Chapter 7
Discussion of the relevance of a holistic approach to weight management in primary care

This chapter begins by looking at the effectiveness of the holistic approach to weight management in terms of weight loss before going on to examine the relevance of identifying different aspects in relation to the whole person. The difficulties of implementing the holistic approach are then discussed, followed by further discussion on the utility of the booklets, the experience of using the holistic approach and the education and support provided. Consideration is then given to the role of practice nurses (PNs), particularly working in partnership with obese individuals and the influence this had on moving individuals towards self management. The difficulties of implementing weight management are considered next and finally, conclusions are drawn in relation to a holistic approach to weight management in primary care.

7.1 The relevance of taking a holistic approach

Overall, the holistic approach developed for this study appeared to have some impact on weight management. It seemed to have an impact on both those individuals who were overweight and also the nurses who used it in practice. However, it is accepted that this is a small study, although, there appears to be some positive outcomes in using this holistic approach as against ‘traditional’ approaches.

7.1.1 The effectiveness of the holistic approach in terms of weight change

In terms of weight change the results suggest that the holistic approach is reasonably effective in the short term. Due to the very small number recruited for this study no true
comparisons with other interventions can be made. However, some indication of effectiveness may be gained by examining the results with other UK primary care studies. In a randomised controlled trial, Moore et al. (2003) found that their intervention for obesity management made no difference. The more effective Counterweight (2004a) model provided greater detail thus allowing some comparison. There were similarities between Counterweight and the holistic approach in mean age (50.6 vs 49.6) and drop out rates (13% vs 14%). Recruits to the Counterweight programme had a lower BMI (36.9 vs 39.4) and had fewer co-morbidities (75% vs 100% with at least one co-morbidity). Fewer Counterweight subjects had lost >5% of their weight after three months (13.9% vs 17%). These results are promising in terms of short term weight loss judging by estimates of 10% success rates (Brown and Psarou 2006) but these comparisons should be treated with extreme caution. No conclusions can be drawn about possible long term outcomes of the holistic approach. Since most people regain lost weight over 5 years (Stern et al. 1995; Anderson et al. 2001) it would be necessary to undertake a much larger and longer study to gain such evidence but other factors also need to be considered.

There are many strands to the holistic approach and therefore many elements might contribute to it’s success or otherwise. The question is what components of the holistic nature of the approach made the difference. It is acknowledged to be a complex intervention (Campbell et al. 2007) looking at the whole person incorporating physical, social and emotional influences on weight management. PNs and individuals who were able to incorporate these perspectives were able to take a broader approach to intervention. There seems to be some advantage to looking at the whole person as it appeared to move people away from just being diet focused. It was apparent from the
findings that people were able to see the relationship between physical, social and emotional aspects of weight management. It also seems that having looked holistically at weight management they learned more about the relevant parts to work on (Thorne 2001). However, not all individuals and practitioners identified with the holistic approach, indicating perhaps, that this approach is not for everyone.

7.1.2 Identifying parts of the whole

The holistic approach identified areas which may not be identified in usual practice for weight management. For example, bereavement issues and being a good role model influenced different stages of weight management. Perhaps these issues came to light because of the holistic nature of the approach.

It appears that unresolved grief may affect how people manage their weight as indicated by the lady whose son had committed suicide. In another instance a man had come to realise that his weight problem began following his brother’s sudden death. On using the materials with his wife he realised the connection between his weight and unresolved grief perhaps showing the importance of spousal support (Cramer 1991; Koivaula et al. 2002). However, there seems to be limited evidence for spouse support in weight management (McLean et al. 2003) perhaps indicating the need to take a holistic approach.

While the usual focus is on how individuals can gain support from others, a different aspect of weight management emerged from this study. The weight management map helped one individual to become aware of her responsibility as a good role model for her daughter thus providing an incentive to make changes in her own life. Families tend to follow similar dietary habits (Rodin 1992) and since mothers are usually the principal
providers of food for the family (Benton 2004) they play a key role in the type of foods provided. The mother in this study planned to reduce her own consumption of take-away meals and snacks which have grown in popularity (House of Commons 2004) in an effort to be a better role model for her daughter. This tactic was also used by a father in a study by Jackson et al. (2005). Being a role model for physical activity is also important as Gable and Lutz (2000) found that television watching was associated with childhood obesity. However, parents who were active themselves and encouraged their daughters to be active were positive role models (Davison et al. 2003).

Coping in the wider community is not always easy as was illustrated by one individual who received a gift of chocolates from a friend. This gift which superficially appeared to be supportive, had a negative outcome. As gifts (Helman 2000) and friendship are so tightly bound there may be a fear of damaging the relationship if gifts are refused. One individual in the exploratory phase found that pressure from friends coerced him into having more alcohol than he planned. These situations demonstrate how influential friends, (Nestle et al. 1998) inadvertently or deliberately sabotage the actions of individuals trying to manage their weight. Friends, however, may not be the only influence on weight management practices.

One individual encountered negative attitudes at the local pool when she made a real effort to return to swimming. In the past, following such a negative experience she would have used food as a comfort. Her reaction on this occasion was different as she was able to see the broader context and take more appropriate action rather than allowing the rejection to drive her to food. However, helping obese individuals to address these issues may be difficult.
7.2 Putting the holistic approach to weight management into practice

Implementing a holistic approach to weight management is not an easy option as PNs not only have to help individuals deal with prejudice but also have to set aside their own prejudices (Brown 2006). It is argued by anthropologists that the ‘blame culture’ in obesity was associated with a puritanical attitude towards food in Northern Europe (De Garine and Pollock 1995) where a lack of discipline was viewed as sinful. Crandall (1994) agreed but further explained that from an attributional stance if obesity is viewed as controllable then individuals will be blamed for their lack of control and stigmatised. Weiner et al. (1988) further clarified that the perceived lack of control was seen as the obese individual being unwilling to make an effort to take control. One PN seemed to find it difficult to take a holistic approach and preferred advice giving but when that failed to have an effect she suggested that the individual go elsewhere for weight management. Health professionals taking this stance may tend to blame and stigmatise individuals. This behaviour could be at odds with the Nursing and Midwifery Council (NMC) code of conduct, which states that nurses must “respect the patient or client as an individual” (Semple and Cable 2003 p.41). It might be argued that the holistic approach to weight management proposed in this study provides the necessary channel to facilitate ‘appropriate behaviours’. Unfortunately, even health professionals such as physicians, nurses and dietitians who are involved in obesity management frequently, and in the researcher’s view incorrectly, relate poor hygiene, lack of will power and dishonesty to obesity (Puhl and Brownell 2001). It follows that these beliefs influence the approach to practice.
Implementing a holistic approach requires some means by which it can be facilitated. The approach taken here was of developing a booklet and weight map in which holism was utilised in conjunction with some educational support from the researcher.

7.2.1 Booklet for holistic care

The booklet ‘My personal approach to weight management’ was designed to aid the development of partnership working between nurse and individual in a holistic way. It seemed to strike a chord with most PNs who took ownership of the holistic approach as it reflected their own philosophy to care. Individuals likewise stated that the booklet helped them take control of how they managed their obesity unlike the study, by Currell and Urquhart (2004) who found the only benefit of individuals keeping their own booklet, was that they were less likely to be lost. The booklet in the present study appeared to achieve its aim of facilitating a holistic approach. It also helped some individuals to address issues such as reflection, taking control, trust and power sharing.

7.2.1.1 Weight management map

In particular, the weight management map, promoted self-reflection, leading to identification of areas for change. It was devised by utilising evidence from individuals in the exploratory phase. The inclusion of quotes from individuals from the exploratory phase may have been part of the reason why those taking part in the intervention found the map relevant to their own needs. Although care had been taken to include only a selection of quotes to stimulate the individuals’ thoughts about the way they managed their own weight that was not always the outcome. One individual was known to have used the map provided for the nurse. The map for the PNs contained a much larger list of relevant quotes from the exploratory phase. This was to help PNs be aware of the range of possible influences on weight management but not intended for use by
individuals. Unfortunately, it was used by one individual as a checklist and, in so doing, did not stimulate her to think about what influenced her own weight. That particular individual had a poor outcome suggesting that using the booklet on its own may not lead to appropriate weight management. Therefore, the weight management booklet needs to be used in conjunction with the nurse as stimulus for discussion within the nurse/individual partnership. Stromgren et al. (2001) had similar results where quality of life questionnaires completed by cancer patients provided a focus for discussion. Furthermore, they compared the questionnaires to nursing records to discover that although nurses were good at pinpointing physical impairments, they less often identified other areas of impaired well-being. This highlights that, rather than only the PN undertaking the assessment it is important to involve the individual. In this study, the weight management map provided challenge without blame, as it was the individuals themselves who identified their current lifestyle. A number of individuals provided evidence for this supposition when they stated that writing things down helped them realise what they needed to do, which is the first step to self-management.

However, the map may bring up uncomfortable topics. The legitimacy of encouraging people to do so may be debatable as not all nurses feel comfortable with this. The experience of one individual was that dealing with the issues raised helped her move forward and make changes to succeed in weight loss. Nonetheless, another individual felt that using the map was intrusive when it identified his depression. Care may be required in selecting with whom to use the approach and highlights the dilemma of helping people change without doing harm. These experiences underline the need for professional skills in dealing with unexpected situations that may arise.
7.2.1.2 Goal and action planning

It could be deduced that both the type of materials and the nurse/individual relationship were crucial for goal setting. Although individuals identified the components of their own lifestyles and the map concept seemed to help them see the links between various aspects, occasionally they did not carry that through to identify goals. It appears that working in partnership with their nurse to create a plan of action was particularly important in these instances. This seems to indicate some individuals find it difficult to implement goal and action planning without support.

It may be that the booklet and map in this holistic approach helps make a distinction between long and short-term goals. Writing down and reviewing the short-term goals seemed to help individuals create and achieve long-term goals with associated rewards. It would appear that when short-term goals reflect the individual’s own goals they are more likely to be achieved and avoid “the danger of disheartenment” (Roper et al. 2000 p.137). Furthermore, as happened occasionally in this study, focusing almost exclusively on food for these goals did not result in weight loss. This highlights the importance of taking a broader holistic approach to identify appropriate goals and action planning.

7.2.1.3 Written plans

The action map, where individuals wrote down their goals, achievements and rewards although very relevant was reported to be more difficult to use at first. A Cochrane review (Toelle and Ram 2006) suggested that the use of such written plans in asthma care did not necessarily improve outcomes. However, these plans were probably focused on medication and peak flow readings. Therefore, the plans were likely to be implemented from a prescriptive perspective rather than holistically as in the present
study where individuals reported that writing things down was very useful. The nurse and individual also worked in partnership to clarify outcomes but time pressures often limited discussion when using the booklet in consultations and this restriction in time may have compromised outcomes. Stapleton et al. (2002) who undertook research into evidence based leaflets in maternity care concluded that if materials were not discussed their potential was greatly reduced. Therefore, if good outcomes are to be achieved, sufficient time must be provided for these discussions. This is particularly relevant for the holistic approach where physical, social and emotional factors may impact on weight management and therefore require time to identify pertinent issues.

This study demonstrated that taking a partnership approach using the booklet ‘My Personal Approach to Weight Management’ could improve outcomes. In an editorial of a medical journal, Holman and Lorig (2000) asserted that taking a partnership approach does produce more effective outcomes. Koch, et al. (2004) in another asthma study demonstrated that where individuals were able to take control through partnership, they were able to alter their lifestyle and improve outcomes. Their conclusion was that “There needs to be a focus on providing people with the means to grow and learn in a participative relationship that cannot be fully realized with ‘off the shelf’ self-management solutions.” (Koch et al. 2004 p.484).

Regardless of being designed for use by everyone, the booklet in this study appeared to provide individualised care by aiding the growing and learning processes for both PNs and individuals. Nonetheless, although some PNs in this study were effective in assisting individuals with obesity management the evidence would suggest that it might not be suitable for every individual and may need further support. Furthermore, perhaps
a greater impact would have resulted if more support and education had been provided for PNs in practice.

7.3 Experience of using the intervention

Irrespective of support and educational needs it could be argued that establishing a therapeutic relationship is not instinctive to nurses and requires effort (Moyle 2003) and the emotional effort involved may be too taxing for some (Smith 1992). Some may prefer to keep a degree of detachment particularly if individuals are likely to want to discuss problems with which the PNs feel unable to deal (McQueen 2000). Hence the holistic approach taken in this study where the ‘weight management map’ appeared to raise awareness in individuals may have been more difficult for some nurses. Nurses may implement blocking tactics to avoid emotional issues disclosed by individuals if they feel uncomfortable and unable to deal with them (Wilkinson 1991). These blocking tactics such as ignoring individuals’ cues and changing topics may enable nurses to concentrate on their own agenda by maintaining control (Wilkinson 1991). Keeping control, it could be argued does not facilitate a holistic approach (Phillips 1996).

The setting in which nurses work also appears to have an impact. If they perceive themselves as having personal support from their practice hierarchy, like practice B, they may be less likely to use blocking tactics (Booth et al. 1996). Dealing with emotional issues, however, “involves feeling, and feeling involves personal vulnerability.” (Henderson 2001 p.131) which, perhaps for some PNS, may have too high a personal cost.
Several PNs who recruited individuals in this study appeared to feel very comfortable with the holistic approach, and this enabled them to introduce the subject of weight with individuals and encompass emotional care in their management. It appeared that the materials encouraged the therapeutic partnership as more than one nurse in this study indicated that the holistic approach was fairly intense but suggested that addressing emotional needs was not unusual in primary care nursing. In fact, one nurse stated that it was worth the time and effort thus providing a great deal of job satisfaction (Staden 1998). This was also the finding of Gallant et al. (2002) but according to Simpson (1991) “deeper feelings the patient has will become known to a nurse only if the relationship is a sound one” (p.96).

Phillips (1996) asserted that the first aspect of involving emotional work in the therapeutic relationship is for the nurse to provide reassurance and a ‘sounding board’ for individuals. One of the PNs in this study used the same terminology when she described working with individuals. It would appear that by “acting as a sounding board against which the patient may air his views and give full expressions to his feelings in a non-judgemental relationship” (Peplau 1988 p.226) she was implementing beneficial nursing care. The outcome of her therapeutic encounters in the study produced good results, which Phillips (1996) indicated was the second aspect of emotional involvement. Emotion, as mentioned earlier, is a key theme of Peplau’s model and is used to help the individual to develop better coping skills. It therefore appears that if a trusting relationship develops between PN and individuals, individuals can talk about their problems and be assisted to recognise their own reactions and coping mechanisms and learn from them (Pearson et al. 2005). By doing so may lead to changes in behaviour and improved coping skills when faced with new situations.
However, as also highlighted earlier, there may be a gender difference in confronting emotional issues. There was evident discomfort expressed by one man when the map raised his awareness of depression. Another man appeared to have difficulty either realising or expressing the relationship between his weight gain and his brother’s sudden death. These situations suggest that men may find emotions difficult to deal with or express. Emotional expression may be learned in childhood. It appears that parents respond differently to the emotions of their offspring as unlike girls, boys are punished for expressing sadness (Garside and Klimes-Dougan 2002). The result may be that in adulthood men are more reluctant to articulate their feelings and seek support (Burleson 2003, Ryan et al. 2005). Awareness of a possible gender difference may be important as it could be argued from the results of the exploratory phase that if emotional well-being is addressed weight loss would be the outcome. However, men may not feel comfortable with addressing emotional issues and so raises the question of the relevance of the holistic approach to both men and women.

7.4 Education and support

Whilst the booklets and partnership working appear to be essential for the holistic approach a further key component must also be a need for PN education as Brown et al. (2007) identified that there is a lack of knowledge and understanding about obesity management. Nurses are aware of their need to continually develop their knowledge and practice (Thomson 1999) but PNs in this study expressed their need for support and training in obesity management.

The booklet ‘A Holistic Approach to Weight Management’ aimed to provide at least a background to obesity and described a holistic approach to management. It produced
small changes in nursing practice in those PNs who were unable to recruit individuals and had no other input from the researcher. Grimshaw et al. (2001) included nursing education in a comprehensive overview of systematic reviews regarding professional education in health care. They found that while education had a positive effect on nurses, printed materials alone had minimal impact. A later systematic review by many of the same authors (Freemantle et al. 2006) came to the same conclusion.

7.4.1 Outreach visits
In this study, other methods of education were employed in addition to materials, including outreach visits. Grimshaw et al. (2001) agreed that outreach visits were generally effective and Fairall et al. (2005) concluded from their primary care study in South Africa that nurse practitioners had improved the identification and treatment of tuberculosis and asthma. However, there was no improvement in smoking cessation (Fairall et al. 2005) perhaps due to the restricted time that nurses had in consultations with individuals or a lack of skills to encourage behaviour change. O’Brien et al. (2006) included a smoking cessation study in their systematic review where outreach visits along with written materials and educational meetings proved successful. In addition to reminders and feedback, they also highlighted the benefit of several outreach visits rather than only one.

In this study, outreach visits were a key part of the planned educational process and considered to contribute to improving weight management. These visits allowed the PN and researcher to discuss difficulties that arose, particularly in relation to PN and individual consultations and how to progress intervention. However, not all PNs took up this opportunity although it appears that situational learning is beneficial (Grimshaw et al. 2001). The greatest benefit seemed to be gained when the researcher and PN
shared a consultation with an individual. This provided an opportunity for the holistic approach to be actioned in practice without the researcher taking over the consultation. Following the consultation, further education took place in the form of ‘reflection-in-action’ (Schon 1987). This reflective practice appeared to aid PNs to see weight management in a new way and recognise a broader range of options to intervention (Paniagua 2001). It may have been, however, that the two nurses who availed themselves of this opportunity had already acquired knowledge and understanding of holistic interventions and perhaps felt more at ease with sharing a consultation. Furthermore, the individuals who came to them for obesity management also indicated their satisfaction with such encounters.

7.4.2 Education and attitudes

It may be that participating in a consultation using the holistic approach had an effect on the PNs approach to weight management. Although the booklets were underpinned by a non-judgemental approach, perhaps sharing a consultation provided further emphasis as the PNs had developed greater self-awareness, facilitating the development of a partnership with individuals.

It may have been difficult for some PNs to avoid being influenced by negative societal beliefs about obesity. A recent review by Brown (2006) confirmed that nurses displayed similar negative views to GPs with regards to individuals with obesity. Any lack of success in weight management may have contributed to feelings of frustration for some PNs in this study. This, in turn, may have led to individuals feeling that they were being blamed for poor outcomes, as found by Ogden and Hoppe (1998), although they also found that nurses with more experience had more positive attitudes. Perhaps
education for obesity management should incorporate societal attitudes to increase understanding of what it is like to be obese and thereby view individuals holistically.

For those PNs who did not share a consultation with the researcher, an educational workshop may have provided generally better outcomes as such interactive groups have been confirmed to improve professional practice (O’Brien et al. 2006). An opportunity to improve therapeutic counselling skills in such groups may aid a better understanding of how to deal with future consultations. For example, one individual identified in her weight management map that she overate and felt guilty. As “secrecy is most often connected with feelings of guilt” (Peplau 1988 p.137) perhaps she was a binge eater. Binge eaters often eat in secret (Lyons 1998) and therefore it is not easy for individuals to admit to themselves, far less to someone else, what they are doing. The weight management map helped raise self-awareness thereby requiring the PN to have good counselling skills in this type of situation to elicit information to explore further the possibility of binge eating. However, this poses the question of what skills PNs are required to have. It seems unrealistic to expect PNs to have specialist counselling skills, such as cognitive behavioural therapy, suggested for eating disorders interventions (NICE 2004). Nonetheless, it seems that PNs do identify individuals who need specific help as several PNs made appropriate referrals to psychologists or counsellors for various reasons.

This seems to emphasise a need for caution in using the holistic approach and the need for better education. However, although PNs in this study indicated their wish to further their skills and knowledge in a way appropriate for nursing it appeared that this may not always be easy.
7.5 The role of the practice nurse in primary care

Like their counterparts in New Zealand it appears that the PNs role is “largely moulded around the GPs in their particular practice” (Kenealy et al. 2004 p.73) thereby sometimes restricting the way in which they practised. The greater emphasis on treating long-term conditions in primary care has resulted in chronic disease management being delegated to PNs as reflected by this study. This change has been influenced by government policy and GPs themselves (Charles-Jones et al. 2003) through the growing demands on the workload by the General Medical Services (GMS) contract.

It appears that nurses involved in chronic disease management may be viewed as substitute doctors to reduce the workload and healthcare costs in primary care (Laurant et al. 2004). Should this be the case, the holistic approach would not fit in with this type of practice as it is not disease orientated and may be time costly. Therefore, support for implementation in practice would be required.

7.5.1 Obesity management in primary care

Nurses may not always receive the organisational support they require to change their practice (McKenna et al. 2004; Brown et al. 2007) even in the short term. It is therefore, important to understand the context in which PNs work.

The allocation of GMS points (NHS 2005) for the identification of obesity in primary care indicated that a greater priority was to be placed on obesity management. However, providing intervention once individuals have been identified as being obese may be compromised by competing priorities and level of general practitioner commitment (Counterweight 2006). Funding influences priorities and the Scottish
government (2008) have very recently committed £15 million directly targeted at tackling obesity over the next three years. Part of that funding is aimed at primary care but there appears to be a lack of enthusiasm to implement weight management strategies, in particular, it seems one that takes a holistic approach.

In the UK both GPs and PNs contend that they treat individuals in their care holistically (Charles-Jones et al. 2003) but this approach is hampered by current incentives in the GMS contract (Howie et al. 2004). One of the PNs in the present study highlighted how the need to document the requirements of the existing contract is detrimental to the interactive relationship between practitioner and individual (Michie et al. 2004).

A bigger influence on implementing obesity management is probably the attitude of GPs towards individuals with obesity. Some PNs in this study suggested that there were GPs who displayed similar attitudes to GPs in research undertaken by Mercer and Tessier (2001) where obesity was viewed as a behavioural problem rather than a medical one. Further studies stated that GPs viewed obese individuals as lacking will power, indulgent, inactive and non-compliant (Foster et al. 2003; Puhl and Brownell 2001). Furthermore, they strongly indicated that individuals were the cause of their own obesity and therefore should manage it themselves (Epstein and Ogden 2005). In such environments, nurses interested in obesity management may experience difficulty in providing adequate time for intervention and could be part of the reason that some PNs in this study felt unsupported although no attempt was made to interview GPs to ascertain their views.

The attitudes of professionals have been explored in stigmatised groups such as substance abusers and were found to impinge on therapeutic care (Moodley-Kunnie
Since obesity is said to be the “last socially acceptable form of prejudice” (Stunkard and Sorensen 1993 p.1037) it seems reasonable to argue that attitudes would affect care in this group. Furthermore, nurse theorists such as Peplau (1988) suggest that quality of care can be compromised by prejudicial attitudes, which are coloured by societal beliefs and values.

Although PNs in this study, like their colleagues elsewhere (Brown et al. 2007) viewed themselves as having a role to play in weight management, it may be that GPs who employed them were generally reluctant to address obesity (Epstein and Ogden 2005). This may have been partly due to the lack of efficacious treatments (Foster et al. 2003) but more likely to be a lack of time, training and remuneration (Puhl and Brownell 2001). Another element in the reluctance of GPs to address obesity is the fact that more than half said they were unsuccessful in treating it (Foster et al. 2003) suggesting that interventions such as the holistic approach might be applicable to other professional groups. However, these results should be treated with caution as although 5,000 primary care physicians were randomly sampled the response rate was only 13%. There may also be cultural differences as that particular study (Foster et al. 2003) was carried out in the United States of America (USA). It may be that the UK is different as both GPs (75%) and PNs (88%) stated they had the motivation to treat obesity (Counterweight Project Team 2004b).

Implementation may also be influenced by the importance attached to an intervention by GPs. For example, it was suggested that failure to implement an evidence based training package to improve urinary continence in primary care (Abbott and Hotchkiss 2001) was partly due to the lack of support from GPs who may have been influenced by
their view of the unimportance of incontinence. Obesity interventions may fall into a similar category.

A UK wide cross-sectional observational study (Counterweight Project Team 2004b) showed that obesity was under-diagnosed. Women were found to have more visits than men to their GP or PN but they were also more likely to be weighed during the consultation (69% of women compared with 57% of men). The same study also showed that obese men, once identified, were more likely to be assessed for cardiovascular risk factors than women with a higher BMI. It may be that, unlike males, females are more aware of their body size, due to cultural pressure to achieve slim figures, and therefore, seek help. This was confirmed in a qualitative study in primary care where obesity was viewed by health professionals as a "woman's problem" and not treated as an important health issue (Mercer and Tessier 2001). While this appeared true for some of the GPs who worked with the PNs in the holistic approach to weight management, the nurses themselves showed awareness of obesity related issues for both men and women and the health implications for all. Nevertheless, it was mainly women who were recruited for this study. One reason may have been that the short recruitment time resulted in women being more accessible as PNs tried to contact them at home during the daytime. It may also have been the case that women themselves were more willing to address their weight by participating in the study. Cultural influences, rather than health concerns, may have had a part to play for both the women recruits and the PNs. Nonetheless, some PNs did recruit regardless of these issues.
7.6 Partnership

The concept of partnership was an important aspect in relation to outcomes in this study. Developing a partnership may falter at the very first steps of orientation and identification (Peplau 1988) if an individual seeks help in managing their weight and the nurse does not accept them in a non-judgemental way, listen to their needs and educate them in understanding obesity. Hewitt-Taylor (2003) sees partnership between the nurse and individual as characterized by negotiation leading to empowerment of the individual and may reflect the quality of care required for better outcomes (Di Blasi et al. 2008). Before going on to look at partnership development it would be pertinent to examine the context in which PNs work and how this might impinge on their ability to develop partnership in practice.

7.6.1 Nurse self-awareness

The evidence in this study also appeared to indicate that some PNs were very self-aware. Self-awareness is a key element in Peplau’s model and is the first requirement in developing a partnership with individuals (Walsh 1991). In the guest editorial of a nursing journal Chavasse (1992) suggested that nurses also need to have a self-awareness of their prejudices. Setting aside prejudices facilitates open communication and “unconditional acceptance” (Peplau 1988 p.235) of individuals, which is vital to providing holistic care. Historically, barriers to achieving greater communication have been organisational in that nurses were task orientated discouraged from becoming emotionally involved with patients (Menzies 1960). Hence, attention was focused on the provision of physical care and other areas neglected (McQueen 2000). This distancing of oneself discouraged the development of a trusting relationship.
Was it the case that PNs who were successful in supporting individuals with weight loss were more able to develop trusting relationships with individuals? FalkRafael (2001) identified a trusting relationship as being non-judgemental, respectful, empathic, enhancing dignity and providing a safe environment. In that same study individuals were interviewed and corroborated these findings. One was quoted as saying “It’s because I feel safe with her, and I feel very, very confident that I don’t have to worry; she is not going to judge me…She’s very attuned to how I’m feeling.” (FalkRafael 2001 p.7). Such findings concur with those of a systematic review of patients in primary care (Wensing et al. 1998) suggesting that central to any intervention such as this is the need for nurses to establish such relationships. This raises the question the extent to which the provision of materials contributes to the intervention. As already discussed, the materials appear to be important but it may be that if the materials are used within a trusting relationship outcomes would improve further. However, it takes time to develop trust in a partnership and it also depends on the particular practitioner as some individuals have found that even after years of attending their practitioner they never got to ‘know’ them (Paterson 2001).

7.6.2 Knowing

The PNs in this study talked of knowing individuals at different levels. Some talked of ‘knowing’ individuals at a superficial level where they arranged appointments times that they knew would suit individuals. Russell et al. (2003) argued that knowing the social circumstances of individuals was crucial in developing partnerships. PNs, particularly in more rural areas where they are usually part of the community themselves, are often aware of social situations pertinent to the individuals in their care. While that level of knowing provides a good base on which to develop a relationship it may not be enough.
In order to achieve a therapeutic effect Williams (2001) contends that a level of closeness and intimacy is required.

It may have been that others who spoke of a deeper ‘knowing’ developed a trusting relationship which evolved to the point where individuals felt confident enough to divulge very personal details. Therefore, the findings of this study would suggest that a deeper level of ‘knowing’ enhances the partnership further and gives increased satisfaction to both individual and professional while improving outcomes. This involves altering the balance of power between individual and professional.

7.6.3 The power balance

The PNs in this study tended to encourage individuals to participate in their care thereby altering the power balance. By doing so they helped individuals to improve their skills “in meeting problems rather than in teaching solutions to problems” (Peplau 1988 p.247). It appeared that unlike the traditional paternalistic approach where the authoritarian style of consultation dictates that the power lies with the health professional (Nyatanga and Dann 2002). In a partnership the power is shared through the professional taking a facilitative role, which leads to empowerment in the individual (Gallant et al. 2002). In essence this means willingness on the part of nurses to relinquish the ‘nurse knows best’ attitude and believe that individuals are capable of making choices. Just as parents are reluctant to allow their children to make choices perhaps nurses who conform to a paternalistic approach had more difficulty in allowing individuals to make their own decisions and set goals (Pill et al. 1999) although they may genuinely believe they are involving individuals in their care. Nonetheless, the result of creating a parent-child relationship could have the opposite effect by disempowering individuals (Malin and Teasdale 1991).
7.6.4 Empowerment through partnership

The evidence in this study appeared to show that individuals became empowered through partnership with the PN. Plans and goals were set to fit in with the individual’s lifestyle by sharing their own experiences of weight management with the PNs who brought their knowledge and skills to the partnership. In order to help individuals achieve change it has already been suggested that nurses first require self-awareness before they can develop a partnership with individuals and get to know them on a deeper level. This, in turn, enables the individual to bring their knowledge of past weight loss experiences, beliefs, values and current life situations to the consultation.

7.7 Self-management

The results from this study appeared to suggest that when individuals worked in partnership with the nurse they participated fully in their care and felt more in control (Henderson 1997). Nonetheless, it has been suggested that not all individuals want to participate in their care (Waterworth and Luker 1990; Biley 1992). These particular studies (Waterworth and Luker 1990; Biley 1992) were carried out in secondary care but a primary care study McKinstry (2000) revealed that interest in participation depended on the type of problem and those with chronic conditions preferred greater input in their care. In a qualitative study exploring the facilitators and barriers to participation of asthma patients, for example, Caress et al. (2002) identified having enough information and continuity of care as facilitators while barriers included the professional’s unwillingness to recognise the patients’ expertise and lack of time during appointments. The findings of this present study suggest that these same factors apply to obesity management and therefore it is imperative that individuals be involved if outcomes are to be improved.
7.7.1 Individual empowerment

Most of the individuals in this study had endured weight problems for a long time and as with any long term condition they would have gained a great deal of knowledge particularly with regards to diet, since treatment has often been focused on diet alone. There is a difference between knowing what to do and how to achieve it. It seems that when PNs only gave advice it probably had little impact. The traditional paternalistic reaction to a lack of success would be to blame the individual for non-compliance which Russell et al. (2003) stated is a way for health professionals to keep control. They argue that transferring power and control to individuals through a person centred approach is a more relevant way forward. Although there are many definitions of empowerment in the literature, the one applicable here is “a social process of recognizing, promoting and enhancing people’s abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives” (Gibson 1991 p.359). A way of doing so may be to incorporate the expertise of individuals into nursing care to encourage their participation. Therefore, taking a participatory, person centred, holistic approach seems relevant.

7.7.2 Towards self-management

This study appeared to show that for individuals to develop self management skills they need self-awareness to enable them to recognise areas of their lives that need to change in order to achieve their goals. The evidence seemed to show that reflection encouraged self-awareness leading to self-management practices (Elfhag and Rossner 2005). and PNs were often able to help individuals in “the processes of self-renewal self-repair, (and) self-awareness” (Peplau 1988 p.251). As identified by several individuals, it was not always easy and even painful for some but with the aid of an empathic PN, individuals were encouraged to believe in their own self worth and so raise their self-
esteem (Eckroth-Bucher 2001). In turn, this appeared to increase confidence (Eckroth-Bucher 2001) in their ability to lose weight.

The results of the current study suggest that taking a holistic approach to goal setting is important (NIH 1998). Having scrutinised various areas of their life and beliefs, to enable them to decide on the areas for change, individuals in this study were encouraged to set goals. The breakdown of these goals into manageable targets may have helped them to feel more in control and thus more confident in their own ability to achieve these targets. However, those who gained weight tended to focus on food and occasionally activity thereby not looking at ‘the whole me’.

As seen in this study some individuals reacted to lapses in weight control by self-criticism (Popkess-Vawter et al. 1998). This is often related to guilt and as “guilt operates outside awareness” (Peplau 1988 p.135) reduces the capacity of the individual to identify the changes required for better weight management. Awareness of the circumstances of a lapse is important if individuals are to learn how best to deal more appropriately with the same circumstance in the future. Therefore, self-monitoring is a useful tool for self-management (Elfhag and Rossner 2005) and incorporating it in the ‘action plan’ appeared to facilitate self-monitoring. Individuals were able to review to what degree they had succeeded in achieving their goals and adjust or introduce new goals as progress was made.

Individuals who made progress with weight management in this study conveyed greater satisfaction with the relationship they had with their PN. Perhaps, taking a person centred approach helped individuals become more involved in their care by participating (Ciechanowski et al. 2004).
In a nutshell, “The nurse promotes client empowerment and competency by maintaining the relationship, reinforcing client progress, supporting decision-making, and assisting the client to learn new knowledge and skills.” (Gallant et al. 2002 p.153). The materials appeared to play an important part in assisting PNs and individuals to achieve empowerment through partnership. Nonetheless, there appeared to be some practical difficulties with implementing the holistic approach.

### 7.8 Practical aspects of implementing the holistic approach

If PNs were expected to take a medical model approach to care it may have had implications for implementing the holistic approach. Should they lack practice autonomy (Zwarenstein and Bryant 2000) they may feel that they have little authority to make changes (Funk et al. 1991).

With regard to appointment times the attempts by PNs to provide longer consultations according to individual need were not always successful. They were restricted to 10 or very occasionally 20 minutes. Current practice for dietitians giving weight management advice is half an hour for a new appointment and follow-up sessions of about 20 minutes duration (Harvey et al. 2002b). In the Counterweight programme appointment times for PNs were 10-30 minutes. The implementation of the holistic approach was therefore, more restricted in the time allocated to individuals. This may partly be explained by the fact that it was not practice driven, unfunded and depended on the interest and good will of the volunteer nurses who were only permitted to take part in the study if it did not interfere with their current workload. In such circumstances the level of PN autonomy may have been more important than for usual practice.
Any complex intervention which includes implementing lifestyle changes may require a longer appointment, at least, initially. Like the individuals in a smoking cessation study, those taking part in the holistic approach may have preferred a shared approach to treatment but this means a longer consultation time (McKinstry 2000). In addition, the recall system now generally in place for chronic disease sufferers, while it improves process outcomes, does not improve patient outcomes (Renders et al. 2005). Robinson (2004) suggested that for good self-management in inflammatory bowel disease, for example, fixed routine appointments were less effective as the disease was unpredictable and relapsing in nature. Obesity follows a similar pattern in that people have lapses of control, leading to relapse, when faced with unexpected life events. Even everyday occurrences, as seen in this study, affect the way individuals manage their weight. As with other chronic conditions it seems that being available for individuals at their point of need improves outcomes. It would therefore seem important to have greater flexibility in the appointment system to allow follow-up to suit individual needs.

Although initially requiring longer consultations this could even have a knock on effect of requiring fewer follow-up appointments (Howie et al. 2004) as individuals gradually learn self-management practices. Improved care evolves through a long term relationship, although Cabana and Jee (2004) say it may take many consultations with the same professional. Both longer appointment times and greater flexibility were recommended by GPs themselves (Freeman et al. 2002) but it does not appear to have materialised. Nonetheless, the majority of PNs in this study managed to achieve flexibility in both appointment time and frequency to the advantage of patient care.

Taking control, however, was no easy matter for some PNs who felt unsupported by their GPs. Their experience was similar to that of Welsh PNs who saw obesity
management as part of their role but were frustrated about not being allowed to allocate
the necessary time (Owen 2004). Primary care nurses in Northern Ireland also felt that
they had neither time nor authority to implement changes in general as they had a lack
of managerial support (McKenna et al. 2004). There appeared to be conflicting
messages given to both the PNs in this current study and elsewhere. GPs, like their
counterparts in Wales and Ireland, generally did not see obesity management as their
role and delegated it to PNs who, it should be noted, were not always given the
authority to organise appointments accordingly. One reason why that might be is that
GPs who themselves spend less time with patients may not be able to be so person
centred and less likely to recognise and deal with long term or psychosocial problems
(Wilson and Childs 2002). They were also more likely to refer people to PNs for
weight management as their interest in addressing lifestyle issues was limited.
Therefore, they may not have viewed longer appointments as being necessary. It may
have been that some nurses, who experienced this had a sense of weight management
being ‘dumped’ on them by the GPs, as expressed by one PN during her interview. PNs
in England had similar experiences (Cadman and Wiles 1996).

Some PNs in this study manipulated the system by not openly challenging the
appointment system but simply overrunning on appointment times. This less visible
influence may have furnished them with more power than if they were to openly
challenge the system and risk being ‘told off’, as was the experience of PNs in Wales
(Owen 2004) when they allocated what was seen as too much time for obesity
management.

Other PNs negotiated to spend longer on appointments and brought together the practice
policy on appointments, the GPs medical care for individuals, and their own unique
intimate knowledge of individual’s concerns, so acting as advocate for those in their care. There is, of course, a responsibility for the outcomes in acting in this way and a need to consider and reflect on how it affects other individuals so as not to compromise their care. Autonomous nurses accept that responsibility by justifying their actions, which is an imperative of the Nursing and Midwifery Council Code of Conduct (NMC 2002).

An example given by several nurses in this study was the decision not to refer individuals to the dietitian, which they justified by explaining the waiting times, lack of follow-up or gain, and inconvenience to individuals. These same PNs, who appeared to provide holistic care, often referred individuals to psychologists or counsellors where a need was identified thus demonstrating an awareness of holistic care. By referring to other members of the healthcare team they also recognised their own limitations thereby demonstrating accountability for their actions. This seems to suggest that the complexity of weight management often requires a multidisciplinary approach. The complexity also suggests that a holistic approach is required. Therefore, other healthcare professionals may benefit from education from a holistic perspective.

7.9 Conclusions

The holistic approach to weight management may be worth exploring further. The hard outcome of weight, where 78% of individuals lost weight compares favourably with the results from other studies. However, it is recognised that this pilot study is very small and a larger study is required.
Other results from this study suggest that obesity management is complex and requires a participatory, holistic, person centred approach to intervention. It seems that looking at the whole person is pertinent to successful outcomes as it sometimes raises issues that may be missed in traditional approaches. Most PNs and individuals expressed their satisfaction with this approach.

Supporting materials, particularly the unique ‘Weight Management Map’, appear to be a key contributing factor to the success of the study. By looking at the whole it seemed to allow identification of the ‘parts’ and the links between them. Doing so, seemed relevant for action planning and goal setting, key components of making changes. Having this in written form was seen as advantageous by both PNs and individuals. It also appeared to help individuals participate in their care leading to self management practices.

The materials for PNs appeared to aid changes in practice, even for those who did not recruit for the study. All PNs expressed their need for obesity education and although most PNs were enthusiastic about the holistic approach, as it seemed to fit with their approach to nursing, for some the minimal educational input for the holistic approach may have compromised their ability to implement change. As a result it could have been more comfortable to apply familiar ways of working to this approach rather than embrace a totally new concept. Educational input, in particular from outreach visits, appeared to be very beneficial when implementing the holistic approach.

PNs who ‘bought’ into the ‘holistic’ concept seemed to work in greater partnership with individuals and have better outcomes. They also appeared to have support from their practices and have more control over their work load. For other PNs the work setting
may have compromised the opportunities to engage at a deeper level with individuals although some nurses may have avoided emotional involvement by simply giving advice.

The evidence from this study suggests the relevance of expanding practice in the area of weight management in primary care through taking a holistic approach. In the next and final chapter the, conclusions, limitations and recommendations of this study are discussed.