



Swansea University  
Prifysgol Abertawe



## Swansea University E-Theses

---

# The social meaning of obesity: An ethnographic exploration of student nurses' care of obese patients in hospital settings.

Sardani, Alexandra Vanta

### How to cite:

---

Sardani, Alexandra Vanta (2014) *The social meaning of obesity: An ethnographic exploration of student nurses' care of obese patients in hospital settings..* thesis, Swansea University.  
<http://cronfa.swan.ac.uk/Record/cronfa42600>

### Use policy:

---

This item is brought to you by Swansea University. Any person downloading material is agreeing to abide by the terms of the repository licence: copies of full text items may be used or reproduced in any format or medium, without prior permission for personal research or study, educational or non-commercial purposes only. The copyright for any work remains with the original author unless otherwise specified. The full-text must not be sold in any format or medium without the formal permission of the copyright holder. Permission for multiple reproductions should be obtained from the original author.

Authors are personally responsible for adhering to copyright and publisher restrictions when uploading content to the repository.

Please link to the metadata record in the Swansea University repository, Cronfa (link given in the citation reference above.)

<http://www.swansea.ac.uk/library/researchsupport/ris-support/>

# The social meaning of obesity

---

an ethnographic exploration  
of student nurses' care of  
obese patients in hospital  
settings

[Volume I of II]

**Alexandra Vanta Sardani**

**Submitted to Swansea University in fulfilment of the requirements  
for the Degree of Doctor of Philosophy**

**SWANSEA UNIVERSITY  
2014**

ProQuest Number: 10805358

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 10805358

Published by ProQuest LLC (2018). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code  
Microform Edition © ProQuest LLC.

ProQuest LLC.  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106 – 1346



## ABSTRACT

The prevalence of obesity is increasing and due to its associated co-morbidities (WHO, 2011) obese people are at greater risk of being hospitalised. While it is evident that student nurses will increasingly be caring for obese patients, there has been a scarcity of studies exploring student nurses' conceptualisation of obesity and participation in obese patients' care.

The aims of this study were to explore student nurses' care of obese patients and the meaning they assigned to obesity. I utilised an ethnographic approach that included 305 hours of participant observation of student nurses (n=11), qualified nurses (n=11), nurse managers (n=3) and health care assistants (n=10) in three hospital settings in Wales (orthopaedic, gynaecological-surgical, and respiratory). Data also included semi-structured interviews with student nurses (n=7), documentary analysis and the technique of drawing pictures.

The thematic analysis generated three themes: 'student nurses' encounters with obese patients', 'constructing the meaning of obesity: the culture and context of care', and 'the consequences of student nurses' involvement with obese patients' care'. Student nurses found the intensity and frequency of their involvement with obese patients' care challenging, particularly in the areas of interaction, food and nutrition, physical care and moving and handling. Integral to their conceptualisation of obesity were student nurses' cultural norms and values, their limited knowledge regarding obese patients' care, professional socialisation, organisational constraints, and patients' contribution to their care. Student nurses felt disempowered because of the emotional and physical labour they experienced when caring for obese patients. In turn, they participated in the exercise of power over obese patients with both intended and unintended consequences. Equally important was the 'covert liking' (Johnson, 1997) that some students felt towards obese patients who engaged in empowering acts of care to compensate for others' controlling behaviours.

The findings provided insights into the student experience of caring for obese patients and raised issues related to the role of culture and context of care in student nurses' conceptualisation of obesity. Drawing on Foucault's (1976) notion of power facilitated understanding of the significance of obesity-related discourses and associated power inequalities in clinical practice. Changes in nurse education and practice are proposed to ensure that nurses are adequately prepared to care for obese patients.

# DECLARATION

## STATEMENT I

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed.....

Date..... 01/04/2014 .....

## STATEMENT II

This thesis is the result of my own independent work, except where otherwise stated. Other sources are acknowledged by explicit references. A bibliography is appended.

Signed.....

Date..... 01/04/2014 .....

## STATEMENT III

I hereby give consent for my dissertation, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed.....

Date..... 01/04/2014 .....

# DEDICATION

I dedicate this thesis in memory of Dr Susan M Philpin.

# TABLE OF CONTENTS

|   |    |
|---|----|
| ABSTRACT .....  | 1  |
| DECLARATION.....  | 2  |
| DEDICATION .....  | 3  |
| ACKNOWLEDGEMENTS.....                                       | 9  |
| List of tables and pictures .....                           | 10 |
| Abbreviations .....   | 11 |
| CHAPTER ONE - Introduction .....                            | 12 |
| 1.1 Introduction.....                                       | 12 |
| 1.2 Rationale for choice of topic.....                      | 13 |
| 1.3 Rationale for choice of an ethnographic approach.....   | 14 |
| 1.4 Aim and research questions .....                        | 14 |
| 1.5 Student nurses' curriculum and practice attendance..... | 16 |
| 1.6 Description of the settings.....                        | 17 |
| 1.7 The structure of the thesis .....                       | 20 |
| 1.8 Summary .....   | 21 |
| CHAPTER TWO - Literature Review .....                       | 23 |
| 2.1 Introduction.....                                       | 23 |
| 2.2 Search strategy .....                                   | 24 |
| 2.3Definitions, origins and patterns of obesity .....       | 26 |
| 2.3.1 Obesity measurement.....                              | 26 |
| 2.3.2 Origins of Obesity.....                               | 33 |
| 2.3.4 Patterns of obesity .....                             | 38 |
| 2.4 Consequences of Obesity .....                           | 40 |



|  |           |
|--|-----------|
| 2.4.1 Mortality and morbidity associated with obesity .....                      | 40        |
| 2.4.2 Obesity stigma and discrimination.....                                     | 43        |
| 2.4.3 The cost of obesity to the NHS .....                                       | 52        |
| 2.5 Nurses' knowledge of obesity and participation in obese patients' care ..... | 54        |
| 2.5.1 Knowledge about obese patients' care.....                                  | 54        |
| 2.5.2 Participation in obese patients' care.....                                 | 56        |
| 2.5.3 Perceived barriers to obese patients' care .....                           | 62        |
| 2.6 Summary .....  | 68        |
| <b>CHAPTER THREE - Methods and Methodology.....</b>                              | <b>72</b> |
| 3.1 Introduction.....  | 72        |
| <b>METHODOLOGY.....</b>  | <b>73</b> |
| 3.2 Qualitative Approach .....   | 73        |
| 3.2.1 Philosophical Paradigms .....  | 75        |
| 3.2.1.1 <i>Ontological position</i> .....  | 77        |
| 3.2.1.2 <i>Epistemological position</i> .....                                    | 78        |
| 3.2.2 Ethnography .....  | 80        |
| 3.2.2.1 <i>Ethnography in Nursing and Health Care</i> .....                      | 82        |
| 3.2.2.2 <i>Culture</i> .....   | 86        |
| 3.2.2.3 <i>Alternative research approaches</i> .....                             | 89        |
| <b>METHODS .....</b>   | <b>91</b> |
| 3.3 Location and Recruitment Methods.....  | 91        |
| 3.3.1 Access: Obtaining permissions .....  | 92        |
| 3.4 Sampling strategy and Inclusion criteria.....                                | 93        |
| 3.5 Data Generation .....  | 99        |
| 3.5.1 Participant Observation.....   | 100       |
| 3.5.1.1 <i>Field Notes</i> .....   | 104       |

|  |            |
|--|------------|
| 3.5.2 Interviewing .....   | 106        |
| 3.5.3 Method of ‘drawing a picture’ .....  | 108        |
| 3.5.4 Documentary sources .....  | 110        |
| 3.6 Data Analysis .....  | 111        |
| 3.7 Ensuring rigour in ethnographic research .....   | 119        |
| 3.8 Reflexivity.....   | 126        |
| 3.8.1 The ethnographic role .....  | 129        |
| 3.8.2 Role of emotions .....   | 131        |
| 3.9 Ethical considerations .....   | 132        |
| 3.10 Summary .....   | 140        |
| <b>CHAPTER FOUR: Introduction to findings .....</b>  | <b>142</b> |
| 4.1 Introduction.....  | 142        |
| 4.2 Student nurses’ encounters with obese patients .....   | 142        |
| 4.3 Constructing the meaning of obesity: The culture and context of care.....                            | 145        |
| 4.4 The consequences of student nurses’ involvement with obese patients’ care                            | 147        |
| 4.5 Summary .....  | 150        |
| <b>CHAPTER FIVE – Student nurses’ encounters with obese patients ...</b>                                 | <b>151</b> |
| 5.1 Introduction.....  | 151        |
| 4.2 Student nurses’ interaction with obese patients .....  | 151        |
| 4.2.1 The derogatory use of humour .....   | 160        |
| 4.2.2 Attenuation of obese patients’ concerns .....  | 164        |
| 4.3 Student nurses’ involvement with patients’ food and nutrition .....                                  | 169        |
| 4.4 ‘You’d need an extra pair of hands’: Physical care and the importance of<br>moving and handling..... | 174        |
| 4.5 Summary .....  | 182        |

|   |     |
|---|-----|
| CHAPTER SIX – Constructing the meaning of obesity: the culture and context of care .....                            | 185 |
| 6.1 Introduction .....  | 185 |
| 6.2 ‘When we’re not looking, he’s eating’: cultural norms regarding obesity and obese patients .....                | 185 |
| 6.2.1 Obesity stigmatisation.....   | 186 |
| 6.2.2 Obese patients’ labelling.....  | 194 |
| 6.3 Obesity assessment .....  | 202 |
| 6.3.1 ‘One of these tasks that were left for the weekends’: The presence and use of obesity-related documents ..... | 203 |
| 6.3.2 ‘It’s a visual thing’: obesity evaluation according to student nurses .....                                   | 207 |
| 6.3.3 Building an obese person’s identity - health problems, ethnicity, sex and age .....                           | 209 |
| 6.3.4 Manual handling needs .....   | 212 |
| 6.4 Professional and organisational constraints .....   | 216 |
| 6.4.1 Professional socialisation.....   | 217 |
| 6.4.2 ‘I tend to go the way they do’: Fitting in with the ward culture and adherence to covert rules.....           | 224 |
| 6.4.3 Shortages of resources .....  | 227 |
| 6.5 Summary .....   | 232 |
| CHAPTER SEVEN - The consequences of student nurses’ involvement with obese patients’ care.....                      | 235 |
| 7.1 Introduction.....   | 235 |
| 7.2 Consequences for obese patients.....  | 235 |
| 7.2.2 Obese patients’ disempowerment .....  | 235 |
| 7.2.2.1 <i>Obesity as deviance</i> .....  | 236 |
| 7.2.2.2 <i>Isolation</i> .....  | 237 |

|  |     |
|--|-----|
| 7.2.2.3 <i>Surveillance and normalising judgement</i> .....                              | 238 |
| 7.2.2.4 <i>Depersonalisation</i> .....   | 243 |
| 7.2.3 Obese patients' empowerment .....  | 248 |
| 7.3 Consequences for student nurses .....  | 253 |
| 7.3.1 Emotional effects .....  | 253 |
| 7.3.2 Physical effects.....  | 263 |
| 7.4 Obese patients' and student nurses' power negotiation.....                           | 270 |
| 7.5 Summary .....  | 275 |
| CHAPTER EIGHT- Conclusion.....   | 278 |
| 8.1 Introduction.....  | 278 |
| 8.2 Overview of research questions .....   | 278 |
| 8.3 Summary of themes.....   | 281 |
| 8.3.1 Student nurses' encounters with obese patients.....                                | 281 |
| 8.3.2 Constructing the meaning of obesity: the culture and context of care....           | 283 |
| 8.3.3 The consequences of student nurses' involvement with obese patients'<br>care ..... | 287 |
| 8.4 Limitations of the study .....   | 290 |
| 8.5 Relevance of this study and Recommendations.....                                     | 291 |
| 8.5.1 Relevance and recommendations for clinical practice.....                           | 292 |
| 8.5.2 Relevance and recommendations for education.....                                   | 293 |
| 8.5.3 Relevance and recommendations for management.....                                  | 294 |
| 8.5.4 Relevance and recommendations for research.....                                    | 295 |
| 8.6 Summary .....  | 297 |

## **ACKNOWLEDGEMENTS**

I would like to thank my supervisors, Dr Susan M Philpin, Dr Daniel Warm, Dr Fiona Murphy, and Professor Joy Merrell, who have offered me their support, enthusiasm, constructive comments and encouragement. I am humbled by the dedication and hard work you have showed throughout this journey. I also offer my special thanks to Dr David Rea for his support and invaluable input.

I am truly indebted and thankful to the student nurses who have participated in this study; thank you for trusting me and giving so generously of your time. I also offer my sincere thanks to the staff, patients and relatives that contributed to this study.

I would also like to thank Swansea University for offering me a Scholarship to pursue my research. Moreover, I would like to thank Dr Deborah Fitzsimmons for her advice and encouragement and Clare Boucher, a dedicated librarian, for her assistance in my research. Thanks also to the secretaries of the School of Health Science, Sue, Karin, Joyce and Leanne, for their consistent help and availability.

I wish to thank my family and all my friends, who have boosted me, supported, read my thesis and offered their advice, and sometimes babysat. Special thanks go to Ela, Laura, Lori, Emma, Silvia, Stephanie, Taghreed, and Dimitris. You are more than friends to me, you are family. To my fiancé, Arturo, there are no words to describe my gratitude for the unconditional support you gave me throughout all these years. It was your love and belief in me that allowed me to finish this journey.

## List of tables and pictures

### List of Tables:

- Table 1. Classification of obesity according to BMI (WHO, 2003).....27
- Table 2. The health consequences of obesity (WAG, 2010).....41
- Table 3. The characteristics of participants.....93
- Table 4. Participant Observation.....101
- Table 5. Formal Interviewing.....107
- Table 6. Examples of codes, categories and a sub-theme.....113
- Table 7. The process of data generation and analysis.....114

### List of Pictures:

- Picture 1. Drawing by John, Newly Qualified Nurse.....154
- Picture 2. Drawing by Carol, First Year Student.....186
- Picture 3. Drawing by George, Newly Qualified Nurse.....187
- Picture 4. Drawing by Lucy, First Year Student.....249
- Picture 5. Drawing by Stacy, First Year Student.....255
- Picture 6. Drawing by Kath, Newly Qualified Nurse.....256
- Picture 7. Drawing by Susan, Third Year student.....261

## **Abbreviations**

|      |   |
|------|---|
| IAT  | Implicit Association Test                   |
| LREC | Local Research Ethics' Committee            |
| M&H  | Moving and Handling                         |
| MRSA | Methicillin-Resistant Staphylococcus Aureus |
| NBE  | National Back Exchange                      |
| NHS  | National Health Service                     |
| NMC  | Nursing and Midwifery Council               |
| SHS  | School of Health Science                    |
| WAG  | Welsh Assembly Government                   |

# **CHAPTER ONE - Introduction**

## **1.1 Introduction**

The present thesis explores student nurses' care towards obese patients and the meaning they assigned to obesity utilising an ethnographic approach. In particular, I inquired into how student nurses conceptualise obesity and the potential influence that their conceptualisation and participation in obese patients' care had on the quality of care they provided to patients they considered obese. Despite data collection occurring in three specific wards within the same Trust in Wales, it is hoped that student nurses, health care professionals, educators and managers will find the generated themes meaningful and applicable in terms of their own experiences.

In this introductory chapter I start with the rationale behind the choice of topic and present the aim and research questions of this study. I also provide background information about student nurses' education and curriculum and describe the settings in which they practised in order to help the reader understand the context in which this study took place. I further describe the structure of this thesis.

Throughout the research process, I endeavoured to take a reflexive approach, so that the reader could be aware how my presence influenced the research process and the outcomes and how I was influenced by the participants and the whole journey of research, which also contributed to the data (Davies, 1999). Moreover, I utilise the first person to communicate the awareness of my presence in the research process (Patton, 2002). In accordance with the reflexive approach, it seems appropriate that the whole study is written in the first person, and this is what I have chosen to do.

Overall, this ethnographic study is unique in that I explore student nurses' culture and clinical practice without being student nurses' educator. Further, this ethnographic study reveals the multidimensionality of student nurses' experience of caring for obese patients and recognises that the difficulty in obese patients' care is situated in wider professional and organisational constraints, such as power relations among student nurses, nurses, other occupational groups and patients.



First, I state my personal motivation for the choice of topic so that the reader understands my underlying interest in this topic.

## **1.2 Rationale for choice of topic**

My interest in the care that student nurses offer to obese patients arose because of my participation in obese patients' care as a student nurse in Greece, where I completed my degree. My experience of caring for obese patients was affected by a combination of a large number of obese patients on hospital wards, lack of staff and scarcity of moving and handling equipment. Moreover, I observed that nurses and student nurses often expressed negative attitudes towards this category of patients. I took the decision, hence, to further my knowledge of nursing practice by studying student nurses' attitudes towards obese patients and the subsequent care they offer to them.

I began this study as a natural consequence of my MSc study (Sardani, 2006) that explored student nurses' attitudes towards obese patients, whereby I interviewed student nurses about their thoughts, beliefs, feelings and experiences of nursing obese patients. An important theme that overshadowed the findings was that of negativity; student nurses stigmatised obese patients and they did not attempt to conceal it. Nevertheless, all participants were adamant that their attitudes did not affect their behaviour towards obese patients; a claim that I was unable to confirm due to the chosen method of data collection.

My motivation to pursue this research endeavour was further fuelled by the realisation that obesity is now characterised as an epidemic (WHO, 2011) because of the rising number of people affected by the disease (Butland et al., 2007; WHO, 2011) and the impact that obesity poses on health (National Institute of Clinical Excellence, 2001; British Nutrition Foundation, 2005b). Moreover, research regarding mortality and morbidity associated with obesity (World Health Organisation, 2004; Kim and Popkin, 2006; Allender and Rayner, 2007; Welsh Assembly Government, 2010) confirmed that obese people are likely to be hospitalised or even become disabled. The extensive costs of obesity to NHS (NHS, 2010; WAG, 2010) signify that more research is needed to ensure that current and future obese patients are offered a high quality of care. However, there is limited research (Peternelj-Taylor, 1989; Culbertson and Smolen, 1999; Petrich, 2000;

Sardani, 2006; Swift et al, 2007) regarding student nurses' care of obese patients; such research present limitations linked to the researchers' scope and selected methodology. This means that research is needed to increase awareness about student nurses' educational needs regarding obese patients' care selecting an approach that would facilitate the exploration of the clinical settings that student nurses practise.

### **1.3 Rationale for choice of an ethnographic approach**

The realisation of the limitations of my previous research methodology (Sardani, 2006) encouraged me to pursue the exploration of student nurses' attitudes and behaviour further. The observation of student nurses enabled me to better understand how their attitudes impacted on their behaviour in a clinical setting. I, therefore, formulated my idea about exploring student nurses' culture and practice in relation to the care they offer to obese patients. Indeed, a literature review revealed that there is a scarcity of ethnographic observational studies exploring student nurses' culture in clinical practice, a gap in nursing literature concentrating on students' needs with regard to obese patients' care and a lack of studies conducted by researchers who were not students' nurse educators.

The idea that student nurses share a *collective* identity (Kuper, 1999) that differentiates them from other students and qualified nurses, and their *marginality* in the clinical setting (Melia, 1987; Holland, 1999) motivated me to utilise an ethnographic approach and explore their culture. In this study, the reader will see how student nurses collectively interpreted obesity and socially constructed the care of obese patients. Further, the reader will gain understanding of how student nurses' marginality was amplified by their involvement with obese patients' care.

Overall, my interest in obese patient care, my previous study and gaps in nursing literature exploring student nurses' care towards obese patients contributed to my decision to pursue this research project.

### **1.4 Aim and research questions**

I have used an ethnographic approach because there is limited research about student nurses' care towards obese patients and because I wished to further understand student nurses' culture. I supported my decision to utilise qualitative methodology in that there is absence of detailed knowledge on this subject (Hammersley and

Atkinson, 2007). My aim was to concentrate on the subjective reality experienced by student nurses, so as to interpret it and discover the meaning they assigned to caring for obese patients.

As happens in any ethnographic study, I refrained from setting up a well-defined concept of what was studied (Angrosino, 2007). Rather than following bluntly a specific theoretical framework that could potentially limit my openness to emerging insights, I developed research questions, according to which the aim and the focus of this study were both expanded and concentrated on (Hammersley and Atkinson, 1995). I followed Fetterman's (1998) advice; the ethnographer should enter the field with an open mind, not an empty head. Thus, the gaps in the available literature were considered in order to study particular social situations and to avoid being lost in the diversity of the social world. The aim of these questions was to turn the foreshadowed problems and gaps in the literature into a set of questions (Hammersley and Atkinson, 2007) and since in qualitative research it is expected that concepts are developed and refined in the process of research (Angrosino, 2007), the original questions were transformed or even abandoned in favour of others as demonstrated in the Findings' Chapters (Chapters Five, Six and Seven).

Following a review of the relevant literature (Chapter Two), the following research questions arose:

- What does a patient 'being obese' mean to student nurses?

This question refers to how student nurses conceptualised obesity as well as what student nurses considered underweight, normal weight, overweight or obese. The aim was to determine whether student nurses complied with the current medical definition of obesity or drew on other criteria.

- Does patients' obesity influence their care? If so, in what way?

Here I sought to discover if there was a relationship between patients' obesity and student nurses' nursing care. I was especially interested in knowing whether student nurses managed to meet obese patients' needs when caring for them. Finally, I

sought to explore whether the quality of patients' care was affected by student nurses' attitudes.

In the following section, I discuss some background information about my participants' nursing education programme to enable the reader to interpret the findings of this study in its historical context.

### **1.5 Student nurses' curriculum and practice attendance**

The standards for my participants' education programme were set out within the Standards of proficiency for pre-registration nursing education (NMC, 2004), which evolved through a series of changes in nurse education (Ousey, 2011) that aimed for the integration of the student experience of practice learning with theory-led learning in University.

The delivery of nurse education in Wales followed recommendations developed through a pilot site initiative called 'Making a Difference' (National Assembly for Wales, 1999). Such developments included the production of the 'Fitness for Practice' (1999) report on pre-registration education, which was influenced by Quality Assurance Agency initiatives, such as the benchmark statements for Nursing (2001) and aspects of broader policy direction, advocated by the National Assembly for Wales, such as 'Educating and training the future health professional workforce in Wales (2001) and 'Improving Health in Wales' (2001). The Knowledge and Skills Framework (DoH, 2003) and Agenda for Change (DoH, 2002) also influenced how nurse education was interpreted and delivered within student nurses' curriculum.

All student nurses that were recruited and selected to attend the programme, spent one year in a Common Foundation Programme whereby they were introduced to clinical skills and attended practice placements as early as possible. After that, my participants spent two years in their branch programme specialising in Adult Nursing Practice. The completion of the programme meant that they would spend 4600 hours of nurse education within a period of three years – fifty percent of that time was spent in clinical practice and another fifty percent in required theory. Their programme included a period of at least three months' 'supervised' clinical practice towards the end of their education- this period was called 'management placement' by students. This follows the 'United Kingdom Central Council Commission for

Nursing and Midwifery Education' (1999) and aimed at consolidating their learning and development through active participation in order to promote their confidence and competence in patient care. Supervision in clinical practice came in the form of mentorship; a mentor was given the responsibility to negotiate relevant practice outcomes with their students.

More recently a new set of standards has been produced (NMC, 2010) and a new curriculum will influence Nurse Education practice starting in the beginning of the 2012 Academic Year. Changes include the abolition of the Common Foundation Programme and the adoption of a 'spiral curriculum', whereby student nurses acquire early essential skills relevant to all fields and age groups whilst developing complex skills within their chosen field.

In the following section, I describe the three wards whereby I observed student nurses' care towards obese patients.

## **1.6 Description of the settings**

I conducted participant observation in three clinical settings located in two hospitals within the same Trust in Wales: in an orthopaedic, a gynaecological-surgical, and a respiratory ward, which I have arbitrarily named A, B, and C respectively. In this section, I provide some information about the organisation, care planning and overall atmosphere of the wards so that the reader may gain knowledge of the context in which the student nurses practised.

### **Ward A**

Ward A was a ward that delivered care for post-operative patients with trauma and orthopaedic problems caused by accidents or worn out joints and tissues. Patients were admitted after the fourth or fifth day post-operatively. The ward had 29 beds that were distributed in five single rooms called 'cubicles' and four six-bedded rooms. If a bed was unoccupied overnight, it was filled with patients from other wards with 'medical' problems. This meant that the ward had usually full bed occupancy. The ward had also service rooms such as clean and dirty utility rooms situated among the single rooms and the nurses' station. There were also storage rooms filled with equipment such as commodes and wheelchairs. Hoists were stored in a corner of one of the patients' rooms and on the corridors.

The ward work was organised on a team nursing basis; the staff nurses and students were allocated to one of two teams, red or blue. In most cases, staff nurses worked primarily with the patients on their team, while students followed the team that their mentor was allocated to. The care plan was based on a routine beginning at 7:00am with the handover report of the night staff in the nurses' office. Student nurses followed nurses' task-oriented approach to care; they made beds, distributed breakfasts, measured patients' vital signs, gave medications and assisted patients with their personal hygiene needs. After the completion of each task, the team went to their office for a short coffee break. At 11:00am, both student nurses and staff nurses sat in their office to update patients' nursing process Kardex. After that, each team including students had their lunch break. At 12:00am student nurses helped with serving lunch, at 13:00pm there was another handover for nurses arriving on the ward for their afternoon shift. The 'back rounds' whereby students checked on patients and ensured that are well started at 16:00pm. At the same time, staff nurses gave medication to patients. At 17:00pm staff and students distributed patients' dinners, at 19:00pm visitors came to see the patients and staff informed patients' charts and folders, while the night shift arrived at 20:00pm to receive the handover, which lasted thirty minutes on average.

Ward A was the busiest ward I visited, because the majority of patients needed assistance with moving and handling. The ward was noisy with patients ringing for assistance every five to ten minutes and staff speaking in a relatively raised voice to patients. The ward was also characterised by a plethora of documents and information posters on walls, the scents of bleach and disinfectant, lack of natural light due to permanently curtain-covered windows in patients' rooms and lack of windows in the sisters' and nurses' offices. On this ward, I observed five student nurses.

### **Ward B**

Ward B was situated in a different hospital and seemed the least busy; while the ward had a 26-bed capacity, there were usually less than 23 patients on the ward. This ward admitted mainly patients requiring major surgery, such as hysterectomy and other extensive surgical interventions. Unlike the other two wards, the entrance to this ward was always locked and visitors had to ring a bell to enter. The ward was

characterised by a long corridor from its entrance to another door leading to surgical theatres. Patients' rooms were situated on each side along this corridor, while the nurses' desk was situated in the middle of the ward. Opposite to the nurses' desk, there was the nurses' office, the treatment room and a storage room. As with the other two wards, there were always two qualified nurses and two health care assistants during the morning shift, and one qualified nurse and two health care assistants on the afternoon and night shift alike.

The ward organisation was also characterised by task-orientation and separation of staff into two teams. While the routine was quite similar, I noticed three main differences. First, the handover report was audiotaped, which meant that the night shift was able to depart when the morning shift arrived. Second, since this was a surgical ward, student nurses cared for patients pre-operatively as well as post-operatively and spent a considerable amount of time accompanying patients to the theatre and back. Third, patients usually did not stay more than five to six days post-operatively, unlike the other two wards whereby patients could stay for two weeks or more.

Ward B had massive windows that sufficiently lit the corridor, the offices and patients' rooms. There were no noticeably unpleasant smells or disruptive noises. Everyone spoke in a rather lowered voice and patients rarely rang for attention. On this ward, I observed two student nurses.

### **Ward C**

Ward C was a respiratory ward providing care to patients with several different types of respiratory disease, including lung cancer, tuberculosis, respiratory failure and chronic obstructive pulmonary disease. The ward had 32 beds that were distributed in five single rooms, four six-bedded rooms and one three-bedded room. This ward had a similar bed occupancy to ward A, and often provided care to patients with medical problems when there were empty beds.

The ward organisation on ward C was also conducted in a task-oriented manner, while patients were separated into two teams, pink and green. Ward C was reminiscent to ward A in terms of lighting, smells and decoration. The notice boards and walls were crowded with documents and posters, the corridors were quiet but

dimly lit by artificial lighting, the corridors were crowded with trolleys, hoists, oxygen cylinders and other equipment. On this ward, I observed four student nurses.

## **1.7 The structure of the thesis**

This thesis contains seven chapters.

Chapter Two reviews the literature regarding obesity and related fields to student nurses' care towards obese patients and nursing. It is divided into three parts; the first part discusses contemporary definitions, origins and patterns of obesity and reviews the conceptualisation of obesity in previous nursing studies. In the second part, I present the consequences of obesity in terms of its mortality and morbidity, the cost of obesity to the NHS and the stigma and discrimination experienced by obese persons in nursing and beyond. The last part critically examines the findings of previous studies relating to nurses and student nurses' knowledge about obese patients' care, their participation in obese patients' care and the barriers they encountered when caring for obese patients. I reveal that there is no apparent study investigating student nurses' care towards obese patients conducted in their clinical practice. Further, I expose a need to explore the meaning that student nurses attach to obesity and obese patients' care.

Chapter Three discusses the methods and methodology used in the present study. I outline the rationale for choosing ethnography and outlay the ontological and epistemological underpinnings of this study. I discuss the data generation and analysis, including access, sampling techniques and recruitment methods. Moreover, I highlight the ethical considerations of this study and examine the ways I achieved rigour.

Chapter Four provides an introduction to the findings, as organised in the three themes generated in this study. It further discusses key concepts utilised that aided interpretation of the findings.

In the following three chapters – Five, Six and Seven- I present and discuss the themes generated in this study. Specifically, in Chapter Five, I describe student nurses' encounters with obese patients and argue that student nurses found obese patients' care challenging, especially in the areas of interaction, food and nutrition, physical care and moving and handling. My findings suggest that student nurses



employed certain techniques to cope with these encounters, for instance, they minimised opportunities of interaction with obese patients, which sometimes resulted in shortfalls in patients' care. In Chapter Six, it is shown that student nurses' culture and the context in which they cared for obese patients played a key role in how they conceptualised obesity. Nevertheless, obese patients also participated in the construction of the meaning of obesity by contributing during their care, for instance, by assisting during their moving and handling. However, professional and organisational constraints highly influenced how student nurses experienced obese patients' care. Chapter Seven discusses the consequences that student nurses' involvement with obese patients' care had on both patients and students. By examining the power relations between student nurses and obese patients, I detected that student nurses participated –implicitly or explicitly– in obese patients' disempowerment, which was justified by the consideration of obesity as a deviance. On the other hand, I also portray the impact that involvement with obese patients' care had on student nurses. It is shown that student nurses were equally disempowered and experienced the effects of obese patients' care on their physical and emotional wellbeing. I suggest that while obese patients' reaction to their disempowerment was characterised by acquiescence and sometimes resistance, student nurses failed to negotiate their power position and experienced obese patients' care as a struggle.

Chapter Eight is the concluding chapter of this thesis whereby I suggest further areas for research and highlight the limitations of this study. I further innumerate possible implications of this study for practice, education, management and research. Overall, I suggest the need for changes in nurse education and practice so that future student nurses are better prepared to care for and meet the needs of an increasing number of obese patients.

## **1.8 Summary**

This chapter has introduced the purpose and rationale for this study. I have presented my aim and research questions and justified my use of an ethnographic approach. I also provided some relevant background information about my participants' nursing programme and curriculum and the wards on which they practised. Finally, I briefly

outlined the structure of this thesis with the aim of assisting the reader to follow the links between the chapters.

The next chapter will discuss existing knowledge in the field regarding obesity and obese patients' care and present the gaps in the literature regarding student nurses' care towards obese patients, subsequently highlighting the importance of doing ethnographic research in this field.

# **CHAPTER TWO - Literature Review**

## **2.1 Introduction**

This Chapter reviews the literature regarding obesity and related fields to student nurses' care towards obese patients and nursing. The aim of this chapter is to reveal the gaps in the literature and critique the methods and methodologies used by previous scholars in the field.

Existing definitions and conceptualisations of obesity are presented and their relevance to nursing is demonstrated. It is suggested that the overwhelming majority of nursing studies implicitly adopt the biomedical conceptualisation of obesity; yet, their findings suggest that student nurses and nurses' obesity interpretation is a rather complex process that is influenced by their culture, previous knowledge regarding obesity and obese patients' care as well as the context they provide care to obese patients. The importance of conducting research in the field is argued through the presentation of relevant statistics and the realisation that there is scarcity of studies researching obesity and student nurses' clinical practice. It is concluded that a study is needed that would explore student nurses' interpretation of obesity without assuming that they accept or reject the biomedical understanding; one that will enquire how student nurses construct the meaning of obesity and the care they offer to obese patients and seek to reveal the context in which this interpretation occurs.

This study is a consequence of a small qualitative research project I undertook for my MSc in Nursing (Sardani, 2006), whereby I looked into student nurses' attitudes towards adult obese patients. While this was a small study (N=10), it raised important issues with respect to student nurses' practice with adult obese patients. My participants revealed that they shared negativity towards obesity, yet my chosen method (semi-structured interviewing) did not allow me to explore whether their attitudes influence the care they provide to obese patients or whether the context in which they care for obese patients influences their formation of their attitudes.

Firstly, I outline the literature search strategy.

## 2.2 Search strategy

The search strategy was very broad and consisted of several stages. The aim of the search strategy was three-fold to identify:

- The meaning of obesity and recognise any related information
- How the meaning of obesity is related to nursing, nurses and student nurses
- Studies related to the care that student nurses and qualified nurses provide to patients that are considered obese.

My search terms consisted of the following list of words put into separate groups. Several searches pairing different groups of words on any one occasion were performed:

1. Overweight /obese / obesity/ bariatric /fat(ness) /heavy(ness) /big /large(ness) /plump /size /weight
2. Care /caring / communication /interaction /clinical practice / ward/ bedside
3. Student nurse(s) /nursing student(s) /nurse(s) /nursing /health visitor(s) /health visiting /health professional(s) /health care worker(s)
4. Discourse /meaning /talk(ing) / terminology /value(s) /significance /implication(s)/ consequences/ impact
5. Attitude(s) /perception(s) /belief(s) /view(s) /bias /prejudice(s) /stigma /stereotype(s)/ stereotyping /anti-fat /deviant(ce)

Such an approach was chosen in order to prevent any biases influencing the selection of literature and maximise the possibility of including all the existing perspectives and explanations on the subject. For instance, I performed searches combining the first and second group of words, the first and second, the first, third and fourth, the third and fifth etc. Furthermore, I conducted searches utilising singular words from each group; for instance, I used the terms 'obese', 'discourse' and 'nursing'.

The search was conducted in numerous resources and databases from conception until December 2013, namely ASSIA (Applied Social Sciences Index and Abstracts), CINAHL Plus, Cochrane Library (Cochrane Database of Systematic Reviews, HMIC

(Ovid), MEDLINE (EBSCO), PsycINFO, Web of Knowledge (ISI), Wiley InterScience, and Google Scholar. Additionally, I searched other resources, such as the National Institute for Health and Care Excellence (NICE), UK National Statistics (the Office for National Statistics website), the Department of Health, Health in Wales, the National Institute for Social Care and Health Research (NISCHR), the Nursing and Midwifery Council (NMC) and the wide resources of journals and books in the Swansea University library. Moreover, I decided to conduct a search in the Electronic Theses Online Service (EthOS) in order to find any theses with similar interests to the present research. After identifying relevant research studies and documents, I further scrutinised their reference and bibliography lists to uncover any overlooked studies in these fields. Lastly, I asked my supervisors for relevant and/or key literature and articles that could be of use to this study.

The limitations of search strategy were that I included only research studies and official documents about obesity, nursing and student nurses' education. For instance, I did not include papers evaluating public health policies related to tackling obesity, evaluating the effectiveness of a diet/fitness approach to losing weight, articles concentrating on individuals' experiences of nursing a specific patient, or advising nurses on the care of obese patients. Since the present study concerned the care of adult patients, I further excluded any studies and literature concerning individuals under the age of 18 years.

Moreover, since only seven studies were identified regarding student nurses and the care they offer to obese patients (Peternelj-Taylor, 1989; Garner and Nicol, 1998; Culbertson and Smolen, 1999; Petrich, 2000; Sardani, 2006; Swift et al, 2007; Poon and Tarrant, 2009), I decided to additionally review studies involving qualified nurses. All studies reviewed are presented in Appendix 1 on a table presenting the aims, methods, sample, main findings and limitations of each study. I justify my decision of including both student nurses and qualified nurses on the basis that they seem to share similar goals connected to serving the patient, operate in the same environment, and have a similar mission (Locsin, 2002). Indeed, there is some overlap in the roles and responsibilities of the qualified nurse and student nurse, as student nurses make their way in nursing culture. Even though student nurses go through rites of passages to undertake the occupational role associated with a nurse in society (Holland, 1999), student nurses and qualified nurses' cultural similarities

cannot be denied. However, it should not be forgotten that student nurses share with each other a cultural identity that also separates them from qualified nurses (Melia, 1987).

The literature search was repeated several times over the course of this study in order to reveal any new research. The review commences with exploring biomedical definitions of obesity and its measurement which were identified as dominating the literature.

### **2.3 Definitions, origins and patterns of obesity**

In this section, I discuss definitions and measurement of obesity which encompass the dominant perspective, namely the biomedical perspective and explore the origins and causes of obesity. Moreover, I present previous studies that explored whether student nurses and nurses embrace its principles in clinical practice.

The biomedical model of obesity describes obesity as a disease, an epidemic and a global health crisis. Indeed, obesity has been officially classified as a disease since 1990 (ICD-9-CM 1990). The biomedical definition of obesity concentrates on its associated health impairments and, has been widely adopted by the nursing community (National Institute of Clinical Excellence, 2001; British Nutrition Foundation, 2005b). Nevertheless, obesity is an issue that is widely disputed in terms of its measurement, causes or even its existence as a medical phenomenon (Campos, 2004; Gard and Wright, 2005; Orbach, 2006; Taubes, 2008, Musingarimi, 2009).

#### **2.3.1 Obesity measurement**

Body Mass Index (BMI) is the current measure used globally to assess the prevalence of obesity and is defined as the weight in kilograms divided by the square of the height in metres ( $\text{kg/m}^2$ ) (World Health Organisation, WHO 2011). Based on BMI, the World Health Organisation (2011) has announced that worldwide obesity has more than doubled since 1980, while 65% of the world's population live in countries where overweight and obesity is reported to kill more people than underweight. Indeed, they concluded that almost all countries experience an obesity epidemic based on BMI figures (WHO, 2011).

Other measures such as give an example have also been developed to identify and assess which people are overweight or obese by both health care professionals and

policy makers, but Body Mass Index (BMI) is said to be more practical and cost-effective at monitoring big populations and assessing their needs. The National Institute for Health and Clinical Excellence (NICE) guidelines also suggest that BMI should be used in clinical practice, despite its limitations (NICE, 2006).

It is suggested that ‘the BMI correlates sufficiently well with direct measures of total body fat to support its use, on an anonymous basis, as a public health tool for monitoring progress in dealing with the obesity epidemic’ (Hall and Cole, 2006; p.283). According to the WHO, who established this classification in 1997, a BMI over 25 kg/ m<sup>2</sup> is defined as overweight; and a BMI of over 30 kg/m<sup>2</sup> as obese. Those with a BMI greater than 40 are considered morbidly obese, which means that they have a higher risk of morbidity and death because of their weight (WHO, 2003).

In particular, the degree of obesity in adults is defined according to the following table.

| Body Mass Index | Classification |
|-----------------|----------------|
| 18.5- 24.9      | Healthy weight |
| 25-29.9         | Overweight     |
| 30-34.9         | Obesity I      |
| 35-39.9         | Obesity II     |
| 40 or more      | Obesity III    |

Table 1. Classification of obesity according to BMI (WHO, 2003)

This measure has been adopted in everyday nursing practice despite the fact that BMI cannot measure directly the amount of fat stored throughout the body (Stein and Colditz, 2004). In effect, the National Institute for Health and Clinical Excellence suggest that the BMI needs to be interpreted with caution because ‘it is not a direct measure of adiposity’ (NICE 2006,p.35), which means that it cannot measure the excessive accumulation of fat in the body or around a person’s organs. For example, BMI may be a less accurate measure of adiposity in adults who are highly muscular. Also, some other subgroups, such as Asians and older people, have co-morbidity risk factors that would be of concern at different BMIs (NICE, 2006). It has also been

stated that the BMI is an imperfect proxy for obesity because ‘there is much individual variability in the relationship between BMI and body fat, cardiovascular risk factors, and long term health outcomes’ (Hole and Cole, 2007; p.283). The opponents of the use of BMI, thus, argue that it is misleading to talk about an ‘obesity epidemic’ which has been speculated utilising a measure that is inaccurate and not based on facts (Campos, 2004).

As far as practical issues are concerned, Cook et al. (2005) suggest that the use of BMI in clinical practice may mask important weight changes and result in failure of identifying a nutritional problem, especially in malnourished elderly patients. The authors, who conducted a study in care home settings, also draw attention to the fact that measuring patients’ height is unrealistic in practice due to lack of staff or difficulty measuring ill or immobile patients (Cook et al., 2005).

The impracticality of measuring the height and weight of patients makes more complicated the calculation of BMI, since studies have shown that self-reported height and weight could classify individuals incorrectly (Spencer et al., 2002). In effect, data from a study conducted on 4808 participants has shown that height is often overestimated and the extent of overestimation is greater in older men and women, shorter men and heavier women. The same study showed that weight is underestimated and the underestimation is greater in heavier men and women (Spencer et al., 2002). Misclassification could potentially result in patients not receiving appropriate care or treatment. In a different study with similar results, it was found that self-reported weight and height led to misclassification effect on the risk estimates for acute myocardial infarction (Oliveira et al., 2009).

BMI has also been proven to be an impractical measure in patients who have oedema or kyphosis, a change that is common with age (Cook et al., 2005). It is also reported that there is often error in converting imperial measurements to metric measurements, especially by students (Cook et al., 2005). Overall, it seems that BMI is not necessarily clinically relevant; however, since no specialised equipment is needed, it is still recommended as the method of choice (National Health Service, 2010).

Other measures that have been studied and suggested include waist circumference, waist/hip ratio, skin-fold thickness and bioimpedance; nevertheless, these measures



have also been found not to capture all the variables that impact risk on patients' health (Stein and Colditz, 2004). Waist circumference has been suggested to be used in addition to BMI because it takes into consideration the issue of fat distribution and determines whether a person is affected by visceral abdominal obesity, which is a major causative factor of insulin resistance and the metabolic syndrome (Ruderman et al., 1998). However, all these measures are rarely recommended because they are considered less reliable when used alone, less accessible, or more expensive than a BMI calculation (World Health Organisation, 2003). From a practical view, a recent small qualitative study, which included four practice nurses, six general practitioners and patients, (Dunkley et al., 2009) revealed that nurses perceive measuring waist circumference as an intimate process and fear that patients might feel uncomfortable or be embarrassed about having their waist measured. The same study suggested that nurses felt that they had limited knowledge and time to perform additional measurements and assessments on patients (Dunkley et al., 2009).

Another example of a measurement that is a rich source of information about health and risk of disease is 3-dimensional body shape, which also indicates the inaccuracy of BMI. Wells et al. (2007) used 3-D data from the 2001-2002 cross-sectional UK National Sizing Survey of adults (SizeUK) in order to investigate the associations between age, sex, BMI, and shape. They utilised a considerably large sample (n=9617 ) and provided an interesting insight into obesity measurement. The researchers discovered that the two main factors associated with weight in men after adjustment for height are chest and waist size, whereas in women they are hip and bust size. They discovered that chest size in men but hip size in women reflect physique, whereas waist size in men and bust size in women reflects fatness. This study found that BMI is insensitive to age-associated changes in the distribution of body weight, which also differ markedly between men and women. However, this study had some limitations. First, the sample was not representative of the UK adult population because the sample was derived from solely urban regions of the UK. Second, the data were cross-sectional; which means that they do not show how individuals change over time. Even though this type of measurement has impractical use in everyday clinical practice, it demonstrates how factors such as sex, shape and age are imperative in the measurement of obesity (Wells et al., 2007).

Despite that the majority of nurse researchers adopt the biomedical understanding of obesity, their findings suggest that Body Mass Index is not utilised in clinical practice to assess whether a patient is obese or not. However, there are no studies documenting how student nurses measure or assess obesity in clinical practice.

Wright (1998) was the only researcher that chose a feminist perspective and the only one who did not take for granted that nurses adopt the biomedical perspective of obesity. Indeed, she enquired nurses about obesity measurement and explored their perceptions about female body size. In this UK study, the ten interviewed nurses used subjective and arbitrary measures to assess obesity; most participants stated that they did not assess weight in any way, while height was never measured. BMI, thus, was not considered part of the patient assessment. The author suggests that nurses may advise or treat patients in relation to weight control from a basis of personal prejudice and preference in body size (Wright, 1998). However, she did not enquire of participants on which grounds they base the assessment they make and what characteristics of a patient make them consider him/her obese. Wright's study (1998) offers limited information about the questions asked and how rigour was maintained, which does not help clarify whether there was any interviewer bias present. Interestingly, she recognised that although she asked participants about the negative effects of weight on health, participants were not asked about the positive values of fat and, consequently, did not have the opportunity to list them.

More recent findings suggest that BMI is not considered a typical procedure in patient assessment by nurses in UK and abroad. When asked to report their clinical activity in relation to obesity assessment, only 36.2% of nurses (n=564) in primary health care responded that they used BMI on a typical week, while just 3.3% replied that they measure waist circumference (Brown et al., 2007). As Brown et al.'s (2007) sample was drawn from nurses working in primary health care, their findings may not reflect the patterns of activity of the general nursing population. Similar results have been found in the US, where in a study of 758 nurses, only 26% indicated using BMI to make the distinction between normal weight, overweight and obesity (Miller et al., 2008). It must be noted that both studies gathered their respondents through random sampling techniques. Indeed, Brown et al. (2007) ensured that the sample comprised of all grades and specialists employed in primary care settings as well as a small proportion of unqualified staff who have been involved repeatedly in obese

patients' care. In effect, this study has a high response rate (72.3%) and the sample was representative of the population in terms of its occupational and demographic characteristics of age, gender, BMI, academic and professional qualifications and experience (Brown et al., 2007).

A plausible explanation behind nurses' reluctance to use BMI is that they do not comply with the biomedical approach to obesity, which includes utilisation of Body Mass Index. In an Australian qualitative study (n=10), nurses were opposed to the use of BMI and expressed the view that obesity is a personal matter and that patients should assess whether they feel comfortable with their weight and whether it affects their everyday life (Jeffrey and Kitto, 2006). However, this is the only study reporting this finding, which leads to another query for further research in relation to the links of BMI utilisation to the values and principles held by student nurses.

It seems that the cut-offs between being considered normal weight, overweight or obese are also blurred. For instance, many participants in Petrich's study (2000) thought that 300 pounds was the weight at which a patient could be considered obese (Petrich, 2000). Interestingly, 300 pounds was the mean response of nurses, who were asked at what weight the challenges in providing care to obese patients became evident (Drake et al., 2008). In Drake et al.'s study, a patient weighing 300 pounds was considered morbidly obese and the need for special equipment was deemed considerably important. However, this study utilised a convenience sample and had a low response rate. These studies suggest that patients who are deemed obese when utilising BMI, may not be viewed as obese if they weigh less than 300 pounds. Utilising different terminology and ignoring the official cut-offs may lead to breaks in the communication between nurses and perhaps patients' care may be influenced. However, these issues have yet to be investigated.

Obesity measurement has been also linked to the practical issues associated with the patients' care, as assessed when the patient is admitted to the hospital. In my previous study, even though student nurses were aware of the clinical assessment of obesity based on BMI, they classified patients as obese when they had mobility issues due to excessive weight; when hospital admission was related to obesity co-morbidities or complications and whether they were bed-ridden (Sardani, 2006). No other study has reported similar findings; nevertheless, these findings give an

indication of the complex elements that interact in the construction of the meaning of obesity for student nurses.

Overall, no study was identified that explores how student nurses assess obesity in clinical practice. Research is needed to elicit student nurses' standards for assessing obesity of their patients and explore what criteria student nurses use when they are forming judgements. Nevertheless, there are studies that suggest that patients' physical appearance influences obesity assessment.

The most prevalent finding among nursing research is that nurses and student nurses alike judge obese individuals through their physical appearance and size. A study that utilised a scenario and sketches of normal weight and obese patients found that obese patients were seen as less socially attractive than non-obese individuals due to their physical appearance (Peternelj-Taylor, 1988). Peternelj-Taylor should be commended on her innovative methodology, which embraced that obesity is a 'visual thing' and, thus, provided respondents with visual stimuli before answering a questionnaire. However, the researcher utilised a convenience sample of 100 respondents and did not disclose whether she pilot-tested her instrument or whether she assessed the validity of the scales, even though similar methodology has been used in the past (Kaplan and Thomas, 1982). Indeed, Peternelj-Taylor (1989) has identified that certain issues connected to the power of the instrument she used have made her study vulnerable to response set bias.

In another study, when student nurses were asked their thoughts when they *see* an overweight person, a quarter of 102 student nurses felt repulsed at obese persons' physical appearance (Petrich, 2000). Petrich classifies her study as 'qualitative', since she utilised open-ended questions but is more like a survey as she selected self-completed questionnaires sent by post as her data collection instrument. Among other questions, students were asked to write a few sentences describing their feelings, thoughts and reactions to the terms 'fat, overweight and obese' (Petrich, 2000). The researcher stated that she opted for this methodology to get rich narratives of the participants' perceptions, but this methodology was flawed in that the extent of these feelings and perceptions was not explored. Indeed, due to the limitations in the design of the study, the researcher, for instance was unable to ask participants about the effect of physical appearance on their judgement.

In a previous qualitative study I conducted, exploring student nurses' attitudes towards obese patients, the ten participants highlighted that physical appearance played a crucial role in patient assessment (Sardani, 2006). Students reported feeling overwhelmed or even shocked by obese patients' appearance and some suggested that they were not psychologically prepared to deal with what they described as 'huge patients'. In that study, I utilised purposive sampling to seize the opportunity to interview any participant who was considered knowledgeable on the topic as well as snowball sampling, where participants brought along their friends/fellow students.

Similar findings were seen in another study in which some participants (n=119) replied that they 'felt astounded by the largeness' of some obese patients (Zuzelo and Seminara, 2006). Zuzelo and Seminara (2006) utilised a mixed method approach, combining a questionnaire developed by Bagley et al (1989) and open-ended questions. The effect of obese patients' physical appearance was revealed as a theme from the qualitative part of the study. Interestingly, the questionnaire data showed that respondents did not hold any negative attitudes towards obese patients (Zuzelo and Seminara, 1989). The inclusion of a qualitative element in their study produced a lot of rich data about nurses' attitudes towards obese patients and revealed that many respondents had negative feelings and experiences of caring for obese patients, which was not identified in the quantitative data. Their study presented some limitations; the Cronbach's alpha score was relatively low, which suggests that the questionnaire may not be reliable or consistent.

Overall, these studies suggest that obese patients' physical appearance plays a key role in the meaning that student nurses may attach to obesity. It is also suggested that BMI is not the sole criterion that patients are assessed against and that student nurses' judgements may be influenced by other factors, such as patients' physical appearance. However, there is no study that shows any effect of obese patients' physical appearance on the care they receive in clinical practice.

### **2.3.2 Origins of Obesity**

Perhaps the most heated on-going debate about obesity is that of the causes behind it. The scientific principle of the origins of obesity is that it results from an imbalance between energy consumed and energy expended by individuals. In other words, over-

nutrition and under-activity are the main determinants of obesity (Lawlor and Chaturvedi, 2006).

The proponents of this view claim that the key causes of obesity are increased consumption of more energy-dense, nutrient-poor foods with high levels of sugar and saturated fats, combined with reduced physical activity (Bloom, 2007). Even though it is recognised that obesity is the result of a complex interaction of many factors and may have psychological, environmental, evolutionary, biological, and genetic causes (Daniels, 2006), proponents of this movement regard that the main driver of obesity is based on an individual's lifestyle choices regarding eating and exercise habits.

The relative contributors of genetics and environment to the aetiology of obesity have been evaluated in many studies. According to Pi-Sunyer (2002), almost 60% to 70% of the variance in BMI can be attributed to environment. He points to the example of Pima Indians; those living in urban Arizona have a high incidence of obesity, while those living in rural Mexico do not. This difference is attributed to the U.S tribe's adoption of a high-fat, calorie-dense diet and sedentary lifestyle, while the Pima Indians still living in Mexico follow a more traditional low-fat diet and have a high activity level. A similar trend has been observed for Africans living in the United States and Asians living in UK (Jebb et al, 2004).

As far as genetics are concerned, it is estimated that genetics account for about 30% to 40% of the differences in people's weight. Twin and adoption studies consistently demonstrate that genetics play a role in BMI, and there are an estimated 300-400 genes involved in body weight (Daniels, 2006). Obesity-related genes can affect how the human body metabolises food or stores fat. Genes can also partly affect people's behaviour; for instance, some genes may control appetite and others increase or decrease the responsiveness to taste, smell or sight of food. In effect, the major impact of genes on obesity is on hunger, satiety and food intake (O'Rahilly and Farooqi, 2006). It must be also noted that in most people any genetic influence is polygenic, acting through a number of susceptibility genes (Axford and O'Callaghan, 2004).

Overall, it is suggested that obesity runs in families, but the influence of the genotype on the aetiology of obesity may be attenuated or exacerbated by non-genetic factors

connected to the environment. The existence of obesity-related genes can make someone susceptible in developing obesity; but they are not essential or sufficient to explain the development of obesity. This hypothesis is supported by research studies done on twins; pairs of twins were exposed to periods of positive and negative energy imbalance. The differences in the rate of weight gain, the proportion of weight gained, and the site of fat deposition showed greater similarity within pairs than between pairs. This means that differences in genetic susceptibility within a population determine those who are most likely to become obese in any given set of environmental circumstances (Warrell et al, 2003).

These examples indicate that the key underlying problem is that 'obesity is largely a consequence of over-nutrition and under-activity' (Lawlor and Chaturvedi, 2006; p.3). It has been recognised that the key causes of overweight and obesity are increased consumption of more energy-dense, nutrient-poor foods with high levels of sugar and saturated fats, combined with reduced physical activity (Bloom, 2007).

However, critics of the biomedical approach argue against the biomedical explanation of obesity, which focuses mainly on the individual and neglects other impeding factors. They suggest that problematic behaviours towards weight are linked to causes connected to the globalisation of our society; namely social (Orbach, 2006), political, economic, cultural and structural changes such as the rise of consumer culture and the competition between commercial interests and public health priorities (Popkin, 2005; Townend, 2009). The link between globalisation and obesity are multiple; for instance, it is argued that global increases in the incidence and prevalence of obesity are grounded in the globalisation of Western food systems and consumer culture, which have modified people's calorific intake and energy expenditure (Sobal, 2001). Campos (2004) and Campos et al. (2006) are some of the critics who claim that obesity is a product of social context, based on multi-national companies that profit from it. Indeed, Campos et al. (2006) add that there are only subtle shifts in weight levels worldwide, rather than an alarming epidemic, according to their calculations.

Specifically, feminists such as Orbach (2006) view obesity within a framework of the oppression experienced by women from questionable weight standards and weight control programmes, which embrace the view that obesity is a sign of addiction and

loss of control. Chernin (1981), Bovey (1989) Wolf (1991), (Allan, 1994), and Orbach (1998) and have all contributed to the idea that women's bodies, especially 'fatness' – as they refer to obesity- is exploited by the Western patriarchal society. According to the feminist movement, the female body is constructed as deficient, associated with illness, with lack of control and rational action (Annandale, 1998). Regardless of the contributions that the feminist movement have made to the conceptualisation of obesity, their work has been criticised for being based on theoretical – rather than empirical findings - and, as such, can be questioned for their credibility.

Most nursing studies indicate that nurses and student nurses believe that obesity is mainly caused by controllable factors, such as eating habits and lifestyle choices (Hoppe and Ogden, 1997; Culbertson and Smolen, 1999; Green et al., 2000; Petrich, 2000; Jeffrey and Kitto, 2006; Brown et al., 2007; Jallinoja et al., 2007; Drake et al., 2008; Poon and Tarrant, 2009; Watson et al., 2008; Budd et al., 2009).

In Hoppe and Ogden's study (1997), for instance, participants rated lifestyle as the main cause of obesity, while 70% of 73 student nurses in Culbertson and Smolen's study (1999) indicated that obese adults have poor food selection. Although Hoppe and Ogden (1997) used a random sample of nurses and had a high response rate, they are rather unclear about the development, testing and validity of their research instrument. Culbertson and Smolen (1999) were some of the researchers (Maroney and Golub, 1992; Garner and Nicol, 1998; Culbertson and Smolen, 1999; Zuzelo and Seminara, 2006) who chose to utilise the questionnaire developed by Bagley et al. (1989), but little is known about the instrument's development and testing. It has been found, though, that this questionnaire is rather vulnerable to response bias due to question phrasing. Further the majority of the studies (Bagley et al., 1989; Maroney and Golub, 1992; Garner and Nicol, 1998; Culbertson and Smolen, 1999) have not disclosed their response rates; the response rate indicates a risk of lower accuracy of the findings, which must be taken into consideration when considering the findings. Zuzelo and Seminara did disclose the response rate, which was considerably low (16.2%); they managed to recruit 119 respondents out of 773.

In Drake et al.'s study (2008), when nurses were asked to rank the factors contributing to obesity, the factor most frequently ranked first was behavioural,



followed by psychological, genetic, and, lastly, physiological factors. A significant limitation in this study, though, was that the questionnaire did not include environmental factors and, thus, nurses did not have the opportunity to select them. However, in Watson et al.'s study (2008), in which nurses did have the opportunity to select environmental factors; eating habits, lifestyle and self-control were ranked highest between factors contributing to obesity, while environment scored the lowest.

However, these findings are contradicted by two qualitative studies regarding nurses' beliefs about the causes of obesity. Brown and Thomson's study (2007) suggested that nurses (N=15) are aware of the complexity of obesity, which they see as resulting from the patient's personal responsibility as well as factors beyond the control of individuals, such as environmental, cultural and economic factors. It is intriguing that less emphasis was given to explanations regarding genetic or medical conditions, which are also factors beyond patients' control. Jeffrey and Kitto's (2006; p.80) participants (N=10) also agreed that obesity has more than one cause; stating characteristically 'it's not just about food'. These two qualitative studies illustrate that there is more depth in nurses' perceptions of the origins of obesity than is uncovered with quantitative studies. It would be interesting to find out whether student nurses' beliefs are based on nursing education they received or other sources of information, such as the media.

The contradictory findings may also indicate educational gaps in students' and nurses' knowledge. Previous research shows that a great proportion of nurses answered incorrectly on statements, such as 'high sugar intake is a more major cause of obesity than a high fat intake' and 'some overweight patients can live on 800-1200 kcal day without losing weight' (Hankey et al., 2003). Hankey et al. (2003) used a systematic stratified sample and had a high response rate, which both increase the reliability of the findings; however, the sample was not representative of the population because less than a third were overweight or obese. It should also be mentioned that Hankey et al.'s study (2003) recruited participants that were members of the British Dietetic Association, which means that they may have a special interest in obesity or nutrition, in general. This study, nonetheless, suggests that nurses may not be well informed about the causes of obesity. The researchers warn that there is potential that nurses give misleading advice, which in turn confirms a need for greater emphasis on nutrition in nurse education.

Apart from the origins of obesity, another important source of information are the patterns of obesity, which provide an indication of the likelihood of student nurses encountering obese patients on the wards they practise.

#### **2.3.4 Patterns of obesity**

Patterns of obesity and its prevalence are explored through considering global, UK and Welsh statistics.

According to BMI measurements, in 2008 it has been estimated that globally approximately 1.5 billion adults, 20 years old and older, were overweight and of these 500 million were obese (WHO, 2008). The prevalence of childhood obesity has risen as well; at least 20 million children under the age of five years were overweight globally in 2005 (WHO, 2005). In 2010, new data were released which indicated a rise in this number to nearly 43 million children under the age of five (WHO, 2011). Since at least half of children become obese adults (Serdula et al, 2003), it is worth considering the above figures. While these studies are based on data collected at least six years ago, they raise concerns since predictions point towards a considerable rise in prevalence in the following years. Indeed, the World Health Organisation predicts that by 2015 approximately 2.3 billion adults will be overweight and additionally more than 700 million will be obese (WHO, 2011).

Policy makers find alarming that data comparing the UK to the rest of Europe show that it is ranked among the highest for the percentage of people diagnosed as obese (WHO, 2011). In a government project to combat obesity, it was estimated that by 2025 four out of ten people in the UK could be classified as obese if current trends continue (Butland et al., 2007).

As far as Wales is concerned, where this study was conducted, the Welsh Health Survey showed that 57% of adults were classified as overweight or obese, including 22% being obese in a sample of around 15,000 individuals (WAG, 2012). In the Abertawe Bro Morgannwg University (ABMU) Health Board, which includes the areas of Bridgend, Neath and Port Talbot and Swansea, it has been identified that 59% of the adult population are overweight or obese, including 23% being obese in a sample of 4722 individuals (WAG, 2010). Since this survey was based on self-reported data, it is likely that there may be some underestimation, because people tend to underestimate weight and overestimate height (Spencer et al, 2002). This

means that the percentage of obese patients admitted to the hospitals, where this study was conducted, could be slightly higher than in Wales overall.

Another concerning point of the report is that there is a significant 10% point difference in the level of obesity between populations living in the most and least deprivation quintiles in Wales (WAG, 2012). The Interim Annual Report of the Director of Public Health of the ABMU Health Board (ABMU, 2011), thus, recognises obesity as a public health priority condition that disproportionately falls upon lower socioeconomic groups. Therefore, they have identified as a priority policy interventions to increase the participation rates in physical activity and the reduction of unhealthy eating; in order to tackle the perceived main causes of obesity (ABMU, 2011).

The trends in England, Northern Ireland and Scotland are similar to Wales and indicate that the whole country encounters similar challenges. In 2009, 22% of men and 24% of women aged 16 or over were classified as obese in England in a sample of 1541 men and 1607 women (National Health Service, 2011). The Scottish Health Survey reveals that 26.8% of Scottish men and 26.4% of women are obese in an overall sample of 6770 individuals, presenting a notable increase since 1995. In Northern Ireland, 24.4% of men and 23.5% of women were obese in a sample of 4085 individuals (NHS, 2010).

Another important aspect of obesity demographics for nursing is that the older the population, the more likely they are to be obese (British Heart Foundation, 2006). Since elderly people are more likely to have health problems and be hospitalised, these statistics ought to be of consideration. According to the Office for National Statistics, the percentage of people aged 45-65 and 65-74 who were obese increased by 10% to about 30% between 1995 and 2007 in England (Office for National Statistics, 2009). Similarly, in the period 1995-2007, the increase in the percentage of people with obesity in the age groups 45-64, 65-74, and 75 and over was twice the percentage increase seen among the younger age group 16-44. These data were based on the Health Survey for England in 2007 and the General Household Survey 1995-2007 (Office for National Statistics, 2009). Having explored the challenges of measuring obesity, the diversity of perspectives which have explored the origins of obesity and patterns of obesity I now discuss the consequences of obesity.

## 2.4 Consequences of Obesity

In this section I discuss the co-morbidities associated with obesity in order to comprehend why proponents of the biomedical model of obesity view this condition as one of the most important public health concerns of our times. Viewing obesity through the spectrum of its recognised co-morbidities is important to aid understanding of the impact that it poses on the NHS, and consequently on nursing. Drawing on research from social psychology, I also explore the extent of obesity bias and discrimination as well as the effects of obesity stigma and the consequences for patients' social and psychological wellbeing. Finally I present the consequences of obesity for the health service with a particular emphasis on costs.

### 2.4.1 Mortality and morbidity associated with obesity

An abundance of research studies directly link obesity to a plethora of metabolic, endocrine, neoplastic, psychological and other conditions (WHO, 2011). As an example, in a large European case-control study, it was estimated that 63% of heart attacks (n=12461) in Western Europe were correlated to abdominal obesity (a high waist to hip ratio), and those with abdominal obesity were estimated to be at over twice the risk of a heart attack compared to those without (Yusuf et al., 2004). The World Health Organisation specifically names obesity as a major risk factor in the development of heart disease and stroke, type 2 diabetes, osteoarthritis, and endometrial, breast and colon cancer (WHO, 2011).

The following table shows the conditions attributable to obesity, in alphabetical order, according to which the costs of obesity to NHS were calculated for the Welsh Assembly Government (WAG, 2010). This table is an indication of the multiple problems that an obese patient could face as well as the different settings that student nurses may encounter obese patients.

|        |                     |                    |                 |                     |
|--------|---------------------|--------------------|-----------------|---------------------|
| Angina | Non-specific cancer | Endometrial cancer | Hyperlipidaemia | Sleep apnoea        |
| Asthma | Cirrhosis of liver  | Fatty liver        | IGT             | Stress incontinence |

|                         |                        |                       |                    |                                      |
|-------------------------|------------------------|-----------------------|--------------------|--------------------------------------|
| Atrial fibrillation     | Coronary Heart Disease | Gall bladder cancer   | Liver cancer       | Stroke                               |
| Back pain               | Deep vein thrombosis   | Gallbladder disease   | Oesophageal cancer | Uterine cancer (corpus uteri cancer) |
| Breast cancer           | Depression/anxiety     | Gout                  | Osteoarthritis     | Varicose veins                       |
| Colon cancer            | Diabetes type II       | Hiatus hernia         | Ovarian cancer     | Vascular problems                    |
| Colorectal cancer       | Dyslipidaemia          | Myocardial infarction | Prostate cancer    | Caesarean delivery                   |
| Cardiovascular diseases | Eating disorders       | Hypertension          | Pulmonary embolism | Gestational diabetes                 |

Table 2. The health consequences of obesity (WAG, 2010)

Moreover, obesity is also linked to day-to-day problems, such as breathlessness, increased sweating, snoring, sleep apnoea, incontinence, back and joint pains, oedema, cellulites, tiredness and varicose veins. Apart from that, obese people are reported to be more likely to suffer from psychological problems such as low self-esteem, poor self-image, or even depression (NHS, 2010).

Another important set of conditions linked to obesity are dermatological conditions (Hahler, 2006). Due to increased adiposity, obese patients experience friction and excessive moisture in skin folds that can lead to skin injury. Moreover, wounds may be difficult to heal due to increased tension on suture lines and decreased blood supply in the adipose tissue (Garcia-Hidalgo, 2002).

The co-morbidities of obesity explain the reasons behind the high number of overweight and obese patients in need of health care. They are also an indication of the variety of hospital wards and settings that nurses could encounter obese patients, as there are no official figures or statistics that show the exact percentage of individuals classified as obese admitted to hospitals. Similarly, looking at the co-

morbidities of obesity is another way of depicting the complexity of nursing an obese patient.

The literature suggests that the majority of student nurses and nurses alike are knowledgeable about the medical consequences of obesity. Previous research suggests that the majority of nurses had sufficient knowledge regarding the links of obesity to certain cancers, heart disease, urinary incontinence, sleep disturbances and psychological problems (Hankey et al., 2003). Other studies (Wright, 1998; Sardani, 2006; Miller et al., 2008) found that nurses and nursing students can name the most important diseases linked to obesity. Interestingly, the participants in Wright's study (1998) did not mention psychological, emotional or social effects on health nor the positive values of fat.

It can be seen therefore that obesity is associated with a multitude of diseases and health problems that affect one's quality of life; some of these have been proven to lead to disability, hospitalisation as well as earlier entry to nursing homes (Kim and Popkin, 2006). As far as disability is concerned, the World Health Report found that overweight and obesity is responsible for between 8% and 15% of disability adjusted life years (DALYs) lost in Europe and North America (World Health Organisation, 2004).

There is also research suggesting that obesity is linked with high mortality. An extensive analysis suggests that over 66,000 deaths in 2003/2004 could have been avoided if the population could achieve a minimum BMI of 21 kg/m<sup>2</sup> (Allender and Rayner, 2007).

However, there are certain occasions where obesity has been found to be protective as far as mortality is concerned; this is called the 'obesity paradox'. This term was coined to refer to the observation that when acute cardiovascular decompensation occurs, for example, in myocardial infarction or congestive heart failure, obese patients may have a survival benefit (Amundson et al., 2010). These findings were based on extensive research studies and meta-analyses, such as the one of Oreopoulos et al. (2008), who showed that overweight and obese patients had significant lower mortality compared to those without elevated BMI. Apart from BMI, other more accurate methods have shown that body fat has a protective effect on patients with heart failure (Lavie et al., 2003). Additionally, it has been suggested

that obese patients tend to recover better after certain surgical procedures, such as coronary artery bypass surgery (Amundson et al., 2010). The proponents of the biomedical perspective, however, suggest that the potential benefits that obesity could present to individuals, though, do not balance out the detrimental physical effects it can cause to them (WHO, 2011). On the other hand, social psychology research suggest that obesity is a stigmatised condition and, as such, it is linked with a plethora of discriminating practices that can affect an obese person's social, psychological or even physical wellbeing.

#### **2.4.2 Obesity stigma and discrimination**

There are a number of attributes assigned to obese persons that confirm that obesity is a stigmatised condition. Obese individuals have been assigned a plethora of stereotypes, such as lack of willingness, discipline and compliance to lose weight, since managing one's weight is considered a personal responsibility (Puhl, 2011). According to Puhl and Heuer's systematic review (2009), which researched a wide range of databases of international research journals, people considered as overweight or obese are perceived as lazy, unmotivated, lacking in self-discipline, less competent, non-compliant and sloppy. Link (1987) and Link et al. (1987) have shown that stereotypes or 'labels' have enduring effects, including social rejection, maintenance of social distance and discriminatory responses of social groups, including health professionals. There is a multitude of research studies concluding that individuals who are considered obese have experienced similar prejudicial and discriminatory practices in employment settings, educational settings, interpersonal relationships as well as healthcare settings (Puhl and Heuer, 2009).

An example of a study that reflects the stigma and discrimination surrounding obesity is a survey exploring the link between being bullied at school and being considered overweight (Puhl et al., 2011). Puhl et al. (2011) discovered that being overweight was the primary reason for being teased/bullied at school (40.8%, N=1555), while more than three quarters of individuals (78.5%) of the same sample reported being witnesses of such incidents. The survey also included open-ended questions with respondents giving answers such as: 'kids at school would make fun of me, and kick me. It made me feel worse about myself. It has made me depressed so I just eat more'. The majority of overweight students reported feeling sad,

depressed, worse about themselves, afraid, and bad about their body (Puhl et al., 2011).

It is of particular interest to discuss the prevailing stigma and discrimination occurring in healthcare settings. Numerous studies have been conducted that suggest that health care professionals are not immune to weight bias (Puhl and Heuer, 2009). Harvey and Hill's (2001) surveyed 255 general practitioners and clinical psychologists in the UK in order to explore their beliefs about the causes, attitudes towards, and perceptions of responsibility of overweight people. Even though such information is self-reported and could be influenced by respondent bias, it is interesting that respondents reported viewing overweight people as having low self-esteem, being less sexually attractive than non-obese, unhealthy as well as responsible for their weight and health problems. In another survey, which included a sample of 620 primary care physicians, more than 50% of respondents regarded obese patients as awkward, unattractive, ugly, and noncompliant (Foster et al., 2003). Similar findings have been found in a British qualitative study, whereby 21 participant primary care physicians reported common weight biases, including that it is the responsibility of the patients themselves to manage their weight (Epstein and Ogden, 2005).

Nurses and student nurses alike have not been immune to stereotyping obese persons. A 2006 review of research focusing on nurses' attitudes towards obese patients reported that nurses consistently express biased attitudes towards obese patients, reflecting common weight biased stereotypes that obese patients are lazy, lacking self-control, and non-compliant (Brown, 2006). Studies conducted before 2000 report the strongest and most negative beliefs about obese persons.

Using the instrument developed by Bagley et al. (1989), findings suggest that nurses in Canada and USA assigned several stereotypes to obese patients, such as lacking self-control, less truthful about their feelings and lacking self-confidence (Bagley et al., 1989; Maroney and Golub, 1992; Garner and Nicol, 1998; Culbertson and Smolen, 1999). However, on a positive side, respondents did not consider obese persons pushy, aggressive, or more demanding than other patients. The questionnaire developed by Bagley et al. (1989) contains Likert-style questions, but their relatively short article does not reveal much information about its development and testing.



This questionnaire is rather vulnerable to response bias due to question phrasing. For instance, respondents were asked whether 'nurses feel uncomfortable when caring for obese adult patients' but were not enquired about the opposite; whether they enjoy it. None of these studies did attempt to improve the questionnaire (Maroney and Golub, 1992; Garner and Nicol, 1998; Culbertson and Smolen, 1999).

However, using other instruments, research has suggested that obese patients are more likely to be labelled negatively. Peternelj-Taylor (1989), who used descriptive vignettes and visual stimuli along with a self-administered questionnaire, also found that her respondents evaluated obese persons more negatively; specifically obese persons were considered as less socially attractive. Negative judgements towards obese patients were also identified in nurses working in the mental health field; in effect, obese women were more likely to be seen as psychologically deviant than non-obese in a hypothetical scenario developed by the researchers (Young and Powell, 1985). In a study exploring students' perceptions of obesity in Canada, it was found that student nurses exhibit similar attitudes to registered nurses; the majority of participants labelled obese persons as unhealthy, inactive, lazy, and lacking self-control (Petrich, 2000). It must not be forgotten that all these studies opted for using convenience sample in their studies, which affects population representation.

More recent studies have reported rather covert expressions of discrimination towards obese people. Nowadays people are aware of the stigma associated with obesity, which results in participants avoiding to show signs of over discrimination (Brown and Thomson, 2007). It has also been suggested that due to the values in nursing, it is more likely that nurses express their attitudes in more subtle ways (Reto, 2003). The most common stereotype assigned to obese persons is that they are neither compliant nor motivated to lose weight (Hoppe and Ogden, 1997; Jeffrey and Kitto, 2006; Brown et al., 2007; Brown and Thomson, 2007; Jallinoja et al., 2007; Poon and Tarrant, 2009). Many participants in Jeffrey and Kitto's study (2006) thought that obese patients were reluctant to change and used weight-loss surgery as a 'quick fix' in order not to do changes in their diet and overall lifestyle. Indeed, attribution of responsibility has been proven to be directly linked to prejudice towards obese people (Crandall, 1994). The assumption that patients are reluctant to change is part of the moral evaluation that people have against obese persons that,

consequently, results in blaming the patient for his/her weight and related comorbidities (Crandall et al, 2001).

The terminology used to refer to obesity exemplifies the complex issues surrounding it. Petrich (2000) looked into medical and nursing students' perceptions of obesity and discovered that obesity, as a term, has a negative meaning. Her participants saw obesity as unhealthy and overweight individuals were automatically viewed as having poor health. In the same study, when looking into the meaning and interpretation of words associated with obesity, such as 'fat' and 'overweight' some controversy was spotted; 17% of nursing students perceived the words obese and fat to be negative, condescending, demeaning terms, while 10% felt it was a clinical, acceptable, and kinder term to use. One student stated that the word fat described the type of body a person had, while another felt it meant chubby (Petrich, 2000). This shows the range of perceptions that nursing students have, which may suggest that student nurses are ambivalent about the acceptability of the terminology of obesity. The ambivalence of using the term obesity could be linked to the stigma associated with it. Even nurses working in primary care, have expressed feeling reluctant to use the term 'obesity' when talking to patients and preferred to utilise softening terms in relation to body fat (Brown and Thomson, 2007). The most obvious reason was that the term 'obesity' was seen as a way of passing negative judgement to the patient due to its negative connotations, which shows nurses' awareness of stigma associated with the condition.

Goffman (1963), in his influential work on stigma, has explained that stigmatised individuals are more likely to be given negative attributes by society in order to explain their inferiority. In effect, nurses have reported that obese patients may not be truthful about their eating habits, are non-compliant and 'want an easy way out' (Brown and Thomson, 2007; p.539). Another example stems from a Canadian study, where obese individuals were assigned the characteristics of low self-esteem, depression and guilt. Respondents felt that obese people are not socially accepted or self-confident and assigned them the stereotypes of being lazy and unkempt (Watson et al., 2007). Watson et al.'s study (2007) ought to be commented on clearly presenting the process of design, development and testing of their instrument, which aimed at measuring nurses' attitudes towards obesity and obese adult patients. Their questionnaire was based on Bagley et al.'s (1989) with further items added to reflect

advances in the field. Watson et al. (2008) preferred not to use a Likert scale, but a visual analogue scale, which allows respondents more options in their responses. In order to avoid response bias, many items were phrased in the opposite direction, and were reversed scored for analysis. Only few studies (Hankey et al., 2003; Brown et al., 2007; Swift et al., 2007; Watson et al., 2008; Kam and Taylor, 2010) reported submitting the questionnaire to experts in the field to establish content validity and Watson et al. (2008) was one of them.

In a previous study I conducted with student nurses as participants, the most common characteristic assigned to obese patients was 'demanding' and was associated with the students' perceived inability to meet obese patients' needs in the allocated time and resources in clinical practice (Sardani, 2006). Johnson and Webb (1994), doing grounded theory research on 'unpopular patients' explored the labelling of a patient as 'demanding'; it was discovered that nurses held that patients are demanding when they did not like them. They used the word 'demanding' with disapproval rather than a merely functional label. Breeze and Repper (1998) have also identified the same issue in their research regarding 'difficult' patients in mental health services. They concluded that patients who were considered difficult were referred as 'demanding' of time and hospital resources that should have been devoted to other patients, who were considered more in need. Other stereotypes attributed to obese patients included being lazy, greedy, unconcerned or unaware of their health problems, unappreciative, unpleasant personality, telling lies, humorous, lonely, depressed, rude, unmotivated and apathetic (Sardani, 2006).

A considerable weakness of all quantitative studies conducted is the issue of social desirability or 'halo effect'; this refers to the tendency of respondents to answer in a socially acceptable way. As already pointed out, instruments that have been used to do research on student nurses and nurses' attitudes are not likely to depict the true feelings and thoughts of respondents because overt discrimination is frowned upon. Several researchers have admitted this weakness of their instrument; Maroney and Golub (1992) suggested that the population they studied have been taught not to express discriminatory attitudes. Peternelj-Taylor (1989) also admitted that the instrument she used could not prevent respondents from answering to the scales in a socially desirable manner; she suggested that since her participants were still students they might have tried to find the 'correct' answer to the questions instead of stating

their true perceptions. Peternelj-Taylor (1989) was able to identify this point in the analysis of her findings; student nurses' answers tended to be at the mid-point (neutral) on the seven-point scale. This is known as the error of central tendency and illustrates the respondents' reluctance to attribute responsibility to obese patients. Brown et al. (2007) also warned their readers to treat with caution findings related to the attitudinal scales of the questionnaire, which had low content validity. Content validity refers to judgements about the extent to which the instrument appears to examine the full scope of the characteristic it is intended to measure; in this case, the characteristic is 'attitudes' (Bowling, 2009). In other words, Brown et al. (2007) discovered that their instrument could not measure attitudes in a satisfactory way.

In effect, it is argued that questionnaires undermine their utility as measures of attitudes as people tend to give non-prejudiced responses to survey questions that reflect their efforts to create a socially desirable image (Devine, 1989) or because they are unfamiliar with the particular object (Vargas, 2004). Vargas has also claimed that independently of the researcher's ability to measure attitudes and behaviour, if respondents are unwilling to report their true attitudes, it is unlikely that 'explicit attitude measures will be good predictors of behaviour' (Vargas, 2004; p.278).

Recently, scientists have been developing implicit attitude measures, such as the Implicit Association Test (IAT). The IAT is a measure that was developed to detect one's automatic responses to evaluate his/her associations between concepts in memory. Instances have to be assigned to these concepts by pressing appropriate keys as quickly as possible; quicker responses are linked to stronger associations. Indeed, an IAT was developed to assess overall implicit weight bias and stereotypes and is based on an individual's automatic association between concepts in memory (Greenwald et al., 1998). This instrument was used on health professionals specialising in obesity and found that the respondents exhibited strong implicit biases towards obesity associating obese people with the stereotypes of lazy, stupid, and worthlessness (Schwartz et al., 2003). However, sceptics have identified some problems and expressed strong critiques especially regarding its construct validity; in other words, they are unsure if the IAT is measuring the underlying concept it purports to measure (Fiedler et al., 2006). Further, there is no experimental research

that could suggest that IAT scores or similar measures could predict implicit anti-fat bias and discriminatory behaviour towards obese individuals (Schwartz et al., 2003).

Overall, both student nurses and nurses assign negative characteristics to obese patients, such as being lazy and lacking motivation to lose weight, but overt discrimination has become less apparent. One explanation could be that previous instruments did not prevent respondents from answering in a socially desirable manner, which shows that there is room for further research utilising a method that surpasses this difficulty.

Judging from the plethora of negative beliefs and stereotypes about obese patients, it is not surprising that there are several research studies, which suggest that nurses and student nurses have negative feelings towards obese patients and their care. Since the earliest study identified (Young and Powell, 1985), it is suggested that obese patients' body size influences nurses' and nursing students' attitudes. The majority of studies support the idea that both nurses and student nurses have negative emotional response when it comes to nursing obese patients. However, there are studies reporting neutral or positive feelings towards obese patients (Sardani, 2006; Zuzelo and Seminara, 2006; Brown et al., 2007).

As far as negative feelings are concerned, frustration is the most common reaction identified towards obese patients and their care (Mercer and Tessier, 2001; Jeffrey and Kitto, 2006; Zuzelo and Seminara, 2006; Sardani, 2006; Watson et al., 2008). For instance, in Watson et al.'s study (2008), respondents replied that they feel irritation, impatience and frustration when caring for obese patients but feelings of disgust, stress, discomfort or repulsion were not statistically significant. The feeling of frustration has been linked to nurses' reporting feeling uncomfortable when caring for obese patients and finding it a stressful experience (Bagley et al., 1989; Maroney and Golub, 1992; Garner and Nicol, 1998). Respondents and participants of the above studies were self-selected, which may mean that they could potentially have different experiences of nursing obese patients than the general population or have a particular interest in the subject of obesity, which led them to their decision to participate in the study. This is illustrated in Watson et al.'s study (2008), whose sample was highly educated in comparison to the nursing population.

Frustration seems to be triggered by the perception that patients lack self-control or are not motivated enough to change. In Jeffrey and Kitto's qualitative study (2006), the participants explained that they felt frustrated because the patients 'have just let themselves get into that situation'. Jeffrey and Kitto's paper (2006) provides an excellent account of their study, research design, validity and audit trail as well as their reflexive approach. They claimed that the reflexive approach provided them with an awareness of any bias that may have occurred during interviewing and explained how building rapport with the participants facilitated the collection of rich data.

On the other hand, there are studies that show that there are nurses and students that have positive feelings towards obese patients, including empathy (Maroney and Golub, 1992; Sardani, 2006; Zuzelo and Seminara, 2006; Brown et al., 2007). In Maroney and Golub's study (1992), for example, 82.1% of 67 respondents disagreed with the statement 'it is difficult to feel empathy for an obese patient', which may mean that nurses have feelings of empathy towards them. However, at least a third of respondents in the same study reported that given the choice, they would prefer not to care for an obese patient and agreed that they feel uncomfortable when caring for them (Maroney and Golub, 1992). This controversy is also seen in Zuzelo and Seminara's study (2006); while the quantitative part of their study revealed that nurses do not have negative attitudes towards obese patients, in the qualitative part nurses said that they felt overwhelmed by patients' needs, astounded by their size and dreading the physical care demands. Nevertheless, many participants said that they felt sympathy towards obese patients for having health problems and getting into the embarrassing situation of needing special equipment in the hospital (Zuzelo and Seminara, 2006). Further, Brown et al.'s study (2007) investigated qualified nurses in primary health care, which may mean that their findings may not reflect the ones of nurses working in other fields or the student nursing population.

I identified a similar theme in my previous study (Sardani, 2006); students felt empathy, pity and sympathy towards obese patients, which was triggered by seeing obese patients being unwell and positioning themselves into patients' emotional and physical world. Witnessing overt discriminatory behaviour towards obese patients was the most powerful trigger of empathetic feelings. Nevertheless, the same participants admitted also having negative feelings towards obese patients, including

frustration (Sardani, 2006). More studies are needed to explore the conflicting feelings experienced by student nurses, the reasons behind the positive attitudes, and whether they influence the care given to obese patients.

There are other studies, however, whose respondents selected to remain neutral or did not reply on questions regarding attitudes. For instance, in Brown et al.'s study (2007), more than half of 394 respondents replied feeling empathy for obese patients, but 38.6% opted to remain neutral. In an Australian study, nearly half of respondents replied that the experience of nursing obese patients was satisfying, while another third appeared neutral. Interestingly, there were a large percentage of respondents who put a 'no opinion' response. The authors suggest that these nurses' experiences were not positive (Drake et al., 2008). In Jeffrey and Kitto's study (2006; p.79) some nurses felt positive about the patients because by electing to do weight-loss surgery they are showing responsibility and 'are trying to do something about it'. There were some nurses, however, who defended their neutrality and said 'it's not for us to make judgements' claiming that the patient's size was irrelevant in how they viewed their patients. Nevertheless, this study's authors also revealed that later on in the interview process, the same participants expressed negative views and feelings about obese patients conveying once again that nurses are experiencing mixed feelings towards obese patients. It must be stated that Drake et al.'s (2008) and Jeffrey and Kitto's studies dealt specifically with the care of morbidly obese patients. It is understandable that morbidly obese patients may differ from obese patients in terms of issues, such as their care requirements; this fact ought to be taken into consideration when looking at their findings.

Overall, it seems that current research has shown that nurses and student nurses are experiencing a wide spectrum of feelings towards obese patients. A large proportion has admitted having negative feelings, but there are still studies confirming that student nurses feel empathetic towards them. It would be interesting to explore whether these feelings are reflected in student nurses' practice.

As with other fields, the pervasiveness of the negative meaning of obesity has proven to affect health care professionals' behaviour towards patients. There are several studies, which report obese people receiving disrespectful treatment due to weight discrimination; this is evidence that the meaning that health care professionals assign

to obesity can affect the quality of services they provide (Puhl and Brownell, 2001). A study, for instance, found that physicians (N=1300) often focus on weight solely as the cause of health problems and may feel reluctance to perform a pelvic examination, or prescribe birth control pills and other medication, citing body size as a precluding factor (Adams et al., 1993). Overweight and obese women have reported that their gynaecologists have refused to believe they were sexually active (Packer, 1990), which also suggests that obese patients may be stigmatised. Another study that examined the effects of obesity on the clinical judgements of mental health professionals, including nurses, found that respondents evaluated obese clients more harshly in a way that influenced their clinical decision-making (Young and Powell, 1985). Indeed, based solely on physical appearance, obese individuals were viewed as psychologically deviant and more likely to cause problems (Young and Powell, 1985). Young and Powell (1985) asked their 120 respondents to complete a questionnaire, which was based on a case history and photographs of what could be considered normal-weight, overweight and obese individuals. As with Peternelj-Taylor (1989), Young and Powell's idea of utilising an instrument tool that provides visual stimuli facilitated better understanding and communication of concepts of what is considered normal weight, overweight and obese. Young and Powell's study suggested for the first time that portrayed obese patients are more likely to be given negative evaluations by mental health professionals because of their physical appearance, but they did not prove that respondents would respond the same way in real life situations. There are no studies, however, that explore whether student nurses' attitudes influence their behaviour towards patients.

Whilst the review has focused on the consequences of obesity for the individual I now turn to discuss the consequences of obesity and in particular the cost of treatment of related co-morbidities of obesity, including patient hospitalisation, to the National Health Service.

### **2.4.3 The cost of obesity to the NHS**

In response to the rise in the prevalence of obesity in UK and bearing in mind the conditions that are associated with it, the UK government has commissioned special analyses and reports on the impact of obesity to the NHS (McPherson et al., 2007; WAG, 2010). The figures illustrate how pertinent the issue of obesity is considered



nowadays and how essential it is to place emphasis on educating current and future nurses in providing adequate care to these patients.

In effect, the number of patients hospitalised who are obese is continually increasing. The impact of obesity on hospitalisations in Wales amounted to £3,470,007 in 2008/09, which represents 0.24 % of total expenditure on in-patients, while the amount is £6,028,347 – 0.42% -if overweight and obese people are included (WAG, 2010). In 2008/09 the number of patients in NHS hospitals in England with a primary diagnosis of obesity was nearly 8,000, which was eight times higher than ten years ago and more than double the number in 2006/07. Similarly, data show that in 2008, the number of prescription items dispensed for the treatment of obesity cost £1.28 million, which is ten times more prescriptions than in 1999 (NHS, 2010).

It has been estimated that the impact of obesity through its recognised co-morbidities has placed a significant and increasing burden on the National Health Service in the UK; this was estimated to be £4.2 billion in 2007, the rise in the costs attributable to elevated BMI is predicted to be £9.7 billion by 2050 (McPherson et al., 2007).

Since this study was conducted in Wales, local statistics were explored. Obesity was estimated to cost the NHS in Wales over £73 million, which increases to nearly £86 million if obese and overweight people are included. In 2008/09, between £1.40 million and £1.65 million was spent each week treating diseases resulting from obesity and amounting to between £25-£29 per person in Wales and between 1.3% and 1.5% of total healthcare expenditure in Wales (WAG, 2010). Scotland is experiencing similar challenges as the cost to the NHS in Scotland of obesity and obesity-related illnesses was estimated to be in excess of £175 million in 2007/2008 (Scottish Government, 2010).

Having identified that the number of people who are obese is increasing and that due to the co-morbidities associated with obesity these people are more likely to be hospitalised, it is evident that nurses and in particular student nurses will increasingly be caring for obese patients. I now review the research which has focused on nurses' knowledge and participation in obese patients' care.

## **2.5 Nurses' knowledge of obesity and participation in obese patients' care**

### **2.5.1 Knowledge about obese patients' care**

Lack of knowledge could influence the meaning that student nurses attach to the term obesity and, in turn, may encourage the development of stigma towards patients that are considered difficult to manage, such as obese patients (Scheurich, 2002). The studies suggest that student nurses may experience lack of instruction, in their university and in their clinical practice, which may increase their ambivalence in participating in obese patients' care.

Research indicates that nurses are knowledgeable about obesity treatment, as the participants of my previous study (Sardani, 2006) referred to patients' changes in food choices, eating behaviour and lifestyle, which includes increasing physical activity, reducing the consumption of alcohol and involvement of a multidisciplinary team consisting of nurses, dieticians and physiotherapists. However, they did not mention anti-obesity drugs or surgery; despite the fact that some participants had nursed patients who were admitted for gastroplasty. Wright (1998) as well reveals that in her study no participants suggested appetite suppressants. Similarly, in Jeffrey and Kitto's study (2006), nurses acknowledged that although bariatric surgery can help in losing weight, it does not provide a cure for the obese patient. These studies may suggest that nurses and nursing students attach lower priority to medically based interventions towards obesity treatment, such as drugs and surgery.

The level of education that nurses and student nurses acquire with regard to the issue of obesity is crucial and needs to be explored to identify any gaps in their knowledge base, which may compromise the quality of care they offer to obese patients.

Hankey et al. (2003) attempted to document nurses' knowledge among other health professionals, with respect to obesity, nutrition and weight management in Scotland. The sample included 613 nurses, who completed a postal questionnaire. Nurses were found to have gaps in their knowledge regarding nutrition and healthy eating principles, and the links between nutrition and obesity.

The respondents in Green et al.'s study (2000) also demonstrated significant gaps in their knowledge regarding current dietary recommendations, and fruit and vegetable

consumption advice to patients with obesity. These findings may mean that nurses may be unable to undertake effective weight management; on the positive side, though, the majority of nurses (86%) agreed that nurses, who are trained to do so, are valuable in providing weight-reduction diets for patients (Green et al., 2000). However, these findings need to be interpreted with caution because Green et al.'s study included a convenience sample of only 45 respondents. The researchers' decision to select the sample because of their close geographic proximity and approach respondents through advertising may have undermined population representation.

Apart from knowledge gaps, the level of satisfaction that student nurses have could be a good indication of the likelihood of feeling confident in caring for obese patients. Current research conveys that nurses and student nurses are not satisfied with the level of training they have received regarding obesity (Green et al., 2000; Swift et al., 2007). Swift et al.'s study (2007), which included 164 nursing students, both diploma and masters students, confirmed that student nurses do not feel satisfied with the teaching they had received about the physical health risks associated with obesity. The same study found that student nurses demonstrated significantly lower levels of knowledge regarding obesity, which means that they may not be well-equipped to work with the obese population (Swift et al., 2007). Despite using a convenience sample and having a low response rate, this study's findings are similar to Green et al.'s (2000), whose respondents felt that they would benefit from further training regarding obesity management despite that more than 65% had received education regarding nutrition since registration.

In my previous study (Sardani, 2006), participants conveyed that they received minimal instruction about obesity in the University. They suggested that they had sufficient knowledge regarding the measurement and morbidity of obesity; nevertheless they had unmet educational needs about moving and handling and providing health promotion to obese patients. Even though the purpose of this study did not involve testing the students' knowledge regarding obesity, it is suggested that the participants lacked the confidence to get involved in obesity management due to knowledge deficiencies (Sardani, 2006).

Similar findings were identified by Petrich (2000) and Green et al. (2000); these studies suggested that obesity was not treated as a separate topic in the students' curriculum. The former researcher found that student nurses were mainly instructed on the issue of obesity regarding the practicalities that are concerned regarding the moving and handling of a bigger patient (Petrich, 2000). The latter suggested that participants received education in nutrition only as part of a course, for example, the management of diabetes (Green et al., 2000). Participants gave mixed responses regarding the type of advice that should be given to obese people, which showed lack of information on the topic (Green et al., 2000). Even though this study had a low response rate (54%) and a small sample, it gives an indication that further research is needed to explore the level of education that student nurses receive regarding obesity.

While previous studies increased our awareness about the knowledge that nurses and student nurses possess regarding obesity, in the following section, I discuss nurses and student nurses' participation in obese patients' care, especially in weight management, which is the area of obese patients' care that has been most researched.

### **2.5.2 Participation in obese patients' care**

Part of the nurse's identity is to provide equal care to all patients and that could potentially influence the care that obese patients receive (NMC, 2004). Being professional means not treating obese patients differently than other patients and participants in previous studies tried to convey that idea (Peternelj-Taylor, 1989; Jeffrey and Kitto, 2006; Sardani, 2006).

This is exemplified in Jeffrey and Kitto's study (2006); when nurses were asked how they approached the nurse-patient relationship with an obese patient, all replied in some form 'no difference' or 'everyone the same'. The researchers concluded that the participants may have wanted to convey that nurses are the ideal, non-judgemental carers conforming to the public perception of nursing. In effect, the researchers admitted that further in the interview, the participants expressed a wealth of contradictions and complexity of discourses of caring for obese patients (Jeffrey and Kitto, 2006). This does not mean that nurses are not professional in their care of obese patients, but they may have controversial thoughts and feelings about them.

Student nurses have also reported trying to be professional. Peternelj-Taylor (1989) attempted to investigate whether student nurses manage to remain neutral in their practice of nursing or they withdrew from obese patients' care. Her chosen methodology was quantitative and her instrument was a combination of a self-administered questionnaire, a scenario of a patient, which was identical in all aspects but weight and sex, and four sketches of the stimulus patient depicted as a man/woman, or normal weight/obese. In her study, student nurses reported considering providing the same care to both normal weight and obese patients and, thus, did not appear to withdraw from patients' care. However, obese patients were evaluated more negatively than normal weight patients, which led the researcher to speculate that the respondents replied in a socially desirable manner. Therefore, she recognised that quantitative methodology is not adequate in assessing the relationship between negative evaluation, attribution and nurse withdrawal (Peternelj-Taylor, 1989).

Overall, studies convey nurses' and student nurses' conviction that they treat obese patients the same as any other patient. Due to the methodology used, the researchers in the above studies were not able to prove that student nurses are non-judgemental in the care they provide to obese patients. Research, thus, is needed to document student nurses' participation in obese patients' care; to explore whether student nurses withdraw from obese patients' care or perhaps dedicate more time than other patients in order to address obese patients' complex needs. An aspect of obese patients' care that has been given consideration in the past is weight management and this is now discussed.

### *Weight management*

Although the Department of Health's Obesity Care Pathway (Department of Health, 2006) states that part of nurses' role is to counsel obese patients about the health risks associated with obesity, a number of studies suggest that this is not the case. Overall, current research suggests that nurses practising in both community and hospital settings do not provide weight management advice. Swift et al.'s study (2007), for instance, noted that only 66% of nursing students agreed it was part of their role to counsel patients compared with 95% of the dietetics students that completed an online survey.

Several studies show that nurses do not offer health promotion to obese individuals consistently either in hospital or community (Wright, 1998; Hankey et al., 2003; Brown et al., 2007; Miller et al., 2008; Watson et al., 2008). In UK, only 53.8% of primary care nurses reported giving lifestyle advice about obesity on a weekly basis (Brown et al., 2007). Other interventions, such as advice about weight reducing diets and physical activity were given by less than 30% of respondents (Brown et al., 2007). In Hoppe and Ogden's study (1997) the majority of practice nurses gave weight management advice more than once a week but spent 10 minutes or less discussing weight loss. In Watson et al.'s study (2008), even though monitoring patients' food intake was considered part of the nurses' supportive role, weight management and emotional support did not score high. In a Scottish study, only 3% of primary care nurses reported having audited their practice population with respect to overweight and weight management; the researchers suggest that there may be lack of interest in being involved with weight management (Hankey et al., 2003). In an American study although 71% of respondents indicated that health promotion is part of their professional role and 93% of nurses acknowledged that obesity requires intervention, more than three quarters of nurses indicated that they do not pursue the topic when they have made the clinical judgement that the patient is overweight or obese (Miller et al., 2008).

If a large proportion of nurses do not view weight management as part of their role and, thus, give sporadic advice to their patients, it is important to seek the reasons behind their actions and decisions.

Nurses and student nurses' participation in health promotion for obese patients is potentially linked to their perceptions about the meaning and the causes of obesity, their attitudes towards obese patients as well as the level of education they have received on the topic. Clinical area –hospital or community – was not relevant to their consistency of offering weight management advice.

The meaning that is attached to obesity was considered important in Wright's study (1998). Participants appeared to suggest that the individual's perception of their size was at least as important as obesity complications and co-morbidities when deciding whether or not to give professional advice on weight management. Indeed, a participant in her qualitative study, which adopted a feminist perspective, said that

she would offer advice only if the patient was considerably obese, according to her own perception (Wright, 1998). This may mean that obesity assessment is directly linked to the likelihood of receiving weight advice. Not only is student nurses' assessment of obesity important, but also their patients' perception of their body size could be an important criterion in offering health promotion to obese patients. These parameters need further investigation to determine their importance for student nurses.

Research suggests that a vital reason behind nurses' unwillingness to participate in weight management could be *obesity stigma*. *Sensitivity* about obesity was a theme that emerged in several studies discussing weight management (Wright, 1998; Sardani, 2006; Brown and Thomson, 2007). For instance, the nurses in Wright's study (1998) expressed discomfort with counselling patients about their weight and viewed this topic as sensitive and personal even though they viewed fat as unhealthy. Brown and Thomson (2007, p.538) commented that their participants viewed the obesity topic as 'being a potentially awkward, difficult, uncomfortable, sensitive issue to address with patients and one in which care was needed'.

In effect, participants expressed their awareness of the negativity surrounding obesity that they considered weight management as reprimanding and, perhaps, that this may compromise their relationship with the patient (Wright, 1998; Sardani, 2006; Brown and Thomson, 2007). In Wright's study, weight advice was seen as giving negative critical attention rather than part of their *role*, which, according to the researcher, confirms the conflict experienced by the nurse about either following the medical protocol or protecting the emotional well-being of the patient (Wright, 1998). Nurses have also been reported to be concerned about the negative effects weight management may have on the *nurse-patient relationship*, perhaps damaging the rapport (Brown and Thomson, 2007). It must be commented that Brown and Thomson (2007) provided a detailed account of their sampling, data collection and analytic methods. Indeed, they were clear about their ontological and epistemological position, data collection and analysis. In effect, their paper includes the interview schedule and a plethora of quotes from the interview transcripts to exemplify the points made. These findings illustrate the link between obesity stigma awareness on nurses' willingness to offer weight advice.

Obesity stigma also seems to influence the motivation levels of nurses in offering advice. None of the nursing students who participated in Petrich's study stated that they felt motivated to help obese persons. This could be linked to the fact that only 3% of 102 nursing students believed that people can be helped to lose weight (Petrich, 2000). In another study, obese patients' non-compliance with advice was rated as the most likely reason for patients' failure to lose weight (Hoppe and Ogden, 1997). Nurses seem ambivalent whether patients are motivated or not. In Brian and Thomson's study (2007), nurses reported that the patient's motivation may change over time, and therefore needs to be assessed before offering advice. In other words, if nurses think that patients are not motivated enough or compliant, they may not feel motivated in engaging in weight management.

Nurse's *confidence* in their ability to offer weight loss advice has been ranked as an important parameter. In Hoppe and Ogden's study (1997), overall respondents were confident about giving weight loss advice, despite reporting that they were not optimistic about the actual outcome of this advice in terms of the patient either following it or losing weight. It seems that nurses in that study felt competent and marked their ability in offering advice independently of the results that it may produce. Other studies show that nurses' feeling of competence may not be that strong. In Miller et al.'s study (2008), only half of 739 nurses indicated that they felt competent to provide professional advice and counselling for patients interested in weight reduction. Brown et al. (2007) reported that only 26.7% of their sample agreed that they felt effective in their work regarding weight management. One reason highlighted was that their personal effectiveness was positively related to organisational support, which they considered inefficient (Brown et al., 2007).

Unsurprisingly, nurses' confidence in offering advice is related to their level of knowledge regarding weight management and obesity. Research suggests that the level of knowledge that nurses and student nurses possess influences their attitudes towards offering weight management advice. In Hankey et al.'s study (2003) practice nurses who had read official governmental obesity guidelines displayed a more positive attitude towards weight management. This is reflected in that 86% of nurses agreed that there is need for specially trained nurses in providing weight-reduction diets to obese patients (Hankey et al., 2003). It must be stated that their sample was not representative of the nursing population, as less than a third were overweight or



obese despite that they used a systematic stratified sample. It should also be mentioned that Hankey et al.'s study (2003) recruited participants that were members of the British Dietetic Association, which means that they may have a special interest in obesity or nutrition, in general. Miller et al. (2008) had similar results; 62% of nurses reported that they need continuing education regarding the health implications of obesity and 78% said that they need continuing education regarding interventions. In Brown et al.'s study (2007) very few respondents appeared to have had specific training. It would be interesting to explore the level of instruction and knowledge that student nurses possess and investigate how their knowledge influences their confidence and motivation in offering weight management advice.

The advice that nurses report offering to obese patients seem to be mainly about their eating and exercise habits, which is connected to their beliefs regarding the causes of obesity (Hoppe and Ogden, 1997; Wright, 1998). Nurses were willing to offer mild exercise such as walking and doing modifications in their diet, such as reducing dietary fat while involving a dietician (Wright, 1998). In Brown et al.'s study, nurses replied that they gave general lifestyle advice about obesity more often than advice about weight reducing diets, and physical activity. A large number of nurses reported that they only provide information resources, such as leaflets (Brown et al., 2007). It is intriguing that low calorie diets, diet foods, appetite suppressants, and involvement in slimming clubs or surgery were offered the least or not at all, which may imply a disbelief in their effects (Hoppe and Ogden, 1997; Wright, 1998; Hankey et al., 2003). The ambivalence of nurses towards weight loss surgery has been also documented elsewhere (Jeffrey and Kitto, 2006). Even though the nurses recognised the benefits that patients could potentially harvest due to weight loss from surgery, they felt negatively about the principles behind it, which conflict with their holistic focus on patient care and treatment and the potential ineffectiveness and surgical complications involved (Jeffrey and Kitto, 2006). In Hankey et al.'s study (2003), 35% of the 613 nurses in the sample did not agree with recommending commercial slimming groups, while another 35% agreed with it. Overall, nurses were divided regarding the type of advice given towards obese patients, which does not seem to follow strict or official guidelines. Further, the advice given by student nurses has not been given attention and therefore needs to be explored and perhaps documented as it occurs in their everyday clinical practice.

Another theme, which is discussed below, emerging from previous research, is that obese patients' care is affected by contextual factors that influence the experience of caring for them.

### **2.5.3 Perceived barriers to obese patients' care**

The respondents in previous studies have agreed that caring for an obese adult is physically exhausting and stressful (Bagley et al, 1989; Maroney and Golub, 1992; Poon and Tarrant, 2009). A large proportion of the participants in these studies felt uncomfortable when caring for obese adult patients (Bagley et al, 1989; Maroney and Golub, 1992). In Bagley et al.'s (1989) study 24.3% of respondents agreed that caring for an obese patient usually repulsed them, while only 5.9% of Maroney and Golub's respondents agreed with that statement (Bagley et al., 1989; Maroney and Golub, 1992). In the statement 'if given the choice most nurses would prefer not to care for an obese patient', nearly half agreed, while a similar number of American respondents disagreed with the statement (Maroney and Golub, 1992). On the other hand, a more recent study in USA revealed that nurses are not repulsed by obese patients (Zuzelo and Seminara, 2006). Similarly, in a study conducted in Hong Kong, the majority of both student nurses and registered nurses stated that they do not feel uncomfortable, impatient or disgusted when caring for obese patients (Poon and Tarrant, 2009).

However, there seems to be a consensus that there are certain factors affecting the quality of care that nurses are able to offer; namely, staffing levels, availability of manual handling equipment, levels of knowledge and experience, the personality of the patient and nurses' personal characteristics. These factors, which could potentially become barriers to obese patients' care, are discussed below.

Further it must be understood that even though all studies provide useful insights into students' and nurses' perceptions of obesity, attitudes and nursing care, they fail intrinsically to detect the effects of attitudes on nurses and student nurses' behaviour towards obese patients. As with questionnaires, the knowledge found through interviews is nurses' *perceived* adequateness rather than the actual quality of care their patients receive. Similarly, previous studies investigate nurses' and student nurses' perceived barriers, which may be different in scale, proportion or intrinsically of what they encounter in reality. Further, these types of instruments are far less

appropriate to investigate attitudes, as people rarely express overt discrimination towards obese people. Overall, interviews and questionnaires cannot be used as a substitute for observing actual behaviour.

### *Staffing levels*

Staffing levels have been considered mainly in relation to meeting an obese person's hygiene needs. If the patient's mobility is impaired additional personnel may be required, especially when turning to provide personal care (Davidson et al., 2003). It has been suggested that morbidly obese patients require almost twice as much time and staff members for their care as well as raising greater safety concerns than care of the non-obese patient (Rose et al., 2006). Rose et al. (2007) utilised structured observation to determine the time spent by nurses caring for morbidly obese and non-obese patients in an acute care ward. A trained research assistant observed nurses caring for patients and systematically noted the time and number of personnel required for nursing activities, such as bathing, turning or positioning, assisting to sit or walk; a field researcher recorded the time and the number of people for each activity (Rose et al., 2007). Although this type of research provides useful information, a major weakness of the study is that nurses observed were aware that they were part of a research project and this apprehension may have influenced their performance. Indeed, their performance could have been either enhanced or impaired in the presence of the 'outsider' researcher, which could potentially influence the reliability of the findings (Bowling, 2009). Nevertheless, Rose et al. (2007) found that when bathing and assisting to walk morbidly obese patients required more staff, when comparing the nurse staffing requirements for the care of morbidly obese and non-obese patients. Further, while nurses spent 7.4 minutes positioning a non-obese patient, they had to spend double the time (14.7 minutes) to position a morbidly obese patient. This observational study also found that bathing and assisting to sit had similar results in staff requirements and total staff time spent on each patient (Rose et al., 2007).

Nurses have realised that low staffing levels may be linked to potential risks to both patients and staff. In a study exploring the challenges of nursing obese patients, only 39% of 109 nurses in hospital settings replied that they had enough staff on the ward to look after morbidly obese patients (Drake et al., 2008). Indeed, other studies have

also indicated that more personnel could ease the difficulty of patient management and increase the perceived safety of both patients and staff (Sardani, 2006; Kam and Taylor, 2010). Nurses in Kam and Taylor's study (2010) specifically noted that mobilisation and positioning of obese patients required more staff than currently available, which increased the risk of injury to staff while lifting. Although this study was conducted in Australia, it coincides with findings from UK studies suggesting that low staffing levels are linked with job dissatisfaction, high burnout levels and deteriorating quality of care in UK hospitals (Rafferty et al., 2007). Nevertheless, there is no study conducted in UK investigating whether staffing levels increase the risk of injury to student nurses or influence the care provided to obese patients. However, there are studies that report that availability and usage of manual handling equipment possess constraints to obese patients' care.

#### *Availability and usage of manual handling equipment*

Availability of manual handling equipment is also deeply connected with meeting obese patients' hygiene needs. A survey of 109 nurses from a variety of practice settings in US regarding their perceptions of challenges in caring for morbidly obese patients identified special equipment needs as a key barrier to providing satisfactory care to obese patients (Drake et al., 2008). The majority of respondents reported having specialised equipment (61.3%); in hospital settings that percentage increased to 85%. However, only 42% of respondents agreed that they use this equipment when providing care to morbidly obese patients. This finding is vital to comprehend the complexity surrounding manual handling equipment's usage. This could potentially mean that nurses may endanger their health and safety when caring for these patients by not complying with current regulations. However, no study was identified in the UK which has explored how the equipment is used in student nurses' practice and the related practicalities involved in obese patients' care.

In the UK, a more recent qualitative study, which utilised focus groups with 17 volunteer second year Degree and Diploma students, shed light onto the factors influencing students' compliance with the manual handling regulations regardless of patients' weight and size (Cornish and Jones, 2010). The participants in that study reported consistently using bed sheets to drag patients up the bed, not completing risk assessments, not assessing patients' abilities, lifting patients, supporting patients'

weight, poor communication and poor management of equipment and not completing equipment safety checks. Students felt that unavailability of special equipment for morbidly obese patients had a negative impact on the patient (Cornish and Jones, 2010). However, they also suggested that larger sized patients were given more consideration when planning manual handling and arranging the number of people required for it, which led to good moving and handling practice, according to students' estimation (Cornish and Jones, 2010). Nevertheless, the majority of student nurses replied that they do not usually comply with the moving and handling regulations (Cornish and Jones, 2007). The reasons behind the poor compliance were multiple, including students' feeling of being powerless, lack of confidence in their skills, the need to fit in and being outnumbered by staff that do not utilise the equipment. Even though this study did not concentrate on obese patients' care, it gives considerable insight into student nurses' experiences of manual handling obese patients. However, since the focus of this study was not on obese patients, further research is needed to explore in depth the issues relating to obese patients' manual handling and perhaps document students' experiences in clinical practice.

There are also studies that mention that the physical demands of caring for obese patients and the availability of equipment play an important role in the attitudes formed towards them (Jeffrey and Kitto, 2006; Sardani, 2006; Zuzelo and Seminara, 2006). In my previous study, the participants mentioned lack of availability of equipment, neglected safety checks, issues with space around patients' beds and lack of confidence correlating with lack of knowledge as important barriers linked to the usage of manual handling equipment (Sardani, 2006). The links between student nurses and nurses' negativity towards obese patients and manual handling equipment have not yet been researched. More research is needed to explore this aspect of care of obese patients, where it occurs, in the natural setting of the clinical wards.

Nurses and student nurses have also cited certain traits of obese patients as an impediment to the care they offered, which are discussed below.

#### *Personality of patient*

A commonly reported barrier to obese patients' care is the personality of the patient (Garner and Nicol, 1998; Sardani, 2006; Drake, 2008, Poon and Tarrant, 2009). As already discussed, nurses and student nurses alike have rather negative beliefs about

the personality characteristics of obese persons. For instance, obese patients have been characterised as difficult and lazy (Brown, 2006; Sardani, 2006). Even though they report that the perceived personality of the patient does not influence their practice, research shows that there are some indications that it could. For instance, offering weight management advice is one field that there are strong indications that it could be affected mainly because nurses are convinced that obese patients do not want to change and lose weight (Brown and Thomson, 2007).

Another popular assumption made by nurses is that gaining weight or losing it is an issue that patients can control, as seen in the section about their beliefs about the causes of obesity. This raises the question whether obese patients are personally held responsible for their weight and, as previous studies suggest, they are (Drake et al., 2008). In effect, in Drake et al.'s study patient's personality was rated as the second highest most important barrier to obese patients' care, after special equipment needs and was considered more important than nurses' attitudes, staffing concerns and safety concerns.

Even though health promotion to obese patients may be affected, other fields have not been fully explored so that currently there is a gap in our knowledge regarding the link between the perceived personality of obese patients and the care they receive when admitted to hospital. Jeffery (1979) in his influential study on deviant patients found out that obese patients were put in the same category as 'smelly' and 'dirty' patients because they possessed characteristics that were objected to. Indeed, there is no study conducted in practice which shows that obese patients are considered difficult or demanding patients because of their perceived personality.

However, there is evidence that obese patients may be considered both as popular and unpopular. In his study about the process of social judgement, Martin Johnson (1997) discovered that obese patients may have a dual evaluation; carrying both negative and positive labels. He learnt that obese patients tended to be unpopular because of the sheer physical toil involved in caring for them, especially when they were bed-ridden and incontinent. Apart from being viewed as work 'very demanding physically and emotionally', it was also considered as stressful because a nurse had to ask for other nurses' assistance, when they were already very busy (Johnson, 1997; p.103). Nevertheless, he identified that certain patients, despite being obese

and 'asking constant attention', were treated as undoubtedly popular. Johnson explored further the concept of popularity and found out that being demanding, in terms of challenging in their care, was not an inclusive factor to be considered unpopular (Johnson, 1997). Spending less time with the patient was one negative consequence that nurses reported when a patient was considered unpopular. Even though Johnson's study provides invaluable insights into the process of social judgement of patients, his study describes only one patient and a single occurrence of obese patients' care, which means that questions remain unanswered regarding the issue of popularity of obese patients on the ward by either nurses or student nurses. For instance, it would be interesting to find out whether student nurses spend less time with obese patients than the ones they consider non-obese.

Another interesting finding of Johnson (1997) was that individual nurses had different personal views of the patients. This may mean that nurses' personal characteristics may play an important role in patient evaluation and judgement. Nurses' personal characteristics and their link to obese patients' care are discussed below.

#### *Personal characteristics of nurse*

This part of the review aims to address the question of whether student nurses and nurses' personal characteristics are associated with their attitudes towards obese patients and the care they provide. Characteristics that have been examined are weight status and BMI, gender, age, years of education and professional experience.

Hoppe and Ogden's study (1997) of a random sample of 586 UK nurses found that nurses with low BMI rated obesity as more preventable than those nurses who were overweight. In the same study, nurses with higher BMI were less likely to suggest eating less in general and more likely to recommend a calorie controlled diet than their thinner counterparts. Similarly, a study conducted in Canada found that thinner nurses were more likely to believe that obesity is controllable (Watson, 2008). This study also demonstrated that there is a link between negative attitudes and weight status; nurses in lower weight categories showed less positive attitudes towards obese patients and were less positive in their response to obese patients than overweight nurses (Watson, 2008). In another study, overweight nurses were also more likely to hold positive attitudes towards obese patients and express empathy towards them

(Brown and Thomson, 2007). Brown et al.'s study (2007) also showed that nurses with higher BMI were less likely to have a negative perception of obesity. A study in Hong Kong, however, showed that nurses' BMI in that part of the world did not play a role in shaping respondents' responses regarding their attitudes towards obese patients (Poon and Tarrant, 2009). The wide collection of these findings show a possible association between high BMI and overweight nurses' ability to empathise perhaps due to their own struggle with weight. Student nurses' attitudes towards their own weight needs to be explored in order to determine whether there is a link towards their attitudes towards obese patients.

As far as gender is concerned, previous studies examining this demographic variable found no association between attitudes and gender (Garner and Nicol, 1998; Poon and Tarrant, 2009). As far as age is concerned, there is no study exploring this variable; however, there are a couple of studies that suggest that nurses with more years of experience and educational level have more positive attitudes (Culbertson and Smolen, 1999; Zuzelo and Seminara, 2006).

These studies show that student nurses' personal characteristics may play a vital role in the shaping of attitudes towards obese patients. Brown and Thomson's study (2007), in effect, suggest that the nurse's perception of their own body image can also be an influential factor. More research is needed to explore how student nurses' personal characteristics shape their attitudes and whether they play any role in the care they provide to obese patients.

## **2.6 Summary**

The literature suggests that the biomedical perspective of obesity plays a dominant role in how obesity is defined; yet student nurses and nurses also draw from other sources of knowledge. To date, there is limited research that explores obese patients' care and none that address how student nurses' interpretation of obesity influences the care they offer to obese patients in clinical practice.

As far as nursing studies are concerned, I have identified a wide spectrum of limitations and possible weaknesses that are related to the studies' reliability and validity of findings. They are mainly connected to the research instruments' power



and design, issues regarding the sample as well as philosophical and theoretical issues.

The first and most obvious observation is that the predominant research tools used in previous studies are self-administered questionnaires and interviews. Even though all studies provided useful insights into students' and nurses' perceptions of obesity, attitudes and nursing care, they fail intrinsically to detect the effects of attitudes on nurses and student nurses' behaviour towards obese patients. As with questionnaires, the knowledge found through interviews is nurses' *perceived* adequateness rather than the actual quality of care their patients receive. Further, they are far less appropriate to investigate attitudes, as people rarely express overt discrimination towards obese people. Overall, interviews and questionnaires cannot be used as a substitute for observing actual behaviour.

I also found that the studies discussed present some limitations, which are linked to their philosophical underpinnings. First of all, it seems that the majority of researchers looked into obesity stigma as if it resides solely in the patient. However, according to the influential theory of Goffman (1963), stigmatisation is a process and a continuum that is subjected to a complex web of forces. Indeed, Goffman (1963) suggested that not only a stigmatised person displays evidence of the consequences of being stigmatised, but also is the stigmatiser. None of the studies adopted a sociological perspective.

Indeed, most studies viewed obese patients as a list of traits inherent in them, rather than the nurse-patient interaction. For instance, a trait that was identified by several studies is the lack of motivation or control of obese patients (such as Bagley et al., 1989; Petrich, 2000; Watson et al., 2008). The possibility that nurses and student nurses' perceptions and behaviour may be influenced by the social context, in which it occurs, is ignored. This is perhaps because they concentrate on nurses' perceptions of obese patients; rather than the interaction that occurs between nurse and patient. By focusing on interaction, issues and variables affecting the social situation could be identified and strategies implemented to seek to enhance the quality of care provided to obese patients.

It is also reported that student nurses and nurses respond to obese patients in certain ways, but it is implied that particular responses by participants/respondents tend to be

set in stone. It is implied that student nurses who have negative attitudes towards obese patients will always feel the same. It is also implied that when a patient is obese, nurses that view obesity negatively are more likely to have negative perceptions about the patient. However, as seen in Johnson's study (1997), the reality is not as straightforward. Indeed, the process has not been fully understood. Factors such as patient's potential weight loss, change in mobility or adherence to treatment have not yet been researched in order to identify their influence on student nurses or nurses' perceptions and influence on the care they provide.

The last observation I would like to put forward is that previous studies have not allowed respondents to participate in the construction of meaning of the issues in question. The majority of research studies assume that the respondents or participants abide to the biomedical definition of obesity despite that the data of the same studies indicate that student nurses and nurses' obesity conceptualisation is broader than an equation of a patient's weight and height. Further, the researchers seem to assume that obesity has a solid and uniform meaning for everyone, but this is not the case, as seen in the first section of the literature review.

After reviewing the current literature, I identified a plethora of gaps regarding student nurses' care towards obese patients.

Research is needed to explore the meaning that student nurses attach to obesity and obese patients' physical appearance and how it influences the care they provide to their patients. While the biomedical perspective dominates previous researchers' conceptualisation of obesity, there is an evident lack of studies that employed a sociological perspective. Such a perspective could challenge the sources of knowledge that student nurses have regarding obesity, and explore their discourses regarding obesity and obese patients' care. Indeed, there is limited information regarding the sources of knowledge that students employ to form their perceptions about obesity and the effects these sources have on their practice. We do not know whether student nurses are satisfied with the level of knowledge they acquire in nursing education and how their levels of confidence in caring for obese patients are influenced.

Many nursing studies have been influenced by the social psychology perspective on obesity; especially in relation to student nurses' and nurses' attitudes and

stereotyping of obesity. Current research provides insights for example that student nurses are likely to believe that obese patients have negative traits and that they are likely to be demanding. However, no study was identified that shows that student nurses have a negative response towards obese patients in clinical practice and, most importantly, whether their attitudes influence their care. For those students that have negative attitudes, it is important to explore whether they manage to remain professional and identify the ways they channel their emotions.

Limited information is known about the care delivered to obese patients by students when they go into clinical placements. Issues regarding the social context in which the student nurse-patient interaction happens needs to be explored; namely the role of the mentor, nursing team, staffing levels, availability of moving and handling equipment and physical environment to mention a few.

Overall, the literature review has indicated the need for observational research, which is conducted in the social context of the student nurse-obese patient interaction. Additionally, it could be of benefit that the study is conducted in more than one clinical setting to gain further understanding of the complex web of factors that may influence student nurses' care towards obese patients. Moreover, the cultural meaning and interpretation of obesity seems to have a key role into how student nurses construct the meaning of caring for an obese patient. A sociological, ethnographic study adopting a social constructionist perspective could incorporate all these characteristics and, at the same time, enable the exploration of student nurses' culture.

In the following chapter the methods and methodological approach chosen to pursue this research study are discussed.

# CHAPTER THREE - Methods and Methodology

## 3.1 Introduction

This chapter discusses the methods and methodology used in the present study. The aim of this chapter is to render transparent the systematic process that was followed throughout this research journey. The rationale for choosing ethnography to explore student nurses' care in relation to patients' weight is outlined. The ontological and epistemological underpinnings of this study are put forward to highlight the reasons why a qualitative research approach was considered appropriate. The data generation and analysis methods used are presented in detail, including issues relating to access, the sampling techniques and recruitment methods. The ethical considerations of this study are discussed and the issues addressing the rigour of this study are examined.

Following a review of the relevant literature (Chapter Two), the following research questions arose.

- What does a patient 'being obese' mean to student nurses?

This question refers to how student nurses conceptualised obesity as well as what student nurses considered to be underweight, normal weight, overweight or obese. The aim was to determine whether student nurses complied with the current medical definition of obesity or drew on other criteria.

- Does patients' weight influence their care? If so, in what way?

Here I sought to discover if there was a relationship between how student nurses socially constructed obesity, the care they offered to patients and the context in which care was delivered.

It is important to mention that, as with any qualitative study, the research design was flexible and was reviewed on several occasions during the study in the light of emerging aspects. For instance, in the light of interesting findings, I modified the research questions in the design enquiry to fit the purposes of the study (Robson, 2002). This flexibility was considered as the greatest advantage of qualitative research and contributed to the richness of the findings. In this chapter, I also

illustrate the research journey, providing an 'audit trail', by outlining my decision-making and the steps taken.

In the following section I explain why I chose qualitative methodology.

## **METHODOLOGY**

### **3.2 Qualitative Approach**

The reason why I chose a qualitative approach is two-fold. First, it was considered suitable for answering the research questions since I was looking into the 'meaning' student nurses attach to caring for obese patients and because I wished to study the natural setting that student nurses care for obese patients, which is not accessible to techniques utilised by quantitative research. Secondly, the philosophical underpinnings of qualitative research match my personal viewpoint.

The field of qualitative research is considerably broad and the term 'qualitative' is used to embrace a plethora of methodologies (Hammersley and Atkinson, 2007). It has been noted that historically, the paradigms of qualitative research have evolved to such a point that the term per se means different things in each of these different 'moments' within this complex historical field (Denzin and Lincoln, 2003). This 'umbrella' term is accompanied by a series of tensions and contradictions, including the need to find a definition that incorporates all its distinctive elements and depict its fingerprint in the history of conducting research (Punch, 2005). Denzin and Lincoln's definition (1998), spanning several sentences, indicates the complexity of this concept.

'Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the word. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them' (Denzin and Lincoln, 1998; p.3).

I utilised this definition to illustrate the way I perceive qualitative research. First, it is the situational aspect of it; as a qualitative researcher I selected carefully a certain

situation and field that I wanted to study. Subsequently, I selected students that were studying adult nursing and chose to observe them in the hospital wards on which they practised. Brewer (2003) has mentioned that qualitative research tends to sacrifice breadth of scope and scale for richness and depth because of the techniques used in research. For instance, I am aware that following student nurses in their community placements could have produced equally interesting findings; however, focusing on hospital wards I was able to immerse myself deeper in the data than I would have if I increased the scope of this study. Then, Denzin and Lincoln's definition stresses that the world can only be visible to people through their interpretations establishing the twofold mission of qualitative researchers; namely, to give interpretations of the phenomena they study by looking into the *meaning* people attach to them and to study these phenomena where they naturally occur. As demonstrated in this extract, researchers can utilise various methods to explore and represent this world according to their purposes and, perhaps, their creativity. I regarded this multi-dimensionality not as a barrier but rather as a challenge and, perhaps, an opportunity, to utilise what any existing field, theory or paradigm had to offer. Thus, as a qualitative researcher I became a 'bricoleur', constructing reality by using different tools, methods and techniques, making what they describe as a quilt that represents and interprets reality (Denzin and Lincoln, 2005). Angrosino (2007) has confirmed that a qualitative researcher is not interested in complying with a certain method but in adapting any existing methods, developing or even inventing new approaches being *faithful to the phenomenon under study* and, basically, adjusting the methods so that they would be appropriate to what is being studied. After all, the first requirement of social research according to Hammersley and Atkinson (1995; p.7) is '*fidelity to the phenomena under study, not to any particular set of methodological principles*'. Therefore, I decided to give priority to the perspectives of my participants so that their own understandings became fundamental in the interpretation of the reality they were living in (Bryman, 1989).

One of the strengths of qualitative research is that it can produce a rich, detailed description of the social setting being investigated, which does not attempt to summarise, generalise or hypothesise (Blaikie, 2000). Also, by choosing qualitative research, I had the opportunity to develop a rapport with the participants, which enabled me to study their culture and discover information shared by them; a

considerable amount of field notes was produced that allowed me to represent the ways in which student nurses experience and manage patients' obesity in their care. Indeed, the rapport achieved was the key element to this study; without it I would not have been able to 'get into their shoes' and immerse into their culture. It must not be overlooked that, as with any research methodology, there were some limitations presented. These are outlined in Chapter Eight.

I have dedicated the following section to outlining the philosophical paradigms I am inclined to. This section is imperative to understanding the reasons behind my methodological decisions and, perhaps, how the data of this study were transformed into findings.

### **3.2.1 Philosophical Paradigms**

In this section, I try to answer three questions: the questioning of the nature of reality (Ontology), the relationship between me as the researcher and knowledge (Epistemology), and the way I went about finding out knowledge (Methodology) (Guba, 1990). As far as reality is concerned, I see social phenomena as outcomes of the interaction of people. My epistemological position is that knowledge can only be obtained through understanding how the social world is interpreted by its participants and, thus, an appropriate methodology would be one that promotes an inductive view of the relationship between theory and research in which theory is built from the bottom through the data themselves (Bryman, 2001).

The main philosophical paradigms I adhere to are social constructionism and interpretivism. After studying the philosophical paradigms and schools of thought that exist, I agree with Patton (2002) that operating narrowly within any singular paradigm can be quite limiting; my idea was to make strategic choices to do what made sense and since this study is of 'real world situations' and not a laboratory experiment, I argue that practicality made me respond differently on different occasions. In other words, reality is messy and not clear-cut as the theoretical ideas and philosophies developed try to convey. For instance, I found symbolic interactionism considerably limiting, since it mainly pays attention to interaction and, thus, I chose to utilise certain elements that I found compelling, like the use of symbols, and decided to look at the '*micro*' element of interaction but also pay

attention to the ‘*macro*’ elements of social, economic, political and policy context, in which student nurses care for obese patients (Barbour, 2008). Nevertheless, it is worthwhile mentioning that the philosophical underpinnings of this study spring from certain principles that derive mainly from social *constructionism* and *interpretivism*. Since there has been some controversy on what these terms stand for, I attempt to articulate how I conceive them and, thus, the way I have applied them in this study.

Social constructionism focuses on the belief that practically there is neither one objective reality nor one objective truth, as far as the social world is concerned. In contrast, reality is constructed; nothing is meaningful until addressed by people in a way that *meaning* emerges out of people’s interaction with the world (Sarantakos, 2005). In this thesis, I construct versions of the social reality of student nurses while being in clinical practice, while I attempt to capture how student nurses socially constructed the meaning of obesity whilst concurrently exploring the context in which social constructions occurred as well as the implications of them for patient care. For instance, I focused on how students’ knowledge of obesity was constructed and examined the practical consequences of such a construction in nursing practice.

However, I do not dispute the existence of an objective reality but I argue that a researcher can only access impressions of that reality. This is important because the absence of an ultimate truth consists of one of the fundamental principles of strict social constructionism (Burr, 2003). This raises several questions in relation to the seeking of knowledge; for instance, people may wonder which version of reality we can trust to base our actions, our choices and decisions. Such position, however, is extreme and most sociologists and researchers accept that there are different ‘degrees’ of reality and assert that social constructionism can aid our understanding of the biased definitions that exist in healthcare and can help us learn about how interactions in clinical settings and social structures play in role in how people view and experience illness (Brown, 1995). In other words, I do not deny that obesity can have real implications to a person’s health. It would be naïve to think that obesity does not exist *per se*, because obese persons experience their obesity within certain symptoms, such as pain of their joints caused by the weight they need to carry. Rather, this study is an attempt to represent impressions of student nurses’ reality



rather than to attain 'the truth'. My aim, thus, is to reconstruct the reality as experienced and constructed by the student nurses; explain how student nurses interpret or construct obesity within their specific social and historical context. Since there is a fear that one's personal impression of reality can influence how one grasps the impression of the participants, I utilised reflexivity among other methods to illustrate how my personal social, historical and biographical background could have influenced the representation of students' reality.

I believe that the key process that assists construction and reconstruction is interpretation. Interpretivism is the framework used by qualitative researchers to discover 'culturally derived and historically situated interpretations of the social life' (Sarantakos, 2005; p.40). Symbolic interactionism is usually labelled under the broader name of interpretivism along with phenomenology and hermeneutics (Hammersley and Atkinson, 2007). According to interpretivists, people's actions are based upon social or cultural meanings. People are guided by their intentions, motives, beliefs, rules, discourses, and values, according to which they interpret the reality they live in (Hammersley and Atkinson, 2007). This concept was influential in the development of my findings; since I discovered, for instance, that weight meant different things to student nurses and, indeed, to the same participant at different times.

### ***3.2.1.1 Ontological position***

From an ontological point of view, I regard student nurses' culture as 'an emergent reality in a continuous state of construction and reconstruction' (Bryman, 2001; p.18). As already mentioned, my position is closer to that of the constructionist paradigm; I sought to determine what the participants in my study thought that was 'real' to them.

My ontological position is inclined to a naturalistic position; as opposed to a positivist philosophy. I cannot commit to producing accounts of factual matters that are independent of my values and political commitments (Hammersley and Atkinson, 2007). Humans do not act as 'machines' and, hence, human behaviour is not governed by 'laws' that can be put under 'causal analysis' and manipulated by distinctive variables (Hammersley and Atkinson, 1995). This perception is admitted

by the constructionist position; according to which reality, as perceived by the members of a culture, is a socially and experientially based mental construction that possesses a sense of constraint, and at the same time is constantly changing (Guba and Lincoln, 1994; Bryman, 2001).

I acknowledge the significance of student nurses' perceptions of reality of nursing their patients; since their reality is grounded in their experiences as reflected and interpreted through their perceptions and behaviour. In this research study, I sought to gain knowledge of how student nurses construct their reality when caring for obese patients. This can be demonstrated in the first research question of my study; I asked participants about the meaning of 'being obese'. This does not mean that I reject the medical definition of obesity but that I support the idea that reality is dependent on the experience of my participants. In other words, there is not one truth 'out there' but many and by doing research one can get closer to discovering them but through a difficult but rewarding process. As Parahoo (2006; p.43) has suggested

'Social phenomena and human behaviour are complex, dynamic, changeable...participants and researchers bring their own prejudices to the research process and...the tools we use can reveal different aspects of the same phenomenon...Different perceptions of the same phenomenon are uncomfortable but can lead to reflection and negotiation'.

### ***3.2.1.2 Epistemological position***

From an epistemological point of view, I am also inclined to the philosophical view of naturalism, 'remaining true to the nature of the phenomenon under study' (Matza, 1969; p.5). My research quest was guided by principles and requirements that spring from this philosophy.

According to my personal set of beliefs, the answer to the question 'how do we know the world?' is that the world has an 'inter-subjective' character. The world, hence, becomes meaningful through the complex process by which people come to grasp or understand their own and other people's actions (Schwandt, 1994). I acknowledge, thus, that the social reality that human beings experience has a particular *meaning* to them, according to which they determine their actions and the acts of others. This means that people act the way they do according to their intentions, motives, beliefs, rules, and values (Hammersley and Atkinson, 1995).

My understanding is influenced by one of the central tenets of qualitative research that is based in the Weberian notion of '*verstehen*'. Weber utilizes '*verstehen*' to define sociology and social action. He clarifies that research ought to be concerned with 'the interpretive understanding of social action' and seek out 'a causal explanation of its course and consequences' (Weber, 1968; p.4). *Verstehen* refers to understanding the act from the point of view of the actor (Porter, 1998). In other words, in order to understand a particular social phenomenon, one must interpret the actions of its participants and not only describe them.

This position is supported by interpretivism that argues for the uniqueness of human inquiry (Schwandt, 1994). According to Weber (1968), there is not one correct answer to a question or one 'true' meaning; everything is subjective. Human behaviour, thus, can only be understood within the context of where it takes place and only when the person's intentions and motivations are studied (Parahoo, 2006).

There were two different kinds of 'understanding' that I sought. The first was the direct observational understanding of the subjective meaning of students' experience of caring for obese patients (Weber, 1968). The second sort of understanding was namely 'explanatory understanding' (Weber, 1968; p.8). Explanatory understanding is defined in terms of the person's motive when attaching a meaning to an action. This means that an action, such as manually handling a patient, had to be also studied from the students' viewpoint and fully understood from the meaning they attached to it within its natural context. This way, the culture of the people studied could be subsequently understood. *Verstehen*, hence, as interpretative understanding, was an essential and significant pursuit in my research project to attain knowledge (Swingewood, 2000).

I agree with Brown (1995) that we should broaden our perspective and the chosen research approach should be a synthesis of ontological and epistemological approaches, depending on the subject matter. Brown's interpretation of the concept of 'social construction' appealed to me because he looked specifically into how health care professionals form diagnoses. According to Brown's interpretation (1995), social constructionism is synthesised by elements of symbolic interactionism and structural/political and economic approaches. What Brown (1995) proposed and

I adhere to is not a new theoretical statement. In practice, as he discussed, this has been adopted by various sociologists. Such an example could be found in Freidson's classic text on the Profession of Medicine (1970). Freidson has named a large section of his book 'the social construction of illness; yet he does not subscribe to the strict social constructionist movement, since his book is mainly an analysis of power possessed by the medical profession and the authority they have drawn from medicalising conditions. Therefore, Freidson does not solely abide to the premise that 'all knowledge is created through human interaction and interpretation' (Gabe et al., 2004; p.130). Rather, he recognised the key influence of structures beyond interaction; external, political, economic and social forces. It is acknowledged, hence, that the context involving intertwining forces can influence how student nurses construct the meaning of obesity and experience the care of obese patients. Brown (1995) suggested that using a social construction framework could be ideal for researchers that are interested in the origins of professional beliefs and with diagnosis, specifically if the aim is to uncover the ways of knowing that are based on the biomedical perspective, current moral and ethical perceptions, the socialisation of health care professionals, the professional and institutional practices within a health care system and, the larger social structures of the society. Such an approach seems relevant to this study because student nurses' ways of *knowing* obesity are central to my research investigation.

After careful consideration, I selected an ethnographic approach, which is described in the following section.

### **3.2.2 Ethnography**

I chose ethnography because I was looking into the culture of student nurses. Since student nurses operate within the broader culture of the hospital wards and nursing, my observations consequently included these wider cultural entities. In this study ethnography was used to explore the social environment of student nurses in their workplace, focusing particularly on the ways in which they managed issues surrounding obese patients.

Broadly speaking, ethnography is defined as a 'portrait of people' (Parahoo, 2006; p.67) referring to people 'in the collective sense' (Angrosino, 2007; p.1). This

description conveys the notion of 'culture' that is central to understanding ethnography. Spradley (1980) has stressed that ethnography is the means to make explicit what is implicit within a culture. According to ethnographers, human behaviour can only be understood in the natural environment in which it occurs.

Hence, I utilised ethnography to understand human activity in terms of people's own views of their cultural systems, and identify the rules of culturally determined behaviour in a social environment (Aamodt, 1991). Hammersley and Atkinson's definition, which looks into the practical aspects of ethnography, complies with a more practical understanding of ethnography.

'We see the term as referring primarily to a particular method or set of methods. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people's lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are focus of the research' (Hammersley and Atkinson, 1995; p.1).

However, doing ethnography is more complicated than selecting some techniques and complying with certain procedures. The aim of ethnography is perfectly demonstrated by Spradley (1980; p.7):

'The ethnographer observes behaviour but goes beyond it to inquire about the meaning of that behaviour...sees artefacts and natural objects but goes beyond them to discover the meanings people assign to these objects...observes and record emotional states but goes beyond them to discover the meaning of fear, anxiety, anger, and other feelings'.

Although ethnography has been primarily linked to participant observation (Bryman, 2001), as depicted in these definitions, in this research study I went beyond observation. In effect, in this ethnographic study I entailed a wide range of data generation methods and sources. Hence, I observed the participants' behaviour, listened and engaged in conversations, I enquired about the meaning of their behaviour, collected documents and looked at their use and significance, and overall strived to develop 'an understanding of the culture of the group and their behaviour within the context of that culture' (Bryman, 2001).

### *3.2.2.1 Ethnography in Nursing and Health Care*

My choice of ethnography was also influenced by its anthropological and sociological tradition; I was intrigued by carrying out observational fieldwork in a previously rather unknown culture to me that was likely to raise challenges somewhat different from those involved in carrying out ethnography closer to my home in Greece (Barbour, 2008). The origins of ethnography lie in anthropology developed in 19<sup>th</sup> century. Ethnography used to mean the descriptive account of a distant to the Western civilization community and culture. Doing fieldwork meant living with a group of people for an extended period of time in order to document their way of life (Hammersley and Atkinson, 1995). During the 20<sup>th</sup> century, ethnography was more concentrated on exploring the effects or impact of urbanization, especially in developing countries.

However, the Chicago School was the one that developed many key aspects of ethnography as it is considered nowadays. The work of the Chicago school era did not rely on studying societies very different to their own; rather the Chicago School followers saw different layers of cultural knowledge within a society. The subcultures and perspectives maintained by different social divisions within society were seen as equally fascinating as the culture of people living in a remote village far away (Hammersley and Atkinson, 1995). The variations in cultural patterns across and within societies and their significance in understanding their social processes is admittedly the reason why ethnography is highly valued as a research method and utilized even in the most familiar groups or settings. My familiarity, yet marginality to the British clinical setting that student nurses practise was one of the reasons I saw ethnography as my chosen method. I elaborate further on this dual stance later in his chapter.

In the field of nursing, I was inspired by figures such as Aamodt (1982), who was the pioneer nurse-anthropologist that incorporated ethnography in nursing research. Since then, a plethora of nurse researchers have adopted ethnography and have specifically embraced three characteristics that are shared with nursing philosophy; holism, being contextual and reflexivity (Morse and Field, 1996). By using ethnography to conduct nursing research I was presented with an advantageous means for gaining access to health beliefs and practices of a culture. Indeed, the

cultural context in which people's health beliefs and behaviours operate can broaden nurses' knowledge base (Morse and Field, 1996). Also, I took advantage of the prolonged engagement in the field that ethnography entails, which enabled me to establish the trust necessary for informants to reveal information that may otherwise be hesitant to share. This information is considered invaluable to gain an understanding of the participant's point of view (Robertson and Boyle, 1984).

Regarding ethnographies conducted about student nurses, I would like to specifically mention two classic studies for their contribution to nursing knowledge. First, Melia's study (1987) *Learning and Working* looked into student nurses' occupational socialisation; she conducted forty-one one-hour interviews defined her study as 'within the scope of ethnography'. Even though Melia did not utilise participant observation, the findings of her study are considerable in that she revealed how student nurses socially constructed the meaning of nurse education. Her contribution lies on that she revealed that the theory-practice gap in nurse education led student nurses to experience segmentation in their behaviour in their desire to fit in and meet the expectations of theoretical education and clinical practice. Indeed, student nurses' perception of the purpose of their training was to overcome a series of constraints posed by theoretical education and practice as opposed to learn how to care for patients (Melia, 1987). The second study that I would like to mention was conducted by Smith (1992), who described her methodology as a collection of participant observation, grounded theory and feminist approach to interpreting the data. Her findings are significant because she revealed the invisible labour that student nurses –and nurses in general- do in clinical settings. She suggested that student nurses' emotional labour was invisible and ward sisters played a crucial role in helping student nurses to learn to care (Smith, 1992).

A further review of studies that looked into student nurses' experience of clinical practice helped me to identify only five studies that met the criteria of using participant observation and looking into student nurses' culture. The first study was conducted by Holland (1999) and explored the transition experienced by student nurses in becoming qualified nurses. A study by Tuohy (2003), which is described as 'mini ethnography' and looked into how student nurses communicate with older people found through participant observation and interviewing that such

communication is poor. Ousey's study (2007) on student nurses' learning in clinical practice suggested that student nurses still face constraints embedded in professionalism, power and inequalities and culture despite changes in student nurses' curriculum and education. Roberts (2008) explored the importance of friendship when student nurses are in the clinical setting. Finally, O'Driscoll et al.'s study (2010), which explored student nurses' learning in clinical practice, found that professional and organisational constraints meant that student learning on a day to day basis fell to health care assistants. All these studies, however, have in common the fact that they were undertaken by student nurses' lecturers, which meant that they were conducted from an 'outsider' perspective and that the reliability of their findings could have been affected by the power relationship between a teacher and a student. Furthermore, none of these studies explored student nurses' involvement with obese patients' care.

I also looked into ethnographic studies of health and medicine to reveal the themes that previous researchers were interested in. Studies such as *Boys in White* (Becker, 1972) and *Asylums* (Goffman, 1961) captivated my interest regarding the role of symbols in the interaction in health care settings; Becker highlighted the role of professional socialisation in medical students' education, while Goffman in *Asylums* looked into the moral career of mental patients. Goffman's works of *Stigma* (1963) and *Presentation of Self in Everyday Life* (1969) also displayed the characteristics of intense study and observation of interaction; even though they cannot be viewed as ethnographies of health care, they include significant insights of his work on health care settings. I was particularly interested in how Goffman (1961) viewed the identity of patients arising not only from their interaction with others, but also how the institutional arrangements can influence one's structure of self. He also developed insights into health care professionals' ability to understand stigmatised individuals because of their prolonged interaction with them and their role in reducing stigmatisation (Goffman, 1963). Another contribution of Goffman is that he regarded and portrayed his participants' identity in relation to their bodies making the body central to people's interaction with others. I was aware, however, that he has been criticised for separating the outcomes of interaction from the effects of institutional structures (Giddens, 1987).



The social construction of medicine is a topic of interest to this study because it discusses how interpretation and meanings are shaped by the motives and motivations of individuals who conduct medical work (Bloor, 2001). This approach challenges that health care professional judgements are guided by universal truths and highlighted how medicine can impose meaning to concepts. A major contribution to understanding how work in hospitals is organised was performed by Strauss and colleagues (1985). Even though their method did not include participation, they documented how health care professionals and patients experienced work in hospitals. They developed insights on the centrality of patients' bodies in the machine work –work that requires the conjunction of patients' bodies with equipment-and health care professionals' multiplicity of work requirements - including conducting comfort and composure work. Further, they documented how doctors determined a patient's diagnosis on deciding whether they should submit patients to dangerous diagnostic procedures or wait until a patient's symptoms fully developed. A significant finding of their study was that patients were also expected to work and contribute to the care they were offered as a social exchange for the services they were provided.

Another significant theme in the sociology of health care is identified as the sociology of the body. Sociologists and nurse researchers developed an interest of how illness is lived by patients and related studies offered an alternative interpretation on medical discourses on health and illness. Parsons (1951) inspired this movement with his pioneer idea of not viewing sickness as simply a biological issue; rather a social significant issue. He viewed patients as having certain social roles, responsibilities and duties. For instance, they should not be responsible for their condition and they carry a responsibility to become well. Moreover, sociologists have been inspired by social theorists such as Foucault (1977) who were critical of health care professionals' means and motives when caring for patients and explained how individuals are subjected to a series of controlling behaviours in order to produce docile and disciplined bodies. The centrality of the body in Foucault's theory is viewed as a critique of capitalist rationality and moral restraint (Turner, 1991). However, Giddens (1995) has criticised Foucault for his theory because it insinuates that individual bodies do not have real choices and possibilities to change their future. Further, Foucault has been criticised that his concentration on individual

bodies meant that his analysis of power neglected how people can struggle collectively (Westwood, 2002). In this theme, Lawler's ethnographic study (1991) on Australian nurses' body work needs to be included for utilising a Foucauldian lens (1973) and revealing how patients' bodies are objectified under the 'clinical gaze'. Despite that Lawler's approach can be criticised for ethical reasons linked to covert observation, she revealed a rather invisible side of nurses' culture and work that was not brought forward into nursing discourse until then; that of the handling and managing patients' bodies. Johnson's study (1997) on nursing power and social judgement belongs to this theme because he developed a theory on how nurses' discourse of labelling is utilised to sustain power over patients and gain control over patients' bodies. Johnson (1997) looked into nurses' culture and described the process, according to which nurses made patients to comply with their wishes and became docile bodies but he also acknowledged how flexible, negotiable and impermanent that process was.

This account so far has indicated the centrality of the study of 'culture' to ethnography; it is therefore useful to explore the meanings, limitations and my usage of this term.

#### **3.2.2.2 Culture**

The distinctive way of life that characterises an organised, enduring group is its *culture* (Angrosino, 2007). The reason why I selected ethnography was based on my belief that students have a collective identity (Kuper, 1999). Kuper (1999) argues that culture is 'always defined in opposition to something else' (p.14). I argue that student nurses share certain characteristics that are unique and that differentiate them from other students and qualified nurses. Student nurses are not *just* students, due to the fact that they are required to work in order to become qualified, as opposed to most students, who are expected to engage fully in studying. In effect, in order to become a nurse, student nurses have to learn the culture of nursing, which is a combination of symbols, customs and shared meanings (Holland, 1999).

Perhaps the most distinguished characteristic that student nurses share is the dual identity of being both a student and a worker (Melia, 1987). Being in the clinical practice, they have to engage in two processes; namely socialization and learning to

become a nurse. Factors such as the ward culture, negative attitudes and their mentors influence these processes (Pearcey and Elliott, 2004). In this setting, they become rather *marginal*, since they are neither a qualified nurse nor a student, because the idea that the student is not a nurse but learning to become a nurse is often forgotten in the clinical practice (Holland, 1999). The marginality of student nurses was one of the reasons I was attracted to conducting this research study, because it enabled me to give voice to a marginal group and, thus, contribute to their empowerment (Kuper, 1999).

The idiosyncrasies of nursing culture can also be attributed to the origins and development of the nursing occupation. The occupation of nursing has battled its way to be defined as a profession (Cooke, 2008) in order for nurses' work to be recognised (Benner, 1984; Smith, 1992; Lawler, 1999) and rewarded. Some nursing leaders, like Henderson (1986) viewed the future of nursing in providing individualised care, which has been highlighted in the Standards of Proficiency (NMC, 2004) and has highly influenced theoretical education, but does not reflect current practices. Nursing in clinical practice has been found to be task-oriented (Melia, 1987; Holland, 1999; O'Driscoll et al., 2010) and technical (Dingwall and Allen, 2001), which poses questions regarding nurses' values and aims (Cooke, 2008). Other professions display a similar preoccupation with theoretical education which adheres to what a profession ought to symbolise rather than concentrating on its adequacy in preparing students for the world they will have to work in (Becker, 1970). Indeed, student nurses have been caught in this argument and have suffered the implications that are often related to the social construction of professionalism and power differentials in practice (Melia, 1987; Smith, 1992; Ousey, 2007).

Parahoo (2006) has underlined that ethnography places culture as its focus because one of its key premises is that people can influence, and be influenced by the culture they live in. The notion of culture is used to describe, interpret, and even perhaps explain student nurses' behaviour. According to Spradley (1980; p. 5), the study of culture involves 'what people do, what people know, and the things people make and use' respectively referred as 'cultural behaviour, cultural knowledge and cultural artefacts'. However, I did not treat culture as a source of explanation in itself. I agree with Kuper (1999; p.6) on the following statement;

‘Culture can offer only a partial explanation of why people think and behave as they do, and of what causes them to alter their ways. Political and economic forces, social institutions, and biological processes cannot be wished away, or assimilated to systems of knowledge and belief’.

Similarly, Angrosino (2007) has warned that culture can be overemphasized in its role of shaping human behaviour; instead people can act actively and respond to external forces. This process is dynamic rather than static and is directly influenced by the meanings people assign to their actions. In other words, things do not have essentially the same meaning to members of one culture. This notion is rooted in the *symbolic interactionism* theory. Symbolic interactionists argue that human behaviour is developed through interaction with others, ‘through continuous processes of negotiation and renegotiation’. People construct their own reality from the symbols around them by interacting with them, because according to this theory symbols are not static (Morse and Field, p.22).

My personal definition of culture complies with Geertz’s (1973; p.89) definition that incorporates the terms of ‘meaning’ and ‘symbol’:

‘Culture...denotes an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes towards life’.

I agree with Geertz that the function of culture is to impose meaning on people so that they can comprehend reality. As an ethnographer, my role was to discover the symbols of my participants’ culture; how they made sense of them, how they used them and in which context. My goal was to interpret the ‘webs of significance’ that student nurses themselves have spun; the webs are a metaphor for culture while my pursuit is to find their meaning (Geertz, 1973; p.5).

In my journey to discover which approach would be more suitable to explore student nurses’ conceptualisation of obesity and the care they offered to obese patients, I also considered other qualitative approaches, which are discussed in the following section.

### *3.2.2.3 Alternative research approaches*

Grounded theory and phenomenology were two approaches, which I considered before embarking on my research journey.

Grounded theory is interested in social processes and aims to develop explanations through models of how humans behave by concurrently looking at the context whereby the behaviour occurs (Glaser and Strauss, 1967). This approach was developed as a response to criticisms coming from a positivistic background relating to the lack of rigour in qualitative research (Glaser and Strauss, 1967). While grounded theorists share some similarities with the methods followed by other qualitative researchers –such as the type of data they gather – they follow a very structured, systematic way of collecting, coding, analysing, and presenting data (Strauss and Corbin, 1994). As opposed to other qualitative researchers, the ultimate aim of grounded theorists is to develop a theory and in the process to establish relationships between concepts throughout the development of the project (Strauss and Corbin, 1994). This, however, was not the aim of this study. While I was interested in social processes –for instance, the relationships developed between student nurses and obese patients - and therefore aspects of grounded theory may have been appropriate, this was not the central focus of my study. Instead, my prime focus was on exploring how student nurses constructed the meaning of obesity and whether this influenced the care they provided, whilst taking into account the context and culture in which care was being delivered.

Grounded theory has been criticised for its inattention to the importance of social structure and culture (MacDonald, 2001). Moreover, grounded theory has been described as being quite constrictive operating in a framework that extensively concentrates on a constant search for relationships between concepts and reducing concepts into a theory (Johnson and Webb, 1995). Nevertheless, Charmaz (2006) has since emphasized the importance of flexibility and openness when utilising grounded theory rather than concentrating on the rules that govern this approach. Charmaz and Mitchell (2001; p.160) have also expressed the conviction that ethnographers can adopt and adapt grounded theory to increase ‘the analytic incisiveness’ of their studies. They suggest that there are certain strategies followed by grounded theorists that can be of benefit to ethnographic studies; such as simultaneous data collection

and analysis, the quest of generated themes through early data analysis, discovery of basic social processes within the data, inductive construction of abstract categories that explain and synthesise these processes and integration of categories into a theoretical framework (Charmaz and Mitchell, 2001).

In effect, I have utilised some of these techniques to increase the rigour of my data collection and analysis. For instance, my analysis of data started the first day of participant observation with the transcription of my fieldnotes and simultaneous literature review of concepts that seemed significant. I have further strived to make sure that the codes and categories were derived from the data rather than deduced from a pre-conceived framework. During this whole process, I kept a research diary whereby I kept notes that facilitated my research journey and developed ideas that were useful in the thematic analysis of my findings. I have further utilised line-by-line coding when coding the data from the interviewing part of the study, which is popular among grounded theorists. However, when coding data from my fieldnotes, I found this method restrictive, since many excerpts had multiple meanings and interpretations that could not have been merged into a single code. Moreover, as many grounded theorists do, I returned several times into the field to gather specific data becoming more selective to issues that seemed significant to my study. In other words, while I utilised some of the guidelines followed in grounded theory, I was reflexive in my choices and modified them to concentrate on the context that student nurses cared for obese patients, to maintain my sensitivity to the different meanings that student nurses associated with obesity and ensure that the importance of culture in people's interpretations, perspectives and voices were highlighted.

Phenomenology, which is perceived as a philosophy as well as a research approach, was also initially considered as it shares features with other qualitative approaches. There are several different approaches which are encompassed within the umbrella term of phenomenology. The key element of the phenomenological approach is that it is concerned with how an individual perceives the world, their experiences in life and the subjective meaning they form about the world (van Maanen, 1990). As opposed to other approaches that look for shared meanings among a group or a population, phenomenologists are interested in how a specific person experiences *this* life at *this* particular time and context (Newell and Burnard, 2011). From that

perspective, phenomenology can offer substantial insight into a wealth of subjects related to nursing and healthcare overall, especially in relation to patients' experiences and care (Benner, 2009). On the other hand, the aim of my study was to explore how student nurses behave, think, feel, experience and do things collectively and, since incidentally I came from a different cultural background, the idea of studying student nurses' beliefs and practices in a unique cultural context triggered my interest in ethnography. I was interested in understanding the culture and context in which student nurses constructed the meaning of obesity and cared for obese patients. A phenomenological approach, which does not favour the use of participant observation –since the researchers aim to get the inner perspectives of people from their own point of view (Todres and Holloway, 2010)- would have been inadequate in this venture. My interest in ethnography was further fuelled by my wish to directly observe student nurses' care of obese patients, as this was identified as a gap in the literature. Participant observation is a core aspect of ethnography. Such a stance has been also adopted by Steubert-Speziale and Rinaldi Carpenter (2007) who suggested that ethnography can be the ideal choice for nurse researchers aiming to explore how social issues influence nursing practice. The study of student nurses, who share common behaviours, experiences and expectations and operate within a specific context, can be achieved through ethnography, which allows the researcher to understand the complexities involved with the participants' emic views (inside perspectives), while bringing the ethnographer's etic views (outside perspectives) (Richard and Morse, 2007; Cruz and Higginbottom, 2013).

In the following section I outline the methods that I used to generate my data.

## **METHODS**

### **3.3 Location and Recruitment Methods**

For nursing, the setting to do ethnographic research can be whenever there are people and activities that give rise to cultural questions related to nursing and health care (Munhall, 2001). My chosen location was any hospital wards that student nurses are sent to do their clinical practice. In order to gain access to my chosen location, I had to find student nurses willing to participate. In this study, I conducted participant

observation on three wards in two urban hospitals in South Wales; namely an orthopaedic, gynaecological and respiratory ward.

Recruitment was the main challenge I faced as a researcher, which presented me with lengthy delays. Barbour (2008) notes that no matter how well thought out are one's sampling strategies, successful recruitment is another matter. Initially, I aimed at identifying participants through advertisements (Appendix 4) placed on the notice boards of their department, so as not to be intrusive. Additionally, I sent several consecutive email invitations to all students of the department who were studying adult nursing. Unfortunately, I received no response and, therefore, I conducted a series of 10-minute presentations to groups of students before their planned lectures, with the lecturer's consent, and distributed information sheets. Students were provided with a brief overview of the research project and were given the opportunity to ask questions. A form asking for contact details was then circulated around the students, and all students who might have been interested in becoming involved in the study were asked to complete the form and hand it in to their lecturer at the end of the session, prior to leaving the lecture theatre.

This way, three third year student nurses volunteered to be observed during their following placements. On each ward I went, students who were already practising also volunteered to take part in the study. When I asked the participants why they were reluctant to get involved, they all replied that they did not like being observed by someone they did not know personally; thus, they had to meet me, and trust me as a person, before agreeing to being observed in their clinical practice.

It should be noted that this difficulty could have been overridden if I had visited the students' placements and asked them to participate while they were in their clinical placements. However, I refrained from doing that for ethical reasons (Section 3.9); first, I did not want to be intrusive and secondly, being aware of the power relations developed in clinical practice, I wanted students to participate freely rather than being forced to do so by the nursing managers.

### **3.3.1 Access: Obtaining permissions**

This study gained approval from the Local Research Ethics Committee (LREC) of the National Health Service (NHS), as well as the Research Ethics Committee (REC)



of the School of Health Science (SHS). Permission was also obtained from the School's pre-registration programme director as well as the students' personal tutors before doing informative presentations during their sessions. Additionally, permission was sought and given by the wards' managers and students' mentors in the clinical practice areas.

Permission was sought and gained from the programme director in order to gain access to their curriculum and the students' study materials so as to explore nursing students' access to sources regarding nursing obese patients. In order to have an insight into the knowledge they have regarding manual handling, I attended their lecture sessions about manual handling with the lecturer's permission. Also, I attended a National Back Exchange (NBE) meeting regarding the care of obese patients in the NHS. This meeting provided me with invaluable information; bearing in mind that the All Wales NHS manual handling passport, according to which students are trained, is created according to the standards laid down by the NBE. Additionally, permission was sought from the ward managers of the students' clinical practice so as to access any relevant written documents and information regarding obese patients being mindful of matters of patients' anonymity and confidentiality.

Since this study involved my presence in the clinical setting, permission was sought and granted by the Local Research Ethics Committee. Permission was also sought by the Trust's managers in the hospitals I conducted participant observation. It should also be pointed that I was offered an honorary contract that acknowledged legally my presence on the wards.

### **3.4 Sampling strategy and Inclusion criteria**

The sampling strategies in this study are described in detail in order to make the interpretation of the findings easier and enhance the possibilities of future replication of this study (Coyne, 1997). My target population was student nurses who were enrolled in a pre-registration undergraduate three year adult nursing course.

The ethnographic approach opened the door for maximum variation sampling, which helped me to achieve as wide an understanding of student nurses' culture as possible

(Patton, 1990). During the early stages of this study, I decided that my sample would include students from all three academic years of their studies, but my key informants would be third year student nurses. A non-probability, purposive sampling strategy was selected for strategic reasons (Polit and Hungler 1999). This meant that I observed sufficient number of students to explore interesting ideas and stopped sampling when I reached a point when there were no more themes to be discovered.

After completing participant observation and analysing the findings, I decided to interview several students to explore the themes revealed during participant observation. Despite capitalising any interviewing opportunities that presented themselves during participant observation, there were still some cultural meanings I wanted to explore further (Spradley, 1980). As seen in Table 3, this study included 16 student nurses participants; 11 of them were observed. I also conducted 7 interviews; two of them were with students I had observed. I conducted formal ethnographic interviews with two students I had observed and five who were not observed. Nevertheless, it was interesting that students that I did not have the opportunity to observe recalled considerably similar accounts to the ones I had observed.

My sampling techniques were also determined by factors beyond my control; such as students' willingness to participate in the study, the amount of time they stayed in practice and the length of time allowed for data gathering. Although there are several studies conducted in the past regarding student nurses, I found remarkable that no other study mentions the difficulty of recruiting students. Reflecting on that issue, I could have overestimated student nurses' willingness to talk about nursing obese patients or agreeing to 'being observed'. Additionally, all previous studies were conducted by students' lecturers, which meant that they had already accomplished rapport with the students, or they could have been influenced by the lecturer's relatively powerful position (Bradbury-Jones and Alcock, 2009).

It must be mentioned, though, that the aim of my sampling strategy was not representativeness of the population studied because generalisation was not sought; my aim was to achieve richness of data that could lead to an in-depth understanding

of student nurses' reality (Brewer, 2000). Another aim of my sampling strategy was to reflect diversity and to provide as much potential for comparison as possible (Barbour, 2008). For instance, one way I utilised to compare participants was their previous working experience as health care support workers, since I realised that the experience they had before they entered nursing education may have influenced the way they cared for patients they considered obese.

The diversity of participants is portrayed in Table 3, which shows their characteristics. Pseudonyms were used to disguise the participants' identity. Similarly, wards where I conducted participant observation have been named arbitrarily A, B and C respectively.

| <b>Name</b> | <b>Age</b> | <b>Years of Studies</b> | <b>Previous experience</b> | <b>Ethnic Group</b> | <b>Observed or not</b> |
|-------------|------------|-------------------------|----------------------------|---------------------|------------------------|
| 1. Suzan    | Early 30s  | 3 <sup>rd</sup> year    | 2 years                    | Welsh               | Ward A                 |
| 2. Betty    | Mid 40s    | 3 <sup>rd</sup> year    | 15 years                   | English             | Ward A                 |
| 3. Simon    | Mid 30s    | 2 <sup>nd</sup> year    | --                         | Scottish            | Ward A                 |
| 4. Rhiannon | Mid 30s    | 1 <sup>st</sup> year    | 5 years                    | Welsh               | Ward A                 |
| 5. Louise   | Late 40s   | 1 <sup>st</sup> year    | 8 years                    | Jamaican            | Ward A                 |
| 6. Alice    | Late 40s   | 3 <sup>rd</sup> year    | --                         | Welsh               | Ward B                 |
| 7. Sally    | Early 20s  | 2 <sup>nd</sup> year    | --                         | English             | Ward B                 |
| 8. Karin    | Mid 40s    | 3 <sup>rd</sup> year    | 10 years                   | Welsh               | Ward C                 |
| 9. Julie    | Early 20s  | 2 <sup>nd</sup> year    | --                         | Irish               | Ward C                 |
| 10. Nancy   | Early 20s  | 1 <sup>st</sup> year    | --                         | English             | Ward C                 |
| 11. Stacy   | Early 20s  | 1 <sup>st</sup> year    | --                         | Welsh               | Ward C                 |
| 12. Kath    | Mid 20s    | Newly qualified         | 3 years                    | Welsh               | --                     |

|            |         |                      |         |            |    |
|------------|---------|----------------------|---------|------------|----|
| 13. John   | Mid 30s | Newly qualified      | 1 year  | English    | -- |
| 14. George | Mid 30s | Newly qualified      | --      | English    | -- |
| 15. Lucy   | Mid 20s | 1 <sup>st</sup> year | 1 year  | Welsh      | -- |
| 16. Carol  | Mid 20s | 1 <sup>st</sup> year | 5 years | Zimbabwean | -- |

Table 3. The characteristics of participants

As already mentioned, I purposefully included students from all three academic years of their nursing studies. Some of the participants were chosen to be key informants; these were third year nursing students who had both the knowledge and experience of three years in nursing education. I was aware that during their ‘management placement’, third year students are involved in decision-making on the ward they practise as well as other managerial tasks such as the handover. I was interested in capturing their experiences since I knew that they had almost completed their studies and they were at the final step before qualifying.

During my time in the field, other student nurses, who were present, were also included in the sample as they willingly offered themselves. This does not mean that I did not take into equal consideration 1<sup>st</sup> year and 2<sup>nd</sup> year students’ experiences and opinions. As already stated, I sought to maximise diversity, in order to discover the commonalities of the sample as a whole, as well as show how the number of years of academic studies and previous experience gave rise either to additional problems or influenced their list of priorities (Barbour, 2008).

As seen on Table 3, I decided that I would also interview newly qualified nurses that had qualified at the same time that the third year students I observed did. Although they had lost their official ‘student status’, their experiences were still fresh and had time to reflect on the experience of being a student nurse. Further, since these newly qualified nurses were in the six-month period of their preceptorship, in one sense they were still in a novice/student role.

I also aimed at recruiting student nurses from various ethnic groups, which is reflected in the multi-cultural diversity of my sample. Further, I recruited student nurses with different weight and ‘obesity’ status to explore whether their weight

influenced their attitudes towards obesity and obese patients' care. However, I discovered that the majority of student nurses, who were female, did not want to be weighed or reveal their weight because they considered it was too personal an issue. Moreover, since they did not regard weight or Body Mass Index as an accurate obesity assessment measure, my participants did not view this information relevant to their interpretation of obesity.

The identification of obese patients for observation was a complex process; first, I asked each student nurse to identify which patients they considered obese, non-obese, and underweight. This information enabled me to interpret their behaviour towards each patient appropriately. Second, I consulted patients' notes and folders about their Body Mass Index to determine whether student nurses' views coincided with the patient's Body Mass Index assessment. Nurses' assessment of obesity was usually determined during the handover that are further discussed in Chapter Six.

Snowball sampling was also utilised, mostly during the interviewing phase of this study, as students who had already participated in my study recommended their friends or fellow students. Although snowball sampling violates the principles of sampling, it provides a useful means of accessing hard-to-reach populations (Atkinson and Flint, 2001). My experience of recruiting student nurses indicated that they belonged to the group of populations that can be characterised as difficult to penetrate because of the degree of trust that is required to initiate contact.

It is important to note that this study, like any study that includes participant observation as the main data generation method, was not just restricted to the chosen participants, namely student nurses (Hammersley and Atkinson, 2007). Indeed, while I was in clinical practice, I also observed and spoke to the ward managers (n=3), qualified nurses (n=11), health care support workers (n=10), patients and their relatives. This was inevitable, as the student nurse culture was influenced by their interactions with the hospital ward culture. For instance, attitudes of nursing staff towards obese patients provided additional insights on student nurses' experience of caring for obese patients (Chapter Six, Section 6.3.1).

At an early stage of my research endeavour, I also realised that there is scarcity of ethnographic studies looking into student nurses' clinical practice, their socialisation

as well as the care they offer to patients –regardless of their weight. Therefore, I decided – as advised by Spradley (1980), that my initial observations on each ward would not be focused on the care offered to obese patients. Rather, I observed student nurses from the first moment they entered the ward until they departed shadowing all their practice moves. This meant that I observed their interaction and care towards *all* patients –regardless of their weight- as well as their interaction with staff, and patients’ relatives. This approach was particularly useful in that it allowed me to appreciate the challenges that obese patients’ care posed on student nurses, as opposed to non-obese patients. Additionally, it enabled me to comprehend the complexity of caring for patients with different needs- as appreciated by student nurses.

In most cases, I also followed students when they went for a break, accompanied patients for tests or to the theatre, attended the pharmacy to pick up medicine or when they left the hospital grounds to smoke a cigarette –since there was a smoking ban in place. It is also crucial to note that early in this process I came to the conclusion that certain members of staff played a key role in my participants’ experiences of working and learning on the ward. These were the ward managers, students’ mentors and the health care assistants with whom they often spent a large part of their shift looking after patients ‘basic’ – as the students’ referred to them – needs. Hence, I often undertook unstructured interviews with these members of staff to complement my data.

My data sources were not limited to people, but I also sampled texts and documents, settings and environments, objects, artefacts, as well as events and happenings (Mason, 2002). Being in the field, I realised that there was a danger of feeling overwhelmed with all the things to be observed and recorded in my field notes (Spradley, 1980). Selecting certain categories to be my specific data sources made my data more manageable and relevant to my research questions. For instance, there were some cases that I considered ‘information-rich cases’ and decided to follow and concentrate on. Patton (1990; p.169) defined information-rich cases as;

‘Informative-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling’.

Examples of cases that I chose to record are student nurses' care towards a difficult normal weight patient, student nurses' care towards a difficult overweight patient, student nurses' care towards 'good' patients, as well as patients who were considered just 'fine'. My observation techniques are discussed further on in this chapter (Section 3.5.1). To conclude, the sampling was an ongoing process and cases were narrowed down by emerging conceptualizations.

In the following section, I present my data generation methods and processes.

### **3.5 Data Generation**

Being influenced by the social constructionist paradigm, I chose to name this section 'data generation' rather than 'data collection' to highlight the relationships developed between the participants, their social world and me (Mason, 2002). Additionally, I wanted to point out that this phase of my study was not just a practical, mundane procedure but rather an intellectual, analytical and interpretive activity (Mason, 2002). The idea of 'generating' data takes account of the active role played by the observer, or interviewer in producing data through interacting with participants. Hence, the research process is one in which researcher and participants are engaged in co-constructing a world (Davies, 1999).

I agree with Geertz that 'what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to' (Geertz, 1973; p.9). Reflexivity (Section 3.8) played a significant role in this phase of my study because it helped me understand the impact I had on the data as well as the impact of the research process on me (Barbour, 2008).

In this study, I have utilised multiple methods of data generation. Denzin and Lincoln (1998; p.4) stress that;

'The use of multiple methods reflects an attempt to secure an in-depth understanding of the phenomenon in question. Objective reality can never be captured... but the combination of multiple methods adds rigour, breadth, and depth to any investigation'.

My main method for generating data was participant observation that involved the production of field notes. Nevertheless, I have also included study of documentation,

in-depth interviewing, and the relatively new technique of ‘drawing a picture’. These multiple data generation techniques complement the data and serve several purposes. First, they serve answering my research questions from different angles. Also, I gained the opportunity to analyse student nurses’ care towards obese patients in greater depth. As initial patterns emerged, I utilised further observations and interviews to strengthen ideas and facts. Finally, this multitude of techniques helped me to achieve data richness (Mason, 2002).

### 3.5.1 Participant Observation

I utilised participant observation because I wanted to discover what happens when student nurses go into clinical practice. My aim was to experience reality the way they do and gain rapport with the participants. Angrosino (2007) argues that the ethnographic method is different from other ways of conducting social research because the researcher is ‘field-based’. That means that the researcher engages in the lives of the participants in the real setting. Also, it is personalised, because it is conducted in day-to-day, face-to-face contact with the participants. It requires long-term commitment; this meant that as an ethnographer I stayed for a prolonged period of time in the clinical setting.

| <b>Time</b>            | <b>Location</b>                  | <b>Students Observed</b>                      | <b>Hours of fieldwork</b> |
|------------------------|----------------------------------|---|---------------------------|
| January-February 2008  | Ward A<br>(Orthopaedics)         | Susan<br>Betty<br>Simon<br>Louise<br>Rhiannon | 105 hours                 |
| July 2008              | Ward B<br>(Gynaecology-Surgical) | Alice<br>Sally                                | 93 hours                  |
| November-December 2008 | Ward C<br>(Respiratory)          | Karin<br>Julie<br>Nancy                       | 107 hours                 |



|        |         |             |           |
|--------|---------|-------------|-----------|
|        |         | Stacy       |           |
| Total: | 3 wards | 11 students | 305 hours |

Table 4. Participant Observation

As seen in Table 4, participant observation took place in three different wards; orthopaedics, gynaecological, and respiratory and was divided in three phases starting from January 2008 and ending in December 2008. In total, I spent 305 hours of participant observation that enabled me to uncover considerably interesting findings regarding student nurses' care towards patients they considered obese. I followed Bryman's (1989; p.135) advice and *immersed* myself in the Organisation for an appreciable period of time.

Although it was initially decided to make daily four-hour observations, I realised that this was not possible as being immersed to the field meant that I was committed to follow students throughout their shift whether it was 'a long day' or a night shift; to be able to capture the reality the way they experienced it. This way, I gathered data that otherwise I would have missed; for instance, how students feel after completing a 12-hour shift. I followed students through their 8 or 12 hour-shifts, weekdays and weekends; day, evening or night shifts. Each period of observation commenced when the students invited me to their practice and ended with their departure from clinical practice.

Apart from being an observer, I was a participant and that meant I was fully involved in their practice; I worked alongside the student and helped him or her in every day practice. I got involved in tasks, such as moving and handling patients, asking students questions, copying their actions and sometimes asking directions on how to do it. At the same time, I was asking for an explanation regarding *why* they did it that way and what does it *mean* to them. That was perhaps the only way to understand the topic under study from the participants' perspective; rather than aiming at studying people, thus, as an ethnographer, I aimed at *learning* from people (Spradley, 1980). My role, thus, was not that of a 'know-it-all' qualified nurse but rather an ignorant outsider, who came from Greece, and wanted to learn more about



the British clinical practice of student nurses. My purpose was to come as close as possible to student nurses' culture.

'The closer the reader of an ethnography comes to understanding the native's point of view, the better the story and the better the science' (Fetterman, 1998; p.2).

Since there was lack of sufficient information about the topic, I decided to conduct overt unstructured observation (Parahoo, 1997) adopting an inductive approach. There is very little observational research of student nurses and what there is has been undertaken by students' lecturers, mentors or tutors. Indeed, the importance of this study lies in the fact that no observational study had been attempted in the past in this field by researchers who were not students' lecturers, mentors, or tutors. Overt meant that I was being open with the participants about the purpose and the scope of this study. However, this was not as straight-forward as I would have hoped; as described in section 3.9. Unstructured meant that I did not develop a specifically structured framework, according to which I conducted my observations. However, there were certain aspects of student nurses' culture that I was specifically interested in.

These aspects were mainly concerned with the clinical setting where nursing students cared for their patients; any relevant characteristics of the sample such as age, and gender; activities performed while nursing patients including conversations with overweight and obese patients; equipment used for their care; non-verbal communication and other information that supplemented the data (Spradley, 1980). I followed Spradley's advice to focus on three fundamental aspects of the human experience;

1. Cultural behaviour (what people do)
2. Cultural knowledge (what people know)
3. Cultural artifacts (the things people make and use)

Observations were divided into three stages; descriptive, focused and selective observations. Descriptive observation consisted of general information of the major features of the ward; 'space, actors, activities, objects, acts, events, time, goal, and feelings' (Spradley, 1980; p.78). This was usually done the first day I entered the

field. I also followed Altheide and Johnson's (1994; p.491) advice on conducting descriptive observation. They suggest that:

'An ethnographic report should include information about the contexts, such as history, physical setting, and environment; number of participants and key individuals; activities; schedules and temporal order; division of labour and hierarchies; routines and variations; significant events, their origins and consequences; members' perspectives and meanings; and social rules and basic patterns of order'.

Before starting participant observation, I was aware that this method has certain disadvantages. First, it was considerably difficult to recruit participants since students, as already mentioned, were concerned that I would be there to 'judge their practice', as most of my participants admitted. Many of them told me that 'they do not like to be observed'; however, students I observed clearly reported that they did not feel like they were 'being observed' and treated me as a member of the team.

Secondly, I discovered that participant observation is not only time-consuming but is a rather exhausting process of getting the information needed. Being a participant meant I was fully involved in the practice; for example moving and handling the patients. Since proper moving and handling techniques were rarely used, as all students I observed, I likewise developed back pain. Moreover, since I joined the students in the consumption of chocolate and candies brought by patients and their relatives I often had stomach aches and gained weight. Nevertheless, this approach enabled me to gain an insight into students' lives that I would never have appreciated otherwise.

Another challenge of participant observation is 'going native' to the point that the aim and the scope of the research are neglected. There were times when I was more concerned about the patients' care and the nurse 'in me' obscured my role as a researcher. In order to ensure that the observational process was not haphazard, I kept field notes (Section 3.5.1.1) in the form of a well-organized diary which is the traditional means for recording observational data (Hammersley and Atkinson, 1995).

Another issue that came forward was my dual role of being a nurse and a researcher. I accompanied student nurses in their full range of activities but decided to

participate in only what they called 'basic nursing', which I considered more appropriate, in order to have more time to concentrate on writing my field notes and for ethical reasons (Section 3.9). Due to my professional background as a nurse and my knowledge regarding obese patients' care, I had considerable insight into the care student nurses provided. On the other hand, I had never worked in a British clinical setting and was afraid that student nurses would make assumptions regarding my understanding of the clinical setting. Gerrish (1997) encountered a similar challenge and, following her advice, I decided to highlight that I have never worked in a British hospital and I had therefore limited information about the details of their practice. As a result, I was allowed to ask questions, which could have appeared to be naïve had not I followed that advice.

My role as a researcher was signified by certain symbols; first, my field notes' notebook that I carried with me everywhere and kept notes almost anytime. Second, my uniform, which was a white coat with buttons on the side, differentiated me from student nurses and members of staff. I had also a badge with my photo indicating my name and my role as a researcher. Third, it was my persistence in asking questions, whose answers were somehow *obvious*. I observed that students rarely asked questions of their mentors and nursing staff; they rather learnt from watching them as opposed to me who I was asking questions constantly to both students and staff. All these symbols worked as reminders to students and staff that I was there as a researcher. It also triggered patients and their relatives to ask questions about my study, as explained further in this chapter.

#### **3.5.1.1 Field Notes**

I used field notes to record my observations for two reasons; first, I am aware that one's memory is limited and, secondly, it was an efficient way of organising my thoughts and observations. According to Angrosino (2007) 'good ethnographic observation necessarily involves some degree of structure' (p.40). Field notes are described as generally summaries of events and behaviour providing a wide-angle view of the situation, and the researcher's initial reflections on them (Bryman, 2001). They are traditionally meant to be the means in ethnography for recording observational data and they are considered a central research activity of an ethnographer (Hammersley and Atkinson, 1995).

Field notes were taken as soon as the observation occurred; nevertheless, for convenience, or practical reasons they were also written or worked up, expanded with further details and developed later on (Hammersley and Atkinson, 1995). Additionally, the activity of note-taking acted as my statement of being a researcher in the field. It also triggered questions to patients, relatives and staff, which provided me the opportunity of offering more information regarding my study and to ask again for their informed consent.

I organized my field notes based on the *chronology* of events and activities that student nurses participated in. Student nurses followed the ward's *routine*; in other words the pattern of data collection was fitted into the rhythm of the hospital. This structured round pattern also facilitated the analysis of data. My field notes also included structural and organisational features of the ward I observed, the people involved, the daily process of activities, special events, and dialogues, reflective and methodological notes (Mulhall, 2002).

Punch (1986) has noted that researchers ought to reflect upon their field notes; how they are constructed, used and managed. After all, field notes are not a 'closed, completed, final text; rather they are indeterminate, subject to reading, re-reading, coding, re-coding, interpreting and re-interpreting'. Reflecting on the routine followed by students, which was ultimately the routine of nursing staff, I noticed how easier it was to follow these routines and task-oriented activities rather than engaging in holistic care of each individual patient. That realisation helped me to resist just describing what students did in the fear that I would become as task-oriented as them and, thus, helped concentrate on the essence of observation, which was the meaning of their actions rather than the actions themselves.

Another significant characteristic of my field notes is the language and terminology I utilised. According to Spradley (1980), the language used in field notes has numerous long-range consequences for one's research. My field notes were filled with the terms and language used by participants and nursing staff, in a way that it was easy to distinguish my voice in the field notes from the voice of participants. For instance, I used phrases, such as 'doing the washes' rather than 'meeting patients' hygiene needs'. Also, I referred to patients with their forenames when describing

their care, since students did the same. Whenever possible, I made a verbatim record of what people said without summarizing, restating and condensing their statements or conversations. Using students' language I depicted their reality more accurately; the way they conceive it, and brought it to the reader convincingly, because the words students used were infused by their specific cultural meaning. Not paraphrasing what students, patients, or staff said facilitated the data analysis.

### 3.5.2 Interviewing

Patton (2002) has repeatedly noticed that interviewing is integral to participant observation and, thus, it should not be separated. The interviews in this study ranged from spontaneous, informal conversations in the clinical setting to formally arranged meetings that were scheduled and audiotaped (Mason, 1996). I conducted informal interviews with student nurses, their mentors, health care assistants and ward managers. The purpose of the informal interviews was to discover the cultural meaning that each individual posed on their everyday practice. Informal interviews took the form of a short face-to-face conversation and sometimes a group conversation in the nurses' office.

The purpose of the formal interviews was to expand on the themes generated by participant observation and confirm that I comprehended the meaning they assigned to obesity and their care towards obese patients. As seen in Table 5, each formal interview, based on an interview schedule, lasted approximately 30-90 minutes; questions posed in the interviews were based on the analysis of my field notes.

| Name     | Age       | Years of studies             | Interview duration | Observed |
|----------|-----------|------------------------------|--------------------|----------|
| 1. Suzan | Early 30s | 3 <sup>rd</sup> year student | 30 minutes         | Ward A   |
| 2. Stacy | Early 20s | 1 <sup>st</sup> year student | 47 minutes         | Ward C   |
| 3. Kath  | Mid 20s   | Newly qualified              | 35 minutes         | -        |
| 4. John  | Mid 30s   | Newly qualified              | 90 minutes         | -        |

|           |         |                              |            |   |
|-----------|---------|------------------------------|------------|---|
| 5. George | Mid 30s | Newly qualified              | 55 minutes | - |
| 6. Lucy   | Mid 20s | 1 <sup>st</sup> year student | 35 minutes | - |
| 7. Carol  | Mid 20s | 1 <sup>st</sup> year student | 45 minutes | - |

Table 5. Formal Interviewing

As with participant observation, I chose to start out *without* being ‘intellectually empty-handed’ (Robertson and Boyle, 1984). Mason (2002) advises researchers to engage in some detailed and rigorous planning. The interview schedule (Appendix 4) was based on the cultural patterns observed and the student nurses’ language so that the information obtained during the interviews was relevant and based on shared understandings between the participants and me (Robertson and Boyle, 1984).

Formal interviews were conducted on an individual basis, face to face, and data were transcribed; while informal interviews were conducted in the field mainly during the breaks and notes were kept in my notebook. Each formal interview took place in the premises of the nursing faculty of the students’ University, for convenience reasons for participants, after gaining permission from the faculty. A ‘do not disturb’ notice was put on the door and I ensured that the room was not affected by external noises, and was well lit.

I strived to give a natural flow to each interview by creating an atmosphere where the student would feel comfortable. Each interview began with ‘getting to know you’ questions and I also engaged in disclosing information about myself. My experience from previous research I undertook (Sardani, 2006), helped me in making on-the-spot decisions about the content and sequence of each interview as it progressed and to keep everything running as smoothly as possible.

According to Brewer (2000), ethnography has four imperatives or requirements. These include *asking* people for their views, meanings and constructions; *asking* people in such a way that they can tell them in their own words; *asking* them in depth because these meanings are often complex, taken for granted and problematic; finally, addressing the social context which gives meaning and substance to their

views and constraints. This statement encapsulates the important role that interviewing had in this ethnographic research. It reflects my belief that the social world, as experienced by student nurses cannot be reduced to what I observed; but is something 'created or recreated, perceived and interpreted by the people themselves' (Brewer, 2000). Therefore, the data produced from the interviews are equally important to the ones from my field notes.

Another way of gaining access to student nurses' interpretation of obese patients' care was achieved by the method of 'drawing a picture'.

### **3.5.3 Method of 'drawing a picture'**

Being encouraged by Mason (2002) to think creatively about methods of data generation, I decided to use the experiential method of 'drawing a picture' to complement my data sources. At the end of the formal interview, each participant was asked to draw a picture regarding the topics discussed during the interview and then invited to explain in detail how these pictures relate to their experience of nursing obese patients and reflect on it. The participants were specifically asked to draw a representation of an obese patient or their interpretation of obese patients' care. I have included all seven drawings at relevant sections of the discussion of themes emerged.

'Drawing a picture' has been commonly used when researching children (Evans and Reilly, 1996); however, it has also been introduced in researching adults and has been relatively successful (Bosco et al., 2005). It is usually used as a complementary method and is based on the argument that visual images sometimes represent more accurately thoughts and feelings than words (Evans and Reilly, 1996). It is similar to the data gathering method of 'narrative picturing' in that participants are asked to 'think in pictures' and then describe the 'recalled images' to the researcher (Simpson and Barker, 2007).

Narrative picturing is usually used to facilitate traumatised people recall memories of the significant events when they are not evident on first recall (Van der Kolk and Fisher, 1995). The similar point that 'drawing a picture' and 'narrative picturing' share is that they both seek to explore meaning within lived experience by using



visual imagery, which is a key process in memory formation influenced by one's emotions and behaviour (Stuhlmiller and Thorsen, 1997; Simpson and Barker, 2007).

Visual images and technologies have been used as part of ethnographic research in the past; since ethnographers are encouraged to develop alternative objectives and methodologies and reject the idea that the written word is essentially a superior medium of ethnographic representation (Pink, 2001). However, 'drawing a picture' has only been used once in the past on research regarding student nurses by Bosco et al. (2005). Bosco et al. (2005) used the method of 'drawing a picture' to explore the goals of student nurses in relation to nursing as a complementary method to distributing questionnaires. This method provided interesting insights to their study; for instance, the majority of student nurses drew stereotypical images of nurses and 'romanticised' ideas. In order to represent their enjoyment of being a nurse and satisfaction they gain from their profession, the participants in their study portrayed themselves with smiling faces or 'sunshine' (Bosco et al., 2005).

The use of such an innovative method also allowed me to reflect on the plausibility of using multiple methods in answering the same research questions and explore the meaning nursing students attach to the care they provide from a different angle (Mason, 2002). Such experiential research methods have been praised for eliciting implicit knowledge and self-identities of participants in a way that other methods cannot (Edgar, 1999). It complied with my intention to generate data with the participants; rather than simply collect data from them and reflected the active role of participants in this study by allowing them to construct their reality in images.

Also, by engaging them to reflect on their drawings, they became part of the analysis process. This mode of enquiry, thus, became a type of data elicitation; students were asked to talk about their drawings and how they represent their opinions, feelings and beliefs about nursing overweight patients. Therefore, they contributed to the interpretive process of the data. This way, students were given the opportunity to express their views, feelings and thoughts in a creative way. Moreover, they used their drawing to reinforce the ideas they expressed verbally. When I analysed their drawing, I realised that the method of 'drawing a picture' had another significant asset; it allowed students to depict their non-verbal communication; for example by

drawing a screaming mouth to depict frustration. Finally, I discovered that this novel approach 'freed' the participants from the typical interview dialogue. After asking the participants to draw a picture, they all seemed to relax, laugh or smile.

### **3.5.4 Documentary sources**

My data generation included any documentary sources that were aimed at student nurses – and student nurses had access to them - as well as any documentation that was related or mentioned patients' weight or Body Mass Index. Their sampling was conducted in a process, which included enquiring student nurses about their relevance in their clinical practice and care of obese patients.

In this study, I perceived documents as something more than mere information (Prior, 2003; Prior 2004). I studied any relevant documentation regarding them as 'cultural artefacts', within the social setting it was displayed or utilized trying to uncover the cultural connotations they had. I strived to distinguish their socially organized and conventional properties, the uses they were put to, in their production, circulation and utilization (Atkinson, 2005). I agree with Prior (2004) that the focus of analysis ought to be the complex functions and the significance of the documents rather than the original intent of the materials. Prior (2003) has claimed elsewhere that documents 'are constructed in accordance with rules, they express a structure, they are nestled with a specific discourse and their presence depends on collective, organized action' (pp 12-13). He supports the idea that 'a study of the use of documents can be as telling as a study of content'. Following Prior's (2003) advice, I did not just 'read' documents, but, also, studied the purpose of their use as well as the frequency of their use. For instance, the lack of documents regarding weight and obesity in students' clinical practice revealed significant information about the people in it that helped me in understanding their reality. Also, the large amount of randomly placed documents hanging in the sisters' office on ward A gave me an insight into the environment and information student nurses are exposed to. Similarly, student nurses' ignorance of the whereabouts of any relevant documents on obesity provides an understanding of the significance of these documents to students. Finally, since I was looking into the *meaning* that student nurses apply to their reality, it was considered important to students to locate the relevant documents for me in the practice and, then, describe their use, purpose, and importance for them.

Several sources of documentary data were perused; academic documentation, as well as documentation used in practice. Moreover, official documents regarding student nurses' practice and professional conduct have been reviewed (Project 2000; Jowett et al, 1994; The NMC Code, 2008; The NMC guidance on professional conduct for nursing and midwifery students, 2009). This documentation was invaluable in assessing the extent of information provided to nursing students; as well as supplementing my knowledge and awareness of the social context in which nursing students care for their patients.

### **3.6 Data Analysis**

This section outlines my approach to data analysis and provides an in depth examination of how the themes, categories and codes were generated from the data.

In line with my epistemological position, according to which we can only obtain knowledge through the understanding of how the social world is interpreted by its participants (Bryman, 2001); I chose an inductive approach of analysing my data. In other words, I did not select a pre-existing coding frame in order to adapt my findings into it. Rather, by following the firm belief that theory is built from the bottom through the data themselves (Bryman, 2001), the themes were derived from my findings rather than selecting a theory to drive my findings.

Nevertheless, I would like to make transparent that the data analysis was based on the understanding and cooperation between me as a researcher *and* the participants. Therefore, the themes derived have multiple meanings and there is always some degree of interpretation when approaching the findings of this study (Graneheim and Lundman, 2004). Moreover, it should not be disregarded that my own theoretical and conceptual understandings have influenced this process and, whenever appropriate, I have utilised reflexivity to make this clear. Even though I have not selected a theoretical framework to conceptualise the generated data, throughout the findings' chapters, I refer to a wealth of nursing and sociological theories to compare and discuss my findings with that of relevant theorists and researchers.

The considerable amount of data generated was analysed using thematic analysis and was based on my philosophical assumption that reality can be interpreted in many

ways and, thus, the understanding is dependent on subjective interpretation. I utilised this method to reflect reality the way I perceived it doing participant observation as well as the way student nurses perceived it and was reflected in their accounts.

Thematic analysis is considerably diverse in terms of its concepts, procedures and measures but no matter what form it takes, it had the purpose of achieving rigour (Graneheim and Lundman, 2004; Polit and Hungler, 1999; Burnard, 1996; Cavanagh, 1997; Braun and Clarke, 2006). Most researchers agree that the process of analysis should be amended and adjusted to suit the research project at hand. Therefore, it seems imperative to explain how I utilised the concept of thematic analysis. I perceive thematic analysis as a method or tool of identifying, analysing and reporting *themes* within data, in order to minimally organise and describe them in rich detail (Braun and Clarke, 2006). This method, though, is not about radical reduction, which reduces data to distinct words; it is about facilitating contextual meaning in text through the development of themes derived from textual data (Bryman, 2001). It is about condensation; which means shortening while preserving the core. It is also about abstraction; which refers to grouping together textual data to create codes, categories and themes on varying levels by always highlighting descriptions and interpretations on a higher logical level (Graneheim and Lundman, 2004). In this process, I had an active role in identifying themes and presenting them in Chapters Five, Six and Seven (Morse and Field, 1996). According to Braun and Clarke (2006), a theme 'captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set'. Practically, it is 'a thread of an underlying meaning through condensed *codes* and *categories*, on an interpretative level' (Graneheim and Lundman, 2004). The themes intertwined and overlapped mainly because themes are expressions of the latent context of data and, thus, had multiple meanings.

An example of codes, categories and a sub-theme from the second theme 'constructing the meaning of obesity: the culture and context of care' is presented in Table 6.

| Sub-theme | Obesity meaning to student nurses   |   |  |   |  |
|-----------|---|---|--|---|--|
| Category  | Current medical definition  | Physical appearance and size  | Manual handling needs  | Health problems   | Body Type and Age  |
| Codes     | -BMI is inaccurate<br>-'it's a rough idea'<br>-Being muscular<br>-Weighing patients infrequently<br>-Not measuring height<br>-Pushed to the back of the queue | -'it's a visual thing'<br>-facial appearance<br>-big belly<br>-fitting on the equipment<br>-looking 'too big' | -in need of a hoist<br>-in need of special equipment<br>-breaking your back<br>-'a lot of rolling involved'<br>-'double handlers'<br>-'you need more than one person to move them' | -'when it affects their health'<br>-typically in bed<br>-breathing problems<br>-heart problems<br>-skin integrity<br>-it takes longer to heal | -'it is ok for older people to be overweight'<br>-seeing a lot of older people being overweight<br>-having a Welsh body type |

Table 6. Examples of codes, categories and a sub-theme

Although presented as a linear, step-by-step process, the research analysis was an iterative and reflexive process. For the purposes of explaining the reader how my fieldnotes were translated into the three major themes, I have chosen to present it as

occurring in three phases that were dominated by 4 stages of analysis of data. Table 7 can assist the reader to visual this process.

| →→→→→→→→→→→ Chronological Order →→→→→→→→→→→ |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| ↓   | Phases of Data Generation        | 1 <sup>st</sup> Stage of Analysis               | 2 <sup>nd</sup> Stage of Analysis                       | 3 <sup>rd</sup> Stage of Analysis  | 4 <sup>th</sup> Stage of Analysis                          |
| ↓   | Participant observation (Ward A) | Manifest Content Analysis<br><br>Coding by hand | Latent Content Analysis,<br><br>Emergence of categories | Condensation<br><br>Comparative Analysis of sub-themes                                 | Abstraction,<br><br>Transfer of codes and themes to NVivo8 |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   | Participant observation (Ward B) | Manifest Content Analysis<br><br>Coding by hand | Latent Content Analysis,<br><br>Emergence of categories | Condensation<br><br>Comparative analysis of sub-themes                                 | Abstraction,<br><br>Transfer of codes and themes to NVivo8 |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   | Participant observation (Ward C) | Manifest Content Analysis                       | Latent Content Analysis,<br><br>Emergence               | Condensation<br><br>Comparative analysis of sub-themes<br><br>Development of Interview | Abstraction,<br><br>Transfer of codes and                  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |
| ↓   |                                  |   |   |  |  |

|   |              |                            |                         |   |   |
|---|--------------|----------------------------|-------------------------|---|---|
| ↓ |              | Coding by hand             | of categories           | Schedule  | themes to NVivo8  |
| ↓ | Interviewing | Manifest Content Analysis, | Coding in NVivo8        | Comparative analysis of participant observation sub-themes to interviewing sub-themes | Induction of categories and sub-themes to 3 Main Themes |
| ↓ |              | Coding by hand             | Emergence of categories |   |   |

Table 7. The process of data generation and analysis

In this study, I endeavoured in both manifest content and latent content analysis (Graneheim and Lundman, 2004). Manifest content refers to the content aspect and the description of the visible, obvious elements of the textual data. This was done during the first stage of analysis. In other words, this was the stage that I coded by mostly paraphrasing the fieldnotes and interview data; a stage that started as soon as I gathered the fieldnotes and typed them on my laptop. During the typing, I made notes referring to analysis and after typing up each day of participant observation, I endeavoured in coding; this took the form of labelling individual lines or paragraphs by codes in the margin of the pages. An example of this form of coding is presented in Appendix 6. At this stage, I chose to code the data by hand, which meant that I printed all my data, bound them as a book and wrote codes and memos at the right and left margin of the pages. I refrained from categorising the codes but kept my eyes open for concepts and ideas that seemed to be repetitive. Such an instance was when students characterised or implied that a patient is ‘demanding’. At this stage, I made a note in my diary that this seemed to be important for student nurses during their everyday reality in clinical practice.

As seen in table 7, analysis commenced as soon as I generated data. It is important to note that at the first stage of data generation and analysis, I did not concentrate my attention just on patients’ obesity, but on student nurses’ culture as a whole. As

already mentioned I gathered and recorded hundreds of pages of descriptive observations in my field notes and, then, typed and expanded them in Word documents. I also typed up the notes from my research diary. Since my fieldnotes also included data that were not directly associated with the research questions (as explained in Section 3.4, using an inductive approach to data collection meant that I gathered a large amount of data about student nurses' clinical setting and culture that were not directly focused on my research questions) I also chose to highlight sections of my fieldnotes that seemed more relevant to the subject of this study and the research questions. For instance, I have a large amount of data regarding student nurses' interaction with elderly patients. Moreover, I highlighted the language that student used when they described their clinical practice, their work, their feelings and any references they made to weight – either their patients' or their own. Additionally, I begun the preparation of the interview schedule with potential questions that I could ask students during the semi-structured interviewing phase of this study.

During the later stages, I immersed into *latent content analysis*, which refers to deeper interpretation of the underlying meaning of the text and abstraction (Graneheim and Lundman, 2004). This is the phase that I began to immerse deeper in my data and go beyond simply paraphrasing. For instance, when a student complained about a patient, I enquired about the reasons behind their behaviour, the implications of labelling –as I witnessed them and as the students interpreted it-, the relationship to the patient's 'obesity' status and its importance to student's overall experience of being on the practice ward. Moreover, I politely asked one of my supervisors to code certain excerpts of my data so that we could compare our codes and discuss the coding process. This process assisted me to identify concepts that could be of importance at later stages of analysis and review the literature in relation to them. Examples of such concepts are 'impression management', 'emotional labour' and 'social judgement'. I drew some categories and sub-categories that showed the association of the codes with each other. Additionally I highlighted relevant phrases and interesting cases to be examined further. Issues such as patient categorisation, the ward environment, student-patient communication, food and nutrition, manual handling, and power relations on the ward were identified early as pertinent to this study. Therefore, I used different colours of highlighter pens to identify them in the textual data.



The data generation and analysis stages of this research study were undertaken concurrently; every time a stage was completed, I returned to the data before undertaking further analysis, in order to make sure that the categories and themes were rooted in the original data. This process is depicted in Table 7, which also illustrates the relationship between the data generation and analysis phases. In the 3<sup>rd</sup> stage of analysis, I condensed the codes and categories and made sure that they refer to separate concepts or aspects of the data. For instance, I coded 'breaking your back' and 'feeling frustration' under the broad category of 'consequences on student nurses'. Similarly, I coded together extracts under the codes 'occupying space', 'looking too big' and 'physical appearance and size', which all expressed students' meaning of obesity in clinical practice. I also drew tables and figures that showed the associations between different codes and categories. I also looked into relevant literature and sought links between my findings and previous research studies and theories developed that could potentially help me comprehend student nurses' reality in a deeper sense. However, I was reflexive, so I would not make any assumptions that could lead to 'contamination' (Morse and Field, 1996). I compared, for instance, my initial findings with that of Melia (1987), who conducted a very influential research study regarding the occupational socialisation of student nurses, and the studies of consequent researchers with similar interests. The exploration of the relevant literature assisted me in reflecting on my findings and my views regarding nurse education, especially in terms of student nurses' clinical placements. It also boosted my confidence in my fieldwork and data generation skills, as I could already identify similarities –as well as differences- between my findings and that of other researchers.

The second and third stages of analysis were also done by hand and aimed at achieving a deeper interpretation of the data. They were signified by the comprehension of categories and patterns, which were further condensed into sub-themes. Data from each phase of observation were compared to each other with the aim of finding similarities and differences. For instance, I looked into how the ward environment and dynamics influenced student nurses in the care they provided to obese patients as well as how the different conditions, health problems and reasons for admission influenced how students viewed and interacted with patients. In addition, I explored how the different sub-themes were interconnected. For instance,

I aimed at finding out what is the connection between student-patient communication and shortage of resources.

After completing the last phase of participant observation and the third stage of the analysis of my field notes, I developed the interview schedule, which was grounded on the findings from my observations. This signified the beginning of the last phase of data generation; the interviewing of student nurses. As soon as possible after the completion of each tape-recorded interview, I replayed the tape and listened carefully to the content, made notes and then transcribed the interview (Morse and Field, 1996). This was done during the same day or the following day. During the first stage of analysis, three interviews were coded by hand in a similar way to field notes.

However, at the second stage, I decided to utilise the computer research software called NVivo8. I, therefore, transferred the interview transcripts and codes developed by hand to the software (Appendix 2) and continued with the analysis of the remaining interviews utilising this software. I found this software considerably useful because it enabled me to manage and organise my data in a way that I could later retrieve hundreds of quotes within codes, categories, sub-themes and themes instantly. I also found this software useful in that sorting and searching for text was done automatically and in far less time than would have been consumed doing so manually (Angrosino, 2007). Had I decided to do it manually, it could have taken a considerable amount of time to organise my data with such efficiency; since I generated such a massive amount of data (Welsh, 2002). This is the reason why I decided to transfer the data and coding from my field notes. Learning how to use it and familiarising with its terminology (for instance, NVivo refers to codes as 'nodes') was time-consuming, but my extra effort was compensated by re-immersing myself in the data. Re-analysing the data led to more systematic and thorough analysis and therefore made the analysis more rigorous, and consequently justified its use.

It must be noted that no package of analysis can generate new codes or ideas, as Barbour (2008) argues, but there is a fear that it can prevent the researcher from critical thinking when coding the text. For instance, it could lead to reducing the data to distinct words. By using alongside pencil and paper, I combined the best features

of the electronic and manual method and avoided this mistake (Welsh, 2002). This means that it is important that the value of both manual and electronic tools in qualitative data analysis and management is recognised, so that one tool is not reified over the other but instead one remains open to, and makes use of, the advantage of each tool (Welsh, 2002). Having this in mind, I organised all codes and categories using the manual method on A3 paper. Viewing the codes and categories on paper, helped me in taking the final decision of re-arranging them into three major themes.

The re-arrangement of the three major themes was a hard, deep thinking process, which often developed as a dialogue between me and my supervisors. The themes were often altered and adjusted, whereby I shifted back and forth codes and categories to examine how these are linked and develop clearer concepts and connections in my data. The last phase of the analysis process was equally hard but also rewarding as the final themes emerged after a dialectic process between my interpretation of the findings, endless conversations with my supervisors and comparison with nursing and sociological literature. The final themes reflect my faithfulness to the social constructionist position, which is concerned with the exploration of how knowledge is created during the interaction of people and the implications of its interpretation in practice (Gabe et al., 2004).

The following section presents the criteria and strategies I utilised to achieve rigour in this study.

### **3.7 Ensuring rigour in ethnographic research**

Although it appears that there is no unified agreement as to what constitutes rigour in qualitative research (Guba and Lincoln, 2005; Morse et al., 2002; Rolfe, 2004), I followed Emden and Sandelowski's (1998) advice and a set of criteria that reflect my personal beliefs and philosophical assumptions. I outline the main arguments of both positions in my effort to explain how they have influenced my choice of evaluation criteria.

The debate regarding appropriate criteria to ensure quality in qualitative research is considerable. Some researchers have aligned with the traditional tenets of quantitative research, suggesting reliability and validity as the sole criteria. Some

others have argued that these criteria can be problematic in a qualitative context; mainly because they clash with the underlying philosophy of qualitative research (Emden and Sandelowski, 1998). Specifically, it is claimed that since qualitative researchers view the world as constructed from a plurality of realities and truths, as opposed to the quantitative approach that recognises only one reality that issues from universal laws and objective truths, it seems inappropriate to apply the same 'rules' that quantitative research does (Bailey, 1997; Cutcliffe and McKenna, 1999). Leininger (1994), for instance, has pointed that 'we must develop and use criteria that fit the qualitative paradigm, rather than use quantitative criteria for qualitative studies' (p.97). There are still researchers, though, that insist that there is nothing to be gained from the use of alternative terms which prove to be identical to the traditional terms of reliability and validity (Long and Johnson, 2000). I agree with the statement that only the fact that qualitative researchers usually conduct studies on human subjects, who think and can change their minds at any given time, means that any form of research into human subjects can only ever offer a 'glimpse of the situation at a particular time and in a particular context' (Newell and Burnard, 2006; p.109). On the other hand, I also agree with Emden and Sandelowski (1999) that *no* one set of criteria can be expected to reflect the needs of every research study. Only the consideration of the diversity of approaches and traditions that is building within qualitative research alone diminishes such a possibility (Morse et al., 2002). I see this debate as a positive challenge to strive to bring about rigour within one's research project rather than a path to uncertainty (Emden and Sandelowski, 1999). In my search for appropriate criteria for this study, I looked into the philosophical underpinnings of this study and decided to utilise a combination of known criteria and strategies that have ultimately a sole purpose; to prove that this study has been completed with goodness and rigour.

The quality of the present study is assessed by two primary criteria; trustworthiness and authenticity (Guba and Lincoln 1994).

Trustworthiness can be established if credibility, transferability, dependability, and confirmability are established (Holloway and Wheeler, 1996; Guba and Lincoln, 1989). As far as credibility is concerned, it refers to presenting the perspectives of the informants as clearly as possible. Credibility is therefore enhanced when

researchers describe and interpret their experiences as researchers (Koch, 1994). Self-awareness was considered essential and, thus, I kept a reflexive journal. I also utilised respondent validation, peer debriefing, prolonged engagement, persistent observation and audit trails as strategies to demonstrate credibility that are explained further in this section.

Transferability refers to how the findings of a study can be applied to a similar context. This means that the readers of this study ought to view its findings as meaningful and applicable in terms of their own experiences (Koch, 1994). My intention, after all, was not to provide a direct experience of being a student nurse caring for obese patients. Rather, I challenge the reader of this thesis to engage in my interpretation of students' reconstructed experience reflecting on their own background knowledge and assumptions – as advised by Atkinson (1990). After a presentation I did in the Royal College of Nursing International Conference (2009), many educators, practitioners and researchers approached me and told me that they have had similar experiences in their settings.

Dependability refers to whether the findings would be similar if the inquiry was replicated in a similar context or with the same subjects and is achieved through a process of auditing (Tobin and Begley, 2004). Having consistency and keeping an audit trail fulfilled the aim of exposing my methods of data generation and analysis, so that this could be made possible. Reflexivity was central in my audit trail because it demonstrated self-criticism and, thus, the reader could gain a clearer insight on the process of decision-making.

Confirmability refers to researcher's freedom of bias and requires one to show the way, in which interpretations have been arrived at via the inquiry. In order to satisfy the criterion of confirmability, I have clearly indicated my research decisions and influences (Koch, 1994; Morse and Field, 1996). Additionally, I have included textual segments of my field notes and interview transcripts throughout this thesis to illuminate findings as they arose from analysis. All segments have been coded and can be traced back to the sources for verification. All major points presented in the findings are supported by at least one textual segment. This was done in a conscious effort to give *voice* to the participants, so that they could be heard by the readers. It is

about letting the participants speak for themselves and giving an emotional immediacy to both my voice and the participants' voices (Guba and Lincoln, 2005).

Authenticity criteria, which focus on knowing, action and fairness, are primarily demonstrated through stakeholder testimony and are supported by an audit trail of evidence of fairness and authenticity (Guba and Lincoln, 2005). Fairness is about reflecting all views, perspectives, claims, concerns and voices to prevent marginalization. I also tried to be reflexive to ensure rigour in my research (Koch and Harrington, 1998). The link between rigour and reflexivity is explained in Section 3.8. At this point, I describe the strategies I utilised in order to meet these criteria.

### ***(1) Prolonged engagement and Persistent observation***

There were limited breaks during the fieldwork, because I was simultaneously recruiting, observing, writing up field notes, transcribing and analysing; during the phase of interviewing I had a similar experience. Retrospectively, I feel that this presented an enormous advantage to this ethnographic study, because it enhanced the research continuity and contributed to data immersion. Further, it provided opportunities to develop rapport with the participants and identify the contextual and institutional factors that influence student nurses' experience of caring for obese patients.

### ***(2) Saturation***

Data saturation refers to the point that a researcher reaches a point, where she knows that she has saturated her categories. Influenced by the research design used in grounded theory (Glaser and Strauss, 1967), from the early conception of this research project, I was determined to stay in the field for *as long as I had to*. The research design in grounded theory is a circular process of moving back and forth between data collection and analysis until saturation has been achieved. Although the aim of this study was not theory building, but knowledge acquisition, I decided to adopt certain principles and notions of grounded theory (Sarantakos, 2005). My aim was to gather data until no new information was obtained. Therefore, I was transcribing my field notes as soon as possible and, then, analysed them to find patterns and themes. When I first discussed this research project, I proposed going to the field just once for a prolonged period of time but after analysing the data, I

realised that it was necessary to return to the field two more times and conduct further participant observation. I generated my data in four different periods; after the end of each phase I endeavoured in analysing the existing data before re-entering the field, thus increasing the rigour. Data from all three hospital wards that I did participant observation were regarded equally important and were given the same consideration in the analytical coding procedure. Similarly, all participants' views received equal consideration whether or not they were observed. To sum up, prolonged engagement in the field, persistent participant observation, documentary review, simultaneous data analysis and multiple interviews were the key points in my attempt to achieve data saturation (Cutcliffe and McKenna, 2002).

### ***(3) Use of different methods of data collection***

One of the ways I chose to ensure rigour in my research study was the usage of more than one method of data collection to answer my research questions. This was not done for the purpose of triangulation but for the sole purpose of direct comparison, in order to provide richness and offer different views of the whole picture. There has been a long debate on whether triangulation, a quantitative method of validity, can be applied to qualitative research (Hammersley and Atkinson, 2007; Mays and Pope, 2000; Barbour, 2001). I agree with Barbour (2001) that it is difficult to apply triangulation properly on qualitative research because the data produced from participant observation, the interviews, documentation and drawing a picture have obvious differences. Moreover, triangulation can undermine the holistic nature of ethnographic research, since it predisposes the researcher to treat data as individual entities rather than a continuum. The reason why I chose to utilise such a variety of methods was to provide different views of the whole picture. My methods complement each other and examine the research questions from various angles (Barbour, 2001). Following Mays and Pope's (2000) advice, I sought a way of ensuring comprehensiveness rather than internal validity.

### ***(4) Respondent validation***

Member checking involved cross checking research findings with the participants of this study. This meant that all students I observed had access to my field notes during participant observation; thus, I managed to record their reactions and get their personal insights on events I recorded and then I incorporated them into the study

findings. Interviewed students had also access to their transcribed interviews and were allowed to make comments on them. I also presented a summary of the themes and categories produced to participants that brought about dialogue, explanation and discussion. I was aware that respondent validation has certain limitations (Cutcliffe and McKenna, 2002) but I considered it important for the participants to recognise something of themselves and their world in the field notes I kept and the themes I produced. It also supported my philosophical position; the participants and the researcher to be involved in a continuous state of construction and reconstruction of reality within a context of a reciprocal relationship. This is the reason why I refer to the student nurses as ‘participants’ and not as ‘respondents’ or ‘informants’. However, respondent validation was not treated as a verification strategy (Morse et al., 2002). Their comments were taken into account as *additional* data, providing more richness, without disregarding my *own* interpretations.

#### ***(5) Audit trail***

As already mentioned, I have kept an audit trail that clearly exposes my method of data generation and analysis. This was done in my research diary and includes information about the chronological sequence of events, decision-making and decisions taken or not regarding location, participants, cases as well as an overview of all stages of data analysis. This thesis is a reflection of the audit trail I kept.

#### ***(6) Attention to disconfirming cases***

My sampling also included a search for confirming and disconfirming cases (Polit and Hungler, 1999). The disconfirming cases were seen as equally important in an attempt to:

‘Preserve and celebrate anomaly, that is, the discoveries and the data that do not fit. Anomalies are levers for transformation’ (Miller & Crabtree, 2005; p.611).

Searching for, and discussing elements in the data that contradict, or seem to contradict, the emerging explanation of student nurses’ care in relation to patients’ weight was one of the tactics I utilised to improve the quality of this study (Mays and Pope, 2000). Giving additional attention to contrasting cases assisted in refining the analysis until it explained all the cases I studied. A striking example springs from the field notes of the third phase of participant observation. Up until that point, all



immobile obese patients were categorized or treated by students and nursing staff as 'difficult' or 'bad' patients. This led me to the assumption that obese immobile patients were considered as difficult. However, I observed that there was one particular immobile obese patient, who was favoured by both nurses and students. This was a female patient, in her mid-twenties who had spinal bifida and end-stage respiratory failure. This contrasting case made me gain a broader perspective of how student nurses view difficult patients and gave me a deeper understanding on how obesity can influence a patient's care irrespective of the staff's and students' attitudes towards them. It also helped me identify how student nurses categorise patients and what bias they held due to their position in their clinical practice (Johnson, 1990).

### ***(7) Peer reviewing***

As suggested by Mays and Pope (1995), I shared my data with my supervisors. In effect, one of my supervisors analysed segments of my data and came to similar conclusions. Peer reviewing has been criticized as antithetical to the naturalistic/interpretive paradigm (Rolfe, 2006). Despite being inclined to the naturalistic/interpretive paradigm, which argues that human actions are based upon, or infused by, social or cultural meanings (Hammersley and Atkinson, 2007), I found peer reviewing helpful and reassuring that my personal intentions, motives, beliefs and values did not influence me in misinterpreting the data of this study.

### ***(8) Fair dealing***

Fair dealing is a technique mentioned by Mays and Pope (2000), which refers to including a wide range of different perspectives, so that different groups can have an equal opportunity to express their views and the meanings they attach to the reality they live in. The diversity of my sample, which included both male and female participants of different age groups and experience, enabled me to achieve a wealth of different perceptions.

### ***(9) Standards for ethics***

I was also influenced by Tobin and Begley's (2004) paper on rigour. They suggest that a study is rigorous when it illustrates truth and consistency; so that the reader is assured that the emerged themes represent reality. This means that a researcher ought to be characterised by integrity and competence, in a way that the standards for

quality are matched up to standards for ethics. During this research project, it was clear that the quality of this research was considerably dependent not only on my knowledge and skills of conducting qualitative research, but also on my integrity to continue with the same high quality criteria irrespective of difficulties, such as limited time and financial resources.

Overall, these techniques and strategies were imperative in achieving rigour in this study but, as already mentioned, this would not have been possible if I were not reflexive throughout the process of this journey.

### **3.8 Reflexivity**

Reflexivity is a term widely used in qualitative research, although its concept has been associated with many meanings (Atkinson and Coffey, 2002). I perceive reflexivity as self-awareness, political and cultural consciousness, and ownership of one's perspective (Patton, 2002). Davies has defined reflexivity as 'turning back on oneself, a process of self-reference' (Davies, 1999 p.4) To be reflexive, then, is to understand 'what I know' and 'how I know it' (Patton, 2002; p.64). It is also recognised that this thesis does not 'simply and transparently report an independent order of reality' (Atkinson, 1990; p.7). Rather, while I took every care to increase my awareness of any factors that could influence my performance as the prime research instrument, I realise that this study – like any sociological endeavour- is an attempt to provide a representation of reality as filtered through myself as well as my participants' perception of reality.

'Reflexivity reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one's own perspective and voices as well as the perspective and voices of those one interviews and those to whom one reports' (Patton, 2002; p.65).

In this study reflexivity was used in various ways; first, as a way of ensuring *rigour*. As Powdermaker has suggested, I developed the ethnographer's role by 'stepping in and out' of the culture I studied to achieve both *involvement* and *detachment* (1966; p. 19). Secondly, I discovered that having a reflexive approach yielded many benefits; particularly it increased my readiness to address issues when they arose. Reflexivity facilitated my research journey by helping me remain alert to new issues and explore these by asking relevant questions and gain new insights throughout the

journey. It also enabled me to generate data not only by observation but also from introspection and, hence, helped to fulfil my active role as a 'research instrument' as opposed to a neutral and passive researcher (Davies, 1999; Punch, 1994). By utilising reflexivity, I wanted to help the reader to gain awareness of a meaningful range of perspectives, experiences and standpoints, including my own. Reflexivity, thus, helped me distinguish different levels of interpretation of reality and this realisation defined my data analysis. The first level was the reality as I perceived it. The second level was the reality as perceived by students and reflected in their accounts. The third level of interpretation was my perception of students' reality as I observed it and understood it through students' accounts. In this thesis, I tried to give equal weight to each of these voices and show sensitivity to every range of interpretation as well as willingness to critique and question my own as well as those of my participants (Mason, 2002). Without reflexivity, I would not have been able to achieve this. Finally, I utilised reflexive commentaries as a means to enliven my writing in my pursuit of engaging the reader by transforming my observations and insights into rather compelling arguments or explanations (Barbour, 2008).

As far as rigour is concerned, the notion of reflexivity is the response to the positivist and naturalist position that it is possible to isolate a body of data that is not contaminated by the presence of the researcher (Hammersley and Atkinson, 2003). Positivism's position dictates that the researcher always has to be a detached and impartial observer (Bryman, 2001). On the other hand, naturalism strives to eliminate the effects of the researcher on the data by 'surrendering' oneself to the culture they wish to study by becoming a 'neutral vessel of cultural experience' (Hammersley and Atkinson, 2003). I argue that it is impossible to separate the researcher from the research, which means that the findings of this study are affected by social processes and my personal characteristics. Nevertheless, I attempted to 'turn back' in each step of the research journey, from the initial selection of my research topic to writing up this thesis, and do a form of cultural critique looking into my involvement in the society and culture of student nurses (Davies, 1999). By doing so, I discovered that I entered the field with two substantial assumptions. First, I was influenced by the assumption that obese patients were considered difficult and, thus, if a patient was obese his or her care would be affected negatively. By being reflexive, I remained open-minded and tried not to favour one case over the other. By this I mean that I

looked for disconfirming cases despite that the majority of my data pointed to one direction. Second, I was influenced by the assumption that my personal attitudes towards obese patients were neutral. In other words, I have never considered weight as a negative attribute. However, after immersing in the field, I realised that my attitudes were slightly changing. This was mainly due to my back pain developed because of using poor moving and handling techniques, while imitating students, and due to obese patients' longer stay on the ward. I reflected on my feelings and I discovered that at some level I felt that my efforts as a nurse were not 'rewarded' by positive outcomes in patients' recuperation. This subconsciously created a frustration that was reflected on my attitudes towards these patients. Nevertheless, this realisation helped me understand how student nurses and nursing staff may have been feeling, as well. Finally, by understanding why I had these negative feelings, I was able to deal with them and dismiss them.

I regard reflexivity as 'critical subjectivity' that has been defined as 'a conscious experiencing of the self as both enquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself' (Denzin and Lincoln, 2005; p.210). I acknowledge that researchers both influence and are influenced by the process of engaging in research (Koch and Harrington, 1998). I was particularly concerned with the influence that my presence had in the clinical settings I did participant observation. However, I was assured by Hammersley and Atkinson (1995), who note that the way in which participants in a study respond to the presence of the researcher may provide the same wealth of information as the way in which participants react to other situations. All in all, instead of futilely attempting to eliminate the effects of my presence, I set about understanding them.

There was a wealth of factors that I tried to comprehend and examine their impact on my research study. According to Brewer (2000), the researcher ought to reflect upon factors such as the location of the setting, the sensitivity of the topic, power relations in the field and the nature of the social interaction between the researcher and the researched. Influential social and historical factors were brought to the fore; for instance, my background as a nurse, my body mass index, my body image, my perception of ideal weight and attitude towards weight and obese patients. My reflexivity took many forms; I kept a journal and a field diary, confided to fellow

researchers and my supervisor and, finally, used critical reflection as a way of organising my thoughts and reflecting on particular incidents (Johns, 1995). For instance, I felt frustration and anger for nurses, who spoke negatively about patients they considered difficult in the staff room, especially obese patients. However, after using critical reflection, I realised that nurses used this way to express their feelings and release their tensions, in a therapeutic way, in order to be able to cope with the amount of daily workload. This realisation made me more empathetic towards nurses and influenced the analysis of my data.

Another aspect that was influenced by reflexivity is my decision-making, regarding my role as 'ethnographer' in this study.

### **3.8.1 The ethnographic role**

There is great discussion in qualitative research regarding the amount of involvement of the researcher in the research situation (Gold, 1958; Gans, 1968; Spradley, 1980; Adler and Adler 1994; Gerish, 1997; Brewer, 2000; Bryman, 2001; Murphy, 2005). Gold's (1958) typology of research roles has become classic outlining four types through which observers gather data; namely the complete observer, the participant-as-observer, the observer-as-participant, and the complete observer. These roles try to balance how involved or detached; how familiar or strange; how close or far the researcher should be to the setting, the participants, and data he/she gathers. Thus, each role implies how involved the researcher ought to be in the settings' activities, how many responsibilities he/she assumes, and how committed to the goals and practice of participants (Adler and Adler, 1994). As explained further, during this study, I adopted all these roles.

The role of the researcher in participant observation can also be seen with regard to the degree to which he/she is an active or passive participant (Bryman, 2004). Gans (1968) has differentiated three roles varying from total participant to total researcher. This multitude of roles is a quite common phenomenon in unstructured observation (Mulhall, 2003). The degree of participation to which he/she can be an active or passive participant has been said to influence the whole research process. Bryman (2004) associates active participation with showing commitment and gaining credibility. Murphy (2005) argues that 'reversion to the more familiar role of nurse in

the field' is a necessary stage in the process of becoming a competent researcher. Using my identity as a nurse I was helpful to achieve rapport with student nurses and members of the staff as well as gaining acceptance on the ward. Active participation was my chosen role, but when it was required by the circumstances, my role became more passive.

Before going to the field I took a decision to be an observer-as-participant. However, I had to adjust my role according to the situation at hand; sometimes I was a complete observer devoting myself to note-taking and sometimes just a participant helping the students with bed-making and washing the patients. This transition occurred gradually and depended on how comfortable the staff felt around me. The degree of participation I was involved in was as an additional person assisting at a procedure, rather than performing nursing as a member of the team. The active participation enabled me to establish rapport with both students and staff, while complete observation was an excellent opportunity to indulge in rigorous note-taking. At the end of each observational phase, the staff were actively asking for my help giving me the confidence that they had accepted me as a member of their team. I was aware that on certain occasions my participation would considerably influence my data. For instance, a student asked me to assist her to insert a urine catheter into an obese patient. I kindly declined explaining the reasons and she asked for her mentor's assistance. Had I assisted her, I would not have observed the interaction between them. Further, since I am not a registered nurse in UK, I decided to perform the activities that a health care support worker would do. The degree of participation supplemented my data as it provided the experience of 'getting into the shoes' of student nurses and attempting to live the experiences the way they did (Savage, 1995). My decision was also influenced by ethical considerations since I had ethical permission to be in the field as a researcher not a member of staff.

Being a nurse, I explored what is essentially an aspect of my own culture. This means that being a member of the 'nursing team' complicated even more this balance. According to Spradley (1980), being 'inside' the situation could change the stance of the researcher since this particular situation had already a certain meaning for me. This phenomenon is called 'social engagement'. This created the potential for bias; by identifying myself in their culture and aligning my developing

understandings with the perspectives of students, there was a potential loss of objectivity (Atkinson et al., 2003). This is the reason why I was reflexive about it, as already discussed.

On the other hand, in addition to this feeling of 'familiarity' with nursing culture, I also had a feeling of strangeness (Atkinson et al., 2003; p.47). In effect, the fact that I am Greek whereas students are British enhanced my 'marginality' towards the participants. This marginality helped towards balancing my objectivity as a researcher. In my reflexive journal, therefore, I endeavoured on reflecting on the cultural differences and similarities between the participants and me. Similarly, I reflected on the differences and similarities of nursing education in both countries. Atkinson et al. (2003) recognise the fundamental importance of making phenomena 'strange or familiar, near or distant' instead of analysing the data produced just on assumptions regarding our own identity (p.47). Davies (1999; p.9) also points out:

'We do not undertake to travel great distances, to situate ourselves among other groupings, to talk to other individuals simply to learn about ourselves and our own cultures'.

Instead by engaging in this research pursuit I felt captivated by the fact that I might learn something 'outside', 'other' than myself.

Apart from my research role, I also reflected about the role of emotions in this study and how they influenced data generation.

### **3.8.2 Role of emotions**

When going into the field, I had to decide whether to be neutral or not, how close or how distant to the student nurses I had to be. I did not consider distance and detachment necessary; rather I viewed empathy and reflexivity as imperative to understand human behaviour.

Qualitative researchers have attempted in the past to remain emotionally detached in order both to keep an interpretive distance from those they were studying and to attempt to understand issues from their point of view (Bourne, 1998). Murphy (2005) also notices that aspects of fieldwork that create negative feelings, such as anger, confusion, frustration or even depression, are often not discussed. Patton (2002)

warns that rigid detachment can lead to lack of understanding of what one is studying, especially if emotions and meaning-making are part of the phenomenon. When researching a sensitive topic such as weight, I felt it was important to reflect on the role of emotions on the research process. Kleinman and Copp (1993) are known for associating feelings and emotions with fieldwork. They claim that treating feelings associated with fieldwork as worthy as additional data might improve the quality of the research project. Therefore, I acknowledge that my feelings might have influenced the research. However, I also consider that by taking into account these feelings and being aware of their existence, especially during the analysis of data, I was able to see the effect they had on my findings. Moreover, the expression of emotions could help communicating my immersion in the field and data produced. Kleinman and Copp (1993) suggest that 'if we examine our uncomfortable feelings rather than dismiss them, we can gain insights into how others feel and why' (p.31). I endorsed Patton's (2002) suggestion on being both empathetic and neutral, which he mentions as 'empathic neutrality'. This term could be seen as an oxymoron, combining controversial ideas. My perception of empathic neutrality is exemplified at fieldwork, during which I adopted a dual stance; on one hand I tried to be considerate and caring towards both students and patients, and, on the other, I tried to be non-judgmental.

In the following section, I discuss the ethical considerations I took when conducting this study.

### **3.9 Ethical considerations**

In this section, the issues explored are linked to informed consent, anonymity and confidentiality, potential harm and benefits to be gained from this study. This study has been developed with consideration of the Nursing and Midwifery Council Code of professional conduct (NMV, 2004), as well as the Research Ethics Framework of the Economical and Social Research Council (ESRC, 2006). The principles that govern my ethical reasoning were based on Beauchamp and Childress (2001) principles of biomedical ethics. However, throughout this study I was presented with ethical dilemmas and challenges that I resolved utilising contextual ethics and, thus, I valued more situational approaches (Griffiths, 2008). Nevertheless, my prime



concern was to strive to protect participants from undue harm arising because of their participation in this research. The first issue discussed is informed consent.

### *(1) Informed consent*

Holding in high importance the principles of autonomy and privacy, the issue of gaining informed consent from the participants of this study and all other parties involved was imperative. My aim was not to coerce participants; but let them make a voluntary decision to participate in this study on the basis of accurate information that they could understand and make it clear that they could withdraw anytime they wished from the study (Hammersley and Atkinson, 2007). Not being a lecturer or a mentor, reassured me that students who opted to participate would do so willingly and therefore were not coerced in any way. I opted not to withhold any information about the study including its purpose and my prolonged engagement in the field. This is the reason why I chose not to approach participants in the clinical practice; instead my recruitment methods included email invitations and group discussions, as discussed in the sampling strategies' section, so as not to be intrusive. As far as participant observation is concerned, I chose to conduct overt participant observation and created a document that I signed and invited each participant to sign, in order to keep it in their records reminding them about the aim of this study, and my ethical responsibilities as a researcher. Students who were willing to participate in the interviewing phase of the study were also presented with a similar document (Appendix 7). Throughout this study, I stressed the principles of informed consent repeatedly to students reminding them about my role as a researcher in the field. Additionally, I provided unlimited access to each participant to my field notes and their individual interview transcript, so they could gain further awareness of my data generation methods. In every arisen opportunity, I talked about my research study, my chosen methods and methodology and their significant role allowing them to ask questions and answering them honestly.

As observed in previous studies (Johnson, 2007; Griffiths, 2008), the boundaries between overt and covert observation are somehow blurred. Even though I aimed at operating in an overt manner, it seemed impossible to tell all people involved in this study everything about the research. Although it was practically impossible to control who entered the fieldwork or not (Murphy and Dingwall, 2001), I distributed

information sheets and placed a notice in plain sight on the reception desk of each ward where I did participant observation. The uniform I chose, which was different to the ones worn by any member of staff and students, as well as my badge that stated my researcher status, were two other ways of revealing my identity. Information sheets were also given to all members of staff who were present informing them about the study, as well as my contact information, so they would be able to contact me. During the breaks, members of staff often asked me questions about my study and I answered with honesty. Since many of them were observed indirectly, while I was observing students, I asked them for their verbal informed consent on several occasions, their option not to be observed if they wished to or speak 'off the record'. In effect, there were several occasions, where members of staff reported 'you are not supposed to see this' or told me something 'between me and you'. Similarly, I did not make field notes about discussions that took place during the breaks, which I felt were of personal or sensitive information about the staff.

With regard to patients' verbal consent, I asked each student I observed to inform the patients and their relatives with whom I was coming into contact about my role and research study. I was willing to answer all their questions and give them information sheets about the study, if requested. Hammersley and Atkinson (2007), though, warn researchers that wish to do participant observation that overt participant observation is sometimes impractical, with many difficulties involved. It seems that, while doing participant observation, the degree of my openness and disclosure of information varied considerably across the different people in the field. As seen, my aim was to inform everyone who was involved either directly or indirectly in the study that a research project is in the process. After consulting with the ward manager of each ward, I did not insist on providing too much information, in order not to be intrusive (Hammersley and Atkinson, 2007). Being aware of each patient's ability to give a verbal informed consent, I modified the amount of information given. This way I wanted to ensure that patients were not overwhelmed with information; since a potential information overload could have been of harm to them (Grinyer, 2001). Long and Johnson (2006) also stressed that asking patients' written consent could be more distressing with regard to their hospitalisation than asking it verbally due to information overload; perhaps they have just received bad news about a poor

prognosis, or they may be in the process of receiving important information about their health or care. Griffiths (2008) also argues that there are certain occasions when the nurse researcher could breach the patient's right to informed consent and privacy when a patient's condition renders it inappropriate, professionally and morally, to bother him or her with information about the research and to seek informed consent for data collection provided that the study's findings will lead to future benefits related to a general potential for care improvements. Indeed, she notes that not including data generated from similar instances 'would have silenced patients' voices and lead to an impoverished account of the reality of nursing practice' (p.355). Patients' respect for privacy and dignity was therefore given important consideration. I saw patients as individuals, with a personal social standing, privacy, personal values and beliefs and acknowledged their vulnerable position as patients. Therefore, on any occasion where I felt that a patient felt discomfort I retreated from the field. On certain occasions, patients asked not be observed and I treated their wishes with due respect. Similarly, on certain occasions where I suspected that my presence undermined patients' care, even when consent was granted, I chose to retreat from the field. For instance, there were times when I left a patient's bedside or cubicle because there was limited space and I felt I obstructed the nurses caring for the patient.

## ***(2) Anonymity and Confidentiality***

In order to protect the participants and other parties' identities I used pseudonyms. I did not discuss with anyone about the real identity of participants, patients or other parties that were involved directly or indirectly in the study. Additionally, I made sure that they would not be identified from any information they mentioned; for example, I used a coding system to refer to hospital names, patients and staff. Overall, any sensitive information that could undermine participants' or any other party's dignity and privacy was handled in a way that would not harm them (Robson, 2002; Beauchamp and Childress, 1994). As with any study of this nature, I am able to recognise participants and, therefore, there was no real anonymity. This constituted me morally responsible to keep the participants' identity anonymous, and assure that the data collected would be confidential. It must not be neglected that since many people were aware that the study was taking place and might be able to identify the source of data after publication and, therefore, are likely to recognise

themselves and one another; I abstained from disclosing any information that might harm their dignity or dignity of others involved. However, I was highly reflexive on the confidentiality issue; I felt that if I observed or heard an account that posed a grave danger to people, I would breach that confidentiality. Nevertheless, I made this perfectly clear to all participants and they accepted this premise without hesitation. Thankfully, nothing of that nature occurred.

### ***(3) Potential harm***

My prime concern as a researcher, as already stated, was to strive to protect participants, nurses and patients from undue harm arising as a consequence of their participation or involvement in the present research. However, as other researchers in the past, I realised that the reality of doing research that involves participant observation is messy and the ethical dilemmas that arose could not have been resolved by the application of strict deontological ethical principles; rather a contextual approach was considered more appropriate (Johnson, 2004; Griffiths, 2008).

It must be stated that I considered myself morally responsible of keeping my participants from potential harm. Further, I was aware that that obesity –weight and body image, in general- is a sensitive issue, I was reflexive about the emotions and concerns that may arouse to participants (Robson, 2002). Being aware of that, I made sure I dedicated enough time to release any tension after each interview and informed them about their University's student support services in case they felt the need of professional counselling. Indeed, a student became rather distressed during the formal interview, but she admitted that the interview assisted her to come to terms with her feelings and reflect on them.

This does not mean that this study was not guided by my commitment not to harm participants or patients. I felt responsible to patients and their families to make sure that research I am involved in is of a high standard. When I started this research journey, I was also aware of my dual role of being a nurse and a researcher. This means that, as with everything in nursing, I was determined to put the patient first. Translated into practice, this meant that in the unfortunate case I witnessed malpractice or unfair practice; I would feel accountable of protecting and supporting

the health of individual patients. In other words, in circumstances that patients' care or safety was jeopardised, it would be my duty to report the persons responsible for the event to a senior person with sufficient authority.

However, I realised that the deontological ethical principles were only partially helpful in resolving the dilemmas in the research context. This is depicted in the following example from my research study. As soon as I arrived in the field, both students and nurses admitted of using poor manual handling techniques. My observations confirmed this and, as I opted in being a participant as well as an observer, I was also involved in moving and handling patients. This meant that I observed and participated in inappropriate techniques that are not allowed in practice because they could undermine patients' skin integrity (Ousey, 2009). This means that despite my clear intentions and motives, I observed and participated in causing potential harm to patients. From a deontological point of view, this is unethical. Nevertheless, I felt that by not reporting this acts or even participating in them, was not completely wrong. Indeed, I felt that the students and staff had the best motives to do so; patients' wellbeing. They explained that they tried their best to meet all patients' needs despite being overwhelmed with the amount of workload. In effect, from my participants' point of view and the way they perceived their reality, not utilising manual handling equipment when moving and handling patients was the only solution to the problem of 'lack of time'. For instance, they explained to me that in order to give patients breakfast by nine, they had to finish 'the washes' by then. The way they perceived their reality, not using the equipment was the only solution. Many students actually were unaware of the complications that their actions could cause. On the other hand, the fact that both students and staff were aware that not using the equipment, they were in risk of musculoskeletal disorders shows their moral integrity and commitment to patients' care. Johnson (2007) has highlighted that one's personal and professional integrity and holding key values are central to assessing one's actions. Therefore, I suggest that the degree of wrongness in that example is partially justified. Hammersley and Atkinson (2007; p.221) have also made a similar claim.

'What is appropriate or inappropriate depends upon the context to a large extent, and sometimes actions that are motivated by genuine ethical ideals can

cause severe problems, not just for researchers but for people they are studying as well’.

There is another considerable reason behind my decision not to intervene. By being reflexive on this occurrence, I realised that the benefits of reporting such findings could prevent such occurrences in the future. In other words, my motive was to improve the chances that in the future such wrongs will happen less by studying and reporting these things. Nevertheless, there were cases where I intervened to protect the patients; it was when I felt that the patient was in danger of serious or permanent harm. I set a ‘bottom line’ of harmful or sub-standard care below which I could not go without saying or doing something (Johnson, 2004). I admit that there were certain occasions that I advised student nurses how to go about patients’ care when I felt that patients’ care was considerably compromised. For instance, I suggested to a student to wash an obese patient by using the excuse of needing more data about her care. I was aware that this could have compromised the trustworthiness of my data but if I did not intervene, the patients’ hygiene needs would not have been met that day. This decision was based on a contextual ethics’ approach. A contextual ethics’ approach is based on the understanding of the context that a particular situation takes place and its critical evaluation to determine the balance of something being wrong or not (Johnson, 2004; Griffiths, 2008). It is therefore important to consider a variety of perspectives when taking a moral decision and reflect on the balance of personal and social power between those involved.

Finally, my decision was influenced by the fact that I did not want to change the behaviour of those students and staff observed, because the consequences for the patients would be ‘unscientific’ (Johnson, 2004). I was aware that ‘meddling’ in the nursing care that students offered would interfere with the rigour of this study. Reprimanding students and staff would have also led to losing the rapport that was so invaluable in the present study (Hammersley and Atkinson, 2007).

To conclude, in this study the ethical principle of not causing harm was highly valued, but as nursing research reality proves, it was not an absolute but was balanced against other good justifications. As Johnson (2004) advises, the most important things in the ethical conduct of a research project are the researcher’s

honesty and integrity. By being honest and reflexive on the decisions and steps taken, I hope I have proved this point to the reader.

#### ***(4) Potential benefit***

This research journey began with the ultimate purpose of 'doing good' and bringing about potential benefits to both nursing education and practice. One way of achieving this was to ensure that the findings of the study would be communicated at conferences and in scientific journals. In effect, dissemination of findings has already begun with a presentation at the Royal College of Nursing International Research Conference (2009). Dissemination of findings will also include nursing magazines that are more widely read by the nursing community. As Oliver (2003) stressed 'in order to put research on a firm moral footing, the key issue is that there should be at least the intent to improve the human condition'. Additionally, the Royal College of Nursing (2007) has noted that nurses' involvement in good quality research is part of nurses' duty to care for their patients. In the long term, it is hoped that this study will benefit both current and future students and qualified nurses, as the findings could inform pre- and post- registration curricula and related teaching and learning.

Despite direct benefits being experienced by the participants and the patients were not predicted in the beginning of this research journey, I found out that this study had a larger impact than I expected. Students who participated told me that they enjoyed the experience and some of them developed an interest in nursing research considering getting involved in the future. Students who were formally interviewed told me that the experience helped them to reflect on the context in which they delivered their care, especially in relation to patients' weight. They also reflected on how they could improve patients' care. Finally, they felt that voicing their experiences and talking about concerns that they could not share with their lecturers in the protected environment of the interview room made them feel relieved.

I would like to mention that I was aware that a power ladder existed in the clinical practice areas where I did participant observation. I felt that students and patients were on the lower steps of this ladder. This realisation made me feel protective of participants' rights in practice and, when challenged, I intervened to protect them. I am aware that this could have compromised the rigour of this study, but I wanted my

participants to somehow benefit from my presence. When reflecting on it, I realised that mentors spent more time with students while I was around and students admitted that to me. The ward manager in one of the wards actually approached each and every single student and asked them if they were happy on the ward, if they had any complaints and made sure they knew that she was available if they needed any help. My assumption is that my presence could have provoked such a reaction and, perhaps, manual handling equipment was used more often than it actually was in everyday reality; therefore, both patients and students benefited from that. These were unexpected benefits that were triggered by this research. Being reflexive on my role, I do not feel that my presence was a compromise to the rigour of this study; rather these occurrences served as additional data to the present study.

Another way I aimed at empowering students was my informed decision to utilise ethnography. Ethnography is known as a process of *learning* from people rather than a method of studying them (Spradley 1980, Morse and Field 1996). It is therefore suggested that the participants' role was rather active in the process of generating data. Exploring student nurses' reality from an 'emic' perspective, that is gaining understanding from the perspective of the participants, was a way to shift the balance of power between me, as a researcher, and the participants

### **3.10 Summary**

This chapter has provided an insight into the methods and methodology used in this study. Since the aim of this study was to explore nursing students' culture, I chose to utilise ethnography. The methods chosen reflect my epistemological and ontological position. In effect, I believe that reality can only be interpreted according to the meaning people attach to it. This reality is constantly changing, such as people change throughout their lifespan due to their experiences and, according to these experiences, their attitudes and their behaviour might change.

In this specific study, a purposive sample was selected because the concept of this study was not the generalisation of its findings but the exploration of the richness of the phenomenon of nursing obese patients from student nurses' point of view. Students were informed about this study by email notifications, presentations and information sheets. The data generation techniques were participant observation,



interviewing, the method of 'drawing a picture', the study of documentation, and the writing of field notes. In order to assess the quality of this study, I employed the criteria of trustworthiness and authenticity. During this research journey, I also endeavoured in being reflexive about my role and the effects of my presence. Finally, it must be stated that this study has gained approval from the relevant ethics' committees. The ethical character of this study was sealed by the ethics that govern my practice, as a nurse.

The following chapter provides an overview of the findings and introduces the main theories that aided interpretation of the findings.

## **CHAPTER FOUR: Introduction to findings**

### **4.1 Introduction**

Within this Chapter I present the themes from the data and introduce the reader to the theories used to make sense of the findings. No one theory could fully explain the wealth of data generated and the complexity of issues identified. Some of the theoretical perspectives discussed emerged from the literature review, and their relevance to my study are presented. Theories of impression management (Goffman, 1959), stigma (Goffman, 1963), social judgement (Johnson, 1997) and Foucault's theory on power (1961, 1973, 1977, and 1980) are then explored as they were used to aid understanding of the data. I then orientate the reader to how the findings and discussion chapters (Five, Six and Seven) are presented. Whilst the presentation purposes the themes arising from the data are presented in a linear way, it is important to state that the themes are interconnected.

From the analysis of the data three key themes were generated. In the first theme, named 'student nurse's encounters with obese patients', I introduce the challenges that student nurses faced when they encountered obese patients in clinical practice and discuss the strategies they developed to cope with the demands of their care. In the second theme, named 'constructing the meaning of obesity: the culture and context of care', I discuss how student nurses conceptualised obesity and identify the professional and institutional constraints that influenced student nurses' experience of nursing obese patients. The final theme of 'the consequences of student nurses' involvement with obese patients' care' considers the implications that the presence of student nurses had on patients' power position on the ward and explored the effects that student nurses' participation on obese patients' care had on student nurses.

### **4.2 Student nurses' encounters with obese patients**

The first theme is that of student nurses' encounters with obese patients and focuses on the micro-level of interaction between student nurses and the patients they cared for on the wards where I conducted participant observation. It is shown that student nurses often found the care of patients they considered obese challenging and subsequently developed coping strategies that may have had negative effects on patients' care.

My findings suggest that student nurses had frequent encounters with patients they considered obese, but found quite challenging three particular areas; namely, interaction, their involvement with patients' food and nutrition and physical care. While the care on all wards was organised in a task-oriented manner, it is argued that student nurses often employed different techniques to distance themselves from patients they were less inclined to interact with. Despite the considerable amount of time that students spent tending to obese patients' complicated needs, their interaction was characterised by avoidance of social or emotional contact. Further, student nurses employed a variety of techniques to limit their interaction with patients, such as looking busy. It is also shown that students participated in obese patients' attenuation of concerns, for instance, by making patients wait when they rang for attention.

It is argued that student nurses employed this variety of techniques, which increased their distance from patients because they were afraid that they were not performing convincingly their role in front of patients. My interpretation was aided by Erving Goffman's (1959) concept of 'impression management', which implies that people assume and play a role when they interact with others in order to create a good impression. He suggested that when people are having encounters with individuals acting out formal roles they put on elaborate performances to convey the image ascribed to their status- in this instance, student nurses attempted to assume the nurse's role. While Goffman has been criticised for his cynical views when analysing everyday people's interactions (Freidson, 1983), he has also been recognised as one of the first sociologists who realised that people are aware that a person's sense of herself/himself is closely bound to how others view her/him (Giddens, 2006).

Specifically, Goffman (1959) suggested that a person will make an effort to present herself/himself to others in a way that is considered acceptable. The role that people play in front of others is called 'onstage performance', while the role they assume in an environment they feel comfortable and relaxed is called 'back stage performance'. His observations led him to believe that when participants wished to put on a successful performance in front of the audience, they needed to keep themselves from actually being carried away by their own show. In that instance, a successful method to prevent 'involuntary expressive behaviour' (p.14) such as 'unmeant

gestures' (p.203) was to limit the time performing. Goffman mentioned 'there would appear to be a relation between the amount of modesty employed and the temporal length of a performance. If the audience is to see only a brief performance, then the likelihood of an embarrassing occurrence will be relatively small, and it will be relatively safe for the performer, especially in anonymous circumstances, to maintain a front that is rather false' (p.215). In other words, student nurses avoided deeper interaction with obese patients because they feared they were not able to perform sufficiently well their role as nurses.

In Chapter Five, it is also shown that student nurses' reluctance to be involved with interacting with obese patients was observed with regards to their involvement with patients' food and nutrition. Student nurses perceived that nutrition was a low priority on the wards on which they practised and they did not think that they shared responsibility in terms of informing or educating obese patients about nutrition. While practice constraints played a key role in student nurses' involvement with obese patients' food and nutrition, student nurses further displayed a reluctance to assist obese patients during mealtimes leaving them until last. The contrast to the attention given to obese patients' food and nutrition was highlighted by the increased importance shown to the food and nutrition provided to underweight patients.

Perhaps the most obvious challenge that student nurses faced when they cared for obese patients was during physical care and moving and handling. It is shown that obese patients' physical care was rather demanding and required considerable physical effort and improvisation at times. Students were faced with limited practical and theoretical knowledge and organisational constraints, such as poor patient assessments. Moreover, their experiences of caring for obese patients with mobility issues were marked by unsafe handling techniques, which posed risks to both handlers and patients. For these reasons, obese patients were less likely to be repositioned or escorted to the toilet, while their physical care was also characterised by omissions.

The shortfalls in obese patients' care and student nurses' experience of caring for them were closely linked to how the meaning of obesity was constructed, which is described in the second theme.

### **4.3 Constructing the meaning of obesity: The culture and context of care**

This theme illuminates how the meaning of obesity was constructed and focuses on explaining and discussing the culture and context in which student nurses cared for obese patients. The focus of attention is on culture – as a wider concept- as well as nursing culture and their influential role in shaping meaning. I support this with evidence suggesting that culture influenced student nurses' interpretation of obesity and their encounters with obese patients. It is shown that the meaning of obesity is not static; it varies from one student nurse to another, from one situation to another, and from one interaction to another. The meaning of obesity manifests within the context of care, but it is shown that patients have some power, although limited, to alter this meaning.

A key concept that aids understanding of student nurses' interpretation of obesity is that of stigma, as explained by Erving Goffman (1963). Even though Goffman concentrated on how stigmatised individuals manage their identity, the concept of stigma offers some explanations of why student nurses view obesity as a stigmatising condition. In effect, it assisted me to analyse students' behaviour towards obese patients, identify the stereotypes imposed on them and helped me to understand how student nurses constructed obese patients' identity. Additionally, it aided my understanding of how students justified their behaviour and identified areas for further enquiry, specifically in relation to labelling. I have supported Goffman's theory on stigmatisation with more recent social psychology research from scholars such as Crandall (2000), who looked into the visibility and the controllability of a stigmatising attribute that could influence others' impressions of that person.

In my effort to explore further student nurses' stereotyping of obese patients, I have also reviewed the literature considering the traits' theory to explain why some patients are considered difficult or unpopular on the ward. The traits' theory, which for many decades has monopolised the interest of scholars studying the diagnosis and care of patients in clinical settings, supported the idea that a specific trait, such as having complex needs, can become a detriment to the relationship between a patient and a health care professional. I compare my findings with that of a variety of sociologists and nursing scholars, such as Roth (1972), Stockwell (1972), and Jeffery

(1979) who applied this theory into their research of why some patients are considered unpopular. However, even though I found similarities between the stereotypes assigned to obese patients and that given to other 'unpopular' patients by the aforementioned researchers, the findings from the participant observation phases of this study show that the traits theory does not fully explain the phenomenon. My observations include examples of patients being obese, with complicated needs and 'demanding' whom are liked or at least cared for with high standards of attention. Drawing from Strauss et al.'s study (1985) on work in hospitals and Johnson's (1997) theory of social judgement, I suggest that the process according to which a patient is considered obese is not static, is highly dependent on nurse-patient interaction and has strong similarities to the process of 'social judgement' (Johnson, 1997). Martin Johnson (1997) examined the process of social judgement from an interpretive perspective in his ethnographic study that explored the stages of the process according to which patients negotiated their popularity status with the nursing staff. His findings parallel the findings of this study in that popularity was not necessarily dependent on patients' certain characteristics, including being obese; many factors were involved including the social context of the time, place and people involved.

I then show that the interpretation of obesity is further constrained by professional and organisational factors. Such factors have been recognised as key inhibitors to quality nursing care and nurse education in previous studies, as discovered by Menzies (1960), Melia (1987), Lawler (1991), and Attree et al. (2008). Moreover, I demonstrate how shortages of resources became a key issue for the formulation of student nurses' perceptions on the ward and the quality and quantity of interaction that the student nurses were able to devote to patients.

These studies provided me with great insights into student nurses' process of constructing the meaning of obesity; however they did not fully explain my findings. For instance, Johnson's theory (1997) assisted me to comprehend that social judgement occurs in different stages and patients can participate in the building of their identity. My enquiry, however, was more extensive, since my findings reveal the outcomes of this process in terms of the positive and negative consequences of

student nurses' participation in obese patients' care. The third theme of this study explores this specific key aspect of student's participation in obese patients' care.

#### **4.4 The consequences of student nurses' involvement with obese patients' care**

This last of my findings and discussion chapter, which encompasses the third theme, suggests that both student nurses and obese patients experienced negative and positive effects from their interaction. In order to discuss the consequences of student nurses' involvement with obese patients' care, I have utilised Foucault's theory of power to help interpret the findings.

While I studied the theories of power that are relevant in nursing (Porter, 1997; Wilkinson, 1999; Kuokkanen and Leino-Kilpi, 2000; Bradbury-Jones et al., 2008) I realised that the concept of power is subject to a diversity of interpretations that presents a unique difficulty in its definition because it takes different forms in different contexts. In order to aid the interpretation of my findings, I was drawn to Foucault's (1977) theory of power as reflected in several of his works and, specifically, I was interested in Foucault's notion that power is utilised to control people's bodies in subtle ways that aim at transforming people into docile bodies. Even though Foucault has been criticised for his extreme views (Westwood, 2002), his contribution to how we view nursing is still considered substantial in that he challenged the 'sanitised' and 'safe' view of how we view and evaluate our practice (Johnson, 2008). Foucault sought to uncover the veil from people's eyes and demonstrate the relationship of power and knowledge even in the caring professions depicting how they can be controlling and intrusive, instead of as angelic and considerate as depicted. I detected these subtle ways of exercising power in student nurses' interactions with obese patients but I also witnessed how power can be utilised in a positive, productive way that Foucault (1980) associates with pleasure, knowledge and the production of discourse. For instance, I noticed how some student nurses were able to de-construct nurses' 'truth' about the unpopularity of obese patients and utilised that knowledge to empower them.

It is also important to remark that I view power as an interpersonal construction and this view has influenced the interpretation of the findings. I agree with Foucault

(1980) that power is not situated within institutions and structures but emerges and is derived from interactions between people. I also perceive power as dynamic and non-linear despite that my findings are organised in a way that illustrates how student nurses exerted power over obese patients. Nevertheless, I also include instances where patients either exerted power or showed resistance over student nurses and nurses alike. However, as demonstrated in Chapter Seven, patients' efforts did not overcome the inequalities they experienced in their care despite causing some disruptions in nurses' work.

Disempowerment in healthcare is very difficult to define because there is a perceived unwillingness to accept that sometimes healthcare professionals do not properly fulfil their role (Wilkinson, 1999; Faulkner, 2001). Restraint, dominance and intimidation are striking examples of disempowerment identified previously in studies of staff and patient interaction (Cattermole et al., 1988; Clark and Bowling, 1990; Mountain and Bowie, 1995; Grau et al., 1995; Draper, 1996). In this study, however, I did not observe such extreme facets of power; rather, student nurses' exertion of power was mostly found through the interpersonal process of communication with obese patients and the subtle, yet important, linguistic nuances of interaction.

I utilise Foucault's theory on power (1961, 1973, 1977, and 1980) to bring into focus the different techniques that contributed to the disempowerment of patients who were considered obese. Similarly, the same theory becomes relevant to aid understanding on how student nurses were part of that continuum of power and became disempowered through a plethora of physical and emotional effects on their wellbeing. Nevertheless, it is shown that student nurses often chose to empower some obese patients by providing excellent care- often invisible and sometimes endangering their own popularity on the ward. This finding coincides with Foucault's (1977) view that power can be a positive force that can surpass the professional-lay power struggle and can be utilised to empower individuals that otherwise might have been oppressed.

Michael Foucault has been praised for his critical and historical examination of the relationships between scientific knowledge, medical training and clinical practice (McNay, 1994). However, utilising a Foucauldian, social constructionist lens to aid



interpretation of my findings can be criticised for denying the underlying reality of biological understandings of the body and the experience of disease (Bury, 1986). Moreover, reliance to a Foucauldian framework to analyse the data may have forced me to assume that student nurses questioned the authority of the biomedical framework of obesity. Instead of relying on such a framework, I endeavoured to recognise the many manifestations of obesity and grasped every opportunity to discuss with my participants how they define obesity. Indeed, my findings reveal that student nurses critically scrutinised the medical knowledge surrounding obesity. They further utilised their own interpretation of obesity to justify why obese patients were cared for last during the rounds, for instance. This prompted me to explore the reasons and the implications of their interpretation of obesity by analysing how a certain condition, in this case obesity, can become a source for differentiating patients and participating in practices that further disempowers patients.

My utilisation of Foucault to interpret my findings also provides a refreshing point of view on how much power student nurses are perceived to have. Student nurses are often viewed as being powerless and unable to contribute to decision-making. Indeed, my findings suggest that student nurses often consider themselves as such. Nevertheless, in chapter Seven (Section 7.2.3) it is shown that students can influence the quality of care that patients receive at the 'micro' level of interaction. Foucault's theory, which supports that power is expressed in nuances rather than domination, enabled me to articulate the positive uses of power and provided considerable insights into my generated themes. It is shown that student nurses with individual acts of empowerment were able to demonstrate great examples of nursing care. These small acts of excellent care provided to obese patients played a symbolic part in the student nurses' defiance against their seemingly low position of power, limited decision-making and physical and emotional labour they experienced during their clinical placements.

Lastly, it is important to state that obese patients did not form a homogenous group that was associated with their weight and physical appearance. Equally, they were not all disempowered in the same way and to the same degree. There were also certain individuals and sub-groups on the wards who were also disempowered because of their gender, disability, social class, and age. Obese patients who

belonged to a lower socioeconomic group were more likely to be disempowered; women were more likely to experience a combination of obesity stigma and sexism. However, all obese patients including higher-class, younger men and lower class older women experienced some form of disempowerment because of their weight, irrespective of the disempowerment that resulted from other social divisions. By concentrating on the disadvantages experienced by obese patients I did not aim to minimise or ignore the effect of disadvantages that resulted from other social divisions.

#### **4.5 Summary**

In this chapter, I have briefly introduced the themes of my study and discussed the theoretical ideas that aided interpretations of my findings. Of particular importance are the theories of impression management (Goffman, 1959), stigma (Goffman, 1963), social judgement (Johnson, 1997) and Foucault's theory on power (1961, 1973, 1977, and 1980).

The following three chapters entail the presentation of my findings as organised in three inter-connected themes. In Chapter Five I discuss student nurses' encounters with obese patients looking into the 'micro-elements' of student nurses' involvement with obese patients' care. Chapter Six exposes the 'macro-elements' that affect student nurses' care of obese patients and discusses how student nurses' interpretation of obesity was affected by them. Finally, Chapter Seven provides a critical analysis of student nurses' involvement with obese patients' care by highlighting the importance of power in the interpretation of obesity meaning and subsequent care that student nurses offered to obese patients.

# **CHAPTER FIVE – Student nurses’ encounters with obese patients**

## **5.1 Introduction**

The aim of this chapter is to describe and discuss student nurses’ encounters with obese patients. This chapter discusses the challenges that student nurses encountered when they cared for patients they considered obese. I further present the strategies that student nurses utilised to cope with these challenges. I start by discussing student nurses’ interaction with obese patients, which was characterised by patient avoidance. A key aspect of student nurses’ involvement with obese patients’ care was food and nutrition. Students reported that they have gaps in knowledge which influenced their participation in obese patients’ food provision and nutrition monitoring. Lastly, I describe student nurses’ role and participation in obese patients’ physical care and explore the importance of manual handling.

At this point it is important to mention that this chapter provides examples of care that may be considered sub-standard; I would like to assure the reader that I engaged in continuous reflection about my role in reporting such conduct and protecting patients. I decided to recount such occurrences so that patients, future generations of student nurses and their educators would benefit from such lessons and avoid repetition of any omissions. In other instances, however, I chose to compromise the trustworthiness of my findings because I considered acting my moral responsibility; there were numerous times that I reported patients’ calls for help to staff and student nurses or even intervened more actively by bringing the commode to a patient, for instance. I agree with Johnson (1997) that systematic intervention may alter the research environment. Moreover, I would like to urge the reader not to engage in criticism of student nurses’ practice, since as demonstrated in Chapters Six and Seven their conduct was bounded in a plethora of constraints and was not guided by malevolence. After all, the aim of this thesis is to explore their practice; not judge, criticise or condemn it.

## **4.2 Student nurses’ interaction with obese patients**

Based upon the present findings, student nurses did not offer individualised care to any patient regardless of their weight due to factors discussed elsewhere in the

literature closely linked to the organisation of care on the wards (Melia, 1987; Benner, 1984; Greenwood, 1993; Mackintosh, 2006). However, the organisation of care enabled them to control the type of interaction they achieved with patients and interaction with obese patients took the form of giving instructions and avoided issues of social or emotional context. As a general rule, when interacting with a physically larger patient, the interaction tended to be more task-oriented and, there were more silent periods during the interaction. Moreover, the bigger the patients were, the more these characteristics of silent interaction were emphasised. This is important because it contributed to patient depersonalisation; evidence of patient disconnection is provided throughout this section.

Student nurses utilised task-oriented communication to distance themselves from patients that they were least inclined to interact with; obese patients were more likely to fall into that category. As illustrated in the following field note excerpt, contrary to the amount of time and consecutive tasks that the student was engaged in the patient's care; the student nurse was able to avoid any social or emotional contact.

After we make the bed, Susan prepares the bowl to wash the patient. She takes the patient's plastic basket and fills it with warm water and soap. She looks into the patient's cupboard and takes out a towel, a new dressing gown, and the patient's soap. When the patient comes from the toilet, Susan draws the curtains. The patient sits on the chair; Susan brings the bed table closer to the patient, so the patient would be able to reach the blue plastic bowl. Susan gives a wet white towel to the patient and tells her to wash herself. She washes her face and then she dries herself with another towel. Then, we help the patient to take off her gown; the patient is completely naked. Susan told the patient to stand up for a little to put a 'green' pad on the chair. Susan says 'Shall I wash your back?' The patient replies 'Yes, please'. Susan washes the patient's back and then she takes the towel and says to her 'Let me dry you'. After she finishes she says 'there you are'. Then, she says 'Would you like some powder (talc) on your back?' The patient agrees and she says 'there you are' once she finishes putting on the powder. The patient says 'thank you' and Susan replies with a smile and says 'So, I'll leave you to do the rest'. The patient washes her face and front body. Susan goes outside the curtains; she takes off the gloves and washes her hands. [Observing Susan, 3rd year student, ward A]

This extract is a typical example of student nurse-obese patient interaction, whereby some interesting characteristics need to be discussed. Firstly, the quick succession of

actions performed by the student nurse indicates how accustomed she was in performing this routine on a daily basis. The patient also seems habituated in this routine procedure and, hence, her consent is not sought when the student performs certain tasks, because a positive reply is assumed. This is important because it illustrates the patient's limitations of choice in her personal care. The questions are addressed from the student towards the patient; not the other way around and a positive reply is expected. At some point, the patient appears to be given choice, for instance about having talc on her back, but the choices are artificial. By this I mean that the reason why the student nurse asked questions or informed the patient about her actions served the purpose of limiting the silence during the interaction rather than assist the patient to select a course of action. I also found that student nurses used closed or leading questions and/or direct statements when interacting with patients they considered unpopular – including patients they considered obese - in order to prevent the occurrence of deeper conversation.

Previous research into nurse-patient interaction parallels the present findings; communication between nurses and students is different to the one described in nursing principles whereby nurses ought to engage in a deeper level of communication with patients (May, 1990; Shattell, 2004). May (1990) suggests nurse-patient communication is technocratic and contextual; while nurses dedicate less than two minutes communicating with each patient and the topic of discussion is linked to the practical nursing task. Moreover, Shattell (2004) alleged that the way nurses communicate with patients is another form of power exertion upon them. In other words, nurses would limit the level of communication with patients who they labelled 'bad'.

This type of interaction has also been observed in Hewison's study (1995), which was a small observational study looking into how nurses interact with elderly female patients. Hewison regarded task-oriented communication as a display and exercise of nursing power towards patients; the nurse desired to control the situation and show that they are in charge. Henderson (2003), who used participant observation and interviewing of both patients and nurses found similar practices among nurses; physical care was the centre of nurse-patient interaction, which took the shape of closed questions on behalf of the nurse and avoiding any information regarding the nurse's psychosocial identity. Concurrent with Hewison, Henderson (2003)

concluded that nurses utilised language to limit the depth and quantity of conversation with patients to maintain control over them.

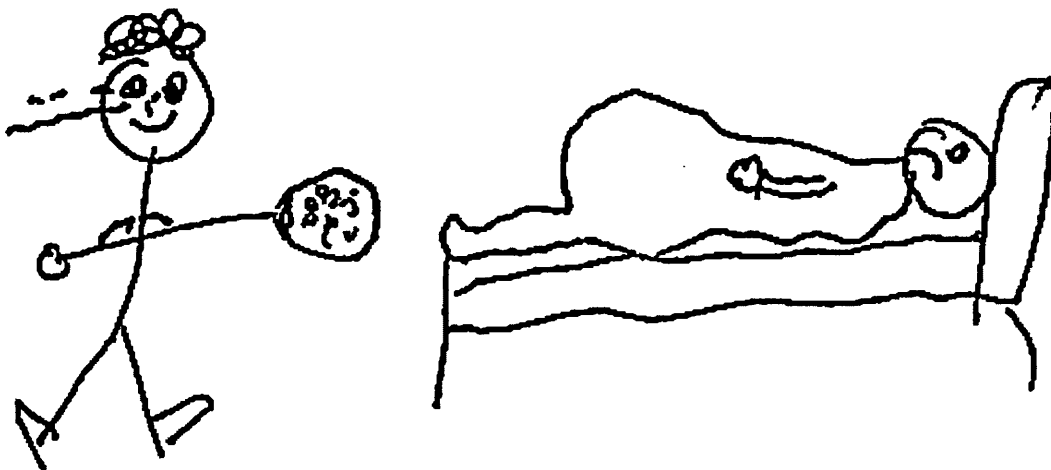
Breaking down the nursing work into smaller tasks, also allowed student nurses to control the amount of time spent with obese patients. For instance, when doing the washes and changing the beds in ward B, students approached patients who were mobile and non-obese. In wards A and C, when students were assigned to wash an obese patient, they would ask a member of staff for help and then, they would adopt a helping role instead of a protagonist role in helping the patient. A helping role meant that the student could avoid task-oriented communication. This also meant that when an obese patient had rather complex needs that required assistance of two or more people, students found it easier to withdraw in the background and avoid interaction. Obese patient avoidance was also noticed when student nurses participated in the 'back rounds'; a routine involving going from room to room 'checking on' patients and asking if they required any assistance. During these times, I observed that student nurses would often omit obese patients, especially if they were in a cubicle.

Another characteristic of the observed obese patient-student nurse interaction was that the bigger the patient was, the shorter the interaction. This became apparent in that my field notes contain a limited amount of data of student nurses interacting with severely obese patients. Further, student nurses interacted more often with non-obese patients, which was also apparent in the amount of field notes I gathered comparatively. On occasions when interaction was unavoidable it was relatively common for the student to remain rather silent during the interaction, as exemplified in the following extract. The length of time was not measured quantitatively because when student nurses engaged with obese patients' care, for instance when performing their personal hygiene, they spent more time with the obese patient for practical reasons. However, such lengthy periods of interaction were marked by silence.

Sally went to take the patient's obs [observation of blood pressure, temperature and pulse]; she's in room 4. She says 'good morning' to the patient and then she is very silent. The silence makes me very nervous; I comment on patient's flowers saying how lovely they are and the patient responds by explaining who brought the flowers. The sphygmomanometer makes a weird noise; it is not working properly. Sally tries again and again to take the patient's

blood pressure unsuccessfully and she is silent all this time. The patient is not talking either, so the only thing you hear is the noise coming from the machine. Sally fanned herself with the patient's chart saying 'it's hot' repeatedly. The patient says 'I'm not hot' but Sally does not answer. She leaves the room and tells me that she will measure the patient's obs later. [Observing Sally, 2nd year student; ward B]

A possible explanation behind student nurses' attempt to limit the time they interacted with obese patients could be because their care was linked with unpleasant feelings. Indeed, previous studies (Bagley et al., 1989; Maroney and Golub, 1992; Garner and Nicol, 1998; Culbertson and Smolen, 1999) exploring nurses' and students' attitudes towards obese patients suggested that they feel uncomfortable when caring for obese adult patients. John, a newly qualified nurse, attempted to convey the link between task-orientation and patient avoidance in his drawing and subsequent explanation of what he drew. He depicted himself serving food to an obese patient, who looks clearly unhappy, while not looking at the patient. Not looking could be a sign of the sentimental work that student nurses performed when they were involved with obese patients' care.



Picture 1. Drawing by John, Newly Qualified Nurse.

That's me smiling. That's the patient and I am not even looking at them because my eyes are looking over there. The patient has a big belly. I am not looking at the patient...looking away and I feel awkward. [Interview with John, Newly qualified]

Indeed, the role of task orientation as a measure of protection against anxiety has been long recognised in the field of nursing (Menzies, 1960; Clark, 1983; Smith,

1992; Philpin, 2002). Menzies (1960) in her anthropological study regarding student nurses' sources of anxiety leading to attrition was first to notice that repetitive actions served as vehicles to the ward managers' aim of reducing anxiety when conducting tasks that were considered 'distasteful, disgusting and frightening' (p.98). Her findings suggest that student nurses avoided coming into contact with the 'totality of any one patient and his illness', so much that they split patients into different categories to achieve depersonalisation and deny their significance as individuals. Philpin (2002) also pointed out that student nurses are given precise instructions from management about how to perform each task, in which order and for how long to ensure that they experience minimum amount of stress in practice.

Students' distancing from obese patients could be also a tool that students utilised to hide any negative emotional effects that obese patients' care evoked. This is further explored in Chapter Seven (Section 7.3.1). Erving Goffman was one of the first sociologists who realised that people are aware that a person's sense of him/herself is closely bound to how others view him/her. Therefore, a person will make an effort to present him/herself to others in a way that is considered acceptable. Goffman (1959) termed this effort 'impression management' and involves the way people assume and play a role when interacting with others that is commendable. His observations led him to believe that when participants wished to put on a successful performance in front of the audience, they needed to keep themselves from actually being carried away by their own show. In that instance, a successful method to prevent 'involuntary expressive behaviour' (p.14) such as 'unmeant gestures' (p.203) was to *limit* the time performing. Goffman mentioned 'there would appear to be a relation between the amount of modesty employed and the temporal length of a performance. If the audience is to see only a brief performance, then the likelihood of an embarrassing occurrence will be relatively small, and it will be relatively safe for the performer, especially in anonymous circumstances, to maintain a front that is rather false' (p.215).

A similar strategy employed by students to control the type and quality of interaction was to look busy. This is important because patients in need may have refrained from asking student nurses' assistance for fear of disturbing them; research has suggested that patients consider this as highly disempowering (Faulkner, 2001). On the other hand, Sally, a second year student practising in ward B told me that sitting down and



chatting with a patient would feel like a contradiction to unwritten rules about student nurses' role on the ward. The constraint of cover rules is discussed in Chapter Six, Section 6.3.2.

Even if you find some time, it kind of feels that you shouldn't because you see other nurses going around and you don't want to be seen sitting with a patient when everybody else is so busy. [Observing Sally, 2nd year student; ward B]

Even though looking busy has been recognised as an almost unavoidable outcome of the group pressure that staff exercise upon students (Melia, 1987), my findings suggest that when a student nurse wished to spend less time with a patient, they would attempt to convey the impression of being busy. In the following extract, Simon, who had previously expressed openly his reluctance to care for Mary (an obese, bedridden patient), was asked to attend to the patient's physical needs. The automatic and fast succession of the student's actions conveyed a sense of urgency, while his silence inhibited the development of a conversation:

A nurse asked Simon 'Can you do me a favour? Mary's been sick; she needs some changing'. We went to her room; she's in a cubicle. She has been sick and she says shyly 'I need changing, too'. She's heavy, weak and we need to change the sheets, too. The patient has diarrhoea, which leaked through her incontinence pad on the sheets and has also vomited. We are not using sliding sheets; Simon indicated to use the patient's sheet to pull her up. He does things automatically, relatively fast and without talking; I roll the patient to my side while he washes her and puts a new pad and clean sheets that I brought earlier. He remains silent, but once in a while explains what we are doing to the patient 'I am going to put some cream on your buttocks, because you are red down there. It might feel a little bit cold'. We washed our hands and left the room. Simon stood still, returned to the room, opened the window and then said to patient 'ring us if you need anything else'. [Observing Simon, 2nd year student; ward A]

Students also enhanced their image of looking busy by signs that symbolised pressure of time, such as completing assigned tasks relatively quick, walking fast through the corridors and writing notes while standing. These signs attempted to convey the message to patients and nurses alike that they were busy as well as hard-working. In effect, the effect of some performances was so successful that some of the patients used to apologise when a student had to spend a lot of time caring for them.

Betty says to Rhiannon that Iris (morbidly obese patient) is 'fragile; she's very tired'. Betty engages the patient in conversation; the patient says how she developed the leg ulcers and mentions that she 'had a stroke'. She apologises 'I'm sorry for putting you in this trouble'. Betty says 'that's all right, dear'... [After completing the task] the patient apologises 'I am so sorry; I get tired easily'. I open the curtains once Rhiannon arranges the patient's sheets. [Observing Betty, 3rd year student and Rhiannon, 1st year student, ward A]

Regardless of whether student nurses intended to control the time they spent with obese patients or if it was a consequence of contextual factors, the result was that student nurses' interaction with obese patients lacked psycho-social elements and emotions. Even when patients attempted to discuss their feelings and thoughts, by utilising task-oriented conversation, student nurses avoided related issues. This is exemplified in the following extract, whereby a patient attempted to discuss his worries regarding his possible discharge from hospital with the student.

Karin went to James (patient) and said 'good morning'. She asked him how did he slept last night and had a small discussion about whether he will go home today. The patient said that he's waiting for the diabetes nurse and then, he'll be able to go home. He is worried that he may not be discharged today. The student did not reply but asked James whether he mind sitting on the chair while we make his bed. She raised the level of bed with a control and brought the Zimmer closer to the patient. She instructed the patient to sit on the chair. 'How is that?' 'Fantastic!' he said. She brought the patient's bowl full of warm soapy water and asked me to find the toiletries in the patient's cabinet. 'We'll leave you to have a wash and come back to make your bed' she said and I drew the curtains. [Observing Karin, 3rd year student; ward C]

The importance of the psychosocial element and emotions in nursing has been cited in numerous nursing studies and are dependent on the definition of caring (Smith, 1992; Wolf et al., 1994; Bone, 2002). Griffin (1983), for instance, defines caring in nursing as essentially an interpersonal process, in which the nurse is required to carry out specific role-related activities in a way that conveys to the recipient the expressions of emotions, such as compassion. Wolf et al. (1994), who conducted a quantitative study studying both nurses and patients discovered that both groups included similar elements in their definition of caring – respect, assurance, feeling connected and empathy.

On the other hand, it has been argued that nurses are not required to provide emotional support to patients and additionally, that the provision of emotional support is impractical and impossible due to time constraints inherent in practice (Dingwall and Allen, 2001). Dingwall and Allen argued that the UK economically-restrained health care system cannot justify this type of interventions because it has disputable cost-effectiveness and efficiency. They suggested that nurses ought to be humane and civil, but any psycho-social interventions are bounded by the same economic limits of technical interventions.

One of the limitations of this study is that I did not interview obese patients to explore their perceptions regarding their interaction with student nurses. Even so, a literature review by Shattell (2004) reveals that patients believed that forming a relationship with the nurse was considered more important than other aspects of care. Patients wanted nurses to be genuine, not in a hurry, available and willing to talk to them and highly valued individualised care. An interesting study (Attree, 2001) that utilised a grounded-theory approach to look into patients' experiences and perspectives of quality of care found that patients valued communication with nurses more than technical aspects of care. Attree asked 34 acute medical patients and 7 relatives to reflect on their experience of quality of care they received on the ward before their discharge from the hospital. She revealed that patients highly valued personalised care, being informed and developing a social relationship with the nurse. Further, she discovered that patients appreciated when nurses foresaw their needs, which meant that they did not have to ring for attention. Finally, nurses who displayed empathy, compassion and sensitivity were highly regarded and appreciated. On the other hand, patients mentioned examples of health care professionals, especially nurses, who were concentrated on the task and not the patient, were distant, unsocial, were difficult to approach and limited their availability to patients (Attree, 2001). These instances were linked to experiences of 'not so good' quality of care, which suggests the importance that communication has for patients in relation to the care they receive.

Another review by Puhl and Heuer (2009) looked into obese patients' views of biased treatment in health care and concluded that obese patients have low satisfaction regarding the care they have received from health professionals and even showed particular awareness of health care professionals' discriminatory practices.

Brown et al. (2006) explored obese patients' experiences of health care; despite that his participants discussed experiences that occurred only in primary health care, their descriptions of 'heavy-handed communication, to very limited levels of psychological support' (p.670) indicate how highly obese patients value interpersonal relationships with health care professions and their disappointment regarding the response they received in their care. Interestingly, the researchers also found that rushed or ambiguous communication aggravated patients' stigma cognition. The patients interpreted the negative response they received from health care professionals as a reaction to their obesity and made them question whether they deserved better.

In this section I have argued that student nurses found challenging their interaction with obese patients and resorted in their limited involvement in emotional and psycho-social care of obese patients. In the following section, I discuss student nurses' utilisation of humour in their interaction with obese patients.

#### **4.2.1 The derogatory use of humour**

In this part of the chapter I discuss the use of humour that student nurses employed while interacting with obese patients during physical care. Although this may have been employed as a light-hearted way to interact with patients and as a coping strategy, based upon the findings, on many occasions the humour used in interaction with obese patients had a derogatory character, which not only conveyed stigmatising attitudes towards obese patients, but also contributed to patients' disempowerment.

I argue that the inappropriateness of humour towards obese patients was based on two conditions; first, it targeted obese patients' sexuality, physical appearance and weight and, second, it was conducted during the intimate procedure of physical care. The context that such humour was delivered in addition to the relatively powerless position of patients raised questions about the appropriateness of such comments, as evident in the following extracts:

Karin is giving a wash to Dorothy. She says 'nothing is better than a good wash in the morning'. When she finished, Dorothy said 'thank you' and Karin replied 'that's alright, sweetheart. You'll have all the boys after you today' and the patient smirked. [Observing Karin 3rd year student, ward C]

The patient's chest is uncovered. She has stretch marks on her belly. Susan comments 'You are half the woman you were before'. Beth, the qualified nurse, comments 'And your boobies are gone'....They cover her chest with the white sheet. Beth says in a humorous way 'Some doctor will come and will see a lot' and helps her adjust the sheet...After that, they put the patient in Trendelenburg position and they advise her 'lift yourself over' to go upper on the bed. Susan puts cream on the patient's belly and powder on the patients' chest, deodorant spray on patients' armpits. Susan said 'You smell sexy', and the nurse comments 'you smell sexy for the doctor'.

[Observing Susan, 3rd year patient, ward A]

In the above examples, it is clear that the patients did not look 'sexy' at the present situation; suggesting that the students wished to criticise the patients' physical appearance rather than praise it. In effect, on most occasions, students used humour to express exactly the opposite of what they meant.

It can be suggested that such humour indirectly denoted the inferiority of the obese patient. Indeed, I argue that its use constituted a violation of student nurses' position of power in their interaction with patients; a suggestion equivalent to Lukes' theory of humiliation. Derogatory humour, according to Lukes (1977), results in the symbolic devaluation of its recipient. Lukes proposed that derogatory humour results in the person's humiliation and it is another way of maltreating people. The moral importance of humiliation is that it is a form of mental cruelty that can inflict mental pain and cause symbolic injury.

Whether the person subjected to derogatory humour experiences it as such is one thing; the other is related to what the student nurse's action conveys about nursing itself. After all, Lukes (1997) has proposed that sometimes powerful individuals are able to convince the less powerful to accept things that may be harmful to them.

The following example involves a first year student named Stacy and Paul, a fifty-two year old morbidly obese, bed-ridden patient. While washing Paul's behind, he released a malodorous 'gas'. This type of humour seemed to serve as a coping strategy for Stacy, who was performing his personal hygiene.

Stacy said 'thank you, Paul' ironically. Paul smiled but Stacy couldn't see that because he was turned towards my side. He said

'you're welcome'. While we move him, as usual, he remains silent with his eyes shut.

[Observing Stacy, 1st year student, Ward C]

The first element of humour that needs to be discussed is that of sexuality. Lawler (1991, p.90) suggests that sexuality 'lies on the margins of what is considered dangerous and potentially polluting', which suggests the taboo issues are assigned by wider societal views. Previous research suggests that during intimate situations in nursing, like providing physical care, nurses utilise humour (Bauer and Geront, 1999; Guthrie, 1999; Philpin, 2004). Bauer and Geront (1999) interviewed nurses that worked in a nursing home for elderly people and found that humour was not only utilised as a coping strategy but also as a means of controlling residents. They found that nurses used humour to express disapproval about patients and to achieve conformity; indeed, humour was used as a sanctioning tool towards the behaviour of elderly residents who actively expressed their sexuality.

Guthrie (1999) attempted to conceptualise the phenomenon of sexuality from the perspective of nurses working in acute surgical wards and found that nurses felt embarrassed by the sexual element of intimate physical care and more actively avoided discussion regarding this subject with patients. On the other hand, the nurses utilised humour as a coping strategy towards embarrassing situations, consistent with the actions of participants in the present study. Guthrie's participants suggested that humour was 'shared' with patients meaning that patients were equally participating in the interaction (Guthrie, 1999). However, since the study did not include observational data, examples of such humour in interaction were not given. Further, since patients were not included in Guthrie's sample, there is no guarantee that patients consented to sexuality-related humour or received it positively.

By referring jokingly to the physical and sexual attraction of the patients, my participants expressed an implicit disbelief of such an occurrence happening, which suggests that the students' cultural beliefs of beauty are congruent to the thin ideal. Previous studies regarding health professionals' conceptualisation of obesity show that they equate obesity with unattractiveness and described thinness as the ideal for themselves and their partners, while obesity was regarded as socially unacceptable (Harvey and Hill, 2001; Davidson and Knafl, 2006). In a different study, obese women reported that their gynaecologists refused to believe that they were sexually

active (Packer, 1990), which also suggests that sexuality in obese persons is treated as a taboo subject.

It must be stated that I did not observe any patient complaining about the context of such type of humour and I did not have ethical permission to discuss this topic with patients, which means that the data allows no more than speculation about their thoughts. Before proceeding, however, it would be worth exploring the concept of subjectification as discussed by Foucault (1980) because it may shed light on how student nurses' derogatory humour could influence obese patients' perception of themselves. Subjectification, according to Foucault (1980) refers to the concept that individual thoughts and actions are shaped by and reflect social power relations. In other words, obese persons as an oppressed group assimilate the characteristics, practices and values of the groups that dominate them, including the perceived normality and inherent superiority of the dominant group. When student nurses utilised derogatory humour about patients' weight and physical appearance, obese patients were likely to ingrain and internalise such subliminal messages, which added to their disempowerment. Indeed, previous research looking into the internalisation of constant exposure of culturally accepted beliefs such as anti-fat bias has shown that obese people share the same strong implicit stereotypes with non-obese, preferring thin people to fat people and associating attributes such as 'lazy' with obese people (Schwartz et al., 2006).

Derogatory remarks and humour about weight or physical appearance is a facet of discrimination that is proven to cause considerable distress and can affect obese individuals' health and wellbeing (Jackson et al., 2000). Whether in a children's playground, street, office, home or health care setting, there is proof that this type of discrimination is a common occurrence in the obese person's life (Puhl and Brownell, 2006). Indeed, in a sample of 2449 adult obese women, the most common stigmatising situations reported were related to humour linked to their weight and physical appearance in the form of nasty comments from children, and inappropriate comments from doctors and family members (Puhl and Brownell, 2006). Indeed, a review and analysis of nurses' utilisation of humour by McCredie and Wiggins (2008) characterised humour as unethical when it is inappropriately targeting the patient's sex, gender, ethnicity or disease-related symptoms.

Interestingly, when I asked students, the majority were critical of nurses expressing derogatory humorous remarks about patients' weight, or physical appearance. This is depicted in the following extract from the following interviewee, who expressed that humour targeting a patient's obesity was not acceptable. She also hinted that obese patients may be aware of the derogatory content of such comments.

Kath: I just think...a lot of people who are obese they know about it...I wouldn't like it if I were obese and people were talking about me like that. But yeah, I think sometimes people have a laugh and a joke and they take it a bit too far and they just laugh at other people's expense. I don't like it because it could be you, innit? Who knows? It's not nice. [Interview with Kath, Newly qualified nurse]

Nevertheless, some students had less negative views about the acceptability of 'joking' about obesity; John, a newly qualified nurse commented that such remarks are 'probably NOT appropriate in any circumstances in an ideal world but I don't think we live in an ideal world' thereby dismissing the idea that nurses ought to be politically correct.

Student nurses' interaction with obese patients was also characterised by attenuation of obese patients' concerns, which is discussed in the following section.

#### **4.2.2 Attenuation of obese patients' concerns**

Student nurses often underestimated or lessened the gravity of obese patients' demands and, as a consequence, put these concerns into low prioritisation. This was expressed in two ways; first, when an obese patient rang for attention, student nurses delayed answering their calls and, second, when a patient voiced their concerns students did not perceive them as important. Apart from psycho-social implications, I noticed that patients, who experienced attenuation of their concerns, were often soiled because of this delay.

In the following example, an obese patient complained that he felt 'dreadful'. The third year student disregarded the patient's reply and concentrated on the task at hand, which was taking the patient's observations. Her characterisation of the patient's state was 'perfection'; exactly opposite to what the patient experienced. Another interesting point of the conversation was that the patient stated that he has



been 'a good boy' implying his compliance to a restricted diet because of his diagnosis of type II diabetes.

Thomas has central obesity. I notice that he has a big tray with chocolate on his table. He is solving crosswords. Karin says to Thomas 'how are you this morning?' The patient trembles as he tries to reach his water and says 'dreadful'. His arm is bruised perhaps from giving blood for tests. Karin notices 'you've got some good bruises' and the patient nods his head. After taking his obs, Karin notes her observations on the patient's chart and says to the patient 'perfection, perfection, perfection' and the patient answered 'so why keep me up?' and then he adds 'because I'm like a guinea pig'. Karin explains that the doctors don't feel he's ready to leave yet' and he replied 'I've been a good boy for the last couple of days'. [Observing Karin, 3rd year student, ward C]

The patient's diagnosis, his signs and symptoms were important elements that provided information to student nurses regarding what to do with patients. Karin's assessment of the obese patient was based on his vital signs, which appeared to be more critical to her understanding than the patient's statement of feeling 'dreadful'. This implies that the patient's perception of wellbeing was disregarded and given lesser importance than the biomedical signs. The patient's reply implied that he felt a struggle of power; he feels like a 'guinea pig', hence not a person with a real identity and a right to make choices regarding his stay in the hospital. Karin, on the other hand, implied her limited input in decision-making by bringing the authority of the 'doctor' to the discussion. On the other hand, the patient still recognised that the student had *some* power over his progress connected to information control; he hoped that that the student would transmit the information of him being 'a good boy'. This example comes to show that student nurses' attenuation of obese patients' concerns could have played a role in the patient's disempowerment, which is analytically discussed in Chapter Seven (Section 7.2); by disregarding their concerns, the student nurse silenced the patient's voice, thus, minimised the control that patients had over their own care.

Another way that student nurses' attenuation of obese patients' concerns was made visible was when they made patients wait. This was particularly noticeable when patients engaged in 'buzzing', which meant ringing the bell for attention. There was an unwritten rule that patients ringing the bell ought to experience a significant

amount of discomfort, such as being in pain, or needing the commode. This rule was generally respected by patients; patients who disregarded this rule were usually classified as demanding, difficult or unpopular; a terminology used to refer to the same category of patients. In any case, unpopular patients –obese and non-obese - were usually made to wait even when the students and nurses were not busy with anything else. When I asked students why they did not address patients' calls, they gave various replies. Some answered that the particular patient is asking for things 'all the time' and it is usually 'not something important'. Others implied that the patient was not truthful about the emergency of his/her needs because he/she was often confused.

I can hear a patient screaming 'help' repeatedly. Susan and the nurse are 'apologising' that Tom has mental problems; he is confused. After a while, a nurse goes to see what happened to the patient. I can hear her talking to him before she entered the room 'What is the matter, Tom? Are you all right?' I can sense from the tone in her voice that she is not worried about what happened to Tom. She *knows* that it is not important. Another nurse wonders 'did he fall?'

[Observing Susan, 3rd year student; ward A]

Tom was a sixty-eight year old obese, unpopular patient in ward A, who was not bedridden but his feet were considerably swollen and was characterised as being 'unsteady on his feet'. Therefore, he required assistance to go to the toilet, since he was given a 'water tablet' every day. Quite often the students or nurses brought him the commode or the bedpan. He was frequently confused yelling 'help' or asking for his sister. Sometimes nurses made jokes about his confusion and rarely answered his worries, but most of the times they ignored him. Simon explained to me that he was placed in a single room 'not to disturb' the other patients. He frequently used the 'buzzer' but nurses rarely responded or responded rather late. Students did the same, apart from Simon, a second year student, who was quite attentive to him. One day, a patient's buzzer broke down, so Susan, a third year student, replaced that patient's buzzer with Tom's buzzer, When I enquired, Susan told me that Tom is loud enough and they could hear him. Later on the same day, Tom wet himself and complained that he was pressing the buzzer but no one came. Susan asked why he didn't call anyone and he replied that they told him not to shout so as not to disturb the other patients.

In the following extract, another obese patient who rang for attention was disregarded and she soiled herself. Furthermore, in fear of being neglected in the future, she accepted wearing an incontinence pad despite not being incontinent:

Susan goes from room to room and asks patients whether they need a bed pan. She says to me 'a lot of patients just want the commode. They just sit on the commode even when they don't want to go to the toilet'. Iris asked for the commode. She went inside the curtains and adjusted the commode close to the patient. The patient told me 'I'm bursting; I've been waiting for a commode all morning'. She adds 'If I could walk, I would go by myself'. Susan guides Iris to hold herself from the side rail of the bed and turn around slowly, and then hold herself from the commode. Once the patient placed both of her hands on the commode; she urinated wetting her gown and legs. Susan guided her to sit on the commode and told her that she will be back in a while. Once we went outside of the curtains, I whispered to Susan that Iris has wet herself'; she told me that she didn't notice. Susan went to the storage room to bring a new pair of 'knickers' pad. She asked the patient whether she would like to wear it and the patient replied 'I don't mind'. She then said 'let's get you on the chair'. She guided the patient to sit on the chair, where there was a green pad and told me to leave it on the patient's table. [Observing Susan, ward A]

Apart from the discomfort, there are further examples which indicate that patients' complaints of pain were also disregarded. In one instance, a patient was left waiting for two hours before her urine catheter was changed. My fieldnotes reveal that the patient displayed symptoms of a urine infection and had repeatedly pointed out that she was in considerable pain by 'buzzing', because she was unable to walk. The second time she rung her bell, she was crying and pleading to have the catheter removed. Even then, instead of prioritising the patient's change of catheter, the procedure of removing and replacing the patient's catheter was given to an inexperienced 1<sup>st</sup> year student as a learning opportunity under the supervision of a 3<sup>rd</sup> year student. Even though the student performed the procedure well, it took much longer that it would have if an experienced nurse had performed it.

16:45

Hillary buzzed (for some time) and Rhiannon said 'I'll go'. I follow Rhiannon. She goes to Hillary's door and she asks 'what's the matter Hillary?' Hillary says that she feels pain 'down there'. She goes to the sisters' office and reports it. The nurse says that perhaps her urine catheter needs changing because 'it has been there for I don't know how long'. Hillary buzzes again and Rhiannon goes. She says to Rhiannon 'please, do something'.

Rhiannon says that they are going to change the catheter 'but be patient for a while, ok?' Hillary says 'Ok, but hurry up'.

18:15

Hillary buzzed and Rhiannon goes to her room 'hello, Hillary. Is everything all right?' Hillary is crying and saying 'please take the catheter off' and 'I can't go on. Take it out!' Rhiannon says 'I'll see what I can do for you, Hild. Let me call the nurse'. She speaks to Betty (another student) about it and Betty goes to sisters' office and reports that. The nurse says that they can take it out. Hillary buzzed again and Rhiannon went and told her that they are going to remove the catheter. She is still crying and saying 'I can't go on like this. I want to go home. I want to go home. Please, let me go'.

We go to the patient's room and Betty says 'hello' to Hillary. She explains that they'll take the catheter off and that they'll put a new one. She asks her whether she minds if Rhiannon does it. Hillary says that she doesn't have a problem 'as long as you take it out'. It's 18:35. [Observing Rhiannon, 1<sup>st</sup> year student and Betty, 3<sup>rd</sup> year student; ward A]

The importance of weight was also demonstrated by the favouritism they usually displayed towards underweight patients. Obese patients who voiced their concerns were assigned the negative label of being 'demanding'. On the other hand, when an underweight patient rung for attention, their calls were answered much faster and their concerns were viewed as 'genuine'. This was illustrated in the language used; a striking example is the different terminology used to refer to the same behaviour. Underweight, older patients who asked for many things were viewed as 'pleasantly confused', while obese patients who rung for attention were viewed as 'complaining'. I asked Simon, a 2<sup>nd</sup> year student, to explain what 'pleasantly confused' meant by applying the term to patients on the ward. Rosalie was an underweight patient, who constantly asked for attention and yet was considered popular on the ward, while Tom, an overweight patient, was accused of 'constantly buzzing'.

I find the opportunity to ask Simon what it means to be 'pleasantly confused'. I saw that he had written it on one of patients' folders, while I was having a look at them. He says that it means that 'they are confused but they are not aggressive. They are calm.' I ask 'like Rosalie or Tom?' and Simon says 'probably like Rosalie. But Tom, no: he shouts at night 'help me' or 'what's happening?'

[Observing Simon, 2nd year student; ward A]

Overall, student nurses' attenuation of obese patients' concerns were based on their interpretation of the importance and truthfulness of their demands. Student nurses

made decisions about answering patients' calls based on certain characteristics. Obesity influenced negatively such an interpretation and affected obese patients' social judgement and the care they received. The phenomenon of social judgement (Johnson, 1997) and obese patients' labelling is further discussed in Chapter Six (Section 6.2.1.2).

In the following section, I discuss student nurses' involvement with obese patients' nutrition and subsequent implications.

### **4.3 Student nurses' involvement with patients' food and nutrition**

Student nurses' care towards obese patients in relation to food and nutrition was influenced negatively by constraints in the clinical practice area as well as several misconceptions regarding obesity and nutrition. As a consequence, the obese patients' needs were regularly neglected despite the plethora of opportunities given to student nurses to be involved. On some occasions, obese patients were put in danger of malnourishment.

Student nurses often participated in obese patients' nutritional monitoring and surveillance; monitoring took the form of recording of information regarding patients' weight, Body Mass Index, vital signs, diet and nutritional status. Further, student nurses observed patients' eating habits, preferences and food displayed on patients' cabinets and bedside tables.

Overall, patients' nutrition and food consumption, regardless of weight, had a low priority on the wards on which student nurses practised. As George, a newly qualified nurse, stated, nutrition have 'gone out of the agenda' for nurses. The majority of students claimed that they did not get involved with obese patients' nutrition monitoring because of time constraints irrespective of patients' weight:

Alex: About nutrition, how important do you think nutrition is in the care of obese patients?

George: As important as it is in the care of underweight patients.

Alex: Have you seen nurses getting involved in it?

George: It is very difficult. I know there is another area that is... because of the demands that nutrition is sort of gone out of the agenda for nurses... because they don't have the time to get involved in nutrition. [Interview with George, Newly Qualified]

Another illustration of nurses' perceived lack of responsibility regarding patients' nutrition was the completion of documents related to patients' nutritional status. The completion of the nutritional assessment risk tool (Appendix 8) for instance, was conducted during the weekends by health care assistants. This type of documentation was given low priority; mistakes were often unnoticed, documents were not filled in properly or completely and when the ward was busy, the documents were not completed at all. Student nurses were also assigned the completion of these documents and seemed to pay little attention to them. Perhaps the assignment of this task to health care assistants and student nurses encouraged student nurses to disregard the importance of monitoring an obese person's nutritional status.

These findings concur with Savage and Scott's (2005) ethnographic study exploring nurses' role and patients' experiences in relation to patients' nutritional care in hospital. They discovered that excessive workload and staffing levels contributed to nurses' low involvement with patients' nutrition that was further linked to nurses' low morale. As with the current study, the demands of excessive levels of documentation on nurses created an aversion towards any type of documentation. Indeed, nurses followed a set of unwritten rules about which documents were important and turned their attention away from the ones seen as complimentary or superfluous. Unless the patient suffered from a combination of severe malnutrition, weight loss *and* being underweight, the nutrition assessment tool was not considered important. Yet, even in that instance, it was utilised as another form to be completed for the patient's referral to a dietician rather than an opportunity to be involved in the patients' care:

Sam (Karin's mentor) and two health assistants do the risk assessment on the patients; while Karin does the obs. Sam asks the patients to report how tall they are. John Morris (morbidly obese) says he's probably 5.8 but because he's getting older he feels like he's 'shrunk a bit' so he must be actually less. He says that he has lost two stones in the last three months that he's been diagnosed with cancer. I ask Sam whether the auxiliaries have been taught how to complete the nutritional assessment charts and she told me 'they're not getting any official education. We teach them'. She notices that John has been classified as 'underweight' and she corrects that. [Observing Karin, 3rd year student; ward C]

Interestingly, the nurse mentioned above did not record the patient's weight loss in the document nor compare his current weight to previous statistics. Overall, on all

three wards it was obvious that obese patients' nutritional assessment was pushed to the back of the paperwork queue. Body Mass Index tended to be calculated based on *patients'* report about their height and were rarely weighed to calculate any significant weight loss. In fact, the mistakes in calculation resulted in patients who were obese being characterised as 'underweight'. The importance of BMI to student nurses' practice is further explored in Chapter Six (Section 6.2.2.2). I suggest, however, that the biggest weakness of these charts was their inability to efficiently measure obese patients' nutritional status as the design of the form seemed to cater for underweight patients' needs. Irrespective of that, obese patients were always given a high score in relation to their appetite even when I observed that their appetite was poor. The combination of these factors resulted in obese patients scoring low on the chart, resulting in them being less likely to be referred to a dietician.

This is important because previous research suggests that many patients in hospitals may be malnourished due to eating difficulties and poor monitoring (Westergren et al., 2010). Malnourishment has been associated with increased risk for complication development, mortality and longer hospital stays. On the other hand, a dehydrated patient may experience impaired cognitive function; such as headaches, hypotension and may lead to hypovolaemic shock and organ failure (Shepherd, 2011). Regarding student nurses' role, the importance of nutrition has been stated in their curriculum as well as within the framework that the curriculum is based on (NMC, 2004), while fears have been expressed regarding student nurses' and nurses' insufficient attention to the issue (Green and Jackson, 2002).

An example that portrays the low prioritisation of obese patients' food and nutrition is demonstrated by student nurses' reluctance to get involved with feeding obese patients. Since feeding patients was considered one of their responsibilities, it was unavoidable. Nevertheless, their reluctance was apparent in that obese patients who were in need of assistance during mealtimes were left until last. This meant that their food often became cold and soggy.

The auxiliaries and students are rushing and choosing patients to ask them what they want for breakfast. However, no one goes to Margaret Morrison (her bed is in a cubicle). Stacy said 'I'll go'. This patient is considered rather 'demanding' by the staff. Margaret told her to push her up the bed. I help Stacy to do so. Again, no slide sheets were used. Margaret is rather heavy and she's not

helpful when moved. She doesn't bend her legs nor does any effort whatsoever. Stacy served her porridge and milk because she's on a soft diet. Margaret asks her to feed her but Stacy insists that she can do it by herself. Margaret also asked her for some water and a straw. After that, she asked her to arrange the pillows. Stacy said 'you must be fine now' and left. [Observing Stacy, 1st year student; ward C]

In the above extract, the students' and staff's reluctance to feed Margaret is obvious since she was the last patient to be served her breakfast. Stacy's involvement with feeding the patient was bound to the unwritten rules of her low hierarchical place on the ward, which meant that sometimes she had to care for patients that others did not wish to; she resigned by saying 'I'll go'. This patient had been labelled as 'demanding' not only because of her weight but also because of 'asking for things'. However, as discussed previously, the notion of being demanding was socially constructed. The strength of such labels is typified in the in situ record of Margaret Morrison's care; in which I specifically comment 'she doesn't bend her legs nor does any effort whatsoever' expressing a hidden frustration and *my own* judgement towards the patient. On reflection, the patient was weak because of a multitude of health problems, including breathing difficulties, and perhaps in need of company since she was isolated in a cubicle. The most important point is that Stacy did not actually assist the patient in eating, or dedicated enough time in assuring that the patient was well-fed. Since patients' plates were not gathered by students or staff, I cannot affirm whether or not the patient ate her breakfast.

Regardless of obese patients' popularity on the ward, I observed that obese patients were never motivated to eat if they declined a meal. A typical example is that of Daisy, an obese patient with chronic heart failure and respiratory failure from ward C. She was usually drowsy and fell asleep during her meals; nevertheless, she never received assistance during mealtimes. I observed several instances whereby a student went to perform a task, reprimanded Daisy for falling asleep, then pushed aside the patient's table and removed her plate in order to perform the required task. I did not observe any student enquiring of Daisy about her appetite nor her ability to feed herself. Carol, a first year student, confirmed my observations regarding the encouragement and help that obese patients received during feeding:

Alex: About overweight patients... did you notice anything interesting in their care?



Carol: Those were not REALLY encouraged to eat as much as the underweight patients. If they didn't want to eat, they'd be like 'oh, well'. [Interview with Carol, 1<sup>st</sup> year student]

Obese patients' low prioritisation in terms of nutrition and food was notable contrary to the prioritisation given to underweight patients' nutrition and food. Underweight patients' diet was given considerable attention by both nurses and student nurses. Student nurses often encouraged underweight patients to eat and drink their nutritional supplements. I also saw that underweight patients were assisted first with their meals. The following extract illustrates the attention dedicated to underweight patients' diet in that underweight patients were carefully monitored regarding the quality and quantity of food and were able to choose who would feed them. Interestingly, while obese patients' diet was given the least attention, nutrition and food became of utmost importance for underweight patients:

Alex: Can you tell me how you were involved in the care of an underweight patient? What were the things that you were looking for, mostly?

Lucy: Well, the first thing that I can think of is that we had to monitor their diet and make sure that they were eating at meal times those who weren't eating... especially students were assigned to...you know...like 'sit with her, feed her if she would let you or encourage her to eat', which was a bit difficult because some of the stroke patients didn't communicate very well or they just choose not to eat or depending who was there, they would eat... so by the time you get to know them it's like 'oh, she prefers, me', you know? [Interview with Lucy, 1<sup>st</sup> year student]

An explanation behind student nurses' limited involvement in obese patients' nutrition and food could be sought in their limited knowledge regarding obesity. There are limited studies that explore nurses' and student nurses' knowledge regarding obesity; four of them are quantitative (Hoppe and Ogden, 1997; Hankey et al., 2003; Green et al., 2000; Swift et al., 2007) and two are qualitative (Petrich, 2000; Sardani, 2006). These studies however suggest that student nurses may experience lack of instruction, in the university and practice that may increase their ambivalence in participating in the care of obese patients. In one particular study (Green et al., 2000), student nurses in the UK indicated that they received some education about obese patients' nutrition only as part of a course, such as how to manage a patient's diabetes. This limited instruction may explain the inherent lack of equal nutritional care for obese patients in their practice. Student nurses' concerns

over unmet educational needs were one of the themes in my previous study regarding student nurses' attitudes towards obese patients (Sardani, 2006). The present study parallels findings from previous studies in that student nurses felt that they did not receive enough education regarding nutrition of obese patients. This is echoed in the following interview extracts from George and Kath, who had just completed their nursing education and, hence, were able to evaluate their course overall. Notably, Kath's reply indicates that she has not been taught about the link between malnutrition or malnourishment and obesity.

George: I don't know if there is enough in the nursing course about nutrition. I don't know how much people know about nutrition... how much nurses know in general about nutrition. I don't know when the majority of nurses who are qualified know enough about nutrition. We had some lessons, I mean, but it wasn't a big part of the course as far as I remember. [Interview with George, Newly Qualified]

Alex: Did you have any lectures in general about obesity?

Kath: No.

Alex: How about nutrition?

Kath: Yes, we do have about nutrition.

Alex: Was it linked to obesity?

Kath: No, a lot of the lectures we had in Uni were about malnourishment. [Interview with Kath, Newly Qualified]

While student nurses did not consider obese patients' nutrition as one of their priorities, obese patients' physical care was highlighted by every participant, as discussed in the following section.

#### **4.4 'You'd need an extra pair of hands': Physical care and the importance of moving and handling**

Existing dangerous patient handling practices combined with students' limited knowledge and experience meant that obese patients were often put at risk of developing pressure sores or even injury. Nevertheless, student nurses claimed that their moving and handling practices were guided by an altruistic motive of caring for the patient – even if the same practice may have had adverse effects on their own musculo-skeletal health.

The first issue that needs to be discussed is patient assessment. Student nurses, following the practices of staff on the wards, did not follow a strict protocol as far as patient assessment regarding moving and handling (M&H) was concerned. Indeed,

during the time that this study was conducted, there was no official bariatric policy in the Trust, which increased the difficulty in planning, assessing and managing the manual handling risks when caring for obese patients with mobility issues. Issues such as the number of staff, appropriate equipment and M&H strategies for morbidly obese patients were discussed with the M&H advisor. However, in wards A and C ward managers complained about breaks in communication between the different agencies as well as unrealistic expectations that were set from people 'higher above'.

All patients had a document called 'Patient Handling Risk Assessment Sheet' (Appendix 9), which was part of their care plan. This form of assessment depended on the calculation of a score deriving from items, such as the patient's weight, diagnosis, level of disability or weaknesses and patient comprehension. Depending on a patient's overall score, patients were assigned one or more people for their care, as well as mechanical aids and equipment. However, I noticed that there were some inconsistencies in its completion and these documents were not regularly updated. My observation was that neither students nor staff consulted this sheet. Instead, I observed that they relied on verbal information during the handover and their own personal judgement. I present an extract from a handover report to give an example of the information provided. In this extract, the first patient was considered needing minimum help, while the second patient is described as 'obese and paraplegic' that meant two or more people were needed for his care:

Morgan is a 60 year old man. He had MIs in the past (myocardial infarctions). He's a lovely man; he doesn't need much help.  
Paul Thomas is 52. He has type 2 respiratory failure. He's on 4lt oxygen and 3lt on nippy [type of ventilator]. He's been ok. He has urosepsis. His blood pressure is low. He's NFR [Not for Resuscitation orders]. He's obese, paraplegic and had a history of hypertension. He has sleep apnea. We're waiting for the district nurse to see his bottom. His wife declined any help at home. His wound is getting worse. [Handover report, ward C]

Even though each ward had a poster discussing the moving and handling equipment available with specifications and indications for proper use, patient assessments were usually performed based on the nurses' and student nurses' experiential knowledge of caring for obese patients:

Alex: When you see a patient, what sort of factors mean that this patient is overweight?

Susan: If she's big; how many people it takes to roll her over. I mean if the patient is generally light, you would have two of you rolling them but if they are obese you would need three rolling and one washing, you know, so that is how we assess really rather than the weight of the patient. [Interview with Susan, 3<sup>rd</sup> year student]

Alex: How did you do the assessment to use appropriate equipment like a hoist?

John: The reality is that you just do it... there will be experienced nurses on the ward that would say 'you're not going to be able to move so and so with that hoist, you will need to bring a bigger one' so it tend to be that I as a student wouldn't take initiative ...Generally, they would already have that assessment made about their mobility and the equipment you should use. And we used a document; it was manual handling assessment risk... You know, if I am to be really honest with you and I will be very honest with you now, I shouldn't say that, as far as I am aware, the only equipment I have ever used was the standing hoist and full sling hoist. Now, I know that each of them has different size slings and each has a capacity, but I don't know what it is... [Interview with John, Newly qualified]

Moreover, neither students nor staff checked the safe working load of equipment. This was probably reinforced by the fact that weighing patients was not performed regularly despite the existence of scales on each ward. Patients that were unable to stand on a scale were less frequently weighed despite there being wheelchairs and hoists with weighing capability on the ward. In the following extract from my field notes, a student moved an obese patient after consulting with her about her level of pain and what she was allowed to do after the surgery. It is obvious that the student took into account the patient's safety and comfort, while she ignored her own risk of a back injury performing the prohibited manual handling technique known as a 'drag lift':

Alice is asking Amy (obese patient, who had total hysterectomy in the morning) 'how's your pain?' while taking the patient's obs. The patient says 'fine'. Her eyes are closed and she's listening to music. They talk about her job; she is a teacher for children with special needs. She's on fentanyl on demand. Alice is informing the patient's chart 'drug infused: 1.28 mg'. She's re-arranging the patient's pillows. Manual Handling: she said to the patient to push with her legs while asking her 'are you allowed to do it?' She puts her arm under the patient's shoulder and pushes her up the bed. She

is not using slide sheets. [Observing Alice, 3rd year student; ward B]

The majority of students recognised that not assessing a patient properly posed dangers to both handler and patient. However, they highlighted that they never intentionally caused harm to a patient. John, for instance, discussed about the degree of 'how wrong' a technique was; for instance, how likely it is for the patient's skin integrity to be affected by the manual handling technique. He suggested that a frail patient with poor skin integrity would be given more consideration than an 'obese, strong man':

Well, yes, with sliding patients and perhaps damaging them. I mean I am...when patients have poor skin integrity I am certainly aware of that and there will be a lot more care but you do...you are more mindful and perhaps you need to be more gentle with some people because the skin will break down very easily. This particular chap I've been talking about he's robust; he's in his 70s. He's a big, strong man who is medically fit just waiting for a bed to come somewhere else; still there is no excuse doing it but to me when you are going to do wrong there are degrees of how wrong it is and the possible implications of doing these things. If you probably read to me what I've just said, I would say 'oh, my God, that's not right' but I do generally think (like that). [Interview with John, Newly qualified]

Students frequently engaged in dangerous handling practices. Most of the students' techniques conveyed a lack of knowledge regardless of years of previous experience working as health care assistants and years of nursing studies. Betty, a third year student in ward B was the only student that I observed who utilised equipment properly, encouraged the patient to participate and conducted properly the manual handling techniques. Carol and George were the only students who said that they used moving and handling equipment regularly when handling patients, yet they still engaged in lifting patients when these patients were characterised as 'people you could do it easily without'.

George: No, I've never been involved in lifting a patient, who you would have thought overweight....for example; you're using a steady just to stand people. That's very... you can do that quite quickly so that...the only people being lifted are people you could do it easily without...

Alex: How about slide sheets? When did you use them? On overweight or normal weight patients?

George: Both I would say. I mean in my management placement there were very good in using sliding sheets for example.

[Interview with George, Newly Qualified]

Alex: Right. When you washed the patients, did you use manual handling equipment to move the patients?

Carol: Yes, most of them couldn't turn themselves so we used slide sheets and steady hoists for those that couldn't walk and others were using a frame.

Alex: Did you always use the equipment?

Carol: Yes, we did. On that one, they were very good. Usually patients had their own pair of sliding sheets, as well.

Alex: Oh, I am impressed. (Laugh) When I observed students....I've been in three different wards, I didn't see the equipment being used very often and I was like 'oh, I hope it's not like that everywhere'.

Carol: (Laugh) No, no. I think because it was a rehab ward and the patients are very fragile; they have to be careful because if they slip and hurt themselves and because their skin is very delicate and it can crack open. So, they're very good at manual handling techniques.

Alex: And do you feel competent enough to do the manual handling?

Carol: Oh, yes.

Alex: Well, you've been working in the nursing home, as well.

Carol: Well, in the nursing home it's a different story... (Laugh)

Alex: Oh, sorry. How is your back?

Carol: It's good. It doesn't hurt.

[Interview with Carol, 1<sup>st</sup> year student]

In effect, third year student nurses used to influence less experienced students not to use any equipment, as seen from the following extract:

Karin asked Nancy if she wants to use slide sheets. Nancy said 'I don't mind, she's fine' meaning that the patient is not 'heavy'. They lifted the patient up the bed and Karin helped Nancy to wash her. [Observing Karin, 3rd year student and Nancy, 1st year student, ward C]

Previous studies suggest that both student nurses and nurses often engage in dangerous handling practices despite that the RCN's code of practice for patient handling practices states that patient handling manually must not involve lifting all or most of the patient's weight (RCN, 1996). An early exploratory study by Green (1996), which included 30 hours of non-participant observation of moving and

handling practices on two medical wards, remarked that both nurses and students often engaged in condemned lifting techniques, such as lifting the patient up the bed, and that risk assessment was usually incomplete. In that study, though, nurses also experienced lack of equipment, such as sliding sheets and glides. However, in the current study all three wards *appeared* to have sufficient equipment; however, equipment availability might have been an issue if all staff and students decided to use it in their everyday practice. I suggest that students and staff chose not to use the equipment provided; nevertheless, if they engaged in consistent use for all patients, such scarcity could have been noticed. A survey (n=432) reported that 48% of their sample used condemned lifting techniques, while over one quarter of students said that they had begun to develop musculo-skeletal pain since becoming a student nurse (Kneafsey and Haigh, 2007). Handling practices, like the one described below, were so common that rarely students felt that they needed to justify their practice:

Simon asks me to go and help him to 'stand up and wash her bottom'. I go from the right side of the patient. Simon guides her to support her weight with her hands pushing the armchair. He washes her bottom, dries it and then we put her on the chair again.  
[Observing Simon, 2<sup>nd</sup> year student; ward A]

When I asked students in practice why they did not use the equipment, the majority told me that it was unnecessary unless the patient was 'big', which was a characterisation they assigned to obese patients. Obesity assessment is further discussed in Chapter Six (Section 6.2.2). While previous research (Attree et al., 2008) suggests that students are aware of the prevalence of risks to patient safety in practice, my participants did not consider that they were harming patients when engaging in such practices. The same study (Attree et al., 2008), which evaluated patient safety in a pre-registration nursing curriculum, found that patient safety was not discussed explicitly in student nurses' curriculum but nurse educators addressed it repeatedly during lectures. Nevertheless, third year students, like Susan, Karin and Alice, told me that they were aware that these techniques were 'nonstandard'.

Even though I did not observe any obese patient experiencing injury during M&H, I observed that several patients were in discomfort especially when student nurses used the 'drag lift' technique supporting the patient from the shoulders as well as when using a smaller sling than appropriate during hoisting a patient.

Because of the intrinsic difficulties of manual handling and other constraints in practice obese patients were often the last patients to be offered required care. Student nurses justified theirs and nurses' decision of washing obese patients last on grounds of resource distribution and other difficulties in patients' care that required the assistance of two or more people:

Well, the heavy patients were always done last. And it would be different because you wouldn't be on your own...maybe two or even three people. She was quite obese and she was demanding and you'd have to move her very carefully because she was heavy and sometimes she wouldn't cooperate, so you'd need an extra pair of hands.

[Interview with Carol, 1<sup>st</sup> year student]

Apart from obese patients' low prioritisation in the routines of the ward, students also mentioned that obese patients were less likely to be repositioned– repositioning is encouraged for prevention of pressure ulcers (Wilson, 2004). My observations show that 'heavy' patients were rarely transferred to a chair during the day. When confronted, some students defended these practices; M&H required the help of more than one person, which meant that the nurse or student responsible for the heavy patient had to wait until another person was available to assist. Susan, a 3<sup>rd</sup> year student, explained that pushing a heavy patient to the back of the queue was a result of wards being unprepared – in terms of human resources - for looking after heavy patients:

You can't give them the full nursing care you would normally give to a normal weight patient because we are short-staffed, you know, maximum two qualified nurses and you're happy if you have two health care support workers. So you have four on the ward and sometimes it needs four of you to roll over a patient and not all of you can be there for the patient.

[Interview with Susan, 3<sup>rd</sup> year student]

One could suggest that nurses could have effectively organised their time and human resources by washing obese patients first and then the rest of patients in need of assistance. Nevertheless, I did not observe such an occurrence. Being pushed to the back of the queue had subsequent consequences on the quality of care obese patients were offered; students made regular omissions, for instance, did not wash patients' back and legs. This meant that their personal hygiene was further compromised.



Lucy, a 1<sup>st</sup> year student described several practices that I also observed on the wards; such as bringing the commode to a patient who was capable of walking with assistance to the toilet:

Alex: Ok. Now, what do you think affect the nursing care that obese patients are offered on the ward?

Lucy: I think it's day to day care. You know, when they buzz and they want to go to the toilet...some people are reluctant to go because 'oh, it's going to take a lot of energy'. This is a heavy task to do. I think sometimes they get less attention and the type of care they get is, you know, they are done last when they do the morning round, bed baths and things like that. By the time they get to them, because it takes energy and because everyone is tired, they might take short-cuts or not do everything that is supposed to be done and say 'oh, I'm tired...she's heavy' and maybe instead of giving her a full bed bath, they'll just do the essentials and say 'we're done'.

Alex: What are the essentials?

Lucy: You know, washing the lower part of her body and the armpits and the face. They ignore the large legs, the hands and the back, yeah. [Interview with Lucy, 1<sup>st</sup> year student]

In order to comprehend student nurses' viewpoint towards the distribution of resources, it is worth looking into the concept of justice. Different philosophical stands determine different criteria regarding fair distribution of resources like time allocation; there is a philosophy that states that all persons are equal and, hence, they deserve equal resources. Others think that resources should be attributed according to different criteria; depending on one's need, effort they make, contribution to society, merit or even free-market exchanges (Beauchamp and Childress, 2001). For instance, nurses should spend more time with obese patients, who have complicated health problems and/or mobility issues, if resources are to be distributed on the basis of need.

When student nurses answered the question whether it is right or wrong to push obese patients to the back of the queue, it seems that they took an utilitarian approach to the ethics of caring. Utilitarianism is an approach to ethics that was first articulated by Jeremy Bentham (1962) and ascribed to the slogan 'that which is good is that which causes the greatest happiness to the greater number'. This principle is all about maximising the value of a certain utility, which in this instance, is student nurses' time. In other words, if student nurses spent more time with obese patients, the greater number of other patients would suffer and, hence, happiness would be

minimised. Following this doctrine, assisting obese patients last can be partly justified because more than one nurse is needed to move an obese patient and could take more time than other patients. This is reflected in Kath's interview, who advocated that putting obese patients' care last was not a discriminatory practice.

Well, you do try to give everyone the same nursing care but obviously when someone is quite overweight then you will need two nurses to...you know...you will need more nurses with the manual handling and things. In that respect, it is harder because even though you're trying to give them the right care maybe they have to wait a little bit longer because you need that extra pair of hands to help roll them or whatever so sometimes maybe it is compromised not deliberately but I cannot think of the word...indirectly, is it? I don't know. Now, that I'm thinking of it, if they are not so mobile. But I don't think I would discriminate against... [Interview with Kath, Newly Qualified]

Overall, all participants stressed that physical care and manual handling of obese patients presented a plethora of challenges. Gaps in their knowledge and condemned manual handling practices put patients at risk, while student nurses put obese patients' physical care at lot priority.

#### **4.5 Summary**

The findings presented and discussed in this chapter suggest that there are three essential areas that student nurses find challenging in their care of obese patients; namely, physical and emotional interaction with obese patients, knowledge and provision of food and nutrition, and appropriate moving and handling.

I identified that student nurses avoided obese patients or employed strategies that limited the time and breadth of communication. While previous studies (Paternelj-Taylor, 1989; Jeffrey and Kitto, 2006; Sardani, 2006) suggest that professional provision of equal care to all patients, regardless of obesity, seemed to be a main concern among student nurses, my study reveals that—willingly or not- the care of obese patients was frequently a low priority. By observing the subtle nuances of student nurses' interaction with obese patients, the findings suggest that student nurses, regardless of the year of studies and previous experience as health care assistants, presented disparities in their communication skills. Moreover, their use of

humour during the physical care of obese patients raised concerns over their definition of professionalism and appropriate practice.

Regarding student nurses' involvement with patients' food and nutrition, I entered the field with awareness – and perhaps misconception - that student nurses in their first or second year may have limited knowledge regarding nutrition. The observed scene was quite complex; student nurses were often involved in activities regarding distribution of food and helping patients that needed assistance during mealtimes. Further, student nurses often participated in monitoring the patients' weight, Body Mass Index, diet and nutritional status. However, they all admitted that these activities were task-oriented; meaning that student nurses did not give attention to the data that were collected nor the type, quality or quantity of food that obese patients were served. However, student nurses intensely observed and criticised obese patients who were seen in possession and/or consumption of high-fat or sugary food. Moreover, they often displayed reluctance to getting involved with feeding obese patients, and obese patients were left until last. When recording information, student nurses – and nursing staff alike – always commented that obese patients' appetite was high – but their appetite was not accurately monitored. Consequently, obese patients were never motivated to eat if they declined a meal. These observations were in stark contrast to the care given to underweight patients' food and nutrition whereby student nurses presented considerable attention to their diet and dedicated more time assisting and motivating them to eat. My observations suggest that student nurses may have certain misconceptions regarding obesity, food and nutrition. The findings, for instance, made me wonder whether student nurses fully realise the link between malnourishment and obesity.

Student nurses' frequent involvement with obese patients' physical care brought into attention the importance of manual handling. Student nurses were often involved in dangerous patient handling practices, which placed patients at risk of pressure sores or injury. Further, student nurses presented considerable gaps in their knowledge of moving and handling bigger and heavier patients. Inconsistencies in obese patients' moving and handling assessment, lack of awareness regarding the availability and inappropriate use of equipment posed dangers to both students and patients. Indeed, it was recognised that only one student out of sixteen who participated in this study documented frequent and proper use of equipment. I also observed that obese

patients were often the last patients to be offered required care and faced compromises in their care. For instance, obese patients were seldom repositioned and often encountered deficiencies in their physical care. Overall, obese patients' physical care was deemed physically exhausting and current practices were defended in terms of student nurses' altruistic motives to 'assist' with patients' care and ethical resource distribution.

The following chapter will further explore the factors influencing student nurses' care towards obese patients, specifically examining student nurses' conceptualisation of obesity and the care of obese patients in conjunction with perceived professional and organisational constraints governing their clinical practice.

## **CHAPTER SIX – Constructing the meaning of obesity: the culture and context of care**

### **6.1 Introduction**

This chapter explains how student nurses constructed the meaning of obesity. It is further shown the importance of the culture and context of care in student nurses' framing of their experience of caring for obese patients.

In the first part of the chapter I suggest that student nurses were influenced by popular cultural beliefs in stigmatising obesity and assigned a plethora of unfavourable stereotypes and labels to obese patients. I further explain the way student nurses assessed obesity and argue that this process was highly individual and dependent on a participant's individual criteria such as acceptable body size and contextual factors, such as a patient's mobility. However, the meaning of obesity was not static; since patients were able to influence the construction of obesity meaning by social exchange means, such as assisting during moving and handling.

The second part of this chapter discusses the sum of professional and organisational constraints that were identified as impeding student nurses' experience of caring for obese patients. Nurses' attitudes towards obese patients and their care are discussed within professional socialisation; I suggest that through the process of professional socialisation my participants were likely to internalise negative attitudes and observed behaviour. The combination of student nurses' desire to fit in with the ward culture and adherence to covert rules contributed to their experience of nursing obese patients because it limited opportunities for interaction with obese patients. Further, it meant that student nurses often compromised their safety due to covert rules regarding moving and handling regulations.

### **6.2 'When we're not looking, he's eating': cultural norms regarding obesity and obese patients**

In this section I look into the cultural norms that student nurses seemed to adhere to in order to comprehend the origins of their perceptions regarding obese patients and their care. First, I look into the stigma theory to aid understanding of the reasons behind obesity stigmatisation and reflect on the stereotypes that student nurses

attributed to obese patients. Second, I explore literature regarding nursing culture and labelling of patients with a view to exploring why student nurses regarded obese patients as unpopular.

### **6.2.1 Obesity stigmatisation**

In this section I outline and discuss my participants' thoughts, beliefs and ideas about obesity and obese patients. While I consider stereotyping to be a normal (if undesirable) consequence of people's abilities and limitations and of the social information and experiences to which they are exposed (Goffman, 1963), student nurses' beliefs about obesity suggest that they stigmatised obesity.

Students' drawings, which most depicted a rather sizeable patient, illustrate how patients' size was a significant reference point when talking about a patient. In the following extracts, Lucy draws attention to the high visibility of obesity that plays role in how patients are perceived. The second extract portrays a more subtle judgement of a patient's size; the student comments discretely but derogatively about a patient's size of clothes to draw attention to the patient's largeness:

Alex: So, tell me about the (obese) patients you've nursed.

Lucy: Well, obviously, you go to their room and you notice that they are big. This is the first thing you see. It makes an impression, you know.

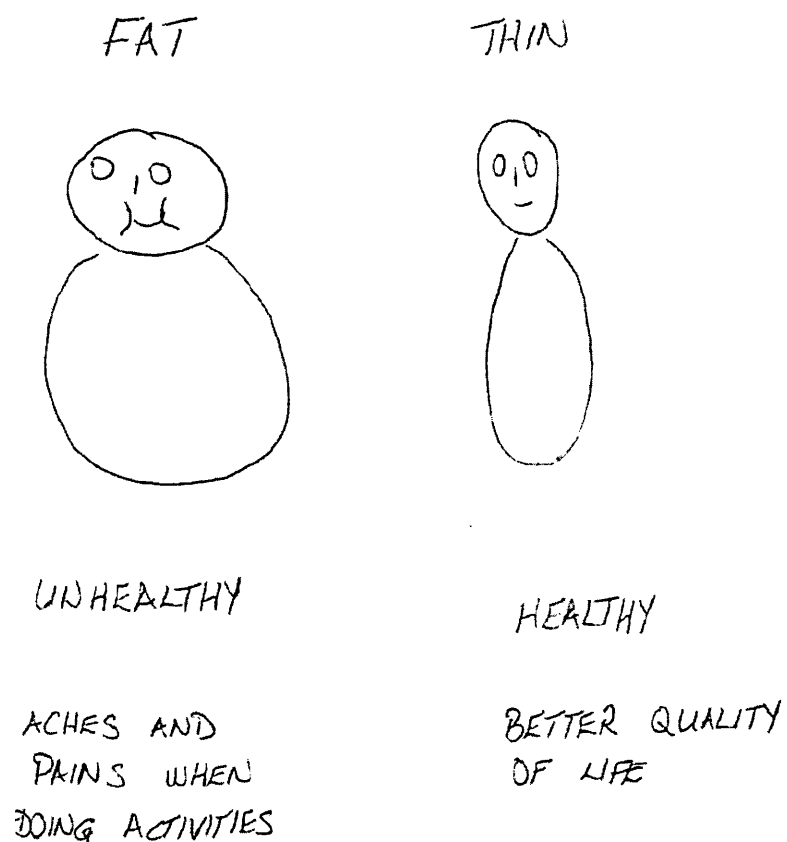
[Interview with Lucy, 1st year student]

Alice went to help a patient pack her belongings. She said to the patient 'we have to pack your clothes, valuables and we should double-check the list'. The patient said she has to go to the toilet and not to worry because 'there's nothing expensive here'. When the patient left, Alice continued folding her clothes, showed me one of the tops and said 'quite posh and pretty. Look, it's size 18- no surprise there'.

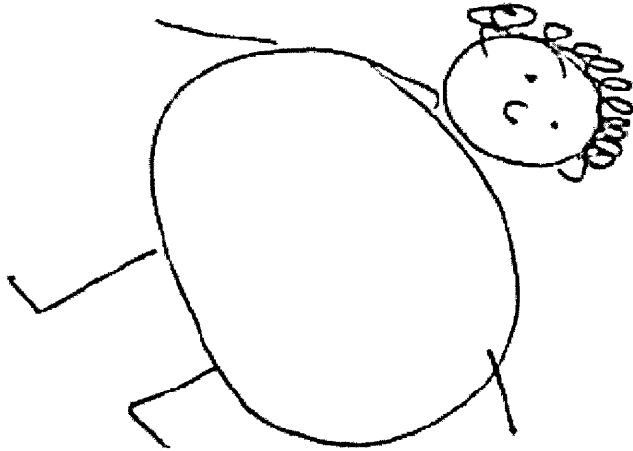
[Observing Alice, 3rd year student; ward B]

By perceiving a difference in obese patients, which differentiates them from others could lead to negative evaluation of the person or group that possesses what Erving Goffman (1963) refers to as a 'deeply discrediting' attribute. Stigmatisation has been characterised as a major disruptor of face-to-face interaction and has been categorised into three types; 'abominations of the body, which include all physical deformities; blemishes of individual character, such as weak will and dishonesty; and, tribal stigma of race, nation and religion (Goffman, 1963; p.14). Even though

Goffman (1963) does not mention obesity explicitly, when student nurses described their interaction with obese patients they made inferences regarding obese patients' body and prescribed negative characteristics. Carol's drawing shows typical inferences that people make regarding obese patients' health status. While George's drawing is another representation of an obese patient, whose size seems to be the main characteristic. These drawings present further interesting characteristics; Carol's figures do not have limbs drawing more attention to the size of their torso, which may imply that abdominal obesity is a more stigmatised condition. George has portrayed a figure with abdominal obesity who does not have a mouth; the absence of mouth denies interpretation of the figure's emotional state.



Picture 2. Drawing by Carol, First year student



Picture 3. Drawing by George, Newly Qualified Nurse

However, none of the students admitted that they stigmatised obese patients. I found that student nurses were less likely to report that they have negative attitudes towards obese patients.

Alex: Was it difficult for you to maintain your professionalism in front of the patient?

John: No. I don't ever think when I am dealing with a patient 'why don't you do us a favour? You shouldn't be like this' because I don't know what's the circumstances behind that.

[Interview with John, Newly Qualified Nurse]

Stacy: I don't have any biases, I don't see any problems with cleaning and washing patients who are overweight; I wouldn't treat them any differently than I would treat anybody else...It would just take longer. It just requires more time... Yeah, no one has the right to judge or say anything. People shouldn't judge... You have to do it; this is your job. You shouldn't be passing on opinions; especially when it's not constructive.

[Interview with Stacy, 1<sup>st</sup> year student]

The reason behind the expression of explicit discriminatory attitudes can be traced to the fact that overt discrimination is prohibitive in British culture, especially in institutions such as a University and the NHS (Vartanian et al., 2005). The NMC



standards of proficiency for pre-registration Nursing Education echo this principle by stating that nurses should practise in a fair and anti-discriminatory way providing equal care to all patients. Further, research suggests that people who may have negative attitudes could truly aspire not to be prejudiced; however, their uneasiness towards obese people may influence them in expressing their feelings in indirect ways (Dovidio et al., 2008). Goffman (1963) has also supported the idea that people are more likely to impute a wide range of imperfections rather than point out the original source of stigma. According to Goffman (1963; p.15) the recollection of these imperfections serves as an explanation of the stigmatised person's inferiority and accounts for the dangers he/she represents. Similarly, in my study, all participants referred to obese patients' certain negative qualities that I analyse below.

The most cited negative stereotypes by my participants were will weak, dishonesty and being demanding. This type of stigmatisation occurs in general society-not just student nurses- as previous studies have shown that people assign a plethora of stereotypes to obese persons, such as lazy, unmotivated, lacking of self-discipline, less competent, non-compliant and sloppy (Rochling, 1999; Puhl and Brownell, 2001; Teachman et al., 2003). Many participants mentioned that obese persons had become unhealthy because of their weak will and their choices regarding food and exercising.

When I enquired of participants, the majority blamed obese patients for becoming unhealthy, which suggests that they share widely-held cultural beliefs about obesity. Susan, Stacy, John, Carol, Betty, Simon, Sally, Karin and Julie were rather upfront about their beliefs. Susan, a third year student, was adamant that it is their fault for being obese and defended nurses for letting them last during the morning routines suggesting that other patients, who did nothing wrong, deserved to be looked after first. Stacy was more subtle, saying that her knowledge is limited because she is in her first year but she believed that too much food is what makes you gain weight. In a discussion about an obese patient with respiratory problems that eventually deceased, she supported the idea that the patient would have lived longer if she reduced the amount of 'bad food' she was consuming. John, a qualified nurse, was straightforward in his answers claiming that it's the obese patient's fault, as well as Carol who did not believe that there is a genetic component in the manifestation of obesity.

Betty and Sally, both overweight, were aware that they had a 'weight problem'; both said that stress contributed to their gaining weight, while Betty, who was in her mid-40s, said that getting older makes it easier to gain weight. However, both of them were resolute that getting obese was something that could be avoided if they paid attention to their diet and exercise. Nevertheless, despite classifying themselves as overweight, these student nurses did not present a considerably different behaviour towards obese patients than non-obese student nurses. This is another example of the propensity of obesity stigma. Indeed, previous research has shown that obese people have as strong anti-fat bias as non-obese people; endorsing beliefs such as obese people are lazier than thin people (Wang et al., 2004). On the other hand, Simon, who was underweight according to BMI, said that he was upset that some people do not look after their diet to the point that they need health care and clearly stated that he did not feel sympathy for people like that. Julie, a second year student who felt she was normal weight, said that she watched her mother getting obese from sitting in the house and eating all the time the 'wrong food', while Karin, a third year student, told me she was aware that she was overweight and knew it was her fault for eating too much, but also because she's Welsh and her body is built this way.

Looking into my participants beliefs about obesity provided an excellent resource to determine whether they had any negative preconceptions about obese people. Previous research suggests that a person's attitude might be primarily based upon the attributes they associate with an object (Maio and Haddock, 2009). In other words, student nurses' negative or positive attitudes towards obese patients are likely to be connected to their beliefs about the attributes associated with obesity. For instance, if student nurses believe that obese patients are responsible for their own fate, they may also think that people's choices are the most important source of what happens to them in their lives (Crandall and Eshleman, 2003). Goffman (1963) utilised the term 'stigma theory' to refer to an ideology that a person develops in order to explain why he/she believes that the stigmatised is inferior to other people. As far as obesity is concerned, making poor choices in one's lifestyle is the first principle of the mentioned ideology. Indeed, people who believe that obesity is caused because an individual eats too much and exercises too little would be more likely to point the finger to obese patients and say that it's their fault for being obese because of their wrong choices.

This ideology has proven to nurture negative stereotypes towards obese people (Garrot et al., 1990; Puhl and Brownell, 2001). Previous research suggests that people discriminate against obese persons based on the perception that they are obese because of their choices and, hence, they get 'what they deserve' (Puhl and Brownell, 2001). Similarly, student nurses who do not view obese persons liable for their weight gain are more likely to have positive attitudes towards them. The majority of studies looking into nurses' and student nurses' attitudes, which I have extensively reviewed in Chapter Two, suggest that their negativity lies in their beliefs about the knowledge regarding causes of obesity (Hoppe and Ogden, 1997; Culbertson and Smolen, 1999; Green et al., 2000; Petrich, 2000; Jeffrey and Kitto, 2006; Brown et al., 2007; Jallinoja et al., 2007; Drake et al., 2008; Poon and Tarrant, 2009; Watson et al., 2008; Budd et al., 2009). It is most likely, hence, that student nurses' beliefs about the causes of obesity influenced their attitudes towards them in that it facilitated the creation of a 'stigma theory' to justify their negativity towards obese patients.

On the other hand, student nurses that believe that obesity is caused by factors that are beyond the individual's control, such as genetic factors, were more sympathetic towards obese patients. This was proven to be truth in Kate's instance, a rather popular obese bedridden patient in ward C, who had spina bifida. My participants partly justified Kate's obesity on that her mobility was considerably limited. Indeed, awareness regarding the influence of genetic and other uncontrollable factors has proven to influence obese patients' care; a study on the impact of educational interventions on nurses' attitudes found that nurses spent more time consulting patients about their weight after receiving the mentioned intervention (Ogden and Hoppe, 1998). Interestingly, the same study found that awareness did not cause any changes in nurses' attitudes showing that obesity stigma is deeply rooted in people's beliefs.

The strongest argument utilised by students for giving less attention to obese patients was that they should be blamed for becoming obese and, thus, they do not deserve the same treatment. After observing Susan in ward A, I inquired her about her experiences of nursing Hillary, a morbidly obese patient. In the following extract from her interview, it is clearly shown how Susan puts the blame on the patient for

the difficulties she encountered during her care. I utilised capital letters to emphasize the rise in Susan's voice:

Alex: How did this make you feel?

Susan: It's quite sad really but then sometimes I thought perhaps IT IS HER fault, you know, for putting all this...and I am breaking my back rolling her, so and it's all about the equipment because that makes it then ten times worse.

[Interview with Susan, 3rd year student]

There were some students, though, who believed that there are factors beyond one's control contributing to obesity or, perhaps, did not wish to reveal their attitudes; Louise and Rhiannon, said that you have to know the individual before you can talk about the causes. Kath, a newly qualified nurse, said that having a diet high in fat can contribute to gaining weight, but she was never taught anything about the subject and never wondered about it. Alice, an overweight third year student, told me that she knew that her lifestyle choices contributed to her gaining weight but claimed that every person has different reasons that need exploring before judging people. She was the only student observed that displayed empathy towards obese patients regarding their weight and understanding about the implications in finding clothes in bigger sizes:

We go to a room with two obese and two overweight patients, according to their files and student's evaluation. One of the obese patients mentions that all women on television are wearing 'lovely' clothes. The other obese patient says 'that's because they're skinny'. Alice, who is also obese, talks with the patients about finding clothes in your size. They comment that it is difficult to find something nice to wear. One of the patients comments that I probably can find any clothes I like because I have a nice figure.

[Observing Alice, 3rd year student; ward B]

Nancy, avoided to answer my question replying that 'it could be everything, liking too much food, lack of money, everything'. Finally, George, a newly qualified nurse, mentioned that obesity is caused by a multitude of factors, as seen in the following extract from his interview:

It's probably a combination of factors, lifestyle related, education related, socio-economic factors related probably, a lot of different facts... But I don't...I mean society has changed, you know, and obesity is a big issue in a lot of countries and you can't, you know, it's dangerous to point a finger at individuals because society it's different than it was after the second World War for multitude of

reasons... But society has evolved and we have so much of everything and people have to work in a different way than they used to. I mean it's yeah, it's very difficult.  
[Interview with George, Newly Qualified]

Even though obesity has been proved to be a multi-factorial disease involving causes closely related to the environment (Banning, 2005), most people perceive that it depends mostly on lifestyle choices (Brown et al., 2007) and this is reflected in students' answers. This is linked to a prominent feature of the belief system that pervades society; namely people's perception that one's accomplishments and failures are outcomes of personal motivations to be successful (Marshall, 1982; Klaczynski et al., 2004). This raises the question whether obese patients are personally responsible for their weight and, as previous studies indicate and my participants suggest, most student nurses believe it is true (Sardani, 2006; Drake et al., 2008). People adhering to this belief system also believe that obese persons are unwilling to lose weight, lazy, passive and undisciplined (Puhl and Brownell, 2001). This ideology has been proven to make people feel that discriminatory treatment is natural, sensible, and fair (Crandall, 1998). Further, research suggests that it is difficult to be shifted because it is usually part of a complex web of beliefs (Crandall, 1998).

This type of moral evaluation; blaming the patient for their weight and related co-morbidities, is mainly based on our societal attitudes towards weight and clear preference to the 'thin ideal', a value held high in our culture (Crandall et al., 2001). The 'thin ideal' is integrally linked to the stereotype that 'beautiful is good' in which physically attractive people are ascribed more positive qualities than unattractive people (Puhl and Brownell, 2003). The media has played a considerable role in linking beauty to being thin. The 'thin ideal' is a message that people from a very young age are in constant exposure to from the media, parents and peers; that the ideal body is one that is almost impossibly thin (Klaczynski et al., 2004). This is promoted in several different ways, including advertising, television programmes, videogames or even animated cartoons (Harrison, 2000; Herboso et al., 2004; Klein and Shiffman, 2006).

The controllability of a stigma, which involves the perceived personal responsibility for having the stigmatising 'mark' in the first place, as well as for maintaining or eliminating the mark, has been characterised as the most important dimension of stigma along with 'visibility' (Crocker et al., 1998). As far as obesity is concerned, controllability involves the obese person's responsibility for being obese in the first place. The importance of controllability lies on the fact that previous studies suggest that negative attitudes towards groups or persons that have a 'controllable' stigmatising condition tend to be stronger (Crandall, 2000). Indeed, findings from studies dating from 1988 (Weiner et al., 1988; Crandall, 1994) confirm that due to the perceived controllability of obesity, obese persons are more likely than other stigmatised groups (such as the blind) to be met with responses of anger and little willingness to help.

The negative connotations attached to obesity are also demonstrated in the positive connotations that were attached to being underweight. My field notes include several examples where underweight patients were described with favourable terms such as 'very, very slender'. According to Oxford Dictionary, slender means 'gracefully thin'. Another interesting term utilised by Welsh-speaking students was the affectionate use of terms including 'bach', which means 'small', and 'twt', which means 'tiny, neat or smart' (English-Welsh On-line Dictionary, 2012). Both terms were commonly assigned to underweight patients and imply favourability towards thinness. Previous research has shown that nurses are not immune to such stereotyping; a study exploring implicit weight bias revealed that health professionals, including nurses, associated obese people with 'bad' and thin people with 'good' (Schwartz et al., 2003).

Student nurses' attitudes towards obese patients are also reflected on their tendency to assign negative attributes to obese patients, which is discussed in the following section.

### **6.2.2 Obese patients' labelling**

Student nurses assigned a plethora of attributes and personality traits to obese patients that followed a certain pattern. Overall, students felt that the source of difficulty in obese patients' care – apart from the physical demands – was located in the obese patient's personality. Therefore, I consider imperative in presenting the

wealth of labels that student nurses assigned to obese patients, which could have influenced their interaction.

Goffman (1963) coined the phrase 'the spread effect of disability' to describe people's tendency to stretch a person's disability to other functions of abilities of the stigmatised person. For instance, people usually speak louder to blind people. Obesity as a stigma became the patients' 'master status', a concept coined by Everett Hughes (1954), signifying a specific trait that a person possesses from which everything about that person is interpreted (Scott and Marshall, 2009). By that I mean that obesity became a dominating quality that influenced how student nurses defined these patients overshadowing any positive characteristics that these patients may have had.

The first label I would like to discuss is that of disobedience; student nurses considered that obese patients were disobedient, which was expressed in different ways. The presence of fatty or sugary foods on patients' bedside tables symbolised their disobedience. All interviewed students accused obese persons of 'eating the wrong food in big quantities'. Further, obese patients were more likely to be accused of not following nursing guidelines. Paul, a morbidly obese patient in ward C, was constantly reprimanded for not eating the food that the hospital provided, because his dietary choices were linked to aggravation of his diarrhoea. A student who was asked regularly to participate in Paul's care commented:

Eating figs and prunes is why he's soiled all the time. He says he's not having them, but I saw his wife bringing them...other stuff too. When we're not looking, he's eating. [Observing Stacy, 1<sup>st</sup> year student; ward C]

Goffman's observational research of a mental institution published in a book called 'Asylums' (1961) viewed the trait of 'not being obedient' as leading to moral evaluation when staff measured patients' mental health in terms of their obedience. Patients who followed staff's commands were given privileges, while others who broke the rules were considered disobedient and were punished by removing such privileges. In his work Goffman did not expand much on the moral evaluation of patients, because he dealt more with issues such as the process of depersonalisation of the patients in an institution as well as the process by which the patient gets

accustomed to the conditions of institutional life. However, his contribution lies on the fact that he viewed moral evaluation as a process, which was dependent on the interaction of patients with staff which means that the patient could change their evaluation if he/she decided to follow the staff's rules. Perhaps, the only limitation that could be mentioned about this study is that Goffman was negatively predisposed towards psychiatry, its systems, philosophy and methods. Even though he recognises his antipathy, his findings could have been influenced by his negative perceptions. Giddens (1987) has further criticised Goffman for falsely separating the study of interaction from institutional order, which resulted in reduction of the importance of Goffman's work in terms of producing a theory of society. Indeed, Giddens criticised him of valuing the micro level of sociology as more fundamental than the macro; he suggested that even when he approached the study of social organisation in his work of 'total institutions', he was mainly concentrated at how the chief features of the organisation stimulated modes of interaction within specific settings. Nevertheless, he suggested that Erving Goffman should be ranked as a major social theorist because of his systematic approach to the study of human social life.

Even though Goffman's study was conducted sixty years ago and his subject was mental patients' loss of self through their institutionalisation in an asylum, there are certain similarities to the way my participants viewed patients. Specifically, in *Asylums* (1961), Goffman suggested that patients used disobedience as a form of resistance to their loss of autonomy as well as a strategy to feel self-worth again. Manning (2003), who studied Goffman extensively suggests that the psychiatric personnel misunderstood the patients' motives and behaviour and took it as another expression and symptom of their mental illness. In my study, both nurses and student nurses attributed patients' disobedience to the patients' character and moral worth rather than social factors or others related to patient's presentation of self. Indeed, the use of the term 'moral evaluation' suggests that patients are criticised for their behaviour on the basis of their morality rather than social circumstances.

Another characteristic often assigned to obese patients was that of having low social worth and being a 'social case' or being 'rough'; any information about an obese patient's social status or even the presence of multiple tattoos became a matter of discussion. There are also several examples in my study of obese patients seen as 'illegitimate' to be cared for. It is important to say that not only obese patients were



considered illegitimate as patients; non-obese patients were also given that attribute. However, obese patients with mobility issues were more likely to be considered as such.

Paul, the morbidly obese patient in the respiratory ward C was also considered 'illegitimate' despite suffering from chronic obstructive pulmonary disease (COPD), type II respiratory failure and being admitted with a chest infection. Karin, a 3<sup>rd</sup> year student, who helped admit the patient to the ward, told me that this patient should not have been admitted to the ward because of his complications.

'He is very big and paraplegic because of a traffic accident he caused years ago. He's passing clots through his wound in the back and we have to turn him all the time; it smells really bad and I have the feeling that this is not the ward for patients like that'.  
[Observing Karin, 3rd year student; ward C]

John, a newly qualified nurse described a similar instance:

He was...ahm...about 17-18 stones and he was not very tall. He wasn't massively obese but he was certainly overweight but he also had a problem with leg ulcers but he wanted to be in bed all the time and we'd encourage him to go out of bed and quite often it would be a case that if he said yes, we'd be like 'oh! Quick, get him up quickly. He wants to get up'. But he's been there for so long and it was a social problem rather than a medical problem because they couldn't discharge him because he wasn't a safe discharge. It was almost as if he was [...] and it was hard then to convince him that we were doing the right thing for him. Does that make sense?

[Interview with John, Newly qualified]

Roth's study on moral evaluation of patients in emergency admissions wards also viewed the labelling of having low social worth and/or being illegitimate as crucial in a patient's moral evaluation. Firstly, it must be stated that Roth (1972) was aware that Goffman (1961) and others conducted their research in situations where there was fertile ground for moral evaluation due to the long-term relationship between patients and staff. Also, he believed that there was little room to perform moral evaluation on patients with medical problems, as opposed to patients diagnosed with mental illnesses who are more likely to be viewed as morally deviant. It ought not to be forgotten that both researchers conducted their study at a time that psychiatry was in its early development. Following this logic, he conducted his study in hospital

emergency wards, in which due to the conditions there were not many opportunities to know the patient's character. His colleagues' and his observations led him to conclude that the staff morally evaluated the patients and categorised them depending on their social worth, a concept instilled through societal values, and the staff's perception of whether it was their work and responsibility to treat them. Older patients, patients with sexually transmitted diseases and those with a low social background were given a negative evaluation (Roth, 1972).

It must be mentioned that Roth's paper gives little information on the rigour that he and his colleagues devoted themselves to increase the trustworthiness of their findings. At some point he mentions that in one of the three hospitals, they only managed to complete an eight hour shift. He acknowledges, though, that more research is needed of this kind. His reliance on the traits approach is obvious throughout his paper, but his contribution to the issue of moral evaluation lies on other grounds; first, he raised the issue of power and how it can influence moral evaluation and, second, he views moral evaluation as a process, which both actors, patient and staff, play an equally important role. He concluded that the patients 'inevitably set off the process' but the structure of the service organisation will affect the way and degree that moral evaluation will influence the service/care they receive (Roth, 1972; p.855).

Student nurses also often attached the label of being demanding, unappreciative and complaining to obese patients. In effect, in ward C students and staff utilised the label of 'hospital acquired disability' - a label that implied that patients did not have real needs; in the following extract Julie explains the meaning of this term:

Julie explains that most patients who come to the ward expect from nurses to do everything for them even if they can do it by themselves. I ask her to give me an example. She tells me that Brenda (obese patient with impaired mobility), for example, is 'fussy'. She knows she has a 'water' tablet because she used to be a nurse and that's why she asks to go to toilet all the time. She adds 'when she came she was wearing an old-fashioned plastic pad. They must be very uncomfortable'. An hour later, Brenda was 'wet' and apologised 'I'm sorry I don't know how this happen' [Observing Julie, 2<sup>nd</sup> year student; ward C)

Similar traits were identified in the seminal work of Felicity Stockwell (1972), who attempted to seek traits that might account for unpopularity in patients first in a quantitative way –which she failed due to research design problems - and then by utilising observation and interviews. Stockwell recognised that interaction was at the core of understanding the concept of the unpopular patient, but her reliance on the traits theory made her ignore other issues that may influence the interaction. The descriptive part of her study mentions four categories of unpopular patients; namely complaining or demanding attention patients, unappreciative, patients who exaggerated their symptoms and patients who Roth's participants (1972) considered 'illegitimate'. On the other hand, popular patients were the ones that had a good sense of humour, knew the nurses well, were cooperative and had fair communication skills.

Even though Stockwell claimed that she used comparative analysis in her study, the analysis of her findings is rather poor and apart from separating her data into 'popular and unpopular patients' case studies there is no thematic analysis to facilitate understanding. It must be noted that at that time qualitative research was not very popular in nursing. Moreover, not all findings are presented with the explanation that they were similar to the ones documented in the book. However, on reading her descriptive analysis I identified certain elements, which betray that there is something more about traits in the process of patient categorisation. For instance, in the quantitative part of the study, it is mentioned that being in the hospital for a long time contributes to unpopularity. Stockwell describes a patient in Ash Ward, though, that was popular despite her prolonged stay in hospital. Further, in Elm Ward she describes a patient that was generally popular but was considered unpopular by junior nurses. Interestingly, his popularity did not contribute to better quality of care to the point that the patient asked the consultant's help to alleviate his worries. In Elm Ward, she also describes a patient who was considered a 'moaner' by the nursing staff but the researcher did not observe such behaviour. The researcher did not put much thought on this finding; however, it may signify that these patients did not possess negative or positive traits but their labelling was dependent on other factors, such as lack of knowledge or awareness as seen in the following example. Stockwell's participants considered unpopular a patient with psychiatric problems because of fear of the patient's aggression. However, by reading the description of

the patient, it seems that the patient's unpopularity was dependent on nurses' lack of awareness and knowledge regarding the side-effects of an overdose of barbiturate. Knowing the patient well was another factor that prevented a patient being considered unpopular, even if the rest of the team regarded him/her as such.

Another contribution of Stockwell's research is that she reports the effects that nursing unpopular patients has on both patients and nurses. Specifically, she mentions that nurses described various feelings of frustration and impatience and guilt for having negative feelings, which shows that nurses' emotional wellbeing could have been undermined. On the other hand, unpopular patients were met with patient avoidance and neglect, and leaving them last in the daily routines. Stockwell, also noticed variations in the patient-nurse communication; the nurse devoted less time with patients he/she considered unpopular, in an interaction the researcher considered 'impersonal'. Sarcasm was another way of sanctioning the patient. Popular patients were also given some privileges as opposed to unpopular patients, which made the distinction more visible; like an extra slice of cake, allowing them to smoke and having visitors out of hours (Stockwell, 1972).

Perhaps the most frequently sought perception about obese patients – with regard to their moral evaluation – was that they carried the responsibility for the state of their health, as discussed in Section 6.2.1. This is highlighted by Carol in the following extract:

I think people should be reminded that at the end it's their mistake; it's because of their actions. Only you can change... you're the one who decides 'do I eat this chocolate or not?' 'Do I take that 30-minute walk or not?' so I think more responsibility should be given to the patient. [Interview with Carol, 1<sup>st</sup> year student]

Such perceptions reflect common paternalistic thinking in healthcare, which is reflected in the Parsonian concept of the sick role (1951). According to Parsons' theory (1951), who assumed that health professionals are altruistic (Johnson, 2008), one of patients' responsibilities is not to be held responsible for their illness. Jeffery's study (1979), conducted in accident and emergency departments in England, attributed the assignment of negative attributes –such as 'rubbish'– to patients breaking unwritten ideological rules that were strongly linked to the

Parsonian concept of the sick role. He discovered that when patients did not meet this requirement, staff felt they had no moral obligation to treat them.

Even though Jeffery's study was the first to mention obesity in the unpopular patient literature, he did not consider that obese patients could be considered 'good'. Rather, he viewed obesity as a negative trait falling only on the 'rubbish' end because they fell 'on a limbo, with no typical career expected for these patients' (p.97) that they could manipulate and, hence, change their treatment. In my study, though, obese patients could fall into different categories, as discussed further in this chapter. Jeffery further seemed to view the principles he developed about patient classification exhaustive; in a way he supposed that if we use his principles to classify patients, one can make predictions about the way patients would be treated by hospital staff.

The importance of obesity in patients' moral evaluation became more notable when compared to labels assigned to underweight patients. My findings suggest that underweight patients - based on student nurses' subjective assessment described in Section 6.3 - were more likely to be considered popular patients and characterised as 'lovely'. This was also conveyed by their non-verbal communication by sighs and smiles when caring for these patients as well as their considerable willingness to participate in their everyday nursing care. Additionally, student nurses were more likely to have an underweight patient as their 'favourite' and show empathy towards them. In the following extract, it is obvious how Betty favours of a couple of underweight patients:

Betty comments about two patients William and Rose; both of them are underweight. She said that they are both so lovely and cute. The nurse comments that both of them are really lovely. Betty says "wrap them up and take them home". Everyone agrees.  
[Observing Betty, 3rd year student; ward A]

This did not mean, however, that all underweight patients were considered popular; some of them were seen as 'ordinary'. In addition, there was one underweight patient that was considered unpopular in ward C; she was a patient who suffered from severe dementia and refused to eat or drink anything. The reason behind that patient's low popularity was that she was at the verge of dying and a conflict was created among the nurses, doctors and the patient's family regarding the continuation of her care. Other patients with dementia, like the one described by Karin in the extract below,

however, were seen more positively, which can be attributed to his general compliance during moving and handling:

Alan is a lovely patient; however, he suffers from Alzheimer's and he can be very aggressive when his family is not around. He's 'on the light side'. He's very helpful; he lifts his bottom when you change him for example.

[Observing Karin, 3rd year student; ward C]

Obese patients, on the other hand, were more likely to be viewed as non-compliant and assign the trait of being 'demanding':

Alex: What do you mean demanding?

Carol: She'd be like 'oh, you're hurting me' or 'oh, don't do this'. Anything we did, it wasn't just right for her and because she was demanding AND overweight you had to be careful and it took long, as well. Sometimes, it took double the time than it would take for a normal weight patient or one who was cooperating.

[Interview with Carol, 1<sup>st</sup> year student]

Overall, obese patients were more likely to be unpopular patients because of the cultural norms pertaining obesity and the negative characteristics assigned to obese patients. However, in the following section I discuss how the meaning of obesity was socially constructed and the evaluation of obese patients depended on the context of care; rather than individual traits.

### **6.3 Obesity assessment**

Obesity had a collective symbolic meaning to student nurses that reflected their knowledge, beliefs and values and affected obese patients' assessment, moral evaluation and care. I suggest that the meaning of obesity was derived through a negotiation process between student nurses and obese patients rather than certain measurements. My findings further suggest that their perception was heavily influenced by the presence and use of obesity-related documents and the use of Body Mass Index in clinical practice.

In order to comprehend how student nurses formed the meaning of obese person, it would be insightful to look into Goffman's theory (1959) of the symbolic significance of the body. His theory seems to encapsulate how student nurses conceived and assessed obesity. Indeed, in his study of stigma, face-work, embarrassment and social self he implicitly assigned a considerable importance to the body in the process of the construction on one's identity through interaction. He

had a radical view suggesting that the meaning of body of a person is not derived from its possessor but from the interpretation of others of the scene and events that are generated from that person's existence. In other words, a person's body come into existence from the doings of people during their interaction with other people – not through its corporeal existence.

First, I look at the presence and use of obesity-related documents to show that they did not play a key role in obesity assessment.

### **6.3.1 'One of these tasks that were left for the weekends': The presence and use of obesity-related documents**

The presence and lack of use of obesity-related documents conveyed the message that obesity was not an important subject. All wards I researched had two relevant posters; one named 'bariatric equipment provision' and 'Body Mass Index ready reckoner'.

The 'bariatric equipment provision' poster (Appendix 10) was an A3 large, colourful poster that clearly explained the availability and variability of bariatric equipment, which was neatly photographed. The procedure required to order the equipment was also explained in easy-to-follow steps. The 'Body Mass Index reckoner' was a poster of equal dimensions displaying a colourful chart that allowed the reader to determine effortlessly whether a patient is classified as underweight, normal, overweight or obese.

The importance and frequency of use of these documents by students was signified by students' knowledge of their content or even existence. In effect, in all three wards both students and nurses admitted that they ignored the existence of the 'bariatric equipment provision' poster, which they attributed to its lack of relevance to their everyday practice. While the majority agreed that they were unaware of the safe handling load of such equipment, they were required regularly to use it. In one occasion, two 3<sup>rd</sup> year students lifted an obese patient in their effort to move her 'up the bed' because they thought 'she was too heavy' for the hoist. However, any hoist would have been suitable, according to the aforementioned poster as well as the weight indications written on each hoist. Regarding the 'Body Mass Index reckoner' poster, this was utilised in two of three wards I researched but height was not measured; rather, the patient was enquired about it. In other words, the initial

purpose of the obesity-related documents was not fulfilled signposting their importance in the reality of student nurses' practice.

Apart from posters, another source of obesity-related information could be found in certain documents meant to be filled and placed in patients' folders; namely, a nutrition risk assessment screening tool (Appendix 8), a Waterlow pressure ulcer prevention sheet and a manual handling assessment sheet. These documents, among other information, included either patient's weight or BMI. However, my observations show that on all wards height was never measured –even though equipment was available - and weight was measured weekly but not consistently. Patients who were confined to bed were rarely weighed, despite that every ward was equipped with hoists with incorporated scales. Nurses told me that they measured weight only when asked by the doctor; for instance, when a patient had suspected heart failure, kidney failure, was on medication that caused water retention or was underweight in order to monitor nutrition intake. The low prioritisation of BMI measurement is depicted in the interview extracts below:

Alex: Did you also measure their height as well as their weight?

Kath: What do you mean by that?

Alex: Well, in order to calculate BMI you need to know the patients height and weight.

Kath: Yes. Well, we would just ask the patient but sometimes this wasn't accurate because they may shrunk and sometimes when you ask them...we do weigh patients but we don't have something to measure their height. [Interview with Kath, Newly Qualified]

Simon: Never did BMI. I did weigh patients; it tended to be one of these tasks that were left for the weekends and if it wasn't done on the weekends, it wasn't done at all. And I do know that there have been patients that had never been weighed. [Observing Simon, 2<sup>nd</sup> year student; ward A]

According to my findings, weighing patients was seen as a bureaucratic procedure that 'had to be done' but was rarely taken into consideration unless a patient suffered from the above named medical conditions. Nurses seemed to avoid participating in this activity, which was seen as a 'chore'. On the orthopaedic ward weight was measured when a patient was admitted, as part of their pre-anaesthetic assessment:

Amanda (Rhiannon's mentor] asks Rhiannon whether she would like to see how a patient is admitted to the hospital. Rhiannon went with her and explained that "he's having a total knee replacement".



I asked Amanda whether she will measure patient's weight and she told me that the patient's weight is only measured in pre-anaesthetic assessment. [Observing Rhiannon, 1<sup>st</sup> year student; ward A]

Previous studies have proven that self-reported data may not accurately describe the true anthropometric parameters. Sex, age, ethnic group and socioeconomic status are some of the characteristics that lead to underestimating one's weight and BMI and overestimating height. Social desirability is also an important influencing factor (Oliveira et al., 2009; Spencer et al., 2002). For instance, a study by Spencer et al. (2002) compared self-reported with measured height, weight and BMI data from 4808 participants in the Oxford cohort of the European Prospective Investigation into Cancer and Nutrition. They found that both men and women overestimated their height, especially older men and women, shorter men and heavier women. Weight was also underestimated, especially among heavier men and women. This meant that using the standard categories of BMI, two out of ten participants were classified incorrectly based on self-reported height and weight.

It seems that the possibility of malnutrition in obese patients was also overlooked. This was exemplified by the fact that obese patients' nutritional assessment tools were not completed consistently and I spotted several mistakes. For instance, on one occasion, an obese patient was marked as 'underweight' in the nutritional assessment tool. The sister explained that due to time restrictions, these sheets are usually filled by health care assistants on Sundays. The orientation towards underweight patients' care was also seen in that the widely used nutritional assessment tool scored overweight and obese patients as 'lower risk', which means that potential malnourishment could have been overlooked.

On none of the wards did I observe the measurement of Body Mass Index in order to assess whether a patient was obese. As discussed in Chapter Two, BMI is the prime instrument of obesity measure despite its limited accuracy in everyday clinical practice. As already discussed, height was never measured and measuring weight was viewed as a secondary task performed during weekends by unqualified staff or students. This shows the consequence that such measurements had in clinical practice and also suggest that the persistent neglect of this task was perhaps a subtle resistance performed by nurses – and thoroughly supported by student nurses –

against the medicalisation of obesity and its consequent surveillance and attempts to discipline the obese body:

A nurse mentions BMI and they all agree it is very inaccurate measure. For example, said a nurse, if someone has muscles the chart can tell you that they are obese but when *you see* them, they are not. Alice agrees with the nurse saying it's an arbitrary measure but says that obesity has become an epidemic disease the last 10 years. [Observing Alice; 1<sup>st</sup> year student; Ward B]

As far as obesity assessment is concerned, nurses' and students' views as well as my observations suggest that BMI was considered a symbol of medical and/or managerial oppression in that both nurses and students expressed how they were forced to utilise certain measures and related documentation that did not serve their goals and were generally considered inaccurate – rather they served doctors' goals. It could also be linked to the logistics of its implementation; nurses felt that they were imposed to follow another form of documentation without being included in the decision of its implementation. Such feelings of oppression and subsequent resistance have also been expressed towards the tool of nursing process because of the 'top-down approach' to its introduction (Mason and Attree, 1997; p.1046). Student nurses and nurses alike conveyed the message that the knowledge gained from such assessment did not benefit their clinical practice. Further, by neglecting or pushing this form of assessment 'to the back of the queue' –as some students characteristically mentioned – they were able to form a subtle resistance against the goals of medicine. This is an example of nursing going further beyond drawing on biomedical understandings to make their assessments of patients' needs. It was considered another standardised method of categorising patients that did not fulfil the practical aspects of nursing obese patients. Patients were weighed only on admission on the surgical ward, but were not weighed routinely. As Latimer (2000) confirms, the bedside is the actual space of observation 'through which nurses extend their lines of sight to include all aspects of patients- clinical, personal as well as psychosocial. The following extract depicts how nurses perceived their conflicting goals with doctors:

I asked Julie whether they weigh patients to determine their BMI and her mentor interrupted: 'I don't need to weigh patients every week to know that we need two people or more to turn them... and I know which patients need nutritional advice. I don't need a

document to tell me that. We spend a ridiculous amount of time filling out all these forms that make the patients' folders look thick... all to make *them* happy'. She says 'them' and points to a group of physicians doing rounds in the room opposite the nurses' office. Julie nods with agreement.

[Observing Julie, 2<sup>nd</sup> year student; ward C]

As opposed to medicine, nursing is local and specific and this is clearly indicated by BMI. Nurses answer the question 'how do you know that a patient is obese' differently than medicine implies. As seen further in this chapter, their judgement was based on a careful observation of symptoms and facts, such as whether a patient fits on a bed or whether they can lift him/her without the use of hoist. In the following section, I discuss the first criterion that student nurses based patients' obesity evaluation.

### **6.3.2 'It's a visual thing': obesity evaluation according to student nurses**

According to all student nurses I observed and interviewed, obesity had a subjective meaning dependent on one's individual criteria that differ from the clinically recognised obesity assessment measures, such as BMI or waist circumference. This is exemplified in the difference of opinion that students had. It is important to notice that when students used the word 'overweight', they meant 'obese' because they found the term 'obese' insulting.

I ask them whether they could point out which patients they think are obese. As far as red team is concerned, Betty said that Audrey, and Rita are overweight. Susan said that she thinks that Audrey, Rita, Judith, and Aida are overweight. Betty commented that Judith and Aida may look overweight on the charts, but they look fine to her.

[Observing Betty and Susan, both 3<sup>rd</sup> year students; ward A]

When I enquired of students about the reasons behind their categorisation of obese and non-obese patients, most of them suggested that it depends on one's perception of acceptable size. 'Looking too big' and having a 'big belly' are examples of how students described obese patients. Central adiposity was also depicted on the drawings they did to illustrate their obesity conceptualisation. Overall, students agreed that obesity is directly linked to a patient's physical appearance and repeatedly referred to its visibility, as seen in the following extracts from interviews:

Alex: can you tell me what are the factors that determine whether a patient is overweight or not?

John: I think my own factors... I think it's a visual thing...I don't think that it is anything more than that. [Interview with John, Newly qualified]

Alex: So how did you actually determine whether a patient is overweight or underweight?

Carol: For me, it was definitely a visual thing. You could definitely see the folds on their stomach, large arms and large legs, yeah.

Alex: And for the underweight patients?

Carol: Oh, it was nearly 'skin and bones'. Yeah. [Interview with Carol, 1<sup>st</sup> year student]

Overall, my findings show that patients' physical appearance played a central role in students' perception of obesity and the way they assessed it. My study parallels previous nursing studies concerning obese patients in that both nurses and student nurses judged obese individuals through their physical appearance and size (Young and Powell, 1985; Peternelj-Taylor, 1988; Petrich, 2000; Zuzelo and Seminara, 2006; Sardani, 2006). Obese patients' physical appearance was cited as the reason why participants in previous studies felt repulsed, astounded or even evaluated patients more harshly when making a clinical judgement.

Student nurses seemed to be unaware of having a culturally acquired knowledge of what size is considered obese; they justified their position on grounds of 'personal knowing', a subjective way of knowledge that requires self-awareness, a pattern of knowledge that was firstly described by Carper (1978). Indeed, student nurses utilised cognitive, intuitive and experiential knowledge in obesity assessment. Such knowledge was also acquired through having considerable contact with patients' bodies while performing physical care-related activities. Berragan (2002) supports the existence and importance of utilising personal knowing in nursing practice, whether it comes from our experiences, interpersonal relationships or intuition. My participants seemed to refer to this kind of knowledge when describing obesity; they just 'knew' that a patient is obese.

Not only was obese patients' physical appearance immediately perceivable by student nurses, but also their sustained contact with a patient's body, made them more susceptible in taking obesity into account in patient assessment. Most student nurses were aware which patients were considered underweight, normal weight,

overweight and obese, according to BMI – when such information was included in patients' folders - but as already stated chose not to refer to this source of empirical knowledge when making judgements about patient's obesity. All participants stated that patient's body size, as perceived through their personal awareness, was crucial in making assessments about the patients' needs and organising their care.

In the following section I demonstrate how criteria such as a patient's health status, ethnicity, sex and age influenced their evaluation.

### **6.3.3 Building an obese person's identity - health problems, ethnicity, sex and age**

All students agreed that the meaning of obesity is closely linked to the factors of health, ethnicity, sex and age. All students, in effect, agreed that a patient is classified as obese only if that person experiences adverse effects on their health that can be directly linked to their obesity:

Karin tells me that she doesn't believe that the obesity measurements that exist are very accurate; there are many people who may fall in the obese category but are perfectly healthy. [Observing Karin, 3<sup>rd</sup> year student, ward C]

Overweight to me is...obviously when their body mass index is high but it's when it starts affecting their health, I think, you know, such as the wound healing thing. A lot of people, they cannot mobilise because they cannot carry their weight. Even they cannot lift themselves from the bed, breathing... [Interview with Kath, Newly qualified]

Apart from skin integrity, mobilisation and breathing difficulties, other students also mentioned patients' skin and nails' condition, high blood pressure, and diabetes type II. Although students were aware about the multitude of health problems that are linked to obesity, such as different types of cancer, they were more likely to link obesity to breathing and heart problems. Overall, students clarified that a patient's health status was a more important parameter in assessing obesity than a patient's weight, height or waist circumference.

Some students mentioned that patients' health ought to deteriorate to the point that the obese patient is found 'typically in bed' when asked to describe an obese patient. This is linked to the importance of patient's mobility in assessing whether a patient is obese or not; this is discussed in Section 6.3.5. Student nurses claimed that obese

patients stay longer in the hospital and their wounds take longer to heal. Prolonged hospitalisation of severely obese patients was observed in this study. Additionally, it was mentioned that occupational therapists could not help obese patients to mobilise until they lost weight.

Since obesity is defined as impairment to health (National Institute of Clinical Excellence, 2001; British Nutrition Foundation, 2005b) by most major health-related organisations it is not surprising that it was commonly mentioned by students. However, a striking finding of this study is that criteria such as ethnicity, sex and age were brought into conversation by the majority of students.

Regarding age, students mentioned that they have encountered a lot of older people that they could be considered obese in hospital. Students linked the increase of weight to lack of exercise and changes in diet when one grows older. Interestingly, many of them agreed that 'it is ok for older people to be overweight'. This gives clues about the different expectations that student nurses have from their patients and how a patient's age can influence their attitudes and the care they provide. As discussed further in this chapter, this may also mean that older patients may be required to contribute less in their care management and, hence influence student nurses' expectations:

Susan said that Ethel, Mary, Beatrice and Claire are overweight. Betty agreed; though, she said 'again, they might look overweight but in their age it is ok'. I asked her what she means by that. She replied that after a certain age, it doesn't matter. She added 'you expect them to look like that' [Observing Susan and Betty, both 3<sup>rd</sup> year students; ward A]

We go outside to the next women's room; Simon is still whispering; the patients on the right hand side of the room are 'normal for their age'. He adds 'you expect them to be a bit overweight because of their age'. [Observing Simon, 2<sup>nd</sup> year student; ward A]

Well, most older people tend to put on a little bit of weight when they get older, so I suppose you allow a little bit more for older people than I suppose for younger people. People tend to put more weight as they get older. Young people are more active. [Interview with Kath, Newly qualified]

Student nurses may favour excess weight in older individuals because they have associated weight loss with chronic disease or illness; being underweight increases the risk of death in elderly individuals (Haslam, 2008). Therefore, when an elderly patient was overweight or obese they viewed it as a sign of health and wellness.

There is research, in effect, that supports that being overweight or obese for patients older than 70 years does not increase patients' morbidity. A research conducted by Flegal et al. (2005) revealed that obesity (BMI equal or greater than 30) was associated with greater risk of dying for patients younger than 70 years, whereas the relative risks were lower for patients older than 70 years. They also discovered that being overweight (BMI: 25-30) was associated with a slight reduction in mortality compared to being normal weight.

Conversely, there is currently division in opinions regarding the benefit of being overweight in older age. There is a movement that argues that weight loss would benefit older generations. The prevalence of obesity reaches a maximum between the ages of 60 and 70 in both men and women, declining in older age-groups (Haslam and James, 2005). The changes in body composition including loss of muscle, which occur with ageing, mean that overweight and obese elderly persons possess more fat (Haslam, 2008). Another significant issue is that fat is usually distributed centrally in elderly persons, increasing their cardio metabolic risk (Haslam, 2008).

Regarding sex, I noticed a difference of perceptions regarding student nurses' visualisation of the obese body; most students visualised this as being a woman, but there were a few who visualised an obese male person. It should be noted that women are generally found to have higher rates of obesity than men for biological reasons (James et al., 2004). On the other hand, this could reflect the cultural idea that obesity is less acceptable in women and, hence, imply that obese female patients are less socially acceptable than male:

When talking about which patients are overweight, Betty said yesterday about Mary (B3) 'I've seen her; she's really big 'down there' (she pointed at her hips) like most women' [Observing Betty; 3rd year student; Ward A]

I have to say that it is rare to see older obese women...It is strange but every time I visualise an obese patient it tends to be always male. I don't know... [Interview with John, Newly Qualified]

Finally, one student mentioned that having a Welsh nationality influences one's body shape and size. On hinting, she mentioned examples of patients that were Welsh and looked 'overweight' because of their body structure. It should also be mentioned that this student was Welsh and obese. Currently, there is no literature exploring Welsh women's perspective on weight; however, there seems to be fertile ground for researching the link between their perceptions and the increasing rates of obesity in Wales:

'Hannah is 83 years old. She transfers very well. She needs minimal assistance. She's a Welsh lady'. Karin tells me that 'Hannah has a similar body as hers'. [Observing Karin; 3rd year student; ward C]

Overall, the plethora of criteria utilised by students to construct the identity of an obese patient indicate that student nurses have certain expectations from patients before their arrival on the ward. The following section discusses students' expectations of obese patients after their arrival and, hence, plays a crucial part in obese patients' assessment.

#### **6.3.4 Manual handling needs**

In this section, I suggest that the construction of the identity of a patient as obese or not also depended on specific events during his/her care and how these events were interpreted by students.

When a patient's size reached a point that special equipment needed to be ordered, students assumed that there was a mutual cultural understanding regarding the status of obesity of a patient's body. In both instances, both patients' obesity was not contested because the combination of their size, weight and *perceived* mobility meant that equipment needed to be used at all times:

We go to the next room. They both agree that Hillary is obese. 'Well, I don't have to tell you about her' says Susan. [Observing Betty and Susan, 3<sup>rd</sup> year students, ward A]

Before he tells me that she's morbidly obese, he notes 'I don't have to tell you about that, do I?' [Observing Simon, 2<sup>nd</sup> year student, ward A]



Indeed, student nurses had to make instant judgements every day that evolved around the interpretation of a person's status as obese. Apart from the use of equipment, fitting the patient on the equipment influenced the process of categorisation. If the patient cannot fit on the equipment, then the status of that person's obesity was considered 'common knowledge':

So, when I say that I assume there are bariatric chairs and I assume there are bariatric hoists and beds but I have never used one. So, I only make that call; right, I look at you and think 'will you fit on that hoist?' But if someone is a lot bigger than you, then I'll use the full hoist.

[Interview with George, Newly qualified]

On the other hand, patients classified as obese, according to BMI, who were able to contribute during moving and handling were seen positively and were not put in the 'obese' category. This is exemplified in the following extract from my field notes:

Stacy is doing the back rounds. Daisy (obese), in the parlour, asked Stacy to put her into bed. I asked Stacy if she needs any help to move Daisy. She told me that Daisy may be fragile but she's capable to move with encouragement.

[Observing Stacy; 1st year student; ward C]

An explanation of this phenomenon can be found in Strauss et al.'s study (1985), according to which patients in hospitals are expected to work and their reputation on the ward is dependent on their cooperation, obedience and successful negotiation about the division of labour with health care professionals. Strauss et al. (1985) conducted a four-year study of extensive observation and interviewing utilising a grounded-theory approach that explored the work conducted in hospitals, in general, but also included an essay on how patients are expected to perform physical and sentimental work. Patients who did not follow responsibilities assigned to their role came into conflict with health care professionals; the researchers also noticed that staff utilised disempowering acts to combat patients' defiance of their authority.

Strauss et al. (1985) suggested that the trajectory of patients' labour begins before the patient goes to hospital and continues when the patient goes home. For instance, a recently diagnosed patient with diabetes type II must learn to inject themselves and continue his routine treatment at home. In my study, when obese patients were inflicted with some impairment that limited the range of work they were able to

contribute they were more likely to be classified as obese. As seen from the following extract, patients' ability to move and, hence, contribute to physical labour, played an instrumental role in deciding whether a patient was considered obese.

I ask her whether she could tell me which patients she thinks are normal or overweight. She says that Muriel is 'slightly overweight. 'Gareth is able to move; there is no problem'. Louise agrees with Rhiannon. [Observing Rhiannon and Louise; 3rd year and 1st year students respectively; ward A]

The patients' physical effort to assist in their own care was highly regarded by students conveying that they expected some sort of social exchange to the services they provided on the ward. Because obese patients' care was considered physically exhausting, my participants highly regarded the patient's ability and/or willingness to assist. My participants viewed the assistance that patients provided as their duty because their perception of care was regarded a collaboration between nurse and patient. According to Weber (1976), who was an attentive student of the Protestant Ethic, the term 'duty' refers to 'an obligation which the individual is supposed to feel and does feel towards the content of his professional activity, no matter in what it consists, in particular no matter whether it appears on the surface as an utilisation of his personal powers or only of his material possessions' (Weber, 1976; p.54). Assigning duties to a patient means that a patient is required to perform some form of work, not in the sense of paid employment but engage in activities, such as lifting their bottom during moving and handling. Following Weber's definition, the patient has some control over their obesity assessment.

Even though student nurses and nursing staff seemed to be the prime constructors of the meaning of obesity, patients also had an opportunity to negotiate their assessment by the amount of control they had over their body and their willingness to assist during moving and handling. Patients were judged on the basis of their willingness to work; some patients, like Muriel, had a bad reputation of not helping out; hence, she was classified as 'big'. Gareth, on the other hand, had a higher Body Mass Index than Muriel but offering his cooperation meant that students viewed him as 'no problem'.

Johnson (1997) reported having similar findings in that patients who conducted some form of 'work' as a contribution and compensation towards their care, generally

experienced less negative judgement from staff. He approached radically the issue of patient categorisation in nursing practice by challenging the common conception of labelling. His study, initially aimed at exploring the 'big moral questions' in nursing, uncovered that patients' traits and stereotypes did not coincide with patients' popularity. Indeed, his findings suggest that patients' popularity varied from nurse to nurse and was dependent on the context of care, which could change over time and under different conditions (Johnson and Webb, 1995). Johnson named the process, according to which patients are categorised and given labels 'social judgement'. In effect, he discovered that judgemental labelling was a key component of nurses' maintenance of occupational power.

Another contribution of Johnson was that he viewed patients as having equally crucial participation in the process of social judgement, depending on how much effort they displayed in their daily care – a finding similar to this study. By utilising Strauss et al.'s (1982) and Hochschild's (1983) theories of physical and emotional labour respectively, he suggested that patients are constantly assessed and evaluated as to how much they contribute in assisting nurses in their care. According to Johnson (1997), if patients carry out the work they are assigned to, they gain some control over their social relations with staff; while patients who are viewed as 'unwilling to work', they are more likely to be viewed unfavourably. In other words, patients have the power to negotiate their popularity if they fulfil the nurses' expectations and can participate actively in the social construction of their labelling, for instance, by lifting their bottom during morning hygiene or by not showing their grief regarding a grim diagnosis. He warned that some experienced patients who valued nurses' views about them were willing to experience considerable physical or emotional discomfort to gain their approval. My observations show that obese patients with limited mobility shared similar experiences –whereby they had to suffer physical and/or emotional discomfort - because they did not have the ability to contribute through physically assisting during their care.

Obese bedridden patients did not have substantial power to negotiate evaluative labels. Indeed, obese patients were disadvantaged in relation to other patients because they caused so much physical and emotional labour to nurses and student nurses alike. Due to their weight, they could rarely prove to be of much assistance

during moving and handling. Further, due to the persisting stigma surrounding obesity, student nurses viewed obese patients as 'unable to meet their needs'.

Johnson (1997) mentions that 'people who have had strokes tend to be unpopular because a lot of people who have had strokes, generalising, are very big and difficult to turn and they are usually, often, incontinent' (Johnson and Webb, 1995; p.84). Further, it is mentioned that a 'heavy' patient may be considered unpopular during moving and handling, but when the physical aspect of his/her care was finished, nurses evaluated each patient according to their personal interaction with him/her (Johnson, 1997). This means that patients' assessment was highly dependent on nurse-patient interaction rather than their 'heaviness'.

Overall, the meaning of obesity was associated with stereotypes and stigmatising attributes but in clinical practice, the social construction and interpretation of obesity was highly dependent on student nurses' personal knowledge of caring for obese patients and obese patients' contribution to their caring. Gaps in their theoretical knowledge of obesity facilitated the persistence of societal and cultural beliefs and assignment of negative traits to obese patients' personality. Nevertheless, obese patients had some control –albeit limited- over the obesity assessment depending on their effort, ability and/or willingness to assist in their care.

In the following section, I discuss the contextual factors that influenced the care that student nurses offered to obese patients.

#### **6.4 Professional and organisational constraints**

A wealth of professional and organisational constraints played a key role in the formation of student nurses' perceptions regarding obese patients and the care that they offered to obese patients.

My findings suggest that student nurses were influenced by nurses' attitudes towards obese patients and their care; which I describe in terms of student nurses' professional socialisation. My participants exhibited behaviours which pinpointed the gradual internalisation of registered nurses' values and norms. Further, covert rules and their desire to fit in with the ward culture dictated student nurses' practice and influenced the quality of care student nurses offered. Lastly, I discuss the

implications of shortages of resources – in terms of human resources and equipment – on the care provided to obese patients, which were identified on all three wards.

Firstly, I discuss how student nurses could have been influenced by nurses' attitudes towards obese patients.

#### **6.4.1 Professional socialisation**

Professional socialisation has been characterised as 'the process through which new comers are instructed in the ways and attitudes of the organisation and gradually adopt the attitudes, values and unspoken messages within the organisation' (Mooney, 2007; p.75). The effect that qualified nurses have on student nurses' attitudes, the learning process and emotional stress have been documented in studies dating as early as the 60s (Menzies, 1960; Melia, 1987). More recent research confirms that qualified nurses are viewed as role models for nursing students to the point that nursing students are more likely to adopt attitudes and practices they observe in the clinical setting and disregard theoretical knowledge they were taught in the classroom (Henderson, 2002).

Even though I did not enquire or formally interview qualified nurses, since it was beyond the scope of this study, I gained a considerable insight regarding their attitudes towards obese patients and their care through participant observation. Additionally, I enquired of my participants about their observations and experiences interacting with nurses and other staff. Overall, the majority of nurses expressed negative attitudes towards obese patients and their care and all student nurses were aware of them, as depicted in the extract below:

They complained that they are very big. 'We'll leave them for today; we won't wash them because they are too heavy'. So, their care was put at the back, really. They're not as important...you know...the nursing attitudes are that they are not as important as normal weight patients...you know, because it's their fault for getting fat in the first place. [Interview with Susan, 3<sup>rd</sup> year student]

An invaluable source of information regarding nurses' attitudes towards obese patients and their care was the handover report. Not only was the handover report a discussion of patients' progress but also an opportunity to pass judgment on patients. On wards A and C, nurses utilised the handover report to pass social judgement on patients they viewed negatively, while also channelling their frustration. On ward B,

however, the handover report was more functional, which could partly be explained on that it was routinely audiotaped. The purpose of audio taping was so that the nurse of the previous shift could leave earlier. Nevertheless, when the tape came to an end, judgmental comments were often expressed. It must be noted that obese patients were not the only patients that were socially judged; however, the majority were viewed as highly unpopular. Indeed, obese patients were often viewed as 'demanding', a term that implied negative evaluation rather than complexity of needs. Another negative characterisation of patients was the mentioning of 'social problems'. The following extracts are verbatim reports from handover reports I observed:

Margaret. (This patient was in a cubicle but they decided to remove her from there because 'otherwise she would never agree to go to a nursing home'. Nurses commented 'moving her to a room with six beds will make her agree to go to a two-bed room that is presently available in the nursing home'. A nurse commented that she pities the patient who will be in the same room with her). She has 'social problems'. She agreed to go to a double room. She's a difficult patient. She shouted 'nurse' for 20 minutes and went to sleep.  
[Extract from field notes; handover report; ward A]

Muriel Knight came with a chronic chest. 'She has confusion'. She is coughing mucus. She's very demanding. She has nasal specs continuously. Her PAS score was 4; she was tachycardic. She settled after she had the nebuliser. She asked to put her fan on and off; 'pull me a drink' (the nurse makes an impersonation of the patient trying to convey that Muriel is demanding). She comments 'she's been a nightmare'. She has infected sputum and a humongous chest.  
[Extract from field notes; handover report; ward C]

Student nurses seemed to adopt the opinions expressed in the handover report. The role of the handover report in the moral evaluation of patients has been identified by Goffman (1961), who considered that nurses amplified patients' behaviour and exaggerated their symptoms and actions. Decades later, studies such as Williams' (2007), who studied the nurse-patient interaction in an Intensive Care Unit, identified the handover report as one of two factors that have considerable influence on the process of a patient becoming 'unpopular'. She suggested that nurses' verbal and non-verbal communication reinforces attitudes about patients and can influence nurses' views of patients before they have ever met. In the following extract notice

how Betty, a third year student, attempted to convince me that Margaret, mentioned in the handover extracts above, is a 'bad' patient:

Margaret, the patient in the cubicle asked for her help. She explains to me that Margaret can be very demanding. She feels lonely in the cubicle and therefore she's one of those patients who constantly ask for things. She told me that happen perhaps because this is how she's used to at home with her two daughters but this cannot happen in the hospital. She tells me that when she started the placement she didn't know about it so she spent more than two hours in the patient's room trying to please her requests. She told me she washed her, she cleaned her watch, she cleaned everything. She tells me that when you go to check on her she's always complaining she's sitting on 'poo' but she's clean. [Observing Betty; 3rd year student; ward A]

In contrast, nurses usually expressed positive attitudes towards underweight patients, which are mirrored in the handover extracts below. Nurses often expressed sympathy, concern and favouritism towards underweight patients; not only during the handover but also in terms of prioritisation in daily routines:

Then, we have our little Rosalie. In the middle of the night she told me (impersonating her) 'I want to pee', so I brought her the bed pan. The nurses smile. [Handover report, ward C]

Ken; he's not eating anything. A nurse says 'the other day he told me that it's his time to go' (suggesting that the patient has no will to live anymore). Betty says 'I'm trying to encourage him with high protein soup'. Another nurse says 'he does want to go' (nurses and students have sad, thoughtful faces and there is a pause in the handover). [Handover report, ward A, Observing Betty, 3rd year student]

When I enquired of students to reflect on nurses' attitudes towards patients of different weight all of them replied that they observed some form of obesity stigmatisation and sometimes discrimination; most students replied that patients' mobility played a key role in how patients were regarded. Stacy portrayed how nurses followed different practices when caring for obese as opposed to underweight patients when they required to be moved, while Kath explained that basic nursing care and manual handling were key aspects of obese patients' judgemental treatment on the ward. Further, Lucy provided an example of a practice I often observed on all three wards:

But you could hear them saying (she makes an impersonation and her face becomes grim) 'oh, she does my head in...oh, I'm tired...oh, what does she want now?' but if someone was small they would be like (She makes an impersonation and she talks in an upbeat way smiling and raising her voice) 'oh, she's so tiny...oh, come on, let's do it, let's just take her'. So, there was a different attitude depending on the weight of the patient. [Interview with Stacy, 1<sup>st</sup> year student]

I heard sort of people, especially doctors say things like you're too big to have surgery, you need to lose weight and things like that... especially like auxiliary nurses who have to do more personal care with the patient, I find them more judgemental because they probably look at the patient like more work for them again because they do need more help and assistance. But yeah, there are a lot of judgemental people; they call them names; not to their faces but... [Interview with Kath, Newly Qualified]

Sometimes if they wanted to go to the toilet and they were a bit mobile and obese, they would give them a bedpan instead to make it easier. [Interview with Lucy, 1<sup>st</sup> year student]

My observations further suggest that nurses attached negative attributes to obese patients and generally considered them 'unpopular'. In effect, nurses often used the nurses' office to vent their frustration. The first extract shows that the nurse named Stephanie was aware that her comment was inappropriate but was still eager to share her views with the rest of the team. In the second extract, the health care assistant could have been overheard by patients; the public context in which the comment was made increases the derogatory meaning implied in it.

We sit in the staff room and Stephanie (Karin's mentor) comes rushing in the room. Stephanie comments on a patient 'she should lose some weight before she speaks or asks for anything'. She looks at me and says 'I shouldn't be saying this in front of you'. I assure her that she'll be anonymous. She complains about an obese patient from the other team who is asking for things all the time. She tells me that research is needed about Hospital Acquired Immobility rather than Hospital Acquired Disease. She tells me that personally she encourages patients to do more but patients come to the hospital and they become lazy. [Observing Karin, 3rd year student; ward C]

An auxiliary, Brenda, asked the staff to help her with Paul (morbidly obese patient). She says loud 'he has had a baby girl' implying that he needed changing. Three members of staff went to Paul's room and drew the curtains. [Extract from field notes, ward C]



Nurses' negativity towards obese patients' care, however, can be partly explained by their limited knowledge regarding how to care for bigger patients. I observed several instances whereby nurses were unsure about the type or size of attachment they ought to use on a hoist. Further, there were many instances when moving and handling an obese patient was conducted with a culmination of improvisations rather than a set of rules. John, a newly qualified nurse, explained that his reluctance towards obese patients was driven by his fear that his confessed inaptitude to care for bigger patients will potentially be discovered:

It's embarrassing to say to your colleagues especially as a qualified nurse when you're working with the health care support worker or a student... to say 'oh, I'm not sure', you know. [Interview with John; Newly Qualified]

Students reported instances when nurses made unfavourable comments about a patient's weight, size or physical appearance in front of the patient. The first extract is from Susan's interview, a student who admitted having stigmatising beliefs about obesity. It seems that she was quite ambivalent about the appropriateness of comments regarding a patient's weight and physical appearance. However, she also implies that nurses' attitudes had a positive effect on the patient because they convinced her losing weight:

Alex: Were they doing that in front of the patient?

Susan: No, they weren't doing that in front of the patient but then again, whenever we were turning a patient...one qualified nurse said about Hillary for instance, 'oh, she's really heavy' to me and 'Hillary you need to lose some weight' and they forget that the patient can hear and they can hear what's going on and they get quite embarrassed about it. When you're turning the patient, the nurse would say 'I can't turn her, she's too fat, she's too heavy. Look at her. I cannot lift off her leg, her legs are too big' and Hillary got quite complexed and that's when she lost all that weight.

[Interview with Susan, 3rd year student]

Alex: Can you tell me about things that you observed...what attitudes towards obese patients do you think exist in the clinical area?

Stacy: Ahm...I think that people can't be bothered, because it takes too much time and there is a lot more effort and you hear people say nasty comments and say 'they're fat' or whatever and it

shouldn't be that way, anyway. They are spiteful, I think.  
[Interview with Stacy, 1<sup>st</sup> year student]

Indeed, the response of student nurses to attitudes they observed towards obese patients was quite varied. However, I noticed that it followed a certain pattern; students with less years of clinical experience were more judgemental towards nurses' comments even when they were made in the privacy of nurses' office. On the other hand, students approaching the end of their studies or those with extensive experience as health care assistants were more likely to be less critical of the attitudes they observed. In any case none of the students challenged nurses for comments or behaviour witnessed, which suggests how disempowered students may feel. Interestingly, previous research on student nurses' perception of empowerment highlighted that silent acquiescence and witnessing poor practice has detrimental effects on students' self-worth, efficacy and emotional being (Bradbury-Jones et al., 2007). Stacy, a first year student with no previous experience became rather upset during the interview while reflecting on attitudes she observed on the ward. On the other hand, Carol, who had several years of experience as a health care assistant, and Simon, who was at the verge of completing the second year of his studies, reported that they were immune, as indicated in the following extracts:

Alex: But, how did that make you feel? These comments...

Carol: Well, I didn't really think about it. Everyone is entitled to their own opinions but it's really the practice. You can think what you like but you have to do your job properly. If the patient wants to go to the toilet and they are mobile, you'd better take them.  
[Interview with Carol, 1<sup>st</sup> year student]

Alex: You said that you've seen a lot of staff say negative comments about overweight patients...can you tell me more about that?

Simon: As a student and as a staff nurse.

Alex: How did that make you feel?

Simon: It probably didn't shock me. It almost seemed to me like a statement of fact; whether it was appropriate or not... 'Oh, God! Did you see Bob? He's eating four bars of chocolate. How can he do that? He's so fat!' [Observing Simon, 2<sup>nd</sup> year student, ward A]

Even though I initially became critical of negative comments expressed by nurses and other staff in the nurses' office, on reflection nurses used the nurses' office as a therapy room where they were able to channel their frustrations and anxieties in order to cope with the demands of patients' care. More than fifty years ago, Menzies

(1960) described how nurses were encouraged to repress their feelings on the ward as a way of dealing with emotional stress and suggested that this coping mechanism against stress was unsuccessful. Lawler (1991) also put emphasis on the suppression and control of emotions within nursing, which is deeply rooted in British cultural traditions. However, my observations show that nurses were overtly expressing their feelings in the safety provided by the ward managers in the nursing office. I suggest that in all three wards the sisters had transformed the nurses' office into an environment where nurses and other staff could express themselves freely without being reprimanded. Even though it was not openly discussed, there was an implied effort of preventing nurses feeling emotional exhaustion closely linked to the emotional labour they experienced nursing patients they considered difficult. This could be partly justified by Benner (2000), who recognised that 'emotions allow the person to be engaged or involved in the situation', while detachment may 'cut the person off from being involved in the situation in a complete way'. Indeed, nurses seemed to acknowledge that the emotional cost of caring is considerable and somehow they provided emotional support to each other and accepted that externalisation of their negativity away from patients' bedside made them better nurses.

However, students who had started their clinical training failed to comprehend this function of the nursing office and felt frustration towards nurses, whom they expected to act as role models. Other students expressed their concerns that one day their humanistic values would be annihilated. Other studies have also found that student nurses often witnessed negative attitudes of nurses not only towards patients but also students (Davies, 1993; Rushton, 1986; Percy and Elliott, 2004). The participants in these studies were often surprised by the amount of negativity expressed by nurses, which made students feel undervalued and lacking positive role models. Percy and Elliott (2004), for instance, interviewed student nurses about their impressions of clinical nursing and found that they felt disappointment and fear that their initial keenness and enthusiasm would be drained out of them and they would lose their ideals that made them go into nursing. Indeed, Greenwood (1993) has defined professional socialisation in nursing as a process that 'tended to lead to an apparent and relative desensitisation of some student nurses to human need' (1993, p.1471). Mackintosh (2006), however, in her study of the concept of caring in

relation to socialisation of student nurses found that personal disillusionment with care and the nurse's role as a carer, which resulted in emotional hardening, was considered a good outcome. Nevertheless, participants in her study expressed their desire to maintain what she calls a 'caring ethos' in the future.

#### **6.4.2 'I tend to go the way they do': Fitting in with the ward culture and adherence to covert rules**

The combination of covert rules and fitting in with the ward culture decisively affected the reality of nursing an obese patient; student nurses repeatedly mentioned examples of their practice whereby they did not provide a standard of care they deemed appropriate because of these constraints, which limited their role in obese patients' care.

In the following extract, Julie, a second year student, was obliged to neglect an obese patient's care because she was asked to. This extract shows the pressure that student nurses feel, which makes them prioritise fitting in with the ward culture as opposed to patients' wellbeing:

A patient buzzed. We went to the room; it's Brenda. Julie says 'hello darling, what can I do for you?' and Brenda said 'I'm dying to go to the toilet'. I closed the curtains and Julie brought the commode. An auxiliary, Joanna, came and asked if we need help to call her and left the room. Julie helped the patient to sit on the bed but noticed that the patient was already wet. Julie asked me if I can find some knickers in the patient's cabinet. Brenda said 'I don't know how this happened' and Julie said 'it's ok and left the room'. I waited for Julie to return but she didn't. I went to the reception room and asked if they've seen Julie. A nurse told me 'she's probably in the pharmacy'. I told them about Brenda and they told me not to worry; Joanna will go when she finishes what she's doing now.

[Observing Julie, 2nd year student; ward C]

The barrier of covert rules to the development of student nurses' practice has been cited in several studies in the past (Melia, 1987; Maben et al., 2006; Attree et al., 2008). The seminal work of Melia (1987) explored how student nurses disregarded theoretical knowledge in order to follow unspoken rules set in practice. These unspoken rules aim at speed and efficiency achieved through task-orientation. In her study, students felt pressured to be fast when completing tasks, to follow orders unquestionably, to cover their emotions by 'pulling their weight' and to look busy

even when they completed their allocated tasks (Melia, 1987). Efforts have been made by the United Kingdom Central Council to eradicate the pressure of following such rules through educational reforms that were introduced under the name of 'Project 2000'. Despite changes in Nurse Education, the majority of my participants expressed the idea that they consistently felt the pressure of following these rules; Stacy, a 1<sup>st</sup> year student, remembered vividly such an example.

Alex: Do you think that you are able to use a hoist?

Stacy: I know that is good practice and I know that it should be done but then I know that the staff say 'no, we're going to do it this way'. It's quicker, it's easier, it's easier...yes, it's more strain on you BUT tough... 'This is the way we do it and this is the way we've always done it'.

Alex: How do you feel about that?

Stacy: Ahm...

Alex: Honestly...

Stacy: It's very awkward because it's easier to go with the flow and just do it but then I think in the future the consequences of that is bad backs and I am the one doing it and I am going to be in trouble because of it. There aren't enough staff to do it.

Alex: I see... Can you tell me...just a second...ahm... Is it the fact you want to fit in influencing your practice? You know, to fit in the team...the nursing team... does it influence the way you practice nursing?

Stacy: Of course, yes, absolutely. I tend to go the way they do. I tend to go with what they do. Ahm... You know, I suggested using the hoist a couple of times and being brushed off. They said 'no need to, we'll be fine'. [Interview with Stacy, 1<sup>st</sup> year student]

Previous studies have also raised concerns that such rules still govern nursing practice (Jasper, 1996; Daiski, 2004; Ousey, 2007; Attree et al., 2008). A more recent longitudinal study that utilised both questionnaires and in-depth interviews of nursing students before and after getting their nursing qualification, found that 'covert rules' represented a major aspect of student nurses' professional socialisation (Maben et al., 2006). Their participants mentioned as of utmost importance the following rules: provision of fast physical care, forbiddance of in-depth interaction with patients and abiding with existing practices. One of their participants characteristically mentioned that 'nurses don't have time to care' (Maben et al., 2006; p.469). Attree et al.'s study (2008) found that patients' safety in clinical practice was often compromised but not reported because of such rules. Their qualitative study, which included focus groups of student nurses (n=15), found that

students' desire to fit it with the ward culture meant that they did not challenge unsafe practices they witnessed, which made some students feel guilty (Attree et al., 2008). Interestingly, students' educators and key stakeholders also perceived that the culture that student nurses practise in is 'defensive, concealing and blaming' (Attree et al., 2008; p.245).

An explanation behind such hidden rules that influence negatively student nurses' practice is that nursing displays characteristics of behaviour of an oppressed group; not daring to overthrow power coming from higher hierarchical positions, they employ horizontal violence – and employ disempowering strategies against other nurses, student nurses or even patients who traditionally belong lower in the hospital hierarchy ladder (Roberts, 1983). A qualitative study looking into such disempowering patterns in nursing, found that student nurses are aware that such form of oppression exists which was commented as 'nurses eating their young' to convey the powerful message (Daiski, 2004).

Previous research regarding adherence to existing moving and handling practices parallel the findings of this study. In a small study looking at what factors influence student nurses when handling patients, half of students responded that they would agree to lift a patient in order to avoid being viewed negatively from the nurses on the ward despite their knowledge, skills and confidence acquired during training (Kane and Parahoo, 1994). In a different study, student nurses reported that nurses were the main influence, followed by the pressure of time and lack of equipment (Swain et al., 2003). A theme that arose in Mitchell et al.'s action research study (2005) was that peer pressure was a detrimental factor for less experienced trained nurses in their decision to participate in condemned lifting techniques. Kneafsey (2000) also referred to the effects of professional socialisation, as described by Melia (1987) when discussing students' poor compliance to safe M&H practices. As Melia (1987) discovered nearly 25 years ago, students would follow the unwritten rules on the ward in order to fit in and avoid repercussions. When there was pressure of time, the occurrence of these incidents was more frequent. It was suggested that senior nurses ought to supervise and enforce safe M&H so that junior nurses would feel less peer pressure (Mitchell et al., 2005).

Student nurses also felt the impact of shortages of resources in the care they offered to obese patients, which is discussed in the following section.

### **6.4.3 Shortages of resources**

There are two different types of resources that emerged from my analysis; first, human resources and, secondly, equipment.

All student nurses expressed that the wards were understaffed; they repeatedly stated that their position on the ward was particularly valuable because they were able to relieve nurses from some of the burden of work. Student nurses and nurses alike justified the way that care was organised on all three wards by referring to staffing levels, which prohibited the feasibility of alternative ways of care organisation. Staff shortages have been identified in the past and recognised by the National Health Service (NHS), which has been linked to problems in recruiting and retaining nurses (Finlayson, 2002). This means that nursing staff has increased workloads and need to care for more acutely ill patients with fewer staff (Meadows et al., 2000).

On the other hand, all sisters reported that they met the official figures of having two qualified nurses and two health care assistants in the morning shift, while during the afternoon and evening shift there was one qualified nurse and two health care assistants. This confirms previous research about the dissonance in opinion regarding staff shortages between registered nurses and hospital executives; an extensive survey reported that the majority of nurses (82%) perceived a serious shortage, while a third of hospital executives perceived that there was no such shortage (Buerhaus et al., 2007).

Indeed, my observations showed that the numbers did not suffice to complete the tasks as dictated by nursing routines when there were obese patients with mobility issues on the ward – which was actually the norm. As discussed in Chapter Two, obese patients with mobility issues require twice as much time and staff members for their care as well as raising greater safety concerns than non-obese patients (Rose et al., 2006). Another study looking into the challenges of nursing obese patients found that only 39% of nurses in hospital settings regarded that they had sufficient staff to look after obese patients (Drake et al., 2008). A more recent study (Kam and Taylor, 2010) specifically noted that mobilisation and positioning of obese patients required

more staff than currently available, which increased the risk of injury to staff while moving and handling.

This meant that student nurses often waived their supernumerary status, which they viewed as a natural consequence of being in clinical practice. As viewed from the following extract, students felt that the immense pressure of time, which was associated with staff shortages, was a restrictive factor which often led them to decisions compromising both obese patients' care as well as their own safety:

I would say that in the best of all possible worlds yeah everybody would be using all the equipment all the time in the correct way but the way it is, the equipment isn't always there, the time pressure is immense and people do things because otherwise you're leaving people for a long time in very uncomfortable position. I mean you have to be realistic, in my opinion. What's the alternative? That's the issue! And most people I observed they're doing things for the right reasons. I've seen things happen but I'm not saying...it's not all the time but you know that the nature of the work is that you do see people that lift people sometimes, you know, you do see people move people without slide sheets but they're doing it because they have to. [Interview with George, Newly Qualified]

John, a newly qualified nurse explains accurately the implications that time pressures and staff shortages imposed on obese patients' popularity on the ward. Obese patients with mobility issues were given the derogative, impersonal characterisation of 'double handlers' with regard to their increased moving and handling needs. This characterisation, which is infused with negativity, reduced patients to a fragment of their identity and revealed issues regarding time pressures and staff shortages. In a practice governed by task orientation, an obese patient with limited mobility symbolised a threat to a student's or a nurse's social status on the ward because their presence meant that they would often require the assistance of already busy staff pushing student nurses into an uncomfortably awkward position. It is not surprising that the thought of caring for a patient that requires the assistance of more than one could resurface such negativity, which students and staff alike tried to channel through the use of derogatory expressions like 'double handlers':

'Oh, John can go to that big one, to that double handler'. We call them 'double handlers'. You have patients who are self-caring, patients who need assistance of one and what they call 'double handlers'.

[Interview with John, Newly qualified]



A recent study by Curtis et al. (2012) further explained that staff shortages affected the quality of care student nurses offered to patients. They utilised a grounded-theory approach interviewing students and their teachers and analysing data from National Health Service (NHS) patients and staff to discover the contextual constraints that prevent student nurses from engaging in compassionate nursing in practice. Students reported experiencing a limitation on the time that they could devote to each patient, which was translated into less communication and prevented the flourishing of compassion. The same study found that over a third of patients also expressed the view that there were not always enough nurses on duty to be able to cover their social and emotional needs (Curtis et al., 2012). As with my study, students expressed that the limitations of practice, closely associated with resources shortages, are further related to financial impediments in both health care and education:

Alex: Now, as far as obesity is concerned, what do you think nursing education needs to deal with it?

Stacy: More money...specifically on weight...specifically on weight because apparently people are getting more and more overweight and youngsters are growing up to be overweight. That needs to be dealt with. And if you could prevent it, then it's wonderful. But you can't prevent everything, so you should be trained and be able to deal with it...and have the equipment and the time and the resources to be able to do it...it's money...it all comes back to money, all the time. [Interview with Stacy, 1<sup>st</sup> year student]

Apart from human resources, equipment was also considered an issue for student nurses, who felt that there was lack of sufficient equipment as well as adequate training for its effective use.

Yes, well, if nurses had more training perhaps they would be more sympathetic and if there was more equipment available perhaps they would be more sympathetic towards obese patients. [Interview with Susan, 3<sup>rd</sup> year student]

Apart from issues regarding availability of equipment, there were also issues linked to its storage and physical space to utilise them efficiently. Further, despite a good system of communication with the M&H advisor for the Trust, who would arrange to visit the ward and help with any unresolved issues, the nursing staff was unhappy about the amount and quality of guidance they received. Before a bariatric patient arrived on ward C, arrangements were made and the patient was provided with a

special extra-wide bed and 'orange' extra-wide sheets were also available. Interestingly, the patient suffered from a highly contagious infection (MRSA) but was not put in isolation because his bed did not fit in the cubicle.

Overall, availability of equipment could have potentially become an issue if all staff regularly used mechanical aids, since on ward A, for instance, there were only three hoists available, only one of them was a standing hoist. Indeed, at least 20 out of 32 patients were in need of M&H that required the use of a hoist. Further, there were issues regarding the storage of mechanical aids, as described in my field notes:

There are three hoists on the ward. These are placed in a corner of a blue team room; they are unplugged. I did not see the use of sliding sheets until the afternoon. I have a look on the hoists that are stored in one corner of the room. There are three hoists and none of them are plugged in. The same hoists were also used during student nurses' training. [Extract from field notes, ward A]

The slings used as necessary attachments to the hoists were often found in the highest shelves of the storage rooms along with other equipment including slings from previous models of hoists no longer used on the ward. Multiple slide sheets of different sizes were also available on each ward. However, they were stored in rather inaccessible shelves of the storage rooms in a rather messy way. The difficulties in availability and accessibility of equipment show that they were a low priority for the staff and, thus, not considered important in the moving and handling of patients. The sporadic use of equipment and its storage also influenced students in believing that there was not enough equipment on the wards. Stacy, a first year student I observed on ward C, indicated her concerns about the availability of equipment and the time available to use it.

Alex: When you're washing a patient or you do the beds...I will ask you a question that I probably know the answer but anyways, do you use manual handling equipment often?

Stacy: No, no.

Alex: So, when do you actually use it and why?

Stacy: Ahm... there is not enough time to use it.

Alex: So, it's a matter of time...

Stacy: Time and ahh... when it's available, because slide sheets aren't always available, are they? Then you have to...maybe with the hoists...they have different sizes of slings and they may not be available. [Interview with Stacy, 1<sup>st</sup> year student]

M&H practice was further undermined because of space limitations and accessibility

of equipment. Regarding space, this was an issue when a patient was in a cubicle, whereby M&H equipment meant that most of the furniture needed to be transferred to the corridor in order for the hoist to be placed in the room. Even though students mentioned that there was lack of space in *all* rooms, I did not observe such occurrence. Further, my observations show that bariatric equipment was transferred fairly quickly on the ward, whereas Kath, who practised in the same hospital, supported the opposite view:

Alex: Did you see manual handling equipment used on obese patients?

Kath: To be honest, although you have the manual handling training, half the time you don't have the right manual handling equipment. I've also known as well we had a patient who needed a bariatric chair and we couldn't get one so the patient stayed in bed for few days because we couldn't get the chair because it's quite awful really and you get passed from different people just making excuses because I think there are just two chairs for the whole hospital. [Interview with Kath, Newly qualified]

Duffy et al. (1999) utilised a descriptive survey of a random sample of 395 trained nurses from 75 wards across eight hospitals and discovered that nurses engaged in condemned lifting techniques and seldom used the equipment because of lack of time, space limitations and the inaccessibility of equipment. Lack of availability and space were also documented by Moody et al. (1996) who interviewed and observed nurses using M&H equipment. A more recent study found that student nurses select the same reasons for participating in unsafe M&H; lack of space, lack of time, staffing levels and equipment were the most common answers (Kneafsey and Haigh, 2007).

John also brought to attention that equipment and availability varied on the different wards he practised. In Mitchell et al.'s study (2005) nurses caring for patients who had a stroke suggested that resources were not adequate for meeting their needs with regard to M&H and suggested that an additional hoist and slings were needed on the ward. Indeed, in the observational phase of the study the researchers confirmed that the extra hoist was needed on four different occasions within an 8-hour period. John reported that when equipment was not readily available for larger patients, smaller equipment was used, which meant that both patient and handlers could have been put at risk of injury:

Alex: Did you have sheets his size on the ward?

John: Ahm... I always use those that are available (smile). When I was training, sometimes we wouldn't have sheets available for everybody, which was a bit awkward because obviously infection control implications as well. Ahm, in that hospital, there wasn't a huge problem of equipment because it was a small hospital, so in wards it seems to me we had our stock and we would use our stock and it lasted a long time. But in this hospital, sometimes you end up using what we've got because we did start using the disposable ones, disposable slide sheets but they are not very good and they are not very sliding. But sometimes, I'm just thinking about this other chap, who was quite a large chap, you've got these little sheets and you have to use them... [Interview with John, Newly qualified]

Overall shortages of staff and equipment presented challenges to student nurses and the quality of care they offered to obese patients. In such a climate, it is unsurprising that student nurses felt reluctant in caring for obese patients.

## **6.5 Summary**

This chapter has explained how obesity was socially constructed and discussed the factors that acted as impediments to the quality of care that student nurses offered to obese patients.

First, it is worth noting that I had entered student nurses' clinical practice believing that student nurses' attitudes towards obese patients may account as the greatest impediment to their behaviour towards obese patients. My perceptions were influenced by my previous study (Sardani, 2006) as well as the literature review that drew the conclusion that student nurses hold negative attitudes towards obesity and obese patients – as highlighted in Chapter Two. What actually transpired was that student nurses' cultural beliefs played only part of the construction of obesity meaning, albeit significant. Despite that obesity has been proved to be a multi-factorial disease (Banning, 2005), nine out of sixteen of my participants blamed the individual for their obesity. Student nurses did point out that they received minimal education regarding obesity; nevertheless, one wonders how strong is obesity stigmatisation and whether more information and instruction on the subject would have prevented students from assigning labels to obese patients, such as being disobedient, and whether it would have affected obese patients' popularity.

Regarding obesity assessment, I was struck by the different interpretations that student nurses gave to the meaning of an obese patient. I realised that current instruments measuring obesity, such as the BMI, were of little relevance to how student nurses assessed and evaluated patients in clinical practice. This finding was significant because it consequently influenced the interpretation of the rest of my data; for instance, I was aware that elderly obese patients that did not require assistance moving were less likely to be stigmatised for their weight. What also surprised me was that BMI measurement was viewed as a symbol of medical oppression in that both nurses and student nurses felt that they were obliged to utilise such documentation regardless of its relevance to nursing practice.

I further realised that student nurses' ways of knowing, assessing and evaluating obesity ought to be given more consideration. In effect, their prolonged contact with the obese body during intimate physical care meant that student nurses were able to grasp a certain level of knowledge that could facilitate obesity assessment that other persons are not able to achieve. Moreover, it was brought to my attention that obese patients with limited mobility have complex manual handling needs that affect patient categorisation and obesity assessment. Most importantly, patients' contribution of labour during moving and handling –by their cooperation, obedience and willingness to assist - heavily influenced obesity assessment leading to the conclusion that the process of assessing obesity had key similarities to the process of 'social judgement' (Johnson, 1997), which refers to the process according to which patients are categorised as popular or not.

On the other hand, student nurses were also faced with a plethora of professional and organisational constraints that explains, and perhaps partly justifies, their negativity towards obese patients and their care. Perhaps the most influential factor was their exposure to ward culture and nurses' attitudes towards obese patients and their care through a process that is known as professional socialisation. Indeed, I observed considerable negativity towards obese patients that was expressed during the handover, breaks in the nurses' office and occasionally in front of patients. Moreover, I noticed how student nurses internalised registered nurses' values and norms. Another interesting finding was that registered nurses also presented gaps in their knowledge on how to care for obese patients; for instance, such gaps were apparent when using hoists and other equipment during moving and handling.

It is also worth mentioning student nurses' response to the attitudes they observed in practice; student nurses at the beginning of their education and with less years of experience as health care assistants were judgemental of nurses' attitudes. On the other hand, student nurses approaching the completion of their studies suggested that they were not 'bothered' about it. By utilising reflection, I realised that the humanistic values they absorbed in their theoretical education – prevented them from comprehending the therapeutic function of the nurses' office.

Lastly, I identified the importance of other aspects of the context in which student nurses practise; their desire to fit in with the ward culture and the existence of hidden rules meant that student nurses often waived their supernumerary status and gave into task-oriented care because it facilitated their acceptance on the ward. They felt that the context of care –limited resources and time pressures - dictated them to take a similar approach when caring for patients' alimental needs and prevented them from questioning the meaning of their actions. It was this context that contributed to their realisation that they needed to adopt nurses' practices in order to meet the demands of clinical practice; even if it meant risking their own and patients' musculo-skeletal health.

In the next chapter, I discuss the implications that student nurses' involvement with obese patients' care had on both obese patients and student nurses.

# **CHAPTER SEVEN - The consequences of student nurses' involvement with obese patients' care**

## **7.1 Introduction**

In this chapter I discuss the consequences of student nurses' involvement with obese patients' care. My findings suggest that student nurses interaction with obese patients was infused with both parties' effort for control over the situations they were involved in. Foucault's theory on power (1961, 1973, 1977, and 1980) has aided interpretation of my findings, while I have utilised Johnson's (1997) theory of social judgement to show how obese patients and student nurses negotiated their power and discuss the results of their negotiation.

In this chapter, I discuss obese patients' care in terms of implications that the presence of student nurses had on patients' power position on the ward. I, hence, explore the different ways that obese patients' disempowerment was materialised, while I discuss the phenomenon of certain obese patients' empowerment by student nurses which exemplifies the complexity of power manifestations in the obese patient-student encounter. Furthermore, I reveal that student nurses' participation in caring for obese patients had similar disempowering effects on student nurses. My participants experienced a plethora of physical and emotional effects directly linked to their involvement with obese patients' care. Finally, I compare and contrast these consequences by revealing how obese patients and student nurses negotiated *some* control over their interaction. I suggest that while certain obese patients managed to exercise some control and power over their care; student nurses failed to negotiate efficiently their position of power and, thus, experienced obese patients' care as a struggle.

First, I discuss my findings regarding the consequences for obese patients.

## **7.2 Consequences for obese patients**

### **7.2.2 Obese patients' disempowerment**

Student nurses through both intended and unintended effects exercised power over obese patients. By intended effects I mean that student nurses were aware that they actively discriminated against obese patients because of their weight; for example, by

choosing to assist obese patients last during feeding. By unintended effects I mean effects caused by student nurses' acts that did not have the intention of such discrimination; the improper use of humour towards obese patients' weight is such an example.

#### **7.2.2.1 Obesity as deviance**

Student nurses' perception that obesity is a form of deviance formed the framework upon which they were able to participate in disempowering strategies exercised on the wards they practised.

The criticism of obese patients' behaviour –as deviating from the expected form – was linked to societal expectations and to a covert set of rules that patients were to follow on the ward. The societal expectations have been discussed in Chapter Six (Section 6.2.2) and refer to the symbolic meaning that people share for obesity; obese persons are regarded as a threat to social order and an opposition to society's values regarding physical beauty and to the protestant ethics of working hard (obese patients are considered lazy) and being responsible for ones' actions (obesity is considered the result of one's actions). These stereotypes often influenced the way obese patients were portrayed in the handover, while obese patients' physical appearance and size was a key element in their differentiation from other patients. As discussed, student nurses and staff often viewed patients' obesity as a 'master status' interpreting their behaviour under the light of the symbolic meaning that obesity possessed for them. In that framework, even the possession of chocolate and other 'forbidden food' brought by visitors and displayed on patients' bedside cabinets symbolised obese patients' deviance. It further reinforced the idea that obese patients did not follow the covert set of rules on the ward of working hard (i.e. losing weight), since patients' weight made more difficult patients' moving and handling and, hence, nurses' work.

In the work of 'Madness and Civilisation' (1961) Foucault outlines his argument that every society finds a scapegoat that they attempt to remove from society to determine what is good/normal and what is not. Between the 12<sup>th</sup> and 14<sup>th</sup> century it was leprosy, in the 17<sup>th</sup> century it was madness. Foucault believed that madness is not a self-evident behavioural or biological fact but it is the product of various socio-cultural practices. He stated that madness is a social construction of society



corresponding to the needs and demands of a given culture that can be substituted with a different social construction to be labelled as the greatest threat to social order. Indeed, lepers and madmen shared the same symbolic significance; according to Foucault (1961), they embodied a danger to what was considered the essence of human existence and helped define what was normal or not. Similarly, mentally ill patients were also considered morally responsible for their own shortcomings and, thus, they ought to be punished for their failings.

It seems that obesity represented a similar kind of threat to the working order of the ward as well as student nurses' learning and working goals. While student nurses practised in a difficult climate of limited resources, expectations to fit in and follow the covert rules, they also had to cope with the presence of obese patients. For these reasons, which have been analytically detailed in Chapter Six, they participated in the following disempowering techniques.

The first one to be mentioned is that of isolation.

#### ***7.2.2.2 Isolation***

Obese patients experienced isolation in terms of the physical space they were confined in and that of communication.

On the hospital ward, obese patients with mobility issues were put into cubicles, hidden from view despite that cubicles allow less freedom of movement due to space restrictions and, hence, utilisation of moving and handling equipment was harder to achieve. Foucault proposed that isolation was a way that the deviant were oppressed within asylums whereby the normals were segregated from the abnormal people. In these institutions, Foucault suggested that moral obligation was joined to civil law, within the authoritarian forms of constraint and regarded the purpose of imposing such rules, like forcing people to work 'to contribute to the prosperity of all' (Foucault, 1961; p. 51). Even though Foucault referred to the treatment of mental patients, this type of confinement is similar to the one described in his works. For Foucault, maintaining someone in confinement was more brutal and dehumanising in its effects than corporeal treatments. He further asserted that the most oppressive aspect of asylums was the extent to which control over the mentally ill was achieved through the utilisation of a judgemental and moralising ethos.

Another form of isolation was that of communication, which student nurses imposed on obese patients by limiting the time of interaction with them and through linguistic nuances. Further, a recurrent theme in my findings is that obese patients' care was given low priority by student nurses and took three different forms; first, it appeared as attenuation of obese patients' concerns, which meant that their concerns were not addressed efficiently or effectively. Second, it was manifested as disregard to obese patients' nutrition and nourishment and, finally, it emerged as a set of compromises in obese patients' physical care and repositioning – which were part of obese patients' care reality of care, as described in Chapter Four.

Another subtle forms of control exercised towards obese patients were that of surveillance and normalising judgement.

### ***7.2.2.3 Surveillance and normalising judgement***

My findings suggest that such surveillance took the form of scrutinising obese patients' dietary choices. While the monitoring of obese patients' weight and overall nutrition was not prioritised, student nurses often observed the presence and consumption of non-hospital food by obese patients. This type of surveillance had a derogatory context and comments such as 'demolishing three Easter eggs' were utilised by student nurses. During the break, humorous remarks regarding obese patients' diet were often exchanged by nurses. Further, even though most student nurses' diets were consisted of a considerable amount of high sugar and fatty foods, they were consistently critical of obese patients' diet:

You find as well is that the patients who are overweight will eat their three meals a day and they'll snack as well...sweets, and chocolates and crisps. Then it's not balanced; it's too much fat and too much sugar.

[Interview with George, Newly qualified nurse]

According to Foucault, it was the introduction of the notion of being responsible for one's actions that led to a subtle change in the techniques of treatment from overt oppression to more subtle forms of control; these forms are surveillance and normalising judgement. These forms of control are successfully achieved through the recreation of the theme of the family whereby the asylum, and in extension any institution that deviant individuals are confined in, reinforces an atmosphere of

permanent moral scrutiny and increases the sense of shame to the mentally ill or otherwise deviant inmates.

Student nurses often witnessed nurses exercising controlling behaviours towards such patients that could be framed under the label of 'normalising judgement' used by Foucault to express how powerful individuals or groups use the information drawn from surveillance to punish persons who did not display an acceptable behaviour (McNay, 1994). Susan, a student I observed in ward C was one of the students who criticised patients' relatives for bringing food she considered inappropriate. In fact, she mentioned the technique of 'stealing away' these snacks in their effort to control patients' diet; a method which met the student's approval. Carol, a first year student also mentioned that nurses tried to control the quality and quantity of snacks by discussing the issue with relatives and mentioned that nurses became '*forceful*'. In both instances, the excuse for such behaviour was the patient's diabetes diagnosis:

Alex: What nutritional challenges do you think an obese patient has to face?

Susan: They are actually assessed because there is a dietician. We usually give them... Well; the food is very healthy on the ward. We don't have chips or anything. But there is lack of health promotion, really. Their family is bringing them over sweets and crisps for them and *we* try to *steal* them away from them. [Interview with Susan, 3<sup>rd</sup> year student]

Carol: ...They would also monitor the food that their relatives bring, you know the snacks. They would encourage them to bring healthy snacks.

Alex: Who would encourage them?

Carol: The nurses...they would talk to the relatives and say 'you know, it's good to bring food, but bring food like low-fat biscuits or whatever'... especially the ones that had diabetes. There was a patient who was a bit overweight and she had diabetes, as well and her family was very lovely. She had visitors all the time and they would always bring her something and they used to bring jars of cookies and things like that. The nurses really did work hard and said 'please, you know, bring something healthier' but some of the relatives didn't listen and you can't force them.

Alex: Aha... And what did this make you think?

Carol: It's good to look at the whole person when you care for them because the nurses at one hand were trying to improve her health by monitoring her diabetes and encourage her to eat healthy things and exercise and the family was doing the opposite. They weren't making any progress; so, they had to be diplomatic and a

bit forceful to make sure she was recovering and her diabetes was a bit serious at times. She nearly went to a coma once and it was because she had eaten half a jar of chocolates (laugh) [Interview with Carol, 1st year student]

In that instance, nurses felt that they had to utilise their power to coerce patients in following the nursing goals. When nurses use coercion as an instrument 'for the patients' own good' an ethical dilemma is created, since questions are raised regarding the value of the patient's autonomy as opposed to his/her beneficence. It seems that when negotiations with patients failed, nurses turned their attention to other means, such as controlling the dietary choices that patients have by forbidding relatives to bring such food or 'stealing' the food. Even though it may seem that the nurses' aim is shielding patients from harm, one wonders whether their acts are morally defensible.

In order to understand nurses' controlling and sometimes intrusive behaviours as well as student nurses' participation in obese patients' food surveillance, it would be insightful to discuss their behaviour utilising a Foucauldian lens (1973). The notion that has specifically gained immense interest in the field of nursing is the one of 'clinical gaze', which refers to the exercise of medical power through constant observation, production of symptoms and signs, and the development of hospitals and wards. In these institutions, people that have been diagnosed as 'not normal' and have been assigned the socially constructed notion of being a 'patient' or 'ill' are admitted and monitored. Being on the ward, they are subjected to surveillance; doctors, nurses and other health professionals monitor, criticise and sometimes aim at controlling their eating habits.

It could be argued that even though these institutions have a benign appearance, that of being a place where one is healed or cured, they may have an oppressive character, since under the medical gaze, people's lives are medicalised and scrutinised as to whether they are what Goffman (1963) calls 'normals' or not. Obesity could be considered an exceptional example of the medicalisation of life in terms of power and the body. Foucault claimed that diseases were 'fabricated' by medicine, but so were the bodies that contained the diseases (Jones and Porter, 1995). Obese patients are viewed through the spectrum of their obesity, which has been socially constructed as a disease. The social construction of obesity as a

medical phenomenon is so powerful that it has received universal acceptance to the point that obese persons accept this fabrication as a concrete reality and stigmatise obesity inasmuch as non-obese persons (Schwartz et al., 2006; Puhl and Heuer, 2009). Indeed, obese persons subject their bodies in a variety of medical interventions, like surgical procedures and consumption of a plethora of medications with various adverse effects, with the apparent aim to cure their disease.

Foucault (1977), who was an avid critic of medicine, claimed that clinical gaze was one of the most powerful weapons used by the medical community. In the hospital, the bodies of obese patients are observed and analysed with the purpose of moulding it to what is considered 'ordinary' or ideal nowadays. The doctors aim at transforming the patient to an ordinary person by normalising him/her; a process which also includes judgement and moral regulation. Perhaps Foucault was not thinking of obesity when writing his works, but this description fits perfectly the dominant view of obese persons, who are judged for losing control, for eating too much, for not being normal and their disease, aka obesity, is viewed via a moral stance. This moral stance starts with the conviction that obesity is largely the result of freely willed, voluntary choice and their attempts to lose weight fail because of not wanting or trying. There is an assumption that everyone has free will and can choose how and what they eat and whether they exercise or not. There is a general tendency to ignore factors, such as genetic inheritance, nurturing and other psychobiologic factors, which produce certain urges and compulsions that 'normals', as Goffman (1963) considers the non-stigmatised, are able to resist (Banja, 2004).

A criticism towards Foucault's theory of 'clinical gaze' can be substantiated by looking into the motives of student nurses and nurses of engaging in monitoring diabetic patients' food choices. One could claim that the surveillance of such food was critical in the amelioration of these patients' health. Perhaps if Foucault was present at this discussion he may have answered that the person's autonomy was overridden when nurses stole patients' food or became forceful. He may have even argued that making a person's body 'docile' and ordinary could have been too big a sacrifice to make. Nevertheless, my observations show that despite the disempowering effects that such surveillance had on patients, it was guided by beneficence.

However, such beneficence was also mixed with social judgement for the patient's weak attempt to master their body. The following extract exemplifies the type of monitoring, criticism and control that patients are submitted to from the moment they enter the ward. Apart from monitoring the patient's weight and enquiring about his height, the patient is criticised for 'being naughty' which influenced his health status (diabetic) and, perhaps, his weight. The comment is offered in a humorous way; yet, there is a notion of implied judgement in the nurse's tone:

Kathryn (Rhiannon's mentor) asks Rhiannon whether she would like to see how a patient is admitted to the hospital. Rhiannon went with her and Kathryn explained that 'he's having a total knee replacement'.

Kathryn and I draw the curtains. The nurse asks the patient to confirm his name and age. She informs a document, according to which, she is asking several questions to the patient. She asks him 'do you like sweets?' and he just smiles (he is diabetic and overweight). She says to him 'you were a naughty boy when you were a kid, ha?' He laughs and says 'yes, yes'. [Observing Rhiannon, 1st year student, ward A]

Indeed, the presence of 'forbidden' foods on obese patients' bedside cabinets became a symbol of non-adherence and defiance of the ward's rules for student nurses and nurses alike despite that there was no indication that the patients actually consumed them. Previous studies have stated that non-compliance is a common stereotype assigned to obese patients by nurses and student nurses (Hoppe and Ogden, 1997; Petrich, 2000; Jeffrey and Kitto, 2006; Brown and Thomson, 2007). This puts under the microscope the usefulness of nurses' gaze and ways of knowing and perceiving obese patients' diet, since other than the presence of these foods in the proximity of patients, there was little knowledge that they engaged in their consumption. Their lack of knowing can be partly attributed to nurses' intermittent and episodic interaction with patients, which consists of 'fragmented and contingent set of encounters' (May, 1992; p.478). The presence of a diabetes diagnosis and obesity was linked to the consumption of 'sweets', while the presence of 'sweets' led to judgement of the obese patient as non-adherent.

In the following section I describe how student nurses depersonalised obese patients; a strategy that is considered highly disempowering in health care settings.

#### **7.2.2.4 Depersonalisation**

Another expression of student nurses' power that I would like to discuss is obese patients' objectification either through direct actions or omissions that were materialised through task- and routine- oriented care and patient avoidance, as described in Chapter Five.

By maintaining a distance from the obese patient, student nurses did not know the patients personally, which meant that they were more likely to form an opinion based on nurses' description during the handover or their first impressions. As discussed in Chapter Six (Section 6.3), obese patients' physical appearance and size played a significant role in nurses' judgement of obese persons. Studies, such as the one of Peternej-Taylor (1989) and Petrich (2000) confirm that physical appearance is a visual stimulus that was the prime element influencing both nurses and student nurses' feelings and opinions towards obese patients.

Controlling the type and quality of interaction also meant that students were often misinformed about patients and assigned stereotyping characteristics based on the misinformation, which has been extensively discussed in Chapter Six (Section 6.2). In the following extract, the student nurse made assumptions about a patient based on such misinformation; the description of an obese patient by a student is false in that the patient was legitimately admitted to the orthopaedic ward. I discovered that her reason for admission was a fractured hip caused by a fall down the stairs. Her increased immobility also caused a severe pressure ulcer at the bottom of her spine, which was infected and needed surgical cleaning. I also discovered that she looked after her mother, not her siblings:

In relation to Hillary, Susan tells me 'she is a very big lady'. She is 66, she is morbidly obese. She highlighted 'I mean she is obese, how do you say it? She is morbidly obese'. She has been admitted because of 'social problems'. I enquired further and Susan explained 'patients who don't have a real reason for admission but they had to come in because of other problems'. She has nine sisters and brothers and two of them have mental difficulties; she cares for them. She also hinted that Hillary comes from a low social background. [Extract from fieldnotes, observing Susan, 3rd year student, ward A]

Objectification of patients has also been explored by Goffman (1961), in his seminal work *Asylums* that looked into how mental patients were treated in total institutions. He found that total institutions depersonalised patients; a process that he named ‘mortification of the self’, which involves stripping off the person’s *identity* by removing characteristics that define a person, including clothes, sleeping habits, privacy and freedom of movement. Even though most of the practices described no longer constitute a reality in health care institutions, the concept of retaining one’s identity when entering an institution has been recognised as crucial in the quality of care patients receive (Wilde et al., 1993). I observed that all patients regardless of their weight experienced some stripping of their identity; for instance, patients wore pyjamas instead of their usual clothes and they followed the routines of washing, eating and sleeping that the institution – and nurses as instruments of the institution - dictated.

Perhaps the only characteristics that a patient’s identity truly distinguished him/her from other patients were the ones attached to their personality; their feelings, thoughts and experiences. I suggest that by distancing themselves from obese patients, student nurses denied them the opportunity to talk about themselves and reveal their true identity. Buber (1958) explored the effects of objectification and stated that getting to know the patient enables the nurse to view that patient as a person and perceive them as an equal to themselves. On the contrary, according to Buber (1958) not knowing the patient has the effect of turning a living person into an object. Objectification meant that it was easier to divide patients into categories and assign them characteristics, like healthy or unhealthy. This is exemplified in the following extract from Carol’s interview, who admitted that dividing practices are an everyday reality, as far as nursing care is concerned. Dividing practices is a term used by Foucault (1980) to describe one of the three elements that signify the objectification of a person or group. It refers to the confining or excluding practices that differentiate one group of people from another:

This is a fat person and people see generally fat people as unhealthy... And compared to a thin person, who they think is generally healthy but which isn’t necessarily true, as well. Fat people complain of aches and pains and thin people have usually better quality of life. They don’t usually complain about their bodies... And if you’re NOT obese, you generally get better care



than patients who are obese. If you are obese, you get less attention. [Interview with Carol, 1st year student]

It could also be suggested that by concentrating on patients' physical care, student nurses omit valuable sources of knowing the obese patient. Providing consideration for the whole person has also been stressed by Smuts (1926), who discussed the idea of holism as viewing a person as a unified whole 'who is different from and more than the sum of his/her parts'. Porter (1997) further defines holistic care as a mutual understanding and communication between nurse and patient whereby patients are encouraged to participate in the decision-making as well as the provision of care. Even though it has been suggested that the term has been over-utilised (Reed, 2009) and has been romanticised (Engebretson, 2009), it still expresses the philosophy behind nursing, which is the integration of all patterns of knowing (Carper, 1978). Carper (1978) in her ground-breaking discussion of nurses' sources of knowledge talks about the component of personal knowledge, which she considers as 'the most difficult to master and teach'. This type of knowledge refers to a 'therapeutic use of self' within interactions between nurses and patients (p.18). This type of knowing, according to Carper, promotes 'wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment; and it denies the manipulative, impersonal orientation' (1978; p.20).

May (1992) conducted a study into nurses' accounts of knowing the patient, which is of particular interest to this study because he explored the importance of knowing the patient as an individual and not just a site of action. He viewed this type of knowing as the 'traditional, listening, caring' role and discovered that nurses found it as valuable and rewarding for both themselves and their patients. Further, he hinted that not knowing the patient means that patients are treated as objects and it is more likely to be viewed through their clinical identity (May, 1992). Latimer's study, on the contrary, has indicated that nurses draw on a wide range of criteria to make sense of what they do and what patients need (Latimer, 2000). Latimer (2000) who observed nurses admitting older people on an acute medical unit suggested that nurses do go far beyond biomedical understanding and made their assessments based on a plethora of aspects of patients' observation, including personal as well as psychosocial elements.

The importance of student nurses communicating with patients in their journey to recovery has also been stressed by the Standards of Proficiency for pre-registration nursing education (NMC, 2004). It is specifically mentioned that students ought to 'engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills'. It is interesting that it is clearly mentioned that effective communication has a therapeutic potential for patients.

While I shadowed student nurses on the wards they practised, I observed and took rigorous notes of their verbal and nonverbal communication with patients regardless of whether student nurses defined them as obese or not. Student nurses' communication with the majority of patients was characterised by affective neutrality learnt through professional socialisation and guided by task orientation. Indeed, student nurses did not spend much time at patients' bedside unless they had to perform a certain procedure or task. This is shown in the following extract from my field notes. Susan, a third year student, is communicating with an obese patient trying to convince her to take her medicine:

Susan: Liz, can I pop this in your mouth, my darling?

Liz responds by opening her mouth.

Liz: Horrible, I hate eating tablets.

Susan: Only a couple of them more. It will make you feel better, darling. Go on, one more tablet.

Liz: No...

She seems to be in distress. She has a difficulty in swallowing.

Susan says in a comforting way:

Susan: Go on, you have your paracetamol to take now the pain. She dissolves the medicine into water and then gives it to the patient.

She comments 'It takes ages to dissolve'.

[Observing Susan, 3rd year student; ward A]

With regard to obese patients' care, student nurses kept even a bigger distance by avoiding obese patients' bedside. This was reflected in the limited amount of data I gathered containing interactions between student nurses with obese patients in comparison to a wealth of data documenting interactions with non-obese patients. While I was unable to interview obese patients to enquire of them whether they felt this lack of communication, a recent study which looked into patient complaints in an NHS hospital found that almost half of complaints were made due to lack of good communication. Specifically, complaints were made about medical care (100%), nursing care (26%), attitudes of staff (25%), poor communication (48%), clinical

delay (9%) and the hospital environment (8%). This study is another confirmation of the importance that patients place on achieving good communication with health care professionals, including nurses (Siyambalapitiya et al., 2007).

Student nurses learnt about obese patients' identity through the means they had available; the handover and their intimacy with the obese body – as achieved through daily physical care. Student nurses' meaning of the obese body was influenced by the fact that they came in touch with obese persons' private body and they perceive it through a special kind of surveillance and observation that could be called 'nursing gaze' (Lawler, 1991). This term has been utilised to refer to a function and integral part of the profession, while others regard it as an extension of the medical profession's 'clinical gaze', which has been described by Foucault (1973) and is still relevant in nursing (Johnson, 1997; Shapiro, 2002). Johnson (1997) connects the nursing gaze with that of 'normalising judgement'; this is the term he coined to refer to a process that nurses exert their power not only by utilising facts or criteria but also a patient's social worth with the aim of monitoring patients' behaviour and distributing punishment for non-adherence to the rules of the ward. In a different paper, Johnson (2005) discusses how such surveillance in nursing can pose threats to a patient's right to privacy and can be utilised to exert power over patients.

Such surveillance, however, may be deemed inevitable due to the nature of nurses' work, which involved constant observation and touch of patients' bodies. It can be argued that a person's body has a dual entity; a public body that a person reveals to the whole world and a private one that is only visible to the intimate circle of a person's social life. Student nurses and nurses alike, due to the nature of their work, are able to overcome the ritual social conventions and encounter the obese body in its most intimate state; naked, in full light and they are able to touch it, manipulate it, move it and handle it in ways that enable them to build a different meaning to the one that the casual onlooker does. In other words, the identity of a patient as 'obese' or not is constructed through 'nursing gaze' (Lawler, 1991), which can be appreciated for its value in a patient's care but should also be viewed through the lens of responsibility carried by those that establish the terms of the negotiation process through which they inscribe identities to patients.

Despite the constraints in student nurses' clinical practice, including their low hierarchical position on the ward, some students managed to make a difference to certain obese patients' care. These empowering acts are described in the following section.

### **7.2.3 Obese patients' empowerment**

An important finding of my study is that certain student nurses chose to empower some obese patients who were considered unpopular on the ward but this was done secretly. Overall, instead of imposing the same negative aspects of control that they experienced as an oppressed group from higher levels of organisation (Daiki, 2004), student nurses engaged in reciprocal interaction, assisted these patients to become autonomous, shared their knowledge and influenced the negotiating process of the patient's access to resources.

Empowerment is a term that has a steady increase in popularity in nursing and allied professions and has been utilised in different contexts and prescribed a wealth of meanings (Rodwell, 1996; McCarthy and Holbrook Freeman, 2008). In fact, there is criticism that it has been used loosely and uncritically (Thomson, 2007). The following definition is enlightening in how I perceived obese patients' empowerment by student nurses: 'Empowerment is both a process and an outcome arising from reciprocal interactions among people, linking autonomy with accountability, involving shared or transferred power, and achieving the ultimate goal of greater access to financial resources or intangible benefits such as knowledge and influence' (McCarthy and Holbrook Freeman, 2004, p.72). I perceive empowerment as an integral part of the nurse/patient interaction; it is a helping process and an outcome with the aim of building a respectful and trusting relationship based on equality.

Not all student nurses distanced themselves from all obese patients; there were some students who selected a patient that displayed effects of their disempowerment, and chose to empower them using several different techniques. In ward A, Simon, a second year student, visited Tom's (morbidly obese patient with dementia) cubicle several times a day to make sure 'he's ok' - for instance, he checked if he had enough water, if he was warm enough or needed someone to talk to. While other students and staff brought the commode or the 'bottle' when he asked to go to the toilet, Simon always found time to walk Tom to the toilet supporting him from his

shoulder. Tom was often forgetful and asked where he was and what day it was; Simon always had the patience to explain everything and reassure him.

In ward B, Alice, a third year student, spent considerable time with Linda, a 78 years old obese patient, who was admitted for exploratory surgery for cancer. The student already knew the patient from her community placement. The staff on the ward Alice practised thought that Linda was 'demanding' and 'difficult'. Alice tried to conceal her liking towards Linda, but on average she spent more time with her than with other patients. Alice empowered Linda by helping her to obtain information about her care, supporting her in making choices and facilitating the negotiation of her care with the nursing staff. In effect, at some point she endangered her own reputation to secure a cubicle for the patient who had previously complained of not resting well because of noise.

In the following example, Alice tried to comfort Linda by staying with her long enough, listening to her, holding her hand and reassuring her.

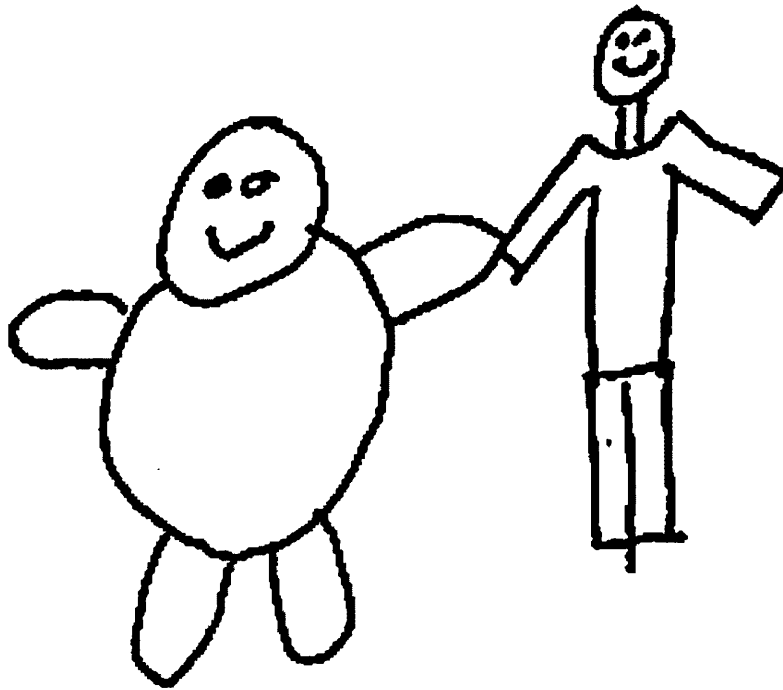
The first patient Alice went to visit in her room was Linda. Linda was very happy to see Alice and she pointed to me that she knows Alice from the community. She said 'it's good to see someone in here that you know'... The patient complained about the drain from her groin wound and said that she's been in the hospital 'for too long'. She asked whether she can go home because she lives very close and return during the night. Alice said that she has to stay in the hospital because the wound is still 'giving liquid' and it has to be reduced to 30ml before she would be able to go home. The patient was worried that this could take up to a month judging from the amount of liquid it is gathering now and Alice said that she will mention it in Linda's file so that the doctor would know. Linda said that it would be better if she mentioned it first and Alice agreed to that. She said that the reason she wants to go home is because her 'nerves' are too sensitive. Alice said that if she goes home now, she will have no good quality of life and that is important. The patient said that she feels healthy. She tried to comfort the patient and said that perhaps if she asks the doctor they may let her go out for a while, perhaps for a couple of hours or so. We stayed in the patient's room for about 10 minutes and then Alice said to Linda that she will return later to see how she is. [Observing Alice, 3rd year student, ward B]

In ward C, I observed a similar relationship between Julie, a second year student and a morbidly obese patient, which other students and staff seemed to avoid. In this

instance, the patient had difficulties in eating that were related to a recent stroke; Julie dedicated time not only feeding the patient but also teaching her to use her left arm to do everyday activities including eating.

Lucy, a first year student, conveyed the importance of empowering all patients regardless of weight in her drawing. Patients are depicted holding hands, which represent unity, and smiling, which represents patient satisfaction. She commented that her drawing portrays her vision of nursing; making happy all patients regardless of their weight:

‘I drew someone who is underweight and someone who is overweight... As a nurse you have to try and look after them and make them happy’ [Interview with Lucy, 1<sup>st</sup> year student]



Picture 4. Drawing by Lucy, 1<sup>st</sup> year student.

Some obese patients' unpopularity triggered deeper levels of interaction with student nurses who felt some *solidarity* over theirs and patients' lowly place in the clinical setting hierarchy. That was the case of developing a covert liking for the patient; students maintained a 'front stage' performance in front of staff pretending that they agree with deprecatory comments, while they developed a 'backstage' performance behind closed doors compensating for the limited attention given to these patients.

This phenomenon has been previously described by Johnson (1997), who coined the phrase 'covert liking' to describe it. This meant that the balance of power was partly restored and these patients sometimes received better quality of care, albeit invisible to others, due to the presence of a particular student on the ward.

A major contribution of Foucault is that he conceived power as omnipresent and productive force (Westwood, 2002) incorporating empowering elements that are inherent in any set of social relations. Indeed, I observed some student nurses utilising their power, which may seem limited and perhaps invisible to the majority of people, as an enabling force that compensated for the unequal treatment obese patients received from the majority of staff.

Strauss et al. (1982) provide a plausible explanation why nurses get engaged in this type of work, which they named 'rectification work'. Their observational study in hospital settings provided a wealth of data regarding the sentimental work that nurses and other health care professionals' experience. They considered rectification work a type of sentimental work that a health care professional provides to a patient with a view to compensating for a patient's objectification by other health care professionals. However, they highlighted that the highest function of such work is not to apologise for others' insensitive approach towards the patient; rather to make sure that the patient will not resist further treatments and procedures.

In my study, however, the purpose of such work had an altruistic context, which is infused in nursing culture; it was also utilised as a way of coping against the task orientated caring that prevailed in nursing practice. I observed some students finding that extra time to spend with patients they selected and provided them with what Smith (1992) and they called 'little things'. These things are part of the compassionate work that both student nurses and nurses do when caring for patients and are usually referred to as 'little' because they are considered intrinsic to the woman's nature to provide them and are understated by the general public and nurses, as well. In effect, even though nursing is chosen as a career pathway by both women and men, I suggest that this has not shifted the inequalities created by decades of constructing the meaning of nursing within female qualities. As Mowforth (1999; p.40) suggests, 'masculinity and femininity are powerful images and have been used to great extent in promoting nursing as a nurturing and caring

profession'. Nevertheless, these examples of brilliant nursing were provided to selected patients because, as students admitted, lack of time prevented them from providing individualised care to all patients.

When a student developed a particular liking towards a patient, the student spent considerably more time with the patient in comparison to the others and empathy was an apparent characteristic of their everyday communication. By empathy I mean that student nurses comprehended the meaning of the patient's situation and tried to employ it in a therapeutic way (Kirk, 2007).

Interaction with obese patients was further compromised due to patients' likelihood of being labelled unpopular by the majority of staff. Indeed, when a patient was considered unpopular on the ward, even if students did not agree with the label attached to the patient, they adopted the same type of interaction that staff displayed during their 'front performance'. Students never disputed nurses' perceptions or confronted any negative attitudes or discriminatory behaviour they encountered; they were motivated by their desire to 'fit in' with the ward culture they practised and feared that they would be sanctioned for it:

I don't want to say 'excuse me, I don't think it's appropriate and we shouldn't be talking about patients like that' because no one would talk to me anymore and it will make my job harder and more difficult. [Interview with John; Newly Qualified]

Since my study involved mainly observation of student nurses, I did not have the opportunity to explore whether nurses displayed similar feelings of covert liking towards obese patients. Student nurses, though, confessed that the reason behind their attitudes towards these patients was to compensate for staff's negative attitudes towards them. Johnson (1997) in his study of social judgement describes how some nurses and student nurses in particular tried to improve unpopular patients' care and prevent any negative consequences that other staff's neglect could have incurred. He argues that this was a form of advocacy of patients and their rights, albeit covert. In other words, nurses and student nurses tried to protect patients' right for equal care and prevent any harm.

Overall, student nurses empowered certain obese patients on a personal level and assisted them in gaining control over their lives; but they did not challenge obese



patients' oppression on a cultural or organisational level since they did not dispute discriminatory stereotypes expressed by nurses and others.

In the following section I discuss the disempowering effects that student nurses experienced because of their involvement with obese patients' care.

### **7.3 Consequences for student nurses**

A significant finding of my study is that student nurses' involvement with obese patients' care had also disempowering effects on them. My interpretation was aided by Goffman's theory of stigma and Foucault's perception of the dynamic nature of power.

According to Goffman (1961), the process of stigmatisation is a continuum, which means that when student nurses stigmatise obese patients, they also feel the consequences of stigmatisation. Goffman (1961) mentions that stigmatised people experience feelings such as self-hate, self-derogation, depression, anxiety and defensiveness. Interestingly, my findings reveal that student nurses experienced similar negative feelings; stress, embarrassment, guilt, anxiety and defensiveness are but a few to mention. I also discovered that student nurses internalised these feelings instead of expressing them; indeed, they utilised the following coping strategies; segmentation of feelings, patient avoidance and power displays.

Further, my findings reveal that student nurses' feelings towards obese patients and their care were directly linked to obese patients' disempowerment. My interpretation was aided by Michel Foucault's viewpoint of power; he did not perceive power as a static force; rather he viewed it as a dynamic process (McNay, 1994). Indeed, obese patients' disempowerment acted as an effect, a trigger and a consequence of student nurses' disempowerment. This was depicted and reflected from student nurses' struggle to care for obese patients.

First, I discuss the emotional effects that student nurses experienced when caring for obese patients.

#### **7.3.1 Emotional effects**

I explored student nurses' feelings towards obese patients and their care from two different viewpoints; first, I looked into their feelings as a source of obese patients'

disempowerment. My decision was based on the functional theory of the development of stigma, according to which people stigmatise others because they represent a threat to their self and, hence, they participate in their disempowerment to protect oneself (Stangor and Crandall, 2000). Second, I looked into student nurses' emotional response as a consequence of obese patients' stigmatisation.

The emotions that student nurses felt can be characterised as complex and messy; they did not see the care of obese patients as enjoyable or a learning opportunity. It was rather felt as a struggle, which involved the awakening of their coping strategies. Obese patients' care required 'more time', which meant less time to learn. Moving and handling equipment was used inconsistently (See Section 5.4) causing anxiety; students also felt stress because of their lack of knowledge. Non-compliance of patients (See Section 6.2) aggravated their negativity leaving students feeling defeated in their attempt to provide 'brilliant' nursing care.

Most students built a wall between them and patients whom they felt were unable to care for, such as obese patients. During the conversations I had with students and during the interviews, it seemed that they grasped the opportunity to surface their emotions and reflect on this 'brick wall'. Indeed, these discussions proved to have a cathartic element for students and were characterised as an opportunity to reflect on their feelings and coping strategies and actions towards obese patients:

I am even confused myself but I wanted to know what I thought and some of the stuff I came up with surprises me a bit like why can't I approach a patient when they are overweight and I do have a block then and it's worrying. [Interview with George, Newly Qualified]

Their feelings about their own body image and relation to food were also awakened; these feelings were ruled by societal values of what is considered beautiful and worthwhile. Indeed, for some student nurses, obese patients represented the failure to prescribe to the 'thin ideal'.

Another feeling experienced by many students was embarrassment that the obese body caused them. Obese patients' care involved intimate touch, handling and touching parts of obese patients' bodies that are considered private:

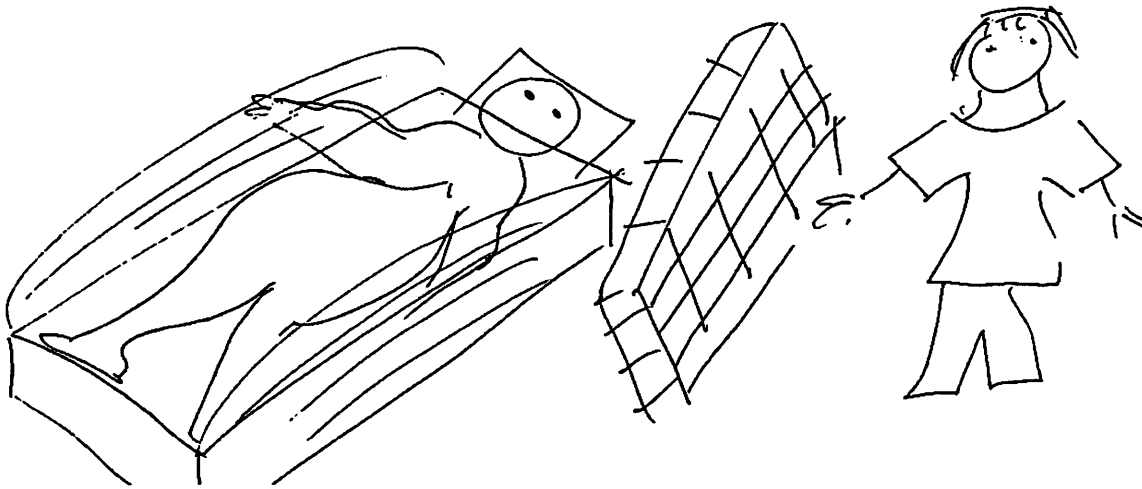
It was a bit...how can I say it? It was a bit daunting to look at her body because, you know, she has been injecting herself so many times and she had bruises...She had diabetes for years. [Interview with Lucy, 1<sup>st</sup> year student]

Lawler (1991) highlights the difficulty that nurses experience dealing with intimate parts of a patient's body linked to his/her sexuality. The participants in Lawler's study confided in interviews that they felt embarrassment when involved in patients' physical care.

Students also experienced segmentation of feelings; they felt sorry for the patient and his/her health problems, they blamed the patient for his/her problems, but felt that it was wrong having these negative feelings. Overall, students admitted that their coping strategies failed to eliminate the emotional components and demands of nursing care, which led student nurses experiencing even more negative feelings.

Student nurses who had stronger negative perceptions about obesity felt a deep struggle and conflict of feelings, some provoked by their social role in society, which criticises and condemns fatness and some by the role of the nurse, as carer, who is taught not to discriminate in any way against their patients. Stacy drew a brick wall between her and an obese patient to portray how she feels the obstacles prevent her from approaching obese patients and providing optimal care:

It's a bit strange...See that's a nurse and this is obviously a patient who is obese. The nurse would have knowledge. So she would have the knowledge of sort of what to do but then they'll be a brick wall which is combined resources and all sorts of moral and different things that would be in the way of dealing with the patient. [Interview with Stacy, 1st year student]



Picture 5. Drawing by Stacy, 1<sup>st</sup> year student.

Some students also reported having unpleasant feelings because they witnessed nursing and medical staff stigmatising obese patients; some reported instances where the nurse or doctor insulted the patient, while most expressed how bad they felt when they heard the staff criticising or even laughing at obese patients in the nurses' office. This feeling was also infused by a fear that one day they will become similarly emotionally detached and critical to patients. Some others felt embarrassment on behalf of the patients and powerless because they felt unable to voice their support for their patients.

Other students said that they felt sadness and frustration when caring for obese patients. They felt like that because they perceived that obese patients usually face a poor outcome and long recovery. There was also a concern that obese patients' presence hindered the care of other patients because of the time that obese patients' care occupied. Kath, for instance, drew a picture of herself feeling frustrated and overwhelmed because of dealing with 'ten jobs' that signifies her feeling of loss of control and powerlessness:



Picture 6. Drawing by Kath, Newly Qualified Nurse.

Alex: Just try and tell me what you're trying to draw there.

Kath: I'll draw me as a stick figure and I'm holding papers and it's like everything is everywhere because I am so stressed and then I just feel like not so happy. I am desperate; it's like ten jobs to do and I am thinking I cannot do any more than I am already doing.

[Interview with Kath, 3rd year student]

Despite feeling overwhelmed with obese patients' care, some students said that they felt sorry for them, while others felt empathy. It must be stated that 'therapeutic empathy' as a way of comprehending patient's reality is highly regarded in the clinical setting (Morse et al., 2006) and it shows that some students were willing to get into the patients' shoes and imagine how they would like to be treated.

Students already felt a low level of power due to their nature of 'passing by' through the ward. Obese patients' care represented a big stress for student nurses because it was the ultimate 'test' that they felt they would be discovered that they do not hold the knowledge and, thus, the credentials to be 'proper' nurses. Feeling powerless could have been the reason why student nurses did not feel motivated for caring for obese patients, since they felt that their efforts were not rewarded. Many students, like Carol, were frustrated when faced with patients that 'nothing could be done' for

them. This feeling was aggravated when patients were perceived as not looking after their diet:

Carol: She had a sound mind, the patient but, sometimes, she was in the habit of eating sweet things because of her family.

Alex: Do you remember why she was in, that patient?

Carol: It was because of diabetes and just general poor health.

Alex: Ok. How did that make you feel?

Carol: At first, powerless because you cannot force anyone, especially here because they REALLY recognise the rights of patients. And you cannot take the food either...so you really have to work on your health promotion and get the message across. Also, it's up to the patient, as well, to understand that this is no good for her. I think there's a major drawback; if the patient doesn't take initiative, take ownership of her own health...you have to work with other people, who might be reluctant to help and they don't see anything wrong with it so... it was working with the family more since the patient wasn't willing. [Interview with Carol, 1<sup>st</sup> year student]

When caring for them, they felt powerless in influencing the quality of their care and some of them reported feeling despondent:

Alex: Do you think your attitudes are negative?

John: My attitude is almost ambivalent, I think. I don't really feel it's my responsibility. I don't think there is anything I can do about it so therefore I just leave it go and concentrate on things I can or I am doing something about. [Interview with John, Newly qualified]

Another important finding of this study was that students felt particularly powerless when they were not sure about the responsibilities they had with regard to the care of a patient or the adequate knowledge to provide a high standard of care. Sally, a second year student on ward B, told me that she has not had many opportunities to take responsibility because she is still a student. Now she just started feeling more like a nurse. She told me she would rather not care for obese patients because 'you never know what might go wrong'.

The feeling of powerlessness that student nurses experienced when caring for obese patients can be discussed within the context of the power dynamics on the wards they practised. There is a recognition that within nursing there are power dynamics involved in relationships between student nurses, nurses, doctors as well as patients that are often based on official hierarchies but sometimes on deeper, less immediately visible, social structures (Wilkinson, 1999). There are several existing

theories of power that can shed light on the phenomenon as experienced by student nurses.

Firstly, some student nurses said that they felt *as powerless as obese patients*, which could be linked to feelings of empathy towards such patients. This led to students expressing a covert liking towards patients they empathised with and attempted to influence the quality of care they received, as discussed previously in this chapter. At this point it could be useful to mention Parson's theory of power (1951) which describes power as a 'variable sum' concept. According to this theory, power increases in a society the more that a society achieves its desired communal goals. Using this theory, it could be supposed that student nurses ameliorated the care of disempowered patients in order to harness a feeling of increased power. In the following extract from Carol's interview, it seems that some students felt that health care assistants also belonged to this coalition. My observations show that student nurses, especially first year students, were more likely to empathise and connect with health care assistants than their mentors, perhaps because they spent more time together and they felt they had a similar power position on the ward:

Alex: Was your mentor helpful?

Carol: Not really... (Nervous laugh)

Alex: (Laugh) who did you find supportive in the practice?

Carol: Oh, it was definitely the auxiliaries. They were excellent. They're the ones, who also pointed out the learning opportunities because for me it was learning from whole different range... so they were telling me 'do this, ask them for this'. [Interview with Carol, 1<sup>st</sup> year student]

The majority of student nurses, however, felt that their limited power was a result of other parties having more power than them; namely management, nurses and unpopular patients. This notion of power, based on the assumption that power is held only at the expense of others because there is only a fixed amount of power, was supported by Weber (1948). Student nurses felt that they suffered and struggled with obese patients' care because it was inflicted on them by nurses, who engaged them on experiencing physical and emotional labour, as well as obese patients, who were viewed as demanding, difficult and uncooperative. In the following extract, George describes how an obese patient manipulated the student in order to satisfy his goals because the patient was aware of the low position in power of the student on the ward:

Alex: Would you consider him a difficult patient?

George: Ahm, not difficult. He came into routine and he *knew* that he could push people and he knew which ones where the ones like me, the student, and he would use that at his advantage and I don't feel...I felt it was a shame that he was there. He wanted to go home that he couldn't quite understand why he couldn't get home.

[Interview with George, Newly Qualified]

The different faces that student presented in front of patients they considered popular, the ones they considered unpopular as well as in front of staff could be explained by what Melia (1987) calls 'segmentation' of behaviour. Student nurses, indeed, tried to fit in and behave in different ways depending on the situation and the people they were interacting with. In other words, when interacting with patients they favoured, they displayed the face of the ideal or 'brilliant' nurse, while with all other patients they seemed to copy the emotionally hardened face of the professional nurse. I suggest that both coping strategies were linked to the student's strive of increasing the control they had over their patients and, consequently, the elimination of the feeling of powerlessness.

The role of the mentor in the power position of the student on the ward was crucial in allowing the ward environment to become a learning experience as well as increase the confidence in student nurses to make decisions about patients' care. Indeed, Smith (1992) found that many student nurses avoided patients whose care was considered emotionally demanding when they did not have the support of more senior nurses. In that instance, some of the students felt that the system let them down and did not allow them to fulfil their potential. My observations are similar in that a mentor was able to protect the student's supernumerary status and let them engage in activities students considered valuable for their training. In the following extract John explains that, as a student, felt pressure from health care assistants not to use moving and handling equipment while nurses would give lessons of 'proper' nursing care:

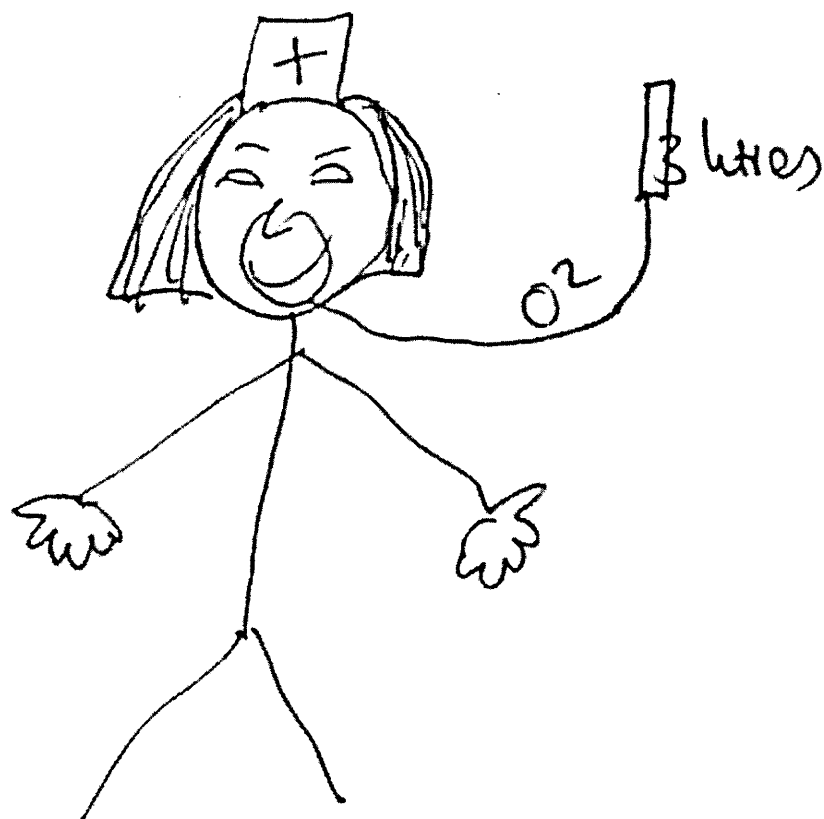
Alex: Did you feel any kind of peer pressure?

John: Yes, from the health care support workers. The health care support workers generally from my experience were less aware of my student status in things like that and that I was training. Nurses very often because I was a student would say 'let's do things properly....will do things properly'. [Interview with John, Newly Qualified]



The presence of support influenced student nurses' feelings towards obese patients and this was particularly noted in its absence whereby my participants appeared reluctant to engage in interaction with such patients. Nicky James (1989), a nurse researcher that did observational research in a hospice found that the emotional demands of nurses were equally as hard as physical and technical aspects of their work. Nurses found the involvement with dying patients and their family particularly emotionally demanding and many chose to adopt a task-oriented approach to their work to avoid the emotionally painful interaction. James (1989) concluded that when nurses engaged in this coping strategy, the 'love' part of the job was lost. Smith's (1992) participants also experienced similar feelings and were drawn in the dilemma of getting involved with patients at a superficial level or used their feelings and 'remain therapeutically involved with the patient' (p.15). In my study, the majority of students selected the former option.

Student nurses chose to disguise and hide these complex feelings; to make them invisible because they felt that they would be judged negatively- not only by other student nurses, staff and their educators but also themselves. They then attempted to display emotions that they considered appropriate to their nursing role. Hochschild (1983) was the sociologist who first conceptualized emotional labour from the study of flight attendants; referring to a worker's endeavour to display emotions according to embedded social and cultural norms rather than what he/she actually feels. Hochschild based his theory on Goffman's (1967) concepts 'impression management' and 'presentation of self', which describe workers' efforts to adopt an outward appearance of expected emotions, as if on stage, while their real emotions remain hidden. As far as nursing is concerned, the concept implies that the ideal emotions and thoughts that nurses should theoretically feel are different than those that they actually experience but cannot express in practice. Emotional labour acknowledges the tremendous emotional effort that nurses do when they encounter with the people for whom they care (Huynh et al, 2008). The drawing by Susan depicts the impression management she had to perform while being involved with obese patients' care. While she drew a smile on her face, she said that she felt that the demands of obese patients' care made her feel that she was in need of oxygen supply and hospitalisation. She also hinted that she felt constantly stressed and exhausted:



Picture 7. Drawing by Susan, 3<sup>rd</sup> year student.

Perhaps student nurses' emotional response towards obese patients and their care was a sign of burnout and exhaustion. Responding impersonally towards patients has been defined as the main characteristic of depersonalisation by Maslach and Jackson (1981). Their research endeavour, which involved the detection of signs of burnout, associated depersonalisation with burnout. One of their conclusions was that responding impersonally was the outcome of an emotionally exhausted worker who feels that they are no longer able to give of themselves at a psychological level. They warned that dehumanising others can create negative attitudes towards them (Maslach and Jackson, 1981). Reading the items of the scale they developed to measure burnout, depersonalisation is associated with treating persons as impersonal 'objects', emotional hardening, not caring and blaming people for their problems; my data reveal that all my participants experienced these effects to some point. Indeed, while describing obese patients' care, issues such as depersonalisation and blaming obese patients were present. This is important because burnout can lead to increased absenteeism and reduction in productivity (Melchoir et al., 1996), while individuals

suffer from issues such as reduced self-esteem and poor job satisfaction (Tavares, 1994).

Apart from emotional effects, student nurses also experienced physical effects because of their involvement with obese patients' care.

### **7.3.2 Physical effects**

Student nurses also felt disempowered because of the physical difficulties of obese patients' care. Indeed, when student nurses were invited to discuss the topic of caring for obese patients in clinical practice, all participants highlighted the importance of moving and handling (M&H). All student nurses but one revealed that they had limited knowledge and negative experiences of participating in M&H of obese patients. Overall, student nurses felt unsupported, unprotected and powerless, which led to a feeling of insecurity.

Student nurses' experiences of M&H were directly influenced by a number of barriers that have individual importance; yet, they are interlinked. First, students expressed their low satisfaction of the M&H training they received in university. Secondly, they addressed that the authentic context of practice forced them to take a pragmatic approach, revealing the existence of a theory-practice gap. Further, constraints such as space limitations and availability and accessibility of equipment were present in their answers. I also observed that professional socialisation and the pressure of time made students adhere to the staff's practices. Due to current practices on all three wards I did participant observation, my participants were constantly involved in dangerous patient handling practices, like lifting and not utilising mechanical aids. Indeed, students followed the routines and rituals on the ward even when they disputed their effectiveness because they felt powerless to react. On the other hand, I observed that staff had also considerable gaps in their knowledge, experience and teaching ability to help students improve their practices.

Alex: How relevant is weight to the nursing care you provide to the patients every day?

Stacy: Very relevant.

Alex: In which ways?

Stacy: It's harder to dress a patient, wash a patient, and put them on the bed...that depends obviously on their mobility usually. They are massive amount of workload, isn't it? And usually the staff levels aren't very high. It's harder to do and usually they get left

last to do because it's harder to get them done. I just think it's hard; just in general hard. [Interview with Stacy, 1st year student]

Student nurses often viewed obese patients in terms of the physical work they had to perform. The characterisation 'massive amount of workload' was a typical description of obese patients encouraged by student nurses' constant involvement in physical aspects of patients' care.

All students I observed participated in a moving and handling course as part of their University training. In order to 'get into their shoes' and get awareness of the education they get regarding manual handling, I attended this course. The course was spread over several days and by the end of the course, each student who completed attendance, received a 'manual handling passport' that certified their knowledge of the proper use of manual handling equipment. During this course, each student had the opportunity to familiarise themselves with the manual handling equipment including the slide sheets and the hoists and learn about the health and safety regulations. However, due to time restrictions, students had usually one or two opportunities to 'have a go' at using the equipment. Time limits of their M&H training were stressed from the majority of students. A previous quantitative study of 432 student nurses also found that students felt lack of confidence regarding their M&H abilities after training because they did not have time to practise (Kneafsey and Haigh, 2007).

All students had the opportunity to be manually handled. However, students who were rather overweight or obese refused to be hoisted and were generally reluctant to volunteer in the role of 'patients' in all moving and handling procedures. Thus, although students get manual handling training before going into practice, the training given did not prepare them in a realistic manner, which has implications for the M&H of patients.

I also observed that sometimes M&H equipment was not used even when a patient was obese, such as Hilda. In effect, I believe that there was no contraindication to using a hoist in her case, as indicated in her M&H risk assessment tool, despite that Susan had such an impression. Perhaps, the only inconvenience was that she was in a cubicle; the use of a hoist would require the removal of her bedside table, cabinet and chair so that the mechanical aid could fit and leave enough space for the handlers to

move. Interestingly, she was placed in a cubicle because –as a general ‘covert’ practice – unpopular patients were often kept in isolation.

They wash her legs and put cream. Ann (RN) says ‘Can you turn over for me, Hilda (obese)?’ Hilda says ‘All right, love’. While Ann supports her with one hand at her back and the other on the hip, Susan washes her back. They used the patient’s sheet to move her up the bed. No sliding sheets, hoists or any other manual handling equipment is used. Susan explained later ‘She is too heavy for the hoist’. [Observing Susan, 3rd year student, ward A]

Even when mechanical aids were used, nurses and students often improvised because of practical difficulties. For instance, when manually handling a morbidly obese patient with spina bifida, they had to take into account the uneven distribution of her body, her delicate skin and a variety of tubes attached to her. Carol also noticed that nurses often improvised when using the equipment, especially when a patient was heavy:

Carol: Yes, but when she was turning to put the sling, it was very difficult. You had to use effort for her to turn. She was heavier and as she deteriorated, she couldn’t do much for herself but she would STILL give instructions, like ‘I want to get out of bed’ and ‘I want to do that’ and people had to improvise because she was SO big and the sling of the hoist was cutting into her skin of the thighs so I remember they used a sheet first and then under the sheet, they’d put the sling.

Alex: Yeah...

Carol: You know, because she was dying and her skin was very delicate. You didn’t want her to get bruises. So, I see that because of the weight of a patient, sometimes you have to improvise and think of new ideas of how to help the patient.

[Interview with Carol, a 1st year student]

When a patient needed more than three people for their care, it seems that the whole ward had to adapt their time schedule in order to assist. In the following extracts, I describe some typical examples of morbidly obese patients. Paul, a morbidly obese paraplegic patient, suffered from necrotic ulcers at the end of his spine a result of a neglected pressure sore. For that reason, the doctor instructed to turn Paul every two hours. In this example, it is shown how nurses and students worked harmoniously as a team. However, the pressure is obvious in the health care assistant’s (Brenda) apology for asking for help from a nurse and a nurse’s (Stephanie) improper remark towards Paul. This event highlights certain practical issues; such as the risk of injury

to handlers due to the limited amount of space. The reason why I have chosen to include such a long extract from my fieldnotes is to demonstrate the complexity of attending to the needs of such a heavy and proportionately large patient:

I went to the toilet and when I returned Stacy told me that she's been looking for me to turn Paul. She told me that she asked the sister for someone to give them a hand and sister Wendy told her to find me. The nurse said that 'it's time to move Paul'. Stacy, the bank nurse, Brenda (auxiliary) and me went to the room. The nurse said that they've already washed his front and wanted to wash his back. I wore an apron and gloves. We used the orange slide sheets, as usual and turned Paul to one side. The bank nurse is on my left and Brenda on my right hand side. Stacy and her mentor are at the opposite side. Stacy washed his buttocks and removed the dermapad (cushion for care of pressure ulcers). Paul passed wind and Stacy said 'thank you, Paul'. Paul smiled but Stacy couldn't see that because he was turned towards my side. He said 'you're welcome'. While we move him, as usual, he remains silent with his eyes shut. The bank nurse asks him from time to time 'are you alright?' and he replied 'yes'. Brenda asked Jenny, the qualified nurse to put a new dermapad on Paul. She asked very politely and said apologetically 'if I knew how to do it, I wouldn't ask you to'. Jenny is changing the pads and Stacy does the washing. The wound smell is intense and unpleasant. It is making me nauseous. After changing the dermapad, Stacy and Jenny changed the sheets and the 'greens' and put the slide sheet on. We moved the patient with the sheets towards Stacy's side and turn him over. Brenda noticed that the mattress somehow slid in a way that Paul's head and the pillows were on the verge of the bed. Brenda instructed them to take the breaks off the bed and we pushed the bed further from the wall. We put the brakes on and then moved behind Paul's bed and, with the count of three; we pulled the mattress up the bed. I felt pressure on my back. There was not enough room to do this manual handling so we used more effort to do it. The bank nurse took the slide sheets off and I put the dirty sheets in the yellow contamination bag. Everyone helped to tidy up. Stephanie (Karin's mentor) came and complained about bringing heavy patients on the ward and not taking them elsewhere in front of Paul. She said 'we want our backs for Christmas'. We opened the curtains and in turn washed our hands in the sink in the patient's room. [Observing Stacy, 1<sup>st</sup> year student; ward C]

It is not surprising that Stacy felt that the experience of nursing Paul was challenging, which she confessed during the interview. As with my experience, she felt pain in her back due to M&H that patient despite that slide sheets were utilised. Indeed, most students felt inadequate in caring for patients who were morbidly obese:

Stacy: Yes, on ward C. That gentleman who was 32 stones?

Alex: Do you mean Paul?

Stacy: Yes. THAT WAS HARD! That was dreadful...cleaning and moving him all the time. I wonder what he's doing actually...

Alex: What particular did you find difficult about nursing Paul?

Stacy: Washing him... changing the bedding... because he was so heavy and then, even when you lowered the bed, turning him over...well, that was just hard, really hard. My back was hurting every time.

Alex: Do you think the manual handling sheets were helping or not?

Stacy: Ahm...they did help but that required a lot of effort to put in... to be able to use. That was an extra chore and then moving him around. Yes, that was hard. And then when you had to lift his arms to wash him. And the repositioning all the time, you know...

[Interview with Stacy, 1st year student]

The following extract involves the M&H of a patient that was particularly popular on the ward; nurses' lack of knowledge is transparent as well as their frustration resulting from M&H such patients:

Stephanie, Karin's mentor, asked for both of our help to change Kate's sheets. Kate is the patient in the cubicle, who has spina bifida and is obese. Stephanie, two auxiliaries and Karin went to help. I also helped but mostly observed. The cubicle is very small and therefore there is not much space. They are not using slide sheets but the white sheet that the patient is on. They notice that it is difficult so Stephanie brings one slide sheet and puts it under the patient. Every time Kate is turned, she closes her eyes and it is obvious that she is in extreme discomfort. She gets breathless but she is not complaining. After changing the sheets, they move the patient up the bed by holding the slide sheet on both sides. After they moved her up, they removed the slide sheet. However, Stephanie notices that Kate is too close to the edge of the bed, so they hold the white sheet and move her this way. Stephanie complains to Kate about her weight and she holds her back to show that she is in pain. Kate says 'sorry'. Stephanie commented negatively on her weight and told her to lose some. [Observing Karin, 3rd year student; ward C]

The use of condemned M&H techniques in combination with poor supervision meant that student nurses were often put at risk of musculo-skeletal injury and back pain. In effect, since I participated in patients' care I also experienced similar symptoms.

The following extract is an example of a student, who used the wrong equipment due to poor patient assessment. Karin, a third year student, decided to use the wrong type of hoist that resulted in the patient's discomfort and us lifting the patient. When the

proper hoist was brought, she experienced difficulties in attaching the right size of sling to the hoist. This process was time-consuming and, therefore, caused unnecessary distress to the patient, while delaying the care of other patients.

Daisy (obese, confused) wants to go back to bed. Karin told me to bring the steady. I drew the curtains and Karin explained to the patient what to do. The patient is too weak and cannot support her weight. Karin told me to try and support Daisy from her shoulder while she pushes the patient's back on the steady. She is too heavy and Karin cannot put the back support properly. I tell her that perhaps it would be good to bring a hoist because my back was hurting considerably. We helped the patient to sit on the chair. She brought the hoist. We put the sling under the patient and I let her attach it to the hoist. However, she finds it difficult and tells me that she needs a bigger one. She went to the reception and Maria (qualified nurse) came back and said 'that's the proper size'. Maria managed to attach it and left. Karin used the control to move the patient on the bed comfortably. The patient looks calm. Karin asked Daisy how she feels and she said that she's been on the hoist before. I covered the patient and we went back to the reception. [Observing Karin, 3rd year student; ward C]

A national survey conducted by Gollancz and Thomas (1996) found out that 52% of 1600 nurses reported injuries sustained in M&H incidents. The same study reported that nurses at junior grades were more likely to sustain injury than more senior nurses because of their more frequent involvement in basic nursing care. A more recent study in Australia found that 40% of 523 nurses also reported injuries resulting from M&H (Retsas and Pinkkahana, 2000). Despite awareness of strict legislation and practice guidelines, both student nurses and nurses continue to lift patients manually. Worryingly, over a quarter of students in Kneafsey and Haigh's study (2007) reported experiencing musculo-skeletal pain since becoming a student nurse, which was either associated with an incident whilst on placement or aggravation of previous injury. However, only 16 informed their mentor, while just 3 students out of 432 informed university staff about it. Nevertheless, 15% of students experiencing pain stated that they took time off their placement because of such pain or injury.

An explanation behind students' reluctance to report any incidents of pain or injury could be linked to feelings of insecurity experienced by students whilst being in their clinical placements. Student nurses reported that they felt insecure in their clinical practice placements not only because of their powerlessness as students and the



staff's pressure to participate in condemned techniques, but also because they felt that the current legal system does not protect them if they sustain a back injury after all. In fact, they felt that the system only acted as an inhibitor for them to report any back pain.

During the break, a nurse asks me about my research. I tell her about the importance of weight in my study. She tells me about Hillary; in the beginning, five members of staff were needed to hoist Hillary from bed to the chair. I ask whether they receive some kind of training in their practice. Louise tells me that while in practice, they are obliged to go to manual handling sessions. 'We're doing it because there is a law'. Louise smiles ironically and tells me that the only reason 'they' do it is because they don't want to give you any money if you hurt your back. [Observing Louise, 1st year student; ward A]

In the past, the Confederation of Health Service Employees (1992) , which was a trade union that has now merged with other unions to form the largest public sector trade union in the UK, UNISON, reported that up to 40% of injuries go unreported by nurses. Green's study (1996) also found that nurses were reluctant to report any injuries - linked to their negative attitudes towards changing practices regarding M&H.

Nurses in Mitchell et al.'s participatory action research study (2005) also felt that their voices were not being heard and expressed frustration about it. Interestingly, by voicing their opinions and seeing changes in the implementation of safer practices during the research project, they felt empowered, rewarded, involved and validated, which they stated that it improved the quality of nursing care they offered to their patients. The same study suggested that collaboration and teamwork between members of staff and other health care professionals were vital for the proper utilisation of M&H techniques and for making sure that the environment that patients are cared for is safe and supportive (Mitchell et al., 2005).

Interviews with first year students showed me that their attitudes towards the use of M&H equipment and correct M&H practices were more positive than those of third year students. Indeed, third year students admitted that their experiences in clinical practice led them to believe that what they were taught in moving and handling was impractical and unrealistic. On the other hand, first year students were more likely to engage in these techniques because of their need to 'fit in' and the staff's reluctance

to change their practices. Overall, third year students seemed to internalise nurses' attitudes towards the use of equipment, which could be claimed that this was linked to the process of professional socialisation as previously discussed in Chapter Six (Section 6.4.1).

My observations show that student nurses were often involved in obese patients' M&H because they were considered an extra pair of hands by staff. I suggest that the combination of barriers that prevented consistent safe M&H techniques influenced their attitudes towards being involved in M&H of obese patients. Indeed, their involvement in M&H of obese patients resurfaced their feelings of insecurity due to gaps in knowledge and a fear that they may be injured. Their participation in unsafe practices pinpointed their level of power on the ward but consistent exposure to clinical practice beliefs made their conviction that the authentic context of practice forced them to take a pragmatic approach stronger.

Overall, student nurses' frequent involvement in activities that required M&H characterised their daily routine on the ward. Poor patient assessment, sporadic use of M&H equipment and dangerous patient handling practices were common data of my fieldnotes. However, when patients were considered 'too heavy' to lift, equipment was utilised but often not effectively or properly. Students' role models, mentors and health care assistants, were often found engaged in condemned lifting practices and used students as an 'extra pair of hands' when patients' M&H required two or more people. Student nurses were rather overwhelmed when they had to M&H obese patients; they were confused about what equipment to use and often experienced back pain. Indeed, they usually described their experiences in terms of the amount of workload they had to perform.

In the following section, I discuss the power negotiation between patients that were considered obese and student nurses.

#### **7.4 Obese patients' and student nurses' power negotiation**

My findings suggest that obese patients complied with nurses' and student nurses' rules; however, student nurses experienced obese patients' care as a failed negotiation of their power position on the ward.

My findings suggest that most obese patients received passively any controlling behaviours exercised by student nurses or staff; the majority of patients did not complain, raise any issues with staff or students. Johnson (1997) suggested that such compliance was part of the process of social judgement and named it 'acquiescing' (p.141), which implies that patients made a decision to comply to nurses' rules and demands. Even though I did not interview patients, their behaviour suggested that they accepted student nurses and nurses' authority to exercise power over them. Johnson (1997) further suggested that patients acquired such behaviour because of their vulnerability or even previous sanctions experienced when they resisted or challenged nurses' and/or doctors' authority.

However, my data also includes examples of patients who were not passive subjects and resisted student nurses and nurses' power. It seems that some patients disregarded nurses' efforts of disciplining them because they prioritised other issues in their care. Such an example was Kate, a 23 years old patient with spina bifida who was highly popular with both students and staff, who was morbidly obese and was admitted due to severe respiratory problems. This patient, who was extremely popular with both staff and students, put strong resistance against nurses' efforts targeting weight loss. Due to complications aggravated by her obesity, Kate died and her death left nurses and students in grief. Her resistance to nurses' efforts was commented upon regularly. Despite favouring Kate, Nancy, a first year student, told me that she still felt judgemental towards the lifestyle Kate chose to lead:

I asked her which patients on the ward she thought were underweight, normal-weight or obese and at the end I asked her about Kate. She told me 'it is hard to say about Kate. She was definitely morbidly obese; she couldn't get up from her weight. But it was hard for her to lose weight because she couldn't exercise. She ate all the wrong things, we all knew about that. Her family didn't give her the right diet and that didn't help her condition. When moving her, she was heavy. You felt her weight even when we were four. At the end of the day, she could have stopped eating if she wanted. She would have lived longer and had a better quality of life. She's the one to blame for dying so early'.

[Observing Nancy, 1st year student; ward C]

The reality is that Kate resisted this manipulation and it seems that her goal in life was not akin to the one of nurses; it could be supposed that she viewed food as the

last pleasure she could enjoy at the end of her life. Hence, it could be suggested that nurses failed to gain total control over Kate.

Overall, my observations indicate that nurses did not achieve all their goals regarding obese patients' control. However, I suggest that the achievement of these goals was not as important as the values it symbolised. These values were in relation to nurses' command over patients' bodies and their 'legitimate' exercise of power over patients. Foucault (1977), who was interested in the techniques used to achieve discipline, suggested that the *symbolic meaning* of the moral barriers that health care professionals pose is so strong that the majority of patients become self-disciplined and comprehend how they should behave. Readers of Foucault have coined the phrase 'moral universe' of the hospital to reflect the effect that it has on the pattern of individual behaviour (Driver, 1995).

An evaluation of student nurses' negotiation of their power position on the ward reveals that student nurses felt that obese patients' care had a disempowering effect on them and perceived that they did not have legitimate power to influence it. I suggest that student nurses failed the negotiation of their role in obese patients' care; the thoughts and feelings they expressed could be described in terms of a 'struggle' (Johnson, 1997).

Johnson (1997), who views struggling as part of the climate of social judgement, suggests that struggling occurs when the persons involved in the social interaction – in this instance, the student nurse and the obese patient- fail to negotiate their relationship, activities and roles to be undertaken or played out. He defines it as 'the collection of strategies and tactics involved in attempting to satisfy personal goals in a difficult climate, whilst presenting an appropriate self to others' (Johnson, 1997; p.129). Due to the resemblance of stigma and disempowerment that patients in Johnson's ethnographic study experienced, I have chosen to utilise the same framework to describe student nurses' struggle to care for obese patients.

Student nurses' struggling to care for obese patients took different forms and shapes; they struggled to form a relationship with the obese patient, they struggled to find the time to provide 'brilliant' nursing, they struggled to fit the obese patient on the equipment and they struggled to possess some control over their social position on

the ward. In fact, obese patients' care was experienced as a struggle because it resurfaced a plethora of professional identity, ethical and personal dilemmas.

The first struggle I would like to discuss is that of forming a relationship with the obese patient. Due to the task orientated care and their negative attitudes towards obesity; they had formed a block that prevented them from forming meaningful relationships with obese patients (as described in 6.3.1). At this point it would be useful to take Benner's (2009) explanation why novices in clinical practice take a task-oriented approach in the care they provide. After observing the actual practice and clinical learning of new nurses, she concluded that one of the most important boundaries that they encounter, which prevents them from viewing patients holistically, is that they view clinical situations as a set of tasks that need to be completed. Her observations led her to conclude that novices are unable to view the patient as a person, but a collection of their problems and physical or technical conditions.

Students also had to encounter the barrier of their personal perceptions about obesity. Their beliefs about their own weight and body image, their negative attitudes towards obesity, the lack of confidence due to lack of knowledge and experience formed a 'brick wall', as described by students, to approach obese patients. Part of this barrier was the perceived non-compliance of obese patients; chocolate and other prohibitive food were symbols of this non-compliance which made students feel unable to provide effective nursing care. Hence, obese patients seemed to have conflicting goals with the nurses and their behaviour was interpreted as defying nurses' and their role.

In order to disguise this struggle, which they experienced as emotional labour (Hochschild, 1983), they utilised strategic politeness to present an appropriate self to obese patients and sometimes humour but this was often done unsuccessfully. Previous researchers (James, 1989; Smith, 1992; Hunter, 2002) raised the awareness that managing one's emotions is a form of labour and, hence, their contribution deserves to be acknowledged and paid for. Awareness has also been raised on the fact that it is unrealistic to expect from students to manage their emotions in all conditions (Smith, 1992). Obese patients' care fell into this category because of the multitude of barriers experienced by students.

Student nurses desire to provide ‘brilliant’ nursing could be found in their extensive involvement in *certain* patients’ care that they favoured. It seems that when caring for these patients, they were able to appreciate what Benner (2009) calls ‘the social and emotional aspect of nursing’, which includes communicating with patients. Nevertheless, even in that case, this was usually done under the veil of secrecy especially if the patient was viewed unfavourably by the majority of staff. This meant that students were involved in further sentimental work to disguise their feelings and their disapproval towards nurses’ actions and reactions as well as their positivity towards such patients. They were also often witnesses of practices that put obese patients to the back of the queue; such practices put their ethical values into test. In other words, they encountered scarcity of role models that would enable them to relate to obese patients and their family and mimic their examples of structuring their interaction.

The reality, however, was that student nurses did not have the *time* to complete all sets of goals as set by their clinical practice and the ones articulated by their University educators. Student nurses expressed repeatedly that nursing obese patients took more time than other patients’ care. This often meant that the routine of the ward was disrupted and some patients’ care was rushed up; obese patients’ care that was regularly completed last suffered the most. Not completing tasks on time created an anxiety to students, who often felt somehow obliged to be utilised as ‘an extra pair of hands’ on the wards they practised.

Obese patients’ care also represented a symbol of their inadequacy regarding the proper and safe use of moving and handling equipment. Due to insufficient training and sporadic practice, they often struggled to find the necessary equipment on the wards they practised, they struggled to position safely and fit the patient on the equipment and use it accordingly. Further, they often felt in the awkward position to ask senior staff for assistance, since everyone looked busy with other tasks. The inconsistent and incorrect use of such equipment had also physical implications on students; most of them complained of musco-skeletal pain on their back. Indeed, it could be argued that they experienced obese patients’ care as a test to their capabilities, a term utilised by Benner (2009) suggesting that a beginner nurse experiences extreme anxiety because they feel personally insufficient to deal with the

demands of a particular clinical situation. This could be another explanation why the thought of being involved in obese patients' care had such a disabling effect to them.

Finally, student nurses considered obese patients' care as struggling because their care was not experienced as a learning opportunity; rather, it was viewed as a 'massive amount of workload'. This meant that student nurses viewed obese patients' care as leaving them with less time and opportunities to engage with 'cases' that they could learn from. Further, the sheer amount of physical work required needs to be acknowledged along with the musco-skeletal complications that learning to nurse such patients was accompanied with.

## **7.5 Summary**

In this chapter I have discussed the power relations developed between student nurses and obese patients and explored the implications of students' involvement with obese patients' care. In my pursuit, a Foucauldian lens aided the interpretation of the findings.

I suggest that student nurses participated in the disempowerment of obese patients even though their exertion of power had subtle manifestations. I discovered that obese patients' disempowerment arose out of the definition and assessment of obesity as deviance, which served as justification for the disempowering strategies they employed.

Such strategies included obese patients' surveillance and normalising judgement; student nurses participated in criticism towards obese patients' eating habits and approved of forceful strategies employed by nurses that aimed at controlling patients' diet. I suggest that such strategies aiming at normalising obese patients overrode patients' right to autonomy and challenged patients' freedom of choice.

Further, I discuss how the distance that student nurses kept from obese patients – either because of professional and organisational constraints or their desire to interact less with obese patients – paved the way to patient depersonalisation. While student nurses came into prolonged contact with the obese body –through physical care- they did not acquire knowledge regarding the patient's emotional and social self. While I have argued that this would have been unlikely due to professional and organisational constraints discussed in Chapter Six – I notice here that patients'

objectification was directly linked to the initiation of discriminatory practices. For instance, student nurses paid less attention to obese patients' alimentation needs as opposed to non-obese patients.

On the other hand, I also documented instances where some student nurses sought to empower obese patients. While covert liking of unpopular patients has been documented before (Johnson, 1997), in this study I reveal the strategies that student nurses used to empower patients. These strategies were the following; assisting patients to become autonomous, sharing knowledge and influencing the process of the patient's access to resources. I suggest that student nurses empowered obese patients for the following reasons; first, they felt solidarity towards obese patients because they recognised that they had a similar lowly place in the hierarchy of the ward. Second, they had altruistic motives in that they wished to compensate for the unequal treatment that these patients received from members of staff. Lastly, it provided them with the opportunity to provide compassionate care to their patients.

Another illuminating finding was that obese patients' disempowerment acted as a trigger and a consequence of student nurses disempowerment. Student nurses experienced both emotional and physical consequences that had a disempowering effect on them. Regarding physical consequences, these were linked to students' prolonged participation in obese patients' physical care and moving and handling, which often resulted in musculo-skeletal pain. Regarding emotional consequences, student nurses felt anxiety, stress, and embarrassment when caring for obese patients, guilt for having negative attitudes as well as empathy for patients that they witnessed of being victims of discrimination. The feelings of powerlessness dominated their decisions regarding participation in obese patients' care, while their participation in obese patients' care triggered the realisation that they belong in a low step of the hierarchy ladder on the ward. Student nurses decided to keep these feelings invisible because they felt that they would be judged negatively and this contributed to their emotional labour. Indeed, the exploration of student nurses' emotional response towards obese patients and their care triggered my questioning regarding whether student nurses were actually experiencing signs of burnout and exhaustion.

In order to complete the discussion regarding power manifestations in the student nurse-obese patient relationship, I evaluated how obese patients and student nurses



negotiated their power. My findings suggest that the majority of obese patients acquiesced with student nurses and nurses' exertion of power over them. Nevertheless, there were some patients who resisted student nurses' and nurses' power by not following covert rules and recommendations. I argued that their resistance was not significant because other patients still recognised the legitimacy of nurses' power over patients. On the other hand, I suggest that student nurses' negotiation of power on the ward had rather unfavourable outcome, which was illustrated in their experience of obese patients' care as a struggle.

# CHAPTER EIGHT- Conclusion

## 8.1 Introduction

This thesis explored the social construction of the meaning of obesity among student nurses and described and explained the care offered to obese patients. Drawing on observational data, interviews, students' drawings and documents, the study provided a better understanding of the care that student nurses offered to patients they considered obese and explored the implications that student nurses' involvement in the provision of care had on both patients and students.

In this concluding chapter, I remind the reader of the research questions and assess whether these have been answered. I further present the key findings and limitations attached to this study. Lastly, I discuss how this study's findings are of relevance for nursing education, practice, management and for the advancement of nursing knowledge.

## 8.2 Overview of research questions

As discussed in the introductory chapter (Section 1.3), I decided to develop research questions instead of objectives to avoid limiting my openness to emerging insights (Hammersley and Atkinson, 1995). The research questions were:

1. What does a patient 'being obese' mean to student nurses?
2. Does patients' obesity influence their care? If so, in what way?

Social constructionism requires that a critical stance towards taken-for-granted knowledge is taken (Burr, 1995) and, as health care professionals; we need to challenge the diagnosis and application of diagnostic labels and criteria in practice (Brown, 1995). The first research question, therefore, considered how student nurses conceptualise obesity and how the meaning was framed in their everyday practice. The findings of this study suggest that the meaning of obesity was not static; it was created within the interaction of student nurses with obese patients and their immersion in the nursing culture developed in clinical practice. For student nurses, obesity was conceptualised as something more than the equation of a patient's height and weight; it was a reflection of their experience of caring for obese patients as shaped through their cultural understanding of obesity, expectations of behaviour

from patients considered obese and contextual factors like limited resources. The term 'obesity' was an evaluative label rather than the result of scientific investigation; it was further linked to a visualisation of a patient who was considered 'demanding', with multiple health problems, immense size, and mobility issues. The categorisation process was the result of social, organisational and professional debates and power struggles rather than medical and scientific investigation. The application of the label was negotiated between the members of staff on the ward, for instance, during the handover. Moreover, it was dependent on an individual's perceptions of acceptable size and physical appearance in relation to a patient's age. Finally, patients had an active role in the categorisation process and could potentially negotiate their labelling as 'obese' by modifying their behaviour to meet the nursing staff and students' expectations. For instance, patients who helped or were at least willing to help during moving and handling were less likely to be considered obese.

In order to answer the second research question, it is important to reflect on two significant issues; the first one relates to the definition of care and the second one refers to the amount of control student nurses had over the quality of care they provided to patients. One of the premises of social constructionism is that knowledge and social action go together (Burr, 1995), which means that student nurses' understanding of their role in obese patients' care can provoke different kind of actions. The adoption of a social constructionist position meant that I opted for questioning student nurses about what was important to them when caring for obese patients and explored how student nurses interpreted their role in relation to caring for obese patients. I also explored the extent to which student nurses were able to make decisions regarding the care they provided to obese patients.

My participants' views of caring evolved around maintaining one's image of professionalism and completing the allocated tasks for the day. Student nurses alluded that they were able to maintain their professionalism when caring for obese patients and completed the assigned tasks related to patients' care. Keeping a professional image meant that students had to maintain an 'onstage performance' (Goffman, 1959) when caring for patients. This meant that they often had to disguise any feelings or thoughts they had regarding obesity and caring for obese patients. My findings suggest that students worked hard to keep that performance by developing certain strategies; for instance, they often distanced themselves from patients by

'looking busy', by avoiding any social or emotional contact and by maintaining long silent periods during their interaction. On the other hand, the association of caring with altruism and advocating for patients enriched my findings with a 'back stage performance' of hidden acts of care that some students offered to patients they liked or felt that their care was compromised because of unspoken rules and practices on the ward.

Regarding the control that student nurses had in relation to their participation in obese patients' care, my findings confirm previous research that suggests that students often feel marginal and powerless (Johnson 1997; Maben et al., 2006). Despite not feeling competent enough to care for patients with such complicated needs, student nurses were considerably involved with meeting obese patients' physical care needs. Due to their low power position on the ward, they often spent more time caring for obese patients with restricted mobility and/or complicated needs as 'an extra pair of hands'. Moreover, I observed and student nurses reported that the intrinsic difficulties in caring for obese patients meant that they spent more time with them because 'it took longer' and because their care often involved the use of moving and handling equipment. However, student nurses were unfamiliar with the use of such equipment and felt that they had received sparse practical education regarding moving and handling of larger patients. This meant that obese patients' care was governed by improper handling practices and viewed as time-consuming.

By exploring student nurses' clinical practice, I discovered that professional and organisational constraints highly influenced the care offered to obese patients. For instance, student nurses reported that obese patients were less frequently repositioned, experienced omissions during a patient's physical care and were often left last during the physical care routine due to unspoken rules governing nursing practice. Such decisions were based on the feeling of 'lack of time' and were justified on claims regarding fair distribution of resources. The majority of student nurses condoned such practices; yet, there were some students that were critical of these practices. Conversely, some student nurses developed a covert liking for such patients and compensated for the omissions made in their care by providing 'hidden care'. This suggests that student nurses had some control over decision-making relating to the care they offered to obese patients. They could have passively accepted the categorisation process and engaged with the practices related to the

aforementioned unspoken rules. However, some students endangered their reputation on the ward and participated in improving patients' quality of care.

Overall, it is suggested that the research questions have been answered. In the next section I set out the main findings presented as three themes emerging from this study comparing my findings with the relevant literature in order to underline the contribution this thesis makes to nursing knowledge.

## **8.3 Summary of themes**

### **8.3.1 Student nurses' encounters with obese patients**

There is limited research conducted regarding student nurses' care of obese patients whilst in clinical practice. Therefore, there was a need for a study exploring what happens when student nurses go into clinical practice to nurse obese patients. Overall, student nurses had more encounters with obese patients than qualified nurses and were more involved with patients' fundamental aspects of care on a daily basis. In the light of that, student nurses found their encounters with obese patients challenging, while patients' care was governed by task orientation in many instances in a context of shortfalls in resources.

My findings suggest that student nurses found obese patients' care challenging and, hence, they developed strategies to cope. In contrast to previous research that suggests that student nurses did not treat obese patients differently to non-obese patients (Peternelj-Taylor, 1989; Jeffrey and Kitto, 2006; Sardani, 2006), in this study I observed that student nurses avoided obese patients or employed strategies that limited the time and breadth of communication with them. Regarding food and nutrition, I observed that most student nurses engaged in practices that discriminated against obese patients, such as choosing them last when assisting patients with their meal, evaluating their appetite as always high and not motivating them to eat. Further, student nurses reported that they were unable to contribute to obese patients' assessment of nutritional needs due to gaps in their theoretical knowledge. Third year students also explained that they dedicated minimal attention to meeting obese patients' nutrition and nourishment needs due to institutional and financial constraints governing clinical practice.

I observed that similar practices existed with regard to obese patients' physical care; patients were often left until last and they encountered omissions in their personal hygiene care. For instance, they were often given a 'quick wash' having their face, torso and intimate care done instead of a 'full wash' which includes the back, arms and legs. Inconsistencies in their moving and handling assessment and inappropriate use of equipment further posed risks to patients' and the participants' wellbeing. The findings suggest that student nurses' gaps in knowledge regarding moving and handling put patients at risk of physical discomfort, pain, pressure ulcers and perhaps injury. Indeed, the present research confirms findings from previous studies (Drake et al., 2008; Cornish and Jones, 2010) that student nurses do not always comply with manual handling regulations. These findings contribute to our knowledge by offering an in-depth account of student nurses' experiences of moving and handling obese patients in the reality of clinical practice and demonstrating that their practices were not always safe for patients and students alike. The present findings further confirmed previous research which suggests that student nurses have gaps in their knowledge about obesity and obese patients' care (Green et al., 2000; Petrich, 2000; Hankey et al., 2003; Sardani, 2006; Swift et al., 2007). While it has been suggested that lack of knowledge could potentially be a barrier to obese patients' care (Bagley et al., 1989; Mercer and Tessier, 2001; Hankey et al., 2003), patient care and related safety implications have not been previously fully researched.

Through observing student nurses in clinical practice, the complex reality of caring for obese patients was revealed. I identified that student nurses' interaction with obese patients, student nurses' involvement with patients' food and nutrition and physical care and moving and handling were the key areas whereby I observed that student nurses faced the greatest challenges. While the literature review (Peternelj-Taylor, 1989; Jeffrey and Kitto, 2006) and my previous study (Sardani, 2006) suggests that student nurses regard their role in obese patients' care as professional, overall it is revealed that student nurses, following practices prevailing on the wards, often provided lower standards of care to obese patients.

While the findings of this theme identified the challenges that student nurses face when they care for obese patients, the following theme discusses how these challenges were linked to the meaning student nurses assigned to obesity as well as cultural and institutional constraints governing clinical practice.

### **8.3.2 Constructing the meaning of obesity: the culture and context of care**

Student nurses' meaning of obesity was highly contextual and the care they offered to patients was influenced by a complex web of professional and organisational constraints. Overall, student nurses felt that they were constrained by the process of professional socialisation, their desire to fit in with the ward culture and adherence to covert rules. Moreover, their practice was further constrained by shortage of resources. By selecting an ethnographic approach, I recognised the importance of culture in comprehending student nurses' behaviour in clinical practice (Hammersley and Atkinson, 1995). Following the social constructionist premise of the centrality of social processes in our formation of knowledge (Burr, 1995), I further outlined how the daily interactions of student nurses with nurses and other staff influenced the meaning they assigned to obesity and caring for obese patients.

Previous research reveals that student nurses and nurses perceived staffing levels, availability and usage of manual handling equipment, lack of knowledge, the personality of the patient and the personal characteristics of a student nurse or nurse to be the main barriers to obese patients' care (Davidson et al., 2003; Jeffrey and Kitto, 2006; Sardani, 2006; Rose et al., 2007; Kam and Taylor, 2010). My findings suggest that obesity meaning was infused with negativity and stigmatising attitudes; whereby patients' size and the visibility of obesity were prominent in influencing how obesity was conceptualised. My study paralleled previous research findings (Bagley et al., 1989; Maroney and Golub, 1992; Garner and Nicol, 1998; Culbertson and Smolen, 1999; Brown, 2006; Sardani, 2006) that suggest that student nurses and nurses alike assign negative stereotypical characteristics to obese persons. During interviews and through their pictures, student nurses identified a list of negative traits attributed to obese patients. For example, student nurses considered that obese patients were demanding, unappreciative, complaining and carrying the responsibility for the state of their health.

However, while student nurses attached negative characteristics to the notion of obesity, in practice not all obese patients were considered unpopular. Moreover, an obese patient's unpopularity on a ward did not presuppose that student nurses would compromise their care. In other words, my findings support the idea that the traits' approach, which claims that the difficulty in people's encounters is located in one's personality, does not explain fully the phenomenon of unpopularity- as far as obese

patients are concerned. What this study adds to current knowledge is that student nurses' responses to obese patients were not singular and unidirectional. In ward A, for instance, a morbidly obese patient with spina bifida and respiratory failure was extremely popular with staff and students despite her resistance to adhere to weight loss recommendations. While previous research (Roth, 1972; Stockwell, 1972; Jeffery, 1979; Kelly and May, 1982; Crandall, 1998; Crandall et al., 2001) suggests that a stigmatised condition, such as obesity, can have adverse effects on a patient's treatment and care, my findings suggest that this was not always the case. My study echoes Johnson's (1997) ethnographic study of social judgement in nursing in that a patient's popularity was a complex phenomenon. For instance, I observed that while some student nurses seemed to condone nurses' negative labelling, they often offered additional support and care to those patients. I further revealed that even though some student nurses thought that obese patients were unpopular as far as their physical care and compliance are concerned, they refused to compromise their care.

Regarding the meaning of obesity, my study confirms the findings from previous studies suggesting that student nurses and nurses alike do not consider Body Mass Index as their prime tool to measure obesity in clinical practice (Wright, 1998; Jeffery And Kitto, 2006; Sardani, 2006; Brown et al., 2007; Miller et al., 2008). This study supports the contention that the meaning of obesity was socially constructed rather than pre-existing clinical definition. I identified that unlike previous studies presuppose, student nurses' understanding of obesity goes beyond the biomedical framework. My participants conceptualised the obese body by drawing knowledge from several different sources; first, they were influenced by popular cultural values and norms, such as the 'thin ideal' inherent in modern society (Crandall et al., 2001). Second, the nursing culture became considerably influential in their interpretation of obesity through the process of professional socialisation. For instance, a key moment into the negotiation of the 'obesity' status of a patient was the nursing handover in which nurses discussed whether a patient is 'big' or 'needs the help of more than one person'- notions often utilised to convey that a patient was obese. Third, their personal experiential way of knowing was intrinsic to their prolonged contact with the obese body during the provision of physical care. Fourth, their own experience and practical knowledge led them to believe that obesity assessment was dependent on contextual factors, especially the types of available



resources. For instance, if the patient could not 'fit into' on the available chairs on the ward and, consequently, special equipment needed to be ordered, then the patient was categorised as 'obese'. Finally, I suggested that obese patients also participated in the construction of the meaning of obesity by their ability and/or willingness to participate in assisting student nurses during moving and handling. The interpretation of my findings was aided by social constructionism's principle that people construct between them their knowledge of the world (Burr, 1995) - including that of obesity. This finding concurs with Johnson's (1997; p.101) study which revealed that patients have minimal, some or substantial control over their categorisation process. In line with Johnson's study, nevertheless, my findings suggest that 'big' patients with mobility issues have minimal control because of the physical and emotional consequences that their care evokes on their carers.

Regarding professional socialisation, no previous research has suggested its influential role in the care that student nurses provide to obese patients. This research highlighted that the majority of student nurses gradually adopted nurses' perceptions, values and unspoken messages about obese patients and their care. While the majority of nurses I observed held negative perceptions about obese patients, they managed to deal with their feelings by expressing and discussing them in the nurses' office. Indeed, the nurses' office acted as a therapy room; a protected environment whereby nurses and other staff could recognise and share the emotional cost of caring. However, student nurses were unable to comprehend this function of the nurses' office and expressed frustration towards nurses during their informal or formal interviews because they expected nurses to act as role models by being non-judgemental.

Another barrier to student nurses' experience of nursing obese patients was that of fitting in with the ward culture and, consequently, adhering to covert rules. In the past, there has been research and discussion of the influence of such rules on student nurses and patients' care (Melia, 1987; Jasper, 1997; Daiski, 2004; Maben et al., 2006) but not specifically in connection with obese patients' care. My findings suggest that student nurses' desire to fit in with the ward culture meant that they did not voice their opinions, followed the rules unquestionably and displayed seemingly limited decision-making about their participation in patients' fundamental aspects of

care. For instance, fitting in with the ward culture meant that student nurses were often engaged in poor moving and handling practices. Students told me that these inferior practices were concealed from their educators in the university for fear of being reprimanded. Interestingly, some student nurses admitted that they condoned such practices and debated the practicality of the use of moving and handling equipment in practice. Of particular interest is the hidden rule of 'looking busy', since student nurses often utilised this 'busyness' in order to minimise their interaction with patients. My findings suggest that this technique was more than often used during their encounters with obese patients.

Shortages of resources was also commonly reported by my participants; this finding echoes previous research, has suggested that staffing levels are not sufficient to meet obese patients' personal care needs (Davidson et al., 2003; Sardani, 2006; Rose et al., 2007; Drake et al., 2008; Kam and Taylor, 2010). This study emphasised that student nurses were often utilised by staff to meet the increasing demands of care, which the presence of obese patients with mobility issues aggravated. My observations also confirmed that a constellation of compromises to obese patients' care were justified by student nurses on the grounds of resource shortages. Student nurses admitted that shortages of resources meant that they felt overwhelmed by obese patients' care and the extra time required delivering quality care, which resulted in them being less empathetic towards them. Further, more experienced students regarded their non-utilisation of moving and handling equipment as a compromise that needed to be made because its use was considered time-consuming. Some expressed the belief that lifting patients was an action done out of necessity or even interest towards the patient's welfare. Indeed, student nurses were willing to potentially compromise their physical wellbeing in order to meet the patients' needs by engaging in prohibited moving and handling procedures.

While this theme demonstrated how student nurses define obesity, and presented student nurses' reasoning and explanations for the care offered to obese patients, the third theme presents the findings in relation to the consequences of student nurses' participation with obese patients' care.

### **8.3.3 The consequences of student nurses' involvement with obese patients' care**

Within this final theme the consequences for obese patients and student nurses' wellbeing are interpreted and understood within the context of the power relations between student nurses and obese patients. The exploration of power relations in social constructionism is considered key to understanding how certain forms of social life are created and upheld (Burr, 1995). My findings parallel Foucault's (1980) theory of how power can be exercised within everyday interactions of people in the lower strata of power and thus assisted me in presenting the intended and unintended effects of student nurses' involvement with obese patients' care in a coherent way.

As opposed to what the literature suggests, the study findings show that the personality of obese patients (Garner and Nicol, 1998; Sardani, 2006; Drake, 2008, Poon and Tarrant, 2009) and the personal characteristics of student nurses (Hoppe and Ogden, 1997; Brown and Thomson, 2007; Watson, 2008) were not the sources of difficulty in the obese patient-student nurse interaction. Rather, my findings suggest that the unequal balance of power in clinical practice is the source of the implications experienced by both student nurses and obese patients.

In light of student nurses' feeling of having a low power position on the ward, and their consequently persistent involvement in fundamental aspects of care of obese patients despite their limited knowledge and experience, my findings suggest that they felt overwhelmed and disempowered by their involvement with obese patients' care. The only previous research that has explored the concept of power differentials as a component into how nurses perceived obese patients' care was Jeffrey and Kitto's (2006) study. They suggested that nurses felt disempowered by doctors' exclusive decision-making in relation to obese patients' treatment and this influenced negatively their perceptions about obese patients' care. They further suggested that the medicalisation of obesity was directly linked to nurses' awareness of being reduced to a secondary role and this reflected their experience of caring for these patients as a struggle. In my study, most student nurses' coping strategy to the aforementioned feelings was to participate, implicitly or explicitly, in the subjection of obese patients into disempowering strategies on the grounds that obesity is culturally regarded as a form of deviance. For instance, student nurses often engaged in surveillance of obese patients' non-hospital food and criticised their food choices-

although not in front of patients. Further, they agreed with several controlling behaviours that nurses exercised, such as taking away 'inappropriate' food from them without their consent.

However, this study also suggested that power does not reside solely in large organisations and powerful individuals; even people in the lower ranking of social order – such as student nurses- have some control over decision-making. While student nurses did not have decisive power into their participation in obese patients' fundamental aspects of care, their persistent involvement meant that they were able to take small yet key steps towards patients' empowerment. My findings suggest that some students took advantage of the information they gained while caring for obese patients that were generally considered unpopular and utilised it for the patient's benefit. In other words, instead of imposing controlling strategies as previously described, some student nurses engaged in a wealth of strategies that contributed to patients' empowerment. For instance, they found time to walk a patient to the toilet rather than bring the commode. They also spent more time talking with these patients allowing them to voice their concerns and supporting them to make choices. Indeed, these students engaged in an interaction with obese patients, which was characterised by reciprocity, encouragement of patients to become autonomous, sharing of knowledge and information, prioritisation of patients' needs and advocacy of patients' access to resources.

This parallels Foucault's (1980) notion that power can be utilised in a positive, productive way, which is associated with pleasure, knowledge and the production of discourse. My findings indicated that some student nurses' actions were guided by a sense of solidarity towards patients that were disempowered and they attempted to rectify the implications caused by others' treatment. Students cited an altruistic motive to provide what Smith (1992) has described the 'small things'. This finding is important because it suggests that student nurses may be able to understand how patients are sometimes disempowered, they can move beyond blaming individuals, assume an advocating position for their patients and provide examples of 'brilliant' nursing (Johnson, 1997)- albeit covertly.

Regardless of whether student nurses chose to participate in disempowering techniques or covertly provided exemplary care to obese patients, this study

supported that student nurses worked very hard on the wards in which they practised providing both physical and emotional labour. The findings indicated that some student nurses felt stressed, oppressed and powerless because of persistent involvement with obese patients' care, while some felt sorry or empathetic towards them. Previous research suggests that obese patients' care evokes *both* negative feelings, such as frustration (Mercer and Tessier, 2001; Jeffrey and Kitto, 2006; Zuzelo and Seminara, 2006; Sardani, 2006; Watson et al., 2008) *and* positive feelings, including empathy (Maroney and Golub, 1992; Sardani, 2006; Zuzelo and Seminara, 2006; Brown et al., 2007). In the present study, students were particularly sensitive when witnessing instances in which nurses had openly stigmatised or discriminated against obese patients. Students suggested that the role of the mentor as protector of student nurses' learning opportunities was instrumental into how they experienced obese patients' care. Further, the findings revealed that student nurses also experienced physical consequences – such as back pain - because of their participation in obese patients' moving and handling. Moreover, their conviction that they could not report such occurrences to their educators further enhanced their feeling of disempowerment. Student nurses also suggested gaps in their training in relation to moving and handling bigger patients, which further contributed to their experience of obese patients' care as a struggle.

My findings suggest that obese patients usually opted to acquiesce to the disempowering strategies utilised by student nurses and staff. This finding parallels Johnson's study (1997) on social judgement that showed that patients often received passively controlling behaviours exercised on the ward by making a decision to comply with nurses' rules and demands. Johnson suggests that this occurs because patients felt vulnerable or had previously experienced sanctions when they resisted or challenged nurses' authority. In my study, a small minority, however, chose to resist control over their care; for instance, by not complying with diet recommendations. Nevertheless, my findings suggest that the achievement of student nurses' and nurses' goals were not as important as the symbolic meaning they carried. This echoes Foucault's (1977) theory of power and discipline, which argues that the achievement of compliance is not as important as the symbolic meaning that such sanctions carry. This meaning was so strong that the majority of patients opted to receive passively the behaviours displayed by nurses and students and often became

self-disciplined. On the other hand, student nurses felt immense pressure associated with the intensity and frequency of their involvement with obese patients care and the associated physical and emotional labour and presented signs that they experienced obese patients' care as a struggle. While caring for obese patients, they experienced a plethora of physical and emotional manifestations of exhaustion, which prevented them from enjoying their experience in clinical practice. Their interviews and drawings further suggest that they attained a pessimistic view of their future as qualified nurses whereby they would encounter similar challenges when caring for obese patients but with the additional responsibility of being accountable for their care.

Having presented the main findings, the reader should be mindful that this study, as any empirical study similar to this, has certain limitations, which I discuss in the following section.

#### **8.4 Limitations of the study**

In view of the limited scope of a doctoral study and of practical choices, the study was restricted to three particular settings over a time-limited period in Wales. However, the aim of qualitative studies is not to generalise the findings but findings may be transferable to similar settings (Mason, 2002; Green and Thorogood, 2004). It is therefore important that the context of the study is sufficiently described without compromising the anonymity of the participants which I have endeavoured to do. I have also aimed to provide sufficient information about the sample's characteristics. Moreover, the utilisation of an ethnographic approach has offered rich data concerning student nurses' actual care towards obese patients that a quantitative approach would not have been captured. For example, I was able to explore student nurses' interaction with obese patients by observing them in their clinical practice and asking student nurses about their experiences achieving richness of data.

Regarding sampling of participants, my sample included sixteen student nurses; I observed eleven of them and interviewed another five students to enhance my data. The sample included students from different ages, years of studies, working experience and ethnic group. Only three male students were included. Only two out of sixteen students were from an ethnic minority group. While I aimed to include a diverse range of individuals in my sample to enhance the transferability of the

findings, the sample of students was not random as students volunteered to be observed. Since generalisation of findings was not an aim of this study, non-probability, purposive sample were deemed acceptable methods of selecting participants. Such a decision was in line with my ethical reasoning of not being intrusive and it allowed students to participate freely rather than being forced to do so by their educators or nursing managers.

While I took advantage of every opportunity to conduct informal interviews with my participants while observing them, I only managed to formally interview two out of sixteen students. Even though I planned to formally interview all students observed, the majority of students were unavailable to participate in that phase of the study. This could have been avoided if there was not such a lengthy interruption between the participant observation and interviewing phase of the study. Even though the opportunity to interview them could have provided more insight into my observational data, it was interesting that students who I did not observe recalled considerably similar accounts to the ones observed.

Not including obese patients as participants could have given the impression that they were 'passive' recipients of their care and targets of stigmatisation. I noted that obese patients did possess some power albeit limited and some chose to exercise it. I recognise that obese patients' interpretation of their reality, their coping strategies and responses are equally important in order to fully comprehend obese patients' care. The comprehension of obese patients' care could only be deemed complete if we explore their needs, goals and motivations that could advance our understanding of how they perceive and interpret the care they receive from student nurses and others. Therefore, I consider not including obese patients' accounts of their care as a limitation of this study.

## **8.5 Relevance of this study and Recommendations**

The relevance and contribution of this study to nursing knowledge can be viewed in terms of the application of its findings in the areas of clinical practice, education, management and research. Student nurses, nurses, other health care professionals, nurse educators, managers and researchers may identify similarities in their practice and benefit by gaining a deeper understanding of obese patients' care.

### **8.5.1 Relevance and recommendations for clinical practice**

This study is part of a limited number of studies that used participant observation to capture student nurses' experience of being in clinical practice. It therefore offers key insights into how student nurses experience clinical practice, the challenges they face, their coping strategies, the enjoyment they gain and the role of caring for obese patients in that process. This study revealed student nurses' experience of learning and working on the wards was influenced by power manifestations and the presence of obese patients in clinical practice. It further highlighted that during the process of caring for obese patients student nurses perform considerable emotional and physical work.

This study furthers the knowledge of the power manifestations in clinical practice and how the culture and context of care may contribute to the construction of difficulty in student nurses' encounters with patients whom they consider obese. Obese patients had the least amount of power because they were stigmatised and because they had complex nursing needs. Student nurses had also a restricted amount of power on the ward because of their lack of knowledge and experience and the limited amount of time they spent on the ward. The relationship between student nurses and obese patients, fuelled by their low position, was based on their power negotiations. The majority of student nurses developed coping strategies and participated –implicitly or explicitly- in disempowering obese patients because they experienced obese patients' care as challenging. Obese patients' disempowerment went sometimes undetected from students or even nurses on the ward; nevertheless, when it was detected it was justified as a 'fair consequence' and an inevitability of health care resource rationing.

Apart from the physical aspect of caring for obese patients, this study suggests that both student nurses and nurses did significant emotion work when caring for obese patients. This part of emotion work is not found in the literature and not acknowledged despite the majority of nursing studies reporting that nurses experience a wide spectrum of negative feelings when caring for obese patients. None of the studies regarding nurses' and student nurses' care towards obese patients have explored how nurses or student nurses deal with emotions experienced while caring for obese patients and whether they receive any support in doing so. In my study, I revealed the broad spectrum of emotions, as experienced by student nurses



and discuss how they expressed or suppressed them. Interestingly, the majority of student nurses engaged in (rather unsuccessful) suppression of their feelings because they considered them inappropriate and contradictory to their role as a nurse.

Recommendations for clinical practice are:

1. To reflect, question and challenge discourses of student nurses and nursing staff regarding obesity and obese patients' care. Alertness is critical in identifying the contextual factors that create the difficulty in student nurses and nursing staff's encounters with obese patients.
2. To critically examine one's values and accept that patients are not a homogenous group; to highlight the importance of adopting non-discriminatory attitudes towards obese patients when considering fair distribution of resources.
3. To identify, minimise and manage safety problems related to obese patients' care and cultivate a culture whereby errors and mistakes in obese patients' care are discussed within a framework of learning, reflection and promotion of patient safety.
4. To provoke further discussion about the value of emotions in nursing obese patients and reflect on the emotional labour of student nurses in relation to obese patients care.

### **8.5.2 Relevance and recommendations for education**

This study is relevant for nursing education because it is the first study that gives insight into student nurses' culture from an 'outsider' perspective - since I am Greek and I have not studied nursing or worked in the UK and I was not the student nurses' teacher or mentor. Further, since the number of obese patients admitted to hospital wards is rising, the study findings are topical and provide insight into the areas of obese patients' care that student nurses require assistance, preparation, guidance, and perhaps protection.

Student nurses' curriculum needs to be examined in relation to the level of theoretical knowledge that student nurses receive on obesity. Nurse educators need to explore whether students require more preparation for their practice placements with

regards to interacting with obese patients, food and nutrition, physical care and moving and handling.

Educators should acknowledge that stigmatisation is a process that no one can escape from and convey that to students to avoid the possible experience of guilt-related feelings that students in this study expressed. Nevertheless, they should provide a fertile ground for discussion and reflection upon these feelings and how they can be diffused. Opportunities to openly discuss feelings and biases that are evoked by obese patients' care could usefully be provided in the safe environment of the University to minimise the chance that any negativity may be displayed in practice.

Recommendations for nurse educators include:

1. Specific training associated with obese patients' nutritional care should be initiated as a standard requirement of student nurses as well as an induction and continuous professional development for existing staff.
2. To ensure that student nurses' education provides them with sound knowledge to care for obese patients, including interacting, counselling, assessment and improvement of patients' nutritional status.
3. To provide student nurses with the practical skills and theoretical knowledge for safely moving and handling heavier and bigger patients.
4. To critically analyse the social and institutional influences that affect obese patients' care and nursing practice. Reflection on their relationship, the social structure and social process in which it takes place, may assist student nurses understand that their interactions with obese patients can be constrained by issues that have to do with the structuring of the health care system and society itself.

### **8.5.3 Relevance and recommendations for management**

Managers should explore whether the care of obese patients with mobility issues poses challenges to student nurses and nursing staff. They need to identify whether students, nurses and health care assistants are recipients of high standards of training, or whether there is a need for an increase in the flow of resources to meet the demands and an attempt to change nurses' attitudes towards the use of moving and handling equipment. Educational in-service training on special topics regarding

obesity, body mechanics, patient safety, risk management and the appropriate use of moving and handling equipment for heavier patients may be helpful in raising levels of understanding and proficiency.

Regarding obese patients' food and nutrition, managers need to explore the levels of nutritional care which obese patients receive in clinical practice and consider ways of empowering student nurses and clinical staff alike to prioritise and focus on this important element of their care. In that spirit, the current process and documentation of nutritional assessment needs to be reviewed to ensure that obese patients' nutritional needs are equally considered. The key focus to date has been in combating under nutrition in hospitals with less attention on obesity.

Recommendations for managers include:

1. To provide adequate resources, in terms of equipment and staffing levels in order to enable compliance with policies in relation to nutrition and moving and handling.
2. To monitor closely the delegation of work in clinical practice. Qualified nurses should act as role models and facilitate adherence to moving and handling policies.
3. To provide opportunities and training for nurses to meet obese patients' nutritional and nourishment needs focusing on the specific challenges that obese patients face when they are admitted to a hospital ward.

#### **8.5.4 Relevance and recommendations for research**

This study has relevance to the research community in several ways.

The first is that by exploring the meaning that student nurses assign to obesity, I offer a re-appraisal of the assumptions made regarding obesity measurement, assessment and conceptualisation in clinical practice. By taking a social constructionist approach, which challenges the creation and use of knowledge (Burr, 1995), I was critical of student nurses' knowledge regarding obesity and its application in everyday practice. The social constructionist perspective was further useful in realising the importance of studying the historical and cultural context in which student nurses' ways of knowing obesity was developed. It further assisted me to concentrate on student nurses' interaction in clinical practice with patients and

others. Such an approach could be useful in any research study conducted in clinical practice that wishes to explore student nurses and nurses' ways of knowing, knowledge and their application in clinical practice.

This study will hopefully encourage other researchers to embark on a journey looking into student nurses' conceptualisation of obesity on a larger scale; a quantitative study looking into how the population of student nurses interpret obesity would be a useful start utilising the findings of this study, perhaps, for the development of a questionnaire. For instance, it would have been interesting to create a survey with visual stimuli to assist student nurses explain what they mean by obesity. Such images could include the depiction of patients with different sizes, different ages, and different mobility issues whereby students could choose which pictures represent more accurately their obesity conceptualisation. A study that would enable generalisation of findings to the whole student nurse population will increase our understanding and perhaps alter the ways in which we interpret current research regarding students' perceptions of obese patients and their care. In order to overcome one of the limitations of the study, this could be extended by exploring how nurses and obese patients conceptualise obesity and the implications that has for service delivery.

I also suggest that the ethnographic approach that I took in this study has much to offer to nursing research. This approach encourages an understanding that student nurses are members of particular cultures and that these cultures will inform their care towards obese patients and their understandings of obesity. Moreover, I make explicit that consideration of the wider context that student nurses practise in and care for obese patients is imperative in understanding their conceptualisation of obesity and behaviour towards obese patients. Furthermore, the utilisation of an ethnographic approach was necessary in order to make explicit the key role that power possesses in student nurses' practice. The use of reflexivity was vital in the interpretation of my findings and my own growth of knowledge through the exploration of the changes of my perceptions about me, nursing practice and society itself. Finally, I would like to encourage future researchers to employ innovative methods of data gathering, such as asking their participants to draw a picture. I believe we need to challenge and extend the boundaries of our methods and

methodologies, because such courage can reward us with additional insights and ways of understanding our participants' reality.

Overall, the following areas require further research;

1. An in-depth ethnographic exploration of qualified nurses and health care assistants' care of obese patients
2. A replication of this study in other settings, including the community to establish whether student nurses experience obese patients' care in a similar manner
3. Obese patients' voices need to be heard; more research is needed to explore how obese patients perceive qualified nurses and student nurses' involvement with their care.
4. The meaning and experience of caring for obese patients needs to be explored across different cultures and social contexts.

## **8.6 Summary**

This study has contributed to advancing nursing knowledge related to the meaning student nurses assign to obesity, the care they offer to obese patients, the context in which they care for them and the implications of their involvement on obese patients' care for both student nurses and obese patients. My research design has been explained in detail and I ensured that the data were collected, analysed and interpreted in a rigorous manner and subjected to a series of strict criteria. Lastly, I detailed the significance of this study and its relevance for nursing knowledge, practice, management and research.

The findings of this study suggested that student nurses found challenging the following areas of obese patients' care; interaction, food and nutrition, and moving and handling. I discovered that the culture and context of care shaped student nurses' conceptualisation of obesity and influenced their experience of caring for obese patients. The findings suggested that student nurses' participation in obese patients' care was linked to considerable physical and emotional labour and contributed to student nurses' feeling of being disempowered. In turn, it often triggered their involvement in a series of disempowering strategies towards obese patients. Nevertheless, some students chose to secretly provide empowering acts of care to

some obese patients who were disempowered by others, but the covert nature of their actions, the risk of being discovered and the additional labour they devoted put further pressure on them. Overall, student nurses experienced obese patients' care as a failed negotiation of their power relations in clinical practice.

My study has shown the value of an ethnographic approach in exploring the social construction of nursing knowledge and its application in clinical practice. By studying how obesity was socially constructed in clinical practice, I have examined the effects of cultural, institutional and organisational structures in shaping the knowledge base of student nurses. An ethnographic study influenced by social constructionism has great potential for exploring the origins of student nurses and nurses' professional beliefs, their ways of knowing, and their socialisation in clinical practice. Additionally, the use of this approach enabled me to explore obese patients' care at the micro-level, observing student nurses' interpersonal communication and their actions while they were happening and appreciate how meaning is constructed within these interactions. Despite the sparse amount of studies that have adopted such an approach in researching student nurses, it is hoped that prospective researchers will recognise the promise of field studies. This study has demonstrated that an ethnographic approach is appropriate for exploring the meaning of obesity and for furthering our knowledge regarding student nurses' care of obese patients within the hospital setting.

# The social meaning of obesity

---

An ethnographic exploration of  
student nurses' care of obese  
patients in hospital settings

**Alexandra Vanta Sardani**

[Volume II of II]

**Bibliography and Appendices**

**Alexandra Vanta Sardani**

**Submitted to Swansea University in fulfilment of the requirements  
for the Degree of Doctor of Philosophy**

**SWANSEA UNIVERSITY  
2014**





# TABLE OF CONTENTS

|  |    |
|--|----|
| <b>BIBLIOGRAPHY</b> .....  | 2  |
| <b>APPENDICES</b> .....  | 37 |
| Appendix 1. Table of nursing studies .....   | 38 |
| Appendix 2. Open Coding in NVivo .....   | 49 |
| Appendix 3. Table that depicts the association between codes, subcategories,<br>categories, subthemes of the 3rd theme ..... | 50 |
| Appendix 4. Advertisement .....  | 53 |
| Appendix 5. Interview Schedule .....   | 54 |
| Appendix 6. Extract from fieldnotes with codes and analysis .....  | 55 |
| Appendix 7. Informed Consent .....   | 60 |
| Appendix 8. Nutrition Risk Screening Tool .....  | 61 |
| Appendix 9. Patient Handling Risk Assessment.....  | 63 |
| Appendix 10. Bariatric Equipment Provision Poster .....  | 65 |

## BIBLIOGRAPHY

Abertawe Bro-Morgannwg University Health Board (2011) *Abertawe Bro-Morgannwg University Health Board: Public Health Strategic Framework 2011/2012*

<http://www.wales.nhs.uk/sitesplus/documents/863/New%20Board%20Papers%20June%202011.pdf> (Accessed: 9 September 2011).

Adams, C.H., Smith N.J., Wilbur D.C., Grady K.E. (1993) 'The relationship of obesity to the frequency of pelvic examinations: do physicians and patient attitudes make a difference?' *Women Health*, 20, pp.45-57

Ajzen, I., and Fishbein, M. (1977) 'Attitude-behaviour relations: a theoretical analysis and review of empirical research', *Psychological bulletin*, 84 (5), pp. 888-918.

Allen, S., O'Connor ,M., Francis, K. (2007) 'The importance of language for nursing: does it convey commonality of meaning and is it important to do so', *Australian Journal of Advanced Nursing*, 24 (4), pp. 47-51.

Allender, S, Peto, V., Scarborough, P., Boxer, A., Rayner, M. (2006) *Diet, physical activity and obesity statistics*. British Heart Foundation Statistics Database.

Allender, S. and Rayner, M. (2007) 'The burden of overweight and obesity-related ill health in the UK', *Obesity Reviews*, 8, pp. 467-473.

Altheide, D. and Johnson, J. (1994) 'Criteria for assessing interpretive validity in qualitative research' in: Denzin, N., Lincoln Y. (eds), *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.

Amundson, D.E., Djurkovic, S., Matwiyoff, G.N. (2010) 'The obesity paradox', *Critical Care Clinics*, 26 (10), pp. 583-596.

Angrosino, M. (2007) *Doing ethnographic and observational research. The SAGE qualitative research kit*. London, Sage Publications.

- Annandale, E. (1998) *The Sociology of Health and Medicine. A critical Introduction*. Cambridge: Polity Press.
- Atkinson, P. (1990). *The ethnographic imagination: Textual constructions of reality*. London: Routledge
- Atkinson, P. (2005) 'Qualitative Research- Unity and Diversity', *Forum: Qualitative Social Research*, 6(3), 26. Available at: <http://www.qualitative-research.net/index.php/fqs/article/view/4/9> (Accessed: 27 July 2009).
- Atkinson, R. and Flint, J. (2001) 'Accessing hidden and hard-to-reach populations: snowball research strategies', *Social Research Update*, Issue 33, University of Surrey.
- Attree, M. (2008) 'Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care', *Journal of Advanced Nursing* 33 (4), pp. 456-466
- Attree, M., Cooke, H., Wakefield, A. (2008) 'Patient safety in an English pre-registration nursing curriculum' *Nurse Education in Practice* 8, pp. 239-248
- Axford, J. and O'Callaghan, C. (2004) *Medicine*. 2<sup>nd</sup> Edition. Oxford, Blackwell Publishing.
- Bagley, C., Conclin, D., Isherwood, R., Pechioulis, D, Watson, L. (1989) 'Attitudes of nurses towards obesity and obese patients', *Perceptual and motor skills* 68, p. 954.
- Bailey, P.H. (1997) 'Finding your way around qualitative methods in nursing research', *Journal of Advanced Nursing*, 25, pp. 18-22.
- Banja, J. (2004) 'Obesity, responsibility and empathy', *Case Manager*, 15 (6), pp. 43-6.
- Barber, P. (1997) 'Caring- the nature of a therapeutic relationship' in Perry, A. (ed.) *Nursing, a knowledge base for practice*. London: Arnold, pp.171-211.
- Barbour, R. (2008) *Introducing qualitative research: a student guide to the craft of doing qualitative research*. London, Sage Publications.

- Barbour, R.S. (2001) 'Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?', *British Medical Journal*, (322), pp. 1115-1117.
- Basiotis, P.P., and Lino, M. (2002) 'Food insufficiency and prevalence of overweight among adult women', *Nutrition insights*, 26, pp. 1-2.
- Bauer, M., and Geront, M. (1999) 'The use of humour in addressing the sexuality of elderly nursing home residents', *Sexuality and disability*, 17 (2), pp. 147-155.
- Beauchamp, T.L. and Childress, J.F. (2001) *Principles of biomedical ethics*. Oxford University Press, Oxford.
- Becker, H.S. (1972) *Boys in White: student culture in medical school*. 2nd ed. Iowa: Brown Reprints.
- Becker, H.S. et al (1970) 'The nature of a profession', in Becker, H.S., *Sociological work: Method and Substance*. London: Allen Lane The Penguin Press, pp. 87-103.
- Befort, C.A., Greiner, K.A., Hall, S., Pulvers, K.M., Nollen, N.L., Charbonneau, A., Kaur, H., Ahluwalia, J.S. (2006) 'Weight-related perceptions among patients and physicians: how well do physicians judge patients' motivation to lose weight?', *Journal of General Internal Medicine*, 21 (10), pp. 1086-1090.
- Bell, D.W. and Esses, V.M. (2002) 'Ambivalence and response amplification: a motivational perspective', *Personality and social psychology Bulletin*, 28, pp. 1143-1152.
- Benner, P. (1984) *From novice to expert: excellence and power in clinical nursing practice*. Addison-Wesley, CA.
- Benner, P.E., Tanner, C.A., and Chesla, C.A. (2009) *Expertise in nursing practice: caring, clinical judgment and ethics (2nd Edition)*. New York: Springer
- Bentham, J. (1962) *The works*. New York: Russell and Russell.
- Berragan, L. (1998) 'Nursing practice draws upon several different ways of knowing', *Journal of Clinical Nursing*, 7, 209-217.
- Blaikie, N. (1993) *Approaches to Social Enquiry*. Cambridge; Polity Press.

- Blaikie, N. (2000) *Designing Social Research: The logic of anticipation*. Cambridge; Polity Press.
- Bloom, S. (2007) 'Hormonal regulation of appetite', *Obesity Reviews*, 8, pp. 63-65.
- Bloor, M. (2001) 'The ethnography of health and medicine', in Atkinson, P., Coffey, A., Delamont S., Lonfland J., Lofland L. *Handbook of ethnography*. London: SAGE Publications, pp. 177-187.
- Bone, D. (2002) 'Dilemmas of emotion work in nursing under market-driven health care', *International Journal of Public Sector Management*, 15 (2), pp. 140-150.
- Bosco, A.M., Ward C., Styles, I. (2005) 'Looking to the future: nursing as a career goal', *Contemporary Nurse* 19 (1), pp.105-114
- Bourne, J. (1998) 'Researchers experience emotions too', in Barbour R.S. and Huby G. (eds) *Meddling with mythology: AIDS and the Social Construction of Knowledge*. London: Routledge, pp.91-99
- Bovey, S. (1989). *Being fat is not a sin*. Pandora.
- Bradbury-Jones, C. and Alcock, J. (2009) 'Nursing students as research participants: a framework for ethical practice', *Nurse Education Today*, 30 (2), pp. 192-6.
- Bradbury-Jones, C., Sambrook S., Irvine F. (2007), 'The meaning of empowerment for nursing students: a critical incident study', *Journal of Advanced Nursing*, 59 (4), pp. 342-351.
- Bradbury-Jones, C., Sambrook S., Irvine F. (2008), 'Power and empowerment in nursing: a fourth theoretical approach', *Journal of Advanced Nursing*, 62 (2), pp. 258-266.
- Braun, V., Clarke, V. (2006) 'Using thematic content analysis in psychology', *Qualitative Research in Psychology*, 3 (2), pp. 77-101.
- Breeze, J.A. and Reeper, J. (1998) 'Struggling for control: the care experiences of difficult patients in mental health services', *Journal of Advanced Nursing*, 28, pp. 1301-1311.

Brewer, A. (2003) 'Qualitative Research', in Miller, R.L., Brewer J.D. (eds) *The A-Z of social research*. London: SAGE.

British Heart Foundation Statistics Database (2006) *Overweight and obesity*. Available at <http://www.bphost.co.uk/ubvo/publications/allender1.pdf> (Accessed: 9 June 2011).

Brown, A. and Draper, P. (2003) 'Accommodative speech and terms of endearment: elements of a language mode often experienced by older adults', *Journal of Advanced Nursing*, 41 (1), pp. 15-21.

Brown, I. & Thomson, J. (2007) 'Primary care nurses' attitudes, beliefs and own body size in relation to obesity management', *Journal of Advanced Nursing*, 60 (5), pp. 535-543.

Brown, I. (2006) 'Nurses' attitudes towards adult patients who are obese: literature review', *Journal of Advanced Nursing*, 53 (2), pp. 221-232.

Brown, I. (2008) 'Images of obesity', *Community Practitioner*, 81 (3), pp. 14-15.

Brown, I., Thomson, J., Tod, A., Jones, G. (2006) 'Primary care support for tackling obesity: a qualitative study of the perceptions of obese patients', *British Journal of General Practice*, 56 (530), pp. 666-672.

Brown, P. (1995) 'Naming and Framing: the social construction of diagnosis and illness' *Journal of Health and Social Behaviour* (Extra Issue), pp. 34-52

Bryman, A. (1989) *Research Methods and Observation Studies*. London: Routledge.

Bryman, A. (2001) *Social Research Methods*. Oxford: Oxford University Press.

Buerhaus, P.I., Donelan, K., Ulrich, B., Norman, L., DesRoches, C., Dittus, R. (2007) 'Impact of the nurse shortage on hospital patient care: comparative perspectives', *Health Affairs*, 26 (3), pp. 853-862.

Burr, V. (1995) *An introduction to Social Constructionism*. London: Routledge

Burr, V. (2003) *Social Constructionism*. London: Routledge

Butland B., Jebb S., Kopelman P., McPherson K., Thomas S., Mardell J., Parry V. (2007) *Foresight Tackling Obesities: Future Choices - Project Report*. Government Office for Science.

Campos, J.D., Saguy A., Ernsberger, P., Oliver, E., Gaesser G. (2006) 'The epidemiology of overweight and obesity: Public health crisis or moral panic?' *International Journal of Epidemiology*, 35, pp.55-60.

Campos, P. (2004) *The obesity myth: Why America's obsession with weight is hazardous to your health*. New York: Gotham Books.

Carper, B. A. (1992) 'Fundamental patterns of knowing in nursing', in Nocoll, L.H. (ed) *Perspectives on Nursing Theory. 2nd edition*. New York: J. B. Lippincott.

Cattermole, M., Jahoda, A., Markova, I. (1988) 'Life in a mental handicap hospital: the view from the inside', *Mental Handicap*, 16, pp. 136-139.

Cavanagh, S. (1997) 'Content analysis: concepts, methods and applications', *Nurse researcher*, 4 (3), pp. 5-16.

Chandler, G. (1992) 'The source and process of empowerment', *Nursing Administration Quarterly*, 16, pp. 65-71.

Chang, V.W. and Christakis, N.A. (2002) 'Medical modelling of obesity: a transition from action to experience in a 20<sup>th</sup> century American medical textbook', *Sociology of Health and Illness*, 24 (2), pp. 151-177.

Charmaz, K. & Mitchell, R.G. (2001) Grounded theory in ethnography. In Atkinson, P., Cofey, A., Delamont, S., Lofland, J., Lofland L. (Eds), *Handbook of Ethnography* (pp.160-174). London: Sage Publications

Chernin, K. (1981) *The obsession: reflections on the tyranny of slenderness*. New York: Harper and Row

Cheung, S.T. (2003) 'The effects of chocolates given by patients on the well-being of nurses and their support staff', *Nutrition and Health*, 17 (1), pp. 65-69.

Clark P., Bowling, A. (1990) 'Quality of everyday life in long-stay institutions for the elderly: An observational study of long-stay hospital and nursing home care', *Social Science and Medicine*, 30, pp. 1201-1210.

Cohen, H.A. (1981) *The nurses' quest for a professional identity*. CA: Addison-Wesley.

Cook, Z., Kirk S., Lawrenson, S., Sandford, S. (2005) 'Use of BMI in the assessment of undernutrition in older subjects: reflecting on practice', *Proceedings of the Nutrition Society*, 64, pp. 313-317.

Cooke, H. (2008) 'Work, professionalism and organisational life', in Cooke, H., Philpin, S., (eds) *Sociology in Nursing and Health Care*. London: Churchill Livingstone, pp. 41-58

Cooper, C. (2010) 'Fat studies: mapping the field', *Sociology Compass*, 4 (10), pp. 1020-1034.

Coyne, I.T. (1997) 'Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?', *Journal of Advanced Nursing*, 26, pp. 623-630.

Crandall, C.S. (1994) 'Prejudice against fat people: Ideology and self-interest', *Journal of Personality and Social Psychology*, 66, pp. 882-894.

Crandall, C.S. (2000) Ideology and lay theories of stigma: the justification of stigmatisation. In: Heatherton, T.F., Kleck, R.E., Hebl, M.R., Hull, J.G. (Eds), *The social psychology of stigma*, London: The Guilford Press, pp.126-150

Crocker, J., Major, B., Steele, C. (1998) Social Stigma, in Gilbert, D.T., Fiske S.T., Lindsey, G. (eds.) *Handbook of social psychology*. Boston: McGraw-Hill.

Cruz, E.Z. and Higginbottom, G. (2013) 'The use of focused ethnography in nursing research'. *Nurse Researcher*, 20, 36-43

Culbertson, M. and Smolen, D. (1999) 'Attitudes of RN students toward obese adult patients', *Journal of nursing education*, 38, pp. 84-87.



- Curtis K., Horton, K., Smith P. (2012) 'Student nurse socialisation in compassionate practice: a grounded theory study', *Nurse Education Today*, 32 (7), pp. 790-795
- Cutcliffe, J.R. and McKenna, H.P. (2002) 'When do we know that we know? Considering the truth of research findings and the craft of qualitative research', *International Journal of Nursing Studies*, 39, pp. 611-618.
- Daiski, I. (2004) 'Changing nurses' dis-empowering relationship patterns', *Journal of Advanced Nursing*, 48 (1), pp. 43-50.
- Daniels, J. (2006) 'Obesity: America's epidemic: What goes up does not always come down. Is there a solution?', *American Journal of Nursing*, 106 (1), pp. 40-49.
- Daniels, S.R. (2006) 'The consequences of childhood overweight and obesity', *Childhood obesity*. 16 (1), pp. 47-67.
- Davidson, J.E., Kruse, M.W., Cox, D.H., Duncan, R. (2003) 'Critical care of the morbidly obese', *Critical Care Nursing Quarterly*, 26 (2), pp. 105-116.
- Davies, C.A. (1999) *Reflexive ethnography: A guide to researching selves and others*. London: Routledge.
- Davies, P. (1993) 'Clinical role modelling: uncovering hidden knowledge', *Journal of Advanced Nursing*, 18 (4), pp. 627-636.
- Denzin, N.K., Lincoln Y.S. (2003) *The landscape of qualitative research*. 2<sup>nd</sup> Edition. London: Sage Publications.
- Department of Health (1999) *Making a Difference: Strengthening the Nursing and Midwifery Contribution to Health and Health Care*. London: Department of Health.
- Department of Health (2001) *Research governance framework of health and social care*. London: Department of Health.
- Department of Health (2002) *Agenda for Change: A Modernised NHS Pay System*. London: Department of Health.
- Department of Health (2003) *The NHS Knowledge and Skills Framework*. London: Department of Health.

Department of Health (2005) *Prescription cost analysis*. London: Department of Health Available at:

[http://www.ic.nhs.uk/webfiles/publications/prescostanalysis2005/PrescriptionCostAnalysis110406\\_PDF.pdf](http://www.ic.nhs.uk/webfiles/publications/prescostanalysis2005/PrescriptionCostAnalysis110406_PDF.pdf) (Accessed: 29 May 2007)

Department of Health (2006) *Hospital Episode Statistics. NHS Health and Social Care Information Centre*. London: Department of Health

Dingwall, R., Allen, D. (2001) 'The implications of healthcare reform for the profession of nursing', *Nursing Inquiry*, 8 (2), p. 64.

Dovidio, J.F., Major, B., Crocker, J. (2000) 'Stigma: introduction and overview', in Heatherton T.F., Kleck R.E., Hebl M.R. (eds) *The social psychology of stigma*. New York: Guilford Press, pp.1-30

Dovidio, J.F., Penner, L.A., Albrecht, T.L., Norton, W.E., Gaertner, S.L., Shelton, J.N. (2008) 'Disparities and distrust: the implications of psychological processes for understanding racial disparities in health and health care', *Social Science and Medicine*, 67, pp. 478-486.

Drake, D.J., Baker, G., Keehner Englelke, M., McAuliffe, M., Pokorny, M., Swanson, M., Waters, W. (2008) 'Challenges in caring for the morbidly obese: differences by practice setting', *Southern Online Journal of Nursing Research*, vol. 8, no. 3. Available at:

[http://www.snrs.org/publications/SOJNR\\_articles2/Vol08Num03Art08.html](http://www.snrs.org/publications/SOJNR_articles2/Vol08Num03Art08.html)

(Accessed: 18 June 2011).

Draper, P. (1996) 'Compromise, massive encouragement and forcing: A discussion of mechanisms used to limit the choices available to the older adult in hospital', *Journal of Clinical Nursing*, 5, pp. 325-331.

Drewnowski A, and Darmon N (2005) 'The economics of obesity: dietary energy density and energy cost', *The American Journal of Clinical Nutrition*, vol. 82 (suppl), pp. 265S-73S. Available at: <http://ajcn.nutrition.org/content/82/1/265S.full.pdf>.

Drewnowski, A, and Specter SE (2004) 'Poverty and obesity: the role of energy density and energy costs', *The American Journal of Clinical Nutrition*, vol.79, no.1, pp.6-16. Available at <http://ajcn.nutrition.org/content/79/1/6.long>.

Drewnowski, A, Darmon N, Briend A (2004) 'Replacing fats and sweets with vegetables and fruits- a question of cost', *American Journal of Public Health*, 94, pp. 1555-1559.

Drewnowski, A. (2003) 'Fat and sugar: an economic analysis', *Journal of Nutrition*, 133, pp. 838S-840S.

Dreyfus, H.L. and Rabinow, P. (1982) *Michel Foucault: Beyond structuralism and hermeneutics. Sussex*. The Harvester Press.

Driver, F. (1995) 'Bodies in space: Foucault's account of disciplinary power', in Jones, C. and Porter, R. (eds) *Reassessing Foucault: power, medicine and the body*. London: Routledge.

East and West Berkshire Dietetics Services (2001) *Weight Management. A strategy for Berkshire. Focusing on coronary heart disease and cancer prevention*. Berkshire Health Promotion.

Edgar, I.R. (1999) 'The imagework method in health and social science research', *Qualitative Health Research*, 9, pp. 198-211.

Emden, C. and Sandelowski, M. (1998) 'The good, the bad and the relative, part one: Conceptions of goodness in qualitative research', *International Journal of Nursing Practice*, 4, pp. 206-212.

Emden, C. and Sandelowski, M. (1999) 'The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research', *International Journal of Nursing Practice* 5, pp. 2-7.

Engelbretson, J. (2009) 'A multiparadigm approach to nursing' in Reed, P.G. and Crawford, Shearer N.B. (eds) *Perspectives of nursing theory. 5<sup>th</sup> edition*. London: Lippincott Williams & Wilkins.

- English, J. and Morse, J.M. (1988) 'The difficult elderly patient: adjustment or maladjustment?', *International Journal of Nursing Studies*, 25, pp. 23-39.
- Evans, W., Reilly J. (1996) 'Drawings as a method of program evaluation and communication with school-age children', *Journal of Extension*, 34 (6), pp.87-91
- Faulkner, M. (2001) 'Empowerment and disempowerment: models of staff/patient interaction', *Nursing Times Research*, 6, pp. 936-948.
- Fazio, R.H. (1986) 'How do attitudes guide behaviour?' in Sorrentino, R.M., Higgins, E.T. (eds) *Handbook of motivation and cognition*. New York: Guildford Press.
- Feldman, S. (1999) 'Please don't call me 'dear': older women's narratives of health care', *Nursing Inquiry*, 6 (4), pp. 269-276.
- Fetterman, D.M. (1998) *Ethnography: step by step. 2<sup>nd</sup> edition*. London: Sage.
- Fieldler, K., Messner, C., Bluemke, M. (2006) 'Unresolved problems with the 'I', the 'A' and the 'T': a logical and psychometric critique of the Implicit Association Test (IAT)', *European Review of Social Psychology*, 17, pp. 74-147.
- Finlayson, B., Dixon, J., Meadows, S., Blair, G. (2002) 'Mind the gap: the extent of the NHS nursing shortage', *British Medical Journal*, 7 (325), pp. 538-541.
- Flegal, K.M., Graubard, B.I., Williamson, D.F., Gail, M.H. (2005) 'Excess deaths associated with underweight, overweight and obesity', *Journal of American Medical Association*, 293, pp. 1861-1867.
- Foster, G.D., Wadden, T.A., Makris, A.P. (2003) 'Primary care physicians' attitudes about obesity and its treatment', *Obesity Research*, 11, pp. 1168-1177.
- Foucault, M. (1973) *The birth of the clinic: an archaeology of medical perception*. London: Routledge.
- Foucault, M. (1977) *Discipline and punish*. Penguin: Harmondsworth.
- Foucault, M. (1980) *Power/Knowledge: Selected Interviews & Other Writings 1972-1977*. New York: Pantheon.

- Foucault, M. (1982) *The subject and power*, *Critical Inquiry*, 8 (4), pp. 777-795.
- Foucault, M. (2003) *Society must be defended: lectures at the College de France 1975-76*. Translated by D.Macey. London: Penguin.
- Francis, L., Monahan, K., Berger, C. (1999) 'A laughing matter: the uses of humour in medical interaction', *Motivation and Emotion*, 23(2), pp. 155–174.
- Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Dodd, Mead.
- Freidson, E. (1983) 'Celebrating Erving Goffman', *Contemporary Sociology*, 12 (4), 359-362
- Friis, K., Ekholm, O., Hundrup, Y. A., Obel, E. B., Gronbaek, M. (2007). 'Influence of health, lifestyle, working conditions, and socio-demography on early retirement among nurses: The Danish Nurse Cohort Study', *Scandinavian Journal of Public Health*, 35, pp. 23-30.
- Gabe, J., Calnan M., Bury, M. (2004) *The Sociology of the health service*. London: Routledge
- Garcia-Hidalgo, L. (2002) 'Dermatological complications of obesity', *American Journal of Clinical Dermatology*, 3 (6), pp. 497-505.
- Gard, M., Wright, I. (2005) *The obesity epidemic: science, morality and ideology*. London: Routledge.
- Garner, C. and Nicol, G. (1998) 'Comparison of male and female nurses' attitudes toward obesity', *Perceptual and motor skills*, 86, p. 1442.
- Geertz, C. (1973) *The interpretation of cultures*. London: Hutchinson of London
- Gerrish, K. (1997) 'Being a 'marginal native': dilemmas of the participant observer', *Nurse Researcher*, 5(1), pp. 25-34.
- Giddens, A. (1987) 'Erving Goffman as a systematic social theorist', in Giddens, A. (ed) *Social theory and modern sociology*. Cambridge: Polity Press, pp.109-139.

Giddens, A. (1995) 'Surveillance and the capitalist state', in Giddens, A. (ed) A contemporary critique of historical materialism, 2nd Edition. Basingstoke: Macmillan.

Giddens, A. (2006) 'Social Interaction and everyday life', in Giddens, A. (ed.) *Sociology* (5<sup>th</sup> ed.). Cambridge: Polity Press, pp.141-145

Glaser, B. G., & Strauss, A. L. (1968). *The discovery of grounded theory: Strategies for qualitative research*. London: Weidenfeld and Nicolson.

Goffman, E. (1961) *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.

Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity*. London: Penguin books.

Goffman, E. (1969) *The presentation of self in everyday life*. London: Penguin Press.

Gorber, SC., Tremblay, M., Moher, D., Gorber, B. (2007) 'A comparison of direct vs. Self-report measures for assessing height, weight and body mass index: a systematic review', *Obesity Reviews*, 8 (4), pp. 307-326.

Government Office for Science (2007) *Tackling obesities: future choices*. London: Department of Innovation Universities and Skills.

Government Social Research (2010) *Assessing the costs to the NHS associated with alcohol and obesity in Wales*. Available at:

<http://wales.gov.uk/about/aboutresearch/social/latestresearch/alcoholobesity/?lang=en> (Accessed: 10 May 2011)

Graneheim, U.H., Lundman, B. (2004) 'Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness', *Nurse Education Today*, 24, pp. 105-112

Grau, L., Chandler, B., Saunders, C. (1995) 'Nursing home residents' perceptions of the quality of their care', *Journal of Psychological Nursing*, 33 (5), pp. 34-41.

Green, S., Jackson, P. (2002) 'Nutrition and nurse education', *Nursing Times*, 98 (34), pp. 59-60.

Green, S.M., McCoubrie, M., Cullingham, C. (2000) 'Practice nurses' and health visitors' knowledge of obesity assessment and management', *Journal of Human Nutrition and Dietetics*, 13, pp. 413-423.

Greenwood, J. (1993) 'The apparent desensitization of student nurses during their professional socialization: a cognitive perspective', *Journal of Advanced Nursing*, 18 (9), pp. 1471-1479.

Gregg, E.W., Cheng, Y.J., Cadwell, B.I., Imperatore, G., Williams, D.E., Flegal, K.M., Narayan, K.M.V., Williamson, D.F. (2005) 'Secular trends in cardiovascular disease risk factors according to body mass index in US adults', *Journal of American Medical Association*, 293, pp. 1868-1874.

Griffiths, P. (2008) 'Ethical conduct and the nurse ethnographer: consideration of an ethic of care', *Journal of Research in Nursing*, 13, pp. 350-361.

Guba, E.G., Lincoln, Y.S (2005) 'Paradigmatic controversies, contradictions, and emerging confluences', in Denzin, N.K., Lincoln, Y.S. (eds) *The SAGE handbook of qualitative research. 3<sup>rd</sup> Edition*. London: Sage.

Guthrie, C. (1999) 'Nurses' perceptions of sexuality relating to patient care', *Journal of Clinical Nursing*, 8, pp. 313-321.

Hahler, B. (2006) 'An overview of dermatological conditions commonly associated with the obese patient', *Ostomy Wound Management*, 52 (6), pp. 34-47.

Hall, D.M.B., Cole, T.J. (2006) 'What use is the BMI?', *Archives of Disease in Childhood*, 91, pp. 283-286.

Hammersley, M., Atkinson, P. (1995) *Ethnography: principles in practice. 2<sup>nd</sup> edition*. London: Routledge.

Hammersley, M., Atkinson, P. (2007) *Ethnography: principles in practice. 3<sup>rd</sup> edition*. London: Routledge.

Hankey, C.R., Eley, S., Leslie, W.S., Hunter, C.M., Lean, M.E.J. (2003) 'Eating habits, beliefs, attitudes and knowledge among health professionals regarding the links between obesity, nutrition and health', *Public Health Nutrition*, 7 (2), pp. 337-343.

Harrison, K. (2000) 'Televisions viewing, fat stereotyping, body shape standards, and eating disorder symptomatology in grade school children', *Community Research*, 27, pp. 617-640.

Harvey, E.L., Hill, A.J. (2001) 'Health professionals' views of overweight people and smokers', *International Journal of Obesity*, 25, pp. 1253-1261.

Haslam, D. (2008) 'Understanding obesity in the older person: prevalence and risk factors', *British Journal of Community Nursing*, 13 (3), pp. 115- 122.

Haslam, D. and James, W. (2005) 'Obesity', *Lancet*, 366 (9492), pp. 1197-209.

Health and Safety Executive (2007) *Risk assessment and process planning for bariatric patient handling pathways*. Health and safety Executive.

Henderson S. (2003) 'Power imbalance between nurses and patients: a potential inhibitor of partnership in care', *Journal of Clinical Nursing*, 12, pp. 501-508.

Herbozo, S., Tantleff-Dunn, S., Gokee-Larose, J., Thomson, J.K. (2004) 'Beauty and thinness messages in children's media: a content analysis', *Eating Disorders*, 12, pp. 21-34.

Hochschild, A. (1983) *The managed heart*. Berkeley, CA: University of California.

Holland, K. (1999) 'A journey to becoming: the student nurse in transition', *Journal of Advanced Nursing*, 29 (1), pp. 229-236.

Holloway, I., Wheeler, S. (2002) *Qualitative Research in Nursing*. Oxford: Blackwell.

Holter, I.A., Schwartz-Barcott, D. (1993) 'Action research: what is it? How has it been used and how can it be used in nursing?', *Journal of Advanced Nursing*, 18 (2), pp. 298-304.



Hoppe, R., Ogden, J. (1997) 'Practice nurses' beliefs about obesity and weight related interventions in primary care', *International Journal of Obesity*, 21, pp. 141-146.

House of Commons Health Committee (2004) *Obesity: Third Report of session 2003-2004*. London: The Stationery Office Limited.

Hunter, B., Smith, P. (2007) 'Emotional labour: just another buzz word?', *International Journal of Nursing Studies*, 44 (6), pp. 859-861.

Huynh, T., Alderson, M., Thomson, M. (2008) 'Emotional labour underlying caring: an evolutionary concept analysis', *Journal of Advanced Nursing*, 64 (2), pp. 195-208.

Jallinoja, P., Absetz, P., Kuronen, R., Nissinen, A., Talja, M., Uutela, A., Patja, K. (2007) 'The dilemma of patient responsibility for lifestyle change: perceptions among primary care physicians and nurses', *Scandinavian Journal of Primary Health Care*, 25 (4), pp. 244-9.

Jasper, M. (1996) 'The first year as a staff nurse: the experiences of a first cohort of Project 2000 nurses in a demonstration district', *Journal of Advanced Nursing*, 24, pp. 779-790.

Jebb, S.A., Rennie, K.L., Cole, T.J. (2004) 'Prevalence of overweight and obesity among young people in Great Britain', *Public Health Nutrition*, 7(3), pp 461-465

Jeffery, R. (1979) 'Normal rubbish: deviant patients in casualty departments', *Sociology of Health and Illness*, 1, pp 90-107

Jeffrey, C.A. and Kitto, S. (2006) 'Struggling to care: Nurses' perceptions of caring for obese patients in an Australian bariatric ward', *Health Sociology Review*, 15, pp. 71-83.

Johns, C. (1995a) 'Achieving effective work as a professional activity', in Schober, J.E., Hinchliff, S.M. (eds.) *Towards Advanced Nursing Practice: key concepts for health care*. London: Arnold. pp. 252-280.

Johnson, J.C. (1990) *Selecting ethnographic informants. Qualitative Research Methods*. Volume 22. London: SAGE.

- Johnson, M. (1997) 'Observations of the neglected concept of intervention in nursing research', *Journal of Advanced Nursing*, 25, pp. 23-29.
- Johnson, M. (1997) *Nursing power and social judgement*. Aldershot: Ashgate Publishing Ltd.
- Johnson, M. (2004) 'Real world ethics and nursing research', *Nursing Times Research*, 9, pp. 251-261.
- Johnson, M. (2005) 'Notes on the tension between privacy and surveillance in nursing', *The Online Journal of Issues in Nursing*, vol. 10, no. 2. Available at: [http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume102005/No2May05/tpc27\\_316019.aspx](http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume102005/No2May05/tpc27_316019.aspx) (Accessed: 10 September 2008).
- Johnson, M. (2007) 'The theoretical and social context of research ethics', in Long, T., Johnson, M. (eds) *Research ethics in the real world. Issues and solutions for health and social care*. London: Churchill Livingstone.
- Johnson, M. (2008) 'Power and communication in healthcare', in Cooke, H. and Philpin, S. (eds.) *Sociology in Nursing and Healthcare*. London: Churchill Livingstone.
- Johnson, M., Webb, C. (1994) 'Rediscovering unpopular patients: the concept of social judgement', *Journal of Advanced Nursing*, 21(3), pp. 466-475.
- Jones, C., Porter, R. (1995) *Reassessing Foucault: power, medicine and the body*. London: Routledge.
- Jussim, L., Palumbo, P., Chatman, C., Madon, S., Smith, A. (2000) 'Stigma and self-fulfilling prophecies', in Heatherton, T.F., Kleck, R.E., Hebl, M.R., Hull, J.G. (eds) *The Social Psychology of Stigma*. London: The Guildford Press.
- Karnehed, N., Rasmussen, F., Hemmingsson T., Tynelius, P. (2006) 'Obesity and attained education: cohort study of more than 700,000 Swedish men', *Obesity* 14, pp. 1421-1428.

- Kelly, M.P., May, D. (1982) 'Good and bad patients: a review of the literature and a theoretical critique', *Journal of Advanced Nursing*, 7, pp. 147-156.
- Kerr, M.P. (2002) 'A qualitative study of shift handover practice and function from a socio-technical perspective', *Journal of Advanced Nursing*, 37 (2), pp. 125-134.
- Kim, S., Popkin, B.M. (2005) 'Commentary: Understanding the epidemiology of overweight and obesity - a real global public health concern', *International Journal of Epidemiology*, 35, pp. 60-67.
- Kirk, T.W. (2007) 'Beyond intimacy: clinical intimacy in nursing practice', *Nursing Philosophy*, 8, pp. 233-243.
- Klaczynski, P.A., Goold, K.W., Mudry, J.J. (2004) 'Culture, obesity stereotypes, self-esteem, and the 'thin ideal': a society identity perspective', *Journal of Youth and Adolescence*, 33 (4), pp. 307-317.
- Klein, H., Shiffman, K.S. (2006) 'Messages about physical attractiveness in animated cartoons', *Body Image*, 3, pp. 353-363.
- Kneafsey, R., Haigh, C. (2007) 'Learning safe patient handling skills: student nurse experiences of university and practice based education', *Nurse Education Today*, 27(8), pp. 832-839.
- Koch, T. (1994) 'Establishing rigour in qualitative research: the decision trail', *Journal of advanced nursing*, 19, pp. 976-986.
- Kramer, M. (1974) *Reality shock: Why nurses leave nursing*. St Louis: C.V. Mosby Co.
- Kuokkanen, L., Leino-Kilpi, H. (2000) 'Power and empowerment in nursing: three theoretical approaches', *Journal of Advanced Nursing*, 31 (1), pp. 235-241.
- Kuper, A. (1999) *Culture: The anthropologists' account*. Cambridge: Harvard University Press.
- Latimer, J. (2000) *The conduct of care: understanding nursing practice*. Oxford: Blackwell Science.

Lavie, C.J., Milani, R.V., Artham, S.M., Olivier, A.C., Ventura, H.O. (2007) 'Does body composition impact survival in patients with advanced heart failure', *Circulation*, 116, p. 360.

Law, C., Power, C., Graham, H., Merrick, D. (2007) 'Obesity and health inequalities', *Obesity Reviews*, 8 (Suppl.1), pp. 19-22.

Lawler, J. (1991). *Behind the screens: Nursing, Somology, and the Problem of the Body*. Melbourne: Churchill Livingstone.

Lawlor, D.A., Chaturvedi, N. (2006) 'Treatment and prevention of obesity—are there critical periods for intervention', *International Journal of Epidemiology*, 35, pp. 3–9.

Light, D.W., Hughes, D. (2001) 'Introduction: A sociological perspective on rationing: power, rhetoric and situated practices', *Sociology of Health and Illness*, 23 (5), pp. 551-569.

Lindsted, K., Tonstad, S., Kazma, J.W. (1991) 'Body Mass Index and patterns of mortality amongst Seventh Day Adventist men', *International Journal of Obesity*, 15, pp. 397-406.

Locsin, R.C. (2002) 'Quo vadis? Advanced practice nursing or advanced nursing practice?', *Holistic Nursing Practice*, 16, pp1-4

Long, T., Johnson, M. (2002) 'Research in Nurse Education Today: do we meet our aims and scope?', *Nurse Education Today*, 22, pp. 85-93.

Lukes, S. (1974) *A radical view*. Macmillan: Basingstoke.

Lukes, S. (1997) 'Humiliation and the politics of identity', *Social Research* 64 (1), pp. 36-51.

Maben, J., Latter, S., Clark, J.M. (2006) 'The theory-practice gap: impact on professional-bureaucratic work conflict on newly qualified nurses', *Journal of Advanced Nursing*, 55 (4), pp. 465-477.

MacDonald, M. (2001) Finding a critical perspective in grounded theory. In: Schreiber RS, Stern PN (Eds) *Using Grounded theory in Nursing*. New York, Springer publishing, pp 113-136

Macdonald, M. (2003) 'Seeing the cage: stigma and its potential to inform the concept of the difficult patient', *Clinical Nurse Specialist*, 17 (6), pp. 305-310.

Macdonald, M. (2007a) 'Origins of difficulty in the nurse - patient encounter', *Nursing Ethics*, 14 (4), pp. 510-521.

Macdonald, M. (2007b) 'Nurse-Patient encounters: constructing harmony and difficulty', *Advanced Emergency Nursing Journal*, 29 (1), pp. 73-81.

Mackintosh, C. (2006) 'Caring: The socialisation of pre-registration student nurses: A longitudinal qualitative descriptive study', *International Journal of Nursing Studies*, 43 (8), pp. 953-962.

Macleod, C.J. (1981) 'Communication in nursing', *Nursing Times*, 77, pp. 12-18.

Maio, G.R., Haddock, G.G. (2010) *The Psychology of Attitudes and Attitude Change*. London: Sage.

Malnick, S.D.H., Knobler, H. (2006) 'The medical complications of obesity', *QJM: An International Journal of Medicine*, 99, pp. 565-579.

Manson, J.A.E., Skerrett, P.J., Greenland, P., Vanitallie, T.B. (2004) 'The escalating pandemics of obesity and sedentary lifestyle', *Archives of Internal Medicine*, 164, pp. 249-258.

Margalit, A. (1996) *The decent society*. Cambridge: Harvard University Press.

Maroney, D., Golub, S. (1992). 'Nurses' attitudes toward obese persons and certain ethnic groups', *Perceptual and motor skills*, 75, pp. 387-391.

Mason G.M.C. & Attree M. (1997) 'The relationship between research and the nursing process in clinical practice' *Journal of Advanced Nursing* 26, pp. 1045-1049

Mason, J. (2002) *Qualitative researching*. 2<sup>nd</sup> Edition. London: SAGE.

- May, C. (1980) 'Research on nurse - patient relationships: problems of theory, problems of practice', *Journal of Advanced Nursing*, 15 (3), pp. 307-315.
- Mays, N., Pope, C. (1995) 'Rigour and qualitative research', *British Medical Journal*, 311, pp. 109-112.
- Mays, N., Pope, C. (2000) 'Qualitative research in health care: Assessing quality in qualitative research', *British Medical Journal*, 320, pp. 50-52.
- McCarthy, H.D., Ellis, S.M., Cole, T.J. (2003) 'Waist circumference in British youth aged 11-16 years 1977-1997: dramatic increases in central overweight and obesity', *British Medical Journal*, 22, p. 624.
- McCarthy, V., Freeman, L.H. (2008) 'A multidisciplinary concept analysis of empowerment: implications for nursing', *Journal of Theory Construction and Testing*, 12 (2), pp. 68-74.
- McCormick, B., Stone, I. (2007) 'Economic costs of obesity and the case for government intervention', *Obesity Reviews*, 8 (Suppl. 1), pp. 161-164.
- McCreddie, M., Wiggins, S. (2008) 'The purpose and function of humour in health, health care and nursing: a narrative review', *Journal of Advanced Nursing*, 61(6), pp. 584-595.
- McLaren, L. (2007) 'Socioeconomic status and obesity', *Epidemiological Reviews*, 201 (29), pp. 28-48.
- McNay, L. (1994) *Foucault: A critical introduction*. Cambridge: Polity Press.
- McQueen, A. (2000) 'Nurse-patient relationship and partnership in hospital care', *Journal of Clinical Nursing*, 9, pp. 723-731.
- Meadows, S., Levenson, R., Baeza, J. (2000) *The last straw: explaining the NHS nursing shortage*. London: King's Fund.
- Melchoir, M., Philipsen, H., Gassman, P. (1996) 'The effectiveness of primary nursing on burnout among psychiatric nurses on long stay settings', *Journal of Advanced Nursing*, 24, pp. 694-702.

- Melia, K.M. (1987) *Learning and working: the occupational socialisation of nurses*. London: Tavistock.
- Menzel, N., Brooks, S., Bernard, T., Nelson, A. (2004) 'The physical workload of nursing personnel: association with musculoskeletal discomfort', *International Journal of Nursing Studies*, 41(8), pp. 859-867.
- Menzies, I.P. (1960) 'A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital', *Human Relations*, 13, pp. 95-121.
- Mercer, S., Tessier, S. (2001) 'A qualitative study of general practitioners' and practice nurses' attitudes to obesity management in primary care', *Health Bulletin*, 59, pp. 248-253.
- Miller, W.L., Crabtree, B.F. (2005) 'Clinical Research', in Denzin, N., Lincoln, Y. (eds) *Handbook of Qualitative Research, 3rd edition*. Newbury Park: SAGE.
- Millerson, G. (1964) *The qualifying associations*. London: Routledge and Kegan Paul.
- Mokdad, A.H., Ford, E.S., Bowman, B.A., Dietz, W.H., Vinicor, F., Bales, V.S., Marks, J.S. (2003) 'Prevalence of obesity, diabetes and obesity-related health risk factors', *Journal of American Medical Association*, 289, pp. 76-79.
- Mokdad, A.H., Marks, J.S., Stroup, D.F., Gerberding, J.L. (2004) 'Actual causes of death in the United States', *Journal of American Medical Association*, 291 (10), pp. 1238-1245.
- Mold, F., Forbes, A. (2011) 'Patients' and professionals' experiences and perspectives of obesity in health-care settings: a synthesis of current research', *Health expectations*. Available at: <http://onlinelibrary.wiley.com/doi/10.1111/j.1369-7625.2011.00699.x/pdf> (Accessed: 15 June 2006).
- Monaghan, H., Robinson, L., Steele, Y. (1998) 'Implementing a no lift policy', *Nursing standard*, 12 (50), pp.35-37.

- Morris, S. (2006) 'Body Mass Index and occupational attainment', *Journal of Health Economics*, 25 (2), pp. 347-364.
- Morse, J.M., Barrett, M., Mayan, M., Olson, K., Spiers, J. (2002) 'Verification strategies for establishing reliability and validity in qualitative research', vol. 1, no.2 *International Journal of Qualitative Methods*. Available at: <http://www.ualberta.ca/~ijqm> (Accessed: 10 July 2006).
- Morse, J.M., Field, P.G. (1996) *Nursing Research: The application of qualitative approaches. 2<sup>nd</sup> edition*. Cheltenham: Stanley Thornes Ltd.
- Mountain, G., Bowie, P. (1995) 'The quality of long-term care for dementia: a survey of ward environments', *International Journal of Psychiatry*, 10, pp. 1029-1035.
- Mowforth, G. (1999) 'Power, gender and nursing work', in Wilkinson, G., Miers, M. (eds) *Power and nursing practice*. London: MacMillan Press Ltd.
- Mulhall, A. (2003) 'In the field: notes on observation in qualitative research', *Journal of Advanced Nursing*, 41 (3), pp. 306-313.
- Munhall, P.L. (2001) *Nursing research: a qualitative perspective. 3<sup>rd</sup> Edition*. London: Jones and Bartlett Publications.
- Murphy, F. (2005) 'Preparing for the field: developing competence as an ethnographic field worker', *Nurse Researcher*, 12 (3), pp. 52-60.
- Musingarimi, P. (2008) 'Obesity in the UK: A review and comparative analysis of policies within the devolved administrations', *Health Policy*, 91 (1), pp. 10-16.
- National Assembly for Wales (1999). *Realising the Potential: A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales in the 21st Century*. Cardiff: National Assembly for Wales.
- National Assembly for Wales (2001) *Educating and Training the Future, Health Professional Workforce for Wales*. Cardiff: National Assembly for Wales.



National Assembly for Wales (2001) *Fitness for Practice All Wales Initiative Project. Draft Guidelines and Principles Papers 1-9*. Cardiff: National Assembly for Wales.

National Assembly for Wales (2001) *Improving Health in Wales*. Cardiff: National Assembly for Wales.

National Institute for Health and Clinical Excellence (2006) *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*. London: NICE.

National Obesity Observatory (2010) *Adult obesity and socioeconomic status*. National Health Service. Available at: [http://www.noo.org.uk/uploads/doc/vid\\_7929\\_Adult%20Socioeco%20Data%20Briefing%20October%202010.pdf](http://www.noo.org.uk/uploads/doc/vid_7929_Adult%20Socioeco%20Data%20Briefing%20October%202010.pdf) (Accessed: 26 April 2011).

Newell, B. and Burnard, P. (2011) *Vital notes for nurses: research for evidence-based practice in healthcare* (2nd ed.). Wiley-Blackwell: New York

NHS The Information Centre for Health and Social Care (2010) *Statistics on obesity, physical activity and diet: England, 2010*. The Health and Social Care Information Centre. Available at: [http://www.ic.nhs.uk/webfiles/publications/opad10/Statistics\\_on\\_Obesity\\_Physical\\_Activity\\_and\\_Diet\\_England\\_2010.pdf](http://www.ic.nhs.uk/webfiles/publications/opad10/Statistics_on_Obesity_Physical_Activity_and_Diet_England_2010.pdf) (Accessed: 9 June 2011).

Nursing and Midwifery Council (2004a) *Standards of Proficiency for pre-registration nursing education*. London: Nursing and Midwifery Council.

Nursing and Midwifery Council (2004b) *The NMC code of professional conduct: standards for conduct, performance and ethics*. London: Nursing and Midwifery Council.

Nursing and Midwifery Council (2008) *The code: Standards of conduct, performance and ethics for nurses and midwives*. London: Nursing and Midwifery Council.

O'Driscoll, M.F., Allan, H.T., Smith, P.A. (2010) 'Still looking for leadership- who is responsible for student nurses' learning in practice?', *Nurse Education Today*, 30 (3), pp. 212-217.

O'Neal, C.H., Finley, C.E., Blair, S.N. (2004) 'Attitudes toward obese individuals among exercise science students', *Medicine and Science in Sports Science*, 36 (3), pp. 468-474.

O'Rahilly, S., Farooqi, I.S. (2006) 'Genetics of obesity', *Philosophical Transactions of the Royal Society Biological Sciences*, 361, pp. 1095-1105.

Office for National Statistics (2006) *Expenditure and Food Survey 2004-2005*, The Stationery Office, London.

Office of National Statistics (2009) *Health and Social Care: Obesity Increased most among older people*. Available at: <http://www.statistics.gov.uk/cci/nugget.asp?id=1268> (Accessed on 9 June 2011).

Ogden, J., Bandara, I., Cohen, H., Farmer, D., Hardie, J., Minas, H., Moore, J., Qureshi, S., Walter, F., Whitehead, M.A. (2001) 'General Practitioners' and patients' models of obesity: whose problem is it?', *Patient Education and Counselling*, 44 (3), pp. 227-233.

Ogden, J., Hoppe, R. (1998) 'Changing practice nurses' management of obesity' *Journal of Human Nutrition and Dietetics*, 11, pp. 249-256.

Oliveira, A.R.E. (2009). 'Self-reporting weight and height: misclassification effect on the risk estimates for acute myocardial infarction', *European Journal for Public Health*, 19 (5), pp. 548-553.

Olshansky, S.J., Passaro, D.J., Hershow, R.C., Layden, J., Carnes, B.A., Brody, J., Hayflick, L., Butler, R.N., Allison, D.B., Ludwig, D.S. (2005) 'A potential decline in life expectancy in the United States in the 21st century', *New England Journal of Medicine*, 352, pp. 1138-1145.

Orbach, S. (2006) 'Commentary: There is a public health crisis - It's not fat on the body but fat in the mind and the fat of profits', *International Journal of Epidemiology*, 35, pp. 67-69.

- Orbach, S. (2006) '*Fat is a feminist issue*'. London: Arrow Books.
- Oreopoulos, A., Padwal, R., Kalantar-Zadeh, K., Fonarow, G.C., Norris, C.M., McAlister, F.A. (2008) 'Body Mass Index and mortality in heart failure: a meta-analysis', *American Heart Journal*, 156, pp. 13-22.
- Ousey, K. (2007) '*Being a real nurse; nurses' accounts of learning and working in practice*'. Unpublished PhD thesis. University of Salford.
- Ousey, K. (2009) 'Heel ulceration - an exploration of the issues', *Journal of Orthopaedic Nursing*, 13, pp. 97-104.
- Ousey, K. (2011) 'The changing face of student nurse education and training programmes', *Wounds*, 7 (1), pp. 70-76.
- Owens, T.M. (2003) 'Morbid obesity: the disease and comorbidities', *Critical care nursing quarterly*, 26 (2), pp. 162-165.
- Parahoo, K. (2006) *Nursing Research: Principles, Process, and Issues. 2<sup>nd</sup> Edition*. London: Palgrave Macmillan.
- Parker, J., Gardner, G., Wiltshire, J. (1992) 'Handover: the collective narrative of nursing practice', *The Australian Journal of Advanced Nursing*, 9, pp. 31-37.
- Parsons, T. (1951) *The social system*. New York: Free Press, pp. 428-454.
- Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods. 3<sup>rd</sup> edition*. London: SAGE.
- Pearcey, P.A., Elliott, B.E. (2004) 'Student impressions of clinical setting', *Nurse Education Today*, 24, pp. 382-387.
- Pearcey, P.A., Elliott, B.E. (2008) 'Exploring clinical nursing experiences: listening to student nurses', *Nurse Education Today*, 28, pp. 595-601.
- Peternelj-Taylor ,C. (1989) 'The effects of patient weight and sex on nurses' perceptions: a proposed model of nurse withdrawal', *Journal of Advanced Nursing*, 14, pp. 744-754.

- Petrich, B. (2000) 'Medical and nursing students' perceptions of obesity', *Journal of Addictions Nursing*, 12, pp. 3-16.
- Philips, C.J., Harper, C., Rance, J., Farr, A. (2011) *Assessing the costs to the NHS associated with alcohol and obesity in Wales*. Cardiff: Welsh Assembly Government Social Research.
- Philips, S. (1996) 'Labouring the emotions: expanding the remit of nursing work?', *Journal of Advanced Nursing*, 24, pp. 139-143.
- Philpin, S.M. (2002) 'Rituals and nursing: a critical commentary', *Journal of Advanced Nursing*, 38 (2), pp. 144-151.
- Philpin, S.M. (2004) *An interpretation of ritual and symbolism in an intensive therapy unit*. Unpublished PhD thesis. University of Wales, Swansea.
- Pink, S. (2001) *Doing visual ethnography: Images, media and representation in research*. London: SAGE.
- Pi-Sunyer, F.X. (2002) 'The obesity epidemic: pathophysiology and consequences of obesity', *Obesity Research*, 10, pp. 97S-104S.
- Podrasky, D.L., Sexton, D.L. (1988) 'Nurses' reactions to difficult patients', *Journal of Nursing Scholarship*, 20, pp. 16-21.
- Polit, D.F., Hungler, B.P. (1999) *Nursing Research: Principles and methods*. 6<sup>th</sup> Edition. Philadelphia: Lippincott.
- Poon, M.U., Tarrant, M. (2009) 'Obesity: attitudes of undergraduate student nurses and registered nurses', *Journal of Clinical Nursing*, 18, pp. 2355-2365.
- Popkin, B.M. (2006) 'Using research on the obesity epidemic as a guide to a unified vision of nutrition', *Public Health Nutrition*, 8(6A), pp. 724-729.
- Porter, S. (1998) *Social theory and nursing practice*. Basingstoke: Macmillan.
- Porter, S. (1999) 'Working with doctors', in Wilkinson, G., Miers, M. (eds) *Power and Nursing Practice*. London: MacMillan Press Ltd.

- Powdermaker, H. (1966) *Stranger and friend: the way of an anthropologist*. New York: Norton.
- Prentice, A. (2006) 'The emerging epidemic of obesity in developing countries', *International Journal of Epidemiology*, 35 (1), pp. 93-99.
- Puhl, R.M., Heuer, C.A. (2009) The stigma of obesity: a review and update, *Obesity*, 17 (5), pp. 941- 964.
- Puhl, R.M., Brownell, K.D. (2001) 'Bias, discrimination, and obesity', *Obesity Reviews*, 9, pp. 788-905.
- Puhl, R.M., Brownell, K.D. (2002) 'Confronting and coping with weight stigma: an investigation of overweight and obese adults, *Obesity*, 14, pp. 1802-1815.
- Puhl, R.M., Brownell, K.D. (2003) 'Psychological origins of obesity stigma: toward changing a powerful and pervasive bias', *Obesity Reviews*, 4, pp. 213-227.
- Puhl, R.M., Moss-Racusin, C.A., Schwartz, M.B., Brownell, K.D. (2008) 'Weight stigmatisation and bias reduction: perspectives of overweight and obese adults', *Health Education Research*, 23, pp. 347-358.
- Punch, K.F. (2005) *Introduction to social research: quantitative and qualitative approaches*. London: SAGE.
- Reed, P.G. (2009) 'Nursing reformation: historical reflections and philosophical foundations, in Reed, P.G, Crawford, S.N.B. (eds) *Perspectives of Nursing theory*. 5<sup>th</sup> edition. London: Lippincott Williams and Wilkins.
- Reis, H.T. (1990) 'The role of intimacy in interpersonal relations', *Journal of Social and Clinical Psychology*, 9, pp. 15-30.
- Reto, C.S. (2003) 'Psychological aspects of delivering nursing care to the bariatric patient', *Critical Care Nursing Quarterly*, 26 (2), pp. 139-149.
- Richards, L. and Morse, J.M. (2007) *Readme First for a user's guide to qualitative methods (2<sup>nd</sup> ed.)*. CA: Thousands Oaks

- Roberts, D. (2008) 'Friendships fosters learning: the importance of friendship in clinical practice', *Nurse Education in Practice*, 9 (6), pp. 367-371.
- Roberts, S. (1983) 'Oppressed group behaviour: implications for nursing', *Advances in Nursing Science*, 5 (4), pp. 21-30.
- Robertson, M.H.B., Boyle, J.S. (1984) 'Ethnography: contributions to nursing research', *Journal of Advanced Nursing*, 9 (1), pp. 43-49.
- Rochling, M.V. (1999) 'Weight-based discrimination in employment: psychological and legal aspects', *Personnel Psychology*, 52, pp. 969-1017.
- Rodwell, C.M. (1996) 'An analysis of the concept of empowerment', *Journal of Advanced Nursing*, 23 (2), pp. 305-313.
- Rolfe, G. (2006) 'Validity, trustworthiness and rigour: quality and the idea of qualitative research', *Journal of Advanced Nursing*, 53 (3), pp. 304-310.
- Rosenberg, M.J., Hovland, C.I. (1960) 'Cognitive, affective, and behavioural components of attitudes', in Hovland, C.I., Rosenberg, M.J. (eds.) *Attitude organisation and change*. New Haven, CT: Yale University Press.
- Royal College of Nursing (2000) *Introducing a safer handling policy*. London: Royal College of Nursing.
- Royal College of Nursing (2006) *Informed consent in health and social care research: RCN guidance for nurses*. London: Royal College of Nursing.
- Ruderman, N., Chisholm, D., Pi-Sunyer, X., Schneider, S. (1998) 'The metabolically obese, normal-weight individual revisited', *Diabetes*, 47, pp. 699-713.
- Sarantakos, S. (2005) *Social Research. 3<sup>rd</sup> Edition*. New York: Palgrave Macmillan.
- Sardani, A.V. (2006) *Student nurses' attitudes towards obese patients*. Unpublished Master's Thesis. University of Wales, Swansea.
- Savage, J. (1992) 'The theory and practice of new nursing', *Nursing Times*, 86 (4), pp. 42-45.

- Savage, J. (1995) *Nursing intimacy: an ethnographic approach to nurse-patient interaction*. London: Scutari Press.
- Savage, J., Scott, C. (2005) *Patients' nutritional care in hospital: an ethnographic study of nurses' role and patients' experience*. London: Royal College of Nursing Institute.
- Schechter, S., Bayley, R. (2004) 'Language socialization in theory and practice', *International Journal of Qualitative Studies in Education*, 17 (5), pp. 605-625.
- Scheurich, N. (2002) 'Moral attitudes and mental disorders', *The Hastings Centre Report*, 32 (2), pp. 14-21.
- Schön, D. (1983) *The Reflective Practitioner*. New York: Basic Books.
- Schwartz, M.B., O'Neal, C.H., Brownell, K.D., Blair, S.N., Billington, C. (2003) 'Weight bias among health professionals specializing in obesity', *Obesity Research*, 11, pp. 1033-1039.
- Schwartz, M.B., Vartanian, L.R., Nosek, B.A., Brownell, K.D. (2006) 'The influence of one's own body weight on Implicit and Explicit anti-fat bias', *Obesity*, 14, pp. 440-447.
- Scott J., Marshall G. (2012) *A Dictionary of Sociology*. 3rd Edition. Oxford University Press, Oxford
- Scottish Government (2010) *Preventing overweight and obesity in Scotland: A route map towards healthy weight*. Edinburgh: Scottish Government. Available at: [www.scotland.gov.uk/Publications/2010/02/17140721/0](http://www.scotland.gov.uk/Publications/2010/02/17140721/0) (Accessed: 9 June 2011).
- Scottish Government (2010) *The Scottish Health Survey: UK Comparisons*. Available at: <http://www.scotland.gov.uk/Resource/Doc/322888/0103950.pdf> (Accessed: 9 July 2011).
- Serdula, M.K., Ivery, D., Coates, R.J., Freedman, D.S., Williamson, D.F., Byers, T. (1993) 'Do obese children become obese adults? A review of the literature', *Preventive Medicine*, 22, pp. 167-177.

- Shapiro, J. (2002) '(Re) examining the clinical gaze through the prism of literature', *Families, Systems and Health*, 20 (2), pp. 161-170.
- Shattell, M. (2004) 'Nurse - patient interaction: a review of the literature', *Journal of Clinical Nursing*, 13 (6), pp. 714-722.
- Shepherd, A. (2011) 'Measuring and managing fluid balance', vol. 107, no.28 *Nursing Times*. Available at: <http://www.nursingtimes.net/Journals/1/Files/2011/8/1/Fluid%20balanceCorr.pdf.pdf> (Accessed: 10 July 2010).
- Simpson, A., Barker, P. (2007) 'The persistence of memory: using narrative picturing to co-operatively explore life stories in qualitative enquiry', *Nursing Enquiry*, 14 (1), pp. 35-41.
- Skidmore, P.M.L., Yarnell, J.W.G. (2004) 'The obesity epidemic: prospects for prevention', *QMJ* 97 (12), pp. 817-825.
- Smedley, J., Egger, P., Cooper, C., Coggon, D. (1995) 'Manual Handling activities and risk of low back pain in nurses', *Occupational and environmental medicine*, 52, pp. 160-163.
- Sobal, J. (2001) 'Commentary: Globalisation and the epidemiology of obesity', *International Journal of Epidemiology*, 30 (5), pp.1136-1137.
- Spencer, E.A., Appleby, P.N., Gwyneth, K.D., Key, T.J. (2001) 'Validity of self-reported height and weight in 4808 EPIC-Oxford participants', *Public Health Nutrition*, 5 (4), pp. 561-656.
- Spradley, J.P. (1980) *Participant observation*. London: Harcourt Brace Jovanovich College Publishers.
- Stein, C.J., Colditz, G.A. (2004) 'The epidemic of obesity', *The Journal of Clinical Endocrinology and Metabolism*, 89 (6), pp. 2522-2525.
- Steptoe, A., Doherty, S., Kendrick, T., Rink, E., Hilton, S. (1999) 'Attitudes to cardiovascular health promotion among GP's and practice nurses', *Family Practice*, 16 (2), pp. 158-163.



Steubert-Speziale, H.J. and Rinaldi Carpenter, D. (2007) *Ethnography as a method*. In Steubert-Speziale, H.J. and Rinaldi Carpenter, D. (Eds) *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 4th Edition. Philadelphia: Lippincott Williams & Wilkins

Stockwell, F. (1984) *The unpopular patient*. London: Croom Helm.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks: London: Sage Publications.

Strauss, A., Fagerhaugh, S., Suczek, B., Wiener, C. (1982) 'Sentimental work in the technologized hospital', *Sociology of Health and Illness*, 4 (3), pp. 254-278.

Strauss, A., Fagerhaugh, S., Suczek, B., Wiener, C. (1985) *Social Organisation of medical work*. London: The University of Chicago Press, Ltd.

Stuhmiller, C.M., Thorsen, R. (1997) 'Narrative picturing: a new strategy for qualitative data collection', *Qualitative Health Research*, 7 (1), pp. 140-149.

Sturm, R. (2002) 'The effects of obesity, smoking, and drinking on medical problems and costs', *Health Affairs (Project Hope)*, 21 (2), pp. 245-253.

Svederberg, E., Nyberg, M., Sjoberg, K. (2010) 'Bus drivers' and assistant nurses' conceptualizations of food and meals during working hours', 11 (2), Art. 15 *Forum: Qualitative Social Research*.

Swift, J.A., Sheard, C., Rutherford, M. (2007) 'Trainee health professionals' knowledge of the health risks associated with obesity', *Journal of Human Nutrition and Dietetics*, 20, pp. 599-604.

Swingewood, A. (2000) *A short history of sociological thought* (3<sup>rd</sup> ed.). Basingstoke: Palgrave

Taubes, G. (2008) *The diet delusion*. Chatham: Vermilion.

Tavares, M. (1994) 'Burnout in AIDS care', *Professional Nurse*, 12, pp. 24-27.

The Quality Assurance Agency for Higher Education (2001) *Benchmark Statement: Health Care Programmes - Nursing*. Gloucester: The Quality Assurance Agency.

Thomas, D. (1999) 'Disempowerment, empowerment and older people', in Wilkinson, G., Miers, M. (eds) *Power and nursing practice*. London: MacMillan Press Ltd.

Todres, L, and Holloway I (2010) Phenomenological research. In: *The research process in Nursing* (6<sup>th</sup> ed.) Gerish K., Lacey A., (Eds). Oxford, Blackwell Publishing Ltd

Townend, L. (2009) 'The moralizing of obesity: a new name for an old sin?', *Critical Social Policy*, 29 (2), pp. 171-190.

Tuochy, D. (2003) 'Student nurse-older person communication', *Nurse Education Today*, 23 (1), pp. 19-26.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2008) *Code of Professional Conduct*. London: United Kingdom Central Council.

Van Maanen (1995) *Representation in Ethnography*. CA: Thousand Oaks

Vanhala, M., Vanhala, P., Kumpusalo, H.P., Takala, J. (1998) 'Relation between obesity from childhood to adulthood and the metabolic syndrome: population based study', *British Medical Journal*, 317, pp. 319-320.

Vartanian, L.R., Herman, C.P., Polivy, J. (2005) 'Implicit and explicit attitudes toward fatness and thinness: the role of the internalisation of societal standards', *Body Image*, 2 (4), pp. 373-381.

Wang, S.S., Brownell, K.D., Wadden, T.A. (2004) 'The influence of the stigma of obesity on overweight individuals', *International Journal of Obesity and Related Metabolic Disorders*, 28 (10), pp. 1333-1337.

Wardle, J., Waller, J., Jarvis, M.J. (2002) 'Sex differences in the association of socioeconomic status with obesity', *American Journal of Public Health*, 92 (8) pp. 1299-1304.

Webb, F., Prentice, A., Webb, F. (2006) 'Obesity amidst poverty', *International Journal of Epidemiology*, 35 (1), pp. 24-30.

- Weber, M. (1968) *Economy and society: an outline of interpretive sociology*. New York: Bedminster Press
- Wells, J.C.K., Treleaven, P., Cole, T.J. (2007) 'BMI compared with 3-dimensional body shape: the UK National Sizing Survey', *American Journal of Clinical Nutrition*, 85, pp. 419-425.
- Welsh Assembly Government (2010) *Welsh Health Survey local authority figures 2008/09*. Available at: <http://wales.gov.uk/topics/statistics/theme/health/health-survey/results/?lang=en> (Accessed: 9 May 2011).
- Welsh, E. (2002) 'Dealing with data: Using NVivo in the qualitative data analysis process', 3(2) *Forum: Qualitative social research*. Available at: <http://nbn-resolving.de/urn:nbn:de:0114-fqs0202260> (Accessed: 20/08/09).
- Westwood, S. (2002) *Power and the social*. London: Routledge.
- Whitaker, C.W., Wright, J.A., Pepe, M.S., Seidel, K.D., Dietz, W.H. (1997) 'Predicting obesity in young adulthood from childhood and parental obesity', *The New England Journal of Medicine*, 337 (13), pp. 869-873.
- Wilde, B., Starrin, B., Larsson, G., Larsson, M. (1993) 'Quality of care from a patient-perspective-a grounded theory study', *Scandinavian Journal of Caring Sciences*, 7 (2), pp. 113-120.
- Wilkinson, G. (1999) 'Theories of power', in Wilkinson, Miers, M. (eds) *Power and Nursing Practice*. London: Macmillan Press Ltd.
- Wilson, J. (2004) 'Obesity: Impediment to postsurgical wound healing', *Advances in Skin & Wound Care*, 17 (8), pp. 426-432.
- Windschuttle, K. (1994) *The killing of history. How discipline is being murdered by literary critics and social theorists*. Sydney: Macleay.
- Wolf, N. (1991). *The Beauty Myth*. New York: Doubleday.
- Wolf, Z.R., Giardino, E.R., Osborne, P.A., Ambros,e S. (1994) 'Dimensions of Nurse Caring', *Journal of Nursing Scholarship*, 26 (2), pp. 107-112.

World Health Organisation (2003) *Global Strategy on Diet, Physical Activity and Health*. Geneva: World Health Organisation.

World Health Organisation (2004) *Comparative Quantification of Health Risks: Global and Regional burden of disease attributable to selected major risk factors*. Geneva: World Health Organisation.

World Health Organisation (2011a) *Media centre: Obesity and overweight*. Geneva: World Health Organisation.

World Health Organisation (2011b) *WHO Global Infobase: data on overweight and obesity, mean BMI, healthy diets and physical inactivity*. Geneva: World Health Organisation.

Wright, J. (1998) 'Female nurses' perceptions of acceptable female body size: an exploratory study', *Journal of Clinical Nursing*, 7, pp. 307-315.

Young, L., Powell, B. (1985) 'The effects of obesity on the clinical judgments of mental health professionals', *Journal of Health and Social Behaviour*, 26, pp. 233-246.

Yusuf, S., Hawken, S., Ounpuu, S., Dans. T., Avezum, A., Lanas, F., McQueen, M., Budaj, A., Pais, P., Varigo, J., Lisheng, A., on behalf of the INTERHEART Study Investigators (2004) *Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART Study): case-control study*, *The Lancet*, 364, pp. 937-952.

Zuzelo, P.R., Seminara, P. (2006) 'Influence of registered nurses' attitudes towards bariatric patients on educational programming effectiveness', *Journal of Continuing Education in Nursing*, 37 (2), pp. 65-73.

# APPENDICES

**Appendix 1. Table of nursing studies**

| <b>Qualitative Studies</b>            | <b>Aims</b>   | <b>Methods</b>   | <b>Sample</b>                                  | <b>Findings</b>   | <b>Limitations</b> |
|---------------------------------------|---|--|--|---|--------------------|
| <b>Wright (1998), UK</b>              | To explore female nurses' perceptions of acceptable female body size        | Semi-structured interviews   | 10 participants (nurses)                       | Nurses had strong beliefs that fat is unhealthy and were reluctant to talk about obesity to their patients  |                    |
| <b>Petrich (2000), Canada and USA</b> | To describe the perceptions of medical and nursing students towards obesity | Open-ended questions about their feelings, thoughts and reactions to obesity-related terms | 102 nursing students (and 28 medical students) | A quarter of nursing students felt repulsed at obese person's appearance<br><br>Only 9% felt empathy for obese patients<br><br>Many participants saw obese persons as lazy, inactive and lacking self-control<br><br>Students said they received minimal instruction on obesity |                    |
| <b>Mercer and Tessier (2001), UK</b>  | To examine perceptions of obesity and attitudes towards                     | Semi-structured interviews   | 10 participants                                | Nurses did not feel enthusiastic about participating in weight management   |                    |

|  |   |                            |                                  |   |  |
|--|---|----------------------------|----------------------------------|---|--|
|  | weight management   |                            | (nurses)                         | Felt frustrated about patients' lack of success<br>Said that they had insufficient training and lack of resources   |  |
| <b>Jeffrey and Kitto (2006), Australia</b> | To explore nurses' perceptions and experiences of caring for obese patients in a bariatric ward | Semi-structured interviews | 10 participants (nurses)         | Obesity was seen as a multifactorial disease.<br>Nurses felt ambivalent about weight loss surgery; some considered it a 'quick-fix'<br>Nurses felt frustration towards patients; they thought they were responsible for being obese       |  |
| <b>Sardani (2006), UK</b>                  | To explore student nurses' attitudes towards obese patients                                     | Semi-structured interviews | 10 participants (student nurses) | Student nurses expressed negative feelings and thoughts towards obese patients.<br>The majority of experiences recalled were negative.<br>Some students felt empathy and pity towards obese patients.<br>Students noted lack of resources |  |

|                                     |  |   |   |  |   |  |
|-------------------------------------|--|---|---|--|---|--|
|                                     |  |   |   |  | and knowledge as main barriers  |  |
| <b>Brown and Thomson (2007), UK</b> | To explore primary care nurses' attitudes, beliefs and perceptions of own body size in relation to giving advice about obesity | Semi-structured interviews  | 15 participants (primary care nurses)                   | Obesity was seen as an awkward, sensitive issue to approach<br>Obese patients were seen as reluctant to change<br>They perceived they had low impact on patients                           |   |  |
| <b>Quantitative Studies</b>         | <b>Aims</b>  | <b>Methods</b>  | <b>Sample</b>   | <b>Findings</b>  | <b>Limitations</b>  |  |
| <b>Young and Powell (1985), USA</b> | To determine whether body weight influences the clinical judgement of mental health practitioners                              | Self-administered questionnaires based on a case history scenario and photographs of best-weight, overweight and obese patients | 120 respondents (percentage of nurses is not disclosed) | Obese patients were given more negative judgements<br>Female, younger participants were more likely to be prejudiced<br>Obese women were more likely to be seen as psychologically deviant | Convenience sample<br>The response rate is not stated<br>Questionnaire was not tested to estimate reliability and internal consistency<br>Issues of 'halo' effect |  |
| <b>Bagley et al (1989), Canada</b>  | To develop and test a scale that measures  | Self-administered questionnaire   | 107 respondents   | Nearly a quarter of nurses felt repulsed when caring for an obese  | Convenience sample  |  |



|  |   |  |                                  |   |  |
|--|---|--|----------------------------------|---|--|
|  | nurses' attitudes towards obesity and obese patients  |  | (nurses)                         | <p>patient</p> <p>Age and dissatisfaction on own body image had a negative effect on attitudes</p> <p>Years of professional education had a positive effect</p> <p>Nurses thought caring for obese patients is a stressful experience</p> | Issues of 'halo' effect  |
| <b>Peternelj-Taylor (1989), Canada</b> | To examine the effects of patient weight and sex on evaluations, attributions and care delivery decisions | Self-administered questionnaire utilising descriptive vignettes and visual stimuli | 100 respondents (student nurses) | <p>Obese patients were evaluated more negatively, were seen as less socially attractive</p> <p>Students stated that they did not withdraw from their care</p>   | <p>Convenience sample</p> <p>Issues of 'halo' effect</p>                     |
| <b>Maroney and Golub (1992), USA</b>   | To assess the attitudes of US nurses and compare them with Bagley et al (1989)                            | Self-administered questionnaire  | 67 respondents (nurses)          | <p>Negative attitudes were similar to Canadians</p> <p>Caring for an obese patient was seen as physically exhausting and stressful</p> <p>Nurses felt uncomfortable caring for them and saw them as over-</p>                             | <p>Convenience sample</p> <p>Issues of 'halo' effect</p> <p>Small sample</p> |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| <p><b>Hoppe and Ogdan (1997), UK</b></p>   | <p>To examine nurses' beliefs about obesity, weight management practices and own BMI</p>   | <p>Self-administered questionnaire</p>                                  | <p>586 nurses (National random sample)<br/>65% response rate</p> | <p>indulgent. Rarely expressing their true feelings, and lacking self-confidence</p> <p>Lifestyle was rated as main cause of obesity</p> <p>Obesity was seen as preventable and treatable</p> <p>Non-compliance and lack of motivation were seen as biggest factors influencing failure of weight loss</p> <p>Nurses spent less than 10 minutes discussing weight management</p> | <p>Issues of 'halo' effect</p>                           |
| <p><b>Garner and Nicol (1998), USA</b></p> | <p>To describe the attitudes of female and male nursing students and examine the relationship with demographic characteristics</p> | <p>Self-administered questionnaire (the same as Bagley et al, 1989)</p> | <p>68 student nurses and 55 patients</p>                         | <p>At least quarter of students held negative attitudes</p> <p>No difference between male and female student nurses was identified</p>   | <p>Convenience sample</p> <p>Issues of 'halo' effect</p> |

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| <b>Ogden and Hoppe (1998), UK</b>        | To examine the impact of 2 educational interventions on obesity management                          | Self-administered questionnaires before, after 1 month and after 6 months of interventions | 240 nurses (random sample)  | The brief educational interventions had no differential effects on nurses' beliefs about obesity. Some changes were found in consultation times and types of weight loss advice   | Issues of 'halo' effect  |
| <b>Culbertson and Smolen (1999), USA</b> | To describe attitudes of student nurses and investigate the relationship with demographic variables | Self-administered questionnaire  | 73 respondents (student nurses)                                   | 70% felt that obese persons have poor food selection<br>Half of students felt that change of diet would result in weight loss<br>54% felt that obese persons lacked self-confidence<br>Age and work experience had a positive effect on attitudes | Convenience sample<br><br>Small sample<br><br>Issues of 'halo' effect              |
| <b>Green et al (2000), UK</b>            | To examine nurses' and health visitors' knowledge of obesity assessment and management              | Self-administered questionnaires   | 45 participants<br>56% response rate (nurses and health visitors) | Respondents were unclear on how to interpret BMI<br>Weight loss advice did not follow current recommendations in many occasions   | Convenience sample<br>Small sample<br>Low response rate<br>Issues of 'halo' effect |

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| <p><b>Hankey et al (2003), UK</b></p>               | <p>To examine knowledge, attitudes, beliefs and eating habits with respect to obesity, nutrition and weight management</p> | <p>Self-administered questionnaire<br/><br/>Systematic Stratified sample</p>                         | <p>613 nurses (within a sample of 2290 respondents)<br/><br/>65% response rate</p> | <p>Nurses have some knowledge of nutrition and weight management<br/><br/>Less than 7% reported having audited their practice population with respect to obesity and weight management<br/><br/>Nurses feel unskilled - insufficient time allocated for weight management</p>   | <p>Sample not representative of population (less than a third overweight or obese)<br/><br/>Issues of 'halo' effect</p> |
| <p><b>Rager Zuzelo and Seminara (2006), USA</b></p> | <p>To investigate attitudes of nurses towards bariatric patients</p>   | <p>Self-administered questionnaire same as Bagley et al (1989) plus<br/><br/>Open-ended question</p> | <p>119 respondents<br/><br/>16.2% response rate<br/><br/>(nurses)</p>              | <p>There was no relationship between self-reported body weight, years of experience, educational level or type of work setting<br/><br/>The majority reported having positive attitudes<br/><br/>Patients' unique needs for specialised equipment, feeling overwhelmed by their needs, making an effort to avoid hurtful encounters, feeling astounded by patients' size, feeling empathy were some of the themes</p> | <p>Convenience sample<br/><br/>Small response rate<br/><br/>Issues of 'halo' effect</p>                                 |

|                                       |   |                                 |   |   |   |
|---------------------------------------|---|---------------------------------|---|---|---|
| <b>Brown et al (2007), UK</b>         | To investigate patterns of clinical practice, beliefs and attitudes with respect to obesity management              | Self-administered questionnaire | 564 participants<br><br>72.3% response rate<br><br>(nurses) | Negative attitudes were detected; the majority agreed that person's lifestyle choices are the cause of obesity.<br><br>Environmental factors scored the lowest (8.7%)<br><br>Only few (8.7%) thought that obese persons are motivated to change<br><br>About half agreed that is rewarding work and feeling empathy | Issues of 'halo' effect                           |
| <b>Jallinoja et al (2007) Finland</b> | To explore views on patient and professional roles in the management of lifestyle-related diseases and risk factors | Self-administered questionnaire | 161 nurses (total of 220 respondents)                       | 95% nurses agreed that patients must accept responsibility for lifestyle-related behaviour<br><br>94% considered unwillingness to change lifestyle as key barrier to obesity management<br><br>Most nurses thought patients had sufficient knowledge of the risks of conditions associated with obesity.            | Convenience sample<br><br>Issues of 'halo' effect |
| <b>Rose et al (2007),</b>             | To compare nurse staffing requirements  | Structured                      | 30 patients observed,                                       | The average of the total staff time required for bathing, positioning,  | Convenience sample                                |

| Australia                      | for the care of morbidly obese and non-obese patients in the acute care setting        | Observation technique                                  | unidentified number of nurses, unidentified period of time of observation                            | assisting to walk or sit was always higher for the morbidly obese patients.<br><br>Bathing and assisting to walk required significantly more personnel.  | A single site observed<br><br>Restricted number of observations made       |
|--------------------------------|--|--|--|--|--|
| <b>Swift et al (2007), UK</b>  | To investigate knowledge regarding the health risks associated with obesity            | Self-administered questionnaire<br><br>(online survey) | 689 respondents<br><br>(sample included 88 nursing Diploma students and 74 nursing Masters students) | Nearly 70% of nursing students agreed that part of their role is to counsel obese patients about the health risks of obesity.<br><br>More than half felt that they had received insufficient teaching on the physical consequences of obesity. | Convenience sample<br><br>Issues of 'halo' effect<br><br>Low response rate |
| <b>Drake et al (2008), USA</b> | To describe the challenges nurses face in providing care to the morbidly obese patient | Self-administered questionnaire                        | 109 respondents<br><br>(nurses)  | Only 61.3% reported having specialised equipment<br><br>Only 42% use equipment when caring for morbidly obese patients<br><br>61% reported having insufficient   | Convenience sample<br><br>Low response rate                                |

|                                    |   |                                 |   | staffing levels   | Issues of 'halo' effect  |
|------------------------------------|---|---------------------------------|---|---|--|
| <b>Miller et al (2008), USA</b>    | To quantify the incidence of overweight and obesity in nurses and assess their knowledge of obesity and associated health risks | Self-administered questionnaire | 760 participants<br><br>15.5% response rate<br><br>(nurses) | Nearly half replied that caring for an obese patient was a satisfying experience<br><br>Almost 54% of respondents were overweight or obese<br><br>Only 26% use BMI to make clinical judgements on obesity<br><br>76% reported not pursuing weight management with overweight and obese patients | Low response rate<br><br>Issues of 'halo' effect   |
| <b>Watson et al (2008), Canada</b> | To develop and test an instrument to measure nurses' attitudes towards obesity and obese adult patients                         | Self-administered questionnaire | 420 respondents<br><br>(nurses)<br><br>46.1% response rate  | The majority of nurses felt irritation, impatience and frustration towards obese patients.<br><br>Obese patients were seen as having low self-esteem, depression and guilt<br><br>Obesity was attributed to eating habits and lifestyle. Environmental  | Sample was highly educated-not representative of nursing population<br><br>Issues of 'halo' effect |

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| <p><b>Poon and Tarrant (2009), Hong Kong</b></p> | <p>To investigate attitudes towards obese patients</p>   | <p>Self-administered questionnaire</p>                        | <p>352 student nurses<br/>AND<br/>198 RN nurses</p>  | <p>impact scored the lowest.<br/>Monitoring food intake and weight management programs ranked higher in the roles taken by nurses</p>  | <p>The majority replied that obese people like food, overeat and are shapeless, show and unattractive.<br/>RN nurses had significant higher levels of fat phobia and more negative attitudes than student nurses</p>                                     | <p>Convenience sample<br/><br/>Issues of 'halo' effect</p> |
| <p><b>Kam and Taylor (2010), Australia</b></p>   | <p>To determine which aspects of emergency department management are adversely affected by patient obesity</p> | <p>Self-administered questionnaire + open-ended questions</p> | <p>736 nurses<br/><br/>(sample included 750 patients, 746 doctors and 333 radiographers)</p> | <p>Overall nurses agreed that the level of obesity increased the difficulty considerably.<br/>Most difficulties were related to mobilisation and positioning of obese patients.<br/>Nurses suggested more lifting equipment and more staff is needed</p> | <p>Overall nurses agreed that the level of obesity increased the difficulty considerably.<br/>Most difficulties were related to mobilisation and positioning of obese patients.<br/>Nurses suggested more lifting equipment and more staff is needed</p> | <p>Convenience sample</p>                                  |



## Appendix 2. Open Coding in NVivo

Look for:  Search In  **Free Nodes** Find Now

### Free Nodes

▼ Name

- Free Nodes**
- SHORTAGE OF RESOURCES
- Humour
- POWER AND BOUNDARIES
- Using condemned lifting techniques
- Rituals-habits-routines-rhetoric
- challenges while nursing obese patients
- dignity and comfort
- breaking your back
- Education regarding obesity
- ward environment
- learning experience
- poor manual handling
- ethics and other research issues
- NURSING RESPONSIBILITIES-it's difficult
- Pushed at the Back of the Queue-priorities
- A positive case
- health problems associated with obesity
- patient's size
- obesity information in the ward, posters
- eating hospital food
- paternalism
- years of experience
- frequency of obese patients' encounter
- confidence caring obese patients
- a brick wall
- the need to fit in
- manual handling training
- Ward culture-socializing
- age
- Occupying space
- cleaning
- Staff room Therapy
- weighing patients
- losing weight
- cultural influence
- role model nursing
- it was a social problem
- Denial
- being a male nurse
- Nursing in the dark- lack of information
- tired-burnout
- Equipment and weight
- body image
- lack of time

In  Nodes

**Appendix 3. Table that depicts the association between codes, subcategories, categories, subthemes of the 3rd theme**

| <i>Codes</i>  | <i>Subcategories</i>                   | <i>Categories</i>                     | <i>Subthemes</i>                       | <i>Theme</i>   |
|---|--|---------------------------------------|--|--|
| 'Perhaps IT IS HER fault'<br>'It is a visual thing'   | Obesity as deviance                    | <b>Obese patients' disempowerment</b> | <b>Consequences for obese patients</b> | <b>The Consequences Of student nurses' Involvement With obese Patients' care</b> |
| Obese patients put in side rooms  | Isolation                              |                                       |  |  |
| 'When we're not looking he's eating'  | Surveillance and normalising judgement |                                       |  |  |
| We call them 'double handlers'  | Depersonalisation                      |                                       |  |  |
| talks with the patients about finding clothes in your size<br><br>spending more time with the patient         | Reciprocal interaction                 | <b>Obese patients' empowerment</b>    |  |  |
| Sharing information about the patient's progress  | Knowledge sharing                      |                                       |  |  |
| Arguing in favour of a patient in the nurses' office  | Advocating for patients                |                                       |  |  |
| Arranging a special mattress<br><br>Finding time to escort patient to toilet rather than bringing the commode | Negotiating resources                  |                                       |  |  |
| Caring as a   | 'A brick wall'                         | <b>Emotional</b>                      |  |  |

|  |  |                                   |  |
|--|--|-----------------------------------|--|
| struggle   |  | effects                           | <b>Consequences for student nurses</b> |
| Washing, lifting, moving   | Being intimate with an obese body                  |                                   |  |
| Own feelings about their weight<br>Embarrassment                   | Emotional labour: hidden feelings                  |                                   |  |
| Frustration  | Powerlessness                                      |                                   |  |
| Less time to learn   | 'I don't think there's anything I can do about it' |                                   |  |
| Having mentor support  | Feeling rewarded                                   |                                   |  |
| Limited knowledge  | 'It is harder'                                     | <b>Physical effects</b>           |  |
| Limited experience   | 'Massive amount of workload'                       |                                   |  |
| Limited support  | 'The complexity of patients' needs'                |                                   |  |
| Improvisation<br>Lifting   | Hidden physical work                               |                                   |  |
| Poor patient assessment  | Confused about their role                          |                                   |  |
| Participating in condemned M&H techniques                          |  |                                   |  |
| 'He thinks that this is a big joke. It could be his way of coping' | Eating what they like                              | <b>Obese patients' resistance</b> |  |
| She doesn't bend her legs nor does any effort whatsoever.          | Not helping during M&H                             |                                   |  |

|  |  |   |   |  |
|--|--|---|---|--|
| <p>Task orientation</p> <p>Patient avoidance</p> <p>Inappropriate humour</p>                     | <p>Struggle to interact</p>                      | <p>Student nurses: struggling to care</p> | <p><b>Obese patients' and student nurses' power negotiation</b></p> |  |
| <p>Physical and technical boundaries</p>   | <p>Struggle to fit the obese patient</p>         |   |   |  |
| <p>Emotional and physical labour</p> <p>Providing hidden care</p> <p>Limited time to 'learn'</p> | <p>Struggle to control their social position</p> |   |   |  |
| <p>'I was a student; I didn't make decisions'</p>  | <p>Limited participation in decision-making</p>  |   |   |  |

**Invitation**  
**For Student Nurses to participate  
in Nursing Research!**

**“An exploration of undergraduate nursing students’ care in relation to patients’  
weight”**

- Are you an undergraduate Student Nurse?
- Are you studying Adult Nursing?
- Would you like to have your voice heard?

**My name is Alexandra Sardani; I am a PhD nursing student and my research study is about YOU! Student Nurses! This is a unique opportunity!**

**I am looking into how you cope with patients’ care when you are in your hospital placements. I want you to show me how is it like to nurse patients with different body weight from the student nurse’s perspective.**

**What will you have to do?**

- **Just be yourself! My method is called “participant observation”; which means that I will be with you in your clinical practice everyday for 4 hours for two weeks.**
- **I will interview you so you could talk about your thought, feelings, and experiences you gained as a student nurse in practice.**

**R e m e m b e r !**

**This is not an evaluation of your knowledge or skills! I can assure you that you will remain completely anonymous and the data will be kept confidential.**

**This study has gained approval from the SHS Research Ethics’ Committee.**

**Contact me for more information!**

**Alexandra Sardani BSc, MSc email: [400915@swan.ac.uk](mailto:400915@swan.ac.uk)**

## Appendix 5. Interview Schedule

1. Clarification of the purpose of the study and ethical implications of the study
2. Demographic data of participant (age, years of studies and experience)
3. Obesity meaning: What does obese mean to you? What factors signify that a patient is obese?
4. How often do you see obese patients on the wards you practised? Tell me about an experience you had nursing an obese patient that you recall.
5. What factors influence the nursing care that obese patients are offered on the ward? Tell me about your experiences.
6. How competent do you feel in caring for obese patients?
7. Tell me about the moving and handling equipment you have used/seen used for obese patients
8. How important is nutrition in an obese patient's care?
9. How important is health promotion in an obese patient's care? Have you offered/observed offering advice regarding weight/nutrition/physical activity to an obese patient?
10. What attitudes towards obese patients have you seen in clinical practice?
11. What is your attitude towards obese patients? How do you manage your emotions?
12. Draw a picture. Finally, I would like to try something different. It's a relatively new research method called 'draw a picture'. I would like you to draw a picture that comes to your mind when you think about nursing obese patients. Take as time as you like. Remember, this is not a test of your drawing skills. Why did you draw this and what does it mean?
13. Conclusion. Do you have any final thoughts you'd like to express? How did you feel being observed? (For students I observed) How did you feel being interviewed?

Thank you very much!

## Appendix 6. Extract from fieldnotes with codes and analysis

have their break. I gave her the consent form, explained her "what is the research about" and asked her some information about the ward, the patients, and how many days she still has before she finishes. She has already handed me a plan that showed the number of patients, their reason of admission and any other relevant information. Later, I will see that nurses and students as well, write their notes about the patients on that sheet.

S: 3<sup>rd</sup> year student  
A: mentor of S  
D: difficult patient  
'normal weight'  
H: difficult obese patient  
T: difficult obese, 'confused' patient

This is information from student:

### CONTEXT

Patients are divided into two teams; the red team and the blue team for reasons of convenience. Both teams have male and female patients. S is working on the blue team. "Nurses form teams to care for their patients better. This way they have also the ability to know better the patients they care for. However, nurses can switch teams whenever is needed or they ask for it. Students are able to stick to one team, for reasons of convenience". All folders and files in the ward are either red or blue, depending on the team the patients belong to. S gave me information about the patients on both teams.

What happens in reality?

### Rhetoric

Categorization of patients: blue/red.

Key information about D according to S

Most patients are here because of "#". This symbolises that a bone- usually a hip or knee- is broken. S gives more information about two patients; the one is called D. This is how S described his situation. He is 25 years old, has multiple injuries (broken bones), he was involved in a car accident. He took his mother's car "without permission". He was driving the car, drunk, "he had a bottle of vodka on his knees" not wearing a belt. 110 miles per hour- speed limit 70. There were two other female passengers that survived the accident. One was wearing a belt, in the front seat, that did not have any cuts or bruises and the other one, who was sitting on the back, was admitted in the Critical Care Unit. She is "fortunately" now out of danger in another ward. Her liver and kidneys were affected by the accident. Throughout the morning, this patient's name comes forward quite often (at least 5 or 6 times). He does not cooperate with either doctors' or nurses' recommendations. For example, he was asked not to move his pelvis, but he does.

### Difficult patient

It was the patient's fault

→ lack of cooperation

How is  
the information  
are page 19

The first thing  
she says  
first impression

language

The latter patient's name is [redacted] She is a very big lady. She is 66. According to S [redacted] she is morbidly obese. "I mean is obese, how do you say it? She is morbidly obese". She has been admitted because of "social problems". S [redacted] explains "patients who don't have a real reason for admission but they had to come in because of other problems". She has nine sisters and brothers and two of them have mental difficulties; she cares for them.

demanding

↳ what is a real reason

Later, I found out that whenever other wards are full, and there is an "The Trauma and Orthopaedics Ward" is a ward that patients come empty bed, patients from post-operatively. Usually, they come after the 4<sup>th</sup> or 5<sup>th</sup> day of the operation. They come here to recover".

all sorts of wards can be admitted. For example, medical ward

What are the actual tasks and responsibilities of students?

S [redacted] has many responsibilities in the ward. She is a 3<sup>rd</sup> year student nurse. She has "learned more during her management placement than the first two years". "During the first year, students usually do whatever the auxiliary nurses do really". During the management placement, in which S [redacted] is currently in, students have "quite different responsibilities". They can do the "drug rounds". They are in charge of the ward, they delegate work to other students and the nurses, as well. They arrange when they will have breaks, when to discharge patients. They do patients' assessments.

rhetoric: using language effectively to please or persuade. She's trying to impress me

rhetoric

Time and Patterns Schedule Routine

She also explained me the timetable of the day. At 8:30 patients have breakfast. After that, the qualified nurses do the drug rounds. Nurses also wash the patients and "do the dressings". At 10.30, nurses have a "half-an-hour" break. At 11:00-13:00, it is usually "quiet". At 13:00, you do the "back rounds". You check the patients, if there is need you wash some of them, you take them to the toilet. 15:00-16:00 is the visiting time. 17:00 is tea time.

Task ORIENTATION

Definition of back rounds

The drugs are locked. Qualified nurses have the keys. They give them to students on request. → S [redacted] told me later that 1st year students are not given the keys and are always supervised by their mentor.



Information provided by A qualified nurse

these are used to prevent skin ulcers on patients who never or seldom leave the bed.

Each bed can hold 267 kg, which is written clearly on each bed. Elderly patients have "special pressure mattresses" to relieve the pressure. The ones in the ward can be also used for overweight patients. "These are the ones that they sent us" - nurse A told me She answer my questions

weight elderly patients -> mattresses abundance of equipment designed for overweight patients

Hoists

There are three hoists on the ward. These are placed in a corner of a blue team room; they are unplugged. I did not see the use of sliding sheets until the afternoon. The event will be described later on.

no specially-designed place for hoists manual handling equipment despite that many patients were manually handled.

THE ROOM

I follow S. She washes her hands, she wears a plastic robe and she joins the nurses to help wash up the patients. When you enter the 6-bed room, you can see that all beds are separated with curtains (to respect patients' privacy) while washing up. This is the room at the back of the ward. It has only female patients. The windows oversee a wall; there is no light this time in the morning (and there will not be during the day).

task-oriented acts 6-bed room no natural light

Washing up.

Patients, who are strong enough, wash by themselves. Nurses, student nurses and support workers help them. S is wetting the towel with soap water, gives it to the patient, the patient washes her face. S takes the towel, rinses it in soap water and gives it back. All patients in this room are old women, and have different body weight.

task-oriented tasks ritual, the same pattern repeated when washing a patient no need to say to patient what to do.

weight physical appearance

Two of the patients look underweight; one of them is emaciated. She has senile dementia. A approaches this patient, who is clearly underweight, and asks her politely "Will you have breakfast today, Mrs S?"

underweight patient

Dying patient: S

This question is not answered because the patient is in a late state of dementia. Mrs S has not eaten or drunk anything for some time. She spits anything is put in her mouth. The staff and students lift her to the chair in order for her to sit without using the hoist. S is too weak to move by herself when transferred to the chair, she does not make any effort at all.

This is A words according to S corrected me: "moved"

Difficult patient: T

I can hear a patient screaming "help" repeatedly. S and the nurse are "apologising" that T has mental problems. He is "confused". A nurse goes to see what happened to the patient. I can hear her talking to him before she entered the room "What is the matter, T? Are you all right?" I can sense from the tone in her voice that she is not worried

Description of patient: Noisy ward: a patient is loud Nurses talking loud T: patient who is "big" (weight) and "demanding"

about what happened to T. She knows that it is not important.

Another nurse wonders "did he fall?"

\* E does not have time to answer the question. She is patronised with "Good?" Politeness that does not transmit genuine concern

S talks to every patient she approaches. She addresses them with their first name. "Hello, how are you doing today? Good?" She

minimal communication task-oriented curtesy question

Socialising  
Student/patient interaction

attends to their requests. "Can I have some water, please?" "Can I have my oxygen mask?" She is talking about how she spent her weekend, mentioning her birthday which is tomorrow, her daughter and her age. She is 31. She is tall and normal weight. Also, she talks about her last-essay results and a job interview she has tomorrow.

to me - not the patient  
Student talking about personal information in front of patient but not towards the patient.

First encounter with obese patient

student mentor  
S and me went to H's room. H has a room by herself. S asks H if she minds if I stay in the room during the washing up. I explain that I am a nurse researcher looking into student nurses and observing them. I do not mention anything about patients' weight. A asks H if she slept well last night, H notes that she saw "pretty woman" last night. A comments that the movie started at 10:30. H says that a nurse switched off the television for her, because she fell asleep.

cubicle: she has MRSA (methylx resistant Staphylococcus aureus)

ethics of research

social talking/chatting

Scenery: noise

The television is on and there is some background noise coming from a "machine" that is under the bed. According to S this machine is "really useful. It takes the slag out". A explains that it "draws the skin back". They both notice that it makes a weird noise, so probably it needs changing. "I don't think the machine will stay there any longer". Later on, while doing H's personal hygiene, they notice that despite the noise, the machine is working properly. H has asked repeatedly to put the machine under the bed after they finish because it distracts the bed table.

noisy ward  
S explains to me.

A says to H

Washing  
Hygiene and Observation

H is soaping her face by herself. S is handing her over the towel. She notices that there is a wound in her left ear; it looks "infected". H explains that she was wearing an earring, but now the wound is healing.

task-oriented washing  
actual conversation with patient. H

→ what's the purpose of humour  
 → when is humour used?

mine @ them  
 Gilbert \*

Humour

A. + S.

They are washing up the patient. The patient's chest is uncovered. She has stretch marks on her belly. S. comments "You are half the woman you were before". A. comments "And your boobies are gone". "We're going to wash down below, all right?" A. comments. H. tries to do it by herself. She cannot. She is advised to hold her belly, and the nurses wash her. They notice that she is sore; they suggest she should not use perfumed powder there. "We'll dry you properly now. We don't want you to get sore". They cover her chest with the white sheet. A. says in a humorous way "Some doctor will come and will see a lot" and helps her to adjust the sheet. H.'s legs are sore, obvious circulation problems, "broken veins" (perhaps chronic circulation problems, hardening of the arteries, varicose veins). They wash her legs and put cream. A. says "Can you turn over for me, H.?" H. says "All right, love". While A. supports her with one hand at her back and the other on the hip, S. washes her back. (No sliding sheets, hoists or any other manual handling equipment is used. S. explained later "She is too heavy for the hoist". A. advises "Stay over, H. for me". S. washes carefully her back and then she dries it very well. H. is commenting 'taking initiative' when placing the green absorbing material "Fold it and put it under, the way another nurse did". After some attempts, they manage to understand the way the patient desires it to be. H. explains "The nurse did it that way and I slept all the night". A. and S. help the patient to roll over, towards S. and A. repeats the washing up from the other side. She puts another "green absorbing material". After that, they put the patient in Trendelenburg position and they advise H. "lift yourself over" to go upper on the bed. S. puts cream on the patient's belly and powder on the patients' chest, deodorant spray on patients' armpits. "You smell sexy", "You smell sexy for the doctor" the nurse says. S. and A. comment on the rugby game this Saturday.

physical appearance of H.  
 dignity + sexuality.

patient's privacy + dignity  
 doctors are men  
 nurses are women

"friendly" name  
 H. turns by herself

not use of equipment.  
 Condemned techniques  
 misunderstanding  
 patient giving suggestion about her care

no use of sliding sheets  
 this manual handling  
 could cause pressure sores

Humour/derogatory

discussion does not include patient

Moving and Handling the patient

patient involved in decision-making

poor practice

8.45

Drug Administration

While the patients are finishing their breakfast, S. has started preparing the trolley with their drugs. The trolley has some syrups and

incorporation of drug trolley

## Appendix 7. Informed Consent

Please read this document and ask any questions you may have before agreeing to be in the study.

This study is conducted by Alexandra Sardani, as part fulfilment of PhD in Health Science, Swansea University.

The purpose of this study is to explore nursing students' clinical practice care in relation to patients' weight.

If you agree to be in this study, you will be asked to be observed for two weeks as well as to attend an individual interview that will last approximately 60 minutes, which will be tape-recorded with your permission.

There are no foreseeable risks connected to this study. However, it might be of benefit to nursing education, as it will identify nursing students' needs, as far as nursing patients with different weight is concerned.

The benefits of participation are:

You will be able to raise your thoughts and feelings about your practice. Moreover, it could be a great opportunity to put forward any problems you might have encountered or any benefits that you might have gained.

Your identity will not be made available to anyone apart from the researcher. However, the data will be shared with the supervisor of the present study and, finally, will be disseminated through conventions and articles in scientific magazines. Nevertheless, your confidentiality and anonymity will be ensured.

Your participation will not affect in any way your current or future relations within your University or in your future workplace. Moreover, if you feel uncomfortable, you could withdraw at any point of the study without affecting those relationships.

You will be given a copy of this form to keep for your records.

The researcher conducting this study is Alexandra Sardani, 400915@swan.ac.uk. The supervisor of this study is Dr Sue Philpin, e-mail s.m.philpin@swansea.ac.uk.

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Investigator \_\_\_\_\_ Date \_\_\_\_\_

# Appendix 8. Nutrition Risk Screening Tool

## NUTRITION RISK SCREENING TOOL

For use with patients 16 years or over

Patient Number.....Ward..... Name.....Hospital

**Guidelines for completion**

- All hospital inpatients should be screened within 24 hours of admission and repeated weekly.
- Weigh patient (Kg) each time using standing, chair or hoist scales as appropriate.
- Circle appropriate score in each section
- Total score and enter at bottom of column and take action according to care plan over page

| HEIGHT  | DATE WEIGHT |         |         |         |
|---|-------------|---------|---------|---------|
|   | .....kg     | .....kg | .....kg | .....kg |
| <b>UNINTENTIONAL WEIGHT LOSS IN LAST 3 MONTHS</b>   |             |         |         |         |
| • Weight stable, no weight loss   | 0           | 0       | 0       | 0       |
| • 0-3 kg (0-7 lbs)  | 1           | 1       | 1       | 1       |
| • 3-6 kg (7-14 lbs)   | 2           | 2       | 2       | 2       |
| • 6 kg (14 lb) or more  | 3           | 3       | 3       | 3       |
| <b>BODY MASS INDEX (calculate from weight &amp; height- BMI chart)</b>  |             |         |         |         |
| • 20 or more  | 0           | 0       | 0       | 0       |
| • 18 or 19  | 1           | 1       | 1       | 1       |
| • 15 to 17  | 2           | 2       | 2       | 2       |
| • Less than 15  | 3           | 3       | 3       | 3       |
| <b>APPETITE</b>   |             |         |         |         |
| • Good appetite, able to eat three meals per day  | 0           | 0       | 0       | 0       |
| • Poor appetite, poor intake, leaving more than half meals provided   | 2           | 2       | 2       | 2       |
| • Little or no appetite, refusing all meals or unable to eat e.g. unconscious, NBM for more than 4 meals.   | 3           | 3       | 3       | 3       |
| <b>ABILITY TO EAT</b>   |             |         |         |         |
| • No difficulties eating or drinking. Able to eat independently.  | 0           | 0       | 0       | 0       |
| • Problems with cutting and/or transferring food to eat. Needs special cutlery.   | 1           | 1       | 1       | 1       |
| • Slow to eat. Needs help with feeding.   | 2           | 2       | 2       | 2       |
| • Problems with chewing and/or dentition affecting intake.  | 2           | 2       | 2       | 2       |
| • Difficulty swallowing*  | 2           | 2       | 2       | 2       |
| • Unable to take food orally. Unable to swallow*. NBM   | 3           | 3       | 3       | 3       |
| <b>NB* COMPLETE SWALLOW SCREENING TEST</b>  |             |         |         |         |
| <b>GUT FUNCTION</b>   |             |         |         |         |
| • No diarrhoea or vomiting.   | 0           | 0       | 0       | 0       |
| • Nausea. Constipation  | 1           | 1       | 1       | 1       |
| • Vomiting and/or diarrhoea.  | 2           | 2       | 2       | 2       |
| • Severe diarrhoea and/or vomiting. Malabsorption.  | 3           | 3       | 3       | 3       |
| <b>STRESS FACTOR</b>  |             |         |         |         |
| • No stress factor (e.g. admitted for investigations only)  | 0           | 0       | 0       | 0       |
| • Mild<br>Minor surgery. Minor infection.   | 1           | 1       | 1       | 1       |
| • Moderate<br>Chronic disease, major surgery, infections, fractures, open/chronic wounds, inflammatory bowel disease, other GI disease, recent CVA. | 2           | 2       | 2       | 2       |
| • Severe<br>Multiple injuries, multiple fractures, burns, severe sepsis, malignancy, renal failure, chemotherapy, acute mental illness              | 3           | 3       | 3       | 3       |
| <b>SCORE</b>  |             |         |         |         |



If unable to weigh please specify reason:

version 2 May 2006

### Nutrition Risk Score and Nutritional Care Planning

**Score 0-3 (low risk):** Weigh and reassess patient weekly or in response to any change in condition e.g. surgery.

- Assist with menu choices promoting adherence to specific dietary requirements +/- healthy eating.
- Attend to the environment - minimise disturbances and movement around the ward at meal times e.g. Drs visits, trips to x-ray. Encourage members of the Multidisciplinary Team (MDT) not to carry out their activities during patient meal times. Clear tables, minimise avoidable unpleasant sights and smells.
- Follow advice re: dietary/fluid intake from Multidisciplinary Team members e.g. Speech and Language Therapist

**Score 4 - 5 (medium risk):** Weigh and reassess in 7 days or in response to any change in condition.

Care plan as for low risk plus the following:

- Prepare the patient - ensure the patient is positioned correctly to eat; is mouth care required? Are dentures clean and fitted? Is the patient painfree and comfortable?
- Serve the correct meal at a temperature and in style of presentation that will encourage the patient to eat e.g. consider smaller portion sizes. Ensure meals are placed in an appropriate and accessible manner.
- Assist with feeding as necessary - suspend non-emergency activities and investigations to reduce disturbance and optimise staff time for assisting with feeding.
- Follow advice re: dietary/fluid intake from Multidisciplinary Team members e.g. Speech and Language Therapist
- Give encouragement.
- Include 'eating & drinking' in care planning documentation for patients assessed as 'at risk'. Implement and regularly evaluate care plans. Monitor the amounts eaten and drunk.
- Give one oral dietary supplement daily (e.g. Build up).
- Implement appropriate management of any GI symptoms which may affect oral intake: diarrhoea/constipation and nausea/vomiting - appropriate use of antiemetics, aperients etc.
- Review medications, which have an adverse effect on nutritional intake, with particular reference to timing and method of administration.
- Involve family/ carers etc and keep informed of progress / difficulties experienced.
- If difficulty in Swallowing - complete swallow screening test and if fails refer to SALT for comprehensive dysphagia assessment.
- Difficulty with sitting balance or co-ordination - if yes refer to physiotherapist/occupational therapist for comprehensive assessment.
- Assistance needed to eat/feeding aids required - if yes nurses to assist with meal times and monitor food intake and if necessary refer to occupational therapist.
- Pain on or after eating/any pain - if yes having explored this with the patient may need referral to GP/ Medic for comprehensive assessment to exclude pathology.

**Score >6 (high risk):** Weigh and reassess in 7 days or in response to any change in condition.

Care plan as for medium risk plus the following:

- Referral to Dietitian for nutritional assessment.
- Maintain food record chart - record amount of portion actually eaten / drunk e.g. 2 tablespoons potato, 100ml tea etc.
- Implement Dietetic advice.

# Appendix 9. Patient Handling Risk Assessment

## Patient Handling Risk Assessment

NHS Trust

### Traffic Light System

- Low Risk**      **Green**      0-8      *Requires assistance of 1 staff member/Nurse*
- Moderate Risk**      **Orange**      9-15      *Requires assistance from 2 staff members/Nurse, according to tasks or use of mechanical aids/equipment*
- High Risk**      **Red**      16+      *Requires assistance from 2 or more staff members/Nurse and/or mechanical aids according to tasks.*

**TOTAL SCORE:** (Sum of score from boxes)

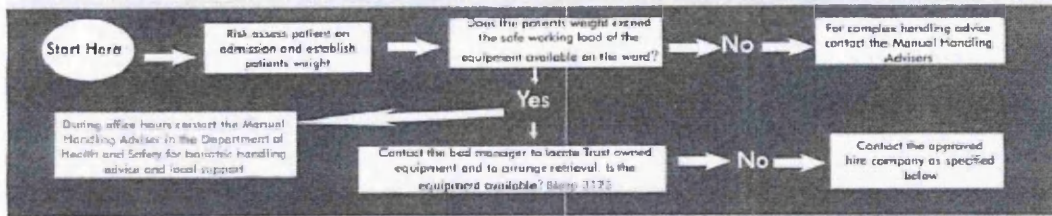
| <b>Patient Details (Label)</b><br><br>   | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">Weight</th> </tr> </thead> <tbody> <tr> <td style="width: 10px; text-align: center;">1</td> <td style="width: 10px; text-align: center;">&lt; 75t      &lt;44.5Kg</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">7 - 125t      44.5 - 76.2Kg</td> </tr> <tr> <td style="text-align: center;">5</td> <td style="text-align: center;">12 - 145t      76.2 - 88.7Kg</td> </tr> <tr> <td style="text-align: center;">6</td> <td style="text-align: center;">14 - 165t      88.7 - 101.6Kg</td> </tr> <tr> <td style="text-align: center;">8</td> <td style="text-align: center;">&gt;165t      &gt;101.6Kg</td> </tr> <tr> <td colspan="2">Height:</td> </tr> </tbody> </table> | Weight                   |  | 1                                   | < 75t      <44.5Kg   | 3                                     | 7 - 125t      44.5 - 76.2Kg | 5                   | 12 - 145t      76.2 - 88.7Kg | 6                  | 14 - 165t      88.7 - 101.6Kg  | 8                          | >165t      >101.6Kg   | Height:                  |    |                                     |   |   |           |   |                               |   |          |   |            |
|--|---|--------------------------|--|-------------------------------------|----------------------|---------------------------------------|-----------------------------|---------------------|------------------------------|--------------------|--|----------------------------|---|--------------------------|----|-------------------------------------|---|---|-----------|---|-------------------------------|---|----------|---|------------|
| Weight   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 1  | < 75t      <44.5Kg  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 3  | 7 - 125t      44.5 - 76.2Kg   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 5  | 12 - 145t      76.2 - 88.7Kg  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 6  | 14 - 165t      88.7 - 101.6Kg   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 8  | >165t      >101.6Kg   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Height:  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Diagnosis/Weakness/Deformity</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> </tr> </tbody> </table>   | Diagnosis/Weakness/Deformity  |                          | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Additional Information</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> </tr> </tbody> </table> | Additional Information              |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Diagnosis/Weakness/Deformity   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
|  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Additional Information   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
|  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">Disability/Weakness etc.</th> </tr> </thead> <tbody> <tr> <td style="width: 10px; text-align: center;">0</td> <td style="text-align: center;">Independent/Weight bearing</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">Minimal assistance/Partial Wt bearing</td> </tr> <tr> <td style="text-align: center;">5</td> <td style="text-align: center;">Moderate assistance</td> </tr> <tr> <td style="text-align: center;">8</td> <td style="text-align: center;">Maximum assistance</td> </tr> <tr> <td style="text-align: center;">10</td> <td style="text-align: center;">Totally dependent/comatose</td> </tr> </tbody> </table> | Disability/Weakness etc.  |                          | 0  | Independent/Weight bearing          | 3                    | Minimal assistance/Partial Wt bearing | 5                           | Moderate assistance | 8                            | Maximum assistance | 10   | Totally dependent/comatose | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">Patients Comprehension</th> </tr> </thead> <tbody> <tr> <td style="width: 10px; text-align: center;">0</td> <td style="text-align: center;">Fully co-operate</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;">Comatosed</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">Confused/unable to understand</td> </tr> <tr> <td style="text-align: center;">4</td> <td style="text-align: center;">Agitated</td> </tr> <tr> <td style="text-align: center;">5</td> <td style="text-align: center;">Aggressive</td> </tr> </tbody> </table> | Patients Comprehension   |    | 0                                   | Fully co-operate                                  | 2 | Comatosed | 3 | Confused/unable to understand | 4 | Agitated | 5 | Aggressive |
| Disability/Weakness etc.   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 0  | Independent/Weight bearing  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 3  | Minimal assistance/Partial Wt bearing   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 5  | Moderate assistance   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 8  | Maximum assistance  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 10   | Totally dependent/comatose  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Patients Comprehension   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 0  | Fully co-operate  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 2  | Comatosed   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 3  | Confused/unable to understand   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 4  | Agitated  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 5  | Aggressive  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">Handling Constraints</th> </tr> </thead> <tbody> <tr> <td style="width: 10px; text-align: center;">1</td> <td style="text-align: center;">Pain</td> </tr> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">Skin lesions</td> </tr> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">Infusions etc.</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">Other</td> </tr> </tbody> </table>   | Handling Constraints  |                          | 1  | Pain                                | 1                    | Skin lesions                          | 1                           | Infusions etc.      | 3                            | Other              | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">History of Falls:</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/></td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 5px;"> <b>Equipment normally used by patient</b><br/> <br/> </td> </tr> </table> | History of Falls:          | Yes   | <input type="checkbox"/> | No | <input checked="" type="checkbox"/> | <b>Equipment normally used by patient</b><br><br> |   |           |   |                               |   |          |   |            |
| Handling Constraints   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 1  | Pain  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 1  | Skin lesions  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 1  | Infusions etc.  |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| 3  | Other   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| History of Falls:  | Yes   | <input type="checkbox"/> | No   | <input checked="" type="checkbox"/> |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| <b>Equipment normally used by patient</b><br><br>  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">Working Environment</th> </tr> </thead> <tbody> <tr> <td style="width: 60%;">Space constraints</td> <td style="width: 40%;"> </td> </tr> <tr> <td>Additional equipment</td> <td> </td> </tr> <tr> <td>Temperature and lighting</td> <td> </td> </tr> </tbody> </table>   | Working Environment   |                          | Space constraints  |                                     | Additional equipment |                                       | Temperature and lighting    |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Working Environment  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Space constraints  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Additional equipment   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Temperature and lighting   |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Name</td> <td style="width: 40%;">Signature:</td> <td style="width: 30%;">Date</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>   | Name  | Signature:               | Date   |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
| Name   | Signature:  | Date                     |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |
|  |   |                          |  |                                     |                      |                                       |                             |                     |                              |                    |  |                            |   |                          |    |                                     |   |   |           |   |                               |   |          |   |            |










# Appendix 10. Bariatric Equipment Provision Poster

## Bariatric Equipment Provision



The Manual Handling Adviser must be contacted before admission or as soon as possible in order to plan the training of staff in specialist bariatric patient handling techniques. NB specialist bariatric techniques are not taught on basic 2-day manual handling training. Please phone The Health And Safety Department

### Trust Owned Bariatric Equipment Bleep 3123

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| <b>Model and Specs:</b><br>Arjo Tenor Mobile<br>Working load: 230 kg / 50 stone<br>Medical Electronics  |  | <b>Commode X 2</b><br>An extra wide seat and strong aluminium frame.<br>Safe working load<br>Seat Dimensions: Width - 71cm<br>Depth - 51cm Height - 56cm<br>Training room |  | <b>Walking frame X 1</b><br>An extra wide walking frame with adjustable legs.<br>Safe working load<br>160 kg / 37 stone                                 |  |
| <b>Ward Chair X 2</b><br>Seat Width 29 1/2" Seat H: 22"<br>Transport Wheels on rear. Height adjustable, Removable Arms. Safe working load<br>330 kg / 70 Stone<br>Training room |  | <b>Burn weight bridge</b><br>Safe working load<br>600 kg / 94 stone<br>Contact ward<br>Patient can remain in bed or in a chair  |  | <b>Wheelchair II A</b><br>with an extra wide frame.<br>Safe working load<br>330kg / 74.7 stone<br>Seat Width 99cm<br>Seat Height 40cm<br>Call portering | <b>Slide Sheets</b><br>extra wide X 2 sets<br>Conduction room                       |

If Trust equipment is not available the following companies have been identified as having suitable products and efficient delivery services.

### Equipment Hire

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| <b>CONTOURA 1080</b> This bed can accept a safe working load of 230 kg / 51 stone safety sides pop out to accommodate extra width. Scales available on request.<br>Hunsleigh Healthcare<br>Tel 08457 342000 |     | <b>CONTOURA 560</b> Safe working load 180 kg / 40 stone. This bed goes down lower than the 1080 and is better for more emulous patients who can assist in their own transfer. |      | <b>Arjo Tenor mobile Hoist</b><br>Safe working load<br>230 kg / 50 stone<br>Also available Arjo Tenor hoist details as above.<br>Pegasus Ltd<br>Tel 02392 784200<br>Ext 237 |  |
| <b>25/20 Stone Riser Recliner chair</b><br>CODE: PCR-25 or 30<br>Recliner Waterproof, Seat Width 26" / 33" Seat Depth 20" / 22", Feet to floor 19"  |    | <b>50 Stone Static Chair</b><br>CODE: PCS-50<br>Micro care Suede or Vinyl Cover, Thermo Contour Seat, Transport Wheels on rear, Seat Width 28"                                |     | <b>40 Stone Wide Commode</b><br>CODE: PCC-40<br>Seat Width 29 1/2" Seat Depth 22" Height Adjustable, Ret-ovable Arms  |   |
| <b>30 Stone Wide wheelchair</b><br>CODE: PCW-71<br>Seat Width: 22" - 32" Seat Depth: 16" - 22" Arm-tip  |   | <b>40 Stone Wide Wheelchair</b><br>CODE: PCW-40<br>Seat Width 26" Seat Depth 20" Attendant Drum brakes  |    | <b>47 Stone Wheelchair scales</b><br>CODE: PCWS-47  |  |
| <b>42 Stone Recliner Wheelchair</b><br>CODE: PCWR-42<br>Seat Width 16" - 24" Seat Depth 16" - 20" Anti-tip  |  | <b>55 Stone Shower Commode</b><br>CODE: PCOW-55<br>Seat Width: 31" Seat Depth: 22"  |  |   |   |

POSHCHAIR UK Phone: 02380 436286 / Fax: 02380 571003

**Weight and Safe Working Load**  
 Before placing or requesting equipment first identify an accurate weight of the patient. On the rare occasions where this is not possible (e.g. weighing apparatus of sufficient capacity is not available) a best estimate must be given (the patient/client or the carer may be able to provide information to help in assessing weight).

**Equipment**  
 General equipment used for patient/client care has safe working load limits. Such limits need to be known by staff, as often the equipment is not suitable for the bariatric patient/client. To help identify equipment use the Ward Equipment list below.  
 Any equipment the patient uses must be identified and together with its safe working load be documented in the risk assessment.

### Basic Ward Equipment Safe Working Loads

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| <b>Bed</b><br>Kings Range bed frame<br>179 Kg<br>26 stone | <b>Arjo Hoist</b><br>159 Kg<br>25 Stone | <b>DMA Commode</b><br>123Kg<br>19.5 stone | <b>All toilet seats in the UK seat frame are fixed assembled on a 140kg weight base</b><br>140 Kg<br>22 Stone | <b>Hospital trolley</b><br>180Kg<br>26 Stone | <b>Ward Chair</b><br>127 kg<br>20 stone |
|---|---|---|---|--|---|

**A Bariatric patient** - refers to patients who weigh in excess of 150 Kg (approximately 34 stone) BM ^ 30.

**Risk assessment**  
 Risk assessment and the identification of manual handling operations must be completed and documented on admission. This documentation must accompany the patient at all times. It will provide information as to the method, the number of staff and the appropriate equipment required to move the patient. The risk assessment must be communicated to all disciplines of staff involved in the movement of the patient.