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Obesity, stigma, and responsibility in health care: A synthesis of qualitative studies

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Abstract

Objective: To synthesize research findings on experiences and attitudes about obesity and stigma in health care.
Methods: We compiled qualitative studies and applied Noblitt & Hare's meta ethnography to identify, translate, and summarize across studies. Thirteen qualitative studies on experiences and attitudes about obesity and stigma in health care settings were identified and included.
Results: The study reveals how stigmatizing attitudes are enacted by health care providers and perceived by patients with obesity. Second-order analysis demonstrated that apparently appropriate advice can be perceived as patronizing by patients with obesity. Furthermore, health care providers indicate that abnormal bodies cannot be incorporated in the medical systems—exclusion of patients with obesity consequently happens. Finally, customary standards for interpersonal respect are legitimately surpassed, and patients with obesity experience contempt as if deserved. Third-order analysis revealed conflicting views between providers and patients with obesity on responsibility, whereas internalized stigma made patients vulnerable for accepting a negative attribution. A theoretical elaboration relates the issues of stigma with those of responsibility.
Conclusion: Contradictory views on patients' responsibility, efforts, knowledge, and motivation merge to internalization of stigma, thereby obstructing healthy coping and collaboration and creating negative contexts for empowerment, self-efficacy, and weight management. Professionals need to develop their awareness for potentially stigmatizing attitudes towards vulnerable patient populations.

Key words: *Obesity, prejudice, health personnel, qualitative research, meta-analysis*

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Average population weight will increase worldwide, and negative health consequences of obesity are well documented (WHO, 2000). Causal explanations are complex (Malterud & Tonstad, 2009), focusing sedentary work, access to food, fast food, and large portions. Who has the ultimate responsibility to change these trends—policymakers, health professionals, or the individual overweight person is debated (Burris, 2008). Regardless of the pending liability conditions, health care providers encounter individuals with weight-related health problems. Obesity is a stigmatized condition with multiple forms of prejudice and discrimination in settings of employment, health care, education, interpersonal relationships, and the media (Puhl & Heuer, 2009). A recent review demonstrated that also health care providers endorse stereotypical assumptions about patients with obesity and attribute obesity to blame (Puhl & Heuer, 2009).

In clinical work, the motivation for lifestyle change for people with obesity is an important success criterion that can be influenced by the provider. Providers' attitudes, communication skills, and capacity for empathy are vital to meet the patient in a way that does not add stones to their burden (Pollak et al., 2007). Still, degrading attitudes and behaviour creating dignity violation are not always recognized by the person in power (Jacobson, 2009; Malterud, 2005; Malterud & Thesen, 2008, Puhl & Heuer, 2009).

Stigma—dynamic interaction

Stigma and prejudice involve exploitation and domination (keeping people down), norm enforcement (keeping people in), and disease avoidance (keeping people away) (Phelan, Link, & Dovidio, 2008).

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Interactive perspectives on s*tigmatization* include interpersonal and structural forms of prejudice and discrimination as well as internalizing attitudes, anticipating negative treatment by members of dominant groups (Stuber, Meyer, & Link, 2008). In this study, we aimed for empirical knowledge from qualitative studies, where the dynamic interaction of stigma processes, including power inequalities, could be taken into consideration (Malterud, 2010).

Stigma is "an attribute that is deeply discrediting", reducing a person "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 13). Goffman conceptualized stigma as "a special kind of relationship between an attribute and a stereotype", proposing three different types: (1) abominations of the body, (2) blemishes of individual character, and (3) tribal stigma of race, nation, and religion (Goffman, 1963, p. 12). Obesity can be included in the first as well as the second class of Goffman's stigma types. Body weight becomes a moral issue, indicating the strength of a person's self. Goffman described how stigma is expressed from others and as internalized perceptions.

However, stigma is more than the exchange of social power. Stigmatization is linked to the discrediting stereotypes mediated by the cultural discourse, and to the reception of oppressive messages by the affected individuals. The normative constraints that create stigma are determined by the interaction between historical conditions and power relations, revealing the complex factors that stigma is situated within.

Foucault's theories on mediation of disciplinary attitudes, often from experts, but also from public authorities, provide additional perspectives to understand stigma within a health care context (Foucault, 1988). Symbolic power is exercised subtly through discursive practices where some people hold the status of authority ascribed legitimate knowers. *Governmentality* denotes the way populations and individuals are designed by ideas and technologies, and the way such actions constitute the subjectivity of those affected (Foucault, 1988, pp. 16–63). The sources and decision lines of governmentality may be blurred, making the messages operate as inevitable facts or freedom of choice.

Objective

We set up a study to explore and synthesize qualitative research knowledge about potentially stigmatizing attitudes and experiences directed towards or perceived by patients with obesity in the health care context.

Method

Qualitative research methods provide access to human and social experience, talk, thoughts, expectations, meaning, attitudes, and processes (Malterud, 2001). These strategies offer a special opportunity to recognize and appraise personal attitudes, emotions, and behaviours that can enhance providers' responsiveness for weight problems (Malterud & Ulriksen, 2010; Ponterotto, 2010). For synthesis of qualitative studies, different methodologies have been presented. In this article, we applied *meta-ethnography*, a stepwise strategy for synthesizing findings across a number of qualitative studies (Noblit & Hare, 1988).

Search and selection of studies

This strategy includes the following steps: Getting started (*step 1*), we aimed to identify available research studies about *obesity* and *stigma* in the English language. We searched MEDLINE, ISI Web of Knowledge, EMBASE, CINAHL, PsycINFO, and AMED up to July 2009 with totally 667 hits. We then limited our search to *qualitative* studies about stigma experiences related to obesity in adults (*step 2*). We confined our focus further to *the health care context*, and finally conducted a negotiated quality assessment for the remaining 13 articles (inclusion criteria: empirical qualitative studies about stigma and obesity in adults in health care). Evaluation was guided by a checklist covering aim of the study, reflexivity, methods and design, data collection and sampling, theoretical framework, methods of analysis, results, discussion, and presentation (Malterud, 2001). All the 13 studies were accepted with sufficient quality for further analysis. Two of them were single case reports, with rich detailed first person accounts. The studies comprised data from totally 153 patients/relatives and 136 providers from three different countries. Information regarding the status of ethical approval for the primary studies was non-consistent, and we decided to trust the authors and editors on this point. Further details of study setting and participants are presented in Table I.

Procedures for analysis and synthesis

First-order analysis is what each of the authors of the primary studies had already conducted to develop their results. *Second-order analysis*, representing our synthesis of the results from the included articles, started by reading their results sections closely (*step 3*). Initially, we identified preliminary themes that became our point of departure for systematic second-order analysis: (1) Lifestyle advice experienced as humiliating, (2) segregation due to weight norms,

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Table I. Features of the 13 primary studies included in the analysis.

Source paper ($N=13$)	Country	Study design	Analysis method	Sample origins	Participants (N)	Age range (years)	First author's background
Brown et al. (2006)	UK	Individual interviews	Generic[a]	Obese patients, primary care	28	19–77	Nurse
Brown and Thompson (2007)	UK	Individual interviews	Generic	Nurses, primary care	15	28–57	Nurse
Diaz et al. (2007)	USA	Focus groups	Not specified	Obese adult Latinos	21	22–81	Unknown
Epstein and Ogden (2005)	UK	Individual interviews	Intepretative phenomenological analysis	GP primary care	21	30–60+	GP
Mercer and Tessier (2001)	UK	Individual interviews	Generic	GPs and practice nurses	10+10	<55	Unknown
Merrill and Grassley (2008)	USA	Individual interviews	Phenomenological approach	Obese patients, primary care	8	20–61	Nurse
Reed (2003)	USA	Single case autobiography	Narrative	Obese adult	1	Unknown	Patient
Robbins (2007)	USA	Single case history	Narrative	Nurse encountering obese woman giving birth	1	Unknown	Nurse
Rogge et al. (2004)	USA	Individual interviews	Phenomenology	Obese patients and family, employed in healthcare	18	24–57	Nurse
Thomas et al. (2008)	Australia	Individual interviews	Constant comparative method	Obese adults, recruited from newspaper	76	16–72	Unknown
Wear et al. (2006)	USA	Focus groups	Generic	Medical students	58	Unknown	Unknown
Whitfield and Grassley (2008)	USA	Individual interviews	Hermeneutic phenomenology	Nurses	12	20–59	Nurse
Wright (1998)	UK	Individual interviews	Generic	Nurses	10	Unknown	Nurse

GP, general practitioner.

[a]The term "generic" has been used when several different references to analysis method, or when procedures for analysis were described step by step in a more general sense.

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and (3) derogatory comments. Determining how the studies were related (*step 4*), we first sorted out which of the 13 articles contained empirical findings representing each of the three themes. The findings from one study might fit in more than one theme, for example, Rogge (Rogge, Greenwald, & Golden, 2004) provided data on lifestyle advice experienced as humiliation as well as derogatory comments. Yet, every primary study did not feed into all the three themes. Items referring to each of the preliminary themes were sorted into a grid with studies listed horizontally and the *content issues* (essential findings and interpretations) vertically. Table II presents an example of how second-order analysis for the first of the three themes was organized, with nine of the 13 articles providing findings of relevance.

As a starting point for further inductive elaboration of each theme, we chose an *index study* characterized by high methodological quality (Malterud, 2001), rich data, and systematic presentation (Brown, Thompson, Tod, & Jones, 2006; Merrill & Grassley, 2008; Rogge et al., 2004).We then translated the studies within each theme into each other (*step 5*), processing content issues from each study, organizing related issues in the same horizontal rows, while trying to preserve the terminology used by the primary author.

After organizing content issues of each study vertically and relating them to each other horizontally, we synthesized the issues from the same row by translation into a common concept (*step 6*). This reconceptualization was achieved by *reciprocal translation* (Noblit & Hare, 1988). Synthesis of interpretations, grounded in convergent findings from the primary studies, was used for the final conceptual elaboration of the three themes, representing the outcome of the *second-order analysis* (Table III). Translation was conducted in editing-analysis style, where theories about stigma as dynamic interaction, mediated by governmentality, were supportive for our reading, although not pre-defining categories (Miller & Crabtree, 1999).

Concepts were also explored for divergent findings across studies, according to *refutational translation* where oppositional accounts are focused (Noblit & Hare, 1988). Reviewing the findings from the second-order analysis, we then conducted *a third-order analysis,* summarizing and condensing apparently contradictive findings (Table III) (Britten et al., 2002).

Results

Second-order analysis

Below, we first present the synthesis from the second-order analysis with reciprocal translation of main findings from the different primary studies for each of the three themes (*step 7*). These findings will be elaborated later, illustrated by selected quotations from primary studies. Subtitles represent the condensed meaning of each category.

Apparently appropriate advice, perhaps well intended—yet perceived as patronizing. Results from the included primary studies presented a broad range of accounts about seemingly adequate attitudes and recommendations from doctors and nurses regarding obesity and health (Brown & Thompson, 2007; Brown et al., 2006; Diaz, Mainous, & Pope, 2007; Epstein & Ogden, 2005; Merrill & Grassley, 2008; Reed, 2003; Rogge et al., 2004; Thomas, Hyde, Karunaratne, Kausman, & Komesaroff, 2008; Wright, 1998). Female nurses expressed a strongly held belief that fat is unhealthy, particularly in relation to coronary heart disease, so that they felt they ought to persuade women to lose unhealthy fat (Wright, 1998). For this purpose, they would suggest exercise and dietary adjustments, yet they expressed various levels of discomfort related to counselling on such a sensitive topic (Brown & Thompson, 2007; Wright, 1998). Primary care nurses tried to steer a balanced course between factors of personal responsibility and factors beyond the control of the individual, while declaring that they took care to avoid stereotypes or overtly simplistic explanations (Brown & Thompson, 2007). Strategies presented by doctors included maintaining a good relationship with the patients, trying to locate the weight problem in the broader context of their lives, despite not having a solution, and offering an understanding of the problems associated with obesity (Epstein & Ogden, 2005). Yet, there were several examples of descriptions where patients' efforts were presented in degrading terms. A British general practitioner (GP) said about one of his patients:

> She is a woman who has had a sort of fairly appalling diet, clueless really about . . . what a calorie is . . . . (Epstein & Ogden, 2005)

Patients, on the other hand, described their ongoing persistence of trying to control or lose weight, in general from their early teens (Thomas et al., 2008). From numerous experiences of unsuccessful dieting, they felt defeated by their weight and their failed attempts to control it, yet they refused to give up (Merrill & Grassley, 2008). They blamed themselves for being unable to stick to or continue with a weight loss plan, rather than the diet (Thomas et al., 2008).

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Table II. Example of grid for reciprocal translation: content issues from the primary articles about life style advice perceived as humiliating.

Brown et al. (2006)	Rogge et al. (2004)	Merrill and Grassley (2008)	Wright (1998)	Brown and Thompson (2007)	Thomas et al. (2008)	Reed (2003)	Diaz et al. (2007)	Epstein and Ogden (2005)	**Our translation**	**Stigma pattern**
(1) Your weight is a problem. (2) Minimal support was offered along with practical advice	It ought to be easy to lose 20 pounds before the operation	Well, you just have to stop eating	Fat is unhealthy and poses serious risks, go home and lose weight before surgery			Just drink more water and push yourself away from the table			Well, you just have to stop eating	Apparently proper advice, probably well-intended—yet perceived as patronizing
(1) Strong sense of personal responsibility. (2) Imagine the worst must be thought about them	(1) Obese people agree with the construction of obesity as their own fault. (2) Assume obesity is due to overindulgence and eating out. (3) The doctor will not be thrilled to hear that I have gained	Persistence of trying to control or lose weight		The importance of personal lifestyles	All participants had attempted to lose weight numerous times in their lives		Familiarity with weight loss methods and failed weight loss attempts	(1) A problem that had been caused and should be managed by the patients themselves, (2) Patients can be in denial, reluctant to accept responsibility, want the doctor to take ownership	The personal responsibility of obesity	
They are putting everything down to your weight		Having their weight addressed instead of the health problem							Attributing any problem to body weight	

Table III. Synthesis (second- and third-order analysis).

Themes	Second-order analysis		Third-order analysis
Lifestyle advice experienced as humiliating	Well, you just have to stop eating The personal responsibility of obesity Attributing any problem to body weight	Apparently appropriate advice, perhaps well intended—yet perceived as patronizing	Responsibility and blame: ● Providers think patients do not recognize the nature of the problem ● Patients express a strong sense of personal responsibility
Segregation due to weight norms	Why bother me with your extra kilos? Struggling to fit in—you do not belong here	Abnormal bodies cannot be incorporated in the medical systems—exclusion consequently happens	Stigma—internalized contempt: ● Subtle derogatory comments from providers ● Vulnerability and experience creating negative expectations in patients
Derogatory comments	Disdain for the unattractive obese body Bad people who deserve reprimands	Customary standards for interpersonal respect are legitimately surpassed—contempt as if deserved	

Participants in the studies included in our analysis presented different examples of communication perceived as insensitive, which had hardly been helpful (Brown et al., 2006). Providers who repeatedly pointed out that the patient's weight was a problem, without providing practical advice and support, might raise awareness but little more (Brown et al., 2006; Wright, 1998). Patients also complained that providers attributed any problem to their weight, without checking the associations (Brown et al., 2006; Merrill & Grassley, 2008). Addressing the problem as if there was a simple solution that had not occurred to the patient was experienced as humiliating (Merrill & Grassley, 2008; Reed, 2003; Rogge et al., 2004; Wright, 1998). A large US woman, considering bariatric surgery, refers the recommendations her GP gave her, where she should

> . . . just drink more water and push myself away from the Table I would think to myself, wow; if only I had thought of that before! (Reed, 2003)

Abnormal bodies cannot be incorporated in the medical systems—exclusion consequently happens. Patients who approach health care with a large body run the risk of being dismissed as inappropriate individuals within the standard physical and cultural framework (Brown & Thompson, 2007; Mercer & Tessier, 2001; Merrill & Grassley, 2008; Reed, 2003; Robbins, 2007; Thomas et al., 2008; Wear, Aultman, Varley, & Zarconi, 2006; Wright, 1998). They said it was a battle to fit into the world of health care (Merrill & Grassley, 2008) and described how physical obstructions would exclude their access to services, where normal body weight determines the sizes of equipment (chairs in the waiting room, blood pressure cuffs, epidural needles) (Merrill & Grassley, 2008; Robbins, 2007). A nurse caring for Trudy (203 kg), arriving at hospital in labour, reported that the anaesthesiologists had trouble placing epidural, and they need a longer needle:

> . . . which they have me rummage through their cart for, no such needle exists. (Robbins, 2007)

More subtle are patients' encounters of frustrated and unrewarding attitudes among nurses and doctors who felt that weight management was an inappropriate use of their time, "off-loading" patients with obesity further down in the system (Mercer & Tessier, 2001). Health care providers seem to be more enthusiastic about obesity management in the context of associated diseases, with negativity and ambiguity about managing obesity alone. Nurses express obvious discomfort when

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advising on weight control behaviours, especially when they act as intermediaries between patients and doctors (Wright, 1998). They feel awkward when they introduce such a sensitive issue, taking care to avoid stereotypes and maintain good rapport (Brown & Thompson, 2007).

Customary standards for interpersonal respect are legitimately surpassed—contempt as if deserved. Analysis demonstrated performances of disdain, blame, and stereotyping of patients with obesity among health care providers (Brown & Thompson, 2007; Robbins, 2007; Rogge et al., 2004; Thomas et al., 2008; Wear et al., 2006; Whitfield & Grassley, 2008; Wright, 1998). An interview study indicated that nurses with a high BMI would be more critical and judgmental about people with obesity, possibly because they were critical of themselves (Brown & Thompson, 2007). Attitudes towards obesity in male doctors as observed by female nurses indicated that women patients were much more likely to be censured for being overweight than men, and negative comments on patients' size were regularly being made (Wright, 1998).

In a study about derogatory and cynical humour among medical students, patients with obesity were the most common target (Wear et al., 2006). Secret codes were described to regulate acceptable vs. unacceptable circumstances for expressing derogatory and cynical humour in clinical settings, with violations of dignity towards patients with obesity justified by blame. One of the students stated this simple formula:

> If it's their own fault for getting into that situation, then you can make fun of them. If someone is walking down the street and gets hit by a car, then you'd NEVER make fun of him. (Wear et al., 2006)

Third-order analysis

The findings from the second-order analysis provided foundation for a third-order analysis. Drawing on refutational translation (Noblit & Hare, 1988), our focus was directed towards apparently opposing information revealed by second-order analysis, especially regarding the role of responsibility, and the consequences of this opposition on stigma interaction. In the following, we elaborate these findings.

General practitioners felt that obesity was ultimately a problem that had both been caused and should also be managed by the patient themselves, although patients are in denial and reluctant to accept responsibility for their problems (Epstein & Ogden, 2005). They said that patients do not recognize the nature of the problem, and rather want the doctor to take ownership. A British doctor referred to one of his patients:

> He was looking to what I was going to do about his weight rather than what he was going to have to do about it. (Epstein & Ogden, 2005)

Nevertheless, patients with obesity expressed a strong sense of personal responsibility (Brown et al., 2006), agreeing with the attribution of obesity as their own fault (Rogge et al., 2004). Adding to the feeling of blame was the fact that few of them had been able to comply with recommendations on exercise, referring to a number of reasonable obstructions (Thomas et al., 2008). Patients expressed familiarity with a broad range of established weight loss strategies, yet stated that they felt like they were a "failure" (Diaz et al., 2007; Thomas et al., 2008). Repeated disappointments regarding enduring weight loss were not due to lack of knowledge. A US large woman stated:

> I have done what I have done ... The blame has to come on my shoulders. When it comes down to it, it's me. (Rogge et al., 2004)

One of the studies demonstrated how interaction around obesity in health care seems to be complicated by the stigmatized nature and the high visibility of the condition (Brown et al., 2006). Another study described the experience of patients with obesity seeking health care as a constant struggle (Merrill & Grassley, 2008).

Synthesis revealed how stigma-related cognitions occur among patients with obesity, who present a general expectation of negative stereotypes in social interactions (Brown et al., 2006). This vulnerability is fuelled from internal thought processes, and confirmed by experiences (Merrill & Grassley, 2008). Patients refer to humiliating comments from doctors, telling them that their bodies are unattractive due to obesity (Rogge et al., 2004; Thomas et al., 2008). They describe how they feel dismissed by professionals—from not being believed to receiving no treatment for their additional health problems (Merrill & Grassley, 2008).

Theoretical elaboration of findings

Our analysis reveals some subtle mechanisms through which stigmatizing interaction is initiated by providers and internalized by patients, mediated by responsibility. *Apparently appropriate and undeniable advice* is presented to the patient as matters of fact, without

checking with the patients whether the actual strategies have been tried before, or why they eventually did not work. Providers seem to equate lack of goal achievements with lack of motivation and knowledge. They seem to underestimate the history and efforts of the patients (Bleich, Huizinga, Beach, & Cooper, 2010), maybe because they consider it difficult to feel empathy for a patient with obesity (Magliocca, Jabero, Alto, & Magliocca, 2005). The message from provider to patient may be factually correct, yet dimly degrading when the implicit assumption is that the patient does not know or has not tried. The sources and decision lines of governmentality may be blurred, making the messages operate as inevitable facts or freedom of choice. Yet, the normative dimensions are powerful, leaving people who do not comply with shame and blame, as clearly demonstrated by our meta-analysis.

Furthermore, the aggregate impact of dismissal experienced by patients with obesity due to *material and spatial norms* in the health care system is highlighted. They simply do not fit in and should, therefore, stay out, so that frustrated providers do not waste their time on problems they are not motivated to manage (Bleich, Pickett-Blakely, & Cooper, 2011). Our findings emphasize problems arising from the conflicting views regarding patients' perceived *responsibility* for weight management as assessed by health care providers and patients. Both of them associate unsuccessful goal achievement with blame. However, patients commented explicitly that providers' assumptions of their lack of motivation and investment add to the cultural burden where insufficient levels of responsibility are associated with blame. Patients with obesity are held accountable not only for their body weight but also for their attributed lack of responsibility by investment on change.

Discussion

Appropriate professional advice may be perceived by patients with obesity as patronizing, they perceive themselves as not fitting into health care and are excluded as abnormal, and they risk blunt contempt that is legitimized as deserved. Internalized stigma fuels are the notion of lack of responsibility, mediating blame, and shame. In the following, we discuss the strengths and limitations of the study design and the impact of these findings.

Methodological challenges

The transferability of qualitative studies including meta-ethnographies is determined by the range of empirical variation within the sample, the recognizability of the context and interpretations, and the utility of the findings in contexts beyond the study environment (Malterud, 2001). The number of cases is less important for external validity than saturation of data required to provide sufficiently thick descriptions of the phenomena under study, and the sample should be purposive rather than exhaustive. Our analysis, based on results from 13 primary studies (of these two single case first person accounts), comprises a broad range of empirical data from totally 269 individuals from the UK, Scotland, the USA, Australia, and New Zealand. Among the patients and their relatives, different ages are represented. Women constituted the majority, leaving conclusions about men more uncertain. Among the health care professionals in the sample, we find GPs, practice nurses, anaesthesiologists, surgical hospital nurses, gynaecologists, obstetricians, chiropractic doctors, internists, bariatric and orthopaedic surgeons, and medical students. In the second-order analysis, we have deliberately combined studies representing patients and providers, respectively, and in the third-order analysis, we are taking advantage of these mixed perspectives by being able to focus the contradictions between apparently similar issues.

Although we applied extensive systematic search as well as manual follow-up search, additional articles may appear, providing supplementary perspectives. We do not believe our sample is complete, including any study ever presented within this area. Nevertheless, considering the rich outcome of analysis presented earlier, we conclude that our sample has provided sufficient saturation of data for a meta-ethnography on our research question.

Some validity limitations related to the sample and the perspectives of available studies should be noticed. First, none of the primary studies are observational studies, representing what actually happened in a concrete event of interaction. Our empirical data represent participants' perceptions and interpretations rather that their actions. Nevertheless, some accounts are pretty detailed, allowing the reader to imagine how the event was experienced.

The purpose of qualitative analysis is to extend the level of interpretation, not to test prevailing conclusions (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005; Malterud, 2001). Compiling qualitative studies will usually result in a diversity of designs where data and study objectives are not sufficiently comparable for a similar strategy. As demonstrated in our study, the different approaches will usually add to the variation of findings. However, a consequence of this methodological challenge is that findings from primary articles, and not data, are taken as the point of departure for synthesis

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(Dixon-Woods et al., 2005). Our study presented challenges especially due to the mixed samples (comprising obese patients, nurses, medical students, and family members). Although a variety of perspectives was included, the strength of each perspective could certainly be discussed. We chose to balance this heterogeneity by following a detailed and transparent procedure for analysis—meta-ethnography (Noblit & Hare, 1988).

What is known —what does our study add?

Our synthesis has presented different formats for enactment and perception of obesity stigma within health care. Patients' accounts of stigmatizing events (Merrill & Grassley, 2008; Reed, 2003; Robbins, 2007; Rogge et al., 2004; Thomas et al., 2008) correspond well with attitudes presented by providers in the studies included in our analysis (Epstein & Ogden, 2005; Mercer & Tessier, 2001; Wear et al., 2006; Wright, 1998).

We are not the first to demonstrate that individuals with obesity experience weight-related stigma when seeking health care. An updated review presents studies on obesity stigma from employment settings, educational settings, health care settings, interpersonal relationships, and media (Puhl & Heuer, 2009). Even providers specializing on weight problems present stigmatizing and stereotyping attitudes towards people with obesity (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). Our study adds to existing knowledge by indicating the subtle ways this is enacted and enforced, or in other words, how governmentality rules within this domain.

Large quantitative studies demonstrate negative attitudes towards patients with obesity among health care professionals (Puhl & Brownell, 2001), viewing individuals with obesity as weak willed, sloppy, and lazy (Fogelman et al., 2002; Foster et al., 2003), lacking motivation (Bocquier et al., 2005; Brown & Thompson, 2007; Campbell, Engel, Timperio, Cooper, & Crawford, 2000; Thuan & Avignon, 2005), or being ugly with reduced attractiveness (Schwartz et al., 2003).

Responsibility, failure, and internalized stigma

The dynamic interaction between the sociocultural discourse and the vulnerability of a person with obesity determines the way stigma will affect the person's self-esteem. The normative dimensions are powerful, leaving people who do not comply with shame and blame. When people with obesity who already struggle internalize stigmatizing interaction, their coping abilities may be jeopardized (Malterud & Ulriksen, 2010).

Our findings explain the degrading effect of being classified as irresponsible within a powerful system. According to Schlenker, Britt, Pennington, Murphy, and Doherty, (1994), *responsibility* is a core concept for understanding how people evaluate, sanction, and try to control each other's conduct. They present a *Triangle Model of Responsibility*, where responsibility is a direct function of the three key elements, perceived by the individual who makes the judgement. The *prescription* that should be guiding the actor's conduct is the citizen's duty to remain healthy, the *events* that occurred as relevant to the prescription are regular habits of nutrition and physical activity, and the *identity images* describing the actor's aspirations and quality include a convincing motivation for weight loss as well as the individual biological vulnerability. Our findings indicate that providers judging the level of responsibility enacted by patients with obesity neglect the agreement between patients and themselves on prescriptions and events, and omit information about patients' motivation (Malterud & Ulriksen, 2010) and individual vulnerability for weight problems (Malterud & Tonstad, 2009). The notion of responsibility and the contradictory perspectives on the efforts of the patient with obesity may add to the burden of stigma.

Heredity explains a substantial proportion of individual differences and determines which individuals who are most susceptible to weight gain under certain circumstances (Maes, Neale, & Eaves, 1997). Such mechanisms are mediated by neuroregulatory determinants of energy balance, affecting individuals' lipostatic regulation system in different ways (Speakman, 2004). Referring to behavioural genetics, Levitt and Manson (2007) discussed the idea of individual responsibility with possible implications for the anti-social behaviour and the criminal justice system. Our study demonstrates the extensive investments for weight loss made by patients with obesity over years, as ways of taking action aiming for control.

A previous study of the Norwegian mass media discourse presented the framework for identity and coping related to body weight (Malterud & Ulriksen, 2010a), another how vulnerable feelings of failure in patients with obesity can be reinforced by well-intended advice by their doctors (Malterud & Ulriksen, 2010). The findings from the meta-ethnography illustrate the power attributed to responsibility, depending on who is judging the investment. A liberal egalitarian approach to responsibility in health care discriminates between holding people responsible for their choice vs. the

consequence of their choices (Cappelen & Norheim, 2005).

The consequences of unsuccessful weight loss should not legitimate blame from health care providers but rather be taken as need for support. Health care is an important context for the normative culture-producing stigma that is internalized by individuals with obesity. Internalized stigma contributes to expectations of negative responses, as demonstrated in a study where patients and doctors reported overall ambivalent attitudes towards obesity, but the doctors reported less negative attitudes than what their patients perceived (Brandsma, 2005). Existing research indicates that such attitudes may actually increase maladaptive eating behaviours, exercise avoidance, and in some cases reduce motivation to lose weight (Puhl & Heuer, 2009). The negotiations of responsibility, shame, and blame merge with internalized stigma in individuals with obesity, thereby obstructing positive response expectations, and coping (Ursin & Eriksen, 2010).

Conclusion

Stigmatizing attitudes towards obesity are enacted by health care providers and perceived by patients. Stigma is mediated by subtle social processes where shame and blame are distributed by providers who discard the level of responsibility in patients with obesity. Contradictory views on patients' efforts, knowledge, and motivation merge to internalization of stigma, obstructing coping, and collaboration. Health care providers encountering obese patients can break vicious circles of negative expectations by recognizing patients' weight management efforts.

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