These things that live on departure understand when you praise them: fleeting, they look for rescue through something in us, the most fleeting of all. Will us to change them entirely, within our invisible hears, into – oh endlessly – into ourselves! Whosoever we are. - Rilke, Duino Elegies

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time
T.S. Eliot, Little Gidding

. . . to be present with the sick or maimed is to find and feel oneself called on. Just here, one sees the real significance of plain talk, a simple touch, the direct look and the sick person's need to hear that world, feel that touch, note that look. That simple human touch, the sound of the human voice, the notice in the human look appear as touchstones of the moral order and enable the person to know in the most immediate way that he or she is recognized and affirmed. This act of affirming of one another, of being with one another in our mutual relatedness, is the hearthstone of our common humanity.
Zaner, 1993, Troubled Voices, pp. 145-146

University of Alberta

In the Queue for Bariatric Surgery: A Phenomenology of Waiting

by

Nicole M. Glenn

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Faculty of Physical Education and Recreation

Spring 2014

Edmonton, Alberta

Dedication

To my family who helped me to get here and Julian who helped me get through.

Abstract

Purpose: To explore the lived-experiences of waiting to have bariatric surgery.

Research Question: What is it to wait for bariatric surgery?

Methods & Participants: I responded to this question using a human science approach to phenomenology of practice. I conducted multiple, in-depth, phenomenological interviews with seven participants recruited from a publically funded bariatric clinic in Western Canada. Experiential sources (i.e., interview transcriptions, written experiential descriptions) were analyzed guided by the phenomenological reflection, reduction and writing practices.

Texts ('Findings'): This inquiry resulted in three manuscripts through which I explored different meaning-aspects of the phenomenon of waiting to have weight loss surgery. The first text, *Making Contact: Experiences From the Weight Loss Surgery Clinic*, focused on experiences of contact within the pre-bariatric surgical period. I questioned the ethical significance of relational encounters that occurred within the wait drawing on the writings of philosophers Alphonso Lingis and Emmanuel Levinas. The second text, *Phenomenological Insights on Mandatory Weight Loss and the Wait to Have Bariatric Surgery*, explored experiences of a pre-surgical requirement that weight loss be achieved prior to surgical approval. I questioned the ethical and practical significance of the practice. In the final text, *Phenomenological Insights and Metaphor: Building a House As the Wait to Have Bariatric Surgery*, I considered the experience of waiting to have bariatric surgery through the metaphor of house building drawing on insights cultivated through

philosophical writings on house, home and building to understand the possible meaning of the experience.

Concluding Comments & Significance: The findings from these three studies share a common thread of considering the experience of waiting within the context of weight loss surgery. Through these texts I explored possible experiential realities from an ethical perspective often pushing the reader to question – what is good versus what is right (for the individual receiving care)? As such, the texts are of particular relevance to clinicians working in bariatric medicine. The studies also address a significant gap in the bariatric surgical literature, as there is little qualitative research in the field and particularly with regards to patient experiences of the pre-surgical period.

Preface: The Pretext – Before Beginning: Reflections on Self, Language & Meaning[1]

> *I feel conspicuous and uncomfortable as I shuffle around in this extra wide, blue vinyl chair. I put my bag next to me then under the chair only to realize that now it is too far for me to grab my things. Are people staring at me? I imagine they are as I drag my bag back onto the seat again. I don't look up. Trying to be as quiet as possible I pull out my notebook and pen – very discrete indeed. Now people must really wonder what I am up to here. I feel like an intruder. What am I doing here? I look around. No one seems to be paying me any attention yet I feel watched. It is I, however, who is here to watch. I don't really like watching, not here, and yet I do ordinarily – I like nothing more than setting myself up at an outdoor café while the world passes by. This is different. This is not a café, not even close. This is the waiting room at the bariatric clinic. This is the place, the space I am supposed to observe. Yet I cannot bring myself to open my notebook to write anything down. Why such discomfort? This waiting room is public, anyone can enter; a password or code is not needed here. And I am not unfamiliar with waiting in medical clinics and have not been uncomfortable with them in the past, even if waiting for someone else, or for news that I anticipate I don't want to hear. Nevertheless, this feels different. 'Maybe,' I think, 'I am different.'*

As I sit in the corner of the waiting room at the weight loss surgery clinic I contemplate myself in the space. I become increasingly conscious of my body as I try to shrink away, to go unnoticed. This is not about me, I think. I am here to watch, to 'immerse,' to begin, to study and to inquire – yet none of those words seem quite right. None capture what I am doing. They describe it as it is frequently described in qualitative methodological texts (Patton, 2002), sure, but these words do not *feel* like what I am doing. What am I doing here?

---

[1] A version of this chapter is being prepared for publication.

I want to know, to understand, to listen and to watch – but for what purpose? I have come here for a reason; I was drawn here, moved to questioning through the story of (an)other. This story, however, although compelling, is not my own. Yet this work is, or at least now I am part of it, the question and the texts that will follow. I will be in those too, as I am in this waiting room – both in and out somehow. I ask myself how to proceed and why, what might be the unintended consequences of the questions I ask, and whose agenda might they serve? Who might be silenced through the words that I write?

Phenomenology aims to show, to return, to evoke and to let shine forth what *is*, as it is, in the everyday world in which we live (van Manen, 1990). It is an ethical endeavour, a thoughtful way of being, a reflective, embodied, embedded practice that requires sensitive attunement and attentiveness. It requires a letting go, a releasing or conscious sitting with and setting aside of pre-conceived notions, assumptions and judgements. Then why do I feel such discomfort? Perhaps it will be helpful to consider how I got here and explore what I thought I knew about people who wait and myself in relation. Here I look to language as a means of understanding, explicating and exploring these very questions because, as Lingis (2012) writes,

> With words we communicate with others, focusing their attention, directing them, challenging, defying, warning, threatening, prohibiting. There are words too that are not addressed to anyone, the words of one's unvoiced inner commentary that accompanies what we do and continues when we are doing nothing, contemplating, dwelling with things. Words are not only units of a code, designating concepts; they have pitch, attack, timbre, volume, and duration. They are ponderous, conveying the weight of things, heavy, weighing down things, or light, lightening, trivializing. (p. 42)

Language is absolutely inescapable (and vital) within the phenomenological project, as it is in essentially all human endeavours. Language impacts lives and lives impact language in turn. What makes me different than

others sitting in the waiting room? Am I really that different? I am not here to wait, not for surgery at least, that is one thing, but why might be the more pertinent question. I am not here to wait because I do not require the treatment that is offered here. I am not obese, clinically, morbidly,[2] however one might categorise. I am not *fat,* although I, like nearly all women I know, I have felt this way many times in my life.

I hesitate for a moment before typing the word fat. It feels offensive yet fat is the word frequently used to describe the bodies (and the people) who wait in this clinic. Is this the source of my discomfort? This word? There are others too I am sure. I wonder if that is what is separating us, me and the people who are waiting, at least separating us in my mind – these words – the bodies and the experiences they entail. I consider the word 'fat.'[3]

> Fat is many things, including a tissue; a signifier and symbol; a self concept; a set of experiences; and an identity that is constituted in relation to others, (sub)cultural norms, and systems of power and privilege. Fat is a curious and contradictory thing, both hypervisible and invisible; both associated with femininity and desexualized. It simultaneously signifies both poverty and abundance; public concern and private well being; inadequacy and excess. . . Fat is often used in the same way as *obscenity*: nobody can quite agree on a definition, but we feel we know them when we see them. (Scott-Dixon, 2008, p. 24)

Fat is more than a tissue that comprises the body – more and at the same time perhaps less than muscle and bone, flesh and blood. Fat is a signifier and is often read as such: lazy, stupid, messy, unlovable, unhealthy – *unworthy* (Lupton, 2013;

---

[2] The term morbidly obese is no longer commonly used and has been replaced in much of the clinical literature with clinically severe obesity, extreme obesity or class III obesity. I choose to use it here because it was the term I first encountered in the clinical literature (it has only very recently changed, see for example Colquitt, Picot, Loveman, & Clegg, 2009) and has connotations that may connect it to the experience of the body that undergoes surgical intervention.

[3] For an in-depth discussion on the topic and as an entry point into critical fat scholarship I refer the reader to Lupton's (2013) recent text, *Fat*.

Puhl & Heuer, 2012; Scott-Dixon, 2008). We have many words to describe it, and the people who have (or *are*) it in excess – corpulent, well-fed, plump, and thick, big-boned, large, round – just to name a few (Barber, 2004). Some of these terms are more or less acceptable, feel more or less 'right' to the people who live in and with bodies considered fat. "I've always been a big girl," explains a woman I spoke to who was pursuing weight loss surgery, "I've never been thin," she continued. The terminology used and how it is understood may be immensely personal and enmeshed within the context, the historical moment and cultural space where it is used (Lupton, 2013; Rothblum & Solovay, 2009). Critical scholars have re-claimed the word 'fat,' preferring it over the medicalized 'overweight' or 'obese,' which they argue perpetuates the understanding of fatness as pathological, a diseased, abnormal, deviant state (Lupton, 2013; Rothblum & Solovay, 2009). I wonder, however, does 'fat' show anything of the experienced body or how it is lived within the world? What about obese, or morbidly obese? What do these words do and what do they possibly show?

Within the first draft of this thesis, composed more than three years ago, I used the words 'obesity,' 'overweight,' and 'morbidly obese' throughout the text. I used these words without consideration or reflection or thought of what they might mean, of what they might *do*. I assumed the words *were*, in the way a table is a table and a chair is a chair. I was not yet immersed in the phenomenological mood, the orientation that I have since adopted (or at least attempted to). I was not yet conscious that words can create but that they can also reduce, qualify, and section off, they can categorize and remove something (phenomena) from the world-as-lived. They can be anything but phenomenological.

Ursula LaGuin (1988) writes a powerful narrative about labels ('names') and being, entitled, *She Unnames Them*. It is an Adam and Eve story of sorts, but not as one might expect. Eve, who is herself throughout the piece without a name (perhaps I would have been best to capture the spirit of the text by too leaving her nameless), unnames the animals in turn. Most accepted namelessness with perfect indifference, the Yaks, however protested as some felt 'yak,' the sound it made as

it slipped off the tongue had a certain fit, but eventually let it go as it was not used among themselves anyway. LaGuin (1988) writes,

> The insects parted with their names in vast clouds and swarms of ephemeral syllables buzzing and stinging and humming and flitting and crawling and tunneling away . . . none were left now to unname, and yet how close I felt to them when I saw one of them swim or fly or trot or crawl across my way or over my skin, or stalk me in the night, or go along beside me for a while in the day. (p. 195)

The names that had been given the animals were not theirs and did nothing to show them as they were in the world, flitting and crawling, scratching, buzzing and biting. The names did not bring her, 'Eve' closer to the animals, if anything she felt more distance, the names were between them, got in the way of her seeing them as they were, or knowing them in a way that was meaningful.

I wonder how the labels, obese and morbidly obese, for example, name the people who enter the weight loss surgery clinic. These labels may name them as different or sick. How might these names create a barrier between us, prevent me from seeing them as they are, in the world, uniquely, as I am uniquely in the world, immensely and impossibly different, yet from each other too and perhaps not so different at all in the end. How might these names prevent me, and others from seeing the experience of waiting within the context of weight loss surgery for what it is, rather than an extension of our accepted understandings of 'obesity' as problematic and in need of intervention? Perhaps, waiting to have bariatric surgery, like most human experiences or phenomena, lies somewhere between or beyond labels, words and names, just outside the grasp of linguistic possibilities. Levinas (1972/2006) considers the limits of language,

> . . . language refers to the positions of the listener and the speaker, that is, to the contingency of their story. To seize by inventory all the contexts of language and all possible positions of interlocutors is a senseless task. Every verbal signification lies at the confluence of countless semantic rivers. (p. 6)

When I began this project obesity and overweight, excess weight and class III obesity represented the language of the majority of the literature from which I drew and the (clinical-scientific) research world with which I was most familiar. It was within the rhetoric of the 'obesity epidemic' that I positioned this inquiry – I argued that because of the existing obesity crisis we (the scholars, the medical community, the practitioners and the policy makers) needed to better comprehend the experiences of individuals pursuing weight loss surgery so we could address their needs and those of the clinic created to treat them, and ultimately, improve 'outcomes.' Through this positioning not only did I present particular bodies as diseased and in need of medical intervention but I also created clear divisions between *us* (e.g., 'the experts') and *them* (e.g., the 'people'). I had not considered the ways that my writing might have named and in doing so moved the inquiry further away from its intention – to return 'things to themselves' (Heidegger, 1953/2010). Furthermore, I did not consider how this positioning produced or re/produced dominant ideals around particular bodies, nor how it might have supported binary understandings of people, knowledges, lives and so on. It is through the doing of this phenomenological inquiry, and reflecting upon where I started that I have come to see just how far away I began. I am also reminded of how far away I remain to this day. I am beginning to understand the power of words and the inability of language to illuminate or 'capture' without changing. Yet this is the struggle of phenomenology. As Heidegger (1953/2010) writes, "it is one thing to report narratively about *beings* and another to grasp beings in their *being*. For the latter task not only are most of the words lacking but above all the "grammar" (p. 36).

In many ways this is an ongoing negotiation, a reflective practice that is in no way complete. I continue to grapple with the terminology, jargon and language that I use in my writing, when I speak about my work, when I am involved in 'knowledge translation' activities or talking to individuals about their experiences. I use the word obesity and related medical terminology quite frequently – I use it to position my work, to apply for funding, to fit within the scope of particular

conferences, events and publications and yet in doing so I may lose grasp on what it is I am trying to hold, to bring closer, to *see*. What is more, through use of this language I may be perpetuating the pathological construction of bodies (and people; among other potentially problematic productions) – I may name 'them' and in doing so reduce, do harm or inflict violence, even if well meaning or unintended. Yet I continue to use such words, words that may not belong to the phenomenon but rather to our scientific conception of it because through language I find access – access to audiences that may not be otherwise open to this type of scholarship (i.e., qualitative, phenomenological, experiential), and who I hope to touch or move with this work. Perhaps this is why I feel such discomfort sitting quietly in the corner of the bright, white waiting room. I think I know something, something that makes me different but I, in fact, may know nothing of this experience in my techno-scientific understanding of the world. In this moment of watching discomfort I have a tacit understanding of the possibilities of what I do not know, of my assumptions and preconceptions and how they may have positioned me, and how they may have positioned the people who wait. And so I begin, with conscious attempts at unknowing, enmeshed in the tensions and problematics of language, with an openness and wondering, a questioning – what is this experience *really* like?

References

Barber, K. (Ed.). (2004). Fat. In *Canadian Oxford Dictionary* (p. 540). Don Mills, Canada: Oxford University Press.

Colquitt, J. L., Picot, J., Loveman, E., & Clegg, A. J. (2009). Surgery for Obesity. *Cochrane Database of Systematic Reviews* (CD003641)*, 15*(2). doi:10.1002/14651858.CD003641.pub3

Heidegger, M. (2010). *Being and Time* (J. Stambaugh, Trans.). Albany: State University of New York Press. (Original work published 1953)

LaGuin, U. (1988). She Unnames Them. In *Buffalo gals and other animal presences* (pp. 194-196). New York, NY: ROC.

Levinas, E. (2006). *Humanism of the Other* (N. Poller, Trans.). Chicago: University of Illinois Press. (Original work published 1972)

Lingis, A. (2012). The weight of reality. *Mosaic, 45*(4), 38-49.

Lupton, D. (2013). *Fat*. New York, NY: Routledge.

Patton, M. O. (Ed.). (2002). Qualitative research and evaluation methods (3rd ed.). Thousand Oaks, CA: Sage.

Puhl, R. M., & Heuer, C. A. (2012). The stigma of obesity: A review and update. *Obesity, 17*(5), 941-964. doi:10.1038/oby.2008.636

Rothblum, E., & Solovay, S. (Eds.). (2009). *The fat studies reader*. New York: New York University Press.

Scott-Dixon, K. (2008). Big girls don't cry: Fitness, fatness, and the production of feminist knowledge. *Sociology of Sport Journal, 25*, 22-47.

Van Manen, M. (1990). *Researching lived experience*. New York: State University of New York Press.

Acknowledgments

I being by acknowledging funding support received from the Canadian Institutes of Health obesity training grant program, the Queen Elizabeth II scholarship, Toronto Dominion Interdisciplinary studentship and the Health Quality Council of Alberta. These funds provided the protected time necessary for me to complete this project and ultimately this doctorate degree.

Thank you to the seven individuals who generously shared their experiences, time and thoughts on the wait to have bariatric surgery with me. This project would have been impossible without your contribution.

Thank you to John Spence and Kim Raine for their supervision. Not only did you help to guide, shape, and challenge this work but also you guided, shaped and challenged me. In me you fostered a sense of what it means to be an academic, a colleague, a mentor and a teacher. I am grateful for all you have done for me in these past four years. Kim, you provided just the guidance and support I needed at just the time I needed it, encouraging me to keep going when I felt most overwhelmed. John, you provided the perfect environment for me to flourish with equal measures of support and autonomy. You urged me to follow the questions that provoked me regardless how strange or far from your own interests.

Thank you to Brenda Cameron for introducing me, so unexpectedly and beautifully to phenomenology. It was your work that first inspired me, pulled me, perhaps more accurately described, toward phenomenological inquiry. Imagine my delight when you then agreed to be on my supervisory committee! Your gentle insistence, questioning and feedback throughout this process have encouraged me to be a better phenomenological researcher, a more contentious academic and to continue to strive to be more tact-ful and caring in and through my work.

Thank you to Cathy Adams and Max van Manen for teaching me to ‘do’ phenomenology and guiding me through my first attempts at the practice. You are wonderful and thoughtful teachers and I return often to my time in your classes, to your writings and all that I learned and am still very much striving to.

Thank you to Erika Goble, Kathy Howery and Iris Yin, the members of the phenomenological writing/reading group that I have been so extremely fortunate to be part of. You have kept me phenomenological (not always an easy task!) and you kept me sane. I am grateful to have had your relentless support and your friendship.

To my family, mum, dad, Dawne, Kristin and Lesley for contributing in ways too big and too small to possibly measure – without a safe place to land I would have never had the courage to take flight, follow my dreams and leave everything behind. For this I cannot thank you enough.

Julian, I find myself lacking the language necessary to express how fortunate I feel and how extremely grateful I am to have had you by my side throughout this journey. I could not ask for a better companion. You have provided endless support and shown genuine interest (even when mine waned) while at the same time never letting me lose sight of that which is truly most important. Whether a pep talk at 3AM or 5 minutes before a big presentation you always found the right words to help me find my way.

Table of Contents

Chapter One: Introduction[1]

> *For in the immediate world, everything is to be discerned, for him who can discern it, and centrally and simply, without either dissection into science, or digestion into art, but with the whole of consciousness, seeking to perceive it as it stands: so that the aspect of the street in sunlight can roar in the heart of itself like a symphony, perhaps as no symphony can: and all of consciousness is shifted from the imagined, the revisive, to the effort to perceive simply the cruel radiance of what is.* (Agee, 1960, p. 11)

A colleague, a consulting physician at a weight loss surgical clinic, speaks about his work, "I primarily attend to post-surgical patients," he explains. "They are mostly successful and show outcomes as expected – reduced weight, lower cholesterol and blood sugars – but. . . " Then his eyes shift and well up. He looks away momentarily as he recounts the story of a woman he recently saw at his practice. Her story tells of sadness and abuse buried deep in the folds of her body. "After the surgery she had lost much of her excess weight," he explained, "She was a great success." Yet, she could not make the shrunken body her own. She longed for the safety and security of the body she had long known, the body she had in some ways created, nurtured, lived in and with. The body she fought and the body that offered protection. There was no going back. "How is this success?" he wondered aloud. "What can I do?"

I find myself sitting there looking up at my colleague but not seeing nor hearing him. I am pulled into his story, called by it somehow. Yet it seems stronger than that even I am confronted with it and find myself dwelling with the question – what might this experience be like? How is bariatric surgery lived? This questioning arose through the story but also from its unsettling relation to the outcome related studies, the empirical evidence I had been presented earlier this very same day. I had learned bariatric surgery:

---

[1] A version of this chapter is being prepared for publication.

Is the only long-term treatment for clinically severe obesity (Buchwald, 2002; Buchwald et al., 2004, 2009; Wolfe & Morton, 2005).

It saves lives (Buchwald, 2002; Buchwald et al., 2004, 2009).

It transforms (Buchwald, 2002).

It cures ills and reverses disease (Buchwald, 2002; Buchwald et al., 2004, 2009).

It improves quality of life (Buchwald, 2002; Wolfe & Morton, 2005).

Yet what about this woman's story? Her life did not seem improved. Why was my colleague so affected? This story was not unique, he said, "I've seen many, too many people like this." Research results reported one thing and yet with his own eyes he saw another. I wondered, what is going on? This question stayed with me long after he left the podium. Beyond the outcome data and findings, what is it like to have this surgery?

This question lead to more questions as I delved into the weight loss surgery (i.e., bariatric surgery, anti-obesity surgery) related literature. The majority of research did report improvements in all cause morbidity and mortality in the post-surgical population, it did support increases in psychosocial wellbeing and quality of life (Buchwald, 2002; Buchwald et al., 2004, 2009; Wolfe & Morton, 2005). Experiential studies mostly echoed these findings (Bocchieri et al, 2002; Earvolino-Ramirez, 2008; Joanisse, 2005; LePage, 2010; Ogden, Clementi, & Aylwin, 2006; Wysoker, 2005) with few exceptions (Groven, Rhåeim, & Engelsrud, 2010, 2012, Groven, Engelsrud, & Rhåeim, 2012; Meleo-Erwin, 2011, 2012; Murray, 2009, Throsby, 2008). Nevertheless, it was within these studies, the 'exceptions,' that I saw a glimmer of the complexities and tensions I noticed in the eyes of the young physician. Post-surgical lives were not so clearly improved and feelings of disability arose (Groven, Rhåeim, & Engelsrud, 2010, 2012, Groven, Engelsrud, & Rhåeim, 2012; Murray, 2009). More worrisome, however, was the outcome research that reported increased suicide and accidental deaths among the post-bariatric surgical population (Peterhänsel, Petroff, Klintzke, Kersting, & Wagner, 2013). These findings, along with the story of the

woman struggling with her post-surgical body, lead me to question the reality of the experience of having weight loss surgery. I wondered: what is it like to undergo this procedure? How is this experience lived?

I diverge here for a moment to provide a brief summary of the procedure and some contextual information about having bariatric surgery, particularly in Canada. Bariatric surgery is a term that covers multiple surgical interventions aimed at reducing body weight through alterations to the stomach and intestines (Colquitt, Picot, Loveman, & Clegg, 2009; Mechanick et al., 2008). These procedures are commonly categorised as restrictive (i.e., mechanical restriction of the volume of food that can be consumed) and/or malabsortive (i.e., reduce the absorption of nutrients in the digestive system; Colquitt, Picot, Loveman, & Clegg, 2009; Mechanick et al., 2008) although the mechanism of weight loss may be more complicated than that (Tam et al., 2011). To qualify for bariatric surgery, according to the guidelines to which the majority of clinics adhere, a person must have a body mass index (BMI) of 40 kg/m^2 or greater (i.e., at least 100 lbs. excess weight) or, 35 kg/m^2 in addition to at least one significant, obesity-related co-morbidity (National Institutes of Health, 1992).

In Canada it is estimated that 1.5 million people may be eligible for the surgery (Padwal, Chang, Klarenbach, Sharma, & Majumdar, 2012) and this number is on the rise (Tjepkema, 2005). Waiting times (i.e., from referral to surgery) average 5 years for publically funded procedures and can stretch upwards of 10 years depending on where a person lives (Christou & Efthimiou, 2009). That is more than five times longer than the next longest surgical queue in the country (Barau, & Rovere, 2012). As more individuals qualify, and subsequently seek out bariatric surgery, wait times may lengthen even further – extending what have already been called 'morbid waits' – as people are literally dying in the surgical queue (Christou & Efthimiou, 2009; Padwal & Sharma, 2009).

The implications of these extended wait times, beyond mortality rates, have yet to be thoroughly explored (Padwal, Majumdar et al., 2012). Preliminary findings, however, suggest that waiting for this procedure has profound effects on quality of life as well as physical, mental and social wellbeing (Gregory, Temple

Newhook, & Twells, 2013; Padwal, Chang et al., 2012). Yet how is this wait lived I wondered? Individuals waiting for the procedure describe the wait as stressful and frustrating as well as physically, emotionally and mentally taxing (Gregory et al., 2013; Padwal, Chang et al., 2012). Sixty-nine percent of people awaiting a bariatric procedure, described physical limitations as worsening over time (Padwal, Chang et al., 2012). Considering these preliminary understandings I was once again struck by the potential lived realities related to the bariatric surgical experience. However, this time it was the pre-surgical and, more precisely, the potentially lengthy wait that brought me pause: what might this be like? What is it to wait to have bariatric surgery? How is this experience lived?

Qualitative studies have explored pre-surgical bariatric experiences and found prominent themes of control and hope (de Silva & Da Costa Maia, 2012; Engström, Wiklund, Olsén, Lönroth, & Forsberg, 2011; Gregory et al., 2013). Loss of control related to food and weight was described as hallmark to pre-surgical life while hopes for control provided motivation for surgical pursuit (de Silva & Da Costa Maia, 2012; Engström et al., 2011). Individuals described feeling hopeless about the future and their ability to lose weight without surgery and surgery was seen as the last resort or final ray of hope (de Silva & Da Costa Maia, 2012; Engström et al., 2011; Gregory et al., 2013). Nevertheless I am left to question how is the waiting experience lived? How might it be unlike waiting in other contexts – waiting for the bus to come or spring to arrive? How is this surgical wait unique from the wait to have other surgical procedures? Available studies provided a glimpse of the pre-surgical experience; however, did not explore waiting within this context or show the experiential possibilities, reveal the taken for granted or assumed of the pre-surgical experience as might be explicated through phenomenological study.

I began the journey into this area of research with a story that evoked wondering and concern. I turned to the existing scholarship, found predominantly within medical journals – focused on outcomes and safety, and then to experiential texts. Next I entered the bariatric clinic, the waiting room to be more precise with a question in mind: What is it to wait within this context? How is the

experience of waiting for weight loss surgery lived in the everyday experience of those individuals who wait?

What follows are the notes from my first day of observations in the clinic waiting room,

> *I step off the elevator and I'm faced with an open entryway. It is cold outside and so the warmth welcomes me, making me feel cozy immediately - light streams in through the windows and the room is bright and open. I don't see any uniforms or scrubs. The staff appears to be dressed casually instead. The woman at the desk, the receptionist I assume, greats everyone who enters with a smile as she motions them over to join her with big sweeping gestures of her arm. There are several women quietly chatting in the U-shaped seating area. A child attempts to capture the attention of one of them, "look at this," she says as she pushes an iPod under her mother's nose. "Yes, yes I see it,' she responds, catching the knowing eye of the other woman before continuing the conversation where she left off. Occasionally the quiet is broken with the sound of footsteps approaching from the long open corridor that extends beyond the reception desk away from the seating area. A name is called and a woman gets up from her place in the room. There is a moment of 'how are yous?' and, 'I haven't seen you for a while,' some gentle laughter and then quiet as they move down the hallway and out of earshot.*

The waiting room here at the bariatric clinic strikes me as ordinary, everyday, it could be anywhere (almost) and gives few cues that it is a clinical space. The motion of the people however seems to divide – the staff are on this side, behind the desk or down the hallway – the patients are on the other, sitting in chairs or standing to read the posters on the walls. I am not sure what I expected – fewer windows, less light, more closed dark spaces, which I am accustomed to encountering in clinical environments – sterile and cold. This place feels much more alive than that. I wonder how this space plays into the waiting experience? I assume it has some impact on the experience; it is the waiting room after all.

Perhaps the waiting that occurs prior to this surgery, however, takes place beyond these walls. Where does one wait for bariatric surgery? The juxtaposition between this space, the openness and the welcoming feel and the statistics I've read recounting the extraordinarily long waiting times and talk of death in surgical queues (Christou & Efthimiou, 2009) is jarring to say the least. Even in my brief observation it becomes apparent to me that this experience may not be what I had expected. I find myself opening to the question – what is it then? What is it to wait to have bariatric surgery?

> Sara, I spoke to about waiting to have the procedure explains,
> This journey towards surgery is a beginning. I took the courses and when I received approval for surgery that was the end of the beginning. Now I'm in the middle – I'm waiting for my surgical date. The surgery is the start of the middle. The end begins when the surgery starts to take effect. That is the beginning of the end. But my story doesn't end until I die. The journey lasts forever or for as long as I live. This wait, this surgery is just bits and pieces of the trail, stringed together – these strings create the threads of my life. Creates the story of my life.

The pursuit of weight loss surgery may represent a beginning, a movement toward a new and different future. It may also be an end, the end to what was before, the necessary end before a new start can be made. The wait that encompasses the entire pre-surgical period may feel like many waits stacked one against the next against the next – there may be the wait to complete the courses, the wait for surgical approval and the wait for the surgical date to arrive. Each wait may be different, unique, separate, where one wait ends the next begins. Waiting, in this context, however, may not be so linear, the waits may overlap and intertwine, enmesh and diverge; they may not be separate but rather parts, necessary aspects of the overall waiting experience – the wait to have bariatric surgery. The pre-surgical period that is waiting by virtue of being a queue may not actually feel like waiting to the person who lives it; then again it might. It may be a journey, as Sara describes, or threads of a life story, or a home that is in the process of being built.

I wonder what is this mode of waiting? How does one wait during this pre-surgical time and what is being awaited – the surgery, the weight loss, something else? What is it like to be on a journey that doesn't end until you die? How does waiting then differ from life itself?

I attempt to respond to these questions in the following three texts in which I explicate the possible meanings of the waiting experience as they emerged from my conversations with individuals who had waited for the procedure. In the first paper I explore the lived-relation of the wait through the metaphor of contact – contact being a touch, physical or otherwise, contact as hearing from and contact as with-tact, an ethical way of being with another. With the second paper I focus on the experience of clinical recommendations, specifically mandatory weight loss prior to surgical approval. Individuals wishing to pursue bariatric surgery must demonstrate repeated, failed attempts at weight loss to be considered for surgery yet to attain surgical approval they must, paradoxically, lose weight. I explore the inherent tensions and possible ethical dilemmas that may arise from such recommendations, and question their impact on the overall experience of waiting for bariatric surgery. In the final paper I explore the possible meanings of lived-body, relation, and space within the context of waiting for bariatric surgery through the metaphor of building a house and the story of Liz, a woman waiting for the procedure. Building a house is work, it requires the expertise of many; it requires time, money, and care – it is an investment for the future. Building a house is the culmination of a dream, a thing for which one plans and imagines in great detail. Who is the builder within this metaphor, one may wonder, and what does the house represent? Drawing on the writings of Bachelard (1958/1994) Bollnow (1961, 1989, 1963/2011), Heidegger (1971), Leder (1990, 2004), Svenaeus (2000a, 2000b), van den Berg (1972, 1969/1978) I consider these questions and, more broadly, the metaphor of building-as-waiting.

These three texts provide a glimpse into aspects of the pre-bariatric surgical waiting experience. They not only address a current gap in the literature with regards to patient experiences of waiting within this context, and qualitative

research in the area more broadly but they may also inform clinical care practice. They may remind us that clinical practices are human practices ultimately intended to treat and care for people (Baron, 1985; Leder, 2004; Svenaeus, 2000a, 2000b). Baron (1985), a physician and phenomenologist, writes of the possible contribution of phenomenological insights to medical practices,

> Phenomenologically informed medicine offers a discipline that serves patients, rather than one that they serve. It requires, as a central task of medical practice, that we reconcile scientific understanding with human understanding, using the one to guide the other. We must learn to hear our patients as well as their breath sounds; after all, what are we listening for? (p. 610)

The texts that follow may enrich and deepen our understanding of the experience of waiting for bariatric surgery providing points of possible resonance and recognition – a felt understanding of what it may be like to wait for this surgical procedure. They may bring the reader to question, to wonder and to consider the previously unseen or unnoticed. The aim is to evoke, through tacit understandings, a felt sense of responsibility, one for the other and in this way to move, shift and change us and, by doing so, bring about a change in our practices – eliciting more tactful encounters within the bariatric surgical clinic.

References

Agee, J. (1960). *Let us now praise famous men*. Boston, MA: Houghton-Mifflin Co.

Bachelard, G. (1994). *The poetics of space*. Boston, MA: Beacon Press. (Original work published 1958)

Barau, B., & Rovere, M. (2012, Jan/Feb). Longer than ever: A patient's wait for healthcare in Canada. *Fraser Forum.* Retrieved from http://www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/articles/longer-than-ever-a-patients-wait-for-healthcare.pdf

Baron, R. J. (1985). An introduction to medical phenomenology: I can't hear you while I'm listening. *Annals of Internal Medicine, 103,* 606-611. doi:10.7326/0003-4819-103-4-606

Bocchieri, L. E., Meana, M., & Fisher, B. L. (2002). Perceived psychosocial outcomes of gastric bypass surgery: A qualitative study. *Obesity Surgery, 12*(6), 781-788.

Bollnow, O. F. (1961). Lived-Space. *Philosophy Today, 5*(1), 31-39.

Bollnow, O. F. (1989). The pedagogical atmosphere. *Phenomenology & Pedagogy, 7,* 5–63.

Bollnow, O. F. (2011). *Human Space* (C. Shuttleworth, Trans.). London, UK: Hyphen Press. (Original work published 1963)

Buchwald, H. (2002). A bariatric surgery algorithm. *Obesity Surgery, 12*, 733-746.

Buchwald, H., Avidor, Y., Braunwald, E., Jensen, M. D., Pories, W., Fahrbach, K., & Schoelles, K. (2004). Bariatric surgery. *JAMA: the journal of the American Medical Association, 292*(14), 1724-1737. doi:10.1001/jama.292.14.1724

Buchwald, H., Estok, R., Fahrbach, K., Banel, D., Jensen, M. D., Pories, W. J., . . . Sledge, I. (2009). Weight and type 2 diabetes after bariatric surgery: Systematic review and meta-analysis. *The American Journal of Medicine, 122*(3), 248-256.e5 http://dx.doi.org/10.1016/j.amjmed.2008.09.041

Colquitt, J. L., Picot, J., Loveman, E., & Clegg, A. J. (2009). Surgery for Obesity. *Cochrane Database of Systematic Reviews, 15*(2), CD003641. doi:10.1002/14651858.CD003641.pub3

Christou, N. V., & Efthimiou, E. (2009). Bariatric surgery waiting times in Canada. *Canadian Journal of Surgery, 52*(3), 229-234.

de Silva, S. S., & da Costa Maia, A. (2012). Obesity and treatment meanings in bariatric surgery candidates: A qualitative study. *Obesity Surgery, 22*(11), 1714-1722. doi:10.1007/s11696-012-0716-y

Earvolino-Ramirez, M. (2008). Living with bariatric surgery: Totally different but still evolving. *Bariatric Nursing and Surgical Patient Care, 3*(1), 17-24. doi:10.1089/bar.2008.9996

Engström, M., Wiklund, M., Olsén, M. F., Lönroth, H., & Forsberg, A. (2011). The meaning of awaiting bariatric surgery due to morbid obesity. *Open Nursing Journal, 5*, 1-8. doi:10.2174/187443601105010001

Gregory, D. M., Temple Newhook, J., & Twells, L. K. (2013). Patients' perceptions of waiting for bariatric surgery: A qualitative study. *International Journal for Equity in Health, 12*, 86-97. http://www.equityhealthj.com/content/12/1/86

Groven, K. S., Rhåeim, M., & Engelsrud, G. (2010). "My quality of life is worse compared to my earlier life" Living with chronic problems after weight loss surgery. *International Journal of Qualitative Studies in Health and Well-Being, 5*, 5553-5568. doi:10.3402/qhw.v5i4.5553

Groven, K. S., Rhåeim, M., & Engelsrud, G. (2012). Dis-appearance and dys-appearance anew: Living with excess skin and intestinal changes following weight loss surgery. *Medicine, Health Care and Philosophy, 16*(3), 507-523. doi:10.1007/s11019-012-9397-5

Groven, K. S., Engelsrud, G., & Rhåeim, M. (2012). Living with bodily changes after weight loss surgery - women's experiences of food and "dumping." *Phenomenology & Practice, 6*(1), 36-54.

Heidegger, M. (1971). Building, dwelling, thinking (A. Hofstadter, Trans.). In *Poetry, Language, Thought* (pp. 145-161). New York, NY: Harper Colophon Books.

Joanisse, L. (2005). "This is who I really am": Obese women's conceptions of self following weight loss surgery. In D. Pawluch, W. Shaffir, & C. E. Miall (Eds.), *Doing ethnography: Researching everyday life* (pp. 248-259). Toronto, Canada: CPSI/Women's Press.

Leder, D. (2004). The experience of health and illness. In S. G. Post (Ed.) *Encyclopaedia of Bioethics*, 3rd Ed. (pp. 1081-1087). New York, NY: McMillan Reference.

Leder, D. (1990). *The absent body*. Chicago, IL: University of Chicago Press.

LePage, C. T. (2010). The lived experience of individuals following roux-en-Y gastric bypass surgery: A phenomenological study. *Bariatric Nursing and Surgical Patient Care, 5*(1), 57-64. doi:10.1089/bar.2009.9938

Lupton, D. (2013). *Fat*. New York, NY: Routledge.

Mechanick, J. I., Kushner, R. F., Sugarman, H. J., Gonzalez-Campoy, J. M., Collazo-Clavell, M. L., Guven, S., . . . Dixon, J. (2008). American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery medical guidelines for clinical practice for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient. *Endocrine Practice, 14*(suppl. 1), 1-82. http://dx.doi.org/10.1016/j.soard.2008.08.009

National Institutes of Health. (1992). Gastrointestinal surgery for severe obesity: National Institutes of Health consensus development conference statement. *American Journal of Clinical Nutrition, 55*, 615S-619S.

Meleo-Erwin, Z. C. (2011). 'A beautiful show of strength': Weight loss and the fat activist self. *Health, 15*(2), 188-205. doi:10.1177/1363459310361601

Meleo-Erwin, Z. (2012). "I Just Couldn't Keep it in Control Anymore:" Weight Loss Surgery, Food Addiction, and Anti-Fat Stigma. *Advances in Medical Sociology, 14*, 201-224. doi:10.1108/S1057-6290(2012)0000014013

Murray, S. (2009). 'Banded bodies': The somatechnics of gastric banding. In N. Sullivan & S. Murray (Eds.), *Somatechnics: Queering the technicalisation of bodies* (pp. 155-168). Burlington, VT: Ashgate publishing.

Ogden, J., Clementi, C., & Aylwin, S. (2006). The impact of obesity surgery and the paradox of control: A qualitative study. *Psychology and Health, 21*(2), 273-293. doi:10.1080/14768320500129064

Padwal, R. S., Chang, H. J., Klarenbach, S., Sharma, A. M., & Majumdar, S. R. (2012). Characteristics of the population eligible for and receiving publicly funded bariatric surgery in Canada. *International Journal for Equity in Health, 11*, 54-62. doi:10.1186/1475-9276-11-54

Padwal, R. S., Majumdar, S. R., Klarenbach, S., Birch, D. W., Karmail, S., McCargar, L., . . . Sharma, A. M. (2012). Health status, quality of life, and satisfaction of patients awaiting multidisciplinary bariatric care. *BMC Health Service Research, 12*, 139-149. doi:10.1186/1472-6963-12-139

Padwal, R. S., & Sharma. A. M., (2009). Treating severe obesity: Morbid weights and morbid waits. *Canadian Medical Association Journal, 181*(11), 777-778. doi:10.1503/cmaj.081508

Peterhänsel, C., Petroff, D., Klintzke, G., Kersting, A., & Wagner, B. (2013). Risk of completed suicide after bariatric surgery: A systematic review. *Obesity Reviews, 14*(5), 369-382. doi:10.1111/obr.12014

Puhl, R. M., & Heuer, C. A. (2012). The stigma of obesity: A review and update. *Obesity, 17*(5), 941-964. doi:10.1038/oby.2008.636

Svenaeus, F. (2000a). Das unheimliche – Towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*, 3-16.

Svenaeus, F. (2000b). The body uncanny – Further steps towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*, 125-137.

Tam, C. S., Berthound, H. R., Bueter, M., Charkravarthty, M. V., Geliebter, A. . . .Ravussin, E. (2011). Could the mechanisms of bariatric surgery hold the key for novel therapies?: Report from Pennington Scientific Symposium. *Obesity Reviews, 12*(11), 984-994. doi:10.1111/j.1467.789X.2011.00902.x

Throsby, K. (2008). Happy re-birthday: Weight-loss surgery and the "new me." *Body and Society, 14*(1), 117–133. doi:10.1177/1357034X07087534

Tjepkema, M. (2005). *Adult obesity in Canada: Measured height and weight* (Health Reports No. Catalogue 82-620-MWE). Ottawa: Statistics Canada.

Van den Berg, J. H. (1972). *A different existence: Principles of phenomenological psychopathy*. Pittsburgh, PA: Duquenese University Press.

Van den Berg, J. H. (1978). *Medical power and medical ethics* (P. Beumont, Trans.). New York, NY: Norton & Company. (Original work published 1969)

Van Manen, M. (1990). *Researching lived experience*. Albany: State University of New York Press.

Wolfe, B. M., & Morton, J. M. (2005). Weighing in on bariatric surgery: Procedure use, readmission rates, and mortality. *Journal of the American Medical Association, 294*, 1960-1963. doi:10.1001/jama.294.15.1960

Wysoker, A. (2005). The lived experience of choosing bariatric surgery to lose weight. *Journal of the American Psychiatric Nurses Association, 11*(1), 26-34. doi:10.1177/1078390305275005

Chapter Two: Phenomenology as Philosophical Tradition & Methodology

> *Natural questions about the world have their ground in the pregiven world as the world of actual and possible experiences* (Husserl, 1954/1970, p. 153).

> *In working out the question do we not "presuppose" something that only the answer can provide?* (Heidegger, 1953/2010, p. 7)

A Brief History of Phenomenology

Phenomenology is a philosophical tradition and a methodological approach. The two are not separate, in fact, Edmund Husserl (1859-1938), the first to articulate the philosophy of phenomenology as a "discernable movement," wrote extensively on the phenomenological method (Dreyfus & Wrathall, 2009, p. 2). Husserl expressed a methodological turn that involved a transcendental attitude (i.e., epochē – a suspension of judgement of belief) and reflective reduction that would uncover 'essences' or *eidos* (i.e., essential structures) of phenomena in the lifeworld (Føllesdal, 2009; Husserl, 1954/1970). Husserl's development of the philosophy of phenomenology came about in response to and, in many ways, was a move away from empirical positivism of the day (i.e., late 19th century) and sought to ground human knowledge in the lifeworld.

The lifeworld is the world of phenomenological interest and can be understood in relation to the objective-scientific world,

> [The] life-world and objective-scientific world, though of course [they are] related to each other. The knowledge of the objective-scientific world is "grounded" in the self-evidence of the life-world. The latter is pregiven to the scientific worker, or the working community, as ground; yet, as they build upon this, what is built is something new, something different. If we cease being immersed in our scientific thinking, we become aware that we scientists are, after all, human beings and as such are among the components of the life-world which always exists for us, ever pregiven;

> and thus all of science is pulled, along with us, into the —merely "subjective-relative"—life-world. And what becomes of the objective world itself? What happens to the hypothesis of being-in-itself, related first to the "things" of the life-world, the "objects," the "real" bodies, real animals, plants, and also human beings within the "space-time" of the life-world—all these concepts being understood, now, not from the point of view of the objective sciences but as they are in prescientific life? (Husserl, 1954/1970, pp. 130-131)

The lifeworld is the pregiven world of our experiential existence and presupposes all other worlds, such as the objective-scientific world (Husserl, 1954/1970). Husserl's phenomenology posits the lifeworld is knowable through human consciousness. An important distinction between the phenomenological project and the scientific project is that phenomenology seeks to describe essential structures of experiences as they are given, not how they are understood theoretically, assumed to be or described using language from other domains (such as science; Dreyfus & Wrathall, 2009).

Martin Heidegger (1889-1976) was Husserl's student and followed in the phenomenological philosophical tradition. However, he was highly critical of Husserl's phenomenology, particularly his methodological approach (the epochē), arguing that the attempt to capture essential structures of consciousness was ultimately no different than the scientific project of categorization that it purported to critique (Wrathall, 2009). Heidegger's (hermeneutic) phenomenology focused instead on everyday being-in-the-world (i.e., actions, temporality, relationality) rather than consciousness, a direction that greatly influenced the human science research tradition and phenomenology of practice (Dreyfus & Wrathall, 2009; van Manen, 1990).

Heidegger, in what is perhaps his most celebrated work, *Being and Time*, concerns himself with the Being of beings, or 'there-being' – that is *Dasein* (Heidegger, 1953/2010; Mulhall, 2005, p. 14). This has also been articulated as 'in-being' – a preontalogical understanding of being (van Manen, 2007, p. 18).

Heidegger (1953/2010) describes phenomenology as a method, he argues, "that can be formulated: 'to the things themselves!'" (p. 26). What he means here, much simplified, is the phenomenological project aims to describe 'self-showing' and thus things as they are within the everyday lifeworld – that is, as they are lived through rather than reflected upon, theorised and so on (Heidegger, 1953/2010; Mulhall, 2005).

Phenomenology, as articulated by Heidegger (1953/2010), is the coming together of *phenomenon* and *logos*. Phenomenon coming from the Greek verb meaning to 'to show itself' – "thus the meaning of the expression *phenomenon is established as what shows itself in itself*, what is manifest" (Heidegger, 1953/2010, p. 27). Logos is understood as 'discourse' – that is the making manifest to another or "letting something be seen by indicating it" (Heidegger, 1953/2010, p. 31). Through his exploration of the Being of being Heidegger (1953/2010) demonstrates the phenomenological attitude (or mood) foundational to the method – that is a questioning attitude of wonder and scepticism (of its self-understanding in particular) that allows things-in-themselves to be seen as themselves (Mulhall, 2005).

Others have taken up and expanded on Husserl and Heidegger's phenomenological projects, including, for example Maurice Merleau-Ponty (1945/2002), who articulated being-in-the-world as embodied, and Jean-Paul Sartre who was concerned with existential phenomenology and the meaning of being (Sartre, 1943/1984). I will not go into a detailed account of their works here as it is beyond the scope of this thesis project however I bring to the readers attention that they extended the methodological articulation of phenomenology and were influential in the formation of the human science/phenomenology of practice tradition from which I approach this inquiry. It is to that tradition that I now turn.

The Utrecht School

There was a phenomenological movement in the 1950's and 60's among Dutch academics and practitioners (e.g., pedagogues, psychiatrists, paediatricians,

psychologists) at the University of Utrecht in the Netherlands, which was foundational to the latter development of phenomenology of practice (van Manen, 1990). These Dutch scholars were interested in 'doing phenomenology' – that is responding phenomenologically to questions of practical and professional import – rather than pursuing the phenomenological philosophical project (like Merleau-Ponty and Sartre, for example – pursuing questions of philosophical-ontological relevance; van Manen, 2007). Their interest in phenomenology arose from practice – that is the professional doing that is embodied, relational, tacit, pre-reflective – and sought to return to practice the understandings of meaning in everyday experiences (and through these understandings inform practice). Phenomenology provided a way of studying the lifeworld and returning to things-themselves. The phenomenological approach provided a way to move away from the conceptualized or theorised knowledges that influenced much professional practice of the day (e.g., through rules, standards, measurements) as they continue to do.

Material for study was gathered in its mode of given-ness, through (pre-reflective) experiential descriptions or observations (concrete). These provided points of departure for phenomenological reflection and writing. Language was essential to the endeavours of these Dutch scholars and they pursued a mode of writing that was evocative and sensitive to the particularities of the experiences of interest (Buytendijk, 1988; Linschoten, 1987; van den Berg, 1972; van Manen, 2007). In this way, members of the Utrecht school (e.g., Buytendijk, Langeveld, Linschoten, van den Berg) developed phenomenology in the direction of a linguistically rich, nuanced descriptive-reflective technique to which writing was paramount (van Manen, 2007). Their work resulted in textual portrayals of concrete phenomena – and here I turn to an example: the experience of falling asleep.

Falling asleep may be considered such a mundane, everyday occurrence in our lives that we probably spend little time thinking of it – it just happens, that is until it does not at which point one may wonder – what is it to fall asleep? Here Linschoten (1987) reflects on the relation between sleep and silence,

> Falling asleep does not mean a becoming-cut-off from the world, but a quiet giving-up of the appeal the world directs to us. That is why the person falls asleep only insofar as this appeal becomes silenced, and he feels at ease about it. Each treatise on falling asleep cites the case of the mother who sleeps through any noises except the distant crying of her child. . . . There always remains a bit of interest in the things we cannot neglect without physical or moral danger. There are, for instance, people who wake up several times a night to determine whether the alarm clock which has to wake them up in the morning still works. We sleep only insofar as we are not with something, be it the baby or the alarm clock. Furthermore one never sleeps better than during a boring speech. . . . The silence we need in order to sleep is not merely the absence of noise, but the meaningless, stilling silence. The ticking of the clock, a speech which is boring, the creaking of the bed, noise made by streetcars and cars, and even a lively conversation around us do not keep us from falling asleep provided they are meaningless and worthless; on the other hand, however, a low soft conversation in the room next door, or an alarming drip from a leaking roof, the irregular breathing of your wife are enough to deprive you of all sleep. This is because they address themselves to us and we have an answer to their appeal. And so it is not noise or absence of noise in a physical sense which maintains a relationship with falling asleep, but silence. (pp. 89-90)

Through Linschoten's (1987) writing it becomes apparent that falling asleep and silence are experientially intertwined, yet, perhaps not in the way we would have imagined. Silence, as is necessary for sleep, is a quieting of the calling of the world; this silent world holds no immediate appeal. This is a world without a grip on us that can, in turn, be let go. Linschoten (1987) shows that it is the letting go of the world that is necessary to falling asleep not silence as in, lack of environmental noise, per se.

This excerpt serves as an example of the work that came out of the

phenomenological movement at the Utrecht school. These descriptive, evocative endeavours were undertaken often in the service of professional practice. The sensitive, insightful, descriptive texts produced elicited felt or *pathic*[1] responses among readers. The texts 'called' for understanding that was embodied, relational, and felt – they were meant to stir something among, and make demands on the readers and through this stirring elicit a change in them, in their way of being, and in their practices. In this way the texts could move readers toward ethical, tactful ways of being that were considerate of and sensitive to the experiential reality of the phenomenon as lived in everyday life.

Following the tradition of the Utrecht school and 'doing phenomenology' Max van Manen (1990, 2007) has written extensively on the methodological approach that is phenomenology of practice. Like the Utrecht movement, this is not a philosophical endeavour but one of practical and pedagogical significance.

Phenomenology of Practice

Phenomenology is a method of questioning. It is an attentive and wondering attitude that focuses awareness on the originary of phenomena as they are within the world-as-experienced (van Manen, 1990). van Manen (1990) articulates the method, or *methodos* – the way[2] – of doing human science research (called phenomenology of practice; van Manen, 2007) in the tradition of the Utrecht school. His primary concern is with the ethical-pragmatic significance of phenomenological understandings and therefore his approach has been taken up extensively in practice-related disciplines such as education, nursing and psychology, to name but a few.

Phenomenology questions the being-in-the-world-ness of particular phenomena – that is what they are as they are lived pre-reflectively, concretely,

---

[1] Pathic is related to em-pathic and sym-pathic – as in felt, emotional, relational, temporal, actional. It also comes from pathos meaning 'suffering but also passion' - in this way it is a general mood and a felt sense of being in the world (van Manen, 2007, p. 20).

[2] The way here is closer to attitude or mood – the way of turning toward, the way of in-seeing

and embedded within the world. Phenomenological understandings are pathic, they are emotive, embedded, relational and embodied rather than cognitive, theoretical, measurable and objective. Phenomenology aims to bring us closer to the world as it *is* - that is before we theorize, conceptualize or categorise it – to *grasp* it rather than *think* it (van Manen, 2007). It is through deep and thoughtful reflection on the pre-reflective world-as-given within human experiences that we may understand the meanings that inhere within the lifeworld and be opened to new and previously unexpected way of being (van Manen, 1990).

Phenomenology does not make any claims regarding causality or effects. What then, we may wonder, does phenomenology do? According to van Manen (2007),

> Phenomenology formatively informs, reforms, transforms, performs, and preforms the relation between being and practice. In-formatively, phenomenological studies make possible thoughtful advice and consultation. Re-formatively, phenomenological texts make a demand on us, changing us in what we may become. Transformatively, phenomenology has practical value in that it reaches into the depth of our being, prompting a new becoming. Per-formatively, phenomenological reflection contributes to the practice of tact. And pre-formatively, phenomenological experience gives significance to the meanings that influence us before we are even aware of their formative value. (p. 26)

In understanding what phenomenology is and what it can do one may question – how can phenomenology be done? In what follows I explore some techniques or ways of 'doing phenomenology,' specifically as they related to this thesis work. For a more thorough explanation of the phenomenology of practice I direct the readers to the extensive works of van Manen (e.g., 1990, 2007).

Doing Phenomenology: Empirical Methods

Collecting lifeworld material. Phenomenology of practice is interested in the meaning embedded within the everyday lifeworld therefore 'data' for

phenomenological study can be gathered from anywhere that is a source of the pre-reflective world (van Manen, 1990). This commonly includes personal accounts (written or spoken), observations, literature, film, documentaries, and art. To illustrate this point I use an example from a film I recently watched, *Harry Brown* (Bell, Brown, Thykier, & Vaughn, 2009). The movie opens with the following scene:

> A grey-haired man sits stooped over a small, Formica table. There are two chairs but only his is occupied. The linoleum tiled kitchen floor is clean but worn as are the paneled cupboards and laminate countertops. The scraping noise of cold butter spreading onto dried toast is the only sound that breaks the silence of the room. Morning light seeps in through the single, small window above the sink yet the room remains dark and gray. The man stares out to the empty space in front of him as he slowly takes his first bite of toast and then the sound of dryness, sandpaper rubbing reverberates as he sets it back onto the plate.

In watching this scene the loneliness is palpable. The sounds of the objects, the kettle rattling on the flame, the scraping of the knife on toast and the faint patter of rain outside are noises yet somehow act as reminders of the silence of this space. This is not the silence of tranquility; however, nor the comforting silence fallen into after a long conversation with a friend. Instead, in watching this scene I am struck by the feeling that the silence of this man's existence stretches beyond this particular space, beyond this moment. He is not lost in his own thoughts of the day about to unfold – if this were the case he would be attending to those things and unlikely to notice the noise made by his slippers as he shuffles along the linoleum floor. This *is* loneliness as it is lived, as it is experienced in the everyday and expressed through the mundane act of having breakfast. This account was found within a film but could have been gathered from an interview or a story heard over the radio. Phenomenological 'data' has a particular, pre-reflective quality, a descriptiveness, a concreteness, an embeddedness that is required as a starting point for phenomenological reflection. It is these qualities

that determine what is considered 'data' for phenomenological study, not the source, per se.

I gathered experiential material (i.e., lived experiences) for this study from multiple sources including interviews and written accounts, observations, literature and online and weblog (i.e., blog) sources. Human experiences (or lived-experiences) provide the source material for various other forms of research; however, with phenomenology these data take on particular meanings – that is, lived-experiences are direct, concrete connections to the everyday lifeworld that bring about a closeness to the originary dimensions of the experience. Next, I expand on the exact procedures I undertook in my thesis work. I begin by describing study recruitment procedures, participants and 'sampling.'

Participants & 'sampling.' Individuals were recruited for participation from pre-surgical information sessions offered at a bariatric medical clinic in a mid-sized Western Canadian city. All individuals who attended these sessions were approved for surgery and waiting for their surgical date. I introduced myself at the outset of the information sessions and remained throughout to answer any questions and provide more information as necessary. All individuals attending the session were given a study information sheet and were informed that their participation was entirely voluntary. Interested individuals contacted me or provided me with their contact information following the pre-surgical information session. I followed up with all interested participants providing additional information and answering any questions that arose. All participants were able to communicate proficiently in English and signed (or provided oral, recorded and transcribed) informed consent. Institutional ethics approval was attained from the University, the health region and the hospital where recruitment took place.

Sampling, as it is understood among other methodological approaches (see Patton, 2002), is not a practice undertaken within this style of phenomenology (van Manen, 1990). Individuals were eligible for participation if they had the experience of waiting to have weight loss surgery and could write or talk about it concretely and with depth. The aim of the phenomenological endeavour is not to create a text that is generalizable or transferable but rather that is particular and at

the same time universal, that evokes a tacit understanding of the experience. The assumption underlying the phenomenological project is that all individuals will experience the world differently (this is the particular or unique) but that the phenomena, the experience itself, as it is understood as embedded within the lifeworld, has a universal quality to it – that which makes it what it *is* – not what it is for *this* person or *that* person (van Manen, 1990). For this reason I did not attempt to select participants from varying backgrounds, genders, ages and so on but focused on gathering descriptive, concrete accounts from anyone who had the experience and was able and willing to articulate it. This would closest resemble a convenience sampling technique (Patton, 2002) but given the aforementioned I would be reticent to use the term sampling in reference to doing phenomenological research.

Seven individuals participated in this study. They were predominantly women and came from across the province as well as the neighbouring provinces/territories. Additional demographic details (e.g., age, weight, marital status) were not collected. Demographic information is not often relevant to phenomenological inquires because, as I explained above, the intention is to show how the experience is in the world (i.e., the what-ness of the phenomena), how is it possible for any person, rather than how the experience is for a particular person or people (as stratified by gender, race, etc.). All participants were awaiting treatment at the clinic when we first met and were recruited from the information sessions as described. This number of participants is typical to phenomenological study, where 'sample size' is often small (van Manen, 1990). Ultimately the number of participants or experiential accounts necessary is established by depth of experiential data collected and not by a pre-determined formula or 'data saturation' (van Manen, 1990). Data saturation is not relevant to the phenomenological endeavour because the assumption is that the phenomenon, in its entirety, can never be fully grasped, described or understood.[3]

---

[3] An assumption underlying phenomenology is that there are infinite experiential possibilities of a particular phenomenon and that when we see it in one way we are not seeing it in another – it is always showing and hiding at the same time

Phenomenological knowing is always tentative, indeterminate, and incomplete, it always returns to the experience with wonder and questioning and the possibility of discovering something anew. It does not claim to reveal essential structures of an experience that will be true for all but rather invariant aspects of the experience as it is in the world-as-lived.

Phenomenological interviews. The data for this study were primarily gathered through phenomenological interviews. This approach to interviewing is unique to phenomenology (and unlike more open or in-depth interviewing styles) in that the focus is on gathering pre-reflective, concrete, descriptive experiential accounts of the phenomena and, at later stages, the hermeneutic reflective work of explicating meaning. Phenomenological interviews are continually oriented to the phenomenon of interest – in this case, the waiting period prior to bariatric surgery. To gather phenomenological data for this study I asked individuals to recount specific, concrete experiences of waiting in the context of weight loss surgery. I used prompts such as, "please think of a specific moment where you felt you were waiting to have this surgery" and, "describe it to me in detail – be specific as possible and I want you to describe what you noticed about your body, others, the space and time." During interviews I used other experiential examples as a way of bringing about remembrances. Experiential accounts often begot experiential accounts (they acted as reminders or evoked a particular memory that was one's own) and demonstrated the kind of description that was being sought.

All individuals participated in at least one interview. These lasted between 45-120 minutes. Four of the seven participants engaged in follow up interviews and hermeneutic conversations where we explored the texts (i.e., findings) and phenomenological themes that had emerged from the initial interviews and other sources. Follow up conversations, some of which took place through writing, as I will describe next, were sources of additional experiential material and served to deepen reflections, tease out possible experiential meaning and 'check the phenomenological quality' of the texts. All interviews were recorded and

---

(Heidegger, 1953/2010; Husserl, 1954/1970; Merleau-Ponty, 1945/2002; van Manen, 1990.

transcribed verbatim. Any identifying information (e.g., names, work places) was removed during the transcription process.

Written accounts. I relied up on a few different sources of written accounts in this inquiry including written responses gathered from participants as well as blog and literature sources. Whenever possible study participants were provided with drafts (via email) of phenomenological texts resulting from the study and asked to provide responses or feedback, as they felt appropriate. Most responses were gathered through follow up interviews however one of the participants shared her thoughts in writing, embedding comments within the text and in email correspondences. These writings were, like the interviews, a source of additional lifeworld material and hermeneutic reflections on meaning aspects of the experience. Other sources of writing that I drew on for experiential material were published sources such a literature and weblogs (i.e., blogs).

Observations. I undertook a period of observation within the bariatric clinic prior to commencing study recruitment. I conducted these observations over the course of several months where I spent two afternoons each week in the waiting room of the clinic. I recorded descriptive accounts of what I noticed about the environment, the people, the sounds, shapes, and movements that took place in the space (as well as noticing about the space itself). This oriented me to the phenomenon more deeply by providing a glimpse into the clinical context from which waiting arose (and, perhaps also took place on occasion). It also allowed me to consider my preconceptions and assumptions about the experience and context as I asked myself – what did I record in these notes? What did I leave out? How is the space of waiting lived differently for me, as an observer, rather than for a person who is there to wait for surgery? What might this reveal about the meaning of waiting as it relates to the experience of weight loss surgery?

I also conducted informal observations in the pre-surgical information sessions where I recruited participants. These sessions were mandatory for all individuals who had been approved for the surgery. A nurse, dietician and a psychologist each conducted a segment of the session where he or she focused on providing important pre and post-surgical information about food, physical and

mental health. I did not record observations during these sessions but I did come to know the presented material very well having sat in on 8-10 of these sessions in total. This provided some contextual information about the pre-surgical wait that informed the conversations that followed as well as the phenomenological texts.

Doing Phenomenology: Writing As Method

What might be deemed analytic among other traditions is understood as part of the method, or way of doing phenomenology and is comprised of, not a series of prescriptive steps, but rather an orientation (i.e., phenomenological attitude) and approach guided by reductions and reflective practices – where writing is the essential modality (van Manen, 1990). The gathering of experiential accounts, as previously described, and the reflective and reductive work of phenomenological analysis and writing occur simultaneously. Van Manen (2011) has articulated this as a "hermeneutic circle that draws us increasingly deeper into the text." This includes bracketing assumptions and pre-conceptions – hermeneutic reduction, crafting anecdotes out of experiential material, focusing on concrete experiences – experiential reduction, orienting the text to possibilities and wonder – heuristic reduction, drawing on insight cultivators, engaging in hermeneutic conversations and reflecting on the existentials, practicing free imaginative variation - eidetic reduction, attending to language, and maintaining a vocative tone.

Analytic Techniques: Reductions & Guided Reflection

Phenomenological reductions and guided reflections are particular attitudes of attentiveness (or guided ways of thinking) that push away, bracket or 'reduce' assumptions (i.e., epochē) and at the same time bring one closer or into confrontation with the originary of phenomena (i.e., reduction) – ultimately moving one into direct contact with the thing itself (as it is lived, pre-reflectively). Reduction, in this sense, returns to the original meaning of the word, to bring back or return to, to engage in phenomenological reductions is to return the world as it is in its originary. The reductions and reflective techniques discussed here are those that I used to guide me to possible phenomenological understandings of the

experience of waiting to have weight loss surgery. This list is not exhaustive of all possible phenomenological analytic gestures nor are these reductions prescribed ways of doing nor necessarily unique motions. They are, instead, attentive ways of being, questioning, attuning, bracketing and so on. These have been adapted from van Manen (1990) and M. A. van Manen (2012).

Hermeneutic reduction. The hermeneutic reduction is a turn toward the unexpected – being open to the phenomenon being as it is rather than how it has been thought about previously. This reductive turn involves a critical self awareness – explicating and then setting aside preconceived notions, assumptions, prejudices and so on (e.g., political, ideological). An example of the hermeneutic reduction in this work can be found in the opening text, the pre-text, where I consider my notes, my 'observations' from my first encounter with the bariatric clinic waiting room. I reflect on my embodied experience (e.g., a sense of discomfort, not fitting in the chair) to consider assumptions, values and pre-understanding that I bring with me to this inquiry (as shown through my embodied 'knowledge') so that I might see them and then set them aside. I am compelled to acknowledge, however that this sweeping aside, or 'bracketing' is always incomplete nevertheless it is an ongoing striving toward a kind of openness. This gesture of confronting and setting aside enables me to move, even if only momentarily, closer to the phenomenon as it is in the world rather than as it is already understood.

Heuristic reduction. Phenomenology strives to evoke wonder in the everyday – the heuristic reduction is a willingness to face what is strange in the familiar. It involves bracketing assumed understandings and taken-for-granted truths so that one might be awakened to the phenomenon with a new sense of wonder. This reduction involves a continued questioning – is this what the experience *is*? Is this how the experience shows itself in the world? In this inquiry I continually returned to the question – what is it like to wait to have bariatric surgery? What is the meaning of waiting in this context?

When I began this inquiry I had assumed that I would find the body emerge at the fore of the experience of waiting in this context – it is the body

which one who waits may hope to transform, is it not? Perhaps, yet perhaps not for I found instead it was relational aspects of the wait bubbling to the surface within many of the experiences recounted. I found myself then caught somewhat unexpectedly, pulled toward the relational within this wait. It is from wondering about the unique meanings of the lived relational aspects of this wait that the first paper on contact began to take shape.

Experiential reduction. This reduction involves bracketing abstractions and returning to the concrete – that is, staying close to the experience as it is lived through rather than theorised and pre-conceived. Paying attention to the language of the phenomenon and how it is lived in everyday life is a move toward the experiential reduction. I collected concrete lifeworld accounts from individuals who had waited for the surgery. I asked them to recount specific detailed moments that stood out to them as waiting to have bariatric surgery, which I then read, re-read, sat with and considered – 'is this moment pointing to a possible unique meaning aspect of this experience?' I asked myself. I returned to the concrete experiential descriptions repeatedly as I wrote the drafts of the texts that now make up chapters three through six. Evidence of the experiential reduction is embedded throughout the texts as I relied on anecdotes, crafted out of the experiential descriptions to show, point to or re-evoke particular or unique meaning aspects of this experience.

Eidetic reduction. This reduction aims to uncover the invariant, foundational aspects of the phenomenon and involves bracketing or reducing the variant or incidental. In this reduction one might ask – what, if left out, would leave the phenomenon in tact and what, if it did not remain, would alter the experience, making it something else instead? Here, I use an example of a chair, the colour and shape of the chair are incidental to a chair's chair-ness – the invitation to sit on it, to let it bear one's weight seem foundational, essential to a chair being a chair and not something else. These would be considered invariant meaning structures.

The eidetic reduction can be found throughout the texts that follow when I consider the wait for bariatric surgery in relation to waiting in other contexts. A

specific example can be seen through Jane's account in the first paper where she describes the wait for bariatric surgery like a child waiting for Christmas. Through the text I consider how the experience of waiting for bariatric surgery may be like the wait for Christmas and how it might different. In this way I play with the tension between the unique (that is the wait to have bariatric surgery) and the universal (that is the experience of awaiting something that is much anticipated and desired) and bring the phenomenon of waiting for weight loss surgery into view through a showing of what it is not yet not completely unlike.

The existentials. Van Manen (1990) outlines four existential aspects of experiences (phenomena) which can be used to guide phenomenological reflection: lived-time (temporality), lived-space (spatiality), lived-body (corporeality) and lived-other (relationality). The existentials are present in all human experiences and can provide lifeworld material for questioning, reflecting and writing and help to guide reflection. I used the existentials as a guide for collecting lifeworld material, often probing participants to describe how they experienced lived-time, space, body and other within the examples provided. I also used the existentials as a way of guiding hermeneutic reflection – asking myself, for example, how is the body experienced as related to the phenomenon? What is the unique (invariant) bodily way of being within this experience? How is the experience manifest in the body as seen in concrete, lifeworld examples?

Lived-space is felt space rather than measured space that is qualified in inches and feet (van Manen, 1990). For example, I live in a condominium and the measured distance between my couch and that of my neighbour's may be a matter of inches. Yet, in the way I experience this space, these two rooms feel much farther apart – I cannot easily traverse this distance, there is a wall and a locked door in between. The space within my condo is mine it is cozy and inviting, it welcomes me and in it I *am* in a particular way. The space of my neighbour's living room that may be mere inches from the couch the place where I relax and feel the stress of the day melt away, nevertheless this space that is so close feels so far. Although identical in floor plan and light my neighbour's living room feels

unwelcoming to me, foreign and distant. In this way, although it may be 'near' as sketched on building plans my neighbours' living room is experienced as far.

Lived-body recognises that we are always experiencing the world through our bodies (van Manen, 1990). Within the world as experienced the body may be lived in very particular ways. An understanding of these unique modes of bodily being reveals something of the meaning of the phenomenon of interest. For example, I may forget my body entirely as I focus all of my attention on the tennis ball coming at me while playing a match. Yet if struck by the ball I may be immediately reminded of the presence of my body and its capacity to 'get in the way.'

Lived-time is subjective time. It is our temporal way of being in the world (e.g., time standing still, time flying; van Manen, 1990). Time may slow as we wait for a bus on a cold day or time may fall away as we catch up over a coffee with an old friend. Time as it is lived may show aspects unique to a particular experience, pointing to meanings inherent therein.

Lived-other refers to our experiences of relations with others in the lifeworld (van Manen, 1990). The way we are in relation to others may provide insight into the uniqueness of a particular experience. For example, when in the company of an old and trusted friend we may forget their presence altogether and find ourselves dancing, singing or speaking as if we are alone.

Insight cultivators. Insight cultivators are ideas or thematic insights that can be gleaned from other experiential, phenomenological or philosophical writings. They serve to deepen reflections and understandings of aspects of the experience as it is lived. For example, I turned to the phenomenological writings of Bachelard (1958/1994) on home and homelessness to reflect on the possible meanings of the metaphor of home in relation to the wait prior to weight loss surgery.

> Bachelard (1958/1994) imagines life without a house,
>
> Without it [a house], man would be a dispersed being. It maintains him through the storms of heaven and through those of life. It is body and soul. It is the human being's first world. Before he is 'cast into the world,' as

> claimed by certain hasty metaphysics, man is laid in the cradle of the house. (p. 7)

Bachelard's (1958/1994) writing cultivates possible insight into this meaning of the metaphor of building a house. He shows how the house, for humans, is not distinct from us but it is us – our home is inscribed on us (Bachelard, 1958/1994). The house, in this way, may root us, not only to the earth, but to who we are as beings. In this way it secures our place in the world. Through Bachelard's writing I may come to question, how is this possibly related to the experience of waiting to have bariatric surgery? Is the wait a move toward rooting one's self in the world, a laying claim, so to speak, to a piece of the world for one's self?

Hermeneutic conversations. Reflective conversations with participants and other phenomenological scholars can lead to new insights and check existing insights for assumptions, eidetic and heuristic resonance and so on. I engaged in follow up conversations with four of the seven study participants where we discussed possible phenomenological themes and ideas and tensions or variations to the findings. I also met regularly (2-4 times/monthly) with a group of phenomenological scholars throughout this thesis work. In this group, or hermeneutic circle, we discussed experiential, lifeworld materials, emergent themes, and writing moving each other to more insightful, phenomenological practices that remained close to the phenomenon and evoked a pathic sensibility.

Doing Phenomenology: Writing As a Vocative Turn

> *To return to things themselves is to return to the world which precedes knowledge, of which knowledge always speaks, and in relation to which every scientific schematization is an abstract and derivative sign-language, as is geography in relation to the country-side in which we have learnt beforehand what a forest, a prairie or a river is.* (Merleau-Ponty, 1945/2002, pp. ix-x)

Phenomenological texts bring us into direct contact with the world offering

plausible insight into possible human experiences. They aim to 'speak' to us, to act as call and through this calling elicit responsiveness, a felt sense of responsibility, a tacit understanding of the possible meanings of a particular experience as it is lived – it is through the call of the text that the power of phenomenology lies. The text may move us moving our very way of being.

Language and writing are essential to the phenomenological project; it is through language that experiences may be brought to life. Paradoxically, however, language can name, label and reduce and in this way we may lose the very thing we seek to grasp. This is why writing is so important to the phenomenological endeavour – one must tread carefully and thoughtfully into the crafting of a phenomenological text as one hopes to lift up, bring closer and open to possibilities of meaning rather than qualify, objectify and close off. Phenomenological texts are not intended to demonstrate understanding of a phenomenon but rather to evoke understanding – recognition of pre-cognitive experiential possibilities of life. Like poetry, the phenomenological texts aim to re-evoke meaning through language not present meanings with language. Phenomenological texts should resonate with the reader and with the world. They should show rather than tell and foster practical insight, ethical sensitivities and thoughtful engagement and leave the reader feeling touched or addressed – moved. Metaphors, anecdotes, poetry, tone, cadence, rhythm and other textual devices are used to craft a text that evokes a tacit understanding of the phenomenon and a sense of wonder in the face of the pre-given world.

Anecdotes. Experiential accounts (i.e., lived experience descriptions) are often re-written, 'fictionalized' or crafted into anecdotes within the phenomenological writing process as a way of moving toward a paradigm case, an example of the experience as it is within the world (not uniquely for this or that person, subjectively). According to phenomenology, individuals' experiences are manifestations of a general type – a plausible example of the phenomenon rather than an exact, 'true' account of what happened (as may be 'measured' through other approaches). Anecdotes are short, simple stories that describe a single moment (incident/experience) in concrete detail and often contain talk or

dialogue. They begin close to the central idea and end on a note of *punctum* ('point' of resonance; Barthes, 1980/1981). Anecdotes have an important role in phenomenological writing because they provide examples of meaning aspects embedded within concrete experiences and can show an experience as it is (or may be).

Phenomenological themes. Phenomenological themes are unlike thematic statements found in other qualitative research in that they are not reductions or summaries of a finding but rather points of resonance or meaning structures of the lived experience. Phenomenological themes point to the eidetic (invariant) aspects of the experience and its meanings (van Manen, 1990). Thematic statements, in this sense, provide points upon which the phenomenological text may be organized. Van Manen (1990) articulates three ways to possibly uncover phenomenological themes existent within lifeworld materials. These are neither prescriptive steps nor are they separate from the reflection and reduction practices previously discussed; rather, they present a way of engaging with experiential 'data' (i.e., lived experience descriptions) to explicate the possible meaning structures embedded.

1. *Holistic or sententious approach*: The experiential text or description is attended to as a whole and the overall significance is conveyed in a single phrase or idea (van Manen, 1990).
2. *Selective or highlighting approach*: The text is read for particular sentences that seem essential to this experience. These phrases or ideas are then highlighted and provide a point of reflection (van Manen, 1990).
3. *Detailed or line-by-line approach*: Each sentence or meaning unit (multiple sentences) is explored for what it possibly reveals about the meaning of the experience being described (van Manen, 1990).

The initial 'themes' articulated through this process are then reflected upon, considered in relation to each other and the experiential descriptions – One may ask, is this what it is? Does this theme show an invariant meaning aspect of this

particular experience and not an aspect that if removed would leave the experience untouched? Commonalities but also uniqueness or difference are explored to understand their nearness to the phenomenon. Themes may provide a point of departure for reflective writing.

Assessing Quality

Rigour is the means by which researchers demonstrate integrity and competence of findings resulting from qualitative inquiry and is akin to 'validity' among quantitative research (Tobin & Begley, 2004, p. 390). Assessing rigour is a continual source of deliberation and debate among qualitative scholars because studies differ, often greatly, in aim and approach and therefore are difficult to judge by a uniform set of criteria (e.g., Lincoln, Lynham, & Guba , 2011; Onwuegbuzie & Leech , 2007; Sandelowski, 1993).

Here I provide criteria (posed as questions) by which phenomenological texts can be assessed for quality. These are adapted from van Manen (2007; van Manen & Adams, 2011) and adhered to by the journal, *Phenomenology & Practice*. After each I provide an example of how I addressed the particular element within this inquiry.

1. *Heuristic attentiveness*: To what extent does the text instil a sense of wonder? Does it evoke curiosity, questioning or thoughtful reflection on the experience?

   In the first paper of the findings section (i.e., chapter three) you will find it opens with a discussion of the word 'contact.' I use etymological and philosophical (i.e., Lingis, 2005, 2007; Levinas, 1972/2006) sources to bring the reader to question along with me what contact might mean to the person who is waiting to have bariatric surgery. In this way I open the reader to questioning and wonder and address heuristic attentiveness.
2. *Descriptive richness*: Does the text provide sufficient description of the phenomena such that the reader feels it can be seen or grasped with greater

clarity? Is there a concreteness to the description that inheres to the lifeworld (i.e., pre-reflective) rather than a theoretical positioning?

In the first paper (i.e., chapter three, *Making Contact: Experiences from the Weight Loss Surgery Clinic*) there are many anecdotes describing specific instances of the wait to have bariatric surgery. For example on in the first paper Sara describes hearing from the clinic for the first time, she tells us about opening the letterbox and noticing an envelope from the clinic. The description provided takes the reader to the moment as Sara lived it and resists providing theoretical interpretations or opinions. In this way it addresses the descriptive richness criteria.

3. *Interpretive depth*: Does the text reveal interpretive nuances, insights and complexities moving beyond the assumed or 'already known'?

   In the fifth chapter of this dissertation (i.e., the third study, *Phenomenological Insights and Metaphor: Building a House as the Wait to Have Bariatric Surgery*) you will see examples of interpretive depth with regards to the idea of home and building through my consideration of the writings of philosophers and phenomenologists on the topic (e.g., Bollnow, 196, 1963/2011; Heidegger, 1971; van den Berg, 1972). For example I use Heidegger's essay *Building, Dwelling, Thinking* (1971) to question the importance of home and the act of building a home to the human need find a resting place.

4. *Rigourous focus*: Does the text remain focused on the question to which it proposes to respond? Does it remain oriented to the phenomena?

   Rather than provide a specific example to illustrate the rigourous focus of these texts I will explain the hermeneutic circle I participated in that ultimately addressed this concern. Throughout my work on these texts I participated in a weekly phenomenological reading and writing group. This group consisted of four to six members of phenomenologists working in various disciplines. We shared our writing, discussed philosophical texts and considered experiential descriptions. These weekly session provided a platform for debate and learning but also to 'check' our

writing, interpretations and insights. We often shared experiential descriptions and discussed their potential meanings. Within this context we continually asked each other and ourselves is *this* the experience? Are these concrete descriptions? Am I missing something here?

Having other phenomenologists read the finding included in this dissertation helped to ensure the texts remained focused on the phenomenon, the descriptions were concrete and the interpretations came from the experience and other relevant texts rather than the other way around.

5. *Strongly embedded meaning*: Are the meanings revealed within the text sufficiently embedded within concrete lifeworld material? Can the reader 'see' and feel these meanings within the text? Does the text show rather than tell?

   I refer the reader to my response to item four, rigourous focus, as my participation in this group functioned to check all of these items related to rigour. Members of the phenomenology reading and writing group read multiple drafts of the texts as well as many related experiential descriptions and provided thoughts, feedback and critique. We discussed matters related to embedded meaning at length and would often question and wonder aloud, ultimately encouraging each other to return to the experience as it was lived within our writing, not to presuppose meaning or interpretation that was not embedded within the experience itself.

6. *Oriented epiphany*: Does the text evoke a nod of recognition (i.e., the phenomenological nod) – a felt sense of understanding? Does the reader feel addressed, moved, or called by the text?

   Drafts of chapters three-five were shared with several of the study participants. I sent copies of these studies in earlier forms to all participants for whom I had email contact information. I then conducted follow up interviews with three individuals and communicated back and forth with a fourth over email to elicit feedback, comments and concerns. I asked, what are your thoughts on the texts? Is this what waiting was like

for you? If not how was it different? And so on. These conversations were fruitful and often lead to changes to the draft – increased insight and experiential description. They also functioned to check the embedded meaning and oriented epiphany. One woman wrote to me after reading an earlier draft of the first paper on contact (i.e., chapter three) saying, 'I found myself crying – I didn't realize how difficult that time was for me but I was nodding as I read, that was *it* and all of a sudden I was there again.'

Van Manen (2007) captures these criteria in another way by describing a successful phenomenological text,

> Perhaps a phenomenological text is ultimately successful only to the extent that we, its readers, feel addressed by it — in the totality or unity of our being. The text must reverberate with our ordinary experience of life as well as with our sense of life's meaning. This does not necessarily mean that one must feel entertained by phenomenological text or that it has to be an "easy read." Sometimes reading a phenomenological study is a truly laborious effort. And yet, if we are willing to make the effort then we may be able to say that the text speaks to us not unlike the way in which a work of art may speak to us even when it requires attentive interpretive effort. (p. 26)

It was my aim to uphold these standards within the remainder of this thesis text, in particular within the three papers that make up the findings chapters of this dissertation.

References

Bachelard, G. (1994). *The poetics of space*. Boston, MA: Beacon Press. (Original work published 1958)

Barthes, R. (1981). *Camera Lucidia* (R. Howard, Trans.). New York, NY: Hill and Wang. (Original work published 1980)

Bell, K., Brown, M., Thykier, K., & Vaughn, M. (Producers), & Barber, D. (Director). (2009). Harry Brown [Motion picture]. United Kingdom: Marv Partners, UK Film Council, HanWay Films, Prescience, & Framestore Features.

Bollnow, O. F. (1961). Lived-Space. *Philosophy Today, 5*(1), 31-39.

Bollnow, O. F. (2011). *Human Space* (C. Shuttleworth, Trans.). London, UK: Hyphen Press. (Original work published 1963)

Buytendijk, F. J. J. (1988). The first smile of the child. *Phenomenology + Practice, 6*(1), 15-24.

Dreyfus, H. L, & Wrathall, M. A. (Eds.). (2009). *A companion to phenomenology and existentialism*. Malden, MA: Wiley-Blackwell.

Føllesdal, D. (2009). Husserl's reductions and the role they play in his phenomenology. In H. L. Dreyfus, & M. A., Wrathall (Eds.), *A companion to phenomenology and existentialism* (pp. 105-114). Malden, MA: Wiley-Blackwell.

Heidegger, M. (1971). Building, dwelling, thinking (A. Hofstadter, Trans.). In *Poetry, Language, Thought* (pp. 145-161). New York, NY: Harper Colophon Books.

Heidegger, M. (2010). *Being and Time*, (J. Stambaugh, Trans.). Albany: State University of New York Press. (Original work published 1953)

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy* (D. Carr, Trans.). Evanston, IL: Northwestern University Press. (Original work published 1954)

Levinas, E. (2006). *Humanism of the Other* (N. Poller, Trans.). Chicago: University of Illinois Press. (Original work published 1972)

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin and Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed.). (pp. 97-128). Los Angeles, CA: Sage Publications Inc.

Lingis, A. (2005). Contact. *Janus Head, 8*(2), 439-454.

Lingis, A. (2007). Contact: Tact and caress. *Journal of Phenomenological Psychology, 38*, 1-6. doi:10.1163/156916207X190210

Linschoten, J. (1987). On falling asleep. In J. J. Kockelmans (Eds.), *Phenomenological psychology: The Dutch school* (pp. 79-118). The Hague, The Netherlands: Martinus Nijhoff.

Merleau-Ponty, M. (2002). *Phenomenology of Perception*, (C. Smith, Trans.). New York, NY: Routledge. (Original work published 1945)

Mulhall, S. (2005). *Routledge philosophy guidebook to Heidegger and Being and Time*, 2nd Ed. New York, NY: Routledge.

Onwuegbuzie, A. J., & Leech, N. L. (2007). Validity and qualitative research: An oxymoron? *Quality & Quantity, 41*, 233-249. doi:10.1007/s11135-006-9000-3

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods* (3rd Ed.). Thousand Oaks, CA: Sage Publications.

Sartre, J. P. (1984). *Being and Nothingness* (H. E. Barnes, Trans.). New York, NY: Washington Square Press. (Original work published 1943)

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advanced Nursing Science, 16*(2), 1-8.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388-396. doi:10.1111/j.1365-2648.2004.03207.x

Van den Berg, J. H. (1972). *A different existence: Principles of phenomenological psychopathy*. Pittsburgh, PA: Duquenese University Press.

Van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

Van Manen, M. (2007). Phenomenology of practice. *Phenomenology & Practice, 1*(1), 11-30.

Van Manen, M. & Adams, C. (2011). *Assessing Rigour* [Course notes]. Phenomenological Research and Writing (EDSE611). University of Alberta, Edmonton, AB, Canada.

Van Manen, M. [Michael] A. (2012). *Phenomena of Neonatology* (doctoral dissertation, University of Alberta, Edmonton, Canada). Available from ProQuest Dissertations & Thesis @ University of Alberta database. (UMI no. NR92577)

Wrathall, M. A. (2009). Existential phenomenology. In H. L. Dreyfus, & M. A., Wrathall (Eds.), *A companion to phenomenology and existentialism* (pp. 31-47). Malden, MA: Wiley-Blackwell.

Chapter Three – Paper One: Making Contact: Experiences From the Weight Loss Surgery Clinic[1]

Encountering Contact In the Weight Loss Surgery Clinic

Weight loss, or bariatric surgery is an umbrella term used to describe a number of restrictive and/or malabsorptive surgical procedures intended to induce significant weight loss (Neff, Olbers, & le Roux, 2013). Some procedures involve cutting away or closing off a portion of the stomach, reducing it in size so as to restrict caloric consumption and retard stomach emptying. Others re-route or cut away a portion of the intestine, limiting the absorption of calories, vitamins and minerals. While some procedures do both – reducing consumption and absorption (Neff et al., 2013). Bariatric surgery is the most effective treatment available for class III obesity (i.e., extreme obesity, clinically significant obesity; Body Mass Index (BMI) ≥ 40 kg/m^2; Neff et al., 2013).

It is estimated that 1.5 million Canadians could qualify for bariatric procedures yet only about 0.1% receive the surgery (i.e., publically funded procedures; Padwal, Chang, Klarenbach, Sharma, & Majumdar, 2012). People are literarily dying while waiting to have the procedure (Christou, & Efthimiou, 2009). Waiting, within this context, is no doubt significant for the individuals in the queue, however, the impact this wait has is yet to be thoroughly explored (Padwal, Majumdar et al., 2012). Preliminary investigation suggests it has a profound impact on quality of life and physical as well as psychosocial wellbeing (Padwal, Majumdar et al., 2012). I wonder what is it like to wait within this context? How is the potentially lengthy period prior to bariatric surgery lived by those who wait?

The bariatric clinic is a place where patients and clinicians interact, connect, and make contact with each other. The wait for bariatric surgery, in Canada, averages 5 years but can stretch upwards to 10 years depending where a

---

[1] A version of this chapter has been published: Glenn, N. M. (2013). Making contact: Experiences from the weight loss surgery clinic. *Phenomenology & Practice, 7*(1), 36-52.

person lives (i.e., the time from referral to surgery; Christou & Efthimiou, 2009). People can wait years before they are even on the formal waiting list, before even entering the queue; waiting to wait so to speak. Once clinical visits begin, the wait can stretch on for a time, years perhaps. Within these waits there may be many opportunities for contact, a touch or a word, between clinician and patient; there may be many opportunities missed as well. I wonder what is the significance of contact within this context? What does the experience of contact mean to the people who are waiting to have weight loss surgery?

I contemplate the word – contact – it is a state or condition of touching, meeting or communicating; it is a person carrying a contagion or a connection for the passage of an electrical current (Barber, 2004, p. 327). Contact originates from com–*tangere* meaning with-touch (Barber, 2004, p. 327). I wonder, however, what does it mean in a clinical context? What about in the context of the pre-bariatric surgical waiting period? It surely is not an experience of connecting electrical currents or the carrying of a contagion, is it? It must be a touch - instrument to skin perhaps, or getting in touch with – clinic to patient or patient to clinic, and also meeting – appointments arranged and attended. These are the modes of contact one may expect to experience within the wait to have reducing surgery. Lingis (2005, 2007) and Levinas (1972/2006) articulate contact in another way, as *con*, that is *with,* tact. This con-tact is an ethical way of being in relation, a kind of seeing that acknowledges the other as unique, as truly and inescapably *other*. This con-tact calls forth responsiveness, a being *for* the other. One would hope that this form of contact is experienced within the bariatric clinic between patient and clinician; however, this may not always be the case. A person who decides to pursue weight loss surgery may be subjected to numerous tests, screening processes and procedures prior to surgical approval. During this pre-surgical waiting period one may find oneself observed, measured by clinicians, technicians and tools that are intended to see scientifically, objectively, to see through the exterior and into the materiality of the body and somehow determine what the outcomes of this surgery might be. In the attempt to see in this way, however, what might be missed?

Levinas (1972/2006) offers some insight here. He writes about the relation between one and an Other as a possibility for tactful engagement, an ethical way of being that extends to being *for* the other. This engagement requires a seeing and openness to the other in their otherness,

> To meet another, one must first welcome a face. This means more than looking at the features in the other face, or the color that characterizes the surface of his skin, or the iris of his eyes – as if in doing so one could perceive, grasp, know. Is not the face first of all expression and appeal, preceding the datum of knowledge? (Levinas, 1972/2006, p. 191)

This kind of ethical seeing that is an appeal, an authentic call, from one to an Other, 'precedes the datum of knowledge,' as Levinas writes. It requires seeing beyond the universal, beyond the results of tests and clinical measurements. How might this kind of seeing, this form of contact take place within a clinical encounter? Is it even necessary or desired? I wonder what other forms of contact may take place within the period of waiting to have weight loss surgery? What might be the significance of these experiences to the one who waits?

Methodology

This phenomenological inquiry followed the human science research and writing practices of Max van Manen (1990). I entered the clinic environment as a researcher, a phenomenologist interested in the experience of waiting to have bariatric surgery – the larger research project in which this particular inquiry is embedded. I am not a clinician, nor did I have a previous relationship with this particular bariatric program. This research inquiry was conducted independently of the clinic; however with their approval. All research-related activities (e.g., interviews, analysis), excluding recruitment and observations, took place outside of the clinic environment. The study was approved by the university ethics review board as well as the ethical review boards for the local health region and the specific hospital from which recruitment took place. All participants were greater than 18 years of age and signed informed consent.

I recruited participants from compulsory, pre-surgical education sessions conducted at a publically funded bariatric clinic in Western Canada. Seven individuals agreed to participate and were selected based on their interest in participation and their ability to communicate proficiently in English. Recruitment ceased upon the collection of sufficiently rich, descriptive lifeworld data. Participants had been approved for bariatric surgery (by the bariatric surgeon at the clinic) and were waiting for their surgical date when the first interview was conducted. These phenomenological interviews were open-ended and oriented to the phenomenon as it arose in each participant's unique experience, rather than being structured or semi-structured as are more commonly used techniques among qualitative data collection. My aim was to gather pre-reflective, concrete, experiential descriptions (i.e., not judgments, opinions, theories and so on) of the phenomenon and, as the interviews progressed, to begin reflective questioning.

Following the initial interviews, preliminary analysis and writing, I engaged in follow up conversations with all interested participants (four of the seven agreed to follow up conversations). These conversations contributed additional lifeworld material as well as served as a hermeneutic exercise where, together, we reflected on emergent insights and phenomenological themes that arose through preliminary writing, reflections, and reductions. All interviews were recorded and transcribed verbatim. They were analyzed using phenomenological reduction and reflection practices, described more accurately an approach or attitude rather than specific step-by-step techniques (van Manen, 1990). With this text I aim to present glimpses into possible meanings of the phenomenon. I focus on six phenomenological themes that emerged in response to the question – what is it like to experience contact while waiting to have bariatric surgery? Contact within the bariatric clinic may be waiting to hear from – waiting to wait so to speak; it may be momentary, a fleeting experience, a tease; it may be passing off or passing over; contact may be a gnostic touch – the palpating hands of a physician; it may be a pathic touch, a caring gesture of felt understanding; and contact may be an invitation for one to be honest, to show oneself to an Other.

These glimpses into the experience as it is lived by the people who have waited to have weight loss surgery may bring to the fore the hidden, taken-for-granted or assumed and thus deepen our understanding of the phenomenon as it is within the everyday lifeworld. This understanding may inspire a pause in practice, a moment to consider and in doing so perhaps shift our way of knowing, and even our way of being, so as to allow space for new, more tactful and ethical practices to emerge. This may be particularly relevant to the caring or clinical professions that populate the bariatric clinic. Baron (1985), a physician and phenomenologist, argues that phenomenological understandings might help bridge the schism between physicians and patients. He reflects on his own experiences and writes, "It is as if physicians and patients have come to inhabit different universes, and medicine, rather than being a bridge between us, has become one of the major forces keeping us apart" (p. 606). He contends that phenomenology within medicine might help the field and those practicing within it to "rediscover and realize the human goals of medicine" (Baron, 1985, p. 606). It is to the human, the experiential dimension of being a patient waiting for weight loss surgery that I now turn.

Not Even On Hold: Waiting to Hear from the Weight Loss Surgery Clinic

Jane, a woman who is waiting to hear from the bariatric clinic for the first time, describes the significance of the wait, of the procedure and the life that she hopes to attain,

> I feel like a small child a Christmas. The excitement I feel about having this surgery is how I once felt before waking up and running down the stairs to find that Santa had come. 'I *want* this surgery,' I think to myself. I will do whatever I have to do, jump through any hoops, say anything I need to, anything the clinic staff wants to hear to get the surgery. I don't think most people understand what it is like to *want* this. 'I feel hopeful for the first time in a long time. I feel hopeful for something I've long given up on.' (Jane)

Jane *wants* weight loss surgery – she's desperate to have it. She will do whatever needs to be done to access it; she'll jump through hoops and do what the clinicians ask, anything to get surgical approval. The promise of the surgery may be the promise of hope for Jane. With the promise of surgery Jane may find the promise of new beginnings and transformation and the promise that things she had given up on may actually be possible.

Waiting to hear from the clinic Jane feels like a child on the precipice of Christmas morn, bubbling over with excitement and anticipation. She cannot wait for the surprises she hopes are in store – what is in store, she may wonder. In store may be a bright future free from discomfort or from pain, free from health related worries that take the shape of "not if, but when." In store for Jane may be a slimmer body, a lower number on the scale. In store may be the ability to shop at "normal people clothing stores," as another woman waiting to have the surgery explained. In store may be a better fit – seats that welcome rather than pinch and bruise, stares that appreciate and admire rather than judge and ridicule. During the pre-weight loss surgical period possibilities abound, at least so far as one awaiting the surgery, like Jane, may anticipate. Yet, weight loss surgery is not like Christmas. The twenty-fifth of December will come each and every calendar year without fail. It may not be celebrated in the same way, with equal measures of gift giving and celebratory mood, but one can be sure that the date will arrive and it will be Christmas day. Bariatric surgery, however, may not arrive with such certainty. It may not arrive at all. A person does not simply apply, wait her turn and then undergo the procedure as Carol explains,

> I submitted all my forms ages ago. I've actually had a baby during this time. A baby! That's a long time to be waiting for something. It has felt like forever. At this point I've pretty much given up on waiting to hear from the clinic. They've not been in touch with me once since my referral was sent. No contact– not even, "oh you're on the list, on hold." Nothing. Nothing at all! (Carol)

Carol articulates the uncertainty of the connection between herself and the clinic while she waits to hear from them for the first time. She does not even know if she is on hold. This may be different than the experience of awaiting other surgical procedures, such as atheroplastic joint surgery or a liver transplant where patients describe waiting as 'life on hold' (Brown, Sorrell, McClaren, & Creswell, 2006; Parsons, Godfrey, & Jester, 2009; Sjöling, Ågren, Olofsson, Hellzén, & Asplund, 2005). Is the wait to hear from the bariatric clinic for the first time a life waiting to be on hold? Or perhaps this is the pre-holding area, the 'wait to hear from' void. Knowing there is much more waiting to come a person may just want to start waiting, to get to it, so to speak. Instead one may be waiting to wait – a no man's land of pre-waiting that can stretch out infinitely ahead.

Carol has reached out to the clinic, submitted her forms and expected that she has entered the queue. Should they not reach back to her? At least let her know her application has been received, is being reviewed, and is complete? Should she not expect some kind of contact in return? So much time has now passed that Carol is no longer the same person she was when she first applied. She is a mother now. What else will transpire in her life while she waits to hear from the weight loss surgery clinic? As her life continues to move forward marked by transitions, big and small, she wonders if her forms have been lost or if she has been forgotten, perhaps they were not submitted after all? Maybe her doctor forgot to send her referral forms on or there was information missing and they've been tossed out? The wait for first contact stretches indefinitely before her and Carols appears to find herself in a black hole of sorts, a contactless void where time and space cease to exist, at least when it comes to this wait to hear. The rest of her life, as she explains, keeps chugging along but the wait, well she doesn't even know if it is a reality. "Am I waiting?" she asks herself over again.

The wait-to-hear-from that feels like a black hole may also represent limitless possibilities – a space where anything could happen. Nevertheless, whether anything or nothing, infinite or limited, nothing is certain. Without any word from the clinic the person who waits, like Carol, must imagine the reasons, fill in the blanks with her own stories and continue to try to make sense of the

void that is this uncertain time of not-quite-waiting. According to Levinas (1978) this is precisely where hope may arise. He writes, "All the acuteness of hope in the midst of despair comes from the exigency that the very instant of despair be redeemed…hope hopes for the present itself…at the very moment where all is lost, everything is possible (Levinas, 1978, pp. 94-95).

Contactlessness, as in the non-response to the reaching out of another, such as described by Carol, may be experienced as gesture of carelessness, a non-touch, a void. Why would the clinic not call or write to say they had received her forms? Carol may feel this means she is unworthy of their time, their energy and their care. Nothing, not a word from the clinic during this time, may be experienced as nothing, a void; a black hole perhaps, limitless and empty. However, there may be more to it than that. Carol may feel like she *is* nothing as she reaches out for connection and hears nothing in return. The wait to hear from the clinic may be a wait to hear back, a wait for response, a wait for responsiveness, for connection and care. One may be reaching out for more than a place in the queue, one may reach out as a question, 'am I worth it?' What if one were instead waiting to have cataract surgery? Would one imagine this kind of non-contact said something about their worth? Yet quite unlike a person who waits for some other form of surgery Carol may feel like she *is* nothing as she reaches out for connection with the bariatric clinic and hears nothing in return.

A person may seek out weight loss surgery for a multitude of reasons. Perhaps one hopes for better health, freedom from infirm and pain. Perhaps it is a more active and fulfilling personal life that one seeks, renewed desire and increased attention. One may hope that surgery will bring about a kind of normalcy previously only imagined, the ability to walk down the street without ridicule and shame. Perhaps it is another reason entirely that moves a person to wait. Regardless of motivation, however, one may anticipate that this surgery will bring transformation, transformation of body and perhaps of self (Throsby, 2008). One may hope that weight loss surgery will bring about a different way of *being* in the world and maybe the world will be different in return (Throsby, 2008). Is it possible that it could be a little less harsh, less judgmental? In this way the move

toward surgery, the request for referral and subsequent wait for contact from the clinic may be more than a 'wait to hear from.' It may be wait for an open door to beckon one forward, into the future and a new way of being in the world. Yet, I wonder how much contactless silence can be endured before a person gives up all hope of ever being invited into the future full of possibilities? How long until Jane's excitement and anticipation fades and then disappears? What may have been a hopeful space, a time of beginnings and promise instead appears to transform into a contactless void full of uncertainty and the unknown. A woman waiting to have the surgery tells me, "I want to call and say have you forgotten about me, was my application lost, what's going on?" Yet she does not, but rather, continues to wait to hear from the clinic and grasp at hope at it slowly slips into the silence.

Hearing From As a Tease

> It was like any other day. I just grabbed the mail and headed into my house. Then I noticed the letter from the clinic. I felt my heart skip a beat. Could this be? I had almost forgotten about the clinic, almost, but not quite. I immediately phoned my husband and then my sister. 'I've heard from the weight loss surgery clinic!' I almost shouted into the phone. Then I felt a knot in my stomach. Panic was setting in; I need to make travel arrangements, what should I expect, where is all the information I need? (Sara)

What begins as an ordinary day may be made extraordinary through the receipt of a letter. Amidst the bills, advertisements and occasional card received in the post this letter seems to stand out. On first glance it may look like the others, a white or beige envelope, typed address on the front. But, then, there is the return address imprinted in the top left corner, the clinic name clearly announcing the *wait to hear from* is over. Excitement and anticipation collide, as the envelope is ripped open. "What do they have to say to me?" Sara asks as she skims through the contents looking for clues. "Am I in? When do I start? What now, what next?"

"The letter of acceptance," as one woman waiting for the surgery put it, contains information about the program and details of the educational courses, or 'modules' that must be completed before a first appointment will be booked. In the letter, a person may find contact information for the clinic and a date by which she must respond to indicate continued interest in the program. On the contrary one may find in this letter very little information about how to get a hold of the clinic and be left feeling like the intended message was, 'don't call us, we'll call you.'

The arrival of the letter from the weight loss surgery clinic may mark a moment long awaited. The black hole, the contactless void has slipped away and in its place, a letter, a ray of hope; a touch in response to the reaching out. This touch may be tentative, fleeting even, like a whisper that is felt and then disappears. Sara, the woman who shared her experience of receiving the letter went on to explain,

> Weeks have passed since I've received the letter and since then there has been nothing, I've not heard from the clinic at all – no follow up, no phone call, no contact at all – like 'Here you go and keep waiting.' The letter just feels like a tease. I think, "Come on lets go, lets get a move on, lets get this started!" (Sara)

Excitement and hope may begin to transform into uncertainty and dread as a person realizes that this is only the beginning, yet again. The wait to hear from the clinic, the nothingness of silence that preceded the request for entry into the surgical queue, seems to be replaced with a new kind of wait; a waiting that *is* the wait for surgery. Although the uncertainty of waiting, as 'am I waiting at all?' falls away the moment the letter is received, it may be supplanted with a new kind of uncertainty, that of 'what now, what next, and when?'

With the letter from the clinic the clock may begin to tick on this wait, it's been five days, five weeks, or five months since the letter arrived. Time may feel less like a vacuum, an infinity that slips in and out of one's consciousness, and more like a presence, something to be counted in minutes and days, something to

be tracked and measured. Impatience may replace the cycle of hope and hopelessness that was, as one feels time slowing with this new form of uncertainty. Questions are left lingering as one searches the letter for answers. “Is this a form letter? What does this letter say about me? What does it say to me?” I wonder how might this moment be experienced differently if one had received a phone call instead? What about an email? What might the form of contact say about the value or worth of a person being contacted? An email or phone call are immediate, letters can take a week or even longer to arrive. Letters can be immensely personal, hand written in swirling script, or decidedly impersonal, lost amidst junk mail and bills. Receiving a letter from the clinic may feel like a careless gesture – Am I not worthy of the time it takes to make a phone call? A person may wonder, is my time so unimportant that I should wait another week to receive this notification by post? Am I so unimportant? Particular to the wait to hear from the bariatric clinic this mode of contact may feel especially thoughtless. Like Carol and Sara, people who are waiting may have been waiting to hear for a very long time already, waiting without even certainty that they were waiting at all. The extra time it takes for the letter to arrive may feel like another sign, among many, that the person who waits for this surgery is less than, unworthy and uncared for (Lupton, 2013).[2]

---

[2] I include here a brief description of the literature from which these statements are drawn. Critical scholars contribute significantly to understandings of fatness/obesity and related treatments and have exposed the complex and often problematic nature of living with, through and in ‘obese’ bodies and reducing through surgical means (Drew, 2008, 2011; Lupton, 2013; Meleo-Erwin, 2011, 2012; Murray, 2008a, 2008b, 2009; Throsby, 2008). They show how fatness is, for example, equated with moral failure, obesity with pathology and bariatric surgery as ‘the easy way out’ (Thorsby, 2008; Murray, 2009). These critical and discursive explorations show the re/productive capacities of language and the power of dominant knowledges and discourses to shape experiences and understandings of self, other and world (Lupton, 2013; Meleo-Erwin, 2011, 2012; Murray, 2008a, 2008b, 2009; Throsby, 2008). These understandings may shape the experiences of the people who pursue bariatric surgery, affecting how they think about their bodies, the procedure and the post-surgical future (among other things). It is within these discourses that individuals seeking bariatric surgical care may be positioned and, furthermore, where they may position themselves.

First contact from the clinic may feel like a tease, a touch that holds promise of one thing but delivers another, or perhaps it delivers nothing at all. To be teased is to be made fun of and can come out of kindness or out of cruelty. To be teased is to be lured into thinking something will arise when it does not and was, in fact, never going to. What is it like to feel teased? Perhaps we enjoy the teasing of a friend, a parent or a lover. This kind of teasing may be a gesture of playful affection, demonstrating closeness and intimate knowledge. On the other hand, teasing may be an unwelcomed picking apart, a passive-aggressive saying without really saying leaving one feeling uncared for and hurt. An unfulfilled promise may feel like a tease, a pulling away of that which was expected and desired. This mode of teasing gives the impression of unequal power, where the one teasing holds all of the strings, and like a puppet master with a marionette, makes the other dance at will. Sara feels teased by the clinic in just such a way. For her, the letter was a sign that contact had begun—and perhaps it had—but not in the way she had expected. She anticipated hearing from the clinic; the moment of first contact would be the beginning of a relationship, a two-way exchange between her and the clinic. Instead, she learns to read between the lines of the letter received – don't call us, we'll call you – and feels distinctly out of touch and alone.

Contact as a Refusal: Being Passed Off and Passed On

Jasmine recounts the moment where she requested a referral to the bariatric clinic from her family physician. This moment has stayed with her years after the referral was made,

> "Can you refer me to the weight loss surgery clinic?" I asked my family doctor. He hesitated and then said, "Okay," but he didn't seem to know anything about it nor care for that matter. It was like, "Whatever. Here you go, here is your referral, now away you go." I don't even think he looked up from the page he was signing to look at me. I have seen him since and he doesn't even ask about it. I have to contact him when something comes up. I'm trying to get my weight and my health under control and it's like

> I'm doing it on my own. I am sure he feels I just need to eat less and move more so he's happy to pass me off to a different doctor. (Jasmine)

In requesting a referral for the bariatric clinic Jasmine seems to be asking for more than a signature on a page. She is reaching out to her doctor with hope, perhaps, that he may reach back, acknowledge her and offer her support. She may be hoping for a connection that is recognition and maybe even a nod of approval, "yes, you are deserving of this surgery, yes, I will be in your corner," she may imagine him thinking. Instead he does not look up from the form that he signs. He does not look at her. She is left feeling as if he thinks her weight is her fault, her problem, not his – eat less and move more – she can feel it, although unspoken. She's heard this a million times before and from a million different people, or so it seems. She thought he would be different, he would know better, he would understand and that he would care.

The recognition of one by the other, expressed through a look, a touch, or a gesture may be similar to the mode of responsive contact described by van Manen (2012); the kind of contact that elicits a sense of responsibility an ethical way of seeing the Other. Instead, Jasmine is refused. She is passed off, so it feels, from his hands to another's, although he does not seem to care whose. What is it to pass off? Passing off happens to things we no longer need, want, or have any attachment to. We may pass off something that is a nuisance, something we no longer care for. Being passed off may be experienced as a deliberate but thoughtless touch—an empty space in which one is alone although in the presence of others. To be alone among others may be different than being alone as in solo, by one's self. Imagine there are people all around and not one of them understands you, or perhaps even cares to? This is a profound kind of aloneness, an aloneness that may be isolating, silencing, dismissive. 'You are not worthy,' it whispers.

Like embarking on a solo expedition, a person who is waiting to have bariatric surgery may feel they are going it alone. However, quite unlike such an endeavour, where the solo expedition may be taken on by choice, the

companionless journey towards bariatric surgery may be neither expected nor desired. One may reach out for support, for companionship, like Jasmine, and be refused. Jane, who earlier described the surgery as Christmas-like, explains, "I am shifted from person to person. I'm seeing a third nurse in two months! There is no constant companion for this journey." Instead of companionship she finds isolation; instead of guidance and support she may be passed off or passed on. This act may be intended as a motion toward the future, a passing from one stage to the next, yet as it is experienced, beyond the control of the one who is passed, it may feel like a hostile move, a careless and tactless gesture. This mode of contact is quite the opposite of con (with) – tact, as articulated by Levinas (Robbins, 2001) and Lingis (2007). The ethical way of being with (and for) the Other, responding to the call of their being. Levinas (1972/2006) writes,

> Between the one that I am and the other for whom I answer gapes a bottomless difference, which is also the non-indifference of responsibility, significance of signification, irreducible to any system whatsoever. Non-in-difference, which is the very proximity of one's fellow, by which is profiled a base of community between one and the other, unity of the human genre, owing to the fraternity of men. (p. 6)

This ethical way of being with the Other is a human way of being, not specific to the clinical encounter, per se. What are the possibilities for this mode of con-tact between clinician and patient? What is the meaning of con-tact to the person who is waiting to have bariatric surgery? The refusal that is the experience of non-con-tact may be isolating leaving a person to feel unseen and alone, refused and unworthy. The refusal is a sign of indifference, as Levinas describes, a non-seeing of the uniqueness of the Other and a reduction to the general case. Is this not the practice of contemporary medicine – the reduction to the same, the seeing beyond the unique to the shared, seeing under the skin to the very core, to the cells? How might a physician in the bariatric clinic *see* the general so as to diagnose and treat yet also see the unique so as to care and respond?

The Gnostic Touch of Contact as Reducing to Sameness

Moments of generalization and categorization cannot be avoided within the bariatric clinical encounter, or, within any clinical encounter it seems. Measurement and testing are a hallmark of contemporary medical practices and can lead to diagnosis and treatment, to cures of illness and pain. There may be different ways of being within the clinical encounter, however, as van Manen (1999) describes. The clinical touch or way of seeing can be *gnostic*, as in dia-gnostic, a technical way of being, probing for answers and palpating beneath the skin. The clinical touch can also be *pathic*, as in em-pathic and sym-pathic, an embodied, relational way of being, seeking to understand, to worry and to care. The gnostic touch is the more common way of being between clinician and patient. I wonder how the person who is waiting to have bariatric surgery experiences this gnostic touch? What possible meanings might of this form contact imbue?

Rachel is waiting to be approved for bariatric surgery. To qualify, she must undergo screening, including providing a detailed medical history. She describes the conversation she has with the intake physician,

> The doctor asks me about my sore knee and then goes onto say, "oh so you got a bit of arthritis." "No." I respond. I know this already because my family doctor x-rayed my knee just last year. There is no arthritis. I am sure of that. I know that pain in my knee comes from a muscle problem, probably because of bad shoes. I walk so much and I haven't been careful about my shoes. I try to tell her all of this but she's already onto the next question. I think, "Okay, so I didn't get that story out. The doctor thinks its arthritis and there is nothing I can say to convince her otherwise." I know there are two things wrong in my chart now. "Oh well," I think, "I'll just let it go." (Rachel)

The physician's trained gnostic eye may see the pain in Rachel's knee and the weight of her body and know how the two are related – this pain was caused by the weight, this knee is arthritic, the physician appears to conclude. The gnostic

seeing of the physician intended to capture Rachel's detailed medical history may capture her instead, entrapping her within an expected history, and reveal nothing of the truth of who she knows herself to be: a walking enthusiast, a buyer of cheap shoes perhaps. She is not the 'stereotypical fat person,' the lazy, the stupid and the miserable (Lupton, 2013). We may wonder, who is? While at the same time asking ourselves, can a fat person really be more than her material body, more than what can be seen with our eyes? Contemporary depictions and understandings of fatness show otherwise – the fat body is first and foremost fat (Lupton, 2013). Scott-Dixon (2008) writes,

> Fat is many things, including a tissue; a signifier and symbol; a self concept; a set of experiences; and an identity that is constituted in relation to others, (sub)cultural norms, and systems of power and privilege. Fat is a curious and contradictory thing, both hypervisible and invisible; both associated with femininity and desexualized. It simultaneously signifies both poverty and abundance; public concern and private well being; inadequacy and excess. . . Fat is often used in the same way as obscenity: nobody can quite agree on a definition, but we feel we know them when we see them. (p. 24)

Rachel may be obese, fat, "big-boned, plus-size, thick, curvy, voluptuous, padded" (Taylor, 2013, para. 2), depending on who is doing the labeling, that is why she is here at the clinic for treatment, yet she is also infinitely more. She is herself and the stories she tells show that self to the world. What then if these stories go unheard? What does it matter if the physician sees her as she is, not as she is expected to be?

The gnostic touch of the physician is intended as an information-gathering touch, a quest for particular forms of knowledge, for understanding and classification. In the clinical encounters that take place prior to bariatric surgery it is frequently weight and height that are recorded, and blood sugar and insulin levels that are tracked. Weight histories, weight loss attempts and comorbidities (i.e., related medical conditions) are important and necessary to the clinicians

providing care at the bariatric clinic. With such a focus, however, what might be lost or remain unseen? Robbins (2001) writes,

> The achievement of knowledge consists of grasping the objects. Its strangeness is then conquered. Its newness, the opening up of its otherness, is reduced to the 'same,' to what has already been seen, already known. In the ethical relation, the other man remains other to me. Despite our exchanges, he remains that which I – closed up in myself – am not. (p. 191)

There may be little space for strangeness within the clinical encounter, particularly within the bariatric clinic where queues are long and care provision stressed (Christou & Efthimiou, 2009). There may be little desire or felt need to face the unfamiliar within that which is increasingly familiar: 'the problem of obesity,' the fat body, ill and in need of fixing, the epidemic that is sweeping the globe (World Health Organization, 2011). We presume to know so much about the obese body, and the person by association (Lupton, 2013; World Health Organization, 2011). Are we really open to understanding differently? How might this presumed knowledge influence experiences of contact within the bariatric clinic?

The contact experienced through the gnostic touch may reduce and silence a person – it may not invite the other to be as she is but instead command her to be as she should be, the 'general case,' *severely obese*. The palpating, gnostic hands of the physician may be almost undistinguishable from the sterile metal tools they so deftly employ. These are hands that know; they know bones and muscles, tissues and cells; they know of life and death. But what do these hands know of the person—the one whose warm skin they prod? What do they know of her pain and suffering? What do they know of the story she tells of her *self*?

The Pathic Touch of Contact: Making the Wait (Weight) Fall Away

Sara is waiting to have bariatric surgery; she is in the hospital being prepped for her procedure. She may be excited and nervous; things are going to change. She

may think, what will it be like after surgery? She has been to the information sessions and done her homework, reading online and talking to others, so she knows what to expect. She also knows to expect the unexpected; she knows that each case is unique and that she may respond differently than others. These thoughts may be occupying her mind as she sits alone in her hospital room.

> I keep checking the clock to see if it's time for me to go yet, time for them to come and get me and wheel me to the operation theatre. The walls are white and I can hear the clock, tick, tick, tick. I'm excited and I'm nervous. I feel sick to my stomach all of a sudden. Am I doing the right thing? Do I really want this? The nurse is in the room adjusting my bed, checking my vital signs, my heart rate, blood pressure and other pre-surgery prep stuff. He starts chatting to me about some show he was watching last night. It turns out it's a show that I watch too! We're talking and laughing away and I forget to check the clock. It feels so normal. Like I'm not there waiting for this surgery. (Sara)

In the final moments of waiting for weight-loss surgery, Sara finds the ticking of the clock broken by the warm voice of the nurse who is there to take her vital signs. He has her lean forward and breathe out as the cold stethoscope touches her back – a gnostic gesture to be certain! – Then he begins to chat. He talks about the unexpected plot twist in his favourite television show watched the night before. He asks if she watches too. (Contact is made!) They begin to laugh, losing themselves in the lives of the fictional characters.

The gnostic palpating touch of the nurse, the cold stethoscope on warm skin, is felt, yet it is not that touch that grabs Sara's attention. It is the pathic touch, the relational being with the nurse that she recalls from that moment, the conversation, the being seen and treated as if she were just another person, not someone with class III obesity awaiting reducing surgery. The wait falls away as she is swept up in the conversation. She forgets, only momentarily, the ticking of the clock that signifies this wait is coming to an end, or at least the pre-surgical wait. A new wait stretches out ahead of her into the unknown. "Am I doing the

right thing?" She questions as her nerves begin to set in. She cannot know the outcome of the surgery and the future that it will bring yet she sits contemplating these things all the same. As she enters into the world of her own head; the solitary, personal space of thought and of doubt, she slips away from the relational world. That is, until she finds herself pulled into conversation with the nurse who is charged with her care. She may have been able to continue thinking about the 'what ifs' and 'what nexts' if not so compelled by the chatter of the nurse. His touch, the coldness of the instruments he employs may have only intensified her thinking, acted as a reminder of what was about to transpire. Instead, however, she finds herself in conversation – conversation originates from the Latin com-vertare, literally to "turn about with" (conversation, n. d.) – turned about by the act of being with her nurse in this way.

There is something so ordinary about a conversation, even within the hospital walls, we may not think of it as a way of being with, in particular a clinical way of being with an Other. Yet the etymology of the word reveals its rootedness within the communal relation coming from *conversatio* or *conversari*, which means the act of living with and to live with, keep company (conversation, n. d.). Nevertheless, Sara's account reminds us of the possible significance of such moments and the meaning they may hold. It is an ordinary encounter, a 'meaningless' conversation that brings her out of herself and into the world. Through this conversation, she is connected to the nurse, not through his probing touch, but through his voice, the pathic touch of his words and gestures. His invitation to enter into ordinary conversational relation is recognition that she is human, not unlike any other (and at the same time completely unlike any other), not a fleshy mass in need of reduction. Such moments of contact, the pathic touch of a nurse or physician, may offer reprieve from the weight, the waiting and the body that others may find difficult to see beyond.

Contact As an Invitation to Be Honest and Show Oneself

> There was this doctor at the clinic. She was wonderful. She asked a question and then waited patiently for me to respond. She just sat there

> quietly until I did, not taking notes, not doing something else, and just sitting there with me. She listened to what I had to say too, she would ask me more questions after I had told her what I was thinking. She said, "You should research the different types of surgery and make the choice depending on works best for you." I feel I can be honest with her, and really *talk* to her. (Carol)

Creating space for the other to be, the silence of listening can be an invitation, a calling forth of one to the Other, 'I am here. I see you as you are,' it suggests. To ask a question and wait, quietly for a response, listening without impatience, without intention or pre-conception is the listening of con-tact (i.e., with-tact), of ethical responsivity (Lingis, 2005, 2007; Levinas, 1972/2006). Engaging with Carol in this way, listening and asking, the physician shows respect for her as a person, respect for her knowledge and also for whom she is and knows herself to be. The physician is not judging, scribbling notes on the page to later review. She simply listens. This may invite Carol to open up, to be honest in ways she has previously felt unable to do.

People waiting to have bariatric surgery report enacting the 'ideal patient' role, feeling they need to do and say what is expected rather than what is truthful (Drew, 2008, 2011). As such, they may feel they must hide themselves, "I will do whatever I have to do, jump through any hoops, say anything I need to, anything the clinic staff wants to hear to get the surgery" explained Jane as she describes the meaning of weight loss surgery to her. You can almost hear the desperation in her voice. This surgery is something she *wants*; something she *needs*. She feels it is her last hope. At the same time, patients may feel the clinicians at the bariatric clinic cannot be trusted; that they are looking for excuses to deny access to the much-desired procedure (Drew, 2008, 2011). As such, the person waiting may find it difficult to open up, to show herself as she is, to reveal her fears and her failings within this particular clinical context. What is more, people who pursue this procedure may already feel their failings are on display, to be read on and through their bodies (Lupton, 2013). They may not wish to perpetuate the image

of their failed selves and perhaps worry that (perceived) shortcomings will prevent them from receiving the surgery. In comparison, for example, a person waiting for hip replacement may reveal the full extent of their pain and worries to their care provider, unafraid that these concerns will hinder their opportunity for treatment. The person waiting to have a hip replaced has no need to 'prove' worthy of the surgery. This is not the case for a person pursuing bariatric surgery. Diet journals tracking each and every morsel consumed are completed and assessed. Weight loss success during the waiting period prior to surgery proves that one is 'on the right track' and a 'good candidate' for the procedure. One must show capacity for the right behaviours, show that one can and should be trusted with a new stomach, with a new way of eating and a new life. How might one feel trust in return? Respectful contact, the listening silence that does not judge but hears with openness, may elicit honest, truthful communication between patient and clinician; it may lead to new ways of being in relation in this clinical context. A physician at the bariatric clinic once said to me, "I wish I could I know what my patients were thinking, what they were truly feeling and hoping to get from this surgery." Maybe he could, maybe he needs to ask and listen in particular ways – make con-tact.

Concluding Reflections

Contact, experienced in relation to the wait to have bariatric surgery, may be a gesture of worth. The contactless void of the wait to hear from the clinic for the first time and the letter received through the post may suggest to the one who is waiting, "You are not worthy of more, you are not worthy of this care." This may be particularly salient to the individuals who pursue this procedure because these feeling of worthlessness and disregard may not be new, and perhaps not unexpected (Lupton, 2013). They may even confirm thoughts a person has of herself. Many individuals I spoke to mentioned convincing themselves that they deserved to have this surgery and that they were "doing something for myself for the first time." How difficult it must be to carry on waiting when the clinic to which one reaches out does not show them worthy of reaching back.

Contact as it is lived within the clinician-patient relation during the waiting period prior to weight loss surgery may be an invitation. It may be a way of genuine being *with* or seeing the Other. The seemingly ordinary chatter of the nurse or a conversation that is truly conversational may make the worries of the weight/wait fall away. These gestures may show the person waiting that she is seen as a person, as more than a body awaiting intervention. The listening silence between clinician and patient may invite a person into honest relation; invite her to be herself, to reveal herself as she is without judgment and shame. The hiding of one's true self, nodding one's head and carrying on, and 'saying whatever they want me to say' may be a response to shame or fear, both of which a person hoping to access bariatric surgery may feel. What are the possible consequences of the patient who does not show her self as she truly is within the clinical relation? She may gain access to the surgery she so desires; yet I wonder if she will receive the care she needs and deserves?

The trusting relation established through the attentive attitude of clinician to patient, the seeing of the Other, during the waiting period prior to weight loss surgery, may shift the dynamics of the relationship, opening it to new and more tactful possibilities. Whereas, contact that refuses to see or recognize the Other in their Otherness, the asking of questions without waiting for answers and the assumptions that reduce to the 'general case' may act as closures. They may shut off potential ethical ways of being with and seeing within clinical encounters that take place during the wait to have bariatric surgery.

References

Barber, K. (Ed.). (2004). *Canadian Oxford Dictionary*. Toronto, Canada: Oxford University Press.

Baron, R. J. (1985). An introduction to medical phenomenology: I can't hear you while I'm listening. *Annals of Internal Medicine, 103,* 606-611. doi:10.7326/0003-4819-103-4-606

Brown, J., Sorrell, J. H., McClaren, J., & Creswell, J. W. (2006). Waiting for a liver transplant. *Qualitative Health Research, 16*(1), 119-136. doi:10.1177/1049732305284011

Christou, N. V., & Efthimiou, E. (2009). Bariatric surgery waiting times in Canada. *Canadian Journal of Surgery, 52*(3), 229-234.

Conversation. (n. d.). *Online Etymology Dictionary*. Retrieved from http://www.etymonline.com/index.php?term=conversation&allowed_in_frame=0

Drew, P. (2008). Weight loss surgery patients' negotiations of medicine's institutional logic. *Research in the Sociology of Health Care, 26*, 65-92. doi:10.1016/S0275-4959(08)26004-7

Drew, P. (2011). "But then I learned…": Weight loss surgery patients negotiate surgery discourse. *Social Science & Medicine, 73*(8), 1230-1237. http://dx.doi.org/10.1016/j.socscimed.2011.07.023

Levinas, E. (2006). *Humanism of the Other*. (N. Poller, Trans.). Chicago: University of Illinois Press. (Original work published 1972)

Levinas, E. (1978). *Existence & Existents* (E. Lingis, Trans). Pittsburgh, PA: Duquesne University Press.

Lingis, A. (2005). Contact. *Janus Head, 8*(2), 439-454.

Lingis, A. (2007). Contact: Tact and caress. *Journal of Phenomenological Psychology, 38*, 1-6. doi:10.1163/156916207X190210

Lupton, D. (2013). *Fat*. New York, NY: Routledge.

Meleo-Erwin, Z. C. (2011). 'A beautiful show of strength': Weight loss and the fat activist self. *Health, 15*(2), 188-205. doi:10.1177/1363459310361601

Meleo-Erwin, Z. (2012). "I Just Couldn't Keep it in Control Anymore:" Weight Loss Surgery, Food Addiction, and Anti-Fat Stigma. *Advances in Medical Sociology, 14*, 201-224. doi:10.1108/S1057-6290(2012)0000014013

Murray, S. (2009). 'Banded bodies': The somatechnics of gastric banding. In N. Sullivan & S. Murray (Eds.), *Somatechnics: Queering the technicalisation of bodies* (pp. 155-168). Burlington, VT: Ashgate publishing.

Murray, S. (2008a). Marked as 'pathological.' 'fat' bodies as virtual confessors. In J. Wright, & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic.' governing bodies* (pp. 78-93). New York: Routledge.

Murray, S. (2008b). *The 'fat' female body*. New York, NY: Palgrave Macmillan.

Neff, K. J., Olbers, T., & leRoux, C. W. (2013). Bariatric surgery: The challenges with candidate selection, individualizing treatment and clinical outcomes. *BioMed Central Medicine, 11*, 8-25. doi:10.1186/1741-7015-11-8

Padwal, R. S., Chang, H. J., Klarenbach, S., Sharma, A. M., & Majumdar, S. R. (2012). Characteristics of the population eligible for and receiving publicly funded bariatric surgery in Canada. *International Journal for Equity in Health, 11*, 54-62. doi:10.1186/1475-9276-11-54

Padwal, R. S., Majumdar, S. R., Klarenbach, S., Birch, D. W., Karmail, S., McCargar, L., . . . Sharma, A. M. (2012). Health status, quality of life, and satisfaction of patients awaiting multidisciplinary bariatric care. *BMC Health Service Research, 12*, 139-149. doi:10.1186/1472-6963-12-139

Parsons, G. E., Godfrey, H., & Jester, R. F. (2009). Living with severe osteoarthritis while awaiting hip and knew joint replacement surgery. *Musculoskeletal Care, 7*(2), 121-135. doi:10.1002.msc.145

Robbins, J. (Ed.) (2001). *Is it righteous to be?* Interviews with Emmanuel Levinas. Stanford, CA: Stanford University Press.

Scott-Dixon, K. (2008). Big girls don't cry: Fitness, fatness, and the production of feminist knowledge. *Sociology of Sport Journal, 25*, 22-47.

Sjöling, M., Ågren, Y., Olofsson, N., Hellzén, O., & Asplund, K. (2005). Waiting for surgery; living a life on hold -- a continuous struggle against a faceless system. *International Journal of Nursing Studies, 42*(5), 539-547. http://dx.doi.org/10.1016/j.ijnurstu.2004.09.009

Taylor, A. (2013, May 10). An open letter from a ‘fat chick’ to Mike Jeffries, CEO of Abercrombie and Fitch [Online news article]. The Huffington Post online. Retrieved from http://www.huffingtonpost.com/amy-taylor/open-letter-fat-chick-mike-jeffries-ceo-abercombie-fitch_b_3249798.html

Throsby, K. (2008). Happy re-birthday: Weight-loss surgery and the "new me." *Body and Society, 14*(1), 117–133. doi:10.1177/1357034X07087534

Van Manen, M. (1990). *Researching lived experience*. Albany: State University of New York Press.

Van Manen, M. (1999). The pathic nature of inquiry and nursing. In. I. Madjar & J. Walton (Eds.), *Nursing and the experiences of illness: Phenomenology in practice* (pp. 17-35). London, UK: Routledge.

Van Manen, M. (2012). The call of pedagogy as the call of contact. *Phenomenology & Practice, 6*(2), 8-34.

World Health Organization. (2011). *Obesity and overweight*. Retrieved from http://www.who.int/mediacentre/factsheets/fs311/en/

Chapter Four – Paper Two: Phenomenological Insights On Mandatory Weight Loss and the Wait to Have Bariatric Surgery[1]

> *People who are sick or injured not only want to know what's wrong, why they're hurting, what can be expected, what can and should be done about it, but they also want to know whether anybody* cares*, whether the people who* take *care* of *them also care* for *them.* (Zaner, 1993, p. 144)

> The surgeon says, "We need you to get your weight down a little more before we can approve you for surgery." I fight back the tears as I drive home. Then I think, "I have to do this. I need this surgery." I work my ass off; I eat nothing but salad for three weeks while I prepare real food for the rest of my family. I go to the gym late at night and settle for five hours sleep because there is no other time in my day with two small children to care for and a husband who works long hours. I struggle but I'll do what ever I have to. I come back for my next visit with the surgeon and I've lost more than he had asked me to yet he doesn't even notice. He doesn't comment on my weight at all!! He says, "You'll hear from my office with a surgical date." "That's it?" (Jane)

Jane, like many others who pursue bariatric surgery (i.e., weight loss surgery or anti-obesity surgery), has had a life long struggle with her weight (Throsby, 2007). She has tried everything, twice, with no success. She loses and gains and loses and gains again, each time feeling increasingly desperate, increasingly disappointed in herself and her body – "what is wrong with me?" she wonders.

Jane has all but given up hope that she will one day drop the pounds, one day be "normal," that is until her physician recommends weight loss surgery.

---

[1] A version of this chapter has been submitted for publication: Glenn, N. M., Raine, K. D., & Spence, J. C. Phenomenological reflections on mandatory weight loss during the wait for bariatric surgery [Under review].

"This is my chance," she thinks, "my last hope for success!" – a common sentiment among individuals pursuing bariatric surgery (Gregory, Temple Newhook, & Twells, 2013). She could be correct too, depending on how one measures success for in fact, bariatric surgery is the only treatment for class III obesity (i.e., body mass index, BMI $\geq$ 40 Kg/m^2 or BMI $\geq$ 35 Kg/m^2 in the presence of a high-risk comorbidity) that has displayed consistent sustained success (i.e., weight loss, reduction in comorbidities and mortality rate, increased quality of life; Buchwald, 2005). Jane then enters the queue for treatment at a publically funded Western Canadian clinic where she can expect to wait about two years to have her first visit (Padwal, et al., 2010).

In Canada, the average time spent waiting for bariatric procedures is approximately five years (i.e., from referral to surgery; Christou & Efthimiou, 2009), which is five times longer than the next longest surgical queue in the country (Barau & Rovere, 2012). This extended wait has a negative impact on quality of life (Padwal et al., 2010) and can result in frustration, anger and feelings of exacerbated inequities among those who wait (Gregory, et al., 2013). People are quite literally dying in the queue (Christou & Efthimiou, 2009; Padwal & Sharma, 2009).

Pre-bariatric surgical screening and assessment procedures vary from clinic to clinic commonly including intensive psychological screening, physical assessments and behavioral interventions (Collazo-Clavell, Clark, McAlpine, & Jensen, 2006; Neff, Olbers, & le Roux, 2013; Padwal et al., 2010). Bariatric surgical candidates are frequently expected to demonstrate their understandings of and abilities to adhere to post-surgical dietary restrictions and behavioral changes (Collazo-Clavell et al., 2006; Ochner, Puma, Raevuorl, Teixeira, & Geliebter, 2010; Padwal et al., 2010). Recommending weight loss, in the range 5-10% of current weight, is not uncommon and often required for surgical approval by third party insurance providers and clinics alike (Alami et al., 2007; Ochner, Dambkowski, Yeomans, Teixeira, & Pi-Sunyer, 2012). Considering Jane's account, however, one might question why such recommendations are made.

What purpose do they serve and what impact might they have reaching beyond body weight?

In this article we consider these questions through an exploration of the experiential. Using a phenomenological approach to qualitative research we consider the lived experience of mandatory pre-surgical weight loss. We contrast patient experiences with empirical literature to understand the potential impact and significance of these practices to pre-surgical bariatric patients and clinicians. Our goal is to contribute to a critical dialogue regarding the ethical and practical aspects of recommending pre-surgical weight loss among bariatric surgical candidates (Cassie, Menezes, Birch, Shi, & Karmail, 2011).[2]

More broadly, we reflect on the potential for experiential knowledges to inform clinical practices and pedagogy (Carel, 2011; Cipolletta, Beccarello, & Galan, 2012; Speraw, 2009; Svenaeus, 2000, 2013; Todres, 2008) and in this way add our voices to others who have contended the hegemony of 'evidenced-based' dogma in clinical practices (and research upon which it is based) must be challenged (e. g., Holmes, Gastaldo, & Perron, 2007; Holmes, Perron, & O'Byrne, 2006; Morse, 2006). We argue practices (and practitioners) which consider experiential knowledges make for more nuanced, tact-ful approaches to medical care that could better address the needs and complex lived realities of the individuals whom they treat (Carel, 2011; Cipolletta et al., 2012; Svenaeus, 2000, 2013; Todres, 2008). What is more, the kind of seeing and understanding called forth through phenomenological study could ensure the dignity and personhood of patients, perhaps too easily reduced to bio-physical characteristics, is not only preserved but brought to the fore (Speraw, 2009).

Methods

We followed the tradition of phenomenology of practice as articulated by van Manen (1990, 1997). Informed by the philosophical writings of Heidegger

[2]We acknowledge that obesity itself is a contested medical condition, however, given the intended scope of this particular article we cannot enter into that debate here. We refer the reader instead to Lupton (2013) and Rothblum and Solovay (2009).

(1953/2010), Merleau-Ponty (1945/2002), and others, phenomenology is unique among qualitative research approaches because it relies on data that is concretely embedded within experience itself (i.e., it is descriptive of the phenomenon as it is lived in everyday life) and not how it is theorized, reflected on, or judged. Phenomenology aims to awaken interest, open the reader to new and previously unnoticed possibilities and evoke a felt sense of understanding of a particular phenomenon through the illumination of invariant meaning aspects of particular human experiences (van Manen, 1990). It is a particularly useful approach to questions related to ethics, pedagogy, clinical practice and experiences of health and illness (e.g., Glenn, 2013, Speraw, 2009; Todres, 2008; van Manen, 2012).

Seven individuals were recruited for participation from a publically funded bariatric clinic located in a large, mid-Western Canadian city. At the first interview all participants had been approved for surgery by a multi-disciplinary clinical team and were waiting for their surgical date. Inclusion criteria were: surgical approval, greater than 18 years old and proficient English speaker. Participants were selected based on interest and ability to articulate their experiences, as is standard practice in phenomenology (van Manen, 1990). Ethical approval was received from the university, the health region and the hospital where the clinic was located. All individuals signed informed consent.

Phenomenological interviews were conducted by the first author and were aimed to gather detailed, specific descriptions of experiences, rather than opinions, beliefs or theories (van Manen, 1990). Interview questions focused on the intersection of experiences of weight and waiting within the context of the bariatric clinic. For example, individuals were asked to describe encounters with the scale/weighing, their weight (in reference to things, space and others), and clinical recommendations procedures and process (specific to weight loss and otherwise). All participants were invited to participate in follow-up conversations and four of the seven agreed to participate. In these follow-up interviews additional experiential accounts were gathered and emergent themes and phenomenological insights were discussed and reflected on. Follow-up exchanges also functioned as a quality measure where emergent themes and drafts of the text

were shared with participants to check for resonance and recognition (van Manen, 1990). All interviews were recorded and transcribed verbatim. Identifying information was removed and pseudonyms are used throughout the article.

Data analysis, aligned with the phenomenological tradition, did not follow a prescriptive set of steps but rather involved a deeply reflective and open attitude and a constant orientation to the phenomenon (van Manen, 1990). This involved moving between gathered experiential accounts, relevant philosophical literature and related phenomenological studies while crafting drafts of the experiential text. This writing process, or "doing phenomenology," was guided by phenomenological reflection and reduction techniques (i.e., 'analysis; van Manen, 1990).

Analytic devices used in this inquiry include hermeneutic (bracketing assumptions), experiential (focusing on concrete experiences), heuristic (orienting the text to possibilities and wonder), and eidetic (practicing free imaginative variation) reductions as well as crafting anecdotes, drawing on insight cultivators, engaging in hermeneutic conversations, reflecting on existentials, attending to language and maintaining a vocative tone (van Manen, 1990). These devices functioned to push away or bracket assumptions (i.e., the epoché) and at the same time draw near to or confront the originary of phenomena (i.e., the reduction) – ultimately moving the researchers into closer relation to the experience as it is lived, pre-reflectively (van Manen, 1990). The aim of this text is to provide plausible insight into the experience of required weight loss while waiting to have bariatric surgery.

Empirical Evidence: The Impact of Mandatory Pre-Surgical Weight Loss

A consensus statement on bariatric surgery recommends,

> Bariatric surgery candidates should have attempted to lose weight by nonoperative means, including self-directed dieting, nutritional counselling, and commercial and hospital-based weight-loss programs, but should not be required to have completed formal nonoperative obesity therapy as a precondition for the operation. (Buchwald, 2005, p. 371)

This sentiment is echoed in the European clinical guidelines on surgery for severe obesity (Fried et al., 2007). Nevertheless, other expert panels recommend pre-surgical weight loss (Blackburn et al., 2009) whereas some insurance providers and clinics make this a requirement for surgical approval (Ochner et al., 2010; Sadhasivam, Larson, Lambert, Mathiason, & Kothari, 2007). According to Alger-Mayer, Polimeni and Malone (2008) 10% pre-surgical weight loss is required in their bariatric clinic,

> . . . based on the hypothesis that patients would have the opportunity to complete the required preoperative screenings, be referred as needed for behavioral therapy to control emotional or binge eating, to become actively engaged in a physical activity program, to demonstrate the ability to comply with a restricted diet, and to have an overall improved surgical outcome. (p. 773)

Existing evidence suggests pre-surgical weight loss does not predict or enhance post-surgical weight loss but is additive resulting in increases in 1-year post-operative weight reduction compared with initial weight (Kadeli et al., 2007). Pre-operative weight loss reduces operating time by shrinking liver and abdominal fat (Colles, Dixon, Marks, Strauss, & O'Brien, 2006), which has been associated with increased safety (Alami et al., 2007). Yet, it does not appear to impact operative complications (Cassie, et al., 2011). Although their study had a high drop out rate and found no differences in excess weight loss or comorbidities between individuals randomized to pre-surgical weight loss or non weight loss groups at 1-year post-operative follow-up, Solomon, Liu, Alami, Morton and Curet (2009) recommend preoperative weight loss and argue it is safe and feasible. They explain, "This is not unexpected, because many comorbidities associated with obesity resolve soon after operation, with mild to moderate amounts of weight loss" (Solomon et al., 2009, pp. 244-245). This begs the question, why recommend additional weight loss?

In theory pre-surgical weight loss decreases surgical complications through a reduction in liver size and abdominal fat, resulting in greater operative access to the stomach and intestines (Colles et al., 2006). Through this mechanism pre-surgical weight loss should have a positive impact on surgical time. Waist circumference, as an indication of intra-abdominal fat, and liver size has been associated with increased bariatric surgical time and incidence of conversions (i.e., from laparoscopic to open surgery – considered a safety concern; Schwartz, Drew, & Chazin-Caldie, 2003). The authors, however, did not find a relationship between post-surgical complications and any measured factor (including liver size, weight or waist circumference; Schwartz et al., 2003).

Several meta-analyses and systematic reviews have explored the impact of pre-bariatric surgical weight loss on post-operative outcomes (Cassie et al., 2011; Kadeli et al., 2007; Livhits et al., 2009; Ochner et al., 2012). Findings in support of the practice are considered tentative or suggestive at best (Cassie et al., 2011; Kadeli et al., 2007; Livhits et al., 2009; Ochner et al., 2012) and further study is considered essential (Cassie et al., 2011). Bearing in mind the inconclusive nature of the evidence to support pre-surgical weight loss why do such recommendations persist? What is the potential, perhaps unintended or unexpected, impact of these recommendations on persons pursuing bariatric surgery?

Experiential Evidence: The Meanings of Mandatory Pre-Surgical Weight Loss

"Just nod your head and carry on:" Dying to get in, lying to get in.

> I know a few people who've had the surgery and they all tell me that same thing – just do what you are told! I ran into a friend, who had the surgery, and was telling him about my frustrations. He said, "If the clinic staff want you to lose five pounds then you need to get the five pounds off and don't put your personal opinion in there, just nod your head and carry on." (Candice)

"Nod your head and carry on" is the advice Candice receives from her peers. They are suggesting that she should just do whatever the clinicians say, she should tell them whatever they want to hear if she wants to get access to the surgery – are her peers suggesting that she should lie? Perhaps it is an act they are recommending, a role they suggest that she should play.

Researchers have identified the "ideal patient" role among clinical and popular discourses related to bariatric surgery (Drew, 2008, 2011; Glenn, McGannon, & Spence, 2013). For example, in a clinical report devoted to assessment and preoperative care for bariatric surgical patients, Collazo-Clavell et al. (2006) refer to the challenges of identifying "ideal" patients, arguing that identifying such patients would contribute to more effective screening practices and ensure optimal surgical outcomes. What else might these screening practices do? Drew (2008) argues they may construct an ideal patient archetype for individuals wishing to access weight loss surgery to follow. In this way screening practices could limit surgical access to people who do not behave in an ideal manner, that is demonstrate: appropriate physiology, evidenced and measure by BMI and co-morbidities; appropriate diet history; appropriate behavior, willingness to follow instructions and partake in pre and post surgical expert care; and, appropriate attitude, the correct desire for surgery (i.e., "health"; Drew, 2008).

Like Candice, individuals hoping for bariatric surgical approval might feel they must be perfect, they must become or at least enact the ideal patient (Drew, 2008). To uphold this role, however, a person might find it necessary to hide who they really are. A person waiting for surgical approval then might discover she can only show part of herself – the "right" parts – that she cannot and furthermore should not be completely honest with her clinical team. One might find it is best to do and say what is expected rather than what is truthful for revealing oneself as flawed, struggling or otherwise "not ideal" could lead to a longer wait or denial of the procedure altogether.

Candice recounts a visit with her case manager,

> "Let's see your food journal,' she says as I hand it over. Of course I had not included the ice cream I had the night before. I bet she has ice cream after dinner sometimes. I'm not perfect but I when I fill in my food journal I know that I'm expected to be so I "forget" things. "Well I can't understand why you're not losing more weight," she responds. "We'll have to take another look," as she flips through the pages of my journal. I know she is playing the gatekeeper, deciding if I am good enough for this surgery. (Candice)

Candice sees her bariatric clinical team as the gatekeepers of the surgery. The required pre-surgical weight loss is one of the tools with which they seem to "guard the gates." A gatekeeper is an attendant, controlling entrance and exit, resources and information (Barber, 2004, p. 619). In the case of bariatric surgery the clinical team is meant to control access, to screen and to assess potential patients to ensure successful and safe surgical outcomes (Grundy et al., 1991). What else might gatekeeping do? Maurer and Sobal (1995) suggest gatekeeping establishes and maintains medical authority, particularly over the treatment of "obese" bodies. In this way gatekeepers render knowledge and experiences of those seeking treatment as insufficient or unimportant.

If we consider Candice's account we can see other ways that gatekeeping leads to unforeseen and potentially problematic consequences. In place to protect the patient (in theory) paternalistic gestures made on the patient's behalf can transform a person waiting from patient into child. In response one might then resort to childhood tricks. One might find secrets and deceptions necessary to sneak past the parent-like gatekeeper and gain access to the surgery. Candice, for example, feels like she has no other choice – to comply or to lie (or to die perhaps; see Padwal & Sharma, 2009).

Sara, a woman awaiting bariatric surgery recounts her struggles to lose weight during the pre-surgical period,

> My hands sweat a bit as I look down at the floor and tell my nurse, "I'm struggling. I need help keeping my weight under control." Her response:

> "Well do you want to quit?" "Quit?" I think, "Hell no! I don't want to quit, I'm telling you that I'm struggling I need assistance, I need your support, I need you to tell me what to do." (Sara)

Sara reaches out to her nurse as she struggles to achieve the weight loss required of her to qualify for surgery. Her words, "just tell me what to do," reveal her desperation but they also confess her failure to be able to do it on her own. For Sara this sense of failure is not new. In her life she has continually failed at weight loss, as is the case among all individuals seeking to have bariatric surgery (i.e., it is a standard recommendation – demonstrated previous attempts at non-surgical weight loss; Grundy et al., 1991). That is precisely why she decided to pursue the procedure, not unlike Jane, whose account began this article, "I have trouble losing weight. That's why I'm here!"

It seems paradoxical then that a history of weight loss attempts (and failures) is recommended for one to be considered eligible for bariatric surgery (Grundy et al., 1991) and yet once eligible one must display weight loss success for surgical approval (Alger-Mayer et al., 2008). Sara finds herself ensnared in the binds of this paradox. She wants to do what she is told, behave in the way the clinic desires so she can gain surgical approval and yet weight loss is among the things she struggles most to do. That is why she is here. Herein Sara faces another tension – she must reveal her struggle to her nurse, name it, and herself a failure to get the help that she needs to lose the weight and possibly qualify for surgery. However, in revealing her struggle Sara risks losing the very thing she hopes to gain. Her honesty is met with a questioning of her intentions, "do you want to quit" asks the nurse. If quitting were what she was after why would she have reached out and asked for help? Nevertheless asking for help reveals a weakness unbecoming of an ideal patient and so Sara, like others pursuing the surgery, learns to just nod her head and carry on, to reveal only what is expected and keep her truth, her reality, her struggle to herself.

Waiting and weighing: Weight consciousness promoted through mandatory practices.

> I step on the scale at the bariatric clinic and I think, "I have to show weight loss. I can't go up." Now I have my surgical date I am even more concerned. At my last appointment my nurse said, "If you gain weight it will kill the surgery." "Kill it?" I think, "I hope not!" I better be extra careful. (Claire)

Claire has worked hard and waited a very long time to gain surgical approval she is not about to give up now. She vows to be "extra careful," increasingly watchful of herself and the scale. She becomes even more conscious of her weight as she navigates the pre-surgical requirements. Of course it was her weight that brought her to pursue bariatric surgery, provided her access to the queue, now her weight could actually prevent her from being approved. She has struggled with her weight, under her weight, with a body that does not fit, one that she worries will make her ill, and now she takes on a new weight-related worry – if she doesn't lose quickly she stands to lose everything. She must gain control over her weight or risk losing the surgery altogether. The nurse suggests greater diligence is required.

Diligence and control related to weight are considered signs of disordered eating. According to the Canadian Mental Health Association (2013), "When someone has an eating disorder, their weight is the prime focus of their life" (para. 1). Is this so different than a person who is waiting to be approved for bariatric surgery? It seems that Claire's clinical team is encouraging her to make weight the primary focus of her life. She explains,

> I have to put my kids and my husband on the back burner. I need to make time to go to the gym twice a day so I can get the weight off before my next appointment or I won't get the surgery. (Claire)

At the very least it seems Claire is urged to make her weight a greater priority, put other parts of her life aside so she can gain access to the surgery. If Claire were

not 100 pounds or more overweight (i.e., corresponding to a BMI ≥ 40 Kg/m^2) one might imagine such behaviors as absurd, selfish even. Yet because of Claire's weight, the absurdity now becomes how she could not make it her priority.

In her piece, *Health at Every Size,* for the National Eating Disorder Information Centre, Burgard (2005) challenges the reader to engage with the story of Julie, a young woman who yo-yo diets, restricts her calories and is otherwise consumed by her weight. Burgard (2005) initially presents the story under the premise that Julie is 5'5" and 105 lbs. She asks the reader – what is your diagnosis? She then reveals that Julie is exactly as described however, 195 lbs. rather than 105. "What is your diagnosis now?" She asks. Burgard (2005) brings us face to face with the issue at hand and begs the question, should body weight influence how we interpret particular behaviors? What about the behaviors we recommend? Is it ethical to promote an increased focus on weight, calories consumed and expended, even within the context of a weight loss surgery clinic? What might be the unintended consequences of such a recommendation?

Paying for surgical approval through weight loss. At the clinic where Claire receives treatment she has individualized counseling with a specialized dietitian, she has access to psychologists and a teams of other health professionals to help her along the way. "No black of white thinking!" is a message she frequently hears from her clinical team. What does that mean one might ask? Black and white thinking, as it is described in the clinic, is the all or nothing attitude that can, for example lead a person into a downward spiral for taking one step off track. The clinic psychologist explains black and white thinking to a group of pre-surgical candidates,

> If you open a bag of potato chips and find that you don't stop eating until about half-way through don't think, "I'm terrible. I've eaten half the bag. I might as well eat the rest." Instead, say, "okay, I've eaten this much but I am done now. I don't have to finish this bag just because I opened it."

Although a laudable goal, is it really possible to escape black and white thinking within a clinical context, a place where measurements and standards are

paramount? Claire, Jane and Sara, for example, are focused on "good" and "bad" behaviors, on the scale, and their weights – are these not black and white?

Jane explains,

> I am at the clinic for my appointment and I hope to talk to my team about having the surgery. I am sitting there waiting for them to stop talking but they're all bent over my food journal and my chart, obsessing about whether I'd gained or lost weight. Then the nurse turns to me and says, "Well we're never going to be able to get you there." I think, "What? I know I can get there." (Jane)

Jane knows she can do what is asked of her. She knows just how much she wants, how much she needs this surgery. She is confident that she will do what it takes regardless of the task. Her nurse, however, is not so sure. "We're never going to be able to get you there," she remarks. "Never?" Jane thinks. What does that mean? Will they not help her on her way?

Jane came to the clinic for the support, guidance and expertise of the clinical team. She might be surprised to find, however, that she is on her own instead. Unlike previous weight loss attempts, Jane is now under the watchful eye of her clinical team and yet they do not even believe that she can do it. At the clinic she might have hoped and expected to find cheerleaders, people in her corner, at the very least. She might find instead resistance, indifference, and a nonchalant dismissal, "we'll never get you there." With these words Jane is marked as a lost cause, something to give up on, not worthy of her nurse's support.

Jane continues,

> The surgery is being held ransom and if I don't behave perfectly I won't get a chance. I mean look at them obsessing over my charts and journal. No one even tries talking to me. The nurse and psychologist tell me, "No black or white thinking" but here they are practicing exactly that! (Jane)

Jane finds her clinical team is obsessed with her food journal and with her weight. She wants to talk to them, obtain information about the surgery, and perhaps what she can do to be approved. Instead she finds them focused on the details in front of them, preoccupied with the numbers, her weight and the information in her file. Do they even care that she is in the room or is it her weight, as recorded on the chart, which catches their attention?

Jane feels the surgery is being held hostage, held for ransom, and it is with weight loss that she must pay. Ransom comes from *raenson* meaning redeeming. In a theological sense to redeem is to deliver from sin or damnation. Redeem also means to make up for or compensate (Barber, 2004, p. 1294). Perhaps Jane must compensate for the sins of her body through perfect behavior and weight loss. Only with redemption will come the possibility of delivery into a new and bright future, only then will she be considered for surgical approval. What is it to be perfect if not flawless and without defect (Barber, 2004, p. 1155)? The irony of the perfect behavior required to access weight loss surgery amidst suggestions to reject black and white thinking is not lost on Jane. She feels that she is told one thing and expected to do another. She should resist the urge to see the world as all or nothing, either this or that, and instead accept the complexities of the grey that exists in the world between black and white. Yet she knows she either loses weight or she loses surgery. It is black or white.

Pre-surgical weight loss and the silencing of alternative stories. "An easy keeper," Trisha calls herself, in reference to the cows on a neighboring farm where she grew up. An easy keeper puts weight on easily, as one can imagine from the term, stores fat quickly and readily. "In cows it's a desirable trait," she says, "in women, not so much." She laughs to herself as she continues her story,

> Every morning I have the same routine. I get up at 5:45 and head to the pool. I swim for a mile. I love being in the water. I shower, head to the office and eat my breakfast at my desk. In the evenings after dinner I go for an hour-long walk. It's not just a stroll either. I work up a sweat. Nevertheless, I keep putting on more weight. What do I do? I don't have any more time in my day for exercise. (Trisha)

Being active is an important part of Trisha's life. It is part of her identity, as it is for many people who create such routines, this is part of who she is. She looks forward to her morning swim and finds the walk after dinner a relaxing part of her day. One might imagine, in reading Trisha's account that she would not struggle with her weight. Someone who exercises daily for two hours is no doubt healthy, in good shape, perhaps even thin? Yet Trisha is pursuing bariatric surgery. She has struggled with her weight her entire life. She finds that no matter what she does, what she eats or how much she exercises that her body just will not respond – a sentiment that is not uncommon among individuals seeking bariatric surgery (Throsby, 2007).

There have been a few times in Trisha's life where she approached thin she recounts, "They were awful." Once she starved herself down to a size 12. "I couldn't focus on my work. I had no energy. I just ate carrot sticks, Melba toast and celery," she remembers. "It's not sustainable. I couldn't go on like that." She had resigned herself to being the size she was, accepted the body she had and was living her life fully. Nevertheless, as she got older she noticed she was gradually putting on more weight. Then her left knee started giving her trouble, aching after her evening walks. "That is when I decided to pursue weight loss surgery," she remarked, "I didn't want to give up on my lifestyle; not be able to swim and walk, garden and do all the things I love to do. That is why I am here."

Recommendations for pre-surgical weight loss imply behavior is the problem. According to Padwal and colleagues (2010), to access surgery patients must demonstrate a commitment to "lifestyle modification and behavioral therapy" (p. 289) the underlying sentiment supports the notation that bariatric candidate are poorly behaved. Individuals accessing the procedure could find themselves entangled in this discourse, feeling the need to justify surgery through the construction of alternative stories of obesity origins (Throsby, 2007). A justification that is unnecessary according to Freedhoff et al. (2012),

> . . . the notion that obesity can be effectively, reliably and reproducibly managed by individually driven diet and exercise alone is akin to the

> notion that depression can be effectively, reliably and reproducibly managed by individually driven bootstrap pulling. (Freedhoff et al., 2012, p. 78)

What is more, other treatment options (e.g., diet, pharmacological) have been deemed mostly ineffective (North American Society for the Study of Obesity, 2000). Why then when pursing bariatric surgery should one be expected to lose weight through non-surgical means?

Recommending pre-surgical weight loss promotes, even if unintentionally, the idea that behavior-induced weight loss is not only attainable, but also necessary (Neff et al., 2013). Focusing on behavior-induced weight loss presumes behavior is the problem and in turn that individuals pursuing bariatric surgery have been misbehaving, eating poorly and not exercising – assumptions that are unfounded (Neff et al., 2013) and potentially stigmatizing (Drew, 2011; Throsby, 2007). This could be doubly problematic for individuals pursing bariatric surgery: Their body size renders them "morally and behaviorally corrupt" (Lupton, 2013) and their pursuit of the normative ideal through bariatric surgery is framed as the "easy way out" circumventing expected bodily maintenance practices such as disciplined diet and exercise regimes (Drew, 2011; Throsby, 2008).

Tom recounts bumping up against assumptions about his behavior when waiting for bariatric surgical approval,

> "When will I see the surgeon?" I ask my case manager. Looking at my file, flipping papers left, right and center she says, 'You're not ready. You haven't lost enough weight." She continues flipping through my file like she can't find something, "you don't have a –what do they call it – an organized exercise program." Okay. Now I guess that means if I don't go to a gym, or I don't go swimming that means I'm not exercising? I walk a six-mile loop every day and I have the pedometer to prove it too! But I don't tell her that. I just sit there while she continues to shuffle through the papers. (Tom)

Tom's case manager does not look up from his file as she tells him he will not be put forward for surgical approval. Instead she shuffles through the papers in the folder seemingly certain the answers will be found there. She does not ask him any questions. It is Tom, his case manager and the file present in this clinical space and the "conversation" appears to be taking place between just two: the case manager and the file. Tom is merely there as a recipient of information.

With regards to weight and the wait to have surgery the file appears to have taken precedence over the person, at least within this particular encounter. Tom's weight, as recorded as a number in the file, is deemed too high and his exercise too low (or non-existent). Through entering into conversation with the file the case manager makes it clear the file contains more valuable, accurate or important information on Tom than Tom himself. In this way the file "speaks" for Tom silencing him in the process. This gesture, although perhaps unintended, implies Tom should not be trusted, is too stupid or maybe just does not know anything that can contribute to this "conversation." As such, it reinforces, even if unintentionally or unknowingly, several assumptions and stereotypes about individuals considered "too fat;" that is for example, they are lazy or stupid and cannot be trusted to be honest about eating and physical activity (Lupton, 2013).

One might be surprised to find that Trisha is waiting to have bariatric surgery so she can maintain her active lifestyle or that Tom walks more than the suggested 10000 steps a day. One might assume that people who struggle with their weight are not active, hate exercise, spend their days lazing about on the couch – commonly held beliefs about individuals like Tom and Trisha, individuals with bodies deemed "fat" (Lupton, 2013). Yet this is not the case for Trisha or Tom, as it might not be for others who are in the queue for bariatric surgery – each person having their own unique story, their own multiple,

complex, and even conflicting identities.[3] What is the potential for such stories to exist within the bariatric clinic amidst standard recommendations and practices? What might these stories reveal?

Presumed ways of being based solely on a reading of body size will silence the stories of people waiting to have surgery, stories such Trisha's, stories of identity, stories of self, stories that not only tell of a person but claim personhood for one's self (Speraw, 2009). If such stories are silenced what might be left in their place? The results of this kind of silencing can be traumatic and even dangerous (Speraw, 2009). In her phenomenological reflection on dignity and personhood Speraw (2009) recounts the experiences of Kelly, a young woman who endured years of cancer treatments. Kelly recalls vividly interactions with clinicians where she spoke but was completely unheard – written off because she was a child (Speraw, 2009). Speraw (2009) shows how this silencing was not only emotionally scarring but robbed Kelly of her dignity, robbed her of her human-ness. Richard Zaner (2004), philosopher and medical ethicist, shows the telling and receiving of stories in a clinical setting is a way of calling forth obligation and responsibility, one for the other. He writes, ". . . we tell stories because that is what we have to do. It's what we're all about. We care for one another with the stories we place in each other's memory" (Zaner, 2004, p. 15).

What might at first seem trivial and unrelated could in fact be deeply intertwined – that is, stories, lives, identities, hopes, ambitions, failures and

[3]We use the example of exercise here because it emerged from conversations with several participants and sat in stark contrast to the behavioral weight loss recommendations made, such as increasing physical activity and participation in structured exercise programs. However, we are acutely aware of the significance of enacting "correct" neoliberal bodily maintenance practices, such as "exercise," and "healthy eating" (Lupton, 2013), particularly in the context of bariatric surgery (Drew, 2008, 2011; Throsby, 2008). It is not our intention to participate in the perpetuation of this discourse and, in particular the sentiment that one must prove one's worth or deservedness to access medical treatment, such as bariatric surgery (Drew, 2008, 2011; Throsby, 2008). We hope instead the example provided illustrates the necessity of listening to the stories one tells of one's self, listening to who one is (as they know themselves to be) rather than as one is assumed to be, based on body size, gender, social-economic status, sexual orientation, age or otherwise.

struggles with practices, clinical and otherwise, recommendations and subtle, potentially unsaid assumptions. Trisha's or Tom's stories remind us that behind each patient presenting for bariatric treatment, beyond the weight, there is a human – a person with a unique history, a set of circumstances unlike any other, who in some way or another will defy our pre-conceived notions if we only listen long enough to the stories they tell of themselves.

Concluding Reflections

Phenomenological texts, such as this one, attempt to "speak" to the reader, to act as a call, and through this calling elicit a response – a felt sense of responsibility or tacit understanding that evokes thoughtful and reflective practices (van Manen, 1990, 1997). This kind of ethical demand has a pedagogical significance that may be particularly relevant to health care practice (Glenn, 2013; van Manen, 2012). According to Frank (2006), ". . . phenomenology, in research as in applied clinical practice, enables new interpretations, which in turn enable new possibilities of action" (Frank, 2006, p. 114). Considering recommended and standard practices, such as mandatory pre-surgical weight loss, through an experiential lens provides new insights regarding the impact of these practices that move beyond the measured (e.g., weight, liver size) and assumed (e.g., weight loss is easy; bariatric candidates do not exercise). In doing so it might act as a necessary critique of unquestioned standard practices and the hegemony of evidenced-based approaches (Holmes et al., 2006, 2007).

Within clinical environments, such as bariatric medicine, best practices are developed based on empirical data focused on outcomes and evidence derived from clinical trials (Fried et al., 2007; Lau et al., 2007). Among other things, these trials simplify the complex; they distil from people to probabilities so as to isolate and ultimately determine the relationship between cause and effect. In reducing the complexity however, I wonder what might be lost? Perhaps we risk losing sight of the patient as our focus narrows, smaller and smaller to this outcome or that cause (Green & Britten, 1998). Within the context of evidenced-based practice phenomenology then could act as a reminder that it is humans, people in

all their unpredictability and complexity that require treatment and care (Baron, 1985; Carel, 2011; Pellegrino, 1985; Speraw, 2009; van Manen, 2012).

According to Pellegrino (1985) it is the moral obligation of the physician to care for his patient, to recognize the patient as a person and to consider her beliefs. There is, he argues, "good" treatment and there is right treatment and that these are not always the same thing (Pellegrino, 1985). Pellegrino suggests clinicians might make errors with regards to medical indication imagining, for example, if any good can be done with this procedure than it should be done. Nevertheless, "Is this the right thing to do?" he asks. Is this "good" practice always right for the patient? Who is it that these recommendations, treatments and practice are in place to care for – the patient or the clinician? Why, for example, do some clinics and insurance providers require individuals, like Jane, who have struggled their entire lives with their weight, to then reduce to qualify for weight loss surgery?

It is no doubt that clinicians have the safety and best interests of their patients at the forefront of their minds when determining best practices, developing guidelines and making judgments about what is a "good" treatment plan (Fried et al., 2007; Lau et al., 2007). However, as Pellegrino (1985) articulates what is the best (i.e., "good") treatment, based on medical indication, measurable outcomes and desired results might not be what is right for this particular patient, this person, this human with their own unique circumstances and values. We do not suggest that clinical care recommendations and standard practices be abolished. However, we urge, along with Pellegrino, that what are good and what are right for this particular person be considered when putting standard recommendations, such as those of mandatory pre-surgical weight loss, into practice. We also contend that clinical practices would benefit from the inclusion of knowledges that go beyond that which can be numbered or measured, controlled or randomized (Holmes et al., 2007; Morse, 2006).

"Phenomenology will not tell us in any particular instance what is the right decision to make, it allows us to talk without shame or embarrassment about patients' feelings and to take such factors into account with a greater legitimacy"

(Baron, 1985, p. 610). As such, this article and phenomenological inquiry more broadly, might contribute to or perhaps even prompt necessary discussions of what is good and what is right treatment with regards to clinically significant obesity – it might elicit renewed consideration for what could otherwise go unseen, namely that which inheres within the experience itself (Carel, 2011). We hope that this article will act as an opening for just such conversations to take place with regards to bariatric medicine and the clinical treatment of obesity. We add our voice to those of other scholars; phenomenologists and practitioners who call for greater inclusion of experiential understandings in shaping clinical care practices, environments and pedagogies (Glenn, 2013; Baron, 1985; Carel, 2011; Cipolletta et al., 2012; Morse, 2006; Pellegrino, 1985; Speraw, 2009; Svenaeus, 2000, 2013; Zaner, 2004). By re-imagining clinical practices related to anti-obesity treatment in this way (e.g., good versus right; affecting each patient in different and complex ways; entwined with life outside of the clinic and humanness) more caring and tact-ful practices can emerge (van Manen, 1990; Zaner, 2004).

References

Alami, R. S., Morton, J. M., Schuster, R. Lie, J., Sanchez, B. R., Peters, A., & Curet, M. J. (2007). Is there a benefit to preoperative weight-loss in gastric bypass patients? A prospective randomized trial. *Surgery for Obesity and Related Disorders, 3*(2), 145-146. doi:10.1016/j.soard.2006.11.006

Alger-Mayer, S., Polimeni, J. M., & Malone, M. (2008). Peroperative weight-loss as a predictor of long-term success following Roux-en-Y Gastric bypass. *Obesity Surgery, 18*(2), 772-775. doi:10.1007/s11695-008-9482-2

Barber, K. (Ed.). (2004). *Canadian Oxford Dictionary*. Don Mills, Canada: Oxford University Press.

Baron, R J. (1985). An introduction to medical phenomenology: I can't hear you while I'm listening. *Annals of Internal Medicine, 103*(4), 606-611. doi:10.7326/0003-4819-103-4-606

Barau, B., & Rovere, M. (Jan/Feb 2012). *Longer than ever: A patient's wait for health care in Canada*. Retrieved from http://www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/articles/longer-than-ever-a-patients-wait-for-healthcare.pdf

Blackburn, G. L., Hutter, M. M., Harvey, A. M., Apovian, C. M., Boulton, H. R. W., Cummings, S., . . . Annas, C. L. (2009). Expert panel on weight-loss surgery: Executive report update. *Obesity, 17,* 842-862. doi:10.1038/oby.2008.578

Buchwald, H. (2005). Consensus conference statement bariatric surgery for morbid obesity: Health implications for patients, health professionals and third-party payers. *Surgery for Obesity and Related Diseases, 1*, 371-381.

Burgard, D. (2005). *What is "health at every size"?* Retrieved from http://www.nedic.ca/documents/HealthAtEverySize.pdf

Carel, H. (2011). Phenomenology and its application in medicine. *Theoretical Medical Bioethics, 32*, 33-46. doi:10.1007/s11017-010-9161-x

Cassie, S., Menezes, C., Birch, D. W., Shi, X., & Karmail, S. (2011). Effect of preoperative weight loss in bariatric surgical patients: A systematic review. *Surgery for Obesity and Related Diseases, 7*, 760-768.

Canadian Mental Health Association. (2013). Eating Disorders [Webpage]. Retrieved from http://www.cmha.ca/mental-health/understanding-mental-illness/eating-disorders/

Christou, N. V., & Efthimiou, E. (2009). Bariatric surgery waiting times in Canada. *Canadian Journal of Surgery, 52*(3), 229-234.

Cipolletta, S., Beccarello, A., & Galan, A. (2012). A psychological perspective of eye floaters. *Qualitative Health Research, 22*(11), 1547-1558. doi:10.1177/1049732312456604

Collazo-Clavell, M. L., Clark, M. M., McAlpine, D. E., & Jensen, M. D. (2006). Assessment and preparation of patients for bariatric surgery. *Mayo Clinic Proceedings, 81*(Suppl. 10), S11-S17. http://dx.doi.org/10.1016/S0025-6196(11)61176-2

Colles, S. L., Dixon, J. B., Marks, P., Strauss, B. J., & O'Brien, P. E. (2006). Preoperative weight loss with a very-low-energy diet: Quantitation of changes in liver and abdominal fat by serial imaging. *American Journal of Clinical Nutrition, 84*(2), 304-311.

Drew, P. (2008). Weight loss surgery patients' negotiations of medicine's institutional logic. *Research in the Sociology of Health Care, 26*, 65-92. doi:10.1016/S0275-4959(08)26004-7

Drew, P. (2011). "But then I learned…": Weight loss surgery patients negotiate surgery discourse. *Social Science & Medicine, 73*(8), 1230-1237. http://dx.doi.org/10.1016/j.socscimed.2011.07.023

Fried, M., Hainer, V., Basdevant, A., Buchwald, H., Deitel, M., Finer, N., . . . Widhalm, K. (2007). Inter-disciplinary European guidelines on surgery of severe obesity. *International Journal of Obesity, 31*, 569-577. doi:10.1038/sj.ijo.0803560

Frank, A. W. (2006). Interpretive phenomenology, clinical ethics and research. *Health, 10*, 113-116. doi:10.1177/1363459306058991

Freedhoff, Y., Sharma, A. M., Kirk, S. F. L., Vallis, M., Poirier, P., Ball, G. D. C., . . . Christou, N. (2012). Realistic first steps for effectively managing obesity in Canada. *Clinical Obesity, 2*, 78-82. doi:10.1111/j.1758-8111.2012.00044.x

Glenn, N. M. (2013). Making contact: Experiences of the weight-loss surgery clinic. *Phenomenology & Practice, 7*(1), 36-52.

Glenn N. M.**,** McGannon K. R, & Spence J. C. (2013). Exploring media representations of weight-loss surgery. *Qualitative Health Research*, 23(5), 631-644. doi:10.1177/1049732312471731

Green, J., & Britten, N. (1998). Qualitative research and evidence based medicine. *British Medical Journal, 316*(7139), 1230-1232.

Gregory, D. M., Temple Newhook, J., & Twells, L. K. (2013). Patients' perceptions of waiting for bariatric surgery: A qualitative study. *International Journal for Equity in Health, 12*, 86-97. http://www.equityhealthj.com/content/12/1/86

Grundy, S.M., Barondess, J.A., Bellegie, N.J., Fromm, H., Greenway, F., Halsted, C.H., … Zipf, W. (1991). Gastrointestinal surgery for severe obesity. *Annals of Internal Medicine, 115*(12), 956-961.

Heidegger, M. (2010). *Being and Time* (J. Stambaugh, Trans.). Albany: State University of New York Press. (Original work published in 1953)

Holmes, D., Gastaldo, D., & Perron, A. (2007). Paranoid investments in nursing: A schizoanalysis of the evidence-based discourse. *Nursing Philosophy, 8*, 85-91.

Holmes, D., Perron, A., & O'Byrne, P. (2006). Evidence, virulence, and the disappearance of nursing knowledge: A critique of the evidenced-based dogma. *Worldviews on Evidence-Based Nursing, 3*(3), 95-102.

Kadeli, D. K., Sczepaniak, J. P., Kumar, K., Youssef, C., Mahdavi, A., & Owens, M. (2007). The effect of preoperative weight loss before gastric bypass: A systematic review. *Journal of Obesity, 2012*. doi:10.1155/2012/867540

Lau, D. C. W., Douketis, J. D., Morrison, K. M., Hramiak, I. M., Sharma, A. M., & Ur, E. (2007). 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children [summary]. *Canadian Medical Association Journal, 176*(Suppl 8), S1-S13. doi:10.1503/cmaj.061409

Livhits, M., Mercado, C., Yermilov, I., Parikh, J. A., Dutson, E., . . .Gibbons, M. M. (2009). Does weight loss immediately before bariatric surgery improve outcomes: A systematic review. *Surgery for Obesity and Related Diseases, 5*, 713-721.

Lupton, D. (2013). *Fat*. New York, NY: Routledge.

Merleau-Ponty, M. (2002). *Phenomenology of Perception* (C. Smith, Trans.). New York, NY: Routledge. (Original work published 1945)

Morse, J. M. (2006). The politics of evidence, *Qualitative Health Research, 16*(3), 395-404. doi:10.1177/1049732305285482

Neff, K. J., Olbers, T., & leRoux, C. W. (2013). Bariatric surgery: The challenges with candidate selection, individualizing treatment and clinical outcomes. *BioMed Central Medicine, 11*, 8-25. doi:10.1186/1741-7015-11-8

North American Association for the Study of Obesity and the National Heart, Lung, and Blood Institute. (2000). *The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*. Bethesda, MD: National Institutes of Health; NIH publication 00-4084.

Ochner, C. N., Dambkowski, C. L. Yeomanas, B. L., Teixeria, J., & Pi-Sunyer, F. X. (2012). Pre-bariatric surgery weight-loss requirements and the effect of preoperative weight-loss on postoperative outcome. *International Journal of Obesity, 36*, 1380-1387. doi:10.1038/ijo.2012.60

Ochner, C. N., Puma, L. M., Raevulrl, A., Teixeira, J., & Geliebter, A. (2010). Effectiveness of prebariatric surgery insurance-required weight-loss regimen and relation to postsurgical weight-loss. *Obesity, 18*, 287-292. doi:10.1038/oby.2009.230

Maurer, D., & Sobal, J. (Eds.). (1995). *Eating agendas*. New York, NY: Walter de Gruyter Inc.

Padwal, R. S., Majumdar, S. R., Klarenbach, S., Birch, D. W., Karmail, S., McCargar, L., . . . Sharma, A. M. (2010). The Alberta population-based prospective evaluation of the quality of life outcomes and economic impact of bariatric surgery (APPLES) study: background, design and rationale. *BMC Health Service Research, 10*, 284-295. doi:10.1186/1472-6963-10-284

Padwal, R. S., & Sharma. A. M., (2009). Treating severe obesity: Morbid weights and morbid waits. *Canadian Medical Association Journal, 181*(11), 777-778. doi:10.1503/cmaj.081508

Pellegrino, E. D. (1985). The caring ethic: The relation of physician to patient. In A. H. Bishop & J. R. Scudder Jr. (Eds.), *Caring, curing, coping: Nurse, Physician, and Patient Relationships* (pp. 8-30). Tuscaloosa: University of Alabama Press.

Rothblum, E., & Solovay, S. (Eds.). (2009). *The fat studies reader*. New York: New York University Press.

Sadhasivam, S., Larson, C. J., Lambert, P. J., Mathiason, M. A., & Kothari, S. N. (2007). Refusals, denials, and patient choice: Reasons prospective patients

do not undergo bariatric surgery. *Surgery for Obesity and Related Diseases, 3*, 531-536.

Speraw, S. (2009). "Talk to me – I'm human": The story of a girl, her personhood, and the failures of health care. *Qualitative Health Research, 19*(6), 723-743. doi:10.1177/1049732309334517

Svenaeus, F. (2000). Das unheimliche – Towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*, 3-16.

Svenaeus, F. (2013). Anorexia nervosa and the body uncanny: A phenomenological approach. *Philosophy, Psychiatry, & Psychology, 30*(1), 81-91. http://muse.jhu.edu/journals/ppp/summary/v020/20.1.svenaeus01.html

Schwartz, M. L., Drew, R. L., & Chazin-Caldie, M. (2003). Laparoscopic Roux-en-Y Gastric Bypass: Preoperative determinants of prolonged operative times, conversion to open gastric bypasses, and postoperative complications. *Obesity Surgery, 13*, 734-738.

Solomon, H., Liu, G. Y., Alami, R., Morton, J., & Curet, M. J. (2009). Benefits to patients choosing preoperative weight-loss in gastric bypass surgery: New results of a randomized trial. *Journal of the American College of Surgery, 208*, 241-245. http://dx.doi.org/10.1016/j.jamcollsurg.2008.09.028

Todres, L. (2008). Being with that: The relevance of embodied understanding for practice. *Qualitative Health Research, 18*(11), 1566-1573. doi:10.1177/1049732308324249

Throsby, K. (2007). "How could you let yourself get like that?": Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine, 65*, 1561-1571. http://dx.doi.org/10.1016/j.socscimed.2007.06.005

Throsby, K. (2008). Happy re-birthday: Weight-loss surgery and the "new me." *Body and Society, 14*(1), 117–133. doi:10.1177/1357034X07087534

van Manen, M [Max]. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

Van Manen, M [Max]. (1997). From meaning to method. *Qualitative Health Research, 7*(3), 345-369. doi:10.1177/104973239700700303

Van Manen, M [Michael]. (2012). Carrying: Prenatal experience of the hospital transfer of their baby. *Qualitative Health Research, 22*(2), 199-211. doi:10.1177/104973231140447

Zaner, R. M. (1993). *Troubled voices*. Cleveland, OH: The Pilgrim Press.

Zaner, R. M. (2004). *Conversations on the edge*. Washington, DC: Georgetown University Press.

Chapter Five – Paper Three: Phenomenological Insights and Metaphor: Building a House As the Wait to Have Bariatric Surgery[1]

> *We find ourselves destined for the world, cast into it. In its undifferentiated expanse the world from the first affects us, weighs on us*. (Lingis, 2012, p. 42)

> I've built a few houses with my family. It takes a really long time before you actually see something that looks like a house. There's a lot of like ground work, plumbing and electrical and there's the foundation – all the things that create the structure of the house. The better they are, the stronger the house. The foundation and the things that you don't even see when you're done take the longest. Then the finishing part, the walls and the roof, those take a while too. That's where I am right now. The foundation has been laid and now the walls and roof are going up. I feel like we're so close, we're nearly there! The surgery comes next. (Liz)

The effort and time put into building a house is familiar to anyone who undertaken such a challenge. It is a long, drawn out process that requires care, commitment, and adherence to a step-by-step process for it to be successful. And even when it is objectively completed, the building of the house still requires that further last step of being lived in and occupied by its residents for it transform from house into a home. Constructing a house is an ambitious project but one that thousands of people feel worthy of embarking upon every year.

What if the house that you are building is not your residence but your own body? What of when it is the building required during one's long wait for bariatric surgery?[2] For Liz, the house of her body that she is currently building is both like

[1] A version of this chapter is being prepared for publication.

[2] Bariatric surgery is also known as (anti-)obesity surgery or weight loss surgery, terms used to describe a group of operations for treatment of class III, or clinically severe/significant obesity (Body Mass Index; BMI, ≥ 40 kg/m^2) aimed at inducing significant weight-loss (Buchwald, 2005).

and unlike the literal houses she has built in the past. It is a metaphor that seems to both resonate with and be revelatory of many people's experience of waiting for bariatric surgery. I wonder what new insights might be gained from considering the experience of waiting for bariatric surgery as the building a house? How might waiting within this context be like or perhaps unlike the building of a house?

There is little scholarship that has questioned pre-bariatric surgical experiences and even less to have explored waiting within this context (Engström, Wiklund, Olsén, Lönroth, & Forsberg, 2011; Glenn, 2013a; Gregory, Temple Newhook, & Twells, 2013; Padwal et al., 2012). Existing research suggests waiting to have bariatric surgery has a significant, negative impact on quality of life (Padwal et al., 2012) – it is, after all, the longest surgical queue in the country (i.e., Canada; Barau, & Rovere, 2012). Frustrating, stressful and anxiety producing are words that have been used to describe this wait (Gregory et al., 2013). Individuals report feeling hopeless with regards to weight loss, living in fear of sickness and death, feeling ignored by health care professionals and living a restricted life during this particular time (Engström et al., 2011, p. 1). Nevertheless I am left wondering what must this wait be like? How is this particular wait lived? How is waiting to have bariatric surgery unlike waiting for a different type of surgery or waiting for weight loss more generally? How might it be similar?

Contact, as in connection, communication or touch between patient and clinician may show an important experiential aspect of the pre-bariatric surgical wait (Glenn, 2013a). Particular modes of contact, ways of being with an Other (i.e., *con*-tact – *with*-tact; Levinas, 1978) may invite or silence, ease or burden (i.e., weight down) the one who waits (Glenn, 2013a). A look or a touch within a clinical encounter can reduce one who waits to sameness or, on the contrary, make the weight/wait fall away (Glenn, 2013a). What about space, time and body, how are these lived within the experience of waiting to have bariatric surgery? What meanings aspects might surface through the metaphor of waiting as building a house? What might be hidden instead?

Phenomenologies of Building, House and Home

The house has particular significance for human beings, as Bollnow (1961) writes,

> Man, a fugitive on earth, gains a stay in so far as with his building, with the solid walls of his house, he roots himself tight to the ground. . . To dwell is not an activity like any other but a determination of man in which he realizes his true essence. He needs a firm dwelling place if he is not to be dragged along helplessly by the stream of time. (p. 33)

Bachelard (1958/1994) describes the house as a place where we "take root," where we are grounded, it is "our corner of the world" (p. 4), the place where we belong. Heidegger (1971) too writes of the idea of dwelling and links it to the act of building arguing the words share a common origin. He contends,

> To be a human being means . . . to dwell. . . man *is* insofar as he *dwells*, this word *bauen* [from which to build and to dwell originate] however also means at the same time to cherish and protect, to preserve and care for, specifically to till the soil, to cultivate the vine. Such building only takes care – it tends the growth that ripens into its fruit of its own accord. (Heidegger, 1971, p. 147)

According to Heidegger (1971), building that is dwelling is a way of caring for a place, tending to the soil and cultivating growth.

Heidegger (1971) traces the etymology of the words dwell and build to the same German route, *bauen*. Nevertheless dwelling may also have an English or Anglo Saxon origin, coming from the word *dwellen* meaning to linger and also to seduce (Skeat, 1993, p. 129). In this way building may be a kind of future dwelling – the earth is cared for so flowers will bloom trees will take root. Dwelling may also show a kind of seduction of the future, a pull toward something yet to be realized. What might this mean for the one who waits to have bariatric surgery where waiting is understood as building? Is waiting a gesture toward the future, a caring cultivation of what may come? Perhaps during the wait

to have bariatric surgery building is dwelling in the way that it is an act of being seduced by a future that entices.

Heidegger (1971) draws on an example of a building a bridge to show the act of building, for humans, brings the landscape into existence. The presence of the bridge (realized through building) invites the objects around it to be, to take shape, and to show themselves as they are (Heidegger, 1971). The landscape may invite the bridge to be built in particular locations (the soil being right, the angles appropriate), joining this land to that, but ultimately the location comes into existence, into presence because of the bridge. Without the bridge there is no human reference point, Heidegger argues, no this-side-of-the-river or that, there is only a river that flows endlessly onward. According to Heidegger (1971), the human world orients itself around the bridge, this tree being noticed for its proximity and that stump for its distance. Humans build to understand the boundaries of the landscape and to determine where *presencing* begins (Heidegger, 1971). Building allows something that is there to appear (as location), to become (Heidegger, 1971). As such the wait for bariatric surgery, understood as building, may be an act of bringing into being, a gesture toward becoming. This nod to the future makes waiting a means to an end. Is this how one experiences waiting in this context? Perhaps instead the metaphor of building understood in this way may hide the experiential reality of waiting in this context. It may instead show waiting for this surgery as one might expect it to be rather than how it is. How is waiting for weight loss surgery like building a house? How might it be different?

Leder (1990, 2004) writes, "the ill body is no longer at home in its world" (Leder, 2004, p. 1082). Svenaeus (2000a, 2000b), building on this work as well as the writings of Freud and Heidegger, went on to develop a phenomenology of illness. One who is ill, he writes, experiences her body as foreign, an alien-like thing that demands attention in new and undesirable or unexpected ways (Svenaeus, 2000a, 2000b). Nevertheless for this person the body-as-experienced is one's self. Therefore the body-self experienced as ill becomes both alien and intimate or familiar – it is the body uncanny – that is eerie, weird or strange in an

unsettling sort of way (Guralnik, 1979; Svenaeus, 2000a, 2000b). Illness experienced as an uncanny relation to one's body-self may lead one to feel a sense of un-home-like-ness, that is a disruption of the everyday, taken-for-granted, passed over way of being-in-the-world (Leder, 1990, 2004; Svenaeus, 2000a, 2000b).

Drawing on Heidegger (2010/1953) Svenaeus writes (2000a), "The being-at-home, being-in-the-world of human being-there (*Da-sein*) is always also a *not*-being-quite-at-home in this world" (p. 7). This results from a lack of control over the self-world relation because the world is inevitably made up of others and these others are not under one's control. This kind of basic human not-quite-being-at-home is considered necessary for future flourishing because it creates the unpredictable, uncontrollable world which ultimately invites future possibilities. However, subtle or not so subtle shifts in one's (bodily) relation to the world resulting from illness (e.g., pain, impairment, tiredness, and so on) can amplify these feelings of not-quite-being-at-home, described by Heidegger, leading to the experience of the body uncanny and ultimately, un-home-like-ness (Svenaeus, 2000a, 2000b). What might this mean for a person who is waiting to have bariatric surgery? Does one seek out surgical intervention as redress for the body experienced as uncanny? How does the experience of pursuing bariatric surgery, understood as building a house, relate to Svenaeus's (2000a, 2000b) un-home-like phenomenology of illness?

Considering phenomenological writings on building, house and home (Bachelard, 1958/1994; Bollnow, 1961; Heidegger, 1971; Leder, 1990, 2004; Svenaeus, 2000a, 2000b, 2011) what insights might be gained about the experience and the meaning of waiting within this context? How might this knowledge add to or inform related clinical care practices? What might it *do* to us, as readers and our practices in turn?

Methodological Approach

I undertook this inquiry using a human science approach to phenomenology of practice as articulated by van Manen (1990). Phenomenology is a particularly

relevant approach to questions related to experiences of health and illness (Ahlzén, 2011). To explore the patients' experience of waiting in this context I relied on concrete descriptive accounts provided by Liz and six other individuals who were waiting to have the procedure at a publically funded clinic in Western Canada. Review boards of the university, the health region and the hospital where recruitment took place granted ethical approval for this study. Participants provided informed consent, were 18 years of age or older, were proficient English speakers and were approved for bariatric surgery at the time of recruitment. All have since undergone the procedure.

This study is embedded within a larger phenomenological research project where I explored aspects of the pre-bariatric surgical experience. The metaphor of house building emerged from a single interview, however, it pointed to potentially deeper meanings bubbling up through the analysis of the experiential descriptions of waiting provided by others as well. I relied on phenomenological writings on house and building as entry points to understanding the possible significance of waiting in this context. Metaphors point to the intentionality, the meaning-directed-action of the phenomenon in question and may be helpful for explicating the possible significance of experiences as lived (van Manen, 1990). According to Lakoff and Johnson (1980), "If we are right in suggesting that our conceptual system is largely metaphorical, then the way we think, what we experience, and what we do every day is very much a matter of metaphor" (p. 124).

Using metaphor as I do in this particular text, however, may also present specific challenges or be problematic in certain ways. Metaphors may reveal something unique of an experience as it is lived but they also may hide or subscribe acting not unlike a pre-supposition, framework or theory – the metaphor may ascribe the meaning of the experience rather than uncovering or revealing it as it is. With this in mind I approached this endeavour with particular care. I continually returned to the concrete descriptions of the experience asking what the metaphor of building a house showed but also questioning what it hid. I attempted to both use the metaphor as an entry point but also to peel it away and in this way come closer to the experience as it is in the world rather than as it is when seen

through the lens of this particular metaphor.

I collected experiential accounts (i.e., specific, pre-reflective, descriptive) of the experience of waiting to have bariatric surgery using phenomenological interviewing techniques (i.e., continually oriented to the experience; focused on detailed, descriptive accounts rather than opinions or judgements). Interviews were conducted in person or over the telephone as per the participants' preference and lasted one to two and a half hours. Four of the seven individuals agreed to participate in follow up conversations where additional experiential material was gathered, emergent themes were discussed and drafts of the texts were checked for resonance – that is the 'phenomenological nod,' a measure of quality in phenomenological research (van Manen, 1990).

The analysis was guided by phenomenological reduction and guided reflection practices – better described as attitudes or gestures of attentiveness that push away assumptions (i.e., epochē) and at the same time bring closer or confront the originary of phenomena (i.e., reduction). The gathering of experiential accounts and the reflective work of phenomenological analysis and writing occurred simultaneously. This included bracketing assumptions and pre-conceptions, crafting anecdotes out of experiential material, focusing on concrete experiences, orienting the text to possibilities and wonder, drawing on insight cultivators (particularly related to house and building; Bachelard, 1958/1994; Bollnow, 1961; Heidegger, 1971; Leder, 1990, 2004; Svenaeus, 2000a, 2000b, 2011), engaging in hermeneutic conversations, practicing free imaginative variation, attending to language, and maintaining a vocative tone (i.e., crafting a text that 'speaks'; van Manen, 1990). I engaged with these practices through writing – the primary mode of 'doing' phenomenology (van Manen, 1990) – ultimately crafting the phenomenological text that follows. Through this text I question the meaning of waiting to have bariatric surgery. How is this experience lived? What might we come to know about the phenomenon of waiting to have weight loss surgery through the metaphor of building a house?

Waiting to Have Bariatric Surgery As a Gesture of Care, Worth and Cultivation

Based on Heidegger's (1971) description we may understand the act of building is more than the creation of shelter, more than bricks and mortar intended as protection from the sun and rain. Building cultivates and in doing so encourages the things around it to flourish, to grow and to bare fruit (Heidegger, 1971). Waiting for bariatric surgery as building may be a time of cultivation, a period of growth and of hopeful anticipation. It may be a time of caring, that is caring for self and imagining a future that will bare fruit, a future where flourishing is possible and perhaps even expected.

We may see this act of cultivation and self care in the moment where waiting began, as Sara describes her decision to pursue the procedure,

> I'm rushing around my dad's kitchen while I make him dinner so I can get to my brother's place to help him with his kids. I chat with my dad trying to pretend my mind is not already on the next thing I have to do. As soon as he has eaten I'm out the door and in the car crossing the town to my brother's. Finally at the end of the night I flop onto my couch completely spent. Then I find myself shoving food into my mouth. I don't even know what I'm eating. I don't taste it. Nothing. I stop suddenly letting my hand fall back down to the table. 'You can't do this for the rest of your life,' I tell myself, 'You'll never succeed!' I start feeling depressed at this point. I've been here so many times before. Then I stop myself, 'No. I'm worth more than this,' I think. 'I have to have the surgery.' (Sara)

Who of us has not found ourselves, like Sara after a long's days work, exhausted, able only to muster enough energy to open the bag of whatever is on offer? Who has not dulled pain, or boredom, sadness or fatigue with this small act, the movement of hand to mouth? Sara is not alone in this experience and yet she finds herself very much so; buried under years, decades perhaps of this kind of self-care – a mode of caring that is ultimately without care, without thought or mental burden (Guralnik, 1979) at all.

Sara has spent much of her life looking after others. Whether cooking for her dad, managing a floor at the hospital where she is employed or looking after her brother's children. She attends to others' needs, feeding them when they are hungry, soothing them when they are sick and watching over them with concern. At the end of the day she has nothing left, she is on empty – everything has been given to those she believes more deserving than herself. In response perhaps, Sara fills herself, literally and figuratively, filling up the emptiness that surrounds her through this care-less act of feeding. She does not even taste the food as it moves from her hand to mouth – such a small gesture but also a grand one, 'You are not worthy of more,' it suggests.

This time, however, something is different; something has changed or shifted and in doing so brought Sara into view. She catches herself, 'What is it that *I* need?' She comes to ask. Weight loss surgery she determines considering herself at the fore. In this moment of contemplation she enacts care, as in a burdened mental state arising from concern (Guralnik, 1979), directed at her self and no one else. For Sara, as it may be for others, choosing to pursue the procedure is choosing to prioritize one's self. Putting one's self first, considering one's own needs, perhaps even above the needs of others. It is a confirmation of self-worth and a mode of building that is caring for (Heidegger, 1971). In this way the pursuit of bariatric surgery may send a message, to one's self but also to others: 'I am worthy!' it exclaims.

If we think about this gesture of worth in relation to the wait for weight loss more broadly (Glenn, 2013b) we may come to see how these experiences may differ. I wonder does one who waits to lose weight (through non-surgical means) imagine this wait as a proclamation of one's worth? Joining a diet group, counting calories or going to the gym may not be experienced as the same kind of commitment or sacrifice as the pursuit of weight loss surgery. One need not consult one's physician or qualify in any way to take out a membership at the gym, for example. A person who waits to have bariatric surgery, however, is accountable beyond his or herself. She must ask for a referral from her physician to even enter the queue. Doing so, may be for others, as it for Sara, a proclamation

of sorts, a semi-public gesture of self-worth – I am worthy of the time, energy and care required to wait and what is more, I am worthy of other's time, energy and care. Through this declaration of worth we may come to see how waiting for bariatric surgery may be experienced differently than waiting for weight loss more broadly.

Waiting as building may show how this is a particular mode of caring that is enacted. Heidegger (1971) describes building as an act of caring cultivation, a way of bringing things into bloom and allowing them to flourish. It is, in this way, a gesture toward the future, a tilling of the soil so, come spring, the tulips will break through the melting snow. Sara and others who pursue weight loss surgery may do so as an act of caring, a gesture of worth but also as a way of cultivating a future where growth is possible, cultivating a future pregnant with possibilities. The wait then for bariatric surgery may be like the tilling of the soil, or the building of the foundation of a house, the important and necessary work that comes before what is noticed and desired begins to take shape. Waiting as building, may be a time of cultivation where the future (and the possibilities therein) is not only welcomed but also carefully attended to and grown. And yet this work, although necessary, often goes unseen, unnoticed or unacknowledged, just as the foundations of a house are so often overlooked. Only when spring comes and the flowers begin to bloom one may realise the fruits of one's labours. What then if the warm sun and spring rain does not bring the colours so promised and desired? What if the flowers, or the house, do not take shape as one had imagined, they do not blossom or grow at all?

Building a Dream Out Of Last Hopes

Liz's surgical date is imminent – the foundation is laid and the walls and roof are going up; the electrical has been installed and plumbing affixed, invisible now behind layers of plaster and drywall – the house is ready, she is ready for the finishing touches to arrive. Will they arrive? What will they look like once they are installed? Will they come together in the way she has imagined? Will this be the house of her dreams? How will the windows let in the morning light and the

door block the draft of the coming winter? How will her things, the precious keepsakes she's collected over her life, fit into this new space? Or will they fit at all?

Waiting to have bariatric surgery, like building a house, may be an exciting time full of hopeful expectation for the future. It may also be a time of hard work, heavy lifting, planning, re-planning, and imagining what will be in the face of what is. When building a house one is confronted with a barren or untamed landscape or a dilapidated shell that requires demolition or perhaps an old, unwanted home that must be built over. One must attempt to imagine what will be in its place, dream of the future vividly enough to bring it alive, plan to the point of seeing. The promise of the post-bariatric future must be so tempting a fate as to entice one through the work of the wait. One must stay focused enough to oversee the digging of the foundation and construction of the walls, to have a chance at the home that possibly waits.

One who builds must anticipate delays or be ready to follow the contingency plan if required. What would be the contingency plan if this particular house, the one which waiting for surgery represents, does not go according to plan? As Liz, and others recount, "bariatric surgery is my last hope. I've tried and failed at everything else. This is my last chance to lose weight, to get healthy, to live my life" (de Silva & Da Costa Maia, 2012). Can there be a contingency plan if this, the surgery, is the last chance? Would that not mean this *is* the contingency, the final plan? What if the surgery does not happen or does not bring about the hoped for future? What if this build does not go according to plan? What if it does but the house that is built is not the home one had imagined?

Through altering the stomach and intestines, reducing calories consumed and absorbed, bariatric surgery can all but promise significant weight-loss, at least for a time (Buchwald, 2005). However, there may be unexpected consequences or complications that result and long-term outcomes are less predictable (Buchwald, 2005; Buchwald et al., 2004; Groven, Rhåeim & Engelsrud, 2010, 2013; Murray, 2009). Insufficient weight-loss or regain is not uncommon among individuals who have undergone the procedure (Magro et al., 2008). There is also

the issue of excess skin, often a problem for those who have been most successful (i.e., have lost the most weight), that may have a significant impact on a person's life, requiring additional surgeries and care (Groven et al., 2013; Kitzinger et al., 2012). These and countless other unexpected outcomes may not be a part of the future that one imagined during the wait. What might one do with a reality that does not measure up to one's dreams? Will one be disappointed or harbour regrets? One may come to make the best of the new circumstances, learn to live with the unexpected floor plan of the house, and in time maybe even come to love it, to call this new place home. Then again, one may not. One may find after the dust has settled in the post-bariatric future this house to be entirely unliveable (Groven et al., 2010, 2013; Joyner, 2010).

When building anew one cannot be sure how the yet-to-be-built space will invite one to live, to be and to thrive. One cannot know how the space will feel. I think about my parents' house only recently completed, an arresting presence on a quiet landscape. This build was their long held dream and a project that spanned more than a decade, not unlike the length of time some people wait to undergo reducing surgery (Christou & Efthimiou, 2009). All things were accounted for within their construction plan – the shadows cast by the late afternoon sun and the breeze off of the lake. The house grew, first on the computer screen and then on the earth, but primarily in the minds of my parents. It took shape according to their dreams and how they envisioned their lives within this yet-to-be-formed space. Of course, as with any build, this project did not go off without glitches and delays, the window frames were too yellow and the roof too dark. Nevertheless, the final house looked as almost exactly it did on the plans, all of the pieces fitted into place.

Now years have passed since they first broke ground and large cedar-framed windows now stand where once were grassy fields. It is indeed a beautiful space they have created, a thing of design magazines and getaway dreams. And yet, there is something not quite right – the rooms, although breathtakingly beautiful somehow do not invite them to live in the way they had envisioned. The rooms are, perhaps, too beautiful, too large, too spectacular for the small acts of

living of my parent's day-to-day lives. I wonder if waiting to have bariatric surgery as building a house involves imagining a dream so grand, so lovely, so foreign from what one is accustomed that one is destined to feel out of place within its walls?

I return momentarily to the story of my parents' home build. Attached to their house, just off to one side is a tiny screened in porch with a stone fireplace and unfinished wood plank floors. More rustic a space one could not imagine. An old wicker patio set and a long table with miss-matched chairs fill the space. These exposed beam and dark screened walls have born witness to Christmas dinners and grand children's first steps. Morning cups of tea that stretch into afternoons and quiet conversations about life occur here, at this garage sale salvaged table in a room that is not even a room *in* the house. The rest of the house meanwhile stands majestic and silent. My parents have all but moved into this tiny, un-insulated space. Amidst all their planning and dreaming they could not have imagined that *this* is where they would *live*.

Building, as with life, may be fraught with the unexpected. I wonder, if this is the last hope for the one who is waiting to have bariatric surgery, the last build, the last home one will attempt to create, what happens if it doesn't fit one's life? What happens if, like my parents, one invests all of one's time, sweat, money and tears into this place, into this wait, this surgery, this future dwelling and it does not go according to plan? There may not be additional finances, energy or choices left to begin again and so one may have to live with this space however ill fitting. The waiting period prior to bariatric surgery offers an imagined future and dreams big or small, but, as with building a house, it is a risk, a gamble, a considerable investment of time and money that ultimately may not go according to plan. One who is waiting to undergo this life changing procedure may not be able to escape such thoughts as she plans and hopes for the future, the 'what ifs' and 'what nexts' may haunt her as the surgical date looms, the floors are laid and the walls begin to go up. As with building, one may have invested so much of one's self that there is no turning back now. The future is going to come in what ever shape it takes and one will do one's best to control it, to schedule and to plan

but ultimately may have to make peace with the uncertainty that building and the post-bariatric future demand.

Waiting As Building the Un-Home-Like Amidst Hopes of Home-Like-Ness

Jane explains why she decided to pursue bariatric surgery,

> I've been this size my whole life. I've tried everything and nothing has worked. I've just got to the point where I have to do something. One of my knees is very sore, and I know it is weight related. Now I'm just waiting for the next knee to go and then my ankles. What am I supposed to do? I don't want to end up in a wheelchair. I am very active. I love going out in my garden and mowing the lawn, I walk every day and I swim. I'm not going to give up my active lifestyle. So, I decided, it had to be the surgery. (Jane)

Jane's concerns about future pain and impairment move her to pursue weight loss surgery. She believes her sore knee is a result of her size. She worries it is just a matter of time before the other knee will go, and then her ankle, and then who knows? She is unsure of what exactly the future holds, but she is certain it will bring diminished mobility attributable to her weight. In this way Jane experiences her body like a ticking time bomb – and she is not alone (see Evans, 206; Gard & Wright, 2005).

Until now Jane has experienced few physical ailments connected to her weight yet she imagines her future full of pain, suffering and bodily decay. She is determined to prevent such things, opting for bariatric surgery as a kind of preventative measure or insure policy, so to speak. She is considered an 'ideal' candidate too she tells me. The doctors have told her so, with no other co-morbidities; she is, other than her weight, 'healthy,' physically active and mental sound. She tells me of her active social life, the job she loves and the garden in front of her home to which she tends. Jane has been classified as having clinically significant obesity (i.e., BMI, body mass index, in excess of 40 kg/m^2) and thus a disease for which bariatric surgery is the treatment. Nevertheless, she does not seem to experience herself as ill. Her body does not take on an uncanny

characteristic nor does she appear to have experienced a disrupted sense of being in the world, un-home-likeness as Svenaeus (2000a, 2000b) describes.

This is not, however, true for everyone who seeks bariatric surgery. Many of the people I spoke to expressed a distinctly uncanny relation to their bodies and severely disrupted relations to the world. One need only turn on one's television and watch, for example, *My 600-pound Life*, or other such documentaries or reality programing to understand that the obese body is frequently experienced as uncanny and un-home-like. Not only is this body the possible source of physical pain and discomfort – an ache here or soreness there – but it also may have a distinct sense of being both of and other than the person.

Individuals who wait to have weight loss surgery may do so for a multitude of reasons and seek a multitude of outcomes. Many may feel a disrupted relation with their bodies or perhaps with the world. One may hope to resolve these relations and restore a sense of being-at-home through this surgical intervention and ultimately the weight that is lost. What about the process of waiting, however? What is the possible relation between the wait to have bariatric surgery and experiences of un-home-like-ness?

> Consider Claire's account of the bariatric clinic waiting room,
>
> I look around the room and I wonder, 'How do some of these people get through life? How do they manage?' I've always found ways to work around my problems, like getting out of the bathtub. I know from our sessions though that there are devices that some people need to help them clean themselves after the bathroom and other such things. Then it strikes me, 'That could be me!' I realize I can see myself in these people. It feels creepy. I don't want to end up like them. (Claire)

Claire looks around the waiting room, surveying, scrutinizing, wondering about the others waiting there. She comes to the conclusion that she is better off than some, not really 'impaired' by her weight in the way others may be – 'imagine needing a device to help in the bathroom!' She thinks. Then, however, as though struck she realizes that she could be these other people; in fact, she *is* them for she

too is waiting for the surgery, she too has been classified as severely obese and is in the queue for treatment thereof, that is why she is here, together with these others in the waiting room. It is merely time or pounds or both, she imagines, which separate her and the others who wait. Suddenly she sees herself differently. She is no longer the same person she was just moments before, she is, instead, the same as the others waiting at the clinic. Claire's experience of her self and her body have suddenly shifted - at once intimate and familiar and uncomfortably strange – she experiences the uncanny (Guralnik, 1979; Svenaeus, 2000a, 2000b).

One may pursue weight loss surgery as a move toward a restored sense of home-like-ness with one's body and the world. Perhaps, however, a person may seek out this procedure, like Jane, for altogether different reasons. Nevertheless she may find that the wait itself evokes feelings of the uncanny and un-home-like-ness. As such, one who expects to find relief and perhaps a mending of one's relation between self, body and world, may find instead further alienation, disruption and disrepair. Quite unlike other conditions for which surgical intervention is required the person for whom weight loss surgery is prescribed may not feel sick or ill or an un-home-like-ness of any kind. Yet this person may find, like Claire, her world is changed through the act of waiting in this context. It is transformed from familiar to strange. Individuals who pursue bariatric surgery may, unlike Claire, experience their bodies as un-home-like and therein a paradox emerges – what is sought may require one to submit to precisely what one hopes to escape. What then if the surgery does not, in the end, resolve feelings of the body uncanny and un-home-like-ness? Is there a possibility that the wait for home-like-ness may foster feelings of un-home-like-ness instead?

Building a House As the Embodied Self

Contemporary medical understandings of the body position it as material – the body is a thing, a sum of many parts like a machine (van den Berg, 1969/1978). The anatomical body is composed of blood and bone, this muscle and that organ. Parts of the body, as understood in this way, relate to each other in the way the floors of a house are related to the windows, both necessary for a house to exist

but with different functions, made of differing materials, requiring different expertise to build and maintain. The bariatric surgeon, for example, may not concern himself with the small bones of the hand or the muscles required to smile. He may be focused instead on the stomach and the intestines, passages where food and nutrients are taken up and exchanged. Van den Berg (1969/1978) shows that the anatomical body captured within medical imaginings is not the body of a human at all but instead the body of a corpse, a lifeless thing, "Muscles and bones come into existence when life has been expelled from the dead, when the dead person has become a corpse" (p. 80). He argues that with this understanding of the body-human the surgeon is not unlike the washing machine repairman,

> . . .the technical skills of the repairman who examines the washing machine and the technical means used by the doctor are one and the same. Very possibly the doctor's instruments were made in the same factory that supplies the repairman with his spare parts. The repairman can discover and correct defects in the washing machine. He can do no more, and no more is required of him. . . [his] technical skill makes the machine and helps it run, but it does not take care of it, cannot repair it when it has broken down completely. (van den Berg, 1969/1978, p. 56)

In this way, the expertise of the bariatric surgeon, although immense, may be no match for the task required. The person waiting for bariatric surgery, where waiting is building a house, may seek an outcome beyond the skills of the surgeon's hands. One who is waiting-as-building may seek treatment, repair, or care for the whole (i.e., the house, the embodied self) rather than the anatomical parts. What is the possibility the surgeon's knife could yield this kind of outcome? Can a literal cut be an act of metaphorical building?

He who decides to pursue bariatric surgery, who waits, who builds, who hopes and dreams may comprehend what the surgery can offer is alterations to the anatomical body, a cut here and a snip there. Nevertheless as Merleau-Ponty (1945/2002) and van den Berg (1969/1978) argue, within the world of

experiences there is no material body, there is no body that is separate from *self*, there is only the self as embodied.[3] Merleau-Ponty (1945/2002) writes,

> In so far as, when I reflect on the essence of subjectivity, I find it bound up with that of the body and that of the world, this is because my existence as subjectivity is merely one with my existence as a body and with the existence of the world, and because the subject that I am, when taken concretely, is inseparable from this body and with world. (p. 408)

Aligned with Merleau-Ponty's articulation, one's body, self and world are inseparable because to be alive and human is to be embodied. We experience the world through our sensing-body; we *are* our bodies (Merleau-Ponty, 1945/2002; van den Berg, 1972).

The body-as-lived, as experienced is a whole body and not merely the sum of its parts – a hand that grasps another in a gesture of care or kindness, an ear that hears the voice of a child and recognizes it as *my* child, a cheek that feels the warmth of the first ray of morning sun knowing it is time for the day to begin. The body on which the surgeon operates, the body found sketched on the pages of medical texts, does not exist outside those pages, or at least not as the experiencing-body (van den Berg, 1969/1978). For the person who *is* her body, bariatric surgery may alter much more than the organs, the stomach and intestines, the 'internal,' that which is unseen (van den Berg, 1969/1978).

Let us return to the metaphor here. The house to which Liz refers is the self, "it's *me*," she says. The foundations of the house, the insides, the hidden parts, not unlike the body organs, that make the house run, the heating and the plumbing, the insulation and the support beams, these are what are being built prior to the surgery, during the wait and perhaps even before. Without these parts

---

[3] Philosophers, theorists, theologians and others have grappled with the meaning of the human body. In this text I have relied primarily on Merleau-Ponty's (1945/2002) articulation of body-self (or embodied self); however, I acknowledge that this is only one possible understanding of body (Turner, 1991). For further reading see Turner (1991) and on phenomenological body (or lived-body) see Zaner (1971).

the house would not stand, it would not become a home. The body's organs, like the inner workings of the house, *are* the house, the organs are the embodied self, without a working stomach or intestines, without a heart that pumps or lungs that breathe in and out one could not feel, smell, speak or love. Without organs one could not live just as without the foundation a house could not stand for long.

There is no inside versus an outside of the embodied self, the self that waits to have bariatric surgery that is waiting-as-building – the self is the organs as much as the skin that covers them, which is itself connected to the veins, fat and tissue below. They are separate as I type them even here in my effort to demonstrate otherwise. All with their own names and functions: lungs push air, arteries circulate blood, the heart pumps. Yet as Merleau-Ponty (1945/2002) and van den Berg (1972, 1969/1978) show the body and self cannot be separated within the world as lived. It is only through language and philosophy that we have divided the 'body' into inside and out, into tissues, organs and cells. As it is lived, however, the embodied self is all of these things at once (Merleau-Ponty, 1945/2002; van den Berg, 1972, 1969/1978). And yet within medical imaginings the body and all its various tissues and organs are separate somehow, this one is the focus of that specialist and that one of another. In the bariatric clinic things are no different. The surgeon is responsible for the stomach and intestines, which in turn are expected to alter the fat that lies under the skin and between the organs. What are the possibilities for this surgeon to build the house when they specialize in only a few of its parts?

Building a House, Hoping For a Home

The wait for bariatric surgery is not like building any structure, as Liz explains, it is a house-building-like experience. How, I wonder, is a house different than a home? The words are so often used almost interchangeably – I go home at the end of the day but when looking at a photo, for example, I might point and say, 'this is my house.' The difference is subtle but it is there nonetheless. A home is the place where one lives; where one is born or raised, a home is one's origin (Guralnik, 1979, p. 289). A house is a building to live in, a shelter, or a family including

one's ancestors and decedents (Guralnik, 1979, p. 293). Not only do the words house and home have different meanings but they have different origins, home coming from *hoom* or *hám*, a village, and house from *hous* or *hús*, a sheath, a coop or an abode (Skeat, 1993, pp. 206, 208). As such, a house is an un-lived-in building offering the promise of shelter whereas a home is a house breathed with life, a house lived so to speak. It is a house being built during this wait to have bariatric surgery as Liz describes yet I cannot help but wonder if it is a home that is really being sought.

Carol explains how she feels about this wait and what she expects to change after the surgery,

> I can't wait until I have the surgery. Time just can't move quickly enough. Then I won't have the anxiety of whether or not I can have the surgery. That much will be done. Finished. At that point it will just be okay and I can get into a routine again. Hopefully that routine will feel more natural. (Carol)

Not unlike the building of the house Carol cannot wait for the structure to be complete, for the wait for surgery to be over and for the house to stand. At that moment, for her, as it may be for others awaiting weight loss surgery, a certain kind of unknown will have passed. Passed may be the period of uncertainty associated with having the surgery or not (there is always a chance, she knows, that she may be denied!). Nevertheless to come may be the unknown and uncertainty of whether the house will become a home. Will this wait lead to another that will ultimately weave its way into a routine, a natural feeling space that becomes a home one awaiting the surgery may wonder. The wait to have bariatric surgery may be just the beginning in fact not unlike the building of the house, the technical-instrumental doing that may, in time, if just right give access to being.

How is this experience different than waiting for other surgical procedures? What might the metaphor of building a house reveal? One who waits for cosmetic surgery for example may imagine that wait in its likeness to building

a house. A person may indeed be awaiting a new structure, one where she feels more comfortable and at home. Does a person 'build' while waiting to have cosmetic surgery, however? Does one work, lay the foundations and put up the walls during this time or does one simply wait for one's surgical date to arrive? Waiting to have cosmetic surgery, if we stay with the house metaphor, may be more like the shopping for a new house or deciding on new siding rather than building from the ground up. The wait for bariatric surgery may be quite unlike the wait for cosmetic surgery, even the wait for a surgery considered similar such as liposuction. For this wait for bariatric surgery may involve building, working on the 'interior' so to speak, so the 'exterior' might transform whereas with cosmetic procedures it may be the 'exterior' alone that one alters. That being said a person who awaits bariatric surgery may also hope for 'interior' changes as well; perhaps one will be 'healthier,' reduce one's medication or breathe and move with greater ease.

Concluding Reflections

It is my aim with this text, as it is of all phenomenological inquiry, to reveal possible aspects of the experience as it lived as a way of opening to the reader to new and possibly unexpected possibilities (van Manen, 1990). With this in mind I do not make any claims here of capturing, in its entirety, the experience of waiting within this context. Nor do I wish to suggest that everyone who waits to have this procedure will experience the wait as a metaphorical build. Nevertheless we can learn something about the possible meaning of the experience through this single metaphor. In doing so I hope to provoke discussion about practice, care and meaning in relation to bariatric surgery adding to the voices of critical and experiential scholars who call for understandings that moves beyond the dominant frame of allopathic medical (Drew, 2008; Groven et al., 2010, 2013; Murray, 2009; Throsby, 2008, 2012).

Imagining the wait to have bariatric surgery like the building of a house may reveal particular meanings aspects inherent to this wait yet I wonder what may be lost or hidden amidst the scaffold of this metaphor? Considering house

versus the home for example may ascribe a structural, thing-like quality to the body-self of the person awaiting this surgical intervention. This quality may in fact exist within the experience, for bodies, particularly those considered 'too-large' or ill or diseased in any way are often constructed as separate, a thing to but judged and fixed (Lupton, 2013; van den Berg, 1978). Nevertheless these self same bodies are also embodied, they are lived through or passed over in a way that they to not become things to be seen but rather they *are* the very way in which seeing or doing of things occurs. The building of a house metaphor may show the disembodied while hiding the embodied aspects of this particular wait. The house versus the home discussion may also pre-suppose an either-or sensibility, either a house or a home rather than something else entirely or some blending or co-existing of the two where one floats between or is at the same moment both house and home, disembodied and embodied, lived and thing-ed. The metaphor of building a house may reveal but it may also hide. It may provide an entry point for understanding the experiential reality of waiting to have bariatric surgery. It may point to aspects of the experience that make it unique, quite unlike waiting in other clinical contexts. At the same time this metaphor may act as a framework limiting what can be seen.

One who waits to have bariatric surgery may be waiting for or building more than a bodily form. A person may seek a new kind of relationship with the world, one where she is seen and heard – one where she is invited to *be* (Glenn, 2013a). How is this different than the wait for weight loss more broadly one may wonder? A person who waits to lose weight may, not unlike one who waits to have bariatric surgery, seek out a new kind of relation with the world (Glenn, 2013b). Perhaps this is in response to cultural value placed, or more accurately, not afforded to, individuals considered too large, in need of weight-loss in the first place (Lupton, 2013; Throsby, 2008; Webb, 2009). Bodies deemed too fat are rarely accepted or welcomed in contemporary Western culture, and certainly not within allopathic medicine where they are classified, measured and treated (Lupton, 2013; Throsby, 2012). Herein we may see where the two waits diverge.

Who among us has not waited to lose weight? Whether those few pesky post-holiday pounds or a more considerable amount. Waiting for weight loss more broadly does not necessarily suggest the presence of illness or disease (although it might). Weight loss surgery, on the other hand, is a prescribed treatment for class III obesity, the only effective intervention available to date (Buchwald, 2005). Waiting for this surgery is acknowledging that one has a medical condition, is diseased, pathological in some way and therefore the new relation to the world may not only involve a slimmer body but also one that is longer ill or diseased. Waiting for bariatric surgery is waiting in the medical realm, a wait that is in many ways out of one's hands. Waiting for weight loss more broadly can occur anywhere at anytime and may give the one who waits at least some sense of control over this particular wait (Glenn, 2013b).

Post-bariatric surgical life can be a life disrupted, challenging or even painful (Groven et al., 2010, 2013; Joyner, 2010; Throsby, 2012). For the person who undergoes the procedure this may be unexpected or unanticipated, particularly given the fairy tale and re-birth narratives that frequently surround the post-surgical experience (Glenn, McGannon & Spence, 2013; Throsby, 2008). Evoking an understandings of the pre-bariatric surgical waiting period through the metaphor of building a house may reveal aspects of this wait that could lead to post-surgical disruption, foreshadowing in a way what may come when expectations enacted through the gesture of waiting are not, or cannot, be fulfilled. If this wait is indeed waiting amidst last hopes, for example, what might clinicians do differently? How might one alter one's engagement with patients given such an understanding? Might one be more careful, thoughtful or empathetic if one were to understand this surgery offers more than possible 'health' and freedom from pain? What if we were to consider waiting for bariatric surgery as awaiting a new relation to the world, a future full of possibilities and hope and at the same time it is lived as a last hope, a last wait of sorts. Might we approach patients with great care and great tact if we were to understand, if only a little more clearly, what it might be like to wait in this context?

Waiting is waiting for, in the bariatric clinic as it is in all aspects of life. Clinicians and practitioners working in bariatric medicine may consider what is being awaited during this time. In doing so they may come to find this wait reaches beyond the desire for treatment of medical 'problems' (i.e., obesity-related complications and comorbidities), as is the accepted, anticipated and maybe even prescribed story (Drew, 2008; Throsby, 2012; Webb, 2009). This wait may be the building of a house, for example, an all-encompassing endeavour. Bodies may be selves embodied, multiple, complex and shifting. Waiting may extend beyond the clinic walls seeping into all aspects of life-lived. An expanded conception of waiting within this context may create space (in the clinic and related practices) for the complex and perhaps conflicting lived-realities experienced by the people who wait. What is more, this broader understanding may inspire more sensitive care that addresses the needs of individuals attending the bariatric clinic. I argue, along with Frank (2006), "Interpretive phenomenology, in research as in applied clinical practice, enables new interpretations, which in turn enable new possibilities of action" (p. 114). It is my hope that this text, this metaphor, may lead to new, unexpected and expanded interpretations of the experience of waiting within this clinical context and perhaps, through this deeper, reflective understanding elicit more tact-ful clinical practices in turn.

References

Ahlzén, R. (2011). Illness as un-home-like being-in-the-world? Phenomenology and medical practice. *Medicine, Health Care and Philosophy, 14*, 323-331. doi: 10.1007/s11019-011-9311-6

Bachelard, G. (1994). *The poetics of space*. Boston, MA: Beacon Press. (Original work published 1958)

Barau, B., & Rovere, M. (2012, Jan/Feb). Longer than ever: A patient's wait for healthcare in Canada. *Fraser Forum.* Retrieved from http://www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/articles/longer-than-ever-a-patients-wait-for-healthcare.pdf

Barber, K. (Ed.). (2004). *Canadian Oxford Dictionary* (2nd ed.). Toronto, Canada: Oxford University Press Canada.

Bollnow, O. F. (1961). Lived-Space. *Philosophy Today, 5*(1), 31-39.

Buchwald, H. (2005). Bariatric surgery for morbid obesity: Health implications for patients, health professionals, and third-party payers. *Journal of the American College of Surgeons, 200*(4), 593-604.

Buchwald, H., Avidor, Y., Braunwald, E., Jensen, M. D., Pories, W., Fahrbach, K., & Schoelles, K. (2004). Bariatric surgery. *JAMA: the journal of the American Medical Association, 292*(14), 1724-1737. doi:10.1001/jama.292.14.1724

Christou, N. V., & Efthimiou, E. (2009). Bariatric surgery waiting times in Canada. *Canadian Journal of Surgery, 52*(3), 229-234.

de Silva, S. S., & da Costa Maia, A. (2012). Obesity and treatment meanings in bariatric surgery candidates: A qualitative study. *Obesity Surgery, 22*(11), 1714-1722. doi:10.1007/s11696-012-0716-y

Drew, P. (2008). Weight-loss surgery patients' negotiations of medicine's institutional logic. *Research in the Sociology of Health Care, 26*, 65-92. doi:10.1016/S0275-4959(08)26004-7

Engström, M., Wiklund, M., Olsén, M. F., Lönroth, H., & Forsberg, A. (2011). The meaning of awaiting bariatric surgery due to morbid obesity. *Open Nursing Journal, 5*, 1-8. doi:10.2174/187443601105010001

Evans, B. 'Gluttony or sloth': Critical geographies of bodies and morality in (anti)obesity policy. *Area, 38*(3), 259-267.

Frank, A. W. (2006). Interpretive phenomenology, clinical ethics and research. *Health, 10*, 113-116. doi:10.1177/1363459306058991

Gard, M., & Wright, J. (2005). *The obesity epidemic: Science, morality and ideology*. New York, NY: Routledge.

Glenn, N. M. (2013a). Making contact: Experiences of the weight-loss surgery clinic. *Phenomenology & Practice, 7*(1), 36-52.

Glenn N. M. (2013b). Weight-ing: The experience of waiting on weight-loss. *Qualitative Health Research, 23*(3), 348-360. doi:10.1177/1049732312468795

Glenn N. M.**,** McGannon K. R, & Spence J. C. (2013). Exploring media representations of weight-loss surgery. *Qualitative Health Research*, 23(5), 631-644. doi:10.1177/1049732312471731

Gregory, D. M., Temple Newhook, J., & Twells, L. K. (2013). Patients' perceptions of waiting for bariatric surgery: A qualitative study. *International Journal for Equity in Health, 12*, 86-97. http://www.equityhealthj.com/content/12/1/86

Groven, K. S., Rhåeim, M., & Engelsrud, G. (2013). Dis-appearance and dys-appearance anew: Living with excess skin and intestinal changes follow weight loss surgery. *Medicine, Health Care and Philosophy, 16*, 507-523. doi:10.1007/s119-012-9397-5

Groven, K. S., Rhåeim, M., & Engelsrud, G. (2010). "My quality of life is worse compared to my earlier life" Living with chronic problems after weight-loss surgery. *International Journal of Qualitative Studies in Health and Well-Being, 5*, 5553-5568. doi:10.3402/qhw.v5i4.5553

Guralnik, D. B. (1979). *Webster's new world dictionary* (Pocket-size ed.). New York, NY: William Collins Publishers Inc.

Heidegger, M. (1971). Building, dwelling, thinking (A. Hofstadter, Trans.). In *Poetry, Language, Thought* (pp. 145-161). New York, NY: Harper Colophon Books.

Joyner, J. (2010). *Designated fat girl*. Guldford, CT: Skirt!

Kitzinger, H. B., Abayev, S., Pitterman, A., Karle, B., Bohdjalian, A., Langer, F. B., . . . Frey, M. (2012). After massive weight-loss: Patients' expectations of body contouring surgery. *Obesity Surgery, 22*(4), 544-548. doi:10.1007/s11695-011-05551-6

Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago, IL: The University of Chicago Press.

Leder, D. (2004). The experience of health and illness. In S. G. Post (Ed.) *Encyclopaedia of Bioethics*, 3rd Ed. (pp. 1081-1087). New York, NY: McMillan Reference.

Leder, D. (1990). *The absent body*. Chicago, IL: University of Chicago Press.

Levinas, E. (1978). *Existence & Existents*, (A. Lingis, Trans.). Pittsburg, PE: Duquesne University Press.

Lingis, A. (2012). The weight of reality. *Mosaic, 45*(4), 38-49. doi: 10.1353/mos.2012.0045

Lupton, D. (2013). *Fat*. New York, NY: Routledge.

Magro, D. O., Geloneze, B., Delfini, R., Pareja, B. C., Callejas, F., & Pareja, J. C. (2008). Long-term weight regain after gastric bypass: A 5-year prospective study. *Obesity Surgery, 18*, 648-651. doi:10.1007/s11695-007-9265-1

Merleau-Ponty, M. (2002). *Phenomenology of Perception*, (C. Smith, Trans.). New York: Routledge & Kegan Paul Ltd. (Original work published 1945)

Murray, S. (2009). 'Banded bodies': The somatechnics of gastric banding. In N. Sullivan & S. Murray (Eds.), *Somatechnics: Queering the technicalisation of bodies* (pp. 155-168). Burlington, VT: Ashgate publishing.

Padwal, R. S., Majumdar, S. R., Klarenbach, S., Birch, D. W., Karmail, S., McCargar, L., . . . Sharma, A. M. (2012). Health status, quality of life, and satisfaction of patients awaiting multidisciplinary bariatric care. *BMC Health Service Research, 12*, 139-149. doi:10.1186/1472-6963-12-139

Skeat, W. W. (1993). *The concise dictionary of English etymology*. Ware, United Kingdom: Wordsworth Editions Ltd.

Svenaeus, F. (2011). Homelikeness and health: An introduction to the theme. *Medicine, Health Care and Philosophy, 14*, 287-289.

Svenaeus, F. (2000a). Das unheimliche – Towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*, 3-16.

Svenaeus, F. (2000b). The body uncanny – Further steps towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*, 125-137.

Throsby, K. (2008). Happy re-birthday: Weight-loss surgery and the "new me." *Body and Society, 14*(1), 117–133. doi:10.1177/1357034X07087534

Throsby, K. (2012). Obesity surgery and the management of excess: Exploring the body multiple. *Sociology of Health & Illness, 34*(1), 1-15. doi:10.1111/j.1467-9566.2011.01358.x

Turner, B. S. (1991). Missing bodies – toward a sociology of embodiment. *Sociology of Health & Illness, 13*(2), 265-272.

Van den Berg, J. H. (1972). *A different existence: Principles of phenomenological psychopathy*. Pittsburgh, PA: Duquenese University Press.

Van den Berg, J. H. (1978). *Medical power and medical ethics* (P. Beumont, Trans.). New York, NY: Norton & Company. (Original work published 1969)

Van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.

Webb, H. (2009). 'I've put weight on cos I've bin inactive, cos I've 'ad me knee done': Moral work in the obesity clinic. *Sociology of Health & Illness, 31*(6), 854-871. doi:10.1111/j.1467-9566.2009.01188.x

Zaner, R. M. (1971). *The problem of embodiment* (2nd ed.). The Hague, Netherlands: Martinus Nijhof.

Chapter Six: Concluding Reflections

> *But there must be an end to this: a sharp end and clean silence: a steep and most serious withdrawal: a new and more succinct beginning. . . Nor may this be lightly undertaken: not lightly, nor easily by any means: nor by any hope 'successfully.'* (Agee as cited in Zaner, 1970, p. 175)

I sit here contemplating the blank page that is the conclusion, the culmination, the finale to this project and I ask myself what I hope you, the reader, will take away; what messages would I like to share with those who participated in the study and those who work in the clinic where I gathered, observed and recruited; what would I say to clinicians or researchers in the field? What questions or wonderings might I hope this work may provoke?

I return to the first moment when I considered the question of bariatric surgery and what it might be like for individuals who pursue it. I am back in the meeting room where I sat many years ago watching Chris, the young physician who works with post-bariatric patients, take to the podium. There he told us, the audience of clinicians and researchers his story. I use *his* story here because it was he who was doing the telling but the story was not really his, although, when I think about it in many ways it was. The story was about Georgia, a woman whom Chris encountered through his clinical practice. Nevertheless the story became his in the way it embedded itself in his very being – he was changed by her story and we, by his retelling of it. Richard Zaner (2011), clinical ethicist and phenomenologist, writes,

> Phenomenologically oriented clinicians, if I may so put it, are hunters and gatherers at the same time, they are seekers and collectors of the stories which make up every clinical encounter. Beyond hunting for, gathering, and listening to, and learning to understand such stories, they are also witnesses and guarantors, ensuring that every clinical narrative has its chance to be told and receives its appropriate hearing. (p. 207)

Chris, although I am sure not a self identified 'phenomenologically oriented physician,' did exactly as Zaner (2011) described, he acted as witness and guarantor, passing Georgia's story on to us that day. And in doing so he drew me in and implored me to engage, to think and to wonder along with him. He was, I now realize, in many ways asking questions that get at precisely what I have tried to do here – he was concerned, worried, wondering about the experience of his post-bariatric surgical patient – he seemed to want more than what the empirical or evidenced based literature could provide, he wanted in some way to get closer to her experience to see it so he might be able to attend to her with greater tact, with greater care. It was his thoughtful and sensitive retelling that brought me to the questioning that ultimately became this work and it is my hope that I have somehow translated that wondering attitude into it bringing you, the reader, along for the ride.

It is in response to the call of that story that I find myself here contemplating the fragmented tales that I now attempt to pull together and to pass on. I hope, like Chris and Richard Zaner (1970, 1993, 2004, 2011) that I have taken care with these stories, honouring the lives of the individuals who generously shared them with me. I have not, for the most part, recounted a single story in a single telling but instead, in the way of van Manen (1990), woven experiential moments together adding insights and reflections along the way.[1] This has been my attempt to make sense of or respond to a question founded out of wonder and concern, "what is this experience like?" "What is it to wait to have weight loss surgery?" I returned to this question over and over as I wrote the texts that became this thesis and I return to it now as I consider moving on, closing this chapter and beginning another. Have I done these stories, these lives, these experiences justice, given them enough care and attention to let them go? Can I part with these experiential understandings and move on? I wonder, is this (as in this chapter) the conclusion, the finale, the last word?

---

[1] I have been greatly assisted in this task by phenomenologists, philosophers, theorists, writers and countless other thinkers and sources of inspiration, reflection or experiential insight.

That is the thing with phenomenology, with stories, with lives and experiences that touch us; we are changed by them, irreversible altered in ways that may take time and space to comprehend. In fact, the impact may go beyond words, ineffable as is the experience itself. When we are affected by the experience of (an)Other, a story or a phenomenological text it reverberates in our very being.

I digress here momentarily to recount a recent experience of my own. I was practicing a presentation for a talk I was giving at a national obesity-related conference. I would be presenting some of the work from this thesis to an audience of clinicians, practitioners and researchers in the field. I was unusually nervous soliciting feedback from anyone who would listen. What concerned me were the expectations of the audience (and mine of them in turn); would they understand the research? Would this work seem important next to the results of a clinical trial? Was it important? Why should the audience care what I had to say and what I 'found'? Why should they concern themselves with a project that does not make claims to cure or to heal? In fact, phenomenology does not posit to produce findings that we can hope to *do* anything with; the results of these studies cannot be summarized and applied like salve to a wound (van Manen, 1990; Zaner, 1970). What then is the value of this work? In particular, I wonder about its value within the realm of clinical care, to practitioners and to patients if not to make one's job easier or offer comfort in some way. In response I turn to Heidegger (1953/2010) who argues the question is not what we can do with phenomenology but rather, if we engage with it deeply, what might phenomenology *do* with us (van Manen, 1990)?

Phenomenology endeavours to move us, to shift the ground on which we stand until we take notice or pause and consider what previously eluded us or perhaps was beyond our very comprehension or concern.

> The sense of phenomenological statements [or texts] is very much like that of an explorer's statements, for the meaning of both is similarly twofold: in so far as they claim to be descriptions of the 'land,' they are at once epistemic (knowledge-claims concerning the land itself) and

> communicative (that is, invitations and guides to enable others to know what to look for). (Zaner, 1970, p. 36)

And so I prepared my presentation, carefully shaping the text into a 12-minute 'talk.' I provided the briefest background on the method giving next to no details on the context, the participants, and the data collection and analysis techniques I employed for there was not enough time to include them. These are, however, standard offering in the biomedical sciences without which suspicions surrounding validity or rigour would no doubt arise. Yet, this is how I proceeded, hoping that showing the experience as lived (always a possibility rather than a fact) through anecdote and description, would awaken their concern, grab their attention and pull them into questioning with me, "What is this experience like?" In doing so my hope was the audience would abandon concerns around this method, as a standard set of practices, and find themselves instead pulled into the experience, nodding with a felt sense of recognition or perhaps struck, surprised by the possibilities inherent to the phenomenon-as-lived. As such, transferring their concern from the method, the validity and rigour of the project, to the patients and their experience of waiting within this context.

As I scanned the room for questions after I finished the presentation and found a sea of eyes staring back at me not one hand in the air I wondered is this the quiet of contemplation or of disinterest? It is not my intention to respond to this question but rather to suggest what phenomenology, the writing and sharing of, aims to do, what *I* aim to do with this work – that is to call, to demand and to evoke bringing us face to face with experiences as they are lived and the wonder of life inherent to the world in which we exist and make meaning. It is in the face of wonder that we may be open to others, to experiences that reach beyond our own, and we may be brought into questioning relation with that which we previously assumed to be true. In this way phenomenology and our engagement with it, has the power to impact or inform clinical practice. It is not through a direct position on this particular technique or that (marking them, for example, as good or bad, helpful or not), but through its impact on us, the readers, who may

find ourselves altered by this new understanding, eliciting a change in our practices in turn.

It turned out there were several audience members with questions, thoughts and concerns generated in response to my presentation as after all the presentations in my session came to a close and break time began I found myself faced with a queue. I entered into discussion with several clinicians working in bariatric medicine, two surgeons debating the merits and ethics of pre-surgical weight loss and the potential impact on patient wellbeing. Other researchers from the field joined the conversation until a thoughtful debate ensued. Not only were people interested what I had shown but it appeared to have sparked some new lines of questioning and perhaps re/consideration of what the patient experience might be within this unique context. This was exactly as I would have hoped given the goal of phenomenology being to provoke thoughtful wonder, challenge pre-conceptions and elicit 'ah-ha' moments, those nods of recognition signifying that something has been seen more clearly, if only for a moment.

In drafts one through five of this concluding chapter I attempted to summarize the findings of this project and highlight for the reader the takeaway messages and key points I hoped he or she would 'learn.' I had the following subsections mapped out on the page: summary, limitations, significance, future directions and final thoughts. I even had the Greek mythological story of Sisyphus, of repeated uphill boulder pushing fame,[2] to tie them all together with a neat little phenomenological bow. Yet somehow this chapter, no matter how many hours, days, weeks I spent wrestling with it would not take shape. I found instead that it was I struggling to push the boulder uphill, destined to fail just as I neared the summit so to speak. Given the specificity of the subheadings I had outlined how could I possibly have gone astray?

[2] Sisyphus, son of Aeolus and Enarete, founder of the city of Corinth and rumored father of Odysseus was a cunning man. He tricked death, not once, but twice, living to be a very old man. When he eventually died, however, the gods of the underworld exacted their revenge. His punishment: to push a boulder uphill that upon reaching the summit would slip from his grasp and tumble back down again. His fate was to repeat this task until the end of time (Howatson, 2011).

Now looking back, mere hours after abandoning previous draft(s) in favour of a blank page, I realise that this may have been precisely the problem. That is, the specificity of the subheadings I had outlined. Through the act of mapping out the concluding chapter I had somehow pre-supposed what I might ultimately find. Doing exactly what phenomenology asserts not to, that is, impose prior ideas and thoughts, opinions and values onto what *may* be – silencing the possibilities and wonder of what *is*. As I draw near the end of this project I realise that this, the text as a whole and even this chapter, is not an ending at all, in fact, it is only the beginning. The three texts that comprise this thesis explore experiences of contact within the wait for bariatric surgery, recommendations of pre-surgical weight loss and waiting as metaphorical house building. Together they re/present only the beginning of what we may come to understand as the experience of waiting to have bariatric surgery. There is so much more that has escaped these three texts and remains hidden from view. This is not intended as a call for more work to be done, although I argue there is much more work that can and should be undertaken related to the question of waiting within this context, but rather to make the point that phenomenological understandings are always tentative and fleeting; they are beginnings rather than endings. Experiences as they are lived in the world will forever be just beyond our grasp, like the infinite sides of a crystal out of view as our eyes come to settle on one of its surfaces, the best we can hope for it to lift the experience, if only momentarily, so we may get a glimpse of it in the light. It is my hope that these texts, taken together or separately, may provide a momentary view of the experience of waiting to have bariatric surgery or act as a guide, as articulated by Zaner (1970), and provide a sense of what we might look for within this experience.

In closing I return to where I began, the bariatric clinic waiting room. The sun streams in through the large windows casting a warm glow across the floor. I am surprised; I admit I did not expect windows here. Nor did I expect the quiet conversations, the shuffling noises of everyday existence, a phone retrieved from the bottom of a purse, a child reminded of the correct way to sit in a chair, and the muffled laughter of two women sharing a joke. What is it that I thought I would

find? I am not sure now, looking back, as I am not sure of many things that I thought I knew in the past. I return to this moment because it reminds me of the taken-for-granted-ness of everyday life, the seeing that is not seeing things as they are but rather as they are expected to be – seeing without wonder. This kind of seeing was how I began this project, not intentionally of course. Nevertheless I entered the clinic space 'without assumptions' that have since become all too apparent to me.

Assumptions are curious things. They are oftentimes completely transparent until they are not, until we are forced to meet them face-to-face. In drawing this exploration to a close, but in no way an end, I do not claim to have left my pre-conceived understandings behind, stuffed between the blue vinyl of the chairs that fill the bariatric clinic waiting room, nor do I expect the reader to have shed his or hers like the skin of a snake. Oh the impossibility of such a task! Instead I hope we will take direction from Zaner (1993) who writes, "Listening to people tell their stories, their triumphs and tragedies, seems to me the best way to understand the human dimensions of the problems we increasingly face during times of illness of injury" (p. 152). I implore us then, the reader and myself included, to listen carefully to the stories that are told, within the bariatric clinic and beyond. It is within these tales that the wonder of the world-as-lived may be revealed if only we can quiet what it is we *already know* long enough to hear their call.

References

Heidegger, M. (2010). *Being and Time* (J. Stambaugh, Trans.). Albany: State University of New York Press. (Original work published 1953)

Howatson, M. C. (Ed.). (2011). Sisyphus. In *The Oxford Companion to Classical Literature* (3rd ed.) Retrieved from http://www.oxfordreference.com/view/10.1093/acref/9780199548545.001.0001/acref-9780199548545-e-2760?rskey=xtDtpd&result=1&q=sisyphus

Van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

Zaner, R. M. (2011). On the telling of stories. In O. P. Wiggins & A. C. Allen (Ed.), *Clinical Ethics and the necessity of stories* (pp. 193-210). New York, NY: Springer.

Zaner, R. M. (2004). *Conversations on the edge*. Washington, DC: Georgetown University Press.

Zaner, R. M. (1993). *Troubled voices*. Cleveland, OH: The Pilgrim Press.

Zaner, R. M. (1970). *The way of phenomenology*. Indianapolis, IN: Pegasus.

Appendix A - Post-Text: An Attempt at a Summary

As I hope to have made clear in the concluding chapter, as well as the papers representing chapters three through five, phenomenological study does not generally produce findings that can be summarised neatly or listed in bullet point form indicating the important 'take home' messages (van Manen, 1990). Summarizing in this way risks loosing the point, the *punctum,*[1] one of the great strengths of phenomenological texts. That being said, however, I understand that in the health sciences there is a tradition of providing these summary points, the 'so what?' messages that emerge from a study. These summary points make practical sense as well and provide some direction to readers who may wish to 'use' the study to direct practice or inform pedagogies. In writing this I hesitate momentarily, thinking carefully about how to proceed. Phenomenological studies are not meant to be 'used' or to direct practice in specific, measurable ways. They are meant, instead, to move and to question, to critique and to expand, to illuminate, re-evoke and to show. Nevertheless, I feel compelled to provide some version of a summary to bring this work to a close (although again I use caution here because it is my hope that this inquiry opens rather than closes, but here it is more a figure of speech and a necessity of such a thesis project than a literal closing). What do the findings of this study reveal about the experience of waiting to have weight loss surgery? What does this understanding of the experience suggest about clinical practices? What might be done differently given the experience of waiting within this context? What are the possible implications for clinical practice?

Waiting to have weight loss surgery may be a time filled with unknown and uncertainty. One who waits may feel unsupported, not understood and alone during this period. From the first study exploring experiences of contact during the wait to have weight loss surgery one might take away the importance of clear

---

[1] Roland Barthes (1980/1981) wrote about punctum as the thing that touches us, that moves us personally, that creates the relationship between a person and the object (or in this case the experience).

and honest communication. From the moment when the first conversation with the family doctor takes place, to the referral process and hearing from the clinic for the first time communication seems key. A family doctor who is supportive, listens, guides and believes in his or her patient seeking bariatric care may provide a solid foundation for one to begin his or her journey toward weight loss surgery. Weight-based stigma previously experienced by many individuals seeking bariatric medical treatment (unfortunately all to common within clinical encounters as well) may make asking for such a referral or reaching out to a clinician for help a difficult task again highlighting the importance of a clinician who is supportive and listens to the needs and concerns of this particular patient. A clinician who is able to meet a person face-to-face in this encounter, to listen and to see beyond the weight may be better equipped to address the needs of their patient at this time.

Once the referral is made individuals may wait years to hear from the clinic for the first time. Participants described this period as a black hole or a void. If the bariatric clinic were to acknowledge receipt of the referral documents and let a person know the forms are complete and they are in the queue (and perhaps even an estimated time one might expect to hear from the clinic again) this might alleviate some of the stresses, the unknown and uncertainty around this particular wait. If reaching out for connection with the clinic is understood as a question, 'am I worth it?' the response, any response may take on greater import than the wait to hear back from common to other clinical queues. Providing supports for individuals during this period, perhaps in the form of peer support or online forums, might also function to elevate feelings of isolation and uncertainty around this particular aspect of the wait.

The second study revealed the tensions that may exist between standard practices, such as mandatory weight loss prior to surgical approval, and the experiences of these practices on the lives of individuals waiting to have bariatric surgery. This study showed how standard practices and guidelines that are created to ensure optimal outcomes may have unexpected or unintended impacts on the lives of individuals that are expected to comply with them. Recommending

weight loss among individuals waiting to have reducing surgery may be particularly problematic because these individuals are often seeking surgery because of challenges they have faced losing weight through other means. Individuals waiting to have bariatric surgery may feel that this recommendation is just a hoop they need to jump through to prove they are worthy of the surgery, which may, in turn, leave them feeling responsible for their weight ('problem') and undeserving of care. Because this practice is not strongly supported by the empirical evidence clinicians may reconsider this particular recommendation until further evidence to support it is available. At the very least, clinics might adopt an individualized approach to such practices rather than expecting all patients seeking care to comply. Furthermore, I would suggest that when creating clinical practice guidelines (in bariatric medicine and beyond) experiential evidence should be considered alongside empirical evidence to create practices that best suit patient needs rather than optimize measurable outcomes alone.

In the final paper we see how weight loss surgery might be like building a house. In this way we may come to understand that the wait prior to surgery is part of the building process where the ultimate goal is a new home – a transformation of sorts, a dwelling place, a place in which to rest. This paper questions what is being awaited and whether it is even possible to achieve it through surgical means. This metaphor also shows the possible complexity of the experience of waiting within this context and the impact it has on many parts of a person's life (beyond the clinic). There may be much more to this wait than the weight. Clinicians may be mindful that patients seeking care may hope for more than a reduction in body size. A person waiting to have weight loss surgery may hope to be seen for whom they are, they may hope to access the world more easily and to fit in (literally and figuratively). Clinicians working in bariatric medicine may care for their patients beyond seeing them safely through the surgery by listening to their stories, acknowledging the uniqueness of each person beyond his or her body weight. This paper reminds us of the power of metaphors to shape experiences and to reveal (but also hide) what may be otherwise difficult to say.

Paying attention to the metaphors used within a particular context (e.g., building metaphors used to describe bariatric surgery as a tool) or by a particular patient (e.g., building a house) may provide important and insightful information to clinicians practicing within the bariatric clinic. Understanding the wait for weight loss surgery as building a house may show the significance of this procedure for those who wait and also reveal the possibility that one who waits may be metaphorically homelessness during this particular period. Providing honest and clear information, outlining timelines, expectations and so on may help a person waiting to feel more oriented during this time. Also, supports in the way of peer networks, online forums and other such modes of connecting individuals during this waiting period may help individuals to feel accepted, acknowledged and less alone.

References

Barthes, R. (1981). *Camera Lucidia* (R. Howard, Trans.). New York, NY: Hill and Wang. (Original work published 1980)

Van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

Appendix B: Literature Review

This section represents an overview of the literature related to obesity and bariatric surgery, critical fat scholarship, phenomenologies of bariatric surgery and waiting. Bariatric surgery is a clinical procedure – it is a medical treatment, performed by surgeons, for an identified disease (i.e., class III obesity or worse). That is not to imply that it is not also a cultural artefact and reflective of social values and contextual-temporal factors. Nevertheless, without a biomedical positioning of obesity there would be no need for medical interventions such as bariatric surgery. Therefore it is within the clinical, biomedical perspective that I begin this literature review. I provide a brief overview of the condition for which bariatric surgery is sought (i.e., obesity, and more specifically class III or clinically severe obesity) as well as a summary of the clinical literature related specifically to bariatric surgery. I then turn to the critical and experiential literature to review how fatness, 'obesity' and bariatric surgery is understood (e.g., socially and culturally) and lived. I give a brief synopsis of research in the area of weight-related stigma and bias and conclude the review with a discussion of phenomenologies of waiting within the clinical context and beyond.

Biomedical & Clinical Perspectives

Obesity. According to the World Health Organization (World Health Organization, 2012), obesity, classified by a body mass index (BMI) of ≥ 30 kg/m^2, is one of the fastest growing health problems worldwide. In Canada trends are similar and prevalence of class III obesity (BMI > 40 kg/m^2; also called clinically severe obesity, extreme obesity; Mechanick et al., 2008) is among the sub-classifications that with the most significant rise (Tjepkema, 2005). There are many detrimental health outcomes associated with obesity including cardiovascular disease, type 2 diabetes, musculoskeletal disorders, and some forms of cancer (Haslam & James, 2005; Must et al., 1999; Swinburn, Caterson, Seidell, & James, 2004; World Health Organization, 2012). The World Health Organization (2012) contends,

> Overweight and obesity are the fifth leading risk for global deaths. At least 2.8 million adults die each year as a result of being overweight or obese.

> In addition, 44% of the diabetes burden, 23% of the ischaemic heart disease burden and between 7% and 41% of certain cancer burdens are attributable to overweight and obesity. (para. 6)

Prevention programs and treatments focused on this segment of the population include diet and exercise programs, counselling, pharmaceutical intervention and bariatric surgery. Research indicates that little significant, long-term weight loss success has been achieved through all but surgical weight reduction programs (Buchwald, 2002; Buchwald et al., 2009; Kramer, Jeffery, Forster, & Snell, 1989; Livingston, 2002; North American Association for the Study of Obesity and the National Heart, Lung and Blood Institute, 2000; Shaw, Gennat, O'Rourke, & Del Mar, 2006; Wadden, 1993; Wolfe & Morton, 2005). Bariatric surgery is the only weight-loss treatment for class III obesity that has displayed consistent sustained success (Buchwald, 2002; Buchwald et al., 2009; Wolfe & Morton, 2005).

Bariatric surgery.[1] Bariatric surgery is an umbrella term used to describe a number of different restrictive and/or malabsorptive[2] surgical procedures including Roux-en-Y gastric bypass (RYGB), vertical banded gastroplasty (VBG), and adjustable gastric banding (AGB). RYGB is both a malabsorptive and restrictive procedure where the stomach size is reduced and a portion of the intestine including the duodenum and upper jejunum is by-passed (Karmali & Shaffer, 2005). Due to the severe restriction in caloric intake and reduced absorption capabilities of the intestine this procedure results in substantial weight loss reaching 80% of excess weight in 90% of individuals (Fobi, 2004). However with the increased invasiveness of this procedure there are also an increased incidence of complications and side effects commonly including malnutrition,

---

[1] For a thorough review of the relevant clinical literature I direct the reader to Mechanick et al., 2008 as well as the Cochrane review, *Obesity Surgery* (Colquitt, Picot, Loveman, & Clegg, 2009).

[2] These procedures may have an impact beyond mechanistic changes to the stomach and the intestines (see Kohli & Seeley, 2013), nevertheless the procedures are currently most frequently described as restrictive and/or malabsorptive.

vitamin and mineral deficiencies, and gastro-intestinal distress (Fobi, 2004; Hydock, 2005; Karmali & Shaffer, 2005). VGB and AGB are restrictive operations – that is the stomach volume is reduced, limiting intake (Fobi, 2004). These alterations reduce the size of the stomach pouch as well as slow emptying to increase the sensation of satiety. With this procedure the digestive system remains intact resulting in minimal incidence of post-surgical malnutrition (Hydock, 2005). However, there are other complications that may arise such as vomiting, reflux, esophagitis, pouch dilation, band slippage and band erosion for VGB and AGB procedures (Hydock, 2005). On average, 50% of people who undergo these procedures (i.e., VGB and AGB) experienced weight loss of 50% excess weight (Fobi, 2004). Overall mortality rates associated with bariatric procedures are low at approximately 1% (30 days and 1 year post surgery; Omalu et al., 2007; Schauer & Ikramuddin, 2001). Nevertheless, a recent Cochrane review on obesity surgery concluded that data regarding safety is lacking therefore the risks related to surgery may not yet be known (Colquitt et al., 2009).

Bariatric surgery is effective at inducing sustained, clinically significant weight reduction and improving all cause morbidity and mortality including normalization of blood lipid, glucose, cholesterol profiles and type 2 diabetes as well as lower rates of depression, anxiety and related mental illnesses (Buchwald, 2005; Buchwald et al., 2009; Christou et al., 2004; Herpertz et al., 2003; Kruseman, Leimbruber, Zumbach, & Golay, 2010; Sjöling, Ågren, Olofsson, Hellzén, & Asplund, 2005). However, there are significant increases in accidental deaths and suicide among the post-surgical population when compared to the general population categorised as obese (Adams et al., 2007; Mirabelli, Petroni, Ferrante, & Merletti, 2011; Omalu, et al., 2007; Peterhänsel, Petroff, Klintzke, Kersting, & Wagner, 2013; Trindle et al., 2010). The trend appears gender-related and is pronounced among men and people who were identified as ‘black’ (Adams et al., 2007; Mirabelli et al., 2011; Omalu et al., 2007; Trindle et al., 2010). Omalu and colleagues (2007) contend suicides were difficult to track among their cohort because death certificates often listed ‘drug overdose’ rather than suicide (and the intention, in these cases, can never be known for certain). Increases in

completed suicides among the post-bariatric surgical population has lead to debate and further inquiry and elicited a call for intensive pre-screening (i.e., selection) and post-surgical follow up procedures (Peterhänsel et al., 2013; Trindle et al., 2010). Possible reasons for increased suicide rates remain unknown; perhaps these statistics are capturing accidental deaths due to unintentional drug overdoses yet maybe there is something about undergoing the surgery or the post-surgical reality that makes life seem entirely unliveable (Stømmen et al., 2009; Mirabelli et al., 2011; Omalu et al., 2007; Peterhänsel et al., 2013; Trindle et al., 2010).

Surgical candidates. The general guidelines for selecting surgical candidates are based on recommendations published by the National Institute of Health (Grundy et al., 1991). Adherence to these guidelines, however, can vary quite widely depending on the clinic and the particular surgical intervention (e.g., RYGB versus gastric banding; Mechanick et al., 2008). Nevertheless, most publically funded clinics in Canada adhere to these (Christou & Efthimiou, 2009):

- BMI $\geq$ 40 kg/m^2 OR
- BMI $\geq$ 35 kg/m^2 plus at least one high-risk, obesity related co-morbidity

Patients also typically (Lau et al., 2007; Padwal, Majumdar et al., 2012):

- Need to have demonstrated attempts (and failures) at behavioural weight-loss treatments
- Be well informed, compliant and motivated
- Have an absence of contraindications such as: Active psychiatric disorders, mental retardation, strong history of substance abuse or self destructive behaviours

Surgical candidates: Mental health. Discussions related to mental health frequently arise in relation to obesity and particularly, bariatric surgery. Clinically severe or class III obesity (i.e., BMI$\geq$40kg/m^2) is associated with major depression (Black, Goldstein, & Mason, 1992; Onyike, Crum, Lee, Lyketsos, & Eaton, 2003) including among the population who present for bariatric surgery (Glinski, Wetzler, & Goodman, 2001). Depressive disorders are prevalent among

individuals seeking bariatric surgery with nearly 60% categorized as depressed, which is significantly higher than the general population (17% prevalence) but consistent with the population categorized as having clinically severe obesity (Glinski et al., 2001). Among bariatric surgical candidates prevalence of childhood trauma and maltreatment (i.e., physical, mental, or sexual abuse) is high – approximately twice the reported rates among the general population (Grilo et al., 2005; Sansone, Schumacher, Wiederman, & Routsong-Weichers, 2008; Wildes, Kalarchian, Marcus, Levine, & Courcoulas, 2008). Nevertheless, no relationship between childhood trauma and bariatric surgical outcomes has been found (Grilo, White, Masheb, Rothschild & Burke-Martindale, 2006; Steinig, Wagner, Shang, Dolemeyer, & Kersting, 2012).

Surgical candidates: Motivation & expectations. Research on motivation for pursing bariatric surgery has produced mixed results, however, health is the most cited reason for surgical intervention (Karmali, Kadikoy, Brandt & Sherman, 2011; Munoz et al., 2007; Wee, Jones, Davis, Bourland, & Hamel, 2006). Physical appearance and avoiding embarrassment have also been reported, particularly among women (Libeton, Dixon, Laurie, & O'Brien, 2004). Motivation for surgery and outcome expectations (e.g., body size, lifestyle changes, co-morbidity reduction, and so on) can influence post-surgical mental health and quality of life (Kaly et al., 2008; Pristed, Fromholt, & Kroustrup, 2011). Surgical candidates may have unrealistic weight-loss expectations (Karmali, et al., 2011; Walfish & Brown, 2006, 2007; Wee et al., 2006), for example, Walfish and Brown (2006) found that nearly one-third of the pre-operative bariatric surgical candidates surveyed expected to lose 90-100% of their excess body weight within a year post surgery. This is well beyond the average weight loss that results from bariatric surgery, which is approximately 60% of excess weight (Buchwald et al., 2004). Realistic expectations among individuals pursing bariatric surgery are important because alignment between pre-surgical expectations and post-surgical outcomes is associated with improved quality of life (Pristed et al., 2011). Yet expectations that were not met were not associated with diminished quality of life scores (Pristed et al., 2011).

Pre-surgical procedures. There is no standard of practice or guidelines to which all bariatric clinics adhere (Mechanick et al., 2008; Ochner, Dambkowski, Yeomans, Teixeira, & Pi-Sunyer, 2012). However, intensive pre-operative psychological screening and treatment programs are often part of the multi-disciplinary approach and practiced in the vast majority of Canadian bariatric clinics (Glinski et al., 2001; Kruseman et al., 2010; Martin, Klemensberg, Klein, Urbach, & Bell, 2011; Mechanick et al., 2008; Sarwer, et al., 2004). Nevertheless, screening procedures may vary widely and contribute to unequal opportunities to access the surgery as nearly 25% of those individuals screened are recommended for delay based on this assessment (Fabricatore, Crerand, Wadden, Sarwer, & Krasucki, 2006; Ochner et al., 2012). Assessment practices can then further increase the time spent waiting for surgery for some individuals or deny access altogether. In this way, assessment practices may induce or exacerbate inequities in access to this particular intervention.

Pre-bariatric surgical process and procedures can be extensive and involved (Ochner et al., 2012). Mandatory pre-surgical weight loss (approximately 10% of excess) is among common practices. Nevertheless evidence supporting the affects of this recommendation on surgical outcomes is inconclusive (Mechanick et al., 2008; Ochner et al., 2012). Ochner and colleagues argue recommending pre-surgical weight loss may even be dangerous (Ochner et al., 2012).

In addition to pre-operative psychological screening bariatric patients are often required to engage in lengthy post-operative follow-up and counselling (Glinski et al., 2001; Kruseman et al., 2010; Sarwer et al., 2008; Song & Fernstrom, 2008). For example, at the Edmonton Weight Wise clinic,

> Within the adult specialty clinic, patients receive approximately 24-36 weeks of intensive lifestyle counselling (diet, exercise, behavioural modification), delivered by a multidisciplinary staff (internists, dieticians, nurses, physiotherapists, and psychologists) according to current recommendations. Patients are seen approximately every 4-8 weeks. Patients interested in bariatric surgery are also evaluated for this procedure by the same multidisciplinary staff. Patients deemed to be appropriate

> candidates are subsequently evaluated by a bariatric surgeon. Patients with BMI levels ≥ 35-39.9 kg/m^2 and a major medical comorbidity (e.g., hypertension, type 2 diabetes, sleep apnea) or BMI levels ≥ 40 kg/m^2 are considered potential candidates for surgery. Absolute contraindications to surgery include pregnancy, uncontrolled psychiatric disease, active substance abuse or smoking (patients are required to quit prior to surgery), an active eating disorder (anorexia or bulimia), and high-risk for surgery medical status (e.g. severe coronary artery disease). Because of limited data documenting the benefits of surgery in patients younger than 18 years of age and evidence for possible harm in patients over 60, procedures are not performed in these age groups. In order to access surgery, patients are also required to demonstrate commitment to attend scheduled appointments and adhere to lifestyle modification and behavioural therapy (Padwal, Majumdar et al., 2012, p. 289)

Access. Bariatric procedures are publicly funded across Canada.[3] It is estimated that 1.5 million Canadians could qualify for bariatric procedures yet only about 0.1% receive the surgery (i.e., publically funded procedures; Padwal, Chang et al., 2012). Those who qualify for the procedure in Canada, based on this estimate, are disproportionately female (66%), less educated and in a lower socio-economic tertile than individuals who did not meet qualification standards (Padwal, Chang et al., 2012). They also exhibited lower scores related to self-reported quality of life and mental health status (Padwal, Chang et al., 2012).

Demand for bariatric procedures in Canada far outstrips supply and wait times can range from 2-10 years (average of 5 years; Christou, & Efthimiou, 2009; Padwal, Chang et al., 2012). People are literarily dying while waiting to have the surgery (Christou, & Efthimiou, 2009). A 600-fold increase in supply might be necessary to meet current Canadian demands (Padwal & Sharma, 2009). Similar issues present South of the boarder (in the USA), however, there is the

[3] Coverage depends on the province, but for those who qualify most Canadian provinces and territories provide some form of bariatric surgical procedure.

added problem of private funding that can create serious barriers to access yet may also relieve waiting times for those who can afford to pay out of pocket (Flum, Kahn, & Dellinger, 2007; Martin, Beekely, Kjorstad, & Sebesta, 2010; Padwal & Sharma, 2009). People who qualify for bariatric surgery in the USA are disproportionately socially and economically disadvantaged (i.e., lower education, socio-economic status) and often black or Hispanic. Yet individuals who undergo the surgery are predominantly upper middle class, white women (Flum et al., 2007; Martin et al., 2010; Padwal & Sharma, 2009). There exist clear social and economically driven disparities with regards to access to bariatric procedures in Canada and the USA, which has resulted in, what Flum and colleagues (2007) refer to as, "an ethical and public health dilemma" (p. 1444).

Waiting. The wait for bariatric surgery can have a profound effect on physical and mental health as well as quality of life (Padwal, Majumdar et al., 2012). Individuals waiting for the procedure describe the wait as stressful and frustrating as well as physically, emotionally and mentally taxing (Padwal, Majumdar et al., 2012). Sixty-nice percent of the people surveyed described physical limitations as worsening over time (Padwal, Majumdar et al., 2012). Research on other surgical waits (e.g., cataract surgery, cardiac catheterisation) indicates that extended waiting times are detrimental to health and can result in increased morbidity and mortality (Hodge et al., 2007; Natarajan et al., 2002).

In summary of the relevant clinical literature, obesity is understood to present a serious global health concern and is associated with a number of detrimental health outcomes (World Health Organization, 2012). Clinically severe obesity is associated among the highest incidence of morbidity and mortality (Flegal, Graubard, Williamson, & Gail, 2005). Evidence supports bariatric surgery as an effective, long-term treatment for clinically severe obesity (Buchwald, 2002). Demand for surgery in Canada (and abroad) outstrips supply and access to the surgery may reflect/perpetuate social inequalities in health (Flum et al., 2007; Padwal & Sharma, 2009). Waiting may have a negative impact on health (Padwal, Majumdar et al., 2012).

Critical & Experiential Perspectives

Constructing the 'fat' body. A fit or lean body, one that fits the current beauty norms, is a signifier of control (Brownell, 1991). It represents the power of self-discipline, "an exemplar of master of mind over body and virtuous self-denial" (Crawford, 1984 p. 70). On the other hand, a fat body can be understood as out of control, lazy, stupid and immoral (Brownell, Puhl, Schwartz, & Rudd, 2005; Lupton, 2013). Individuals who pursue weight loss surgery live in and amongst discourses of fatness/obesity, which undoubtedly contribute to how they see and experience themselves and their world (Throsby, 2007). For this reason I include here a brief review of several discourses foundational to contemporary understandings of weight, obesity and fatness. There is abundance of literature exploring bodies, weight and weight loss using a critical lens (e.g., Bordo, 2003; Braziel & LeBesco, 2001; LeBesco, 2004; Lupton, 2013; Murray, 2008b; Rothblum & Solovay, 2009); however, I will focus this review by briefly exploring three more common, often taken-for-granted (as 'truth'), constructions of corpulent bodies (and individuals).

"The term 'discourse' is commonly used in post-structuralist writings to denote the patterns of ways of thinking, making sense of, talking or writing about, and visually portraying phenomena such as the human body, medical and nursing practices, sexuality and reproduction, illness, disease, and death" (Lupton, 2000, p. 51). Discourses create ways of knowing and being and are re/productive of particular values, 'truths,' power structures, and ideologies (Lupton, 2000, 2013; Foucault, 1997/2003). Discourses influence our possibilities for being in the world – they affect how we understand ourselves and others – how we engage and what we experience (Lupton, 2000, 2013). Discourses *do* many things but for the purpose of this review I am interested, in particular, how they might influence experiences and understandings of 'fat' bodies and the surgical treatment thereof.

One of the prevailing discourses about fatness is positioned with the biomedical realm –weight is equated with health and fatness is labeled as a medical condition (i.e., obesity, excess weight, BMI) rather than, for example, a natural human variation in body size, or a socially constructed phenomenon

(Lawrence, 2004; Lupton, 2013; Murray, 2008a, 2008b; Wray & Deery, 2008). It is within this rhetoric that the 'obesity epidemic'[4] has been formed instilling in all a sense of at-risk-ness and fear (Gard & Wright, 2005; Lupton, 2013; Saguy & Almeling, 2008). In their work on weight-based stigma, bias and discrimination, Puhl and Heuer (2010) argue that genetic and biological understanding of fatness, that is situating weight within biomedical realm,[5] can function to reduce stigma, ultimately benefiting individuals labeled as obese. Critical scholars, however, contest biomedical constructions of obesity contribute to stigmatization because within this discourse fatness is understood as pathological, diseased, non-normal, deviant – other (Bordo, 2003; Braziel & LeBesco, 2001; LeBesco, 2004; Murray, 2008b; Rothblum & Solovay, 2009).

The biomedical positioning of obesity lends a medical legitimacy to the 'condition,' allowing those who qualify (according to standard classifications, such as BMI) to access medical care and treatment (Lawrence, 2004; Lupton, 2013; Wray & Deery, 2008). Beyond the problematic of measurement tools such as BMI, scholars critique the ubiquitous and 'neutral' positioning of knowledges created and re/enforced within this discursive structure (Gard & Wright, 2005; Lupton, 2013; Saguy & Almeling, 2008). Neutrality, these scholars argue, is a mode through which these particular biomedical structures of power and knowledge are perpetuated and often taken up as unproblematic, unbiased, apolitical, taken-for-granted truths (Gard & Wright, 2005; Lupton, 2013; Saguy & Almeling, 2008). Knowledge, within this and all discursive structures, is not neutral, however. It is enmeshed in power relations and political, social, historical

---

[4] There is substantial literature exploring the construction of the 'obesity epidemic.' I refer the reader to Gard & Wright, 2005 and Saguy & Almeling, 2008 for a thorough exploration of the topic.

[5] Although biomedical understandings of body fat may include biological and genetic stories of origin (aetiology) they do not exclude other potentially causal factors such as the environment and behaviour. There remains a prevailing notion within the medical community that fatness (i.e., obesity), although a medical condition, is caused by lifestyle related choices. This is an example of how discourses are often overlapping and intertwined (biomedical and neoliberal, for example).

and other contextual ideologies (Foucault, 1997/2003). For example, within the biomedical discourses experts play a central role defining the boundaries of what is knowable, what is known and what is worth knowing creating clear distinctions between those who can and do know (e.g., physicians, researchers) and those who can and do not (e.g., the 'lay' public; Gard & Wright, 2005; Lupton, 2013; Saguy & Almeling, 2008). Standardized tools, practices, guidelines and so on, available only to a select few, further contribute to the re/production of particular types of knowledge and power structures creating a self-reinforcing feedback loop of sorts (Lawrence, 2004; Lupton, 2013; Wray & Deery, 2008). The positioning of obesity as a disease necessitating treatment, such as bariatric surgery, is, perhaps paramount to the experience of individuals waiting to have the procedure. Without an understanding of weight as unhealthy there would be no need for surgical intervention, and thus no need to wait within this context.

Neoliberal discourses frame weight as an issue of individual control and responsibility. These discourses represent pervasive contemporary values embracing the rhetoric of personal responsibility, rights and choice (Lawrence, 2004; Petersen, Davis, Fraser, & Lindsay, 2010; Townend, 2009). Neoliberal citizenship involves individual responsibilities and social obligations, which include ongoing bodily maintenance to be practiced through particular 'health behaviours' and displayed through the resultant 'healthy,' 'thin' body (Petersen et al., 2010; Lupton, 2013). 'Excess weight' is understood as resulting from poor choices and thus reflects personal (moral) failure, overconsumption and lack of restraint (Lawrence, 2004; Lupton, 3013; Murray, 2008b). Attributing weight to personal responsibility and constructing it as within individual control make it a clear target for moral evaluation and can lead to prejudice and punishment (Crandall et al., 2001; Townend, 2009), stigma and discrimination (Puhl & Heuer, 2010, 2012) and perpetuate social inequalities (Rothblum & Solovay, 2009). Knutsen and colleagues (2013) contest that weight reduction programs aimed at 'empowering' 'obese' individuals, such as weight loss surgery or counselling, often adhere to neo-liberal ideologies ultimately trapping individuals "within the ambivalence of freedom and control" (p. 75).

The Health at Every Size and size acceptance movements offer resistance to the positioning of fatness as inherently problematic (Millman, 1980; Saguy & Riley, 2005). The Proponents of the Health at Every Size criticise the use of medical categorizations based on measurements of body size (i.e., BMI; Burgard, 2009; Millman, 1980; Saguy & Riley, 2005). Rather, they maintain that the focus should be on broadly understood conceptions of health ('holistic') including spiritual, mental, physical, social aspects and so on (Blair & LaMonte, 2006; Burgard, 2009; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Saguy & Riley, 2005). The Health at Every Size movement purports that one can be both healthy and 'fat' (Blair & LaMonte, 2006). Size (and self) acceptance is part of the Health at Every Size mandate, in addition to ending weight bias, enhancing health, encouraging joy in moment and pleasure in eating (Burgard, 2009, pp. 42-43).

The size acceptance movement (which exists within but also beyond the Health at Every Size movement) relies on discourses of human rights and equality and has advocated for the rights of all individuals regardless of body size (i.e., anti-size discrimination policies). "Reverse discourses, such as size acceptance, offer hope for body diversity and a dismantling of the concept of the ideal female form" (Germov & Williams, 1996, p. 644). In support of size acceptance, Saguy & Riley (2005) argue that focusing public policies on reducing body size may distract public attention (and political power) from real health issues such as physical inactivity, unhealthy diets, poverty, health inequalities and so on. What is more, policies aimed at individuals (i.e., body weight) rather than systemic issues such as poverty and access to health care may function to further marginalize already disadvantaged populations such as poor and minority groups (who are among those with highest incidence of 'obesity') and ultimately "legitimate social inequality and health disparities" (Saguy & Riley, 2005, p. 912).

Positioning weight loss surgery. Critical scholars have explored re/presentations of weight loss surgery drawing on pop cultural, news media and conversational sources (e.g., Drew, 2008, 2011; Glenn, Champion, & Spence, 2012; Glenn, McGannon, & Spence, 2012; Knusten, Terragni, & Loss, 2013;

Meleo-Erwin, 2012, 2011; Murray, 2007, 2008a, 2008b, Salant & Santry, 2006; Throsby, 2007, 2008, 2012). These inquiries provide social-cultural readings and understandings of weight loss surgery and individuals who access it. Like 'obesity,' understandings of weight loss surgery are embedded in social discourses. These discourses may shape the experiences of the people who pursue the surgery, affecting how they think about their bodies, the procedure and the post-surgical future (among other things) and potentially contributing to the re/production of weight-related stigma (Meleo-Erwin, 2012). It is within these discourses that individuals seeking bariatric surgical care may be positioned and, furthermore, where they may position themselves. I review in brief several of the dominant discourses that may be negotiated during the waiting period prior to weight loss surgery.

The understanding of obesity as a health problem (i.e., biomedical discourse) is essential to the positioning of bariatric surgery as a necessary medical treatment (Glenn, Champion, & Spence, 2012; Salant & Santry, 2006). Salant and Santry (2006) explored bariatric clinic websites and found the need for surgery was reinforced through promises of transformation and relief from physical, emotional and psychological suffering – the undertones of which construct fatness as problematic and dangerous and surgery as the benevolent saviour. Fairy tale narratives of transformation were also found in a study to which I contributed, exploring news media representations of bariatric surgery. Hetero-normative gender ideals, stereotypical representations of 'fatness' and the benevolence of a government who provides care for un-citizen-like citizens who do not care for themselves were reinforced through the media sources explored (Glenn, McGannon, & Spence, 2012). The news media ultimately constructed a narrative of the ideal bariatric patient – re/creating the standard to which individuals interested in pursuing surgery should conform. While at the same time the ideal patient was positioned as inherently flawed by virtue of the body they possessed (i.e., an obese body) and the means through which reduction was sought (Glenn, McGannon, & Spence, 2012).

The ideal patient narrative was reported among other research as well (Drew, 2008, 2011). According to Drew (2008), the ideal patient is constructed around surgical screening procures and standard guidelines in that a person seeking access to weight loss surgery must demonstrate (as an 'ideal patient'): i) appropriate physiology – as evidenced and measure by BMI and co-morbidities; ii) appropriate diet history – demonstrated past attempts at dieting and failure and may include required diet induced weight loss in the pre-surgical period; iii) appropriate behaviour – willingness to follow instructions and partake in pre and post surgical care requiring approval and guidance from a team of multidisciplinary experts; and iv) appropriate attitude – evidence of the correct desire for surgery (i.e., health), mental approach and motivation as demonstrated through, for example, knowledge and realistic expectations. Individuals accessing surgery primarily reported embracing the ideal, while others had a mixed response (embracing and challenge specific aspects of the ideal) and some strategically complied but maintained that the archetype was built on arbitrary criteria that functioned to gate-keep access to surgery (Drew, 2008). Drew argued the screening procedures and the coincident ideal patient archetype ensured compliance (with normative discourses and practices as well as medical regulations and practices) and functioned to weed out those who resisted (Drew, 2008). People who undergo or are pursuing weight loss surgery may be invested in the re/production of institutional narratives for various reasons (e.g., access, justification) and thus be reticent to discuss alternative/resistive perspectives.

Bariatric surgery is frequently positioned within neoliberal discourses of individual freedom and responsibility (Glenn, Champion & Spence, 2012; Glenn, McGannon & Spence, 2012; Knutsen et al., 2013; Meleo-Erwin, 2012; Murray, 2007; Salant & Santry, 2006; Throsby, 2008). For example, Salant and Santry (2006) found surgery described as a 'tool' that required individual yielding (i.e., hard work, discipline, diet, exercise and so on). Knutsen and colleagues (2013) found individuals described their pre-surgical selves as lacking in control and to blame for body size thus re/enforcing neoliberal values of personal responsibility and freedom of choice. "Happy to be dieting like a normal person," was what

post-surgical candidates reported as they demonstrated their commitment to normative body practices of regulated diet and exercise (Throsby, 2008). Regardless, however of these practices and ultimately the weight loss achieved the new, post-surgical body (and 'new me') was rendered somewhat inauthentic because others judged the surgery as circumventing the expected hard work and discipline of weight regulation (Throsby, 2008, 2012). Individuals discussed the need to constantly re/negotiate the post-surgical self, and how this self was revealed to others (i.e., revealing surgical intervention or not; Throsby, 2008, 2012).

Discourses of transformation and rebirth are common among portrayals of bariatric surgery (Drew, 2008; Glenn, Champion, & Spence, 2012; Glenn, McGannon, & Spence, 2012; Salant & Santry, 2006; Throsby, 2008). News media, bariatric clinic websites, and individuals who have had the procedure overwhelmingly re/present the surgery as positive – life saving, life changing and transformative, and ultimately inducing required bodily changes. Post-surgical transformations, however, went beyond the body to encompass and implicate life more broadly – rebirth signified a 'new me' a better or more authentic version of self. Discourses of transformation and rebirth position the pre-bariatric surgical self, the fat body as undesirable, something from which one should escape or attempt to transform and ultimately suggest this body – that is the fat, 'obese' body more broadly – is or should be considered unliveable (Drew, 2008; Glenn, Champion & Spence, 2012; Glenn, McGannon & Spence, 2012; Salant & Santry, 2006; Throsby, 2008, 2012).

The negotiation of discourses, clinical and popular, related to bariatric surgery may be foundational to the surgical experience (Drew 2008, 2011; Meleo-Erwin, 2011, 2012; Throsby, 2007, 2008). These discourses frequently position fatness as inherently problematic (e.g., risky, immoral), surgery as potentially necessary yet also problematic (e.g., easy way out), and surgical candidates as flawed (Drew 2011; Meleo-Erwin, 2011, 2012; Murray, 2007, 2008a, 2008b, 2009; Throsby 2007, 2012). These discourses could contribute to the

re/production of stigma related to fatness (Meleo-Erwin, 2012), weight loss surgery and the people who have the procedure (Drew, 2011).

It is the literature on stigma that I now provide an overview. For a more comprehensive review of weight-based bias, stigma and discrimination I direct the reader to the works of Puhl and Brownell.

Weight Bias and Stigma

Weight bias, stigma and discrimination are significant problem among Western industrialized countries (Brownell et al., 2005; Puhl & Brownell, 2012; Puhl & Heuer, 2012). Salient examples can be found everywhere, including on television, film, and in the news (Brownell et al., 2005; Glenn, Champion, & Spence, 2012). A significant contribution to the literature on weight-stigma, bias and discrimination comes from a research group at the Rudd Centre for Food Policy & Obesity at Yale University lead by Kelly Brownell and Rebecca Puhl. Their work consistently demonstrates weight bias exists in all facets of life including education, work, and health care, and intimate relationships (Brownell et al., 2005; Puhl & Brownell, 2012; Puhl & Heuer, 2012).

Weight affects how individuals are cared for and judged by treating physicians (Hebl & Xu, 2001; Malterud & Ulriksen, 2011). For example, Hebl and Xu (2001) explored the treatment recommendations made by physicians' in response to complaints of migraine headaches presented by patients categorised as normal, overweight or obese. They found, compared to normal weight patients, those considered overweight or obese were noticeably more likely to be subjected to multiple, unrelated tests and consultations (i.e., consult about weight loss and nutrition, recommend a psychological consultation; Hebl & Xu, 2001). Experiential inquiries have corroborated these results (Malterud & Ulriksen, 2011; Murray, 2009), as, for example, Murray (2009 recounts,

> . . . I reluctantly decided to visit a doctor for investigation. Having a history of clinical consultation where most every complaint from colds to broken ankles linked tenuously (but allegedly inarguably) to my overweight, it was with trepidation and wariness that I sat in the doctor's waiting room. (p. 154)

The mechanisms through which stigma may impact health is complex and can be indirect, for example through reduced overall access to health care services or direct, such as via influences on mental and social wellbeing (Brownell et al., 2005; Puhl & Brownell, 2012; Puhl & Heuer, 2012). Individuals who have experienced weight-stigma within health care encounters may be reticent to seek out clinical care, and thus delay treatment or avoid it altogether (Adams, Smith, Wilbur, & Grady, 1993; Brownell et al., 2005). There is also an inverse relationship between weight and preventative health care service access among women (Fontaine, Faith, Allison, & Cheskin, 1998). With regards to mental health, experiences of weight-stigma have been associated with poor body image and weight loss treatment outcomes, reduced psychosocial functioning, and increased binge eating and depression (Annis, Cash, & Hrabosky, 2004; Wott & Carels, 2010). There are few studies that have inquired into experiences of stigma among bariatric patients. Sarwer and colleagues (2008) reported levels of weight-related stigma experiences were low among bariatric patients, corresponding to "several times in you life." Others, however, have reported stigmatizing experiences were common among bariatric patients, and furthermore, these experiences were associated with depression, anxiety, body image disturbance and binge eating disorders (Friedman, Ashmore, & Applegate, 2008).

Experiencing Bariatric Surgery

Qualitative inquires exploring the experiences weight loss surgery have predominantly focused on the post-surgical period (Bocchieri, Meana, & Fisher, 2002; Earvolino-Ramirez, 2008; Joanisse, 2005; LePage, 2010; Murray, 2009; Ogden, Clementi, & Aylwin, 2006; Sutton, Murphy, & Raines, 2009; Throsby, 2012; Wysoker, 2005; Zijlstra, Boeije, Larsen, van Ramshorst, & Geenen, 2009). Several studies have considered the lived-experiences of bariatric surgery using phenomenological methods (Earvolino-Ramirez, 2008; Engström, Wiklund, Olsén, Lönroth, & Forsberg, 2011; Groven, Engelsrud, & Rhåeim, 2012; Groven, Rhåeim, & Engelsrud, 2010, 2012; LePage, 2010; Ogden et al., 2006; Wysoker, 2005), critical-experiential approaches (Murray, 2009; Throsby, 2012), or general

qualitative methods (de Silva & da Costa Maia, 2012; Joanisse, 2005; Sterling Lynch, Chang, Ford, & Ibrahim, 2007; Sutton et al., 2009; Zijlstra et al., 2009), while others have attempted to contribute to theoretical understandings through the use of grounded theory (Bocchieri, Meana & Fisher, 2002; Engström & Forsberg, 2011).

Phenomenological studies have focused on post-surgical experiences (Earvolino-Ramirez, 2008; Groven, Engelsrud, & Rhåeim, 2012; Groven, Rhåeim, & Engelsrud, 2010, 2012; LePage, 2010; Ogden et al., 2006; Wysoker, 2005), with one exception (Engström et al., 2011). I would argue that the findings of these studies, with the exception of the work by Groven and colleagues (2010, 2012), provide qualitative descriptions and thematic statements found through the use of other general qualitative methodological approaches (see Patton, 2002), rather than phenomenological insights (or showing) in the way of this thesis work.[6] Nevertheless, these studies provide descriptive understandings of bariatric surgery related experiences important to the overall bariatric surgery literature and will be reviewed here. The exception is the work of Groven and colleagues, which is deeply phenomenological and points to aspects of the post-bariatric experience that I will review in greater detail below.

Control frequently emerged as an aspect of the bariatric surgical experience (de Silva & da Costa Maia, 2012; Engström et al., 2011; Engström & Forsberg, 2011; Ogden et al., 2006). Individuals described feeling a loss of control prior to surgery (related to eating, food, weight, obesity), choosing surgery as a means of attaining control, and finding control in the post surgical experience (de Silva & Da Costa Maia, 2012; Engström et al., 2011; Engström & Forsberg,

---

[6] This is evidenced by many things including the thematic focus of the findings – that is listing themes and sub-themes and then speaking to these themes rather than to the phenomenon; the use of 'thematic' or other analytic approaches (rather than phenomenological reflection and reduction practices; and the lack of phenomenological insights, lived-descriptions and philosophical literature, which are hallmark to the tradition of phenomenology of practice (and, I would argue, broadly to phenomenology). Please see the methodology section for a detailed description of the phenomenology of practice as undertaken in this thesis work or see van Manen (1990).

2011; Ogden et al., 2006). Transformation was another theme that came up among many qualitative inquires (Bocchieri, Meana, & Fisher, 2002; Earvolino-Ramirez, 2008; LePage, 2010; Murray, 2009; Ogden et al., 2006; Throsby, 2008; Wysoker, 2005). Ogden and colleagues (2006) found participants reported feelings of "rebirth" as well as renewed confidence, more positive body image, energy and quality of life as a result of their dramatic weight loss. The only negative aspect of surgery that emerged was the challenge of adjusting to the new, post-surgical body (Ogden et al., 2006). The authors concluded the majority of participants were happy to have chosen the surgery (Ogden et al., 2006). Other research has similarly found bariatric surgery to be experienced as predominantly positive and life changing yet somewhat paradoxical with tensions arising due to these changes (Bocchieri, Meana, & Fisher, 2002; Earvolino-Ramirez, 2008; Engström & Forsberg, 2011; Joanisse, 2005; LePage, 2010; Meleo-Erwin, 2012; Sutton et al., 2009; Wysoker, 2005).

The paradoxical nature of the surgery was captured in Samantha Murray's (2009) critical-experiential study of her own post-bariatric experiences. She inquired into her 'banded-embodiment' and the tensions she faced related to the health/aesthetic dichotomy and her identity as a fat activist (Murray, 2009). She described her post-surgical self as, in many ways, paradoxically dis-abled – due to surgically induced complications (e.g., ulcers, gallstones, chest pain related to eating), disturbed eating patterns, and other 'transformations.' She argued,

> I find a strange and disturbing synchronicity at times with the experience of bulimia and my current experience of managing the gastric band. Sharing dinner with friends, who may offer me compliments about my weight loss and changed appearance echo in concert with the distress at having food caught painfully in my chest, and repeated requests to be excused to go the bathroom, with explanations I have developed to hide my discomfort, such as "I 've had a bit of an upset stomach over the last few days." For those who don't know about my surgery, my reduced food intake may simply be interpreted as part of the 'diet' that must have resulted in my noticeable weight loss, thus attracting little attention.

(Murray, 2009, p. 162)

Phenomenological texts point to the complexity and ambivalences of post-surgical lived-realities (Groven, Rhåeim, & Engelsrud, 2010, 2012; Groven, Engelsrud & Rhåeim, 2012). In their study of 'worse life experiences' among individuals in the post-surgical period, Groven and colleagues (2010) found feelings of increased restriction and disability among individuals in their post-surgical lives. Fatigue and body-dissatisfaction related to excess skin, for example, contributed to the overall feeling among participants that bariatric surgery caused more pain than it relieved (Groven et al., 2010). Individuals described, "being damaged on the 'inside'" by the surgery revealing a problematic aspect of the post-bariatric experience (Groven et al., 2010, p. 8). Although predominantly negative individuals did report feeling elation related to the initial body transformation (i.e., weight loss; Groven et al., 2010). Groven et al. (2010) cautioned that post-bariatric experiences can be unpredictable transforming otherwise healthy ('obese') individuals into people living with chronic pain.

In their explorations of the post-surgical experiences of the gendered-lived body and dumping syndrome Groven and collegues (Groven, Engelsrud & Rhåeim, 2012) revealed tensions arising from the public versus private body – where the surface of the body in its slimmer form was read as healthy yet the inner body, known only to the individuals themselves, was oftentimes unpredictable and the source of pain or discomfort (e.g., dumping syndrome, excess skin). Excess skin resulting from post-surgical weight loss was also a source of challenge and concern for individuals having undergone the procedure (Groven, Rhåeim, & Engelsrud, 2012). As captured in the thematic title, "slimmer and smaller, looser and looser" participants reported grappling with increasing excesses of skin as their weight loss became more pronounced (Groven, Rhåeim, & Engelsrud, 2012, p. 9). Experiences of dumping further exacerbated feelings of uncertainty or the unknown around the post-surgical body and revealed the possible unpredictable nature of the post-bariatric life-as-lived (Groven, Engelsrud & Rhåeim, 2012). Taken together, these phenomenological

explorations exposed the possible complexities, paradoxes and tensions of living with the post-bariatric surgical body (Groven, Engelsrud & Rhåeim, 2012, Groven, Rhåeim, & Engelsrud, 2010, 2012).

Focusing on the pre-surgical population, Engström and colleagues (2011) considered the meanings of waiting among bariatric candidates – a question not unlike the one I ask. They identified six main themes related to the experience: "experiencing food as a complex element in life, feeling hopeless regarding weight loss, living in fear of future sickness and death, living a restricted life, being ignored by health care professionals and hoping for control and opportunities" (Engström et al., 2011, p. 1). The authors concluded bariatric patients had experienced significant struggles related to food and obesity and saw weight loss surgery as a last hope to attaining good health (Engström et al., 2011). de Silva and da Costa Maia (2012) sought to understand how pre-surgical candidates made sense of obesity and surgery as a treatment. They, like Engström et al. (2011), reported surgery as a last resort; however, participants in this study revealed a contradiction between feelings that surgery required great commitment and seeing the surgery as a miracle that would change their lives without much effort (de Silva & da Costa Maia, 2012).

With few exceptions (i.e., Groven, Rhåeim & Engelsrud, 2010; Joanisse, 2005; Murray, 2009) the majority of the qualitative inquires included in this review were descriptive and uncritical (in their findings). They frequently used generic qualitative approaches to reveal thematic descriptions and understandings of the procedure from the 'patients' perspectives.' That is not to say that this literature does not add to the discussion about the experiential realities/complexities of weight loss surgery, potential barriers and tensions. However, I suggest that these studies may be preliminary and further, in-depth qualitative scholarship, like the work by Drew (2008, 2011), Groven et al. (2010, 2012), Joanisse (2005), Murray (2009) and Throsby (2007, 2008, 2012) is required to better understand the nuanced and potentially unexpected realities, possible tensions and problematics of undergoing bariatric surgery. Additionally, a notable gap in understanding exists with regards to experiences of the pre-

surgical period. For the purpose of this review I will attempt to address this gap by considering the experience of waiting for other, non-bariatric, medical procedures as well as experience of waiting more broadly, as it may be understood phenomenologically.

Experiences of Waiting For Surgical Procedures

Phenomenological explorations of experiences of waiting, related to medical procedures or treatments other than weight loss surgery, show waiting has a profound impact on people's lives and sense of identity (Brown, Sorrell, McClaren, & Creswell, 2006; Parsons, Godfrey, & Jester, 2009; Sjöling et al., 2005). Waiting, within the context of liver transplant surgery was experienced as transformation – that is people gained a new perspective on life in facing death (due to end stage liver disease) and considered being placed on the transplant list a 'second chance' (Brown et al., 2006). However, waiting was described as a life on hold while paradoxically understood as the only chance for survival – in this sense waiting was a kind of limbo, described as a purgatory of being neither here (i.e., alive) or there (i.e., dying; Brown et al., 2006). Transplant patients felt proving their 'legitimacy' through extensive pre-surgical evaluation and mandatory participation in substance abuse programs bestowed a sense of trust in their surgical team (Brown et al., 2006). Being on the transplant waiting list, however, was a surrender of control over one's life and accompanied with feelings of loss, isolation and despair; yet in the same instance provided time for individuals to create new ways of being during the wait and often lead to acceptance, patience and a renewed sense of control (Brown et al., 2006). Illness progression, extended waiting times and uncertain outcomes impacted individuals' sense of self worth and identity and required continual negation and struggle (Brown et al., 2006).

Life on hold, a struggle and the wait to return to normal were among experiences of waiting for other surgical treatments (Parson et al., 2009; Sjöling et al., 2005). People waiting for athroplastic joint surgery felt waiting rendered life meaningless and undignified due to increasing experiences of disability and pain (Sjöling et al., 2005). Nevertheless, waiting within this context was depicted as an

attempt to live a full life despite pain (Sjöling et al., 2005). The importance of trusting relationships with health care providers was highlighted (Sjöling et al., 2005). To alleviate suffering and uncertainty that accompanies surgical waits researchers point to the role of attentive and caring clinicians and the provision of timely and relevant information (Brown et al., 2006; Parsons et al., 2009). Understanding the experiential significance of waiting within the context of other surgical procedures, such as liver transplant and joint surgery suggest possible shared aspects of the waiting experience within pre-surgical contexts (e.g., struggle, life on hold) but also possible points of divergence (e.g., grappling with life and death, living a 'full' life). These findings indicate the phenomenon of waiting is of experiential import within a clinical context, specifically prior to surgical intervention. Waiting may be meaningful in particular ways during the pre-surgical period and an understanding thereof could inform or guide clinical practice in such a way as to address, with greater care and tact, the specific, and perhaps previously unanticipated needs of individuals during this time (Brown et al., 2006). I close this review with a glimpse into phenomenological reflections on experiences of waiting.

Experiences of Waiting

> In the experience of waiting, I suggest, we awaken to the repressed rhythms of duration and thus also to the deeper dimension of our being (Schweizer, 2005, p. 778).

To wait it to be human; it is to anticipate the future to be watchful or wishful, to wonder and to expect. Waiting requires that something or someone be awaited; it requires a kind of attentiveness, a tacit knowledge that there is something to come. Waiting originates from the French word *watier*, to watch, and implies a hostile intent. Waiting is close to wake – to stay in the some place, to see to it that something occurs (wait, n.d.). Waiting is inescapable – we wait for things we know will come, buses, elevators, and trains; we wait for the first signs of spring, night to fall, and the clouds to part after the rain. We wait for things we cannot be sure will arrive – the blush of first love, the touch of a friend, the understanding

nod of someone who knows, someone who cares – we cannot be certain of their arrival but we may remain hopeful and trust that these experiences will come to us with time. Waiting and hopeful expectation may go hand in hand. Waiting may be patient or enduring, beset with boredom or a kind of forward momentum. Waiting may be different again when one waits for one's child to take his or her first steps, or for the tulips planted in the fall to emerge from the snow. Then there is the waiting that is also in some way what is awaited – the becoming mode of waiting where one waits for understanding or growth. I wonder what mode of waiting takes place in the period prior to weight loss surgery? How might this wait be understood?

Fujita (2002) suggests that modes of waiting are informed by an objective aspect, that is what is being awaited and a subjective aspect, how one waits. Yet, he cautions, these qualities (the objective and subjective) may not distinct, but rather intertwined within particular experiences of waiting. Waiting in the case of a traffic light changing colour or the arrival of the post may be a necessary evil, a means to an end punctuated by boredom and unproductive time (Fujita, 2002, p. 126). This mode of waiting, where what is awaited is expected and somewhat certain to arrive is described as waiting within the world of instrument-machinery (Fujita, 2002). Waiting unfolds within this world as unimportant but necessary – how one waits will not, for example, affect the time it takes for a computer to turn on or the bus to arrive (Fujita, 2002). What is being awaited, such a spring blossoms or the sun to rise, may shift the experience into waiting in the world of nature (Fujita, 2002). Waiting in this world is experienced as just outside of human control (Fujita, 2002). One may help their garden to grow yet the cherry trees will bloom pink and produce fruit rich with redness and nothing else (Fujita, 2002). What is awaited may exist in a world of becoming – a world that is particularly human in which we become ourselves (Fujita, 2002). In this world what is being awaited may be ambiguous or unclear, unlike waiting within the natural and instrument-machinery worlds where what is awaited is known. Fujita writes, "this does not mean that there is no such thing as what is waited for, but that what is waited for exists only in a more flexible and tacit form which is

inseparable from the sense of directionality and value" (p. 132). Although separated here and within his own writing, Fujita (2002) suggests these modes of waiting may not always be distinct and instead can overlap and shift as what is being awaited for shifts and changes.

Bollnow (1989) and van den Berg (1972) address questions of how is it that humans wait, the subjective character of waiting as Fujita (2002) describes it. Bollnow (1989) demonstrates the distinctness waiting; each form has its own unique relation with time, self and other. He uses the examples of waiting for a garden to grow, a child to learn and a craftsman to create a work of art to illustrate the possible ways we wait (Bollnow, 1989). Waiting for the garden requires patience and trust, it requires time and care; sunlight, water, and soil (Bollnow, 1989). The exact conditions for success are known although not entirely under the control of the gardener. Waiting for a child to learn presents itself differently. Waiting for a child may be less certain. A teacher may provide guidance and encouragement but ultimately this wait requires a unique kind of patience and openness to the path of that particular child. Although we may be able to guide, suggests Bollnow (1989) we cannot control the outcome of a child's progress. In contrast, the wait of a craftsman presents itself with certainty. The craftsman enters into a particular relation with time – he must not rush if he is to create the perfect piece. However he can be sure that with the proper care and attention to detail he will succeed in his creation (Bollnow, 1989).

Van den Berg (1972) shows the phenomenon of waiting, the relation between expectation and disappointment, with an example of a cancelled visit from a friend. He has uncorked a bottle of wine and stoked the fire on a cold winters night in anticipation of his friend's immanent arrival. The phone rings and he finds his friend must cancel because of an impending storm. He opens a book and begins reading, time slows and the night begins to crawl by and then something captures his eye – the wine bottle sparkles as it catches the glow from the fire. Seeing the bottle he is reminded of the missing presence of his friend and his aloneness on that winter's eve. The unmet expectation of the wait is relived and he feels more acutely alone than he would have if the bottle of wine were not

sitting open before him (van den Berg, 1972). How we wait for a friend to arrive may be a kind of preparation, setting out the table or uncorking some wine to share – gestures of invitation that if unmet leave one to feel disappointed and alone. Van den berg (1972) shows that experiences, in this case waiting, inhabit the things of our world, such as the bottle of wine, and are lived through time, space, the body and relations with others. He reminds us that waiting is a particular way of being-in-the-world (van den Berg, 1972), a sentiment that is articulated by Schweizer (2005),

> The objects the waiter perceives – his clairvoyance produced by his fundamental existential awareness that he shares the phenomenology of things – have been plucked out of their quotidian context that would have given them purpose and made them invisible. The person who waits sees objects – and in them himself . . . (p. 783)

He continues, "In seeing objects in time, the waiter sees himself passing through time" (Schweizer, 2005, p. 784). I wonder how a person who waits within the context of bariatric surgery might pass through time? What can the objects of one's world reveal about this wait? How might one be-in-the-world of waiting while in the queue for bariatric surgery? How is waiting for surgery lived differently perhaps than the wait for a friend to arrive, the garden to grow or the elevator to descend to our stop?

References

Adams, C. H., Smith, N. J., Wilbur, D. C., & Grady, K. E. (1993). The relationship of overweight to the frequency of pelvic examinations: Do physicians and patient attitudes make a difference? *Women Health, 202*, 45-57. doi:10.1300/J013v20n02_04

Adams, T. D., Gress, R. E., Smith, S. C., Halverson, R. C., Simper, S. C., Rosamond, W. D., . . . Hunt, S. C. (2007). Long-term mortality after gastric bypass surgery. *New England Journal of Medicine, 357*(8), 753-761. doi:10.1056/NEJMoa066603

Annis, N. M., Cash, T. F., & Hrabosky, J. I. (2004). Body image and psychosocial differences among stable average weight, currently overweight, and formerly overweight women: The role of stigmatizing experiences. *Body Image, 1*(2), 155-167. http://dx.doi.org/10.1016/j.bodyim.2003.12.001

Black, D. W., Goldstein, R. B., & Mason, E. E. (1992). Prevalence of mental disorder in 88 morbidly obese bariatric clinic patients. *American Journal of Psychiatry, 149*(2), 227-234.

Blair, S. N., & LaMonte, M. J. (2006). Commentary: Current perspectives on obesity and health: Black and white, or shades of grey? *International Journal of Epidemiology, 35*(1), 69-72. doi:10.1093/ije/dyi259

Bocchieri, L. E., Meana, M., & Fisher, B. L. (2002). Perceived psychosocial outcomes of gastric bypass surgery: A qualitative study. *Obesity Surgery, 12*(6), 781-788. 10.1381/096089202320995556

Bollnow, O. F. (1989). The pedagogical atmosphere. *Phenomenology & Pedagogy, 7,* 5–63.

Bordo, S. (2003). *Unbearable weight* (10th anniversary ed.). Berkley: University of California Press.

Braziel, J. E., & LeBesco, K. (Eds.). (2001). *Bodies out of bounds*. Berkley: University of California Press.

Brown, J., Sorrell, J. H., McClaren, J., & Creswell, J. W. (2006). Waiting for a liver transplant. *Qualitative Health Research, 16*(1), 119-136. doi:10.1177/1049732305284011

Brownell, K. D. (1991). Dieting and the search for the perfect body: Where physiology and culture collide. *Behavior Therapy, 22*, 1-12. http://dx.doi.org/10.1016/S0005-7894(05)80239-4

Brownell, K. D., Puhl, R. M., Schwartz, M. B., & Rudd, L. (Eds.). (2005). *Weight bias nature, consequences, and remedies*. New York, NY: The Guilford Press.

Buchwald, H. (2002). A bariatric surgery algorithm. *Obesity Surgery, 12*, 733-746.

Buchwald, H. (2005). Bariatric surgery for morbid obesity: Health implications for patients, health professionals, and third-party payers. *Journal of the American College of Surgeons, 200*(4), 593-604.

Buchwald, H., Avidor, Y., Braunwald, E., Jensen, M. D., Pories, W., Fahrbach, K., & Schoelles, K. (2004). Bariatric surgery. *JAMA: The Journal of the American Medical Association, 292*(14), 1724-1737. doi:10.1001/jama.292.14.1724

Buchwald, H., Estok, R., Fahrbach, K., Banel, D., Jensen, M. D., Pories, W. J., . . . Sledge, I. (2009). Weight and type 2 diabetes after bariatric surgery: Systematic review and meta-analysis. *The American Journal of Medicine, 122*(3), 248-256.e5. http://dx.doi.org/10.1016/j.amjmed.2008.09.041

Burgard, D. (2009). What is "Health at Every Size"? In E. Rothblum, & S. Solovay (Eds.) *The fat studies reader* (pp. 42-53). New York: New York University Press.

Campos, P., Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The epidemiology of overweight and obesity: Public health crisis or moral panic? *International Journal of Epidemiology, 35*(1), 55-60. doi:10.1093/ije/dyi254

Christou, N. V., & Efthimiou, E. (2009). Bariatric surgery waiting times in Canada. *Canadian Journal of Surgery, 52*(3), 229-234.

Christou, N. V., Sampalis, J. S., Liberman, M., Look, D., Auger, S., McLean, A. P. H., & MacLean, A. P. H. (2004). Surgery decreases long-term mortality, morbidity, and health care use in morbidly obese patients. *Annals of Surgery, 240*(3), 416-424. doi:10.1097/01.sla.0000137343.63376.19

Colquitt, J. L., Picot, J., Loveman, E., & Clegg, A. J. (2009). Surgery for Obesity. *Cochrane Database of Systematic Reviews* (CD003641)*, 15*(2). doi:10.1002/14651858.CD003641.pub3

Crandall, C. S., D'Anello, S., Sakalli, N., Lazarus, E., Nejtardt, G. W., & Feather, N. T. (2001). An attribution-value model of prejudice: Anti-fat attitudes in

six nations. *Personality and Social Psychology Bulletin, 27*, 30-37. doi: 10.1177/0146167201271003

Crawford, R. (1984). A cultural account of 'health'" Control, release, and the social body. In J. B. McKinlay (Ed.), *Issues in the political economy of health care* (pp. 60-103). New York, NY: Travistock.

de Silva, S. S., & da Costa Maia, A. (2012). Obesity and treatment meanings in bariatric surgery candidates: A qualitative study. *Obesity Surgery, 22*(11), 1714-1722. doi:10.1007/s11696-012-0716-y

Drew, P. (2008). Weight loss surgery patients' negotiations of medicine's institutional logic. *Research in the Sociology of Health Care, 26*, 65-92. doi:10.1016/S0275-4959(08)26004-7

Drew, P. (2011). "But then I learned…": Weight loss surgery patients negotiate surgery discourse. *Social Science & Medicine, 73*(8), 1230-1237. doi:http://dx.doi.org/10.1016/j.socscimed.2011.07.023

Earvolino-Ramirez, M. (2008). Living with bariatric surgery: Totally different but still evolving. *Bariatric Nursing and Surgical Patient Care, 3*(1), 17-24. doi:10.1089/bar.2008.9996

Engström, M., & Forsberg, A. (2011). Wishing for deburdening through a sustainable control after bariatric surgery. *International Journal of Qualitative Research on Health and Well-Being, 6*(1). doi:10.3402/qhw.v6i1.5901

Engström, M., Wiklund, M., Olsén, M. F., Lönroth, H., & Forsberg, A. (2011). The meaning of awaiting bariatric surgery due to morbid obesity. *Open Nursing Journal, 5*, 1-8. doi:10.2174/187443601105010001

Fabricatore, A. N., Crerand, C. E., Wadden, T. A., Sarwer, D. B., & Krasucki, J. L. (2006). How do mental health professional evaluate candidates for bariatric surgery? Survey results. *Obesity Surgery, 16*(5), 567-573. doi:10.1381/096089206776944986

Flegal, K. M., Graubard, B. I., Williamson, D. F., & Gail, M. H. (2005). Excess deaths associated with underweight, overweight, and obesity. *Journal of*

the American Medical Association, 293(15), 1861-1867. doi:10.1001/jama.293.15.1861

Flum, D. R., Khan, T. V., & Dellinger, P. (2007). Toward the rational and equitable use of bariatric surgery. *Journal of the American Medical Association, 298*(12), 1442-1444. doi:10.1001/jama.298.12.1442.

Fobi, M. A. L. (2004). Surgical treatment of obesity: A review. *Journal of the National Medical Association, 96*(1), 61-75.

Fontaine, K. R., Faith, M. S., Allison, D. B., & Cheskin, L. J. (1998). Body weight and health care among women in the general population. *Archives of Family Medicine, 7*, 381-384.

Foucault, M. (2003). *"Society must be defended"* (D. Macey, Trans.). New York, NY: Picador. (Original work published 1997)

Friedman, K. E., Ashmore, J. A., & Applegate. K. L. (2008). Recent experiences of weight-based stigmatization in a weight loss surgery population: Psychology and behavioral correlates. *Obesity, 16*(S2), S69-S74. doi:10.1038/oby.2008.457

Fujita, M. (2002). Modes of waiting. In van Manen (Ed.), *Writing in the Dark*. London, Canada: The Althouse Press.

Gard, M., & Wright, J. (2005). *The obesity epidemic: Science, morality and ideology*. New York, NY: Routledge.

Germov, J., & Williams, L. (1996). The sexual division of dieting: Women's voices. *Sociological Review, 44*(4), 630-647. doi:10.1111/j.1467-954X.1996.tb00440.x

Glenn N. M.**,** McGannon K. R, & Spence J. C. (2013). Exploring media representations of weight-loss surgery. *Qualitative Health Research*, 23(5), 631-644. doi:10.1177/1049732312471731

Glenn, N. M., Champion, C., & Spence, J. C. (2012). Exploring online media coverage and corresponding comments regarding weight loss surgery on CBC using qualitative content analysis. *Clinical Obesity, 2*(5-6), 125-131. doi:10.1111/cob.12000

Glinski, J., Wetzler, S., & Goodman, E. (2001). The psychology of gastric bypass surgery. *Obesity Surgery, 11*(5), 581-588. doi:10.1381/09608920160557057

Grilo, C. M., Masheb, R. M., Brody, M., Toth, C., Burke-Martindale, C. H., & Rothschild, B. S. (2005). Childhood maltreatment in extremely obese male and female bariatric patients. *Obesity Research, 13*(1), 123-130. doi:10.1038/oby.2005.16

Grilo, C. M., White, M. A., Masheb, R. M., Rothschild, B. S., & Burke-Martindale, C. H. (2006). Relation of childhood sexual abuse and other forms of maltreatment to 12-month postoperative outcomes in extremely obese gastric bypass patients. *Obesity Surgery, 16*(4), 454-460. doi:10.1381/096089206776327288

Groven, K. S., Engelsrud, G., & Rhåeim, M. (2012). Living with bodily changes after weight loss surgery - women's experiences of food and "dumping." *Phenomenology & Practice, 6*(1), 36-54.

Groven, K. S., Rhåeim, M., & Engelsrud, G. (2010). "My quality of life is worse compared to my earlier life" Living with chronic problems after weight loss surgery. I*nternational Journal of Qualitative Studies in Health and Well-Being, 5*, 5553-5568. doi:10.3402/qhw.v5i4.5553.

Groven, K. S., Rhåeim, M., & Engelsrud, G. (2012). Dis-appearance and dys-appearance anew: Living with excess skin and intestinal changes following weight loss surgery. *Medicine, Health Care and Philosophy, 16*(3), 507-523. doi:10.1007/s11019-012-9397-5

Grundy, S.M., Barondess, J.A., Bellegie, N.J., Fromm, H., Greenway, F., Halsted, C.H., … Zipf, W. (1991). Gastrointestinal surgery for severe obesity. *Annals of Internal Medicine*, 115(12), 956-961.

Haslam, D., & James, P. (2005). Obesity. *Lancet, 366* (9492), 1197-1209. doi:10.1016/S0140-6736(05)67483-1

Hebl, M. R., & Xu, J. (2001). Weighting the care: Physician's reactions to the size of a patient. *International Journal of Obesity, 25*(8), 1246-1252. doi:10.1038/sj.ijo.0801681

Herpertz, S., Kielmann, R., Wolf, A. M., Langkafel, M., Senf, W., & Hebebrand, J. (2003). Does obesity surgery improve psychological functioning? A systematic review. *International Journal of Obesity, 27*, 1300-1314. doi:10.1038/sj.ijo.0802410

Hodge, W., Horsley, T., Albiani, D., Baryla, J., Belliveau, M., Buhrmann, R., . . . Lowcock, E. (2007). The consequences of waiting for cataract surgery: A systematic review. *Canadian Medical Journal, 176*(9), 1285-1290. doi:10.1503/cmj.060962

Hydock, C. M. (2005). A brief overview of bariatric surgical procedures currently being used to treat the obese patient. *Critical Care Nursing Quarterly, 28*(3), 217-226.

Joanisse, L. (2005). "This is who I really am": Obese women's conceptions of self following weight loss surgery. In D. Pawluch, W. Shaffir, & C. E. Miall (Eds.), *Doing ethnography: Researching everyday life* (pp. 248-259). Toronto, Canada: CPSI/Women's Press.

Kaly, P., Orellana, S., Torrella, T., Takagishi, C., Saff-Koche, L., & Murr, M. M. (2008). Unrealistic weight loss expectations in candidates for bariatric surgery. *Surgery for Obesity and Related Diseases: Official Journal of the American Society for Bariatric Surgery, 4*(1), 6–10. http://dx.doi.org/10.1016/j.soard.2007.10.012

Karmali, S., Kadikoy, H., Brandt, M. L., & Sherman, V. (2011). What is my goal? Expected weight loss and comorbidity outcomes among bariatric surgery patients. *Obesity Surgery, 21*(5), 595-603. doi:10.1007/s11695-009-0060-z

Karmali, S., & Shaffer, E. (2005). The battle against the obesity epidemic: Is bariatric surgery the perfect weapon? *Clinical and Investigative Medicine, 28*(4), 147-156.

Knutsen, I. R., Terragni, L., & Loss, C. (2013). Empowerment and bariatric surgery: Negotiation of credibility and control. *Qualitative Health Research, 23*(1), 66-77. doi:10.1177/1049732312465966.

Kohli, R. & Seeley, R. J. (2013). Diabetes: The search for mechanisms underlying bariatric surgery. *Nature Reviews Endocrinology, 9*, 572-574. doi: 10.1038/nrendo.2013.159

Kramer, F. M., Jeffery, R. W., Forster, J. L., & Snell, M. K. (1989). Long-term follow-up of behavioral treatment for obesity: Patterns of weight regain among men and women. *International Journal of Obesity, 13*(2), 123-136.

Kruseman, M., Leimbruber, A., Zumbach, F., & Golay, A. (2010). Dietary, weight, and psychological changes among patients with obesity, 8 years after gastric bypass. *Journal of the American Dietetic Association, 110*, 527-534. http://dx.doi.org/10.1016/j.jada.2009.12.028

Lawrence, R. G. (2004). Framing obesity: The evolution of news discourse on a public health issue. *Press/Politics, 9*(3), 56-75. doi:10.1177/1081180X04266581

LeBesco, K. (2004). *Revolting bodies*. Boston: University of Massachusetts Press.

LePage, C. T. (2010). The lived experience of individuals following roux-en-Y gastric bypass surgery: A phenomenological study. *Bariatric Nursing and Surgical Patient Care, 5*(1), 57-64. doi:10.1089/bar.2009.9938

Libeton, M., Dixon, J. B., Laurie, C., & O'Brien, P. E. (2004). Patient motivation for bariatric surgery: Characteristics and impact on outcomes. *Obesity Surgery, 14*(3), 392-398. doi:10.1381/096089204322917936

Livingston, E. H. (2002). Obesity and its surgical management. *American Journal of Surgery, 184*(2), 103-113. http://dx.doi.org/10.1016/S0002-9610(02)00914-5

Lau, D. C. W., Douketis, J. D., Morrison, K. M., Hramiak, I. M., Sharma, A. M., & Ur, E. (2007). 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children [summary]. *Canadian Medical Association Journal, 176*(Suppl 8), S1-S13. doi:10.1503/cmaj.061409

Lupton, D. (2013). *Fat*. New York, NY: Routledge.

Lupton, D. (2000). The social construction of medicine and the body. In G. Albrecht, R. Fitzpatrick, & S. C. Scrimshaw (Eds.), *Handbook of social*

studies in health and medicine (pp. 50-63). Thousand Oaks, CA: SAGE Publications.

Malterud, K., & Ulriksen, K. (2011). Obesity, stigma, and responsibility in health care: A synthesis of qualitative studies. *International Journal of Qualitative Studies in Health and Well-Being, 6*(4). doi:10.3402/qhw.v6i4.8404.

Martin, M., Beekley, A., Kjorstad, R., & Sebesta, J. (2010). Socioeconomic disparities in eligibility and access to bariatric surgery: A national population-based analysis. *Surgery for Obesity and Related Diseases, 6*(1), 8-15. doi:10.1016/j.soard.2009.07.003

Martin, A. R., Klemensberg, J., Klein, L. V., Urbach, D., & Bell, C. M. (2011). Comparison of public and private bariatric surgery in Canada. *Canadian Journal of Surgery, 54*(3), 154-160. doi:10.1503/cjs.048909

Mechanick, J. I., Kushner, R. F., Sugarman, H. J., Gonzalez-Campoy, J. M., Collazo-Clavell, M. L., Guven, S., . . . Dixon, J. (2008). American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery medical guidelines for clinical practice for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient. *Endocrine Practice, 14*(suppl. 1), 1-82. http://dx.doi.org/10.1016/j.soard.2008.08.009

Meleo-Erwin, Z. C. (2011). 'A beautiful show of strength': Weight loss and the fat activist self. *Health, 15*(2), 188-205. doi:10.1177/1363459310361601

Meleo-Erwin, Z. (2012). "I Just Couldn't Keep it in Control Anymore:" Weight Loss Surgery, Food Addiction, and Anti-Fat Stigma. *Advances in Medical Sociology, 14*, 201-224. doi:10.1108/S1057-6290(2012)0000014013

Millman, M. (1980). *Such a pretty face*. Toronto: George J. McLeod Limited.

Mirabelli, D., Petroni, M. L., Ferrante, D., & Merletti, F. (2011). Risk of suicide and bariatric surgery [Letter to the Editor]. *The American Journal of Medicine, 124*(8), e17. doi:10.1016/j.amjmed.2011.02.028

Munoz, D. J., Lal, M., Chen, E. Y., Mansour, M., Fischer, S., Roehrig, M., . . . le Grange, D. (2007). Why patients seek bariatric surgery: A qualitative and

quantitative analysis of patient motivation. *Obesity Surgery, 17*(11), 1487-1491. doi:10.1007/s11695-008-9427-9

Murray, S., (2007). Corporeal knowledges and deviant bodies: Perceiving the fat body. *Social Semiotics, 17*(3), 361-373. doi:10.1080/10350330701448694

Murray, S. (2008a). Marked as 'pathological.' 'fat' bodies as virtual confessors. In J. Wright, & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic.' governing bodies* (pp. 78-93). New York, NY: Routledge.

Murray, S. (2008b). *The 'fat' female body*. New York, NY: Palgrave Macmillan.

Murray, S. (2009). 'Banded bodies': The somatechnics of gastric banding. In N. Sullivan & S. Murray (Eds.), *Somatechnics: Queering the technicalisation of bodies* (pp. 155-168). Burlington, VT: Ashgate publishing.

Must, A., Spadano, J., Coakley, E. H., Field, A. E., Colditz, G., & Dietz, W. H. (1999). The disease burden associated with overweight and obesity. *Journal of the American Medical Association, 282*(16), 1523-1529. doi:10.1001/jama.282.16.1523

Natarajan, M. K., Mehta, S. R., Holder, D. H., Goodhart, D. R., Gafni, A., Shilton, D., . . . Yusuf, S. (2002). The risks of waiting for cardiac catheterization: A prospective study. *Canadian Medical Journal, 167*(11), 1233-1240.

North American Association for the Study of Obesity and the National Heart, Lung and Blood Institute. (2000). *The practical guide: Identification, evaluation, and treatment of overweight and obesity in adults* (NIH publication: 00-4084). Bethesda, MD: National Institutes of Health. Retrieved from http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf

Ochner, C. N., Dambkowski, C. L. Yeomanas, B. L., Teixeria, J., & Pi-Sunyer, F. X. (2012). Pre-bariatric surgery weight loss requirements and the effect of preoperative weight loss on postoperative outcome. *International Journal of Obesity, 36*, 1380-1387. doi:10.1038/ijo.2012.60

Ogden, J., Clementi, C., & Aylwin, S. (2006). The impact of obesity surgery and the paradox of control: A qualitative study. *Psychology and Health, 21*(2), 273-293. doi:10.1080/14768320500129064

Omalu, B. I., Ives, D. G., Buhari, A. M., Lindner, J. L., Schauer, P. R., Wecht, C. H., & Kuller, L. H. (2007). Death rates and causes of death after bariatric surgery for Pennsylvania residents, 1995-2004. *Archives of Surgery, 142*(10), 923-928. doi:10.1001/archsurg.142.10.923

Onyike, C. U., Crum, R. M., Lee, H. B., Lyketsos, C. G., & Eaton, W. W. (2003). Is obesity associated with major depression? results from the third national health and nutrition examination survey. *American Journal of Epidemiology, 158*(12), 1139-1147.

Padwal, R. S., Chang, H. J., Klarenbach, S., Sharma, A. M., & Majumdar, S. R. (2012). Characteristics of the population eligible for and receiving publicly funded bariatric surgery in Canada. *International Journal for Equity in Health, 11*, 54-62. doi:10.1186/1475-9276-11-54

Padwal, R. S., Majumdar, S. R., Klarenbach, S., Birch, D. W., Karmail, S., McCargar, L., . . . Sharma, A. M. (2012). Health status, quality of life, and satisfaction of patients awaiting multidisciplinary bariatric care. *BMC Health Service Research, 12*, 139-149. doi:10.1186/1472-6963-12-139

Padwal, R. S., & Sharma. A. M., (2009). Treating severe obesity: Morbid weights and morbid waits. *Canadian Medical Association Journal, 181*(11), 777-778. doi:10.1503/cmaj.081508

Parsons, G. E., Godfrey, H., & Jester, R. F. (2009). Living with severe osteoarthritis while awaiting hip and knew joint replacement surgery. *Musculoskeletal Care, 7*(2), 121-135. doi:10.1002.msc.145

Patton, M. O. (Ed.). (2002). Qualitative research and evaluation methods (3rd ed.). Thousand Oaks, CA: Sage.

Peterhänsel, C., Petroff, D., Klintzke, G., Kersting, A., & Wagner, B. (2013). Risk of completed suicide after bariatric surgery: A systematic review. *Obesity Reviews, 14*(5), 369-382. doi:10.1111/obr.12014

Petersen, A., Davis, M., Fraser, S. & Lindsay, J. (2010). Healthy living and citizenship: An overview. *Critical Public Health, 20*(4), 391-400. doi:10.1080/09581596.2010.518379

Pristed, S. G., Fromholt, J., & Kroustrup, J. P. (2011). Relationship between morbidly obese subjects' attributions of low general well-being, expectations and health-related quality of life. *Applied Research in Quality of Life, 7*(3), 281-294. doi:10.1007/s11482-011-9163-5

Puhl, R., & Brownell, K. D. (2006). Confronting and coping with weight stigma: An investigation of overweight and obese adults. *Obesity, 14*(10), 1802-1815. doi:10.1038/oby.206.208

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health, 100*, 1019-1028. doi:10.2105/AJPH.2009.159491

Puhl, R. M., & Heuer, C. A. (2012). The stigma of obesity: A review and update. *Obesity, 17*(5), 941-964. doi:10.1038/oby.2008.636

Rothblum, E., & Solovay, S. (Eds.). (2009). *The fat studies reader*. New York, NY: New York University Press.

Saguy, A. C., Almeling, R. (2008). Fat in the fire? Science, the news media and the 'obesity epidemic.' *Sociological Forum, 23*(1), 53-83. doi:10.1111/j.1600-0838.2004.00399.x-i1

Saguy, A. C., & Riley, K. (2005). Weighing both sides: Morality, mortality, and framing contests over obesity. *Journal of Health Politics, Policy and Law, 30*(5), 869-921. doi:10.1215/03616878-30-5-869

Salant, T., & Santry, H. P. (2006). Internet marketing of bariatric surgery: Contemporary trends in the medicalization of obesity. *Social Science and Medicine, 62*(10), 2445-2457. http://dx.doi.org/10.1016/j.socscimed.2005.10.021

Sansone, R. A., Schumacher, D., Wiederman, M. W., & Routsong-Weichers, L. (2008). The prevalence of childhood trauma and parental caretaking quality among gastric surgery candidates. *Eating Disorders, 16*, 117-127. doi:10.1080/10640260801887196

Sarwer, D. B., Cohn, N. I., Gibbons, L. M., Magee, L., Crerand, C. E., Raper, S. E., . . . Wadden, T. A. (2004). Psychiatric diagnoses and psychiatric

treatment among bariatric surgery candidates. *Obesity Surgery, 14*(9), 1148-1156. 10.1381/0960892042386922

Sarwer, D. B., Fabricatore, A. N., Jones-Corneille, L. R., Allison, K. C., Faulconbridge, L. N., & Wadden, T. A. (2008). Psychological issues following bariatric surgery. *Primary Psychiatry, 15*(8), 50-55.

Schauer, P. R., & Ikramuddin, S. (2001). Laparoscopic surgery for morbid obesity. *Surgical Clinics of North America, 81*(5), 1145-1179.

Schweizer, H. (2005). On waiting. *University of Toronto Quarterly, 74*(3), 777-792.

Shaw, K., Gennat, H., O'Rourke, P., & Del Mar, C. (2006). Exercise for overweight or obesity. *Cochrane Database of Systematic Reviews,* 4(Art. No.: CD003817). doi:10.1002/14651858.CD003817.pub3

Sjöling, M., Ågren, Y., Olofsson, N., Hellzén, O., & Asplund, K. (2005). Waiting for surgery; living a life on hold -- a continuous struggle against a faceless system. *International Journal of Nursing Studies, 42*(5), 539-547. http://dx.doi.org/10.1016/j.ijnurstu.2004.09.009

Song, A., & Fernstrom, M. H. (2008). Nutritional and psychological considerations after bariatric surgery. *Aesthetic Surgery Journal, 28*(2), 195-199. doi:10.1016/j.asj.2008.01.005

Steinig, J., Wagner, B., Shang, E., Dolemeyer, R., & Kersting, A. (2012). Sexual abuse in bariatric surgery candidates - impact on weight loss after surgery: a systematic review. *Obesity Reviews, 13*(10), 892-901. doi:10.1111/j.1467-789X.2012.01003.x

Sterling Lynch, A., Chang, J. C., Ford, A. F., & Ibrahim, S. I. (2007). Obese African-American women's perspectives on weight loss and bariatric surgery. *Journal of the Society of General Internal Medicine, 22*(7), 908-914. doi:10.1007/s11606-007-0218-0

Stømmen, M., Kulseng, B., Vedul-Kjeisås, E., Johnsen, H., Johnsen, G., & Måvik, R. (2009). Bariatric surgery or lifestyle intervention? An exploratory study of severely obese patients' motivations for two different

treatments. *Obesity Research & Clinical Practice, 3*(4), 193-201. doi:10.1016/j.orcp.2009.04.004

Sutton, D. H., Murphy, N., & Raines, D. A. (2009). Transformation: The "life changing" experience of women who undergo a surgical weight loss intervention. *Bariatric Nursing and Surgical Patient Care, 4*(4), 299-306. doi:10.1089/bar.2009.9948

Swinburn, B. A., Caterson, I., Seidell, J. C., & James, W. P. T. (2004). Diet, nutrition and the prevention of excess weight gain and obesity. *Public Health Nutrition, 7*(1A), 123-146. doi:10.1079/PHN2003585

Throsby, K. (2007). "How could you let yourself get like that?": Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine, 65*, 1561-1571. http://dx.doi.org/10.1016/j.socscimed.2007.06.005

Throsby, K. (2008). Happy re-birthday: Weight-loss surgery and the “new me.” *Body and Society, 14*(1), 117–133. doi:10.1177/1357034X07087534

Throsby, K. (2012). Obesity surgery and the management of excess: Exploring the body multiple. *Sociology of Health & Illness, 34*(1), 1-15. doi:10.1111/j.1467-9566.2011.01358.x

Tjepkema, M. (2005). *Adult obesity in Canada: Measured height and weight* (Health Reports No. Catalogue 82-620-MWE2005001). Ottawa: Statistics Canada. Retrieved from http://www.aboutmen.ca/application/www.aboutmen.ca/asset/upload/tiny_mce/page/link/Adult-Obesity-in-Canada.pdf

Townend, L. (2009). The moralizing of obesity: A new name for an old sin? *Critical Social Policy, 29*(2), 171-190. doi:10.1177/0261018308101625

Trindle, H. A., Omalu, B., Courcoulas, A., Marcus, M., Hammers, J., & Kuller, L. H. (2010). Risk of suicide after long-term follow-up from bariatric surgery. *The American Journal of Medicine, 123*(11), 1036-1042. doi:10.1016/j.amjmed.2010.06.016

van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

van den Berg, J.H. (1972). *A different existence: Principles of phenomenological psychopathology*. Pittsburgh: Duquesne University Press.

Wadden, T. A. (1993). Treatment of obesity by moderate and severe caloric restriction: Results of clinical research trials. *Annals of Internal Medicine, 119*(7II), 688-693.

Wait. (n.d.). *The Online Etymology Dictionary*. Retrieved from http://www.etymonline.com/index.php?term=wait&allowed_in_frame=0

Walfish, S., & Brown, T. A. (2006). Patient expectations of weight loss from bariatric surgery. *Bariatric Nursing & Surgical Patient Care, 1*(3), 205-210. doi:10.1089/bar.2006.1.205

Walfish, S., & Brown, E. C. (2007). Male patient presurgical expectations of weight loss from bariatric surgery. *Bariatric Nursing & Surgical Patient Care, 2*(4), 281-284. doi:10.1089/bar.2007.9950

Wee, C. C., Jones, D. B., Davis, R. B., Bourland, A. C., & Hamel, M. B. (2006). Understanding patients' value of weight loss and expectations for bariatric surgery. *Obesity Surgery, 16*(4), 496-500. doi: 10.1381/096089206776327260

Wildes, J. E., Kalarchian, M. A., Marcus, M. D., Levine, M. D., & Courcoulas, A. P. (2008). Childhood maltreatment and psychiatric morbidity in bariatric surgery candidates. *Obesity Surgery, 18*(3), 306-313. doi:10.1007/s11695-007-9292-y

Wolfe, B. M., & Morton, J. M. (2005). Weighing in on bariatric surgery: Procedure use, readmission rates, and mortality. *Journal of the American Medical Association, 294*(15), 1960-1963. doi:10.1001/jama.294.15.1909

World Health Organization. (2012, May). *Obesity and overweight* (Fact sheet No. 311). Retrieved from http://www.who.int/mediacentre/factsheets/fs311/en/

Wott, C. B., & Carels, R. A. (2010). Overt weight stigma, psychological distress and weight loss treatment outcomes. *Journal of Health Psychology, 15*(4), 608-614. doi:10.1177/1359105309355339

Wray, S., & Deery, R. (2008). The medicalization of body size and women's healthcare. *Health Care for Women International, 29*(3), 227-243. doi:10.1080/07399330701738291

Wysoker, A. (2005). The lived experience of choosing bariatric surgery to lose weight. *Journal of the American Psychiatric Nurses Association, 11*(1), 26-34. doi:10.1177/1078390305275005

Zijlstra, H., Boeije, H. R., Larsen, J. K., van Ramshorst, B., & Geenen, R. (2009). Patients' explanations for unsuccessful weight loss after laparoscopic adjustable gastric banding (LAGB). *Patient Education and Counseling, 75*(1), 108-113. http://dx.doi.org/10.1016/j.pec.2008.09.023