, avoiding stereotypes and/or overly simplistic explanations (Brown and Thompson, 2007). Additionally, morbidly obese nurses used self-disclosure as a way of lessening the awkwardness of conversations. Likewise, Zuzelo and Seminara (2006) reported that nurses carefully monitored their facial expressions and body language during care situations so as to present a professional demeanour of being respectful, cordial and non-prejudice. Despite the different contexts of whether obesity was central or peripheral to the conversation, communication tactics were similar across studies, where the main emphasis was on preventing unnecessary loss of 'face' for the patient which would result in embarrassment or hurt.

Euphemisms within nursing and medicine have been used routinely as polite ways of referring to taboo subjects (Costello, 2001; Main, 2002), stigmatising conditions (Collier, 2010), and discussing altered bodily functions (Wald, 2007). In most cases, euphemisms have been used to conceal uncomfortable feelings felt by staff (Main, 2002), to disguise non-disclosed patient information (Costello, 2001), and prevent patient and staff feelings of discomfort or embarrassment (Wald, 2007). In both ICU and Costello's (2001) work, euphemisms were used to communicate between healthcare teams in the presence of patients however, their use within conversations served different purposes. Costello (2001) identified that euphemisms allowed staff to continue having conversations regarding non-disclosed information whereas, ICU staff used euphemisms as a way to save 'face' by lessening the harshness of the communication to which the patient could hear.

Likewise, indirect speech, an example of a secret code, was used during conversations between ICU staff in the presence of morbidly obese patients as a way to share information that was only intended for the other staff member to understand. Indirect speech has been defined as a type of communication which allowed a speaker to say something that he does not literally mean but the hearer interprets it as it was intended (Pinker, 2009). The purpose of indirect speech was to prevent embarrassment, avoid awkwardness, save 'face' and reduce tension (Pinker, 2009). Although the indirect speech used by ICU staff adhered to the definition described by Pinker (2009), it differed from much of the literature on its use as a form of face-saving.

The sensitivities surrounding fatness during interactions between staff and morbidly obese patients have had minimal exploration in nursing studies. An exception to this is the work of Brown and Thompson (2007) who identified that awareness of fat stigma and the psychological and physical impacts of obesity caused social awkwardness during nurse-patient consultations. The degree of nursing staff awkwardness was affected by the primary purpose of the consultation, the perception that it was difficult to achieve change or help the patient lose weight, and how the trusting relationship was negotiated (Brown and Thompson, 2007). The size of the nurse affected the degree of social awkwardness, with slim nurses expressing particular awkwardness and concern about not appearing empathetic to patients.

In any socially awkward interaction, non-stigmatised people experience anxiety resultant from uncertainty and self-consciousness when interacting with stigmatised people. In Hebl et al.'s (2000) work, the impact of such anxiety on verbal and non-verbal responses was detailed. Non-stigmatised individuals were unsure of how to act or what to say to stigmatised people. This anxiety, or hesitant disjointed behaviour, was observed in the way ICU staff restricted their bedside language, used euphemisms and engaged in secret non-verbal gestures when interacting with morbidly obese patients. Therefore, the ICU staff, attempted to suppress all verbalisations concerning stigma by avoiding topics of conversation related to obesity.

Managing socially awkward moments during care situations was identified as a fundamental component of maintaining or re-establishing positive social interactions between staff and morbidly obese patients in ICU. The strategies adopted to prevent or resolve awkwardness shared similarities with those described by Clegg (2012) of avoidant or direct behaviours. Avoidant behaviours blocked direct communication about the indiscretion that occurred or involved distancing behaviours that negated future encounters. Whilst strategies of avoidant behaviours, such as eluding conversations about obesity or pretending not to notice the patient was morbidly obese were employed by ICU staff to resolve social awkwardness, these were further used as a means to prevent awkward situations from occurring in the first instance. Behaviour

changes of this nature only served to reinforce the feelings of social awkwardness and extend the social tensions into future encounters.

Mutual pretence was observed as one strategy to manage social awkwardness. It was present in many of the interactions where the awareness of fat stigma influenced and affected the interactions between staff and morbidly obese patients. In ICU, mutual pretence was a modification of open awareness, because both staff and the morbidly obese patient were fully aware of the patient's obesity but pretended not to be. This awareness context occurred in situations where the morbidly obese patient concurred with the pretence of ICU staff, who were pretending the patient was not morbidly obese. Neither persons' acknowledged or mentioned anything to do with obesity. This way of interacting with each other was mutually beneficial for saving the 'face' of both staff and patient by helping to alleviate embarrassment or shame in certain care situations. For example, when a patient did not fit easily into care equipment neither staff or patient acknowledged this fact and both continued on as if nothing was amiss. This act of not noticing the threat to the morbidly obese patient's 'face', Goffman (1967) referred to as "tactful blindness" (p. 18). However, on occasion, the staff pretence that the patient was not morbidly obese was challenged by the morbidly obese patient through direct conversations about their obesity in an attempt to achieve an open awareness context. In this situation, ICU staff encountered a threat to 'face', as their 'line' of pretence was challenged.

What differentiates this study from the original understandings of knowledge management in the awareness context of dying (Glaser and Strauss, 1965) was visibility and the type of knowledge that required management. The visibility of obesity meant that there was no closed or suspicion awareness context as everyone could see the patient was morbidly obese and the patient knew he/she was morbidly obese. Secondly, the management of knowledge was not about whether someone was aware they were morbidly obese but instead about the management of fat stigma during interactions, specifically 'enacted' stigma by ICU staff, or 'perceived' stigma felt by morbidly obese patients.

In raising awareness of social awkwardness during care of morbidly obese patients in intensive care, this study draws attention to current behaviour and practices. It is clear that more work needs to be undertaken to move towards more socially acceptable forms of interaction and language, concerning morbidly obese patients. This will enable more open communication that is acceptable, meaningful, and respectful to patients and to others in the clinical team when addressing care issues.

## 5. Study limitations

Both a strength and a limitation of this study was the intention to only understand the 'situated' experiences of the ICU staff as they engaging in the care of critically ill morbidly obese patients. The strength of this approach meant that issues pertinent to the staff in the delivery of ICU services to morbidly obese patients became the primary focus of the research. The limitation was that only one perspective of the social interaction during care was recorded. If serial interviews had been conducted with morbidly obese ICU patients a greater understanding of social interaction could be elicited. A further limitation of this study was the use of one study site thereby limiting transferability of findings. By using one site, this ethnographic research offers depth rather than breadth of understanding in caring for critically ill morbidly obese patients.

## 6. Conclusion

Caring for critically ill morbidly obese patients can be socially challenging for health care staff. The awareness of the social stigma that surrounds obesity can create anxiety and social awkwardness for healthcare staff and patients during care practices.

This study has demonstrated new and important ways of understanding how social interactions and aspects of care, involving this socially stigmatised population were managed to alleviate the social awkwardness present. It extends the understanding of social awkwardness through its application to healthcare settings, and by describing situations in which awkwardness occurred, and how it was managed in the context of obesity and care practices in intensive care. The management of social awkwardness for staff during care was a significant issue raised in this study.

Healthcare organisations need to acknowledge and be responsive to the burden of social awkwardness that exists in providing care to morbidly obese patients. This could be achieved by addressing the anxiety and discomfort for staff, and developing an infrastructure that better equips staff to manage this patient population. This would require senior clinical staff to take leading roles in monitoring for social tension during care for this patient population. Strategies such as use of specific professional development initiatives raising awareness of social awkwardness, and developing skills to hold more open discussions with patients and staff about morbid obesity need to be developed.

The existing stigma attached to morbidly obese patients within the healthcare setting needs to be addressed. Health care professionals need to consciously challenge personally held views and professional practices to influence care delivery that impacts on health care services for morbidly obese patients. Greater education and training that specifically addresses issues of fat stigma and that focuses on stigma reduction interventions require development.

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