

Integrating person-centred care and social justice: a model for practice with larger-bodied patients

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ABSTRACT

Person-centred care (PCC) has been touted as a promising paradigm for improving patients' experiences and outcomes, and the overall therapeutic environment for a range of health conditions, including obesity. While this approach represents an important shift away from a paternalistic and disease-focused paradigm, we argue that PCC must be explicitly informed by a social justice lens to achieve optimal conditions for health and well-being. We suggest that existing studies on PCC for obesity only go so far in achieving social justice goals as they operate within a biomedical model that by default pathologises excess weight and predetermines patients' goals as weight loss and/or management, regardless of patients' embodied experiences and desires. There remains a dearth of empirical research on what social justice-informed PCC looks like in practice with larger patients. This interview study fills a research gap by exploring the perspectives of 1) health practitioners (n=22) who take a critical, social justice-informed approach to weight and 2) larger patients (n=20) served by such practitioners. The research question that informed this paper was: What are the characteristics of social justice-informed PCC that play out in clinical interactions between healthcare practitioners and larger-bodied patients? We identified five themes, namely: 1) Integrating evidence-based practice with compassionate, narrative-based care; 2) Adopting a curious attitude about the patient's world; 3) Centring patients' own wisdom and expertise about their conditions; 4) Working within the constraints of the system to advocate for patients to receive equitable care; 5) Collaborating across professions and with community services to address the multifaceted nature of patient health. The findings illustrate that despite participants' diverse perspectives around weight and health, they shared a commitment to PCC by upholding patient self-determination and addressing weight stigma alongside other systemic factors that affect patient health outcomes.

INTRODUCTION

Person-centred care (PCC) has been touted as a promising paradigm for improving patients' experiences and outcomes, and the overall therapeutic environment (Kalra *et al.* 2020; Wakefield and Feo 2017). PCC focuses on the whole person rather than just their medical conditions, and its related principle, person-directed care, positions the individual to lead care-based decisions (Lines, Lepore, and Wiener 2015). Within this framework, clinicians move beyond the traditional biomedical approach, attending not only to a person's medical diagnoses and physical measurements, but their social,

psychological and emotional needs, as well as their strengths, weaknesses and values (Lines, Lepore, and Wiener 2015). This approach represents an important shift away from a paternalistic, disease-focused and traditional top-down paradigm in which power and authority are placed largely in the hands of health professionals (Franklin *et al.* 2021). However, PCC runs the risk of reinforcing neoliberal individualistic approaches to care in which the management of health conditions is shifted away from social responsibility towards the individual patient, amplifying moralistic judgement of patients who do not adhere to health directives (Lewis *et al.* 2022). As a counter to the increasing individualisation of healthcare, we suggest that PCC must be explicitly 'reconfigured within a social justice [...] framework' (Pulvirenti, McMillan, and Lawn 2014, 303) to achieve optimal conditions for health and well-being. We define the concept of social justice as the distribution of goods, services, opportunities and rights within a societal context that allows all individuals to maximise their capacities (Russell-Mayhew 2006). This framework allows individuals to have self-determination over their own bodies and lives, while understanding self-determination as a fundamentally social process that is engendered by supportive relationships and environments (Raines 1989). We distinguish the concept of self-determination from the discourse of individualism, in that the former enables the person to narrate their strengths and their understandings of health, whereas the latter compels the individual to strive towards a narrowly defined ideal of health. The transformative social justice potential of PCC lies in shifting the practitioner-patient power dynamic, as well as in addressing the intersecting social determinants of health, such as income, social support, education and discrimination. Such an approach is particularly important for centring the voices of historically marginalised groups who face challenges in accessing care and getting health needs met (Drury and Louis 2002; Wilson and Neville 2008).

PCC has been applied as a framework to study a range of medicalised conditions, including diabetes (Boström *et al.* 2014), dementia (Kim and Park 2017), cancer (Pel, Engelberts, and Schermer 2022) and obesity (Kalra *et al.* 2020). While understanding patients' values and preferences has been embraced in theory, it is often less clear what should be done in practice when patients' values, knowledge and preferences diverge from practitioners' (Carey 2016; Franklin *et al.* 2021). Research suggests that even practitioners who claimed to be person-centred reported taking on the role



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of ‘expert’ and ‘privileging their professional knowledge over patient knowledge’ (Franklin *et al.* 2021, 345). Carey (2016), in his critique of the current model of PCC for mental health, notes that improving patient *compliance*—often cited as a key benefit of PCC—appears to be fundamentally incongruent with the core tenet of patient self-determination. This notion of compliance, also referred to as adherence, has been discussed in relation to obesity to describe patients’ ability to maintain health behaviours such as exercise and weight loss (Shay 2008). While PCC is presented as the solution to countering pervasive weight stigma and discrimination in healthcare (see Cardel *et al.* 2022), the goals of weight management and loss may still be promoted. This model of care places the power of diagnosis in the hands of so-called obesity experts and obscures the voices of larger patients who do not desire medical intervention on their weight. We contend that a social justice informed approach to PCC in the context of working with larger individuals must seek to facilitate a safe environment where individuals can leverage their strengths to direct their own healing journeys—which may or may not include weight management.

In the following sections, we begin by outlining the value of integrating PCC with social justice. We then demonstrate how the existing studies on PCC for obesity seek to combat weight stigma in healthcare settings, but only go so far in achieving social justice goals as they operate within a biomedical model that pathologises excess weight and predetermines patients’ goals. There remains a dearth of empirical research on what social justice-informed PCC looks like in practice with larger patients. This study fills a research gap by exploring the perspectives, experiences and relational dynamics of (1) Health practitioners who take a critical, social justice-informed approach to weight and (2) Patients served by such practitioners. The research questions that informed this paper were: What are the characteristics of social justice-informed PCC that play out in clinical interactions between healthcare practitioners and larger-bodied patients? How does this approach to care impact larger patients’ experiences?

INTEGRATING PCC AND SOCIAL JUSTICE

The integration of PCC and social justice presents a potentially powerful framework for addressing a range of health issues. This framework understands individual health behaviours as circumscribed by the broader context (Pulvirenti, McMillan, and Lawn 2014) and recognises that individuals have situated agency to direct changes in their life conditions (Gkiouleka *et al.* 2018). The concept of situated agency emphasises interconnectedness, departing from individualistic accounts of the self as divorced from its economic, political, social, cultural, and environmental contexts (Bevir 2017). Research on patient-practitioner interactions in relation to chronic disease management illustrates the pernicious effects of the discourse of individualism: patients who were unable to successfully self-manage were deemed as moral failures, thereby undermining the therapeutic relationship (Lewis *et al.* 2022). Mol (2008) proposes a relational logic of care as a contrast to the pervasive logic of choice: Good care goes beyond patients’ individual choices, and requires clinicians’ collective efforts to interweave technical expertise, critical consciousness, and compassion to create safe environments for patients. Within such environments, patients can leverage their strengths to direct their own healing journeys, which for larger patients may or may not include weight management. Ultimately, patients’ capacities for self-determination

can only be optimised if ‘society at large, healthcare policy, healthcare infrastructures and health care professionals alike [...] both reflect and promote this orientation’ (McWilliam 2009, 284).

PCC challenges the traditional model of clinician-patient communication, premised on the assumption that patients and clinicians necessarily have the same beliefs and values towards medical information, and that such information will be regarded by patients as a resource to acquire (Kennedy *et al.* 2017). Frank (2002) argues that this misguided assumption is what underpins ‘the conflict between the story [that the patient] is caught up in and the story that medicine tries to impose on [them]’ (19). PCC seeks to resolve this conflict by cultivating practitioners’ narrative competence, defined as the ability to elicit, acknowledge, comprehend, and act on patients’ stories (Charon 2001). It allows practitioners to attend to how beliefs and values arising from social and behavioural factors shape the clinician-patient interaction (Ha and Longnecker 2010). Some patient beliefs and values include a preference for alternative therapies and a distrust of the healthcare system and prescribed therapies (Ha and Longnecker 2010). To demonstrate narrative competence, clinicians can ask questions beyond patients’ presenting health conditions to uncover other underlying issues in their social contexts (Kalitzkus and Matthiessen 2009). More unstructured and unpredictable than traditional medical history taking, this approach asks open-ended questions like ‘would you like to tell me why you came here?’, ‘what would you like to return to?’ and ‘what are your goals?’ (Naldemirci *et al.* 2020, 239). Although time constraints and other barriers may limit clinicians’ abilities to fully delve into patients’ stories, clinicians can briefly scan patients’ records in advance to maximise time spent with patients, avoid repeating questions and help themselves ‘[imagine] and [predict] the social, personal story of the patient’ (242).

Another essential component of PCC is interprofessional collaboration (IPC), which is based on the understanding that patients’ complex needs require collaborative efforts across professions and coordination with community stakeholders (Hines-Martin and Nash 2017). IPC can take different forms, such as organising healthcare practitioners into teams or coordinating and networking efforts (Oelke, Thurston, and Arthur 2013). Referrals to other professionals is an important first step in building relationships and sharing patient-related information to meet patients’ needs (Aboueid *et al.* 2018). Referrals may not necessarily lead to collaboration, but they nonetheless offer opportunities for continuity in the delivery of care (Aboueid *et al.* 2018). Although interprofessional practice is widely regarded as an ideal to strive towards, its implementation is undermined by some key barriers: Territoriality, mistrust, perceived lack of respect, and power differentials (McDonald, Jayasuriya, and Harris 2012; Oelke, Thurston, and Arthur 2013). Research on IPC shows that within the hierarchy of healthcare, doctors are still regarded as the experts and attempt to protect their professional autonomy and independence in their relationships with other practitioners (McDonald, Jayasuriya, and Harris 2012). Power differentials in healthcare settings are often understood implicitly but not confronted head on, leading to unresolved tensions and conflicts (Oelke, Thurston, and Arthur 2013). Nevertheless, these issues can be mitigated by conducting training activities for different professionals to engage in self-reflection and dialogue, thereby gaining a deeper understanding of one

another's roles and working styles (McDonald, Jayasuriya, and Harris 2012).

PCC AND ALTERNATIVES TO THE DOMINANT MODEL OF OBESITY TREATMENT

Weight stigma is widespread in healthcare settings, evident in how many health practitioners blame and shame heavier patients for their weight, undermining patient dignity and quality of life (Phelan *et al.* 2014). Practitioners who hold such prejudicial attitudes tend to attribute obesity to a lack of personal control and conflate weight management with moral worth, revealing an individualistic ideology that places responsibility for health solely within the hands of patients (LeBesco 2011; Nutter *et al.* 2016). The dominant model of obesity treatment within biomedicine and public health has tended to focus on individual-level factors such as a person's genetics and lifestyle choices (Saguy 2013). Many clinicians subscribe to the energy deficit or calorie model, which focuses on controlling food intake and exercise for weight management (Schaefer and Magnuson 2014). However, this approach to treating obesity has been found to have detrimental outcomes for larger patients, including increased psychological distress and disordered eating patterns (Schaefer and Magnuson 2014). In light of these concerns, numerous studies have explored how PCC can be used to improve the quality and success of obesity treatment (Kalra *et al.* 2020; Leske, Strodl, and Hou 2012). These studies define PCC in varying ways, though common themes include treating patients with compassion and respect, including patients in shared decision-making, allowing patients to take ownership of goals, and listening to patients' health narratives. Other studies have examined how IPC can improve clinical outcomes for obesity by fostering an exchange of knowledge on weight management among physicians, dietitians, psychologists, nurses, and physical therapists, among others (see Aboueid *et al.* 2018; Ward, Gray, and Paranjape 2009). Collectively, the research on PCC for obesity suggests that individuals are empowered to resolve their ambivalence around lifestyle behaviour change and seek medical help for obesity (see Kyle, Stanford, and Nadglowski 2018). However, these studies (see Leske, Strodl, and Hou 2012) foreground weight management as the goal and label larger people as sick, irrespective of patients' overall health status and desire to lose weight, and are thus incompatible with social justice goals (Saarni *et al.* 2011).

Another proposed counter to the dominant model is the Health at Every Size (HAES) or weight-inclusive approach, which shifts the focus away from weight towards enhancing health, regardless of where individuals fall on the weight spectrum (Aphramor and Gingras 2011; Burgard 2009; Rich, Monaghan, and Aphramor 2011). HAES promotes the adoption of a healthy lifestyle including exercise, nutrition, and sleep, and recommends that indicators of health beyond body mass index (BMI) and body weight be established (Rich, Monaghan, and Aphramor 2011). HAES is a fluid movement taking multiple directions, and some configurations of HAES have been criticised for their individualistic emphasis on lifestyle factors and for positioning health—rather than weight—as a moral imperative (Gingras and Cooper 2012; Lupton 2013). Other strands of HAES explicitly adopt a social justice lens that locates individual choices and behaviours within broader social and economic inequities (see Burgard 2009 for a counter-response to critiques of HAES). Although the HAES model has been extensively explored in the theoretical literature and intervention studies measuring clinical outcomes (see Bacon *et al.* 2005; Steinhardt, Bezner, and Adams 1999), there remains a lack of qualitative research on how this lens

shapes the patient-practitioner relationship and interaction. A smaller body of literature has examined practitioners' beliefs and attitudes towards alternatives to weight loss counselling such as HAES and intuitive eating practices (Barr *et al.* 2004; Schaefer and Zullo 2016; Willer, Hannan-Jones, and Strodl 2019). Willer, Hannan-Jones, and Strodl (2019) found that HAES is a 'familiar and accepted (though somewhat misunderstood) practice' (412) among Australian dietitians, some of whom were misguidedly using this approach for the purpose of weight management. While these studies pave the way to subverting the dominant paradigm of obesity treatment, they tend to focus on HAES' principles of non-dieting and body acceptance, paying less attention to how weight stigma is entangled in other systemic inequities such as racism and colonialism (Harrison 2021; Strings 2019).

We contend that a social justice-informed approach to PCC for larger patients must not only centre their perspectives but connect individual agency with the broader social context. Furthermore, weight stigma should not be tackled as an isolated issue but located within other systems of oppressions that patients are immersed in. This theoretical framework of integrating social justice and PCC that we adopt will guide our research methods, which we outline in the following section.

METHODOLOGY

Language, labels and reflexivity

We adopt the stance that researcher reflexivity is not inherently radical nor transformative (Lynch 2000), as 'we do not escape from the consequences of our positions by talking about them endlessly' (Patai 1994, 70). Nevertheless, we do not believe that the solution is to give up on reflexivity, but rather, to use our positionalities in ways that encourage open discourse and awareness-raising (Pillow 2003). As part of the first author's larger PhD study, she engaged in reflexive writing, examining how her social identity and background had shaped her values and beliefs, including her choice of research topic and approach to data collection and analysis. She also engaged in regular reflexive dialogue with her PhD supervisors, who are this paper's coauthors, to explore feelings and thoughts that emerged during her interactions with participants. During the entire research process, a key issue that came to light was the nuances and tensions in participants' perspectives on obesity and its associated language, which echoes what has been found in the literature.

Within these linguistic and ideological debates, the dominant biomedical model considers excess weight to be a health problem warranting intervention, and uses the terms 'obese' and 'overweight' to describe bodies that deviate from weight normative standards (Campbell 2022). Conversely, critical fat/weight scholars reject such biomedical language, which they regard as pathologising and stigmatising larger people (Burgard 2009; Cooper 2011). Some of these scholars connect antifat discourse with other systems of oppression, such as white supremacy, classism and patriarchy; they also seek to reclaim historically denigrated terms such as 'fat' in order to diminish their negative power (Guthman and DuPuis 2006; Strings 2019). Nevertheless, reclaiming language is a fraught process, as evident in how patients displayed contesting preferences around weight-related terminology (Volger *et al.* 2012; Ward, Gray, and Paranjape 2009). Aligning with a PCC approach, we asked patients to self-identify with descriptors during the interview process. In this article, we have decided to use the term 'larger-bodied' to capture patients' collective experiences. While we strive to be

allies in fat acceptance, we are not self-identified fat people and thus do not use fat as an identity descriptor. In light of fat's politically contentious underpinnings, we believe that the decision should lie with the individual to self-identify as such. When using the term fat, we refer to participants' own descriptions of their bodies and identities. We use the term obesity to represent the divergent discourses around the phenomenon, which comprise both dominant biomedical and critical fat/weight approaches.

Data collection: interviews

The data presented here are part of the first author's doctoral study featuring qualitative one-on-one, in-depth and semistructured interviews with 22 healthcare practitioners and 20 of their patients. Each interview lasted between 45 min to 1.5 hours and was conducted over the phone or Zoom, enabling the recruitment of participants from different Canadian provinces. The doctoral study featured (A) practitioners who self-identified as social justice-oriented and (B) patients under their care, in order to examine how social justice is understood, enacted and experienced in weight-related clinical interventions. An interview guide for the study was designed around four overarching questions pertaining to interactions between practitioners and larger patients: (1) What does social justice mean to practitioners and patients? (2) How do practitioners translate principles of social justice into concrete practices and behaviours when interacting with larger patients? (3) What are the challenges of practising social justice that practitioners encounter when working with larger patients? (4) How does social justice-informed care impact larger patients' experience? Both practitioners and patients were asked about their definitions of social justice in practice, the nature of patients' involvement in healthcare decisions, the manner in which patients' social challenges were identified and addressed, and how they dealt with experiencing and/or witnessing weight-stigma in healthcare. Practitioners were also asked about their views on weight management practices, and patients were asked about whether they felt their weight impacted their health, and what they appreciated most about the care they received from practitioners. Since interviews took a semistructured format, follow-up and clarifying questions were determined according to what participants revealed and highlighted during the discussion.

A combination of methods was used for recruitment, beginning with purposive sampling of practitioners. To start, the first author reached out by email to healthcare professionals in Canada who in their public profiles self-identified as advocates of social justice and/or weight-inclusive approaches that encompassed a variety of terminologies such as HAES and intuitive eating. Practitioners were provided with sample interview questions exploring social justice in healthcare practice to determine if they would be a good fit for the study. Those who confirmed that they were able to speak to social justice practices and had experiences interacting with larger patients were then included in the study. Next, the first author drew on the healthcare practitioner liaison approach, which refers to leveraging personal contact from a fellow healthcare practitioner to recruit participants (Asch *et al.* 2000). Her PhD committee member, a physician-activist, served as the key liaison point. Finally, using snowball sampling, shortlisted candidates were asked to refer other relevant practitioners. Given that this paper was part of a broader PhD study that explored the intersections among weight stigma and other oppressions, where possible clinicians of colour and those serving marginalised communities including low-income and non-dominant racial groups were targeted. Clinicians who

agreed to participate then assisted with recruitment of their patients by disseminating flyers at their clinics or e-flyers via their patient electronic mailing lists. The flyers outlined the study and invited patients who self-identified as being larger-bodied, fat, overweight or living with obesity to participate. This approach of self-identification of bodily experience is aligned with PCC and critical fat/weight studies which avoid BMI as an inclusion criterion (Bombak, McPhail, and Ward 2016). All 20 patients who participated were recruited from 6 out of the 22 practitioners in the study; the remaining practitioners could not recruit their patients either because of recruitment restrictions or a lack of patient interest. Patients were seeing practitioners for a variety of reasons including weight management, coping with weight stigma and/or for general medical appointments. As an equity measure for historically disenfranchised communities (Collins *et al.* 2017), each patient received \$50 remuneration for participation. All participants provided written informed consent. Participants were assigned numeric identifiers (10XX for practitioners and 20XX for patients) to retain confidentiality. Online supplemental figure 1 indicates the breakdown of participants' demographics. The majority of the practitioners were registered dietitians, female and white, and the majority of the patients were female and white, and were seen by medical doctors.

Patient and public involvement

Patients and the public were not involved in the design of the study.

Data analysis

The first author transcribed the interviews verbatim and examined the interview material using the method of critical thematic analysis (Lawless and Chen 2019), which is compatible with a PCC and social justice framework that seeks to uncover critically informed themes of power hierarchies and social inequities in interview discourses. The data analysis process integrated both deduction and induction, but began deductively with theory (Smith and Elger 2014). A deductive coding scheme was developed a priori based on the theoretical framework of social justice-informed PCC, the literature review and research question, all of which were broadly focused on thematic categories of the social determinants of health, weight-based discrimination, patient self-determination, narrative competence, IPC and community linkages. Next, the first author developed preliminary themes, applied them to a few transcripts and assigned codes to their corresponding themes. Through this process, the original themes and codes were refined, combined, and reorganised. Drawing on the established comprehensive code manual, the process was repeated with both the initial and remaining transcripts. Inductive coding was concurrently used to examine the repetition, recurrence and forcefulness of themes that had not been initially listed but were nevertheless connected with the broad thematic categories (Owen 1984). To enhance rigour, the first author's two PhD supervisors and coauthors independently reviewed and critiqued the preliminary themes and findings.

FINDINGS

In the following section, we discuss five themes, with each theme reflecting the perspectives of both practitioners and patients. These themes include: (1) The need to integrate evidence-based practice (EBP) with compassionate care; (2) The value of practitioners taking a curious attitude about the patient's world; (3) Centring patients' own wisdom about their conditions; (4)

Advocacy for patients to receive equitable care, and; (5) The benefits of IPC and community linkages.

The need to integrate EBP with compassionate care: 'This is not a "fluffy approach"' (practitioner)

All practitioners conveyed that narrative-based skills such as active listening and compassionate witnessing were essential components of clinical practice that had to be brought to the forefront of the patient-practitioner interaction, particularly with marginalised patients who had been repeatedly disappointed by the system. A dietician called attention to how EBP and its associated principle of scientific objectivity tended to be privileged over a narrative approach that explored the individual stories of patients. Noting that practitioners often had their 'science blinders' (1002) on, he contended that 'the biggest challenge arising from that is [practitioners] don't have good people skills and [...] need to [...] work on that [...] so that [they] can talk to people about their lives and how their lives are impacting their health' (1002).

Similarly, a doctor pointed out that compassionate communication was crucial with patients who were 'outside of the norms, whether it's with weight or [...] color, or [...] other issues' and who had already experienced 'lot of communication that [was] hurtful' (1021). He cautioned against the lack of 'helpful healing communication [...]' with patients:

Patients will come away from interactions that have been hurtful with the idea, well, who cares? Why should I care? [...] I'm not worth it. [Patients] will [...] do things that further reduce their health as opposed to being inspired to do things that improve their health and happiness. (1021)

As a dietician professed, even though this approach to care was 'often seen as [...] fluffy approach [...] as a clinician', it was ultimately what 'makes or breaks the deal' (1016).

Correspondingly, patients' narratives overwhelmingly demonstrated the need for practitioners to integrate scientific knowledge with compassion. One patient alluded to how knowledge itself was a contested terrain, evident in the range of conflicting evidence around obesity and weight management. As such, she viewed knowledge alone as insufficient to guide the clinical encounter, and highlighted the need for clinicians to display compassion when discussing scientific evidence:

The knowledge part can be tricky because if you want to believe a certain thing, you can find research to back that up. [...] If you've got a patient who is reading different things, [...] a health care practitioner [...] needs to have compassion to meet me where I'm at in my journey. (2001)

Another patient concurred that compassion and knowledge were intertwined, as practitioners who were well read on issues of weight stigma and its intersecting inequities were able to display greater awareness of patients' struggles:

My dietitian was the first one to introduce to me [the notion of racism and weight stigma being intertwined...] Anytime we talked about [it] and she lends a compassionate ear, I find this very impactful because she's [...] reinforcing what I know [and] that's very healing. [...] A lot of the [...] things I've read about, she has read about too. [...] There's an exchange of knowledge around [...] the issue [...]. (2004)

On the other hand, a patient pointed to how the lack of knowledge could detract from compassion. Describing her mother's doctor (not featured in the study), the patient remarked: 'her

doctor [...] believes that the compassionate thing to do is to try to motivate her to not eat doughnuts, except that it's not working.' (2001). The patient noted that such an approach had the unintended consequence of exacerbating her mother's shame, and emphasised that she wanted to see more doctors familiarise themselves with the 'research [on weight-neutrality] that says [...] maybe it's not possible to actually lose weight [...] in a sustainable way' (2001). Ultimately, doctors who did not understand the complexity of weight could have a well-intentioned, but misguided approach to caring for patients.

The value of practitioners taking a curious attitude about the patient's world: 'I'd rather they ask a lot of questions' (patient)

All practitioners underscored the importance of displaying inquisitiveness about patients' lives beyond their presenting medical issues and asking difficult questions about their social context, including experiences of discrimination and barriers to care. A social worker contended that body size needed to be recognised as a social justice issue to counter the prevailing choice narrative: '[There's an idea] that people are choosing to make bad choices about food and [...] exercise. And that it's all about [...] individual behaviors rather than wider determinants' (1007). A general practitioner echoed: 'When a person has a problem it's almost always from their social environmental situation. [...] I'm quite comfortable asking because I think that's where the meat is' (1022). He went on to say: 'One of the challenges is to make sure that the patient actually feels you're comfortable with the answer. [...] You want to make sure that in a negative answer [...] there's room for it' (1022). Some questions that practitioners asked included 'What is going on in your life? [...] Are you stressed out because of finances?' (dietician, 1008).

Another general practitioner noted that initiating lines of inquiry fostered a sense of emotional safety for patients:

A lot of people suffer things and [...] don't tell us [...] They [...] have been burned by [...] not being able to have conversations [...] in a way that makes them [...] feel okay about themselves. [...] They're very hesitant to start that conversation because they don't want to be belittled, especially by a doctor. [...] (1014)

At the same time, probing had to be done respectfully, given that the very nature of the clinician-patient relationship involved an asymmetrical power dynamic. Approximately a third of the practitioners brought up the role of obtaining patients' consent: '[...] A huge piece of what I'm working on is [...] asking [...] consent to talk about those things, and if they're even an issue for them [...] and not make assumptions that they are' (Dietician, 1008). Another dietician conveyed that she 'always [thought] about autonomy and asking for permission [...]' and would reassure patients of their '[...] choice [...] to respond or not' (1006) whenever she enquired about what they were going through.

About a quarter of the practitioners conveyed that despite having awareness about extraclinical factors that affected patients' health, it was nevertheless challenging to incorporate such discussions into patient interactions. As one dietician remarked: 'There's still a part of me that [doesn't] think a person expects me to ask these questions or [...] it could just be [...] my own [...] hang ups about talking about money' (1003). A general practitioner explained that sometimes what stood in the way was his 'lack of confidence in [his] own ability to sufficiently address the issues [...] whereas [...] if it was something that [he] felt [...] confident [...] assisting [...] with more readily, then [he] would be more likely to address it' (1019). A white dietician admitted

that she approached sensitive topics such as racial oppression with caution: '[I hesitate to ...] just outright say what is your experience based on [...] the colour of your skin in accessing healthcare [...] I don't want [...]to... insult the client or open up something that is really traumatic for them' (1004). Additionally, time constraints could undermine practitioners' ability to have in-depth discussions about a patient's social challenges. A general practitioner explained: 'the difficulty [...] is you don't want to open a can of worms that's going to take 30 minutes when you have a 10-minute patient appointment' (1014). To work around these challenges, she attempted 'to start the ball rolling and start thinking about things, [...and then...] refer them to somebody else who can do more counseling [...and...] those deep dives' (1014).

For their part, the majority of patients expressed that they appreciated practitioners who proactively demonstrated a genuine interest in their lives by asking thoughtful questions. One patient described her dietician as a refreshing change from her previous practitioners: 'I always felt that she was actually interested in me as a person [...] The questions that she asked in response to [...] whatever I had to say [...] felt like she honoured [...] where I was at [...]' (2001). For another patient, there was no such thing as too many questions: 'I'd rather they ask a lot of questions. [...] I find it better for them to have the information. That way they can tailor it to care better for you' (2011). The kinds of questions patients wanted to be asked revolved around their priorities, concerns and challenges. For example, a patient listed her desired questions such as 'How long have you dealt with this? What are your symptoms? [...] What does your day to day [...] look like?' (2018).

Moreover, this narrative approach represented an important shift away from weight-normative care towards PCC that sought to explore patients' own goals, whether weight-related or not. In one patient's words:

[There should be] a curiosity for [...] what the patient [...] wants [...] for... their health or [...] what the patient's ideals are [...] and not putting on an assumption of [...] you must want to lose weight [...] or their [...] own ideas of [...] health onto the patient. (2007)

Another patient echoed that she appreciated how her doctor (not included in this study) would gently explore her preferences during weigh-ins: 'she asked me if I want to be weighed and I can decline so [...] as someone [...] with an eating disorder that's super helpful' (2002). The patient explained how such simple yet thoughtful gestures could be healing for patients who experienced weight-related anxiety and who sought to let go of bodily scrutiny.

Centring patients' own wisdom about their conditions: 'You know yourself best, I don't know you best' (practitioner)

While practitioners in the study had their own stances on the relationship between weight and health, almost all highlighted that effectively caring meant positioning patients as the experts. Over half of practitioners viewed obesity discourse and intentional weight loss as harmful, but sought to balance their ethical positions with patients' goals. One dietician contended that the word obese was stigmatising: 'There's a lot of history with that word. [...] I feel like it would [...] perpetuate the perspective that [...] a higher body weight is bad or negative.' (1008). Another dietician similarly challenged the paradigm of obesity management but emphasised honouring patients' desires even if they contradicted her own: 'I may have [...] this inner desire to want [...] them to have a specific perspective [of acceptance]

around their own bodies and weight. But [...] that's just not my approach of forcing that on them. [...] I just plant a seed' (1010). Another dietician said she preferred to facilitate client self-discovery despite her own opposition to dieting:

If a client's still very insistent after they've been seeing you for a while that they really want weight loss, [...] I'll tell them [...] let's do an experiment [with restrictive eating plans], since this is very important to you, and you know yourself best, I don't know you best. (1009)

She described how many of her clients reported observing a negative impact on their well-being after such experimentation, and through the process came to look beyond dieting and weight control. As the dietician remarked: '[the patient's] own experience is much more valuable than anything anyone else can ever tell [them]' (1009).

The remaining practitioners were not categorically opposed to obesity discourse, but were careful not to prescribe weight management unless patients had specifically indicated an interest in pursuing this goal. For example, a dietician who worked at an obesity medicine clinic and who believed in the disease model of obesity stressed that treatment always accounted for patients' values: 'I work with my patients in regard to what matters to them. [...] I do a lot of shared decision-making [...] talking to patients about the pros and the cons [of different treatment options]' (1006). A general practitioner similarly felt obesity posed health risks but refrained from assuming larger patients wanted or needed treatment for their weight. Instead, he took an exploratory approach:

I first ask them, [...] what are their views about this? [...] What have they tried? [...] I do not have a prescribed approach. [...] If you're wanting to help people, you need to align with their belief system. [...] You first need to understand it and [...] determine where they want to go with it. [Then] you need to try and encourage and facilitate that. [...] (1021)

All patients recounted the value of being placed 'in the driver's seat' (2018) and having their own expertise recognised. One patient articulated that she wanted to be 'acknowledged as someone who [...] is [...] an expert as [...] the only person who's had this body for [...] 32 years [...]' (2007). She highlighted the importance of practitioners asking patients if it was okay to talk about BMI or weight, explaining that it represented 'a shift in the power relationship [...] based on consent and permission, [...] rather than [...] one person being the expert and [...] the one who [...] can make all the decisions and [...] withhold treatment or [...] referrals' (2007). Another patient expressed appreciation that the clinic staff played a facilitative rather than directive role in his health journey:

They are here just to show you different methods of living. And it's up to you to decide [if] you want to choose this path or that path. [...] There wasn't any direct instruction [...]. (2012)

As with practitioners, patients' views on weight differed, and about a third of patients rejected weight management entirely. One patient described directing attention away from weight loss towards overcoming internalised weight stigma. She praised her practitioner for respecting and supporting her goals: 'She'll discuss suggestions and [...] ask my opinion on them [...] There are things that I don't agree with [...but...] she's open minded. She listens to me. [...] She puts the power in my hands' (2004).

In contrast, other patients sought out weight loss yet wanted autonomy to define their own goals. As one patient described:

I don't feel like I was ever instructed to lose weight. [...] I brought forth myself [that] I wasn't comfortable at my weight [...] No one has ever said to me, this is how much weight you need to lose [...] which is actually different than other doctors I've had. [...] It was [...] very refreshing to [...] have doctors not be forceful with [...] putting a restrictive weight number on you. (2014)

Likewise, another patient showed appreciation for her clinic's compassionate and non-judgmental approach to weight loss: 'They give you strategies [...] to use if you choose to use them. [...] I've never heard [...any...] guilt invoking word [...] from that place' (2016). A patient who attended the same obesity clinic noted that the clinic's intake assessment revolved around understanding the patient's underlying goals: 'Is [weight] what's important to you? [...] Is it your health? Or is it your weight? They ask you all those questions in the beginning' (2010). As with other patients, she underscored the importance of being fully involved in decision-making around weight and health.

Promoting equitable care for patients: 'I try and advocate for myself, up to a point' (patient)

Because weight-based discrimination was prevalent in healthcare, most practitioners highlighted that being person-centred meant standing up for patients and ensuring that they received fair treatment. As a dietician declared: 'To make sure that my patients are getting proper care [...] I bust weight bias and discrimination when I see it and hear it' (1006). A general practitioner described how the injustices she witnessed against patients could feel 'immobilizing' yet she recognised that her 'incredible [...] power' (1017) could be used for activities such as writing letters for patients to access the care they needed.

Over a third of practitioners conveyed that advocacy could be challenging, particularly given the lack of like-minded practitioners, as noted by a dietician: 'It's very easy to feel isolated [...] being the only one with this approach [...]' (1001). She described having to tread carefully and 'maintain professionalism' (1001) while contesting her colleagues' views. Another dietician echoed that advocacy against weight discrimination was tricky when it involved other, higher-ranked healthcare practitioners:

It's a bit more delicate because you are dealing with a physician [who sees] themselves as the expert. So, in my notes, I [...] delicately [...] give my opinion as to why I think that the patient's problem is not weight-based or why I focus on behaviour change rather than weight itself [...]. (1004)

Likewise, a dietician expressed frustration that patients often still deferred to the authority of doctors even when other weight-inclusive practitioners had attempted to educate them about the harms of dieting:

Unfortunately, people will still hold the doctor in higher regard. So if the doctor's saying [...] the keto diet is best, then [the patient is] going to be doing a keto diet [...] even if they fail over and over again at it, and then [...] blame themselves for failing at it. (1016)

Advocacy also entailed supporting the patient to speak up for themselves against weight discrimination. A social worker described techniques she had used to empower her clients such as 'role playing to help the client be able to gain some confidence in [...] explaining to their doctor why the doctor's weight loss recommendation is not going to be helpful to them' (1012). A doctor working in obesity medicine similarly related how he taught his patients assertiveness skills:

If someone makes a [...] comment about your weight, stand up to them, right to their face and say it's not appropriate, how dare you

talk to me about my weight and offer me advice. And if it's a physician, report them to the College of Physicians and Surgeons. [...] (1020)

Nonetheless, all practitioners recognised that individual-level approaches to PCC such as defending and empowering patients had constraints in the face of a fat-phobic society. As a general practitioner remarked, speaking up on behalf of larger patients was not a straightforward process. She recalled that when she had offered to talk to her patient's specialist, the patient's first response had been 'oh god [...] don't ever draw attention to me' (1014). Similarly, a dietician lamented that being deluged with antifat messages was 'very demanding of the patient [...] because [...] it calls for the patient to really tap into [...] deep within themselves, to find the strength to deal with this crap that shouldn't be happening in [...] the first place' (1001).

Over half of the patients reported attempts to self-advocate during negative encounters with clinicians and others in their social circles. One patient mentioned resisting clinicians' attempts to force tests on her solely because of her BMI:

[I don't want to] let [...] outdated ideas on BMI and health impact the level of care I'm receiving. [Self-advocacy] looks like asking more questions and getting [...] fuller answers on why you're asked to do certain things. [...] Where's the research? [...] What is this based on? (2006)

Another patient asserted that self-advocacy meant not settling for suboptimal care and finding alternative practitioners who were better able to meet her needs:

If [...] the person I'm seeing is not really into social justice or [...] treating me [...] as a person as opposed to a number, [...] I'll ask to go see somebody else. [...] I'll tell my doctor [...] I didn't really like them [...] My doctor [will say] okay, I have somebody else who's better in mind for you. (2009)

Patients also asserted that advocacy was often limited by broader sociocultural constraints. One patient described with a sense of resignation that she could only do so much to change others' deep-seated weight-bias: 'I try and advocate for myself, up to a point. [...] But at the end of the day, [...] I can't rely on [my doctor]. [...] So I don't spend as much energy trying [...] to explain where I'm coming from [...]' (2007). Another patient noted the challenges of larger-bodied people being taken seriously when they were advocating for weight inclusivity and felt that the interviewer's thin privilege could be used responsibly to raise awareness about the issue:

People will take [...] weight inclusive words from you, they won't take it from me [...]. If people in smaller bodies stand up and say [...] diet culture is wrong [...] then people will listen [...] and [...] take it in a little easier than somebody [...] like me ranting and raving because they're going, you're fat, you got to do that. (2003)

Likewise, a patient asserted that individuals should not be expected to single-handedly solve the problem of weight-based discrimination: 'I think we're [...] told that [...] if only I can be better then [...] I can change the world. [...] I mean, it's good to start with ourselves but systemically, [...] there has to be a huge change' (2002). In her view, the solution was about 'finding where [...] self-care and [...] community-care can coexist' (2002), which meant not only taking care of herself, but being part of a community where she could leverage her privilege to provide care that benefited others.

The benefits of IPCs and community linkages: 'It can't happen in a silo' (practitioner)

All practitioners highlighted that IPCs and community linkages were crucial for a social justice-informed approach to PCC that entailed addressing patients' intertwined health and social needs. In the words of a dietician: 'Social justice [has to] happen across the board. It can't happen in a silo' (1006). A social worker remarked that 'more voices together are sometimes helpful depending on the needs of the person if they're more complex' (1007). Furthermore, when seeking to address patients' needs, practitioners did not automatically assume that larger patients had weight-related health issues; rather, they sought to identify what kinds of support would benefit patients most. A general practitioner emphasised that 'being larger doesn't necessarily mean that someone's having health issues, but if they're having health issues, then [...] we [address those issues] with the people that they need' (1017). A dietician reported that when she received referrals from a provider that were weight-related, she did not take the referral at face value and would 'find out from the patient exactly what [...] the issue [was]. It may not be weight related at all' (1004).

Given their difficulties finding similarly oriented practitioners who adopted a weight-inclusive and social justice lens, almost half of the practitioners expressed that they were prudent about patient referrals, so as to avoid causing patients more harm. A general practitioner stated:

I'm [...] constantly worried about sending patients to specialists [who] are going to traumatize them. [...] Knowing that someone is social justice oriented is super important and [...] helpful [...] But it's tough because [...] we also oftentimes have to just [...] try to get people to whoever can see them sooner [...] (1017)

In particular, mental health interventions and referrals were mentioned by most practitioners as key to addressing patients' internalised weight stigma and emotional issues related to weight. From this perspective, the psychology of 'fearing fatness and feeling fat' (Windram-Geddes 2013, 42) was no less important than the material reality of fatness and its accompanying health issues. As one dietician remarked, 'the literature shows that weight bias internalization affects everybody across the BMI spectrum' (1001) rather than just those of heavier weight, suggesting that weight stigma is in itself an important health issue independent of BMI. Similarly, another dietician noted: 'I [...] had a fair number of referrals on to [...] counselling support [...] because the issue isn't that [they're] fat but rather, [they're] feeling bad about being fat' (1002). A social worker highlighted that weight-related anxiety was intertwined with other social factors such as racism, and had to be addressed with an intersectional lens. She described working with clients of colour to explore issues related to disempowerment, control and belonging:

Wanting to [...] fit in [...] be a part of this [...] culture sometimes can [...] lead to an increased desire to restrict food and lose weight. [...] That's what they sort of feel like they have control of. They can't change their race, but at least they [...] become thin and then fit better with all of their white colleagues [...] (1012)

Apart from collaborative efforts with fellow clinicians, all practitioners emphasised linkages to social and community services. As a dietician explained, enhancing patients' well-being entailed improving the social determinants of health: 'It's very hard to feel food secure or to work on better nutrition or [...] physical activity if you don't have stable housing' (1006). A social worker

remarked that since social isolation was a key factor to tackle, she had facilitated her patients' participation in activities such as 'accessible gym programs, [...] art classes through a local church, [...] and [...] more volunteer programs to get them connected' (1007). These perspectives underscore that weight itself was not necessarily the core issue that larger patients needed support with, and what took priority was assessing patients' well-being holistically to see what would benefit their lives most.

Most patients appreciated practitioners collaboratively making referrals to other practitioners and community services to address the multifaceted nature of their health conditions. Praising her clinic, one patient mentioned that 'they'll look into [...] every [...] facet of [your health]' (2015). She pointed out that it was a welcome change from 'other clinics and other doctors [who did] everything by piecemeal, and [not] want to [...] touch an area that's not theirs' (2015). Another patient acknowledged that practitioners understandably had gaps in their knowledge, and wanted them to 'take some time to actually refer [patients] somewhere [...] if they [didn't] know [how to deal with an issue]' (2020). One patient suggested that practitioners could ensure continuity of care by asking questions such as: 'Is there anything that we can do for you after you leave this setting? [...] Are there any resources that we can refer you to [...] after you leave this office [...]?' (2011). Another patient stated that in order for referrals to be helpful, they had to account not only for patients' health conditions but also their socioeconomic positions:

Sometimes [...] family doctors or clinicians will say [...] here's a referral to go to a counselor, [or] a dietitian, [or] a nutritionist [...] And I can't afford to go to any of those places. [...] I don't know where to go from [there]. (2014)

She stressed the need for clinicians to be more sensitive to patients' barriers to care and to provide free or low-cost resources for lower-income patients.

A couple of patients spoke up about the lack of IPC they had observed in healthcare. One patient related the 'gap in services' (2002) that was characterised by a lack of dialogue between professionals serving the same client. She explained that neither her dietician nor psychologist had addressed body image issues with her: 'It was sort of like [...] my dietitian assumed that I would be discussing those issues with my psychologist, and then my psychologist assumed that I would be discussing those issues with my dietitian' (2002). In her view, 'branches could be talking to each other more' (2002) to ensure that patients did not fall through the cracks.

DISCUSSION

Collectively, the five themes demonstrate how patients and practitioners experienced, understood and enacted social justice-informed PCC. To begin, they underscored that the quality of compassion was brought to the forefront of clinical practice despite the prevalence of EBP, and its elevation of scientific knowledge above patient experience. They noted that practitioners who displayed curiosity about the patient's world by proactively asking questions fostered environments in which patients felt safe to disclose their concerns without judgement. Both practitioners and patients valued approaches that allowed patients to uncover their own expertise without having predetermined goals imposed on them. Participants sought to defend the right for patients to receive equitable and weight-inclusive care, though their efforts were often undermined by a system steeped in weight stigma. Finally, they suggested that the delivery of

equitable and comprehensive healthcare required IPC as well as mobilising and connecting patients with community resources.

Findings from this study must be contextualised within broader discursive tensions between EBP and person-centred, compassionate care (Baker *et al.* 2018; MacLeod 2011). The dominant discourse in medicine continues to be EBP, which has privileged research-based scientific knowledge while silencing other kinds of knowledge such as patient experience (Baker *et al.* 2018). In line with Natvik, Råheim, and Sviland (2021) narrative phenomenology of a larger-bodied female patient, participants' accounts in the present study reveal how 'medical and experiential narratives seem partly incongruent, favouring normalization of bodies and lives over uncertainties, failure and vulnerability' (258). However, Heney (2016) has suggested that rather than position EBP and PCC as diametrically opposed, we can reconcile the insights from the two models. Evidence matters in clinical practice, though what is needed is a 'broader understanding of what counts as evidence' (Heney 2016, 117), particularly the recognition of patient narratives as a form of evidence. The transformative power of research exploring the historically subjugated narratives of larger individuals in healthcare lies in exposing their experiences of marginalisation, opening up spaces where resistance and change are possible, and generating new knowledge about health and illness (see Bombak, McPhail, and Ward 2016; LaMarre *et al.* 2020; Pausé 2014).

While the debates around obesity persist, participants' accounts indicate that qualities such as narrative competence, compassion and empathy associated with PCC must be combined with scientific evidence on the complexity of weight and health to effectively address patients' needs. This finding supports past research demonstrating that practitioners who asked about patients' lives in a sensitive and caring way motivated patients to open up about their symptoms and concerns (Halpern 2001). In the present study, patients had varying health goals, ranging from weight management to fat acceptance and encountered a range of structural forces such as discrimination and lack of social support that impacted their health. Most patients shared the sense that clinicians honoured their needs, goals and expertise. Clinicians in the study displayed principles of PCC by transcending weight-specific outcomes derived through a biomedical lens, and by accounting for patients' subjective understanding of their health priorities. Thus, clinicians encouraged patients to communicate the extent to which their weight and other determinants of health affected their day-to-day living, if at all. Even clinicians who subscribed to the obesity model were careful not to lead with weight loss as a prescription and demonstrated respect for a patient's decision about whether or not they desired to lose weight. In turn, patients who sought out weight management reported that they were able to approach treatment as a partnership rather than as a directive imposed on them. These findings depart from prior research on PCC for obesity that draw on principles such as patients' goal ownership and increased self-efficacy to facilitate their compliance with weight loss practices (see Armstrong *et al.* 2011; Wakefield and Feo 2017). In contrast, participants in the present study eschewed the notion of adherence to obesity treatment, which is part of the same moralistic and blaming discourse that demonises larger patients for not taking responsibility for losing weight (Lupton 2013).

Correspondingly, both practitioners and patients felt compelled to advocate for weight-inclusive treatment as part of a person-centred approach. The theme of patient advocacy aligns with past research indicating that though larger patients experienced healthcare as a persistent struggle, some attempted to assert their needs with their healthcare providers or find alternative providers

who were able to honour their preferences (see Buxton and Snethen 2013; Merrill and Grassley 2008). Buxton and Snethen (2013) report that patients in their study confronted their initial discomfort with being assertive because they believed that they '[had] a responsibility to say what they want and to seek it out' (257). In this study, however, both patients and practitioners perceived self-advocacy to be a valuable trait, yet recognised that patients' abilities to assert themselves were dependent on their social positioning. Thus, they were careful not to place the onus on patients to single-handedly resolve the systemic problem of inequitable treatment. This finding supports research by LaMarre *et al.* (2020) on the healthcare experiences of women and trans men diagnosed as 'overweight' or 'obese' who are pregnant or seeking to become pregnant. LaMarre *et al.* (2020) found that patient self-advocacy sometimes did result in better care, though patients highlighted that they should not be required to engage in this level of self-advocacy. Rather, what was needed was a collective shift towards more inclusive healthcare spaces that were accepting of differences around weight and other intersecting identities. In the present study, participants' accounts similarly demonstrate the importance of systems-based practice, which refers to recognising and responding to the broader system of healthcare and seeking out innovative solutions (Bourgois *et al.* 2017). Hence, the vast majority of participants rejected the notion of individual responsibility for health, instead emphasising IPC and community linkages, though some challenges in executing these goals remained. For example, practitioners found it difficult to make appropriate referrals due to a lack of weight-inclusive practitioners in a system rife with weight stigma. This theme of enhancing collaboration among healthcare practitioners to improve patient outcomes has been found in previous studies that examine IPC for obesity management, though such studies adopt a weight-normative perspective (see Claridge *et al.* 2014; Teixeira, Pais-Ribeiro, and Maia 2015). As Aboueid *et al.* (2018) demonstrate in their systematic review of IPC for obesity with a focus on dietetic referrals, dietitians are critical team players because nutritional counselling has been shown to enhance patient adherence to lifestyle modifications. Other studies on weight management across pregnancy and postpartum care likewise explore the important role of IPC between midwives and maternal and child health nurses to provide basic advice on establishing healthy food environments in the home (see Walker *et al.* 2019). In contrast, the present study takes a stance that IPC is beneficial not necessarily for the narrowly defined goal of weight management per se, but for advancing social justice through holistically addressing interlocking behavioural and social factors implicated in patients' overall well-being.

LIMITATIONS

Practitioners who were successfully recruited were limited to medical doctors, dietitians and mental health professionals. Research indicates that weight stigma is also rampant among other clinicians such as physiotherapists (Setchell *et al.* 2015) and nurses (Mulherin *et al.* 2013). The majority of the patients enjoyed good access to healthcare, including dietetics and mental health counselling, which are not covered by Canada's public health insurance. Future studies could examine the perspectives of larger patients who encounter more severe health inequities in basic care to offer a more comprehensive understanding of patient needs.

CONCLUSION

To our knowledge, the present study is the first that draws on perspectives from the practitioner-patient dyad to examine how

an explicit social justice framework addressing systemic inequities can inform PCC for larger-bodied patients. The findings illustrate that despite the divergence in participants' perspectives around weight and health, they shared a commitment to PCC by promoting patient self-determination and acting on systemic factors that affect health outcomes. In light of participants' challenges finding weight-inclusive and person-centred practitioners, it is pertinent to raise awareness about such approaches among interdisciplinary healthcare teams and to ensure that patients receive consistent messaging across the board. Ultimately, a social justice-oriented approach to PCC for larger patients requires both individualised and collective approaches that integrate micro-level strategies for individual healing and empowerment with a macro-level framework that targets the broader social determinants of health.

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Supplementary Figure 1.

