Chapter 6

Implementation and outcomes of the holistic approach to weight management in primary care

The previous chapters examined the relevance of including physical, social and emotional well-being to develop materials for a holistic approach to weight management. This chapter explores in depth how Practice Nurses (PNs) and individuals used these materials to implement weight management in primary care and the resulting outcomes. These results move on from having previously looked at the separate parts to learn more about ‘the whole’ to examining how the parts link and interact with ‘the whole’ in everyday situations. Data collection was achieved through the compilation of a number of sources:

- questionnaires about the nurses’ background and current practice;
- telephone interviews between nurses and the researcher;
- booklets devised by the researcher and used by individuals and nurses in planning and assessing weight management;
- documents containing measurements of individuals taken by nurses and;
- questionnaires devised to gain feedback from individuals about the holistic approach.

Therefore, in the presentation of quantitative data, percentages are rarely given as figures were not always consistent, neither were all booklets (My Approach to Weight Management) fully completed. Furthermore in an attempt to reduce the complexity of presenting the results for individuals no distinction was generally made between male and female.
The themes of role development, contextual influences and barriers to weight management emerged from the qualitative data collected, coded and categorised from the various sources listed above. The application of these themes to two case studies highlighted similarities and differences in using the holistic approach to weight management to practice.

After detailing the recruitment process and characteristics of PNs and individuals there is an assessment of the role of PNs, their support and education for role development and, in particular, obesity management. Once this foundation is laid the subsequent qualitative data analysis provides insight into the implementation and outcomes of the holistic approach to weight management.

### 6.1 Nurse recruitment

All recruited nurses were female and involved in chronic disease management. Of the 24 nurses who responded, 4 were not recruited for the following reasons: 1 changed jobs, 1 was involved in another study, 1 had staffing problems with someone off sick and the remaining one did not respond to follow-up. That left 20 nurses.

#### 6.1.1 Geographical spread

Of the 20 nurses recruited, one practised in a deprived city area while the others were based either in towns or villages. The city practice of nearly 10,000 patients had the unfortunate distinction of having one of the highest morbidity rates in Scotland particularly for cardiovascular disease. The other 19 nurses, whose practices were often remote from each other, were in a geographical area covering approximately 2,000 square miles, where the local economy is based on agriculture, forestry, tourism and a
few light industries. The combination of this rural location and the fact that it was
distanced from the researcher’s base meant that it was crucial for travel and practice
visits to be planned and co-ordinated well in advance.

6.1.2 Background information of nurses

Following the recruitment process, 18 of the 20 participating nurses provided
background information. Although initially having agreed to participate and being
provided with materials, 2 nurses from the same practice decided to withdraw due to
time pressures and thus provided no further information. Those nurses who were
recruited at a later date had either less time to identify and approach individuals for the
study or were unable to recruit any individuals. Each practice was given a letter as
code, therefore, when referring to a nurse the code letter is used and when referring to
an individual from that practice the same code letter is used together with the number
allocated to that individual. Details for all 18 nurses are shown in Table 6.1
<table>
<thead>
<tr>
<th>ID code</th>
<th>Years qualified</th>
<th>Years in primary care</th>
<th>Age Group</th>
<th>Hours of work per week</th>
<th>Number of Diplomas</th>
</tr>
</thead>
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<tr>
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<td>13</td>
<td>40-49</td>
<td>37.5</td>
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<td>E ○</td>
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<td>F ○</td>
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<td>G ♦ ○</td>
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<td>W1</td>
<td>24</td>
<td>3</td>
<td>40-49</td>
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** missing data ♦ Nurses who recruited individuals ○ 1 month recruitment time

Table 6.1 Table of the years qualified, years in primary care, age group, hours worked per week and number of diplomas for each recruited nurse.

All the nurses had a great deal of nursing experience having been qualified between 11 and 36 years (mean 26.2 sd 7.4). The portion of that time based in primary care varied between 3 and 29 years (mean 13.3 sd 8.0). Five worked full-time with the remaining thirteen working part-time (mean 28.4 sd 7.9). Following initiation of the study one nurse (P) became unwell and took early maternity leave before recruiting any individuals. Of the remaining 17 nurses 9 were able to recruit individuals with obesity.
6.2 Recruitment of individuals

All nurses were requested to recruit five individuals each and the only recruitment criteria stipulated was a BMI $\geq 30$ kg/m$^2$. They used a variety of strategies to identify suitable candidates. One nurse tried searching the practice database without much success indicating that either the search parameters were inappropriate or the system did not allow obesity to be identified. The most common approach was to target those who had appointments already booked, although those who were short of time occasionally tried to contact people by telephone. This also created problems as one nurse identified. “I think nowadays with everybody working or whatever. I know even trying to get back for blood results you’re ending up leaving messages on machines and things and it’s not ideal.” (V) Occasionally, GPs were asked to pinpoint individuals but mostly nurses tended to target those who were known to them through chronic disease management clinics. Table 6.2 shows the details of individual recruitment and the data collected from them. That is, it details how many obese individuals were approached to take part in this phase of the study and those who were recruited. It also identifies how many individuals returned their booklets, and questionnaires at the end of the study in addition to the physical measurements taken by the PNs.

<table>
<thead>
<tr>
<th>Individual recruitment and data collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approached (n)</td>
</tr>
<tr>
<td>57</td>
</tr>
</tbody>
</table>

Table 6.2 Table of individuals approached and recruited by nurses, booklets and questionnaires returned by individuals, and physical parameters taken by nurses.
6.2.1 Background information of individuals

Of the 28 individuals recruited, 4 were lost to follow-up. Figure 6.1 shows the age range by gender for 23 of the remaining 24 individuals.

Figure 6.1 Clustered bar chart showing distribution of age range of males and females.

The age range of the individuals was 32 to 76 (mean 49.6, sd 12.2). The intervention population, although smaller in number than those recruited for the exploratory phase, showed a similar pattern of age by gender in that the women tended to be younger than the men but unlike those in the exploratory phase there was no-one under 30 years of age. In both phases recruitment showed a similar gender bias with women outnumbering men. Although the bias was stronger in the intervention phase, it has to be borne in mind that the numbers were smaller. Nonetheless, it does appear that women, particularly younger women, are more likely to be identified and targeted for weight management. The BMI range by gender is shown in Figure 6.2
Figure 6.2 *Clustered bar chart showing the number of males and females in each BMI category.*

The mean BMI was 39.4 (sd 7.4). Body weights ranged from 79.1kg to 143.0kg (mean 103.9 sd 19.8). This compared to a broader range of 62.3kg to 185.7kg and a mean of 110kg for the population in the exploratory phase. However, it would appear that primary care nurses, like their colleagues in secondary care where the exploratory phase was carried out, are providing care for individuals who are obese and may suffer the consequent range of co-morbidities. Furthermore, the individuals recruited by primary care nurses, included those who were extremely obese, that is with class III obesity, and as shown in *Table 6.3* a high percentage of individuals had numerous co-morbidities. Within the same table, comparative data is presented for both phases, calculated to the nearest whole number.
### Table 6.3 Table showing the number of co-morbidities per individual for the exploratory and intervention phases.

This would suggest that the primary care cohort of the intervention phase had even higher co-morbidity rates than their secondary care counterparts in the exploratory phase. It would seem that there are many physical problems associated with obesity for which the Roper, Logan and Tierney (2000) model is applicable. The range of co-morbidities are shown in Figure 6.3

#### Obesity related co-morbidities of individuals

![Pie chart showing the number of individuals having each co-morbidity.](image)

Unlike in the exploratory phase, individuals with type II diabetes were included in the intervention phase and it was these individuals who tended to have the greater number of co-morbidities. Similarities were shown in both phases in the prevalence of anxiety.
and depression levels. Other commonalities, particularly highlighted in the 17 ‘weight management maps’ returned, were problems with mobility (n = 13), sleep (n = 8) and bladder (n = 4) again indicating the relevance of activities of living (Roper et al. 2000).

Previous attempts at weight loss were explored. Of the 28 individuals recruited 20 indicated the number of attempts they had made at managing their weight varied, as shown in Table 6.4

<table>
<thead>
<tr>
<th>Number of previous attempts at weight loss</th>
</tr>
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<tbody>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
</tbody>
</table>

Table 6.4 Table showing the number of previous attempts at weight loss by male and female.

Not only had some individuals tried to lose weight on numerous occasions they also employed a variety of strategies. These strategies, together with the professionals who had been consulted to assist with weight management are presented in Figure 6.4
Figure 6.4 Clustered bar chart showing the number of strategies employed by individuals in previous attempts at weight loss and the professionals they consulted by male and female.

In an effort to address their weight, some individuals used a variety of approaches. Since all individuals had at least one co-morbidity related to obesity, as seen in Figure 6.3, each one of them had important health issues. As all the PNs were involved in chronic disease management this may have been their prime reason for targeting and recruiting these individuals.

Although these individuals had previously attempted to address their weight problem, some of them on many occasions, after using the holistic, person centred approach, 78% were successful in losing weight. The changes in weight are presented in Figure 6.5
For individuals themselves, a range of emotions also played a significant part in weight management as had been shown earlier in the exploratory phase for those attending a secondary care clinic. Individuals in primary care were no different as indicated in the following statements gathered from their booklets.

- *Feel like ‘big blob’* (A01)
- *Guilty* (B01)
- *I get angry with myself* (G05)
- *I feel inadequate and a failure a lot of the time* (H04)
- *I don’t like looking at my body. It depresses me* (J02)
- *I am very self critical* (Q01)
- *Disgusted with lack of self control* (R01)

Having presented some background information of both PNs and the individuals they recruited the next section introduces the context in which the holistic approach to weight management was implemented.
6.3 PN role in primary care

Role development emerged as an important theme in relation to implementing the holistic approach to weight management. The categories relating to role development were: support and education, support for obesity management and obesity education as seen in Figure 6.6

![Figure 6.6 The theme of role development and related categories of support and education, support for obesity management and obesity education.](image)

The PNs who volunteered for this study were all involved in chronic disease management. They viewed obesity management as relevant to their role particularly in relation to their remit in chronic disease management, saying that those with obesity:

"have chronic disease problems anyway so I’d be seeing them for another thing. That’s why I think practice nurses are in a good position to do things like this" (S) and it was “easier to broach maybe in the context of them having some kind of chronic disease and you can say, you know, if you lose a bit of weight, then that’s maybe going to help your condition” (K).
6.3.1 Support and education for role development

In order to carry out their remit for chronic disease management PNs were supported to undertake diplomas to fulfil the requirement of the GMS contract.

“If it’s something that the GPs sort of say that I have to go on then they will pay for me but if it’s something that, for instance, the COPD course, it was an initiative by our LHCC. They actually paid for it, but again, if I had wanted to do that and I had asked a few years ago they would have said ‘No, it wasn’t within the remit of the practice’ but because of the contract it suddenly was plummeted, well made the remit”(S).

The type of diplomas undertaken, as seen in Table 6.1, have obesity as a common link. However, how PNs view obesity education and management within the chronic disease management diplomas appears to differ. One nurses’ experience was that obesity management “wasn’t a big part of it at all”(G). Another nurse undertaking a different diploma said, “You know, it’s healthy eating, weight management in general, so I found that valuable really”(E). Although there are differences in either the perception or content of diplomas for co-morbidities it appears that dietary advice is still the main focus of weight management.

Even for these diplomas which are encouraged PNs found that “a lot of the study time is all your own time, you know. It’s a shame for any nurse who wants to develop themselves”(B). For some this means that they “usually use up some of my holiday time”(S).
Some GPs, however, “are better than others at seeing the importance of it. You know that nurses need to keep their development up but personal development plans are slightly alien in general practice”(B). If practices accept Agenda for Change the situation may improve for everyone as

“things are now changing and our GPs have now taken on Agenda for Change so they’ve actually been looking at the personal development side. Therefore, there is a wee bit more negotiation and compromise with that.”(R).

There still exists, however, an obvious tension between the needs of the practice and educational needs, as nurses themselves see it. “What they see as specific requirements for the job are not necessarily what you feel are the personal requirements.”(R).

In recognition of this the practice nurse advisor in one area recently negotiated with all the local managers to allow practice nurses time for continuing professional development. A programme was developed in conjunction with the local school of nursing. “We’ve chosen things that are pertinent to practice nursing but also slightly different from the chronic disease stuff as well”(B). Unlike other educational sessions, nurses themselves could request items of interest so “we asked if we could have stress management (Q2). PNs are therefore, looking for interventions that are relevant to nursing practice.

**6.3.2 Support for obesity management in practice**

Practice nurses feel unsupported in weight management. “There’s nothing locally to help us and we as practice nurses see it all the time, have to deal with it and basically we felt a bit unsupported, really”(J). Although there was the option to refer patients to
dietetics the waiting list was several months long and offered only one appointment. This was probably due to a shortage of available dietitians. Most of the nurses who did refer individuals to dietetics tended to use the service mainly for diabetic patients.

Unfortunately, some nurses had negative feedback from patients. “They weren’t told anything they hadn’t been told already in practice and they’ve got to trail up the Infirmary to be seen as well”(B). While this was also the experience of other nurses they sometimes saw it “more as a reinforcement of what they’ve already been told”(D). Some others felt that they had good support from the dietitian for dietary information particularly in relation to co-morbidities. For diabetes management, for example, one nurse had received support from dietetic colleagues, occasionally having study days with them with the result that she felt “quite confident on the dietary side of things”(S).

However, as has been argued previously, obesity management is far more complex than simply focusing on dietary aspects. This, and the fact that the experience of individuals was not always positive, may indicate why individuals were rarely referred only for obesity management.

In addition, some doctors have the attitude that ‘no fat people came out of Belsen’(W) and feel that “giving patients time is just blethering”(W). Therefore added to the fact that there are no ‘brownie points’ for obesity management at the time the study was undertaken, there was sometimes little support for it within some of the practices. There is therefore a need for support as “overall, practice nurses are all desperate to find ways to deal with weight management because it’s such a problem”(B). As one nurse put it, you “Tend to bang your head up against the wall”(R) and all agreed that it was “quite a difficult area, not full of success”(V). In addition to frustration at the lack of success there appears to be a need for educational courses on obesity management.
6.3.3 Obesity education for PNs

One PN reflected this need for obesity education saying she “could do with maybe some training or something in that aspect of things. I’ve just never come across anything sort of relevant”(G). Furthermore, it seemed that obesity management is not a priority in education as another PN discovered. “I have recently requested their prospectus for next year and there’s definitely nothing related to weight management”(E). Even when specific courses on obesity were identified they did not always come up to expectations.

“I was looking for something extra, something different that I could try and I didn’t really find it there. Hmm, it really, I mean, there was a nutritionist speaking and obviously some doctors speaking as well and it really was just, I just feel telling us what we already know......It was really just, healthy eating and the effects of poor diet”(D).

However, greater satisfaction was experienced when a broader picture was portrayed at a different study day, funded by the pharmaceutical industry.

“They were sort of trying to instil in us that to encourage, and you know, the patients and not to have too outrageous goals. To treat everybody as an individual. They all had different needs, different emotions, different reasons why they needed to lose weight.”(S).

It appears that PNs have an interest in obesity management but are often frustrated at the perceived lack of suitable education to support them in practice. Greater insight into what PNs view as relevant may be gained by identifying their previous educational experiences.
6.3.4 Educational influences on PNs’ approach to obesity management

Many of the PNs undertook their training when nursing was task orientated and treatment of individuals in their care was undertaken using the paternalistic, biomedical model. For some, the experience of this training may have led to a restricted view of weigh management and made it difficult to adopt a holistic, person centred approach. However, other PNs who trained in that same era allowed other educational experiences to influence their practice.

One nurse candidly reported that in relation to weight management she was probably looking for a ‘quick fix’ for treating individuals. She went on to describe her current practice in the following way:

“patients either refer themselves or it comes from the doctor. They just come and we have a discussion about their diet and I do all the weights...they really just come and we try and review their diet situation and hmm, basically just that's about it really”(T).

Therefore, it may be that some PNs either do not consider viewing weight management from a holistic perspective or found it difficult to do so.

Nursing has changed a great deal over the last few decades from being task orientated to a more person-centred approach and many of the nurses had integrated changes into their practice. One nurse spoke of how undertaking further education had impacted on her practice.
“That certainly broadened my knowledge about research based practice because I was a task orientated trained nurse which was 30 years ago, obviously, and when you’re maybe having students and things like that plus you own work, I found that was a very helpful course to attend…..So really, basically, I went because I really knew that I had to go so that I would practice more safely and more effectively”(R).

Another nurse who also trained in what may be considered a task orientated era was one of the first nurses to undertake a degree and recalled the impact a psychology tutor had on her practice and why she was attracted to the holistic approach to weight management.

“I suppose that’s how I looked at weight management, sort of like, getting underneath the problem because often there is a problem. I’ve always tried to sort of look on it, probably the way you’ve done in a more holistic way and sort of tried to unravel why they’ve become, especially if they are particularly overweight, why they’ve become the weight they are. Strip off all the old, you know, slimming classes, because a lot of them they have tried them all and then go back to let’s start again…. looking at the whole thing, exercise, lifestyle, how they see themselves. Very much what’s in your wee booklet but I didn’t have it just as organised”(J).

The holistic approach to weight management seems to have relevance for this type of practice.
“I think with the information that you gave us that you’re not really dealing with the weight, the weight isn’t the prime issue. It’s what’s causing the weight and I thought that this was, well it looked a really good approach and it looked as if there was a wee bit of a structured framework to work towards. Although you could say to patients, where do you live and what are the other influences in life, what are their personal beliefs and perceptions, nothing was put on paper” (R).

Therefore, although some PNs were attracted to the holistic approach to weight management others found it difficult to view weight management from a broader perspective, regardless of when they trained. Education would appear to play an important part in how obesity is viewed. Therefore, education and support for implementing the holistic approach to weight management seemed important. Furthermore, it needs to be relevant to nursing.

6.4 Support for implementing the holistic approach to weight management

The means of providing support and education for implementing the holistic approach to weight management had to take into consideration the context in which the PNs practiced. In large geographical areas, such as the one where most of the nurses were recruited for this study, nurses often travel many miles as well as using their own time to further their own professional practice and development. The interest in obesity management was obvious by these nurses doing just that for a one-hour meeting in the evening to introduce the study. For those who could not attend, the researcher visited each nurse at their place of work. A planned study day failed to materialise due to constraints on funding, the difficulty with nurse time and the geography of the
participating practices. Most nurses felt that “another meeting would have been useful to go through the patient booklet more thoroughly” (W). While attempts were made to facilitate this there was great difficulty trying to arrange a suitable time for everyone and due to the time limited research it had to be abandoned.

As a result, apart from the one-hour input there was a lack of opportunity for teaching although the researcher was available to the nurses by telephone and email. Due to most nurses having to implement this research within their restricted appointment times these contacts when they did occur were often made in the nurses off duty time. Two nurses took up the offer of the researcher sitting in on a consultation. However, whether uptake of the support offered was influenced by the PNs’ personal choice or the context in which they worked may have been influenced by their level of responsibility and autonomy.

6.5 Contextual influences on implementing the holistic approach to weight management

Contextual influence emerged as a theme which influenced the implementation of the holistic approach to weight management. The theme categories were autonomy, negotiation and bending the rules as seen in Figure 6.7
Figure 6.7 *The categories of autonomy, negotiation and bending the rules in the theme of contextual influences*

Whether the level of responsibility and autonomy was dictated by the practice context, devolved responsibility from others within the practice, or personal choice was difficult to ascertain. However, it became apparent that most PNs tried to increase their autonomy through negotiation with practice colleagues or simply ‘bending the rules’ as one PN put it.

### 6.5.1 Autonomy

The nurses in this study appeared to exercise various levels of autonomy. One nurse “just look(ed) at the notes and see what to do from the notes”*(T)*. Viewed simplistically this can be interpreted as simply carrying out instructions within a hierarchical system and reflect the historical view of nurses being ‘doctors’ handmaidens’ (Darbyshire` 2006). Other nurses appeared to have greater autonomy, particularly with regard to chronic disease management reflecting how the nursing role has changed.
“I totally have control of that so once they’re on my disease register I’m the one that decides when to see them. Of course, in liaison with the GP, if he feels, or she feels that, you know, they wanted them seen sooner but usually at the end of the day I’ll tell them what’s happening and if they’re not happy we can reschedule. Usually they just accept what I feel is okay for the patients” (S).

“The GPs don’t see them at all unless there is something that I specifically want them to see them about” (Q).

However, although nurses can and do have a say in day to day nursing practice, there has been another development in primary care, that of the introduction of practice managers. Practice managers have power when it comes to allocating appointment times and are influenced by the General Medical Services (GMS) contract. High on the agenda of the GMS contract is chronic disease management so it is usually given “protected time” (A).

Emotional and social aspects may be important to weight management it is crucial that individuals be given time within the consultation to address such issues. Most chronic disease appointments were allocated between 15 and 30 minutes. Initially at least, the increase in the length of appointments combined with the fact that nurses have increased their hours of work gave the impression of providing more time for direct patient care. However, this extra time appeared to be taken up with documenting the requirements for the GMS contract or local enhanced services needs, both of which are driven by funding. “We’ve got half an hour for CHD and stroke and we need that to fill out this enormous template of three screens” (A). This had a detrimental effect on consultations
as it “doesn’t allow us much time to make eye contact with the patient far less listen to their worries”(A).

It is hardly surprising then that nurses view the contract as being a “number crunching game”(S) where “points are prizes”(A) and instead of being the ‘doctor’s handmaiden’ perhaps feel that they are the manager’s handmaiden as they are seen as being “the people that collect the brownie points”(J). A further illustration of the influence of the GMS contract was where there were difficulties incorporating podiatry care into diabetic management to gain GMS points. A solution was found by “reconfiguring our clinic to try and cover all the contract points”(A). Although weight management was mentioned in the National Frameworks for Coronary Heart Disease and Diabetes, it did not earn ‘brownie points’ when the study was undertaken so nurses had difficulty allocating time for it. Yet, nurses were expected to provide within the allotted appointment time a weight management service to those who needed it. How they viewed this remit differed, ranging from “Yes, it’s coming into the equation there”(V) to being “part and parcel of a lot of the chronic diseases”(A). When working within these constraints some found ways of trying to give more time through negotiation or manipulation of the system.

### 6.5.2 Negotiation

For weight management it was sometimes possible to negotiate an earlier appointment “if I’m keen to bring these people back early then I can justify it to the manager”(E).

Another nurse negotiated extra time for the duration of the study “I had agreed with the practice that I could spend a wee bit more time with these people than I would normally
do”(A) while another was unable to achieve extra time and explained the effect she thought it had on outcomes.

“It would have been nice to have maybe 20mins per patient but again with the GP contract and the number crunching game, I was only allowed to do this if it didn’t interrupt the rest of the work….On hindsight a wee bit longer probably, maybe the other two who didn’t come back maybe if I’d had a bit more time with them it could have been more beneficial to the patient”(S).

Sometimes more subtle ways of creating time were found. One nurse explained how she used the appointment to allow time to address weight management issues when screening a husband and wife who were new to the practice. “He was pretty straight forward. Sometimes you can whiz through them if they are straight forward, no health problems and everything’s normal…. So I probably managed to do that with him and then spend longer on her”(B). Others nurses simply ran late.

6.5.3 Bending the rules

In one practice there was a protocol for seeing people for weight management on a weekly, two weekly and then monthly basis.

“It’s officially a set pattern but I consider everyone on an individual basis and if I feel that it’s really a benefit to see somebody at three weeks or two weeks rather than a month for additional support, as long as I know it’s going to be short term or have an idea it’s going to be short term then I’m prepared to…I’ve got two who are coming back in a month’s time, or who plan to come back in a month’s time, I’ll bring them in slightly earlier but I’ll put them both in for a 15
minute appointment which is not ideal but I know that they are going to be able
to touch base at that point. So I do bend the rules” (E).

This demonstrated the difficulties of time when taking individual needs into account in
an effort to deliver person-centred care. Time constraints in general were a problem for
all the nurses but some did not mention trying to manipulate the system to benefit
individuals in their care. It was within this context that PNs recruited individuals for
this study.

6.6 Barriers to weight management

The theme of barriers also emerged as influencing the implementation of the holistic
approach to weight management. The categories within the theme of barriers are shown
in Figure 6.8

![Figure 6.8](image)

**Figure 6.8** The categories of motivation, not ready, can’t cope, too deep, blamed by
others and self blame in the theme of barriers to weight management

From analysis of the qualitative data provided by individuals, a number of barriers
emerged. The utility of using the participatory, holistic approach was reflected in the
variety of barriers identified. Each type of barrier, defined in terms used by the
participants in the study, is discussed under the categories, of motivation, not ready, can’t cope, too deep, blame by others and self-blame. However, it also emerged that when PNs worked in partnership using the materials with individuals, barriers were sometimes reduced.

6.6.1 Motivation.

One PN described how, in her previous approach to weight management, she was “struggling with trying to get people motivated. They just weren’t – it was a case of I would advise them to go to weight watchers because they just weren’t listening to anything I was saying”(T). It seems that advice giving to individuals caused frustration for the nurse and led to poor outcomes for individuals.

Nurse S elucidated how using the holistic approach differed. “They’ve never seen anything like this before and never been asked what they thought before. They have been told rather than being part of a partnership”(S). It seems that Peplau’s partnership approach is relevant.

Raising the subject of weight is not always easy. “If you suggest they are overweight you see the barriers going up straight away with some patients”(C3). One of the individuals highlighted this in her weight management map when she wrote “I hate being told I need to lose weight”(J02). Several nurses thought it easier for them, rather than the doctor, to raise the subject of weight because of the relevance to their area of work in chronic disease management. One explained how she would broach the subject:
“I can say, you know, you’re knees will be a lot better if you were a little bit lighter and we could do something about that. Would you like to? I give them the option, I don’t say ‘You’re too fat, you need to lose weight!’ I say, you know, if you’d like help to move your weight down, I use sort of words like that, then I’m here and that’s part of what I do”(J).

It appeared that this approach was more empathic and in line with a person centred approach. Another stumbling block pointed out by Nurse E was:

“If people are quite comfortable with the weight themselves. I think that’s probably where I find sometimes a little bit difficult obviously trying to educate and explain. It’s quite easy to upset some people if they feel, you know, that they don’t have a problem or that there isn’t any need to lose weight….My confidence has definitely grown with that and you can judge how to approach it”(E).

The manner in which individuals are approached does seem to be important and barriers can be broken down as nurse J explained:

“I do get the odd barrier but even some of those eventually, because often they keep coming back to me because they are asthmatic or something I have the opportunity to slowly break these barriers down with them. They get to know me as a person and that I’m not being judgemental. I’m just thinking about their well-being then they’re more likely to open up if you’re not judgemental”(J).
Individual H04 confirmed the importance of not being judgemental by writing “My nurse practitioner is a good mentor without judging me”.

Part of the art of good communication, a key area for both Peplau and RLT, is knowing when the individual’s choice, which should always be respected, is to be accepted at face value. Repeated failed experiences may have dented confidence thereby creating a barrier to trying a new approach.

“One of the ladies in particular is a lady who is 20 stone, you know and has been coming to me since, oh I think, particularly since I was here, over just 15 years, and been to the dietitian, been through all sorts of things and I think that she just felt that this isn’t going to make any difference to me either. That was kinda reading between the lines but she never said that” (D).

Sometimes confidence building and conveying a sense of support may be required before changes can be attempted.

Nurse R felt that the materials were helpful in that respect:

“I think some of the comments on the pages like, you know, small permanent changes are the key to long term success. It had an encouraging aspect to it...The hands on the front.... There’s someone shaking my hand or reaching out a hand to help me and then the wee circle and things like, these wee cycles of change going on there, but that’s me personally, you know. I don’t know how patients would identify with that” (R).
It would appear that involving individuals in partnership rather than simply giving advice may improve outcomes. Furthermore, barriers may be broken down when PNs build a good rapport with individuals and are non-judgemental in their approach.

### 6.6.2 Not ready

Most nurses felt that a good number of the 29 individuals who refused to take part in the study were not motivated to address their weight at that time. Nurse R explored the possibility of other reasons before coming to that conclusion.

> “They looked at the books and things like that and really, basically what it was, ‘I’m not really ready. I mean, that was the main reason. They didn’t say ‘Oh, that’s too complicated’. They didn’t give me anything like that. I said or is it that you don’t want to put things on paper? Do you think this is going to be a painful experience for you having to think about these things? Maybe what past experiences have been. No, none of them came up with that. They just said ‘Oh, I can’t be bothered just now. I just took that as ‘I’m not ready’”.(R).

Nurse S who had three refusals spoke of lack of time in addition to not being ready. “It was the time factor. They didn’t want to be, you know, having to come in and they didn’t feel ready. They didn’t feel this was the right time”(S).

Other individuals agreed to take part in the study but were externally motivated. “Oh, I don’t mind helping somebody with research. That’s good if it will help some other, I don’t mind that”(S02). This was confirmed by Nurse R who had one individual who “liked the idea that this was going to be researched and this was a good reason for partaking in something like this. It might help others. Not her”. These externally
motivated individuals did less well than others in weight management thereby demonstrating the importance of helping individuals focus more on internal motivators.

The materials helped some to identify internal motivators such as looking at their beliefs about weight management as one individual wrote, “It’s up to me to do something about it. I have to do it for me and no-one else” (J01). It seemed as if this individual was ready to take control and have an active role in the partnership.

6.6.3 Can’t cope

Sometimes, individuals felt that they could not cope with making changes. “The other lady, her home circumstances when she looked at it, at home in greater detail, I think she got a bit frightened by the weight management map. She said ‘Oh, I can’t cope with that’” (F). Nurse F clarified that it wasn’t the layout of the map but actually looking at it and starting to think what it meant to her that she couldn’t cope with. Perhaps this lady felt a sense of hopelessness created by the map over her circumstances indicating a stable attribution and that the effort to make changes was too difficult and therefore she was unlikely to succeed (Weiner, 1985).

One individual’s reaction to the booklet reported by nurse V was: “don’t like that, it tells me things I don’t want to know” (V). Although this individual, like the previous one, did not participate in the study he continued to attend the nurse who said “Funnily enough, there are issues, most of the self image issues have come back into play just recently for different reasons and I think he is really going to knuckle down and make a big effort now” (V). Although the booklet had raised issues he did not want to face at the time, perhaps at a later date he felt more ready to address them with the help of his nurse.
Another individual, who did not complete the study, could not cope for different reasons as Nurse R explained:

“*

She had a past experience of a son who committed suicide a year and a half ago.... She just said to me yesterday, I don’t think I was really ready. Probably she was still grieving, you know, but at the time when I told her about it, she said ‘I really must lose weight because this lady had got rheumatoid plus diabetes and she’s really unhappy with the weight that she had gained’”(R).


The nurse’s reaction seemed to indicate that she saw this lady as not being to blame and therefore reacted with empathy towards her (Weiner 2006).

6.6.4 Too deep

Nurse D, who did not manage to recruit anyone, thought the materials were off-putting for some individuals. “*

They just felt that they didn’t want to sort of go, I suppose, too deep into the sort of psychological side”(D). There was the possibility that she did not feel comfortable in dealing with any issues that might arise. On the other hand it may have been that some individuals felt the materials to be intrusive. One such example was an individual who, in spite of having a good experience when using the ‘holistic’ approach, felt that the weight management map was “too personal” (A03) as it revealed that he had depression. He did have a depressive episode during the study resulting in a weight gain of 6kg before he lost it again. However, most nurses who did recruit individuals had a different point of view.
“For some reason, just working through the booklet and I mean, it’s very good it doesn’t dig too deeply. People don’t have to say what’s happening but they can do…it’s not too diggy, not too psychology” (J).

Nurse R who had many years experience in primary care provided further evidence that individuals had the choice to withhold information. This nurse recognised that for one individual “there were a lot of things bubbling beneath the surface but she wasn’t willing to come up with it” (R). It appears that individuals have the option of how much to reveal. In addition to having this option it seemed that there was no pressure to complete all sections of the weight management map as two individuals omitted one section while completing all other sections. The materials appeared to be beneficial in aiding nurses and individuals to work together in partnership. However, it can be more difficult at times to maintain a good rapport with individuals.

6.6.5 Blamed by others

Nurse A recognised how easy it was to convey the wrong messages. “Your mood changes as much as anybody else’s. You might have a bad day and approach it the wrong way. You have to be aware of that and the body language” (A). The professional’s own views can also unintentionally be conveyed to the individual making them feel that they are being judged. “They say they’re good and then they haven’t lost weight” (T). Values, beliefs, attitudes and prejudices may influence what impression is given (Roper et al. 2000) therefore it would seem that communication skills are important.

The following experience of S02 demonstrated how sensitive individuals can be, indicating the fundamental importance of adopting good communication skills. In spite
of a good relationship with her nurse and making progress with weight management, she had a bad experience with another health professional. She had been prescribed a weight loss drug (Xenical) but when her weight became static was refused another prescription with the following result:

“Felt like I was being punished for not losing weight! (I had PMT). This reinforced my feelings of being a ‘failure’. I’ve since regained the weight I’d lost” (S02). It may have been that the protocol for the weight loss drug was being followed but the individual’s understanding was compromised by poor communication.

This demonstrates the importance of having an awareness of how professional interaction affects individuals. It would seem that individuals do feel that they are being judged even by their own families like J01 who felt “My Mum always puts me down”.

These reactions could be explained by attribution theory where individuals are viewed as having control over their weight and by not making an effort elicit anger from others who then blame them. It seems too that if lack of effort is considered to be ongoing more anger is engendered (Weiner 2006).

6.6.6 Self-blame

It is not only professionals and family members who were thought to be judgemental but the obese individuals tended to judge themselves harshly as Q01 recognised: “I am very self critical”. Negative feelings, including anger and guilt, were prevalent among the individuals and often directed towards themselves like G01 who was “angry with myself” and R01 who was “disgusted with lack of self control”. These attitudes are
therefore not only common in society but among the obese themselves. Again, this reflects attribution theory.

“Some people if I gave it to some of my regular patients/clients you know, they would be ‘Oh, what’s this all about?’ You know, I’m here for help to lose weight….. I kind of feel that the type of patients that were coming to me were wanting more dietary advice and support. A lot of them maybe know what they should and should not be eating but if they know they are seeing me on a regular basis, for they’re wanting to please me as well as themselves”(C).

Nurse Q shared her thoughts on how negative feelings and trying to please the professional can be detrimental. Her awareness encouraged her to provide extra support.

“I think at times there’s a bit of embarrassment and shame that they don’t lose weight. In fact, I think they are pleasing me or the person who is doing it and it’s not really that. Sometimes, people do the same if they go to a weight management class. I’m as guilty about it myself, I’ve been to them all. And you feel guilty if you put on a pound or two because you weigh yourself before you go and think ‘oh dear, I don’t want to go because of that and then you don’t turn up for the next appointment because it’s got worse. Telephoning there is handy, which I did”(Q).

Nurse J shared her views on how the holistic approach was different from familiar approaches to obesity management.
“By the time they get to me they’ve been through all the slimming classes and they are very, very relieved to get away from calorie counting and treats and good and bad and, you know, all this kind of jargon that all these slimming classes are laced with. People coming feel guilty because they’ve eaten a chocolate biscuit, you know. I think actually, everybody I’ve approached about it or talked to have seemed almost relieved to think that there can be a different way. It’s not about restriction and doing without. It’s about actually just looking at your life right across the board and I think they seem to be quite relieved and sort of think, oh I’m not going through one of those kind of, you know, again where you’ve basically just got to eat what somebody tells you to eat”(J).

An individual expressed a similar view when she wrote “The booklet has made me think about the ‘whole of me’ and all areas I need to sort out in my life. Thanks!”(R01)

In conclusion, these barriers demonstrate the interplay between all aspects of the holistic approach to weight management.

In the following section each practice is viewed as a single unit comprising of PNs, the individuals they recruited and the context in which they interacted with each other. It builds on the data already presented. Greater insights were accessed through in-depth data analysis as the level of interactions between PNs and individuals deepened. The theme of partnership between PNs and individuals emerged as central to helping individuals make changes and is discussed in the following section.
6.7 Partnership

Partnership is viewed by Peplau as the essence of nursing (Pearson et al. 2005). It appears that when PNs worked in partnership with individuals they helped them come to a realisation of what they needed to do by identifying the problem areas of weight management through reflection. In turn, reflection helped individuals become self aware and empowered them to take responsibility for their weight management. The various themes linked to partnership are shown in Figure 6.9 and subsequently addressed in the text below.

Figure 6.9 The categories of realisation, identifying the problems, reflection, facilitating reflection for empowerment, self-reflection for empowerment, knowing the individual, self-awareness and responsibility in the theme of partnership.

The following cases, although used to emphasise one theme also collate the various themes in keeping with the holistic approach.
6.7.1 Realisation

Most of the nurses who recruited individuals for the study appeared to already have an approach congruent with holism but lacked the tools to facilitate partnership working in weight management. One nurse explained her usual approach: “I start off by saying, well, you help me and I’ll help you, kind of thing. This is a joint affair. How badly do you need it and want it and what for and what good things it will be for. Why do you really want it?”(Q). From this, it appears she was involving the individual by encouraging them to think about why they wanted to manage their weight better and what the benefits would be.

She gave an example of how this worked out in practice when using the study materials.

“He realises he has to do it for his heart. He’s not long having had heart problems. He realised he had to get fitter. He started going walking, he felt his trousers were looser. He felt better, he cut down on drink, not that he drank that much. In himself he felt better although he didn’t lose very much so I will be keeping an eye on him”(Q).

It would appear that the nurse and individual worked together with the materials. The outcome of the partnership seemed to help the individual realise that he had to lose weight to prevent worsening his heart condition. Furthermore having identified the problem, reflected upon what he needed to do, he took responsibility and felt empowered to implement the necessary actions. The PN also realised the importance of follow-up to encourage continued progress.
6.7.2 Identifying the problems

The ‘weight management map’, as seen in the following case study, not only aided the individual to identify the problem areas but helped the nurse to highlight other areas to target for treatment.

<table>
<thead>
<tr>
<th>A 48yr old divorced female with a BMI 37.5, did in spite of living with her brother and three children, felt lonely and isolated. She had not addressed her weight problem before, although she identified that it started with problems in childhood and was also affected by family life. Her arthritis troubled her at times and she also suffered from hypertension, anxiety and depression</th>
</tr>
</thead>
</table>

The ‘weight management map’ helped her to recognise that she was comfort eating, particularly in the evening, so she planned to eat only when hungry. She also planned to go out more. During the consultation, her nurse picked up from the ‘weight management map’ that there were sleep difficulties so this was also explored to find connections with various other factors. There was an improvement in sleep as shown in the following Table 6.5 together with other changes
<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular activities</td>
<td>I do a lot of studying to try to enhance my career prospects</td>
</tr>
<tr>
<td>Eating and drinking</td>
<td>I often have take away meals</td>
</tr>
<tr>
<td></td>
<td>Porridge for breakfast Smaller portions</td>
</tr>
<tr>
<td>Mobility</td>
<td>Knees painful most of the time – worse in damp weather</td>
</tr>
<tr>
<td></td>
<td>Walk more</td>
</tr>
<tr>
<td>Feelings about myself</td>
<td>I am not confident I am very self critical</td>
</tr>
<tr>
<td></td>
<td>I accept things I can not change</td>
</tr>
<tr>
<td>Body dissatisfaction</td>
<td>I like nothing about my body</td>
</tr>
<tr>
<td></td>
<td>I don’t like my body</td>
</tr>
<tr>
<td>Benefits of weight loss</td>
<td>I would feel better</td>
</tr>
<tr>
<td></td>
<td>I climb stairs more</td>
</tr>
<tr>
<td>Beliefs about weight management</td>
<td>My weight is all my fault</td>
</tr>
<tr>
<td></td>
<td>I am trying to reduce my weight</td>
</tr>
<tr>
<td>Social contacts</td>
<td>I have few friends outside of work</td>
</tr>
<tr>
<td></td>
<td>I do not see many people</td>
</tr>
<tr>
<td>Support</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>I do not have help from friends</td>
</tr>
<tr>
<td>Health problems</td>
<td>Worry a lot I do not sleep well – dog disturbs sleep Painful knees</td>
</tr>
<tr>
<td></td>
<td>I sleep better</td>
</tr>
</tbody>
</table>

Table 6.5 Weight management map for Q01

As the partnership between nurse and individual developed providing a vehicle for trust and openness it was agreed that stress counselling would be of benefit. Prior to referral to the counselling service, which was available within the practice, weight had been fairly static in spite of the other measures taken. Had stress not been tackled perhaps weight loss could not have been achieved and demonstrates, as the nurse recognised, the importance of trying “to look at the whole picture” as “Sometimes you have to look at
what it is that’s causing them to be like that. Home circumstances or stress or lonely, not having friends to go out with even to do a little walking and exercise…..It’s looking at the pattern not just the signs on the scales”(Q). This view was supported by the individual themselves as they found that the most helpful parts of the ‘holistic approach’ were “trying to assess why I am overweight” and “regular contact with nurse”(Q01).

The nurse was often seen as a source of support particularly when individuals perceived a lack of support and social contacts. In this context, six individuals in this study specifically identified the practice nurse as providing support and indicates the relevance of Peplau’s idea of surrogacy.

6.7.3 Reflection

Nurse J felt that reflection helped people to be honest with themselves and spoke of how she approached it using the materials. “I said to him, ‘It’s like looking at yourself in the mirror and saying well look this is the way it is. This is why it is and you know, it’s up to me. What are you going to do about it?’”(J)

However, not everyone agreed with encouraging individuals to reflect. One nurse felt it inappropriate. “Reflections, sort of looking back, you know, I think a lot of people thought, well in my view, would maybe, know they are overweight and they know they’ve had hang-ups over the years but they don’t need to be reminded about it.”(C).

Perhaps there was a reluctance to try and help individuals address these ‘hang-ups’ for fear that difficult issues be raised. Nurse R, on the other hand, appeared comfortable
about the possibility that issues other than purely physical problems may be identified in the holistic approach

“because it does open a few cans of worms, being able to refer in whatever different direction they need to go to and be ready for that.... I think it was intense but you get that all the time anyway. It doesn’t matter who walks through the door”(R).

She gave examples of how emotion can be associated with asthma and hypertension.

“General practice patients can come in with asthma but there’s a whole pile of other stuff because it’s been an emotional thing that’s triggered off their last asthma, therefore hyperventilation and so it goes on, you know. That’s not an unusual thing. Or they come in and the blood pressure’s a bit elevated and that and they’ve had a terrible time and this is what’s been going on”(R).

During her everyday practice, it appeared that Nurse R recognised the need to address emotional issues raised by individuals having reflected on their situation. Emotions are therefore, an important element of weight management. It also demonstrates a person centred approach as does the following example.

6.7.3.1 Facilitating reflection/empowerment

The importance of reflecting on how emotions and social issues are closely intertwined with physical health is demonstrated in the following case study. Furthermore, it
reveals that when the nurse and individual work in partnership to aid reflection it may result in empowering the individual to change the situation for the better.

A female (R01) who lived with her retired husband had a BMI 46.2 and lost 3kg overall. She suffered from diabetes, arthritis, gallstones and anxiety, had often tried to lose weight including attending the nurse and at one stage had been prescribed Xenical.

Due to her mobility problems, where even dressing and showering were difficult, she occupied her time with a variety of sedentary pastimes. As a result, managing her weight was very difficult for her.

The benefits she hoped to gain with weight loss were better mobility and to feel better about herself. The key areas she identified for change were her eating habits and self control. The nurse and researcher saw the individual together in an atmosphere of trust and respect. This may have helped her to reveal during the consultation that, although she had written that her husband gave her good support, it was not always appropriate support. She felt unable to change the situation resulting in an increase in her levels of anxiety. The main focus of the consultation was therefore to empower her to find ways of reducing her anxiety levels to facilitate change.

She had been a singer and loved music but her husband watched a lot of television with the result that she no longer felt able to listen to music although it was important to her and helped her relax. She talked it through and then felt empowered to make plans to achieve change through negotiation with her husband.
As the nurse commented in the interview at the end of the study:

“it’s actually given her courage and strength to talk about her relationship within her household. That has opened quite a few doors for her and it’s made her kind of manage things a wee bit better at home as she was becoming very resentful and things about the home situation. It was making her think a bit more about that and how she could maybe have coping skills about trying to detach from the situations that make her eat more and stuff like that”(R).

The nurse’s interpretation that coping skills were developed seemed to be borne out in the action map. The action map also illustrated how self-reflection was facilitated leading to empowerment of the individual.

### 6.7.3.2 Self-reflection/empowerment

R01 had lost 5kg when other influences came into play as can be seen in the following items from one of the action maps (Table 6.6)

<table>
<thead>
<tr>
<th>Identified area</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>Exercises in bed increased</td>
</tr>
<tr>
<td>Pastimes</td>
<td>Exercises before needlework</td>
</tr>
<tr>
<td>Activity</td>
<td>Hoovering every day</td>
</tr>
<tr>
<td></td>
<td>Moving around more</td>
</tr>
<tr>
<td>Eating and drinking habits</td>
<td>Smaller portions of food</td>
</tr>
<tr>
<td></td>
<td>Drinking lots of water</td>
</tr>
<tr>
<td>Support</td>
<td>Negotiate change (smaller plate)</td>
</tr>
<tr>
<td>Social</td>
<td>Have had visitors on and off for 3wks not helpful with diet</td>
</tr>
<tr>
<td>Feelings</td>
<td>relaxation</td>
</tr>
<tr>
<td></td>
<td>Music I’m enjoying</td>
</tr>
</tbody>
</table>

Table 6.6 Action Map for R01
In the action map R01 identified that over a three week period there had been many 
visitors with the result that her eating pattern was different and she had gained 6kg. Her 
pain levels also increased at that time. Realisation of the influences of social and 
physical issues on her eating pattern may have helped her with the aid of the nurse to 
develop better ways of managing these difficult times. This would seem to be the case 
as, at a later date, when again many visitors and an increase in pain occurred, there was 
a much smaller weight gain of 0.6kg. At that time her joint pain was so severe that she 
required a steroid injection.

It would appear then that completing the booklet was “very helpful, wish I had been 20 
years younger though!” and in combination with regular, empathic contact with her 
“wonderful nurse” had helped her reflect on the influences on how she managed her 
weight and was empowered to make changes.

6.7.4 Knowing the individual

Nurses talked about knowing their patients on different levels. There was a superficial 
level when trying to accommodate appointments “once you get to know the patients, 
you know when they like to come early in the morning and get on with things”(T). Then 
there was a more personal level where “you get to know your patients and quite often 
they have a weight problem. It’s quite a, you know, if you suggest they are overweight, 
you see the barriers going up straight away with some patients” (C). The final level of 
‘knowing’ was much deeper and achieved when a trusting relationship had been 
established. “I got to know her a bit better. Yes, she opened up to me in the end and at 
the finish of this approach with her”(Q).
Using the materials appeared to help another nurse to get to know one individual on a deeper level and resulted in him being able to open up to her. At first he was unsure of the materials but the uncertainty was negated through working in partnership with the nurse and his wife.

“Even the chap who thought ‘oh this is going to be too much, all these pages and all this bother, in fact, as I was showing him the booklet, he thought ‘och’ but when I actually worked through each page with him you could see he thought ‘Yeah’, but he still wanted his wife to read it to fully understand it…. He came back very interested. She thought it was great. I think they will use it quite well” (J)

The final outcome is unknown as he had to be excluded from the final analysis, due to the time restrictions of data collection but this approach appeared to help him to open up.

“The guy I actually did it with, he was just about in tears, you know, he was actually, because I think he realised, I can’t remember if I told you. He was the chap that his wife had written in a little bit beneath the reasons why - the three things they wanted to change. First of all she’d written in his weight gain had accelerated since his brother died very suddenly four years ago and he hadn’t spoken to him for three years so that was a major trigger” (J).

This suggests the possible utility of the booklet in helping individuals identify issues of which they had previously been unaware. It appears that completing the weight management map raised bereavement issues for the man who had not previously
realised the connection between his brother’s death and his own weight gain. However, it could be that this connection may not have been made without the aid of his wife. Whether this indicates a gender difference is an issue for debate. Nonetheless, identification of the problem meant that he could then make appropriate plans to deal with the bereavement issues thus subsequently enabling him to lose weight. It also demonstrates the value of looking at the whole person as unexpected triggers can emerge.

6.7.5 Self-awareness

Nurse A agreed that individuals were not always aware of what influenced their ability to manage their weight and that using the booklet in the partnership was helpful. “I think it promotes discussion when you’re looking at all these other areas and the patient may be unaware that these areas impact on their eating habits so it was definitely relevant”(A). This was confirmed by one of the individuals she recruited who felt that the most helpful part of the approach was being “helped to identify with nurse changes I needed to make”. The result was that he had “stopped eating rubbish” and “continue(d) to exercise”(A01).

Even if individuals became self-aware they still required support. “Support from nurse”(R02) was identified by one individual who made changes such as “Not buying certain foods (biscuits,cakes); tried to facilitate more hobby time; recognised stress/eating link”(R02) as being important. It seems that taking a person centred holistic approach may be of benefit to individuals. An example of the outcome in failing to access support in spite of becoming self-aware is demonstrated in the following case study.
A 44yr old female (S04) with a BMI 30.2 appeared to have been helped to realise that she had to make changes. Unfortunately, when returning for a follow-up appointment her usual nurse was on holiday. She did not feel able to discuss her weight management with the other nurse, probably because she had not built up a trusting relationship with her. In fact, she did not want the nurse to see the booklet. This meant that while the most helpful part of the ‘holistic approach’ for this individual was that “It made me admit I have problems with my weight and how I manage it”(S04) her unwillingness to share these insights with the other nurse meant that she could not support her in an appropriate way. The working partnership was diminished and the individual did not return for some months resulting in a 4 kg weight gain. It would therefore appear that the booklet, the nurse and the individual may each have a crucial part to play in weight management once mutual trust has been established.

### 6.7.6 Responsibility

Working in partnership with PNs to take responsibility for their own health may not be easy for some individuals. Previous consultations with health professionals may have taken the ‘passive patient’ approach, which tends to encourage dependency but individuals in today’s health service climate are encouraged to take some responsibility for their own health. Both nurses and individuals sometimes found this shift of emphasis difficult. “People come expecting you to tell them what to do”(W). but this may not produce results according to nurse T. “I know for a fact that if the doctors tell them to lose weight it never works. It just never works because it is not coming from them”(T). However, even by taking a different approach and inviting individuals to participate in their care may not work either. Nurse V highlighted that people “expected me to do more of an instant fix rather than sending them away to think about
this, that and the next thing”(V). They were unwilling to take responsibility by “doing some homework and I think people weren’t prepared to put the effort into it as well as not wanting to hear what the results were saying”(V). The lack of effort as identified in attribution theory and associated poor outcomes appears to be endorsed by the individuals who wrote that he “found that all the help in the world won’t work if you yourself are not dedicated to making the changes”(S01).

It does seem that the holistic approach did encourage individuals to be less dependent on health professionals and take some responsibility for themselves.

“I think it made the patients take equal responsibility which is quite important here because we do have a population that’s, they’re quite dependent on what the medical profession say and they’ll do but primarily they don’t seem to take on the responsibility for that. They think it’s okay just to turn up at the surgery and, oh yeah, well I didn’t manage that or you know because”(R).

She specified how the individual’s booklet gave an opportunity to challenge people.

“I felt that working with the paper exercises of it, you can say to the patients, well you’ve put this down. How well have you got on with that or has there been a problem with that or is there a different way of managing that or have you maybe tried this”(R).

Therefore, it appears that writing things in the booklets assisted not only the identification of problem areas but also in assessing progress for both individuals and
PNs. It may have helped individuals take responsibility for making changes but also challenge them if no changes had been made.

Several individuals agreed with this. For example, A03 who found the most helpful part was to “put ideas/thoughts on to paper”(A03) or as S01 put it “having things written in black and white”. It also helped them to focus on areas for change. “I knew most of the areas I needed to think about already, but it was a useful tool to reinforce them and make me focus on my weak areas”(S02). As a result it helped them to take responsibility for making these changes. “Took control of what I ate and drank. Can’t blame anyone else if I go wrong”(S01).

However, Q03 pointed out that, “The individual needs to want to lose weight and although the map helps to clarify reasons, the individual may need more help than that.” One individual who found the weight management map not that easy to complete suggested that the nurse played a vital role in that situation. “Needed time with nurse to clarify and make it clear” although she commented that it was a “really good idea”(R02).

Although the weight management map appeared to be an important component for clarifying problem areas, the working partnership between PN and individual would also seem to be a vital aspect in providing further clarification before changes can be implemented.

Having examined the overall picture of how PNs and individuals work together in partnership the following section provides a more in-depth look at two specific practices.
6.8 Practice comparison in context

Two practices were selected on the basis of weight outcome for more in-depth examination. Three of the five individuals who gained weight over the duration of the study came from the same practice. Therefore, this practice (G) was selected for deeper exploration along with practice (B) where individuals lost most weight.

These two practices were set in rural locations, each having two GPs and a single practice nurse. For reasons of confidentiality the practices were given the codes of B and G. The two nurses shared a lot of similar attributes as shown in Table 6.7.

<table>
<thead>
<tr>
<th>Nurse</th>
<th>B</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group in years</td>
<td>40-49</td>
<td>40-49</td>
</tr>
<tr>
<td>Years qualified</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Years in primary care</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Hours of work</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Areas of work</td>
<td>Diabetes, CHD, hypertension, Cervical cytology, Asthma, COPD, Weight management, Travel health, Phlebotomy</td>
<td>Diabetes, CHD, hypertension, Asthma, Weight management, Travel health, Phlebotomy</td>
</tr>
<tr>
<td>Diplomas</td>
<td>Diabetes, cervical cytology, Asthma, COPD</td>
<td>Diabetes, asthma</td>
</tr>
<tr>
<td>Comfort at raising the subject of weight</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Confidence in helping people manage their weight</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Obesity training</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Recruits</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Drop outs</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 6.7 Table of background information for nurses B and G.

Note: 1 individual in practice G developed lung carcinoma after recruitment and died.
When it came to select individuals to take part in the study both nurses, in common with all the other nurses, targeted those who had previously been attending for weight management. In spite of commonalities between the two nurses, apparent differences in their approach to weight management began to emerge. Practice G, where individuals had weight gain, is the first to be addressed.

6.8.1 Practice G

Nurse G was one of the nurses with least experience of primary care nursing but one of the best recruiters for the study in spite of having only one month to do so. It appeared that in this practice, as in others, there was an expectation that the nurse would take on the role of dealing with weight management as it was “something that seems to fall on to the practice nurses and the GPs are a bit bad at sending the people through - to go and see the nurse about losing weight”(G). Although she initially indicated that she felt comfortable and confident about taking on this role (see Table 6.7), during the interview this was less evident.

“Certainly since I came into post they’ve used me. I mean they did sort of discuss and I said yes, I was happy to see people but never felt I was really skilled at it. I’ve certainly had no training. It’s a bit adhoc and I’ve managed to get leaflets from health promotion and various reps and things which we’ve sort of gone through, so nothing terribly structured”(G).

Although nurse G undertook weight management as requested by the doctors she was uncertain about how to go about it. In addition, she did not appear to have a great deal of control over the appointment system. All appointments were 10-15 minutes with no
variation for the different chronic diseases. She indicated that she would have liked more time with individuals for the study.

“I always seemed to be a bit pushed for time with this and I think it would have been nice to have longer, to have half an hour or something with them….I can get them to come in for double appointments but often if I haven’t made the appointment the girls don’t know to do that or the patient doesn’t ask so it doesn’t happen. It’s just a fault of the system” (G).

The ‘knock on’ effect was that while seeing the need for longer appointments not being able to arrange them so that she could “try and talk through” (G) with individuals meant it may have been difficult for her to develop any in-depth relationship. This, however, did not appear to be the only impact on nurse-patient relationships.

There seemed to be a lack of trust as she was sceptical about individuals telling the truth because she

“went over what they’d changed, what the progress was but equally they seemed to be doing all these things and they identified the actions they’d changed, their progress seemed to be good and yet they just weren’t losing weight. So you begin to wonder were they just telling you a piece of, you do, you know.” (G).

The lack of trust in a relationship prevents people from being more open and honest as they may feel they are being judged.
If this is the case it may explain why individuals dropped out of the study in this practice. Nurse G saw two reasons for this.

“Some of them are just poor attenders, they’re working, they can’t fit their appointment into our times. The times aren’t always that great because I don’t go after 3 o’clock. It’s hard for the workforce to come. I equally think they knew they weren’t losing weight and they didn’t want to come back. …they probably feel guilty or they’ve let you down, you know, they’ve failed. Maybe you’ve put all this work in and they’re not doing their bit” (G).

The idea of patients not playing the game was emphasised when she talked about recruitment. “I’d no difficulty recruiting them. They all said ‘Oh, yeah’. Like I probably could have had more but the difficulty was sort of hanging on to them and getting them to tow the line” (G). It appears that it was difficult for individuals to maintain motivation even for regular attendance.

Nurse G was good at data collection but appeared to view the study in a mechanistic way as she talked of following the protocol step by step and completing the paper work. When she mentioned the benefit individuals gained from completing the booklet ‘My Personal Approach to Weight Management’ and how it made them think, her thoughts focused more on obesity related diseases.

“It really made them think about why they’d got to that stage and why they, let me see, they have to think back to when their weight problems started and identify their own health problems and things. That was really quite a good
exercise I think, for most people and what previous approaches they’d tried and,
as I say, a lot of them had tried lots of them”(G).

However, since she was one of the last nurses to come into the study there may have been an issue about the individuals she recruited as she recognised “It’s not for people going for the quick fix which may be some of these people”(G) or they may simply not have been ready to address their weight problems. When asked about any issues that individuals raised when using this approach she replied, “Nothing really that I wouldn’t have expected”(G). As can be seen in the following case studies using the holistic approach did not aid the development of a partnership with individuals.

When one 34 yr old female (G01) with a BMI of 31.6 returned her ‘weight management map’ she had written “I have cravings for food…..I get angry with myself and can feel guilty after I have eaten lots” indicating the possibility that she was a binge eater. This was not explored, probably because Nurse G, not surprisingly, would be unaware of the possible link. The individual also kept cancelling appointments thereby providing no opportunity for their professional partnership to develop. Had the relationship developed it may have provided a safe environment in which the individual could reveal more or allow clarification of what she meant. Nevertheless, as will be seen later, Nurse G did not see the depth of this approach as being very relevant for the individuals she had recruited.

Even for those who attended regularly, like the 61 year old mother (G04) of the previous individual (G01), the outcome was weight gain. During her time in the study she changed from Class I to Class II obesity. Her weight appeared to be influenced by socio-cultural issues and demonstrates that including social issues are pertinent.
The family were very sociable and lived in a farming community. Nurse G gave an example of the difficulties of this social culture. Kittens born on the farm were given to friends. Since there was no charge, chocolates were given as a ‘thank you’ putting pressure on the mother to eat them. Nurse G seemed unsure as to how to help the mother deal with these situations highlighting the need for further education in addressing cultural beliefs to aid individuals to reflect and develop better coping skills.

The only other individual to attend regularly was a 75 year old with multiple co-morbidities (G05). The three key areas she wanted to work on were

- I would like to sleep better
- Have more confidence in solving my weight
- I would like to be healthier

In spite of this all her action maps although very specific were entirely food focused. In fact, all the ‘action maps’ returned from individuals in this practice were food orientated with occasionally a brief mention of activity as seen in the following Table 6.8

<table>
<thead>
<tr>
<th>ID</th>
<th>Action 1</th>
<th>Action 2</th>
<th>Action 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>G01</td>
<td>Eat more fruit and exercise work out to try and lose stomach</td>
<td>Replace chocolate biscuit with plain biscuit Stop eating between meals esp crisps</td>
<td>Make time for walks regular especially after meals</td>
</tr>
<tr>
<td>G04</td>
<td>Trying to cut out between meals</td>
<td>Eating strawberries without cream</td>
<td>Having new potatoes without butter</td>
</tr>
<tr>
<td>G05</td>
<td>Have 1 digestive biscuit instead of 2 at night with ovaltine</td>
<td>Have 1 crackerbread with morning tea instead of 2</td>
<td>Really try to avoid salted peanuts as a snack. Try fruit instead</td>
</tr>
</tbody>
</table>

Table 6.8 Action maps for G01, G02 and G03.
Since the holistic approach is different from the traditional ones in use, the expectations of both nurse and individual may have been that food would be the focus of the goals. This is a feasible argument since Nurse G had acquired dietary knowledge and the individuals had “tried everything before… They had all been dieting before”(G). In addition, the individuals who returned the questionnaires indicated their satisfaction about their experience of using this approach. They also indicated that they had made changes. One individual wrote that “knowing what to eat” and “visiting the nurse to weigh you” (G04) was most helpful. The least helpful part for another individual was “actually making myself do it. Will power was needed”(G01). These comments seemed to confirm that consultations were in line with traditional approaches.

It would appear, therefore, that Nurse G may not have entirely understood this approach. Although individual needs were acknowledged it appeared that addressing these needs in practice was difficult for Nurse G. Therefore, whether this approach was unsuitable for these individuals is debatable. It is more likely that the convergence of several factors influenced outcomes. Some of these issues could possibly have been avoided had there been more coaching time. The researcher and nurse had only one hour on a one to one basis prior to implementation of the study in this practice. While Nurse G acknowledged the need to improve her knowledge of obesity management “I still feel I could do with maybe some training or something in that aspect of things.” she did not access the available continued support. Neither the opportunity for the researcher and Nurse G to see an individual together nor the support offered by email and phone were taken up. The only opportunity for further learning was during visits by the researcher to the practice for the purposes of data collection. Unfortunately, these were limited in time due to nurse workload and frequency due to distance.
Nurse G’s lesser experience in primary care; short recruitment time; limited appointments in both length of time and time of day; difficulties in developing a partnership and insufficient learning opportunities with the researcher may all have influenced outcomes. It is also possible that her limited education on weight management may be why she focused on food and tended to ignore a more holistic approach but this was not a finding in any of the other practices.

6.8.2 Practice B

Nurse B acted in an advisory role with the local health board in addition to working in the practice. Unlike Nurse G she had several months to recruit and recruited only two. The two individuals she targeted had tried many times to lose weight in the past, and in many ways, including hypnotherapy and counselling. Nurse B decided to recruit two individuals for the following reasons: “They both had diabetes as well and both very overweight and both very unhappy as well. I thought they were the ones who to me were likely to be motivated to do something.” She felt extremely comfortable about raising the issue of weight and saw it as “part and parcel of a lot of the chronic diseases as well, especially diabetes”(B). For initiating the study she was able to allocate a 30 minute appointment as she had complete control over her appointment times and varied them according to the need of patients and communicated this to other members of the practice team.

“The receptionists have got a list out front that I’ve made up. How long things take, for example, the longest appointment would be someone who is coming for spirometry with reversibility. That’s quite a long appointment. It can take 40 mins and it takes a bit of organisation as well. Other things like chronic disease reviews, they are 20 minutes, smears are 20 minutes. The shortest appointment
I have is a 10 minute appointment and that might be for blood pressure checks, blood samples”(B).

As well as having control over practice appointments, Nurse B, can decide on whether or not to refer individuals in her care. Part of the reason was that there was a “real lack of dietetic input, timewise, manpower. There’s a severe shortage”(B) but she also took into consideration whether or not it was advantageous to the individuals.

“I refer all the diabetic patients to the dietitian but sometimes the feedback from patients is not always positive. They’ve had to wait a long time on the appointment. They weren’t told anything they hadn’t been told already in practice and they’ve got to trail up the Infirmary to be seen as well.... I tend not to refer obese patients”(B).

She recognised that the holistic approach to weight management was different from traditional ones and explained what it was that encouraged her to explore it’s potential utility in practice.

“Well, I just thought it sounded really different, interesting and overall practice nurses are all desperate to find ways to deal with weight management because it’s such a problem. The sound of it, the holistic sound of it, sounded really interesting to me in making people look at themselves inside as well, you know. Not just a case of weighing them once a month, you know”(B).

However, on receiving the support materials for the holistic approach she expressed some initial reservations, although they soon subsided.
“I think, initially I was concerned at the sort of depth of it, I guess you would say. The reading involved, the amount of work. We all want an easy life. None of us want extra work, filling out forms and things if you think it’s not going to do any good. It really has made them look at themselves in a different way and try and address the real issues rather than just, you know. They were both fed up to the back teeth of diets and you know, just life was taken up with thinking about food. So this has made them look at different aspects of their lives”(B).

Her experience of using the holistic approach was quite different to that of Nurse G. The two individuals she recruited were friends and wanted to see the nurse together. While the approach was intended solely for use with each individual, the researcher did not want to impose restrictions as both nurse and the two individuals were keen to work on it together. After all, the idea was to test the utility of this approach in practice.

Nurse B’s willingness to accommodate their request indicated how her practice was flexible and person centred. The researcher was invited to share the first consultation during one of the outreach visits to the practice and this seemed to help her understanding of the approach and how to use it. “I certainly found it helpful to have you there at the initial consultation to go through it because I didn’t feel confident in myself not being involved in it’s make up”(B).

Following that initial consultation the researcher and Nurse B kept in touch by phone and email which provided the opportunity for both to learn from each other. In emails the problems of seeing two individuals simultaneously were discussed. In particular,
the fact that they had different problems and the consultation was focused more on one than the other. In a later email, Nurse B conveyed

"Interestingly B02 phoned me in the pm and said she was worried that B01 wasn’t getting a chance to open up. She asked if I would phone B01 and make sure she was happy for B02 to be there.”

They still wanted to come together but as subsequent visits became more in-depth a slight tension began to creep in. Nurse B was sensitive to this and took the opportunity when circumstances allowed, to separate the appointments. This permitted both individuals to gain more from the consultations without compromising their friendship.

"Certainly one of them was far more open about things after looking at the book. In fact, we’re considering even a referral to psychology for her. She’s thinking about that at the moment to try and address some of her issues that she has which go right back to childhood really. She has an adopted daughter and she worries about her weight and she’s worried that she’s not being a good role model. The booklet certainly has made her aware of her role as a mother and how she can be a good role model to this girl” (B).

Nurse B explained how the partnership had developed and benefited both of them. She spoke of knowing the individual on a deeper level and how this helped trust and openness to evolve thereby leading to better outcomes.

"I have been seeing her very regularly and she’s someone who I knew a little bit before but not very well. I feel we really have formed a very close relationship,
professional obviously and she feels comfortable. She always comes to the appointments whereas before my previous experience of her was that she was a bit of a non-attender which made me think she was burying her head basically and didn’t want anybody telling her what she was doing wrong and you know, she didn’t want to hear it really, I think before. She’s someone who’s been sent to me. She tends to be sent to me when she’s not towing the line. She’s someone who also has asthma and smokes. She used to use God knows how many ventolin inhalers in a month. We would try to address that. We tried to make a proper diagnosis. We tried to get her to use inhaled steroid and she wouldn’t have it really. She wasn’t interested but I think things in her own personal life changed as well. Her marriage broke up and she’s on her own now with this girl and she’s really had to come on has learned to drive. She had to sell the family home and she lives in a horrible flat in a horrible estate. Her husband had told her she would never do it so things have changed in her own personal life too. Maybe we were just lucky that it was the right time to approach her and she attended very regularly and was very happy to come to me and talk about all sorts of issues in her life. At the same time has managed to lose some weight so we are encouraged.”

This demonstrates how the development of a real partnership can help people change. It also showed that Nurse B had insight into using a holistic approach. It seems that this approach encompasses both the art and science of nursing when sometimes “You’re seen more as a sounding board or a support rather than a sort of clinician, if you like”(B). It is acknowledged that taking a holistic approach is not an easy option for either nurse or individual but the partnership can prove beneficial.
One morbidly obese, 49 year old female (B02) started the study with a weight of 113kg (BMI 48.9). She had enjoyed swimming in the past and decided that she would try it again. Due to mobility problems she found it difficult to get in and out of the pool so made arrangements for the use of a hoist. She had been several times when the hoist broke. Unfortunately, the attitude of the pool attendant made her feel that she was to blame. In the past this would have made her comfort eat but through completing and discussing the map with Nurse B she learned how to cope better with stressful situations. “The map brought up feelings about myself and the way some people reacted to me. This was very difficult at times.” (B02)

Learning new coping strategies takes time and sometimes the situations very stressful. Unfortunately, when her daughter was hospitalised and required emergency surgery she coped less well resulting in some weight gain. Nevertheless, overall she still lost 2 kg during her time in the study and was not disheartened. For someone with such complex problems this was a good start and she certainly valued the partnership built up with her nurse. “My nurse is wonderful. There is no pressure, and I hope to continue until I reach a good weight. Thanks!” (B02)

The following extracts from her booklet reflect how useful the weight management map may be in identifying areas for change and seeing what has been achieved. (Table 6.9)
<table>
<thead>
<tr>
<th>Weight Management Map</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular activities</td>
<td>Dog walking</td>
<td>Walking</td>
</tr>
<tr>
<td></td>
<td>Garden</td>
<td>swimming</td>
</tr>
<tr>
<td></td>
<td>reading</td>
<td>stairs at work</td>
</tr>
<tr>
<td>Eating and drinking</td>
<td>Too many take-aways</td>
<td>Less take aways</td>
</tr>
<tr>
<td></td>
<td>Meals are OK but too much snacking choc and</td>
<td>Still snacking a bit</td>
</tr>
<tr>
<td></td>
<td>biscuits</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>Going upstairs is a problem</td>
<td>Improved</td>
</tr>
<tr>
<td></td>
<td>Sore feet sometimes</td>
<td></td>
</tr>
<tr>
<td>Feelings about myself</td>
<td>Still tend to run myself down</td>
<td>Up and down but less</td>
</tr>
<tr>
<td></td>
<td>More confident than I used to</td>
<td></td>
</tr>
<tr>
<td>Body dissatisfaction</td>
<td>Everything!</td>
<td>Pleased that I’m feeling better but still hate my body</td>
</tr>
<tr>
<td>Benefits of weight loss</td>
<td>Health improvement</td>
<td>Fitter</td>
</tr>
<tr>
<td></td>
<td>Feel better about myself</td>
<td>Clothes</td>
</tr>
<tr>
<td></td>
<td>Clothes</td>
<td>Example to K (daughter)</td>
</tr>
<tr>
<td>Beliefs about weight management</td>
<td>Need to get organised properly</td>
<td>I’m sure I can do it if I can keep reminding myself</td>
</tr>
<tr>
<td></td>
<td>More exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control fats and sugars</td>
<td></td>
</tr>
<tr>
<td>Social contacts</td>
<td>Limited outside work</td>
<td>Still same small circle of friends and sister</td>
</tr>
<tr>
<td>Support</td>
<td>Not a lot in family apart from my sister</td>
<td>Sister</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse</td>
</tr>
<tr>
<td>Health problems</td>
<td>Diabetes</td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td>Self-esteem</td>
<td></td>
</tr>
</tbody>
</table>

**Table 6.9 Before and after weight management maps for B02.**

Her 53 year old friend (B01) was taller and weighed 143 kg giving a BMI 51.3. Her problems were less complex but nevertheless difficult for her. Her husband had a long-
term illness and with the addition of other family commitments she had no time to herself. With encouragement she too looked at herself in a much more holistic way and decided to build in time during the day for herself and targeted three key areas for action.

- To walk better
- Not feel so guilty
- To have a hobby

These key areas reflect how different this approach is. Later she also went swimming with her friend but there was no ‘weight management map’ completed at the end of the study to document changes. Although she was less diligent about completing the booklet, perhaps recording it elsewhere as Nurse B explained when giving comments on the booklet

“I think it’s a good diary, if you like, of progress. It’s a handy size, although one of my patients did comment that she would have preferred a sheet that she could put up somewhere that she could refer to. She knew what it was and it would remind her. The book she tended to leave it lying about and then forget where it was”(B).

Confirmation was given by B01 when she wrote comments about the ‘Weight Management Map’. “I would prefer a poster format that I can put on the kitchen wall so I don’t lose it and see it more often.” An additional thought about ‘My Action Map’ was also expressed. “A wipable one can be upgraded as you progress”(B01).
These suggestions showed that she took ‘ownership’ of this approach and wanted to personalise it for her own particular needs and this may partly explain why she lost 7kg.

The two individuals who were recruited in this practice seemed to have been helped to take a much broader view of obesity management than those from practice G. Although, in common with some others, “The initial thinking about it” (B01) was important and another change had taken place in that it helped her to “focus more on the successes (with rewards) rather than on failures” (B01). She did not specify in the data what these rewards were but her friend aimed to reward herself with “a few days away” (B02). B02 also demonstrated that sometimes before any food or activity changes can take place other adjustments need priority. “That feeling better about myself doesn’t need to be losing weight. Liking myself more for who I am.” (B02). This starting point can then lead to “making me more conscious that losing weight makes me feel better in myself” (B02). Only once confidence is gained does weight management become beneficial and not cause such negative feelings.

The following is an example of an individual in one such practice. She (W03) had long term weight problems and a number of years previously had been referred to specialists for weight management without success. More recently, while taking part in this study, she had been prescribed Xenical and later Reductil, again without success. She, in common with another individual in the practice believed that “diets have been proved not to work for me” (W03). Ingrained beliefs such as these are very difficult to deal with. In spite of viewing the booklet as being good she did not find it at all easy to identify and decide on areas for action with the nurse. Her comment that “overeating was never the problem” (W03) might indicate that she felt as if she were being accused of overeating and therefore, her experience of using the approach was very poor.
However, at a later date, it may be that as the therapeutic relationship built up with the nurse she was helped to be more self-aware and honest with herself resulting in a loss of 3.5kg. Progress may have been hindered by a lack of support from other team members in practice.

Having examined in depth interactions between PNs and individuals on a one-to-one basis, the following sections looks at how PNs view the holistic approach to weight management generally, including those PNs who were unable to recruit.

6.9 Filling the void in weight management

This section provides feedback from PNs on their general experience of using the holistic approach to weight management. An emergent theme from using the holistic approach was that it appeared to ‘fill a void’ in weight management although there were also limitations to it’s use as demonstrated in the following categories: time issues, fear of unknown, credibility of materials, changing practice, working in partnership, taking a holistic approach, not for everyone and future use, as shown in Figure 6.10
6.9.1 Time issues

Time was a scarce commodity making implementation of this approach difficult for nurses especially as most of them had to incorporate it into their existing time schedules.

“My only problem is the time factor. Not just for my personal approach way. It’s like for anything that you have to motivate people and help them change their behaviour. You don’t have the facility or the time factor so this is all done in a 10 minute slot”(S).

However, for those who could spend longer with individuals it seems that the benefits outweigh the time required.

“I feel it’s probably quite time consuming BUT obviously the benefits are there if you are willing to put in the effort and the work and the time because it’s not a
quick 10 minute appointment. Then hopefully the benefit of that would encourage you to use it more" (B).

This approach was not intended as a quick fix but takes a long-term view. Even individuals who gave encouraging signs that they intended to make changes permanent realised that change took time as there were “still areas I want to change but am taking it slowly” (S01).

6.9.2. Fear of the unknown

Although PNs viewed the educational booklet ‘A holistic Approach to Weight Management’ as relevant, most of them found it initially daunting. In addition to the format of the booklet, part of the reason for the initial feelings may be due to the holistic approach to weight management being “very different, completely different from anything I’d done before” (G). One nurse suggested that the A4 size of the nurse booklet was forbidding as “it looked like exam time” (S) so perhaps an A5 size would have been better. Her initial reaction of “Oh no, look at this writing” soon subsided when she “sat down with a cup of tea, and I enjoyed it, especially, as I say, the case studies. I can identify with that” (S).

Another nurse reported similar reactions

“It’s the fear of the unknown as well, you know. We’ve never had this before. I thought, oh God, what have I got into here, you know….BUT when you actually take the time to sit down and read it, it all makes so much sense and the two patients that I did have involved in it said exactly the same” (B).
Rather than the materials being daunting it was carrying out the study that made one nurse hesitate before committing herself. “When I saw that I thought ‘Yeah, that looks like a good idea and then I thought oh trying to get patients and trying to get them to follow it could be a hassle but then when I actually looked at it’”(J).

6.9.3 Credibility of the materials

Once the nurses had a look at the educational materials they became more enthusiastic. “It sounded a super idea and its well laid out and you think, this is something I could really use, you know” (F). For some there was too much depth in the nurse booklet but one nurse expounded her view on why this was required.

“I think there was a fair bit of depth there but I think obviously you needed to have some kind of evidence to back up what you were saying. You know, I mean you get a lot of stuff through the post or whatever and you think, yeah, that sounds great but where’s you evidence to back this up. But certainly there’s evidence there to back up what you were saying. I think that made it a bit more credible.”(K).

All the nurses liked the case studies. “I love the case studies, I think that’s the way to go for nurses”(S) for the following reason “I think it’s when you’re working with patients all the time that it gives you something to relate to” (K).

The patient booklet appealed to all the nurses who used it with patients.
“It appealed to me because it’s not a big huge thick book that I think patients would find daunting. I mean, if they saw pages and pages ‘oh, boring, before they even start. I felt it was quite a nice simple straightforward well laid out approach’ (R).

Nurses therefore found the holistic approach a credible, relevant and practical alternative to traditional ways of dealing with obesity. There was interest too from GPs in one practice. “It just happened to be mentioned in the coffee room so I jumped on the opportunity and showed the GP the info and stuff like that. She was really quite interested, you know” (J). The interest appeared genuine as the materials were acquired by others. “Two of the GPs have walked off with them” (J).

6.9.4 Changing practice

The materials had an effect even when nurses were unable to recruit for the study. Some took on board the holistic message for their practice.

“The material did bring that home to me that I hadn’t looked at it quite from, looked in more depth at it from a holistic, and that does take a bearing with your patients when you’re talking to them, asking them if there is any other things involved, and stresses and problems and what have you and taking that into account more so now” (V).

One nurse detailed the effect on her practice.

“I probably have made a lot of changes. Again, it boils down to this holistic approach. I think again I was very channelled in how I educated patients but now I think I can make them, you know, look at a much broader picture of their
life of what’s going on in their life to sort of then obviously be able to focus on their sort of weight management. Although I haven’t actually recruited anybody it’s definitely helped”(E8).

Her enthusiasm extended to thinking about “if there are going to be any future studies and I’d definitely be interested”(E8). However, another nurse seemed apprehensive about changing her practice.

“I would like to try and do things differently. So I’m gonna have to try and do maybe even talk to them a bit longer about getting – you know, bring feelings up and things, oh I don’t know, it’s just time, I think”(T).

Her uneasiness about addressing feelings may be why she was reluctant to explore this approach. “I should have gone into it a lot more”(T). She blamed herself for being unable to recruit the two individuals she approached, as it was “probably my fault that neither of them worked, really”(T).

In addition to raising awareness of what impacts on obesity the materials were useful. “Just being a bit more aware of the wider issues and to not focus in maybe just so much in on what people are eating and how much exercise they’re doing. You know, whether there’s maybe social things going on or whatever… I would definitely adopt the 10% thing, I think it is a good, a really good gauge to start with”(K).
When applying it to practice one of the nurses said, “It’s just having your finger on the button really and it turns weight management into something very concrete and quite important without them getting sort of obsessed with calories and things like that” (J).

The conversion chart also proved useful. “It obviously speaks volumes that it’s sitting her on my desk and I’m using it” (K). Another nurse who did recruit individuals pointed out the relevance of the conversion chart to practice. “You could see the light in their eyes when they had lost lbs but say half and kilo or point something. They say, well what does that mean anyway?” (S)

6.9.5 Working in partnership

Individuals had “never seen anything like this before and never been asked what they thought before. They have been told rather than being part of a partnership” (S).

The experience of working together in partnership with individuals seemed to add to the appeal of this approach for nurses as “It makes the person take part as well and take some ownership of it” (Q6).

6.9.6 Taking a holistic approach

One nurse said how “We were initially very focused on sort of diet a little bit of lifestyle where I think this was more as it is – a holistic approach to weight management. It looked a every aspect of their life so I think that’s where we were quite keen” (E). Another nurse explained how the holistic approach fitted in with her approach to practice by providing a framework. “It looked a really good approach and it looked as if there was a wee bit of a structured framework
to work towards. Although you say to patients, where do you live and what are the other influences in life, what are their personal beliefs and perceptions, nothing was put on paper”(R).

However, there were mixed opinions as to the suitability of the holistic approach for everyone.

6.9.7 Not for everyone

There were reservations voiced as to the suitability of the holistic approach for everyone.

“I felt that the patients needed to have a certain amount of hmm, how shall I put it, for want of a better word, enough savvy to really think about this. Not picking the ones that weren’t the brightest of the bunch because we do have one or two that I really don’t think would be able to get their head round it”(V).

This is a key issue when considering how to best to help individuals but in actual fact it was used by Nurse J with someone who had learning disabilities. Her carer helped her to complete the booklet and she started losing weight although put some back on when becoming “excited about holiday”(J01).

Another potential difficulty was the lack of literacy skills. It had been anticipated and was highlighted by the experience of Nurse A. “I didn’t realise one of them had difficulty reading so that was a problem for her and it ended up we wrote out the book together. I wrote what she told me”(A).
Nurses tended to select those ‘heart sink’ individuals who had tried many times in the past to lose weight. It seems that the advice giving of prior interventions were not always successful. “It’s all very well giving the advice if they take it and it works then that’s fine. If it doesn’t then it’s not so easy after that.”(V). Judging by the results of this study it would appear that the holistic approach is particularly suited to weight management, in particular those who are in the higher BMI bracket and individuals with long term weight problems.

6.9.8 Future use

Most nurses said they would use this approach again and some asked for more booklets to use with other individuals post study. One nurse, however, could not “see myself being able to commit that sort of time again”(A). Others suggested that if it was modified they would consider using it. The part that everyone agreed caused greatest difficulty was the design of the ‘action maps’. They were “a bit complicated”(S) and “a wee bit fiddly”(J) resulting in individuals “struggling to fill that bit in”(Q). Although nurse R agreed she said that “once they got the hang of it they were up and running, they were away ahead of me. Basically, with that wee bit extra time they seemed to kind of, you know, manage quite well”(R). The researcher took on board these messages so the action maps were adapted (APPENDIX 20) on completion of the pilot study to make them simpler and provide more writing space. It is hoped that with the adaptations time would be saved.

Some nurses said they would be selective in their future use because
“some people don’t have huge problem with it but would like to just be monitored. The fact that they are coming to see someone, something to aim for, sometimes that’s just enough for people and not everyone can afford to go to clubs and things”(B)

but use it with “probably people who are grossly overweight and had to have very risky health problems due to their weight”(B).

Others saw the potential for using the approach with everyone. “I would like to even use this first hand, right at the very beginning for everybody”(R). One nurse thought she would “use it quite a lot because it is a rising problem in our practice”(J) and again specified “I will use it with like people coming newly to me”(J). Opinions as to the value of this tool for every individual therefore differed but the final word is given to Nurse J. “I think having a structured positive holistic tool like this I think I would hopefully, my patients would benefit more. It’s not my success, it’s their success”(J).