NURSES' EXPERIENCES OF CARING FOR BARIATRIC PATIENTS

A DISSERTATION

SUMITTED IN PARITIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

PAULETTE J. WHITFIELD, MSN

DENTON, TEXAS

AUGUST 2008

ACKNOWLEDGMENTS

On my journey to achieve my doctoral degree I have been blessed to have had many people at Texas Woman's University Denton campus supporting me. First, I would like to thank my dissertation committee members, both current and past, who have assisted me in completing this journey. I would not have completed this scholarly work if it had not been for the dedication and support of Dr. Jane Grassley and Dr. Tommie Nelms both of whom were my committee chairs at different stages in the study. I also would like to thank Dr. Gail Davis and Dr. Jeff Huber for their invaluable suggestions for this study. Thank you, also, to numerous faculty of TWU nursing department who stepped in at various times to come to my aid during periods of uncertainty in this journey. I also would like to extend my heartfelt gratitude to all my coworkers, peers, and people in the research department of Scott and White who helped me achieve my educational goals.

Along my journey I met many wonderful people who were first classmates and later became friends as a result of the many trips we undertook during our distance education endeavors. A special thank you goes to Dr. Mary Aigner who kept my spirits high, let me vent my frustrations, and encouraged me to explore areas outside my comfort zone during our educational experience. Dr. Phyllis Tipton kept me laughing when I did not see a reason to laugh and helped me to understand that almost any situation has a light side. I also want to thank my two adult children, Jean Stamper and Harold Whitfield

always appreciate my ever present partner Samuel R. Owens who never allowed me to limit my aspirations to mediocrity. I will forever be indebted to him for his support and encouraging words.

Finally, I dedicate this dissertation to my mother Beverly Jean Henderson who raised me to never stop learning. She gave me much needed emotional support throughout most of my journey and I am sure she is looking down from heaven with a big smile on her peaceful face that I have finally completed my life long educational goal.

ABSTRACT

PAULETTE J. WHITFIELD

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Obesity is increasing worldwide and is so pervasive in the United States as to be classified an epidemic. Obese persons are discriminated against in all aspects of their lives including health care. Although research has demonstrated that nurses exhibit prejudicial attitudes toward obese patients, it is not known if this prejudice extends to obese patients who undergo surgery for weight loss. The purpose of this hermeneutic phenomenology qualitative study was to understand and interpret the phenomenon of nurses' experiences of caring for postoperative bariatric patients. Eleven nurses who took care of postoperative bariatric patients were interviewed. Colaizzi's model of data analysis was used to explore nurses' experiences.

Two themes were revealed during data analysis. *Getting up for the first time* and *Negotiating with families* constituted these themes. Nurses' stories of their experiences of caring for postoperative bariatric surgery patients revealed the arduous challenges of caring for this patient group. The challenges consisted of power struggles between nurses, patients, and families over getting up for the first time and unsupportive family behaviors. Recommendations are offered for nursing research, education, practice, and social awareness.

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CHAPTER I

INTRODUCTION

Focus of Inquiry

Obesity is an insidious and deadly disease that has been on the rise in the United States (U. S.) for more than two decades. The prevalence of obesity has risen 50% each decade since 1980 which has led health care authorities to classify obesity as an epidemic (Centers for Disease Control and Prevention [CDC], 2005; National Institutes of Health [NIH], 2005; U.S. Surgeon General, 2004). As of 1999, 61% of the U.S. adult population was considered overweight or obese. The NIH defines obesity as any adult who has an accumulation of body fat that results in a body mass index (BMI) of 30 or more. The risk for premature death increases as the adult population's girth expands to a level of obesity (CDC, 2008; NIH, 1998). The risks for increased early mortality in the obese population are related to the development of various health conditions such as hypertension, Type 2 Diabetes, sleep apnea, coronary heart disease, osteoarthritis, and some types of cancers.

In addition to compromised health, the obese population is often the recipient of prejudicial treatment (Faulkner, 2001; Puhl & Brownell, 2001). Several research reports have identified obesity as the last socially acceptable form of prejudice (Myers & Rosen, 1999; Rand & MacGregor 1990; Rogge, Greenwald, & Golden, 2004). Prejudicial attitudes toward obese people permeate all aspects of their lives, including health care. Negative attitudes may be related to views that obese people are lazy, of low intelligence,

and unmotivated to change (Drury & Louis, 2002; Myers & Rosen, 1999; Rand & MacGregor, 1990). While some studies report obese people feel discriminated against by others, including health care professionals (Rand & MacGregor, 1990; Wright, 1998) other studies have found this not to be the case (Wadden et al., 2000). Given that nurses are part of the general population as well as being members of the health care team, it would seem that they are as likely as others to hold such prejudicial attitudes. Although research studies have verified that nurses can be prejudicial when caring for obese patients in outpatient settings (Bagley, Conklin, Isherwood, Pechiulis, & Watson, 1989; Garner & Nichol, 1998; Harvey & Hill, 2001), it is not known how nurses view the experience of caring for obese patients who take positive steps to lose weight by surgical means.

Increased surgical options for weight loss and the likelihood of no longer living with life-threatening medical conditions have resulted in large numbers of morbidly obese persons undergoing bariatric procedures at surgical centers around the country. *Bariatrics,* a term meaning weight (baros) and medical treatment (iatrics), identifies surgical or medical programs specializing in all aspect of caring for obese patients. The increased number of obese patients undergoing surgery for the purpose of losing weight has resulted in nurses caring for an increased number of morbidly obese patients on postoperative nursing units (Sugarman & DeMaria, 2001).

The nursing profession's goal is to deliver safe, nondiscriminatory care to patients. In order to accomplish this goal, delivery of nursing care should be accomplished without overt or covert prejudicial behavior on the part of nurses (Texas

Nurse Practice Act, 2003). Views held by nurses and patients regarding delivery of care to people who are considered stigmatized have been investigated. Within the body of nurse caring literature there have been studies investigating nurses' views of caring for drug abusers, alcoholics, AIDS patients, and newborns of drug abusing mothers. However, there have been no studies regarding how nurses view caring for obese people who are trying to improve their health by losing weight through surgical means.

Purpose

The purpose of this critical phenomenological study was to examine nurses' experiences of caring for postoperative bariatric patients. This study, however, will investigate how nurses view caring for obese inpatients who take positive steps to lose weight by surgical means. Improved understanding of how nurses view caring for postoperative bariatric patients can be used to enhance the care received by this group of surgical patients.

Background

In recent years the media has inundated the public with information about increased obesity in the United States, the risks that result from obesity, and ways to remedy this medically challenging disease (Labib, 2003; Owens, 2003). There are frequent advertisements, news reports, television programs, or new research information attesting to the detrimental affects of obesity and medical or surgical ways to successfully lose and keep weight off (Associated Press, 2004; Reuters, 2004; Schultz, 1999; Trossman, 2005; Wells, 2004). Despite this onslaught of information and the multitude of

programs available to help individuals lose weight, obese persons have found themselves in a constant and often futile battle to lose weight and maintain their lower weight levels.

One option available to obese people who desire to lose weight is surgical intervention. Several different surgery procedures, all classified as bariatric surgery, are available for morbidly obese persons who have had previously unsuccessful attempts with medical managed weight loss and who still desire to lose weight. Bariatric surgeries that have been developed over the last forty years now offer patients opportunities to lose significant amounts of weight which can result in improvement or elimination of pre-existing co-morbidities (National Task Force on Prevention and Treatment of Obesity, 2002; Sugerman & DeMaria, 2001).

Multiple, different procedures have been attempted and refined in the past 40 years to assist obese persons in losing weight and then maintaining their weight loss. Currently in the U.S. there are two dominant surgical weight-loss procedures that are being used for this purpose (Sugerman & DeMaria, 2001). Both procedures reduce the size of the stomach reservoir. Gastric banding is a procedure where an adjustable, flexible band is surgically placed around the antrum of the stomach. Patients eat less but have no alteration in their absorption of consumed foods. In an outpatient setting, the band can be made tighter or loosen depending on the patient's symptoms and weight loss.

A second procedure known as gastric roux-en-y bypass involves dissociating the atrum of the stomach from the remaining stomach and connecting it to a section of the small intestine thereby creating a small, one ounce pouch. The remaining stomach and small intestine is then reattached about 12 to 16 centimeters from the newly created

pouch. The gastric roux-en-y bypass results in the patient eating less and in having slightly altered absorption of the consumed food. As a result of these two enhanced surgical procedures, patients lose significant amounts of weight which often result in improvement or elimination of co-morbid conditions such as diabetes, hypertension, and cardiovascular disease (National Task Force on Prevention and Treatment of Obesity, 2002).

Literary Context

The literature is abundant with studies exploring topics related to the obese population. There are studies addressing the experience of being obese, obese patients' perceptions of care received during health care visits, and health care providers' attitudes toward obese patients (Carryer, 2001; Rand & MacGregor, 1990; Wadden et al., 2000; Wright, 1998). Additionally, research findings support the idea that nurses do indeed exhibit prejudicial attitudes toward obese patients, which are reflected in the care they give (Bagley et al., 1989; Garner & Nicol, 1998; Harvey & Hill, 2001). However, researchers have avoided investigating nurses who care for postoperative obese patient populations.

Carryer (2001) undertook a two-year study interviewing nine women to examine the experiences of obese women. The author of the study asserted that the women physically suffered, felt socially isolated, and thought they were viewed as being disabled due to being obese. The women perceived their obesity as contrary to socially created ideals that being thin equates to being healthy. Findings supported the notion that obesity is stigmatized and viewed as a result of gluttony and laziness.

Rand and MacGregor (1990) conducted a study to explore morbidly obese patients' perceptions of prejudice and discrimination before and after bariatric surgery, which has become the treatment of choice when dietary efforts fail. Results of a nurse administered telephone questionnaire to 57 morbidly obese patients revealed that the patients experienced prejudice and discrimination prior to surgery from family, friends, and the general public. After losing a significant amount of weight, however, the patients perceived less prejudice and discrimination from the same groups of people. Nurses were not included in patient responses.

Wadden et al. (2000) investigated obese women's perceptions of their physicians' attitudes and practices regarding weight management. Respondents reported they had been treated with respect by their physicians but indicated their physicians did not have a good understanding of how difficult weight loss was for them. The researchers analyzed questionnaires from 259 obese women to evaluate what the women experienced during health care visits. Although physicians' and nurses' attitudes toward caring for obese patients in outpatient settings have been researched, there has been a lack of research investigating nurses' experiences of caring for hospitalized bariatric surgery patients.

Nurses' attitudes toward obese patients in an outpatient setting were investigated in another study. Ten Northern Ireland nurses were interviewed by Wright (1998) to explore the relationship of health care professionals' attitudes towards medical treatment of obese patients. Although the focus of the study was attitudes of female nurses toward obese women, it was found that nurses, as well as physicians, displayed discriminatory

attitudes toward obese females by withholding treatment or making unkind remarks. Wright also found that attitudes toward obese men were not discriminatory.

There is a void on the topic of nurses' experiences of caring for bariatric surgical patients in a postoperative setting. This study gathered data from nurses about their experiences of caring for bariatric surgical patients. This may shed light on how nurses might be contributing to obese patients' perceptions of discrimination.

Philosophical and Theoretical Frameworks

Hermeneutical phenomenology and critical social theory were blended to create the framework that guided this study. Phenomenology originated in the early twentieth century with the German philosopher Edmund Husserl. Husserl's concept was one of exclusively reflecting on the content of one's mind which he believed would lead to understanding the meaning of one's experiences (Walters, 1995). According to Husserl exclusive and conscious reflection on events and objects was required in order for persons to understand their world. During the course of reflection Husserl believed individuals should and could suspend knowledge of previous experiences in order to avoid influencing what they understood about their present experience (Todres & Wheeler, 2001; Walters, 1995). Thus, Husserl viewed phenomenology as the study of what humans experience and how they make sense of everyday experiences while having the researcher suspend his or her previous knowledge (Holloway & Wheeler, 1996).

Heidegger, Husserl's student, colleague and critic, expanded the phenomenological concept as the ability to make obvious what is hidden in everyday experiences. Heidegger's view of *being-in-the-world* was grounded in common, everyday

events and the use of individual interpretations to explain those events. Heidegger, unlike Husserl, however, believed it was not possible to ignore *a priori* knowledge during the process of exploring present events. Heidegger stressed that a person's history led to the way that individual interpreted and explained present day experiences. In this way, who the individual was and how they became who they were was part of how they viewed and interpreted current events (Racher & Robinson, 2002).

Phenomenological research is a methodology by which poorly understood human phenomena are explored through the language of those who have experienced it. Hermeneutic phenomenology is more than basic phenomenology in that hermeneutic is the *interpretation* of a phenomenon rather than being purely descriptive. When hermeneutic phenomenology is undertaken, the researcher becomes immersed in the data in order to have what is hidden revealed. The *nature* of a phenomenon is examined by analyzing data as a whole, in parts of the whole, and returning to the whole. The more the researcher becomes engaged with the data, the more likely the human experience is understood and the essence of the phenomenon presents itself (Dieklemann, 2005). In this way, the researcher is able to know and, therefore, describe and interpret what participants' stories reveal. Each stage of analysis increases understanding of the phenomenon as expressed by those who have lived it (Holloway & Wheeler, 1996; van Manen, 2002).

Critical social theory (CST) was developed at the Frankfurt School in Germany by Habermas, Adorno, Horkheirmer, and Marcuse after World War I to promote critical analysis of social situations. CST espouses examination of unequal domains of power as

they exist within social settings. Unequal power domains are indicative of oppression of one group of people by another (Agger, 1999; Kincheloe & McLaren, 1994). Thus, in this study nurses were interviewed in order to establish how they viewed caring for bariatric surgical patients.

One of CST's later developers was Germany's Jüergan Habermas (Cranton, 1996). Habermas viewed the use of CST as a means to generate knowledge through the use of unrestrained and undistorted communication. He promoted the idea that knowledge is generated through technical, practical, and emancipatory human interests. He viewed the practical human interest as relating to language and, therefore, considered language as what maintained the power structure relationships within society.

Using CST as a methodology for research, the language of participants will be scrutinized. The researcher may be able to demonstrate prejudicial attitudes if the language used by participants is determined to be negative, demeaning, or otherwise oppressive (Hedin, 1986; Holter, 1988). Because Habermas also identified the emancipatory human interests of CST, the use of CST in research could lead to a reflection of a society's rules, habits, and traditions (Browne, 2000; Mill, Allen & Morrow, 2001; Wlson-Thomas, 1995). As a result of social reflection it is likely one would question the assumptions of the social setting for which there is concern. Questioning the assumptions could lead to identifying and possibly initiating change of what is viewed as the wrongs of that society. Thus, the use of CST in qualitative research supports analyzing the language used by individuals to unveil inequitable power domains

in societal settings and can lead to the instigation of emancipatory efforts to improve that society's inequalities (Boutain, 1999).

Hermeneutic phenomenology was appropriate for this study because of its premise that individuals who experience a phenomenon are the experts in conveying the essence of that phenomenon to others. In order to have a better understanding of what is occurring during bariatric patients' postoperative hospitalization, information from those who care for these patients is needed. Critical social theory and hermeneutical phenomenology were blended in this study in order to unearth nurses' attitudes as revealed by the stories they told. By having nurses tell their stories, the essence of what it was like to care for postoperative bariatric patients was revealed. Once it has been determined how nurses view caring for postoperative bariatric patients, plans can be initiated that may lead to improved patient care of this patient population.

Significance of the Study

The following sections give the reader my thoughts about using the results of this study in nursing practice, education, and research. The reader may wish to use these ideas to expand their own practice and knowledge regarding patients who are obese.

Nursing

Nursing care delivered to hospitalized obese patients is often difficult because of the limited ability of obese patients to assist in their own care as well as the limited resources available to nurses providing care. Not only are obese patients limited in self-care due to their size, they have difficulty in mobilization. Limited mobility leads to weakened musculature and increased weight which further limits activity and self care.

Limited activity and increased weight can then lead to spiraling diminished health. Thus when obese persons are hospitalized, nursing care becomes complex and challenging to accomplish for both the patient and the nurses who care for them.

A goal of nursing is to deliver safe care to all their patients including the obese. In order to deliver safe care, nurses must have adequate equipment such as large wheelchairs, shower chairs, walkers, beds, and other over sized equipment. Given that adequate equipment is available, nurses must also rely on additional personnel to ambulate, transfer, and care for obese patients (Knight, 2004). In the current health care environment of doing more with less nurses can, and do, find themselves with limited equipment and fewer personnel available to assist them in the daily care of obese patients. The lack of adequate equipment and limited personnel can lead nurses to unconsciously avoid caring for obese patients. This avoidance can be perceived as prejudicial behavior. Knowledge from this study about nurses' experiences of caring for postoperative bariatric patients may uncover barriers that have precluded adequate treatment of this vulnerable population. Understanding these barriers that impede nurses caring for obese patients could then lay a foundation for interventions that would enhance the ability of nurses to care for this patient population and avoid patients' perceptions that nurses harbor prejudices against them.

Findings from this study could expand existing knowledge into the area of how nurses experience caring for a stigmatized population such as obese patients. As a result of this knowledge, nurses will become more cognizant of how delivery of their nursing care may affect patients' perceptions. Acknowledging the impact that their actions have

on patients has resulted in nurses becoming more aware of their behavior toward patients they may not like. Increased awareness of how nurses view caring for a stigmatized population such as obese patients could be useful in other settings. Other settings where nurses practice and are likely to interact with stigmatized patient populations are those patients who have AIDS, are alcoholics, and drug abusers. Additionally increased awareness of how nurses view one group of potentially stigmatized patients could generate other research regarding nurse attitudes toward other stigmatized patient populations.

Nurse Educators

Nurses' initial exposure to their profession is often through their education. During that education nursing students have clinical experiences in real-life settings such as hospitals, nursing homes, clinics, and home health care (Murphy, 2005). Since what nurses learn during their educational experiences permanently shapes how they practice, it is important that they learn current information and how to incorporate research findings into their everyday practice. Nurse educators are not only responsible for teaching students what they need to know, but also serve as mentors and models of the nurse image. As a result of being aware of this study, nurse educators could have a greater understanding of how they might be modeling their prejudices to students. Thus, nurse educators are likely to be more conscientious of their own behavior and how it is perceived by others.

Nurse educators are expected to stay current in their nursing practice. They are also responsible for teaching students evidenced based nursing (National League for

Nursing, 2005). Research findings often reveal previously unknown information and can help educators and students identify improved ways to care for patients. Knowledge from this study could assist educators in increasing their knowledge of how nurses view caring for bariatric surgical patients. This increased knowledge could assist faculty members in understanding the differences between caring for postoperative bariatric patients and other surgery patients which they can convey to their students. Knowledge gained from this study could be incorporated into nursing curricula through the use of the internet and into textbooks. This would change the current understanding of how nurses view caring for this and other stigmatized patient populations.

Participants

Staff nurses who give voice to their practice concerns often feel a lack of acknowledgement of the concerns, or worse, experience negative repercussions. This may be especially true in the current atmosphere of cost cutting and other drastic changes in the health care industry. Additionally, nurses have voiced a lack of receiving appreciation by the people for whom they care (Fiesta, 1999; Phillips, 2004; Schira, 2004). Not being acknowledged by either employer or patients as a valued health care team member, coupled with possible repercussions for being outspoken, can cause nurses to lose their sense of purpose as to their professional role.

The lack of being acknowledged can also result in nurses feeling a loss of personal power (Kettle, 2004; Roberts, 2005). Once nurses perceive they are being heard, empowerment is likely to follow. Empowerment could result in initiation of changes that further empower the individual, decrease hostility, and increase one's self-worth

(Doherty & Hope, 2000; Hess, 2004; Hutchinson, Wilson & Wilson, 1994). As participants in this study, nurses may benefit from having their voices heard when sharing their stories. A sense of satisfaction and pride in being heard in a non-threatening environment and sharing their stories with others may have enhanced participants' self-esteem and sense of control. By agreeing to take part in this qualitative study, participants may benefit from their involvement by being able to express personal views on a subject that might otherwise not be heard. Participants may also have validation of their self-worth, an increased sense of their professional purpose, and an increase of self-awareness as a result of study participation.

Hermeneutic phenomenological research is the investigation and interpretation of an aspect of peoples' lives as told through their stories. When persons have the opportunity to relay their stories, they are more likely to reflect on what was said (Bedini & Henderson, 1996). Reflection may increase participants' awareness of how their language and attitudes affect their nursing care delivery. The increased awareness of previously concealed language and attitudes can lead to changes in attitudes and language by participants (Hutchinson et al., 1994). Changes that result from participants' increased awareness can lead to improved interactions between nurses and obese patients resulting in improved patient care. Improved interactions between nurses and patients are likely to result in improved perceptions by patients of the care they receive during their hospitalization. Additionally, nurses are likely to be more responsive to patient needs as a result of improved interactions with them. As a result of the improved communication

between patients and nurses, patient care will likely to be perceived by both parties as being enhanced.

It is also possible participants in this study will reflect on what transpired during the interview. Reflection may identify areas of caring for bariatric patients that are positive as well as those in need of improvement. Enhancing areas that are already identified as positive as well as improving those areas acknowledged as less than ideal will likely lead to a better environment for both nurses and patients. Thus, nurses will likely respond to bariatric patients in more understanding and positive ways. Once patients are assured their needs will be met, it is possible they will be less demanding and less critical of the nursing care received.

Society

Recent media attention has brought the issue of obesity as an epidemic to the forefront. Research has demonstrated that obese persons are treated prejudicially in all aspects of their lives. Prejudice towards the obese population is considered the last socially acceptable bias in this country (Chambliss, Finley, & Blair, 2004; Faulkner, 2001; Puhl & Brownell, 2001). Knowledge from this study will likely raise awareness of societal attitudes toward obese people. This increased awareness could lead readers to challenge their own values and beliefs. Examining one's values and beliefs could result in recognition and acknowledgement of less than desirable behavior and attitudes toward obese persons. Recognition of negative behavior and attitudes can initiate changes within society which can potentially result in more sensitive treatment of obese persons and a kinder, gentler society.

Researcher's Relationship to Topic and Assumptions

My nursing career which expands 40 years in a variety of clinical settings began as a bedside nurse caring for medical and surgical adult patients. The last 20 years I have been a nurse in an outpatient general surgery clinic. During these 20 years, my role has changed from that of clinical staff nurse to one of being a Nurse Practitioner (NP). My current NP role as bariatric surgery coordinator began over eight years ago when the institution's general surgery department initiated the bariatric weight loss program.

Throughout my various roles in nursing I have cared for a variety of patients. Some patients were small and frail, while others were obese and seemingly healthy. There have been times when caring for obese patients that I resented having to work harder than average to accomplish basic patient care. I found it frustrating to have to ask others for assistance when caring for obese patients who were not able to help themselves. My view that obese patients were "lazy" would often lead to less than ideal nursing care. I would sometimes leave my shift feeling frustrated for not being able to do my job and resenting the fact that some patients were not always able to participate in their own care.

As an NP, however, when I began caring for obese patients seeking surgery to correct their obesity I found my attitude began to change. I began to understand obese patients' frustration, embarrassment, and anger at not being able to do what they knew they should be able to do. Thus, my personal history as well as my many years of experience has helped me realize that obese patients deserve a chance to improve their

lives through surgical weight loss programs. They do not deserve to be treated in a prejudicial manner by anyone in the health care system, especially nurses.

Throughout my career I remember having heard health care providers, including nurses, make derogatory remarks about groups of people for which they felt disdain. I have seen nurses delay answering patients' calls because of a dislike for the patient either as an individual or for what the patient represented. I have also seen and heard health care workers, including nurses, display unkind behavior and remarks about groups of patients who were viewed as unlikable such as prisoners, alcoholics, drug abusers, and obese persons.

During my tenure as bariatric surgery coordinator, I have had the opportunity to visit patients in the hospital as well as follow them in my NP outpatient clinical practice. My interest in the topic of prejudice toward obese patients was peaked during frequent hospital rounds when I happened to overhear unkind remarks made by those who were supposed to be the care providers to this patient population. It surprised and disappointed me to hear bedside nurses making harsh remarks or making rude faces and noises about this vulnerable patient population. My surprise and disappointment intensified when patients told me stories of receiving what they considered to be poor nursing care.

Being in the nursing profession has always given me enormous satisfaction and pride because of my ability to help others. I have assumed that all nurses felt the same way and that we all fostered positive attitudes toward and fair treatment of everyone in our charge. How distressing it has been for me to become aware of patients' negative perceptions of the nursing profession and the nursing care received during their

hospitalization. As a result of my own observations and of patients' comments, as well as being a bariatric surgery patient, I became intrigued about the interaction between patients and their nurses during the brief but intense postoperative hospitalization following bariatric surgery.

Assumptions

I began this study of nurses' views of caring for postoperative bariatric patients with several assumptions. Each assumption was based on my unique experiences as a nurse and as an individual and was based on what I know is true for myself. Any assumptions that are based on another person's ideas are so referenced.

1. Human beings are not always conscious of their own prejudices.
2. All humans, including nurses, have preconceived ideas regarding some aspect of their lives. I found myself behaving prejudicially toward health care providers who lump all obese people into the categories of being lazy and of low intelligence.
3. Prejudice can lead to oppressive behavior even when the prejudice is unintentional or unrecognized.
4. Research participants are the experts in their experiences and therefore what is said by them is assumed to be true.
5. Language reveals prejudices and oppression (Agger, 1998).

Summary

This chapter presented the issue investigated, the research problem, and established what research had been done on the issue of prejudice toward obese patients. This chapter also identified where research is deficient about the experience of nurses who have cared for obese patients who have undergone bariatric surgery. The theoretical and philosophical frameworks that guided this study were discussed. The researcher's relationship to the study was presented along with the assumptions guiding the study.

CHAPTER II

LITERARY CONTEXT

Overview

In recent years there has been a plethora of media attention regarding the rise in obesity levels in the U.S. (ABC News, 2004; Allison & Saunders, 2000; Daniels, 2006; Madge, 2004; MSNBC, 2004; Schultz, 1999; Trossman, 2005; Wallis, 2004; Wells, 2004). However, whether the information making headlines is anecdotal or research based, the media downplays the subject of detrimental attitudes toward obese people. Reported anecdotal information has focused on the dramatic weight losses following surgical intervention or has imparted information about the risks and management of obesity (ABC, 2004; Grossman, 2004; Trossman, 2005; Wells, 2004). Health care researchers have focused on physicians' attitudes, medical treatments of obese patients, and obese patients' perceptions of attitudes of others (Anderson et al., 2001; Cade & O'Connell, 1991; Mercer & Tessier, 2001; Price, Desmond, Krol, Snyder, & O'Connell, 1987; Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). Only a few researchers have investigated nurses' perspectives of caring for obese patients (Bagley et al., 1989; Maroney & Golub, 1992). No literature was found that focused on nurses' view of caring for patients after bariatric surgery, a common intervention for obesity. This chapter, therefore, provides a context for exploring this phenomenon by discussing pertinent literature related to the experience of being obese, obese patients' avoidance and

perceptions of health care, obesity treatment issues, nurses' views of caring for obese patients and nursing literature regarding care of bariatric patients.

The Experience of Being Obese

Obesity is a devastating and complicated disease which affects all aspects of a person's life such as emotional well being, physical well being, and socio-economical status. Obesity is defined by the National Institutes of Health (NIH) as having a Body Mass Index (BMI) of 30 or more, which is the equivalent of being 30 pounds above ideal body weight (IBW). A BMI of 19 to 24 is considered ideal body weight and a BMI between 25 and 30 is defined as being overweight. Obesity has consistently increased for more than three decades in the U.S. Because more than 61% of the U. S. adult population is currently classified as being overweight or obese, obesity is now considered an epidemic by the Surgeon General (Centers for Disease Control and Prevention [CDC], 2004; Li, Bowerman, & Heber, 2005; Short, 2004). As the rise in obesity levels continues, health care providers are likely to be inundated with managing patients who have complex and challenging medical conditions.

Society, in general, stigmatizes obese people through covert and overt prejudicial behavior such as limiting access to education, employment and health care. Additionally, obese persons often internalize society's devaluation of obese persons which presents as poor self-image and can result in psychological distress (Friedman et al., 2005; Latner, Stunkard, & Wilson, 2005). Society, including the health care community, has preconceived ideas that losing weight is a simple matter of eating less and exercising more even though the literature contradicts this naive attitude. The solutions regarding

society's increasing levels of obesity are complex and difficult to accomplish. Over the last 20 years bariatric surgery has developed into a more accessible option for those who struggle with obesity. In order to better assist obese people to recognize how their lives can be improved through weight loss and give them motivation to lose weight either through medical management or surgery, it must first be determined how obese people view their experiences.

Obese people often feel stigmatized by society. This stigmatization frequently results in feelings of shame for their excess weight coupled with a poor self-image. Latner et al. (2005) investigated obesity stigmatization and various disabilities among 348 university men and women of various ethnic backgrounds who were young (mean age of 21) and were at ideal body weights (mean BMI of 23). The researchers concluded that white women reported more negative beliefs regarding obesity than African-American and Asian-American women. Men were found to have more negative views of obese people than women.

Poor self-image may manifest itself as psychological distress in the forms of depression and anxiety (Paquette & Raine, 2004; Stunkard, Faith, & Allison, 2003). Friedman, Reichmann, Costanzo, and Musante (2002) and Friedman et al. (2005) studied the relationships among obesity stigmatization, weight beliefs, and psychological functioning of men and women seeking weight loss treatment. They concluded that as the level of obesity increased so did psychological distress and low self-esteem. The researchers of both studies found that obese people often internalized society's negative

beliefs that obese people are responsible for their weight which results in increased body dissatisfaction and feelings of shame.

Social and economic factors such as the ability to be employed, maintain employment, and earn an equitable wage are important for one's mental and physical well being. Klarenbach, Padwal, Chuck, and Jacobs (2006) investigated the relationship of obesity to participation in the workforce. The researchers analyzed pertinent information from the Canadian Community Health Survey of 73,531 persons to conclude that a positive association existed between obesity and work absenteeism, especially with severely obese persons.

A study by Baum and Ford (2004) used the National Longitudinal Survey of Youth to examine the effects of obesity on wages. The researchers concluded that the lower wages obese persons experienced were independent of their health limitations. They also concluded that although obese men and women suffered lower wages, the penalty for obese women was twice that of obese men. However, the researchers found that the lower wages of obese workers were not dependent on the specific jobs of the workers. The researchers conjectured that employers may discriminate against obese workers by not encouraging them to attend work related training opportunities which could result in limiting their ability to earn higher wages.

Socio-economic status (SES) may influence women's weight control practices. Jeffery and French (1991) investigated the relationship of weight control practices of 998 women from diverse socio-economic levels. The participants, aged 20 to 45 years old, were surveyed regarding their health practices, weight concerns, social support, and

weight control practices. The researchers' conclusions verified that women in the lowest socio-economic levels were less attentive to their weight and more tolerant of weight gain, perceived less social support in their attempts to lose weight, and observed fewer healthy weight control practices such as healthy eating practices than women in higher socioeconomic levels.

The investigation of relationships of SES to women's weight control practices by Jeffery and French (1991) was supported by Martin, Robinson, and Moore (2000) who gave an overview of how socio-economic issues affect obesity treatments such as weight loss management through medical means or the use of surgery to aid in weight loss. The researchers surmised that those overweight people who were able to obtain and maintain jobs were more likely to have lower incomes, be less educated, and have lower levels of emotional well being than persons of normal weight. The researchers also emphasized that the only successful therapy for losing and maintaining weight loss was through surgical means, often excluded in insurance policies especially for those persons in low paying jobs.

The more recent study by Zhang and Wang (2004) contradicted the findings from Martin et al. (2000). The authors analyzed data from the National Health and Nutrition Examination Surveys from 1971 through 2000 of 28,543 adults, 20 to 60 years of age, to investigate the association between SES and obesity. They concluded that the prevalence of obesity had disproportionately increased in high SES groups and women were more affected than men. However, the researchers found a weaker relationship between the different SES (high, medium, and low) groups and obesity than other researchers. Zhang

and Wang also concluded that individual characteristics such as SES and gender may not be a reason for the increase in obesity over the last three decades.

Obese persons frequently encounter societal discrimination. Three studies addressed obese persons' perceptions of some aspect of discrimination such as mistreatment by others (Falkner, et al., 1999), discrimination by the medical community (Kaminsky & Gadaleta, 2002), and social discrimination before and after bariatric surgery (Rand & MacGregor, 1990). A two-year longitudinal study by Falkner et al. (1999) examined whether 987 healthy men and women, aged 20 to 45 years, perceived they had been mistreated because of their weight. Mistreatment from a spouse or loved one was reported 22% of the time while stranger mistreatment was reported 27% of the time. The only significant difference found between genders was that women perceived mistreatment from a stranger more often than men. However, mistreatment was reported significantly more often by all participants with the highest BMIs.

An individual's weight can impact his or her attitude toward obese people. Glenn and Chow (2002) investigated the attitudes of 239 university students and hospital personnel from Canada to determine the differences between male and female attitudes toward obese persons, while taking into account the participants' BMI. The 44-item scale yielded four factors consisting of stigmatization, self-confidence, diet, and exercise. The researchers found that, generally, women held more positive attitudes toward obese people than men. These attitudes were even more pronounced when both groups were obese.

The issues involving societal stigma of obese persons carry over to the health care arena. Obese persons will sometimes avoid health care visits and thus put themselves in jeopardy for additional health risks because of this stigma. In order to improve health care delivery to obese patients, health care providers, including nurses, must first understand the experiences of obese patients and appreciate the discriminatory behaviors displayed toward them. Obese persons are often viewed by themselves and society, of which nursing is a part, as being self-indulgent, lazy, and unmotivated to change. It is important that detrimental attitudes of society at large and the health care community specifically improve in order to better help obese patients receive equitable care.

Treatments for Obesity

Obesity is a chronic, multi-factorial disease that often leads to multiple morbidities and early mortality (Fox & Spencer-Jones, 2003; Labib, 2003; Owens, 2003; Sugerman & DeMaria, 2001). The belief that obesity can be corrected by eating less and exercising more is the impetus for the current multimillion dollar weight loss industry in the U. S. However, losing weight involves more than the naive concept "eating less and exercising more."

Weight loss is the first step toward improving health and maintaining an ideal body weight. Maintaining weight loss is a long-term goal for all obese people and requires healthy eating balanced with consistent daily exercise over time (Melcher, 1998; Owens, 2003). In general three approaches are used for weight loss. They are diet and exercise, pharmacologic interventions and surgical interventions. All three approaches require the obese person to make permanent life-style changes.

The National Institutes of Health (2002) recommends that all obese persons start their weight loss through diet and exercise with an initial goal of losing 10% of their body weight. Once this is achieved, increased weight loss can be attempted until an ideal body weight is achieved. In order to lose weight through diet and exercise, a person must expend more energy than calories consumed. Therefore, the NIH recommends maintaining a moderate weight loss rather than losing and regaining large amounts of weight since vacillating between extreme high and low weights is detrimental to the overall health of the individual.

However, if weight loss does not occur with diet and exercise, there are two other methods to achieve weight loss. One method is pharmacological intervention that either alters the absorption of consumed fat or suppresses the appetite. The two most frequently prescribed medications are considered safe, but not everyone can financially afford the long-term follow-up and medication expense nor tolerate the medications' side effects (Huber & Raines, 2000; Sarwer & Wadden, 1999; Wechsler & Leopold, 2003).

A third method of weight loss involves surgery. Bariatric surgery has become an important surgical option chosen by obese persons and their physicians. Surgery for weight loss has been undertaken for more than 50 years in the U. S. with gastric roux-en-y bypass and gastric banding being the current procedures of choice. Surgeries limit the persons' food intake; in addition the gastric roux-en-y has a mal-absorption component to it. As with other weight loss programs, both surgeries require a permanent life style change on the part of the patient (Baxter, 2002; Deitel & Shikora, 2002). Thus, regardless

of weight loss method, patients ultimately need to change their life styles through healthy eating and consistent, frequent exercise.

Existing research focuses on patients' perceptions of physician attitudes regarding weight loss management and discriminatory practices surrounding bariatric surgical options. Anderson and Wadden (2004) investigated patients' perceptions of physician attitudes and practices. They surveyed 105 bariatric and 214 nonbariatric obese patients' perceptions of their physicians' interactions about their weight, weight loss management, management of weight loss as directed by their physician, and their satisfaction with their physicians' management of their general health. Although participating patients reported improved perceptions of physician attitudes in general care, descriptions of their interactions with their physicians regarding weight was negative. The researchers were surprised to find that bariatric patients were more satisfied with their physicians than nonbariatric patients which led the researchers to conclude that surgeons' frequent discussions regarding weight issues increased patient satisfaction levels.

Two studies investigated obese patients' perceptions of discrimination before and after bariatric surgery. Kaminsky et al. (2002) analyzed completed surveys from 40 postoperative bariatric patients who had surgery at four different East Coast bariatric hospital centers. The researchers investigated patients' retrospective perceptions of discrimination during their peri-operative experiences, such as health care personnel attitudes and appropriateness of equipment for obese patients. The participants were mostly women, aged 21 to 61 years, with weights ranging from 224 to 510 pounds preoperatively. The findings of the researchers affirmed that 20% of patients' primary

physicians were resistant to give a referral for bariatric surgery which resulted in 17% of patients changing physicians. Participants also reported use of equipment in their physicians' offices that inappropriately fit them such as scales, tables, blood pressure cuffs, and gowns. Thus, the researchers concluded that not only did bariatric patients feel misunderstood, but the medical community displayed a lack of consideration for their needs, such as appropriate furniture and medical equipment.

In this same study, participants were generally well satisfied with their bariatric surgeons and staff as well as with most of the consulting physicians such as pulmonologists and gastroenterologists. This study exemplifies that although laws exist prohibiting discrimination of specific people groups, obese people continue to be treated unfairly even in some health care settings (Kaminsky et al., 2002). Respondents, however, had higher satisfaction rates with specialists, including the bariatric surgeon and staff.

Rand and MacGregor (1990) surveyed 57 obese patients' perceptions of social discrimination before and after bariatric surgery. Prior to surgery and significant weight loss, at least 40% of patients reported discrimination and prejudicial treatment by their families, in the work place, and in public. Patients also reported preoperatively that their moods were depressed, and they rarely felt cheerful, self-confident or attractive. Postoperatively, patients who experienced at least a 100 pound weight loss reported fewer instances of discrimination, had higher self-esteem, and felt more attractive. One finding from this study emphasized that participants were affronted by medical personnel's prejudicial and discriminatory comments. Many chose to change physicians

rather than continue being subjected to rude and offensive remarks. Thus, the perception by obese people of negative treatment by health care personnel may lead to health care avoidance (Rand & MacGregor).

Health care providers who specialize in the care of obese patients tend to display more positive attitudes toward their patients although their negative attitudes are not completely erased. Two studies investigated attitudes of providers who specialize in the care of or undertake research in the area of obesity. The conclusions of both groups of researchers were that those who care for obese patients remain biased but to a lesser degree than their peers. Schwartz, O'Neal-Chambliss, Brownell, Blair, and Billington (2003) found that participants who work with obese patients had a higher level of understanding the experience of being obese. This correlated to less bias toward obese people. However, younger physicians tended to have more negative attitudes toward obese patients.

Harvey and Hill (2001) found providers displayed neutral rather than completely negative attitudes toward obese patients and participants felt patients were not always responsible for their excess weight. The researchers also reported providers held extremely obese people more accountable for their weight than those who were moderately obese. Thus, even those providers who specialize in studying and caring for obese patients are not completely free of negative attitudes toward those for whom they care. Although there is scant research regarding nurses who care for bariatric patients, negative attitudes may also be true for nurses in this specialized field of patient care.

Social discrimination toward obese people is well documented both anecdotally and through research. Research has also demonstrated how the discriminatory social attitudes have carried over to the health care arena. Additionally, despite the documentation of how obesity impacts peoples' lives and how the health care community responds to obese patients, it remains important to understand patients' perceptions in order to improve their health care.

Patients' Perceptions of Health Care

Obese patients' perceptions of the health care they receive are important for their satisfaction and acquiescence to a provider's recommendations. There are numerous citations in the literature that state "obesity is the last socially acceptable form of prejudice" (Chambliss et al., 2004; Glenn & Chow, 2002; Hebl & Xu, 2001; Rogge, Greenwald, & Golden, 2004; Wang et al., 2004). In order to eliminate this last form of prejudice, it is necessary to recognize and understand how patients view the health care they receive. The studies involving obese persons' perceptions of health care they received will be the focus of this section.

The health care community promotes the concept of preventive medicine through regular check-ups and appropriate screenings. Early detection of medical conditions such as breast and colon cancer, dyslipidemia, hypertension, and diabetes has been shown to prevent or postpone long-term negative outcomes (NIH, 2000). However, obesity has been demonstrated to be a barrier for persons in accessing regular health care. Olson, Schumaker, and Yawn (1994) surveyed 310 health care workers to determine the reasons participants delayed health care visits. The most common reason for patients to delay

health care visits was embarrassment over their weight. Additionally, one-third of the respondents perceived discussions with their physicians regarding their weight as negative. Drury and Louis (2002) surveyed 216 women to explore the association of weight to utilization of health care. They found that as participants' BMI increased, they tended to delay or avoid health care visits.

Fontaine, Faith, Allison, and Cheskin (1998) investigated the association of BMI and use of medical care services of 6981 women who were part of the 1992 National Health Interview Survey (NHIS). The researchers, using multiple linear regression analysis of the data, concluded that there was a direct relationship between BMI and increased physician visits. However, the researchers also found that obese and severely obese women were more likely to delay preventative exams such as breast and gynecologic exams although obtaining mammograms was not avoided. Avoiding health care because of obesity often complicates the treatment of chronic diseases and can lead to premature death (NIH, 1998).

Bertakis and Azari (2005) also investigated the differences in use of health care services by 509 obese and non-obese patients. Their findings contradicted the studies by Drury and Lewis (2002), Fontaine et al. (1998), and Olson, Schumaker, and Yawn (1994). When controlling for SES, as obese patients' health status decreased, they had more primary care visits and more use of diagnostic services. The researchers concluded that obese patients and their physicians perceived obesity increased patient's health risks resulting in more frequent visits and diagnostic testing. This study was conducted in a

teaching environment which may have led to increased follow-ups and frequency of diagnostic testing.

Once obese persons are being followed in the health care system, many perceive their care by health care providers as inadequate. Wadden et al. (2000) surveyed 259 obese women about their perceptions of physicians' attitudes and practices regarding weight. Although participants were generally satisfied with the medical care they received, 75% did not seek their physicians' assistance when attempting to manage their weight. Obese persons may seek help with weigh management outside the health care system that may put them at risk for unhealthy weight loss practices. This can negatively affect their co-morbidities and sabotage their attempts at losing and maintaining weight loss.

Patients expect that their health concerns will be addressed at health care visits by their providers. However, when one is obese, this may not always be true. Brown, Thompson, Tod, and Jones (2006), using a grounded theory methodology, interviewed a purposive sample of 28 men and women to explore their perceptions and experiences during primary care visits. They concluded that patients demonstrated ambivalence regarding health care providers' support as a result of insensitive or ambiguous communication on the part of the provider. They also found that participants felt responsible for their obesity and perceived a sense of stigma and negative stereotypes during their visits which contributed to their reluctance to access health care.

Investigations of how obese patients perceived the medical community's attitudes toward them (Brandsma, 2005; Kaminsky et al., 2002; Zandbelt et al., 2004), patients'

satisfaction of primary care delivered after being diagnosed as obese (Brown et al., 2005; Falkner et al., 1999), and views of bariatric patients regarding their physicians' attitudes and practices before and after surgery (Anderson & Wadden, 2004; Rand & MacGregor, 1990) have had mixed results. Brandsma (2005) compared obese patients' perceptions of their physicians' attitudes with the physicians' attitudes about obesity. Two different attitude scales were administered to 26 mostly male physicians and 26 mostly female obese patients. Both groups generally reported ambivalent attitudes with physicians showing more positive attitudes toward obese patients than perceived by the patients. The study by Kaminsky et al. (2002) supported these findings.

However, both of these studies contradicted the findings of Zandbelt et al. (2004) who investigated physician and patient satisfaction with an outpatient clinic visit in an academic teaching hospital. The 30 physicians and 330 patients responded to similar satisfaction questionnaires. The researchers asserted patients were generally more satisfied with the visits than physicians. Older patients and those in better physical and mental health were found to be more satisfied with physician visits. Patients also reported greater satisfaction with female physicians and with those whom they had had previous visits. Physician satisfaction was higher with well-educated patients, patients who had better mental health, and those who did not desire a lot of information. The researchers concluded that physicians and patients use different criteria to evaluate satisfaction. This is an important consideration when trying to accommodate a group of patients who have generally been thought of in negative terms. In other words, it is important for physicians to focus on patients medical concerns during their outpatient visits.

Ambivalent findings regarding obese patients' satisfaction with the care given by their primary physicians have been reported. Some researchers concluded that obese patients are generally satisfied with health care encounters while other studies have concluded the opposite (Fong, Bertakis, & Franks, 2006; Wee et al., 2002; Zandbelt et al., 2004). There does not seem to be a clear explanation for the contradictions. There does seem to be a correlation between the decade in which the study was done and the results. For example, conclusions drawn by Rand and MacGregor (1990) contradicted the conclusions drawn by Anderson and Wadden (2004). Both studies were conducted using similar settings, types of patients, and methodology. The contradictions in the studies may have been a result of attitude changes during the fourteen years between them or may reflect an increase in negative attitudes toward obese patients.

Perceptions of obesity are influenced by ethnicity and gender largely as a result of social and cultural influences (Kaminsky et al., 2002; Paquette & Raine, 2004; Rand and MacGregor, 1990). African-American and Latin-American women have a tendency to be more accepting of larger body sizes than white women, in general, and are more accepting of excess weight in men than in women (Latner, Stunkard, & Wilson, 2005; Sanchez-Johnsen et al., 2004; White, O'Neil, Kolotkin, & Byrne, 2004). However, more recent studies found that African-American women were dissatisfied with their excess weight (Davis et al., 2005; Laferrere, et al., 2002). Patient perceptions of care delivered by providers were influenced by the level of obesity, disability, and decisions to have weight loss surgery (Anderson and Wadden, 2004; White et al., 2004). Of the studies including men and women, females reported more negative experiences regarding their

obesity regardless of setting. Women reported occurrences of negative or prejudicial attitudes in their encounters with families, friends, co-workers, service oriented people, and health care providers such as harassment, slurs and insults, negative judgments and assumptions and discrimination (Cossrow, Jeffery & McGuire, 2001; Pain & Wiles, 2006). Some authors concluded that patients felt lower self-esteem, increased frustration and self-recrimination, and negative body image as a result of discrimination and negative comments (Chang, Liou, Sheu, & Chen, 2004; Davis, Clark, Carrese, Gary, & Cooper, 2005; Paquette & Raine, 2004; Ziebland, Robertson, Jay, & Neil, 2002). Thus, perceptions obese patients have of health care providers' treatment during health care visits have been reported by multiple investigators to be negative.

Obese persons suffer emotionally, socially, and physically as a result of social stigmatization. With the increasing incidence of obesity in the U.S. over the last two decades, these issues are becoming more obvious and problematic. It is imperative that the health care community, of which nurses are a part, change the mistreatment of obese patients. Improving the care of obese patients cannot be accomplished if it is not known how and when the mistreatment occurs. Understanding health care providers' perceptions of their care of obese people is important in order to identify what is viewed by patients as negative. This section of the literature review has reviewed how obese patients view what they encounter in medical community settings. The next section will discuss nurses' attitudes toward obese patients.

According to the National Institutes of Health (2005), "obesity is a complex multi-factorial chronic disease ..." The reported research has demonstrated that physicians often demonstrate inequitable and discriminatory care toward obese patients (Anderson et al., 2001; Cade & O'Connell, 1991; Campbell et al., 2000; Price et al., 1987). In clinical practice, nurses may be the first practitioner to assess and assist in the management of a patient's obesity while simultaneously giving encouragement and instructions on how to lose weight. Unfortunately, the time involved in these tasks, coupled with poor success rates, can lead nurses to give minimal attention to weight loss of obese patients. As a result of this minimal attention, obese patients have a tendency to not rely on the medical community for help with weight loss. This can result in obese patients using unhealthy practices to lose weight (Mercer et al., 2001).

Understanding how nurses view and deliver health care services to obese patients is important to ascertain what it is during health care encounters that patients perceive as negative. Discovering how and in what context negative attitudes are displayed is the first step toward improving patient care and patients' perceptions of the care they receive.

Researchers have investigated nurses' attitudes toward obese patients with mixed results. Bagley et al. (1989) conducted an early study of nurses' attitudes toward obese patients. They surveyed 107 Canadian female hospital nurses using their 15-item Nursing Management Scale and 13-item Personality and Lifestyle Scale to measure attitudes about care of persons who are obese. They found that a negative view of obese adults significantly correlated with a negative attitude about providing nursing care for obese

patients. Almost one-quarter of nurses agreed or strongly agreed with the statement, "Caring for an obese adult usually repulses me" (p. 954). They also compared the relationship between nurse characteristics and nurse attitudes. Nurses who were older or dissatisfied with their body image had less favorable attitudes towards obese patients. In contrast, nurses with higher levels of professional education reported more favorable attitudes. From later studies, it appears that they combined these two scales into one scale, the Nurses' Attitudes Toward Obese Patients (Culbertson & Smolen, 1999; Garner & Nicol, 1998; Zuzelo & Seminara, 2006).

Other researchers have built upon the findings of this study. Maroney and Golub (1992) used the findings from Bagley et al. (1989) to compare the attitudes of 67 U. S. nurses with the attitudes of the 107 Canadian nurses in Bagley's study. They developed a questionnaire of 24 questions, which included 20 questions about attitudes towards obesity and four about ethnic attitudes. Although they provided no explanation of the psychometric properties of their tool nor how they compared their study participants' responses to those reported by Bagley et al., the U. S. and Canadian nurses appeared to have similar attitudes, such as preferring not to care for the obese patient or that obesity could be prevented by self-control.

Garner and Nicol (1998) adapted The Nurses' Attitudes Toward Obesity Scale (Bagley et al., 1989) to survey 45 female and 23 male nurses and 27 obese and 28 non-obese patients about nurses' attitudes. They found no gender differences in level of negative attitudes among the nurses. However, they found that obese patients were more likely to report nurses' attitudes toward them as negative than non-obese patients.

Using The Nurses' Attitudes Toward Obesity Scale (Bagley et al., 1989), Culbertson and Smolen (1999) surveyed 73 nurses (66 were female) who were register nurse (RN) to Bachelor of Science in Nursing (n=33) or RN to Masters of Science in Nursing (n=40) students. Like nurses in earlier studies, these participants reported negative attitudes toward caring for obese patients and if given a choice, said they would decline caring for them. Unlike Bagley et al. (1989) these researchers asserted that older nurses had more positive attitudes towards obese patients. Similar to nurses in the Maroney and Golub (1992) study, these nurses related obesity to poor life-style choices.

These studies all used small, convenience samples. In a recent study, Zuzelo & Seminara (2006) surveyed 119 nurses who practiced in three different care settings of a single health care network. The researchers concluded that these nurses reported positive attitudes towards obese patients as measured by The Nurses' Attitudes Toward Obese Adult Patients Scale (Bagley et al., 1989). They also analyzed an open-ended question that asked the nurses to describe entering an obese patient's room for the first time. From their qualitative analysis of this question, the researchers identified that these nurses believed obese patients deserved special treatment and had unique care needs. However, as nurses in previous studies, these nurses reported feeling overwhelmed by the needs of obese patients and dreaded the demands that caring for obese patients requires. They were also concerned that they might become injured when assisting obese patients. The researchers concluded that these nurses needed increased knowledge regarding safe nursing practices for obese inpatients including the need for specialized equipment to aid in protecting nurses who care for this special patient group (Zuzelo & Seminara).

Most of these studies investigated nurses' attitudes toward care of patients in acute care setting. However, nurses who work in primary care settings are sometimes delegated to manage weight loss attempts. Hoppe and Ogden (1997) investigated nurses' beliefs regarding obesity and their outpatient practices. The 586 nurses surveyed reported patient obesity was related more to life-style than biological factors and that obesity was a serious threat to patients' health. The nurses were confident in their skills of managing obese patient issues and viewed poor patient weight loss as a result of poor compliance rather than inadequate advice or follow-up. The authors came to the same conclusions in a follow-up study (Ogden & Hoppe, 1998). Thus, nurses perpetuate society's view that obese people are responsible for their excess weight.

The results of these quantitative studies demonstrate that nurses were overwhelmed when caring for obese patients and, given a choice, would choose not to care for them. Additionally, nurses held obese people responsible for their excess weight which was viewed as a result of poor life style choices. However, nurses also reported that when caring for obese people their unique needs and conditions should be given special consideration. It was also concluded that increased education regarding managing obese patients might be helpful in improving nurses' attitudes. However, all the research questions involved care of obese patients in general and did not focus on those obese individuals who were proactive in their weight loss attempts by undergoing surgery to achieve their goals.

The majority of studies investigating nurses' attitudes toward obese patients have been quantitative, often using the Nurses' Attitudes Toward Obese Adult Patients Scale

(Bagley et al., 1989). However, there were three studies that used qualitative methods to investigate nurses' attitudes regarding obesity. Wright (1998) used an exploratory research method to examine 10 nurses' values related to female body size and how they viewed overweight women. Although the majority of participants viewed obesity as unhealthy with increased health risks, they also reported reluctance to initiate conversations with patients about weight loss. The author surmised that nurses had conflicting feelings regarding what should be done to help patients improve their health status and what was actually achieved with this group of patients. The author concluded nurses needed to work on becoming patient advocates. Participants also reported obese women were humiliated and discriminated against by medical staff, whereas this was not observed with obese men. Although the nurses reported prejudicial behaviors conflicted with how they viewed their role as health care members, they continued to follow physicians' orders regarding weight control advice.

Mercer and Tessier (2001) interviewed 10 general practitioners (GP) and 10 practice nurses (PN) in Scotland to explore the issues of how nurses managed obesity and what barriers existed regarding their role. The predominantly female participants (n = 17) reported obesity management as part of their role, but the GPs mostly delegated the job to PNs. Provider frustration, lack of successful weight loss, and lack of patient motivation were recurrent themes expressed by participants. Participants also viewed obesity as predominately a "female" issue and said the national guidelines for weight management were not useful. The participants, however, expressed a desire to learn how to motivate patients regarding weight loss attempts.

Drake, Dutton, Engelke, McAuliffe, and Rose (2005) used focus groups to investigate how nurses viewed caring for morbidly obese patients in an acute-care facility. From the 17, mostly female, expert nurse participants, several themes evolved from the focus group interviews. Participants voiced a lack of adequate personnel and equipment when caring for obese patients. They also were concerned about psychosocial and safety needs of obese patients and the safety of those who care for them. The authors concluded this qualitative study by identifying several areas requiring further research regarding adequately caring for the increased numbers of obese inpatients.

Two review articles were found that addressed different aspects of research regarding obese patients. Puhl and Brownell (2001) reviewed literature involving discrimination toward obese persons as it relates to employment, health care, and education. The reviewers also gave recommendations on research needs. The authors found the existing studies demonstrated discrimination toward obese persons in employment, medical care, and education but also noted the studies had limitations in their methodologies and sampling. Areas needing further research involved several domains. Much work needs to be done in the assessment of how weight bias is expressed, examining how nurses' negative attitudes influence all aspects of patient care and what strategies are productive in changing biased attitudes.

The review article by Brown (2006) focused exclusively on existing literature of nurses' attitudes toward adult obese patients. He found the majority of research studies conducted used quantitative methodology while only three were qualitative. The author concluded that generalizations from these studies should be done with extreme care since

the methodologies, samplings, and aims were moderately diverse. He also noted that while, in general, nurses displayed negative attitudes toward obese patients, nurse participants were not specifically trained in the care and needs of obese patients. Another notion of the author was that very little research addressed nurses' beliefs and attitudes toward obese patients. He concluded that rigorous qualitative studies would be a good initial step to learn more about the attitudes of nurses who care for the obese patient population.

Summary

Nurses' views of what it is like to care for obese patients are important to understand in order to uncover how nurses' views might be negatively projected to patients. Understanding what it is nurses do that result in patients' reports of prejudicial treatment is the first step in addressing the issues of how to improve patient care for obese patients. In order to uncover nurses' existing attitudes, the researcher must be able to analyze and decipher the language nurses use when discussing their experiences of caring for obese patients.

It has been demonstrated in this review that there is little research on the lived experiences of nurses caring for obese patients. In order to understand and arrive at the meanings of nurses' experiences about this often maligned patient group, one must investigate what has repeatedly been reported anecdotally by patients as nurses' negative attitudes. Since one interpretation of phenomenology is "being in the world" this method allows the researcher to gather and analyze data from those who are "in the world" of caring for postoperative bariatric patients. Using critical social theory to investigate nurse

participants' experiences, as revealed through their words, will give meaning and understanding of how it is they view caring for this group of patients. Hermeneutics is the investigation, interpretation, and analysis of data in such a way that the researcher becomes one with the data (Leonard, 1994). Meshing hermeneutics with phenomenology and critical social theory allows the researcher to make sense of the collected data in such a way as to give meaning to nurses' lived experiences of caring for postoperative bariatric patients.

This chapter presented several areas of literature review which are pertinent to the study being undertaken. Understanding patients' experiences of being obese and their views of health care received are important to help them maneuver through the health care system so they will not be reluctant to access much needed services. It is also important to understand how nurses view caring for obese patients in order to understand their experiences and change whatever negative behaviors might exist when caring for this group of patients.

CHAPTER III

METHODOLOGY

Overview of the Study

Obesity is at epidemic levels in the US with more than 60 percent of the adult population classified as either overweight or obese. The co-morbidities that accompany obesity are a strain both financially and physically on the patient, family, and health care system (CDC, 2005; NIH, 2005; US Surgeon General, 2004). One of the issues involved with obesity is the manner in which obese persons are treated by society in general, and nurses and other health care professionals specifically. Although studies have been done regarding how health care members, including nurses, affect outpatient care, no studies were found about how nurses view caring for hospitalized obese surgical patients (Culbertson & Smolen, 1999; Hoppe & Ogden, 1997; Maroney & Golub, 1992; Mercer & Tessler, 2001; Teachman & Brownell, 2001). This study investigated how nurses viewed caring for postoperative bariatric surgery patients. The purpose of this critical phenomenological study was to discover how nurses experienced caring for postoperative bariatric patients. Registered nurses were asked to talk about their experiences of what it was like to care for bariatric patients in the hope their stories would lead to more caring and sensitive nursing care for this group of patients.

Research Design

Methodology is the underlying ideas and principles on which research studies are based. Qualitative researchers choose their methodology according to the question(s) they investigate (Holloway & Wheeler, 2002). The methodological frameworks chosen for this study were hermeneutic phenomenology and critical social theory (CST). Hermeneutic phenomenology is the study, interpretation, and comprehension of poorly understood human phenomena (Patton, 2002; van Manen, 1990; Wiklund, Linholm, & Lindstrom, 2002). The use of CST is warranted when social situations seemingly result in some form of inequality for human beings. Critical social theory (CST) was used as a lens to critically evaluate and analyze language used by nurses during interviews in order to determine what attitudes revealed about caring for bariatric patients (Agger, 1999).

In this chapter an overview of the historical fundamentals of the philosophical frameworks guiding this study is presented, along with a discussion of the research plan. A discussion of human participant protection and methodological rigor will follow. The chapter concludes with presentation and critique of the pilot study.

Hermeneutic Phenomenology

Phenomenology is a philosophy and methodology used to investigate the world in which humans live. Phenomenology began in Germany in the early part of the 19th century as a systematic method to investigate and understand human experiences. It was mathematician and philosopher Edward Husserl whose philosophical concept of phenomenology began and remains central to the development of phenomenology. One

of Husserl's philosophical ideals within phenomenology was the belief that one could better understand human phenomena when one suspended or bracketed *a priori* knowledge of one's own experiences. He viewed the ability to suspend previous knowledge related to the phenomenon as ideal in order to have a clear, uncluttered mind to foster a thorough understanding of the phenomenon under study (Spiegelberg, 1984).

Phenomenology was furthered in the 20th century by Martin Heidegger, Husserl's student, colleague, and critic. One of Heidegger's areas of interest was the concept of Being. Heidegger used the term Being to mean living in the world in a specific way. In other words, Being to Heidegger meant to become more fully a part of the world such as humans do when they research and theorize about their world (van Manen, 1990). Heidegger proposed that Being is interpreted uniquely by each individual because each has varied and unique experiences. He also perceived the concept of Being as part of a whole but also separate from the whole. In other words, an individual is part of the entire world but is also a separate and complete entity within the world (Spiegelberg, 1984).

One aspect of Being, according to Heidegger, was that Husserl's notion of bracketing was not feasible. Heidegger believed humans could not suspend *a priori* knowledge because previous experiences influenced their unique views of the world (Conroy, 2003). Heidegger's belief was that persons should accept and acknowledge the existence and influence of previous experiences and knowledge. In other words, Heidegger theorized that humans incorporate all past experiences and knowledge into how they perceive and interpret their lives. Thus, according to Heidegger past

experiences cannot and should not be discounted when interpreting human phenomena (Leonard, 1994). In using Heideggerian phenomenology in this study I acknowledged my previous experiences and knowledge related to obesity while attempting to minimize or clarify the influence of *a priori* knowledge and experiences during the conduction of the study.

Phenomenological researchers investigate the experiences of *Being* (van Manen, 1990). In other words, using a phenomenological approach in research requires the researcher to seek out the meaning of *Being* rather than what is known about its existence. Thus, the goal of using phenomenology in this study was to gain a better understanding of the meaning of each individual's life experiences. Given that this study was about *Being in the World* of nurses who care for postoperative bariatric patients and given that understanding the essence of this phenomenon can only be gained from those who have lived the experience, phenomenology was a good methodological fit for this study.

Hermeneutic is a term that has been applied for centuries to the interpretation of historical documents. Heidegger believed the most effective and significant way to exist in the world was in being aware of one's existence through interpretation of one's world. Heidegger applied the word hermeneutic as the interpretation of *Dasein*, a term he used for being human. Given that Heidegger believed that humans interpret their lives as they live them, the term hermeneutic, or interpretation, was applied to his brand of phenomenology (Spiegelberg, 1982).

Hermeneutic phenomenology requires that one immerse oneself in the data until the meaning of the data surfaces and presents itself. This also means the researcher must accept participants' views of reality as being true and valuable. Thus, the richness of the data as given by participants is the basis for all that is interpreted. The meaning of the data is not self evident and cannot become evident without intense and careful analysis. The researcher will develop an understanding of the data by repeatedly reading and listening to the data, separating the data into units of meaning to facilitate analysis, and reinserting the units into the whole to be sure the understanding of the unit actually exists within the data (Diekelmann, 2005; Leonard, 1994; Mackey, 2004).

Hermeneutics is also a research method by which one investigates and analyzes, through interpretation, the world and those who live in the world. Using a hermeneutic approach as part of the method of investigation encourages the researcher to become one with the data as they are found (Leonard, 1994). The meshing of hermeneutic with phenomenology in this study meant the researcher had a fit for gathering and interpreting data regarding the essence of what it was like to care for bariatric patients as told by nurse participants who cared for them.

Critical Social Theory

Critical social theory (CST) originated after World War I in Germany's Frankfurt School. It was conceived by German philosophers Theodor Adorno, Max Horkheimer, and Herbert Marcuse as a result of the emerging forms of capitalism. The originators of CST wanted to raise society's consciousness of social situations and motivate members

of society to initiate social changes that would avoid or correct domination of one social group by another (Manias & Street, 2000).

Critical social theorists reject social law concepts and attempt to explain social history in order to gain insight into how society can be altered. The proponents of CST theorize that gaining knowledge of the world will raise the consciousness of society's members resulting in social change that will lead to a reduction of inequality within society. The originators of CST upheld the notion that society's members should become conscious of existing social inequalities in order to become motivated to correct the injustices that result from domination of one group of society by another (Agger, 1999; Wilson-Thomas, 1995). This increased consciousness develops as a result of dialogue about a subject between society's members. It was my assumption that as a result of the research interview dialogues, nurses would likely recognize injustice within their domain of caring for patients and initiate action to correct those injustices.

Within the health care arena the medical community has been viewed by the public as being responsible for all aspects of health care. However, physicians have delegated specific tasks and roles to nurses and other medical personnel. Nurses have been viewed as an oppressed group for several decades because a great deal of their practice has been dictated by physicians (Roberts, 1983; Roberts, 2000). Within this study, however, it was not the nurses who were viewed as being oppressed but rather the patients for whom nurses were caring. Thus, the focus of this study was an investigation

of the oppressed group behavior of an oppressed group (nurses) toward another oppressed group (obese patients).

All hospitalized patients are dependent, to some degree, on nurses to meet their daily needs and to assist them in achieving their pre-hospitalized level of independence. Obese patients have sometimes amplified dependencies related to their incapacitating obese levels that result in physical limitations. This patient dependence on nurses to provide even basic needs provides opportunities for nurses to have a level of power that may be used to control and possibly oppress the people they profess to be helping. However, nurses may not be conscious of that control and possible oppression of patients. Therefore, as a benefit of being actively engaged during interviews and having interactive dialogue with one another, nurse participants and I, as the researcher, may develop increased awareness of existing inequalities between patients and nursing staff. This increased awareness could instigate nurse participants to initiate changes in their work environment to improve how bariatric postoperative patients are treated. Additionally, increased self-awareness will likely have a positive impact on the patients for whom I deliver care. Given that nurses' language in the form of interviews about a certain care experience was gathered in this study and given that language "speaks" human values and beliefs, I anticipated that an analysis of the language nurses used about their experiences of caring for bariatric patients might reveal their true feelings about this population of patients. Such efforts were a fit for the CST methodology.

Jùergan Habermas, a German student of Horkheimer, further developed CST by focusing on the notion that knowledge consisted of the three domains of work knowledge, practical knowledge, and emancipatory knowledge. In Habermas' view, work knowledge was based on pragmatic knowledge and governed by technical rules such as those found in physics, biology, and chemistry. The domain of practical knowledge addressed communication and understanding of the conditions in which communication is effective. In this study I planned to use of Habermas' view of practical knowledge when viewing how nurses communicate about *Being in the World* of and caring for postoperative bariatric patients. Habermas viewed practical knowledge as addressing communication in social situations which included analyzing spoken language with respect to how that language influenced social groups. Additionally, he believed as a result of everyday communication people, at times unknowingly, strive to become autonomous and emancipated (Fulton, 1997). Thus, Habermas' belief was that as a result of dialogues between society's persons, those involved would take time for self-reflection. Individual self-reflections would result in recognition of the power they possessed to determine their own destinies resulting in the initiative for societal changes.

Habermas viewed the third communication domain as emancipatory knowledge which is gained through self-reflection and self awareness (MacIsaac, 1996). As a result of this critical self awareness, insights are gained and the individual can identify why it is they think and act the way they do. Using emancipatory knowledge in this study was accomplished by me when I reflected on my views and interpretations of my experiences

during the process of the interactive interviewing nurse participants, data analysis, and writing the report.

According to CST any language that can be construed to be negative, demeaning, or otherwise leading to subjugation, would demonstrate oppression. According to Habermas, in order for understanding to occur between persons, a dialogue must take place. During this dialogue the involved persons can question each other as to whether what has been said is meaningful, truthful, sincere, and whether the speaker has a right to say what is being articulated (Holub, 1997; The Literary Encyclopedia, 2005). Therefore, by using Habermas' view of communication during data collection and analysis, dialogues between nurse participants and the researcher, nurses' attitudes may be uncovered about caring for postoperative bariatric patients through the language used when telling their stories (Agger, 1998; MacIsaac, 1996).

Critical social theory's focus is to promote social change through initiating changes (Agger, 1998). The use of CST in this study began during the interview process and continued during data analysis. Critical social theory was used as a lens to facilitate scrutinizing nurses' language during data collection and analysis in order to uncover how they perceived caring for bariatric patients. During the researcher's discovery phase that was anticipated to occur during interactive interviews with nurse participants, there was a possibility nurse participants would take time to self reflect about the interview. During this reflection nurse participants might recognize that their patient interactions, as revealed through the language they used, could be interpreted by patients as oppressive or

prejudicial. If nurse participants take time to reflect on their research participation and recognize that their views could be perceived as prejudicial, it was hoped those nurse participants would become political activists in the process of instigating needed changes in their work environment. These work changes may lead to improved care for this patient group.

As the researcher, I also had opportunities during the research process to reflect on what I had discovered. During this reflection I anticipated that as my prejudices were revealed, I would initiate changes that demonstrated a decrease in prejudicial attitudes toward patients I did not particularly like. I also acknowledged that because of my role as the researcher, I was perceived by nurse participants as having power over them. This perception of power could result in nurse participants not being as open and forthcoming with their stories. Through my own integrity I hoped to overcome this barrier by reassuring nurse participants of their confidentiality and the importance that their stories and experiences had in improving patient care.

Research Plan

Setting

I planned to conduct the study at a 485 bed teaching institution in a central Texas community of more than 60,000 inhabitants. The institution's patient population came from Texas and the surrounding states. The institutional setting was a multi-specialty hospital and clinic that was a source of education and research for nurses, physicians, and other medical personnel.

A single 40-bed general surgery hospital unit that housed postoperative adult patients from general surgery and neurosurgery was the planned location for recruitment of nurse participants. In addition to having postoperative bariatric patients, the nurses on this unit cared for patients who have had hernia repairs, bowel resections, cholecystectomies, spleenectomies, liver resections, or neurosurgery procedures. Additionally, patients who have undergone any type of trauma recover on this unit. The 40-bed unit is usually at full capacity with a high daily patient turnover rate. The average number of bariatric surgery patients cared for on this nursing unit is between fifteen and twenty patients per month.

More than 90 percent of bariatric surgery patients stay in the hospital for 36 hours with no time spent in the intensive care unit. The nursing unit staff consists of a mix of unit clerks, nurse assistants (NAs), licensed vocational nurses (LVNs), and RNs. On a typical eight or twelve hour shift, the staff usually consists of two to four RNs, four to six LVNs, four to five NAs, and one or two unit clerks.

Recruitment of Participants

Purposive sampling is the selection of participants according to characteristics important to the research question. I planned to use purposive sampling of Registered Nurses (RNs) in this study. It is generally intentionally small so the researcher can investigate in-depth the characteristics of those who participate in the study (Patton, 2002). Because RNs have a common educational foundation which is different from other staff members, only RNs were eligible to participate in this study. Participants must

also have cared for at least three postoperative bariatric patients. Caring for at least three postoperative bariatric patients was likely to give RNs adequate patient variety upon which to reflect when telling of their experiences of caring for bariatric patients.

I anticipated beginning recruitment with a meeting between the unit supervisor and myself. I planned to discuss the goals of the study with her and obtain her verbal permission to post flyers about the study (Appendix A) in the nursing staff locker area. I also planned to attend bimonthly staff meetings in order to explain the study and ask for volunteer RN participants. During these meetings, I would explain that the purpose of the study is to gain insight into nurses' experiences of caring for bariatric surgery patients. Potential participants will be informed that participation in the study involved completing a demographic data form (Appendix B) and an audio taped interview conducted with the researcher regarding what it was like to care for postoperative bariatric patients. Potential participants would also be informed that interviews were anticipated to last between 40 to 60 minutes and that no identifying personal information will be shared when the study is presented or published. I planned to also explain to all participants that participation is voluntary and they could withdraw from the study at any time without repercussion.

The anticipated number of participants for this study was eight to twelve. The appropriate sample size was determined when data saturation was reached (Erlandson et al., 1993; Patton, 2002). Data saturation is accomplished when interviews reveal no new or different information.

As a Nurse Practitioner who had been associated with the postoperative nursing unit where bariatric patients recovered, I was considered a peripheral part of the unit. However, as a result of my frequent and long-term tenure in making visits to this particular nursing unit I had learned, through observations and conversations, something about the environment of this nursing unit. As a result of this prolonged engagement, the nursing staff was comfortable with my presence. Thus, my plan to obtain data from nurses who work on the unit was not likely to be thought of as a threat.

Data Generation Strategies

The use of hermeneutic phenomenology has a primary focus of interpreting what it is like *Being in the World* of human experiences. Face to face interviews can generate information that reveals personal insight into the experienced phenomenon (Christ & Turner, 2003). Therefore, the use of semi-structured, face to face interviews seemed appropriate for data generation for this study. I planned to conduct audio taped interviews with nurse participants in a private, quiet place where there will be a minimal chance of interruption. Possible locations for the interviews were private offices on the nursing unit or my private office in the clinic which was totally removed from the hospital section of the institution. I planned to have audio tapes transcribed by a paid transcriptionist to create the text for analysis. At the time of the interview each participant will be asked to fill out a demographic data form created by the researcher with information regarding age, gender, socioeconomic status, marital status, level of education, number of bariatric patients cared for, and each nurse's perception of his or her weight.

I planned to conduct interviews in a conversational style to put participants at ease and to facilitate the sharing of stories. Using this approach will likely encourage nurse participants to reflect on their experiences and give them insight into their experiences of caring for bariatric surgical patients. I planned to begin the interviews with the open ended statement, "Tell me a story about what it is like to care for postoperative bariatric patients." Probing questions were used to better understand and clarify what had been said and to encourage nurse participants to share their thoughts, feelings, and experiences of caring for this group of patients (Appendix A). Additionally, I anticipate taking notes of interview details to facilitate in-depth descriptions necessary for readers to better understand the context of the study.

Face to face interviews can provide insight for research participants by allowing them to reflect on experiences they might not otherwise acknowledge. Appropriate questions were to be asked of the participants to help them initiate reflecting on their experiences. An example of such a question will be "Tell me how your care of bariatric patients has changed over time." Reflections on what transpired as a result of the interview dialogue may enlighten participants and ultimately lead to validation of their nursing experiences and self-worth. Additionally, self-reflection allowed for new understandings of a phenomenon that participants might not otherwise have had (Hutchinson, Wilson, & Wilson, 1994).

Conducting interviews can allow an opportunity for the researcher to gain a different perspective on real life experiences from the participants' view point. New

perspectives could also lead researchers to gain new insight into their own life experiences that might not be gained through other research methods (Bedini & Henderson, 1995; Hutchinson, Wilson, & Wilson, 1994).

Another benefit of interviewing can be that of participant satisfaction and empowerment. Participants sometimes take part in research in order to help others. The willingness to become involved in research can add to participants' sense of fulfillment. Additionally, knowing one's story will be shared with others might lead to participant empowerment. Empowerment might be a result from knowing their stories will be acknowledged by the researcher and those who read the final reports. This satisfaction and empowerment could be the impetus for participants to initiate needed changes they may have identified as a result of research participation (Bedini & Henderson, 1995; Hutchinson, Wilson, & Wilson, 1994).

Data Analysis

I planned to accomplish data analysis of the study texts by using Colaizzi's (1978) seven step process:

1. Listen to each audio-taped interview and read each transcribed interview to establish a general understanding of the whole.
2. Read each interview again line by line to determine what words or phrases give meaning to the lived experience.
3. Extract meaningful words or group of words from the interview and analyze separately to formulate units of similar meanings.

4. Organize the meaningful units into themes and refer back to the interview to validate the existence of the themes with the understanding that some ambiguities may exist.
5. Compare themes between interviews in order to establish congruency between and among each interview as to the meaning and significance of each theme. Reinsert data that make up each theme into its original interview to confirm that the theme actually exists within the interview.
6. Return the exhaustive description of the themes uncovered to as many participants as can be located to validate the themes and findings.
7. Write an exhaustive description of the phenomenon (Sanders, 2003).

The reading and rereading, analyzing meaningful words and phrases from the texts, comparing of themes across interviews, and reinserting all the words and phrases into original interviews, and writing an exhaustive description of the phenomenon for clarity requires the researcher to go back and forth between and among individual interviews. This back and forth flow encourages the researcher to become immersed in the data in order for themes to become obvious (conversation with Dr. N. Dieklemann, June 2005). Additionally, I planned to continuously use the lens of CST by critically analyzing participants' words and phrases in order to identify whether or not there was evidence of oppressive attitudes toward baratiric surgical patients.

I planned to use paradigm cases and exemplars to support thematic analysis. Paradigm cases are examples of the way participants think about and view the

phenomenon being investigated. Paradigm cases included all dimensions of the lived experience as perceived by a participant. Exemplars are sections of the interview that demonstrate similarities or contrasts between themes and interviews (Benner, 1994). Both paradigm cases and exemplars were used during the writing of the thick description of the phenomenon in order to foster understanding. Once the thick description was written, I developed a better understanding of the essence of the phenomenon of nursing care of the postoperative bariatric patient.

I planned to use the computer program *Qualrus* to manage data during analysis. The *Qualrus* software program assists with qualitative data analysis without forcing any specific research style on the user. This program could display relationships between themes once all data are inserted into the program (Ideaworks, 2006).

Protection of Human Participants

Protection of human participants in this study was to be accomplished by having each participant read and sign an informed consent. This consent included the purpose of the study and informed participants that their confidentiality would be maintained within the extent allowed by the law throughout the study and any reports generated from the study. If participants used real names when telling their stories, I planned to change the names in the transcripts and any generated reports and assign a pseudonym to protect identity. All tapes and interviews were to be stored separately in locked cabinets and destroyed within five years of study completion. Approval for the study was obtained

from the Institutional Review Boards of Scott and White Memorial Hospital and Texas Woman's University.

Steps to Ensure Methodological Rigor

Rigor was to be attended to in this study through the use of the trustworthiness and authenticity criteria (Patton, 2002). Trustworthiness means one must be "fair, balanced and conscientious" when proceeding through a qualitative study (Patton, 2002, p. 575). Trustworthiness was sought through the use of strategies to insure credibility, transferability, dependability, and confirmabilty. Authenticity, the shared but separate truths of the researcher and the participants, was to be established through meeting the criteria of fairness and ontological authenticity (Guba & Lincoln, 1989; Lincoln & Guba, 1985).

Credibility is the ability to establish the truth value of the inquiry and was to be met through the strategies of prolonged engagement, member checking, and maintaining an audit trail and reflective journal. Prolonged engagement is to be demonstrated by the fact that the last 24 of my 40 years in nursing has been in an area where postoperative bariatric patients receive care and I have been familiar with the environment of the nursing unit. Additionally, I am seen regularly on the nursing unit where staff members are conscious of my interaction with bariatric patients and the nurses who care for them. I also planned to establish prolonged engagement through the 40 to 60 minute individual interviews as well as the months I had spent with the topic of this study.

Member checking was to be accomplished during the interviews by clarifying and verifying participants' statements. Additionally, I planned to do member checking after data analysis by attempting to locate participants and give them a copy of the findings of the study for their input. Reading the findings might give participants an opportunity for reflection of what transpired during the interviews. Participants were to be encouraged to give me their feedback.

A reflective journal of thoughts, impressions, and processes as well as an audit trail was maintained by the researcher throughout the study. An audit trail consisted of contextual documentation such as field notes, details of the environment during data collection, audio tapes, interview transcripts, and a reflective journal. Additional pertinent information to the study such as the computer program used and analytical notes made during all phases of data analysis was to be maintained in the audit trail (Erlandson et al., 1993; Rodgers & Cowles, 1993).

Transferability is the ability to apply the findings of a study to different settings (Erlandson et al., 1993). Transferability in this study was to be addressed through thick description and purposive sampling. Thick description is a detailed account of the environment, the participants, and any other information that will give the reader a picture of what transpired during the study and how the findings were determined. Painting a picture through words allows the reader a thorough understanding of the study by sharing demographic data, verbatim participant interview quotes, and details of the study contents. Purposive sampling allows for selection of individuals who were likely to

reveal rich data essential for adequate exploration of the study focus. Although each participant was unique in his/her view of the world, when similarities were found across and among interviews it will be feasible to broadly apply the findings of the study to other settings.

Confirmability, the ability to demonstrate that study results are directly related to the data and not researcher bias, was supported through quotations from participants' stories and through researcher journaling (Erlandson et al., 1993). Quotations from participants' stories can support the themes and patterns found in the study and give voice to participants' experiences. Reflective journaling, a part of the audit trail, might reveal the thoughts and decisions of the researcher as the study was conducted. I planned to journal detailed decisions made regarding all aspects of the study throughout the study and the rationale behind those decisions. Dependability in qualitative studies documents how the study was conducted as well as variances that occur. Dependability was to be addressed by having the researcher meticulously maintain an audit trail described previously.

Authenticity is the ability of the researcher to present participants' views of reality as revealed by them (Guba & Lincoln, 1989). The authenticity criteria used in this study are that of fairness and ontological authenticity. Fairness was to be established by inviting all registered nurses in the setting who met the inclusion criteria to participate in the study. Ontological authenticity is the result of participants' improved understanding of their world as a result of participation in the study. Ontological authenticity was to be

determined during member checking if participants acknowledged changes in their lives as a result of study participation.

Pilot Study

A pilot study was conducted with two purposes. One purpose was an initial exploration of how nurses viewed caring for post operative bariatric patients. The second purpose was to affirm the fit of hermeneutic phenomenology and CST in exploring this phenomenon. Participants read and signed an informed consent. The consent included the purpose of the study and informed participants that their confidentiality would be maintained within the extent allowed by the law throughout the study and any generated reports. Participants chose their own pseudonyms. If participants used real names during the interview, the names were changed in the transcripts. All tapes and interviews were stored separately in locked cabinets. Approval for the study was obtained from the Institutional Review Boards of Scott and White Memorial Hospital and Texas Woman's University. The pilot study discussion presents the data collection and analysis process and the findings and conclusions of the study. The discussion also includes a critique of the study with suggested improvements.

Data Collection

Data collection was done at the central Texas multi-specialty teaching hospital approved for this study. The nursing supervisor of the nursing unit where postoperative bariatric patients recover was approached as to the feasibility of conducting a pilot study using RNs from the unit who had experience caring for this group of patients. After

receiving permission from the nursing supervisor, the goals of the study were explained to several RNs who were recommended by the supervisor. The nurses were asked if they would be willing to participate in the study. Four nurses agreed to participate and completed the demographic data sheet and a fact to face interview with me. Of the four nurse participants, aged 26 to 50 years, three were female and one male. The four nurse volunteers described their weight as normal to slightly overweight. None described themselves as being obese. At the time of the interviews, three of the four nurses had an Associate degree in nursing and the fourth had a Bachelors' degree. One of the nurses was attending undergraduate classes to obtain a Bachelors of Science Degree in Nursing. Each participant had worked with postoperative bariatric patients for at least 3 years and had cared for more than three bariatric patients.

Having chosen a quiet area in which face to face interviews could be conducted with minimal distractions and interruptions, a convenient time was decided on by each participant. The consent form was signed after participants' questions were answered. Each participant chose a pseudonym to be used throughout the study. Participants were informed they could withdraw from the study at any time without repercussions. Interviews began with the statement, "Talk to me about what it is like to care for bariatric surgical patients." Additional probes were used to assist participants in telling their stories. I kept notes during the interview of pertinent information that would be used in adding to the thick description of the study. Interviews lasted between 30 to 40 minutes each and were transcribed verbatim by me.

Data Analysis and Findings

Data analysis was conducted according to Colaizzi's seven step process as previously described. Participants discussed caring for bariatric surgery patients with a primary focus on nursing tasks and tended to avoid open discussions of their personal feelings and attitudes toward this group of patients. The themes uncovered the essence of the phenomenon of nurse participants' experiences of caring for postoperative bariatric patients. The two themes were (a) a dichotomy of feelings and attitudes toward bariatric patients with a sub-theme of love/hate relationships between nurses and patients; and (b) the importance placed by participants on social support for patients. A discussion of the two themes follows.

Dichotomy of feelings and attitudes toward bariatric patients. During data analysis I found participants' language revealed both positive and negative attitudes toward caring for bariatric patients. These attitudes were revealed through words and phrases participants used in describing the experiences of caring for bariatric surgical patients. Using the lens of CST to critically view and analyze all words and phrases reinforced that nurse participants' stories revealed dichotomous feelings and attitudes toward this group of patients. These dichotomous feelings and attitudes were reflected in all nurse participant interviews and stated best by Daisy. Daisy, a nurse in her 50s who considered herself to be normal weight to slightly overweight, described one patient in these words:

> ...he was so big and his wife, his mother, and any female in his family was used to doting on him. He was one of these that I call "the tea glass shakers" — you know—fill my glass (Daisy demonstrated an imaginary glass being shaken) and shake the ice and you know that is exactly how they were treating him here in the hospital too! He was here to lose weight, to improve ***his life*** but he was not doing anything to work towards that goal—his family was hand feeding him, brushing his teeth, washing him!

In contrast to the tone of some of the experiences she described, Daisy later said how she admired patients for their willingness to undergo what she considered to be a drastic but elective procedure for the sole purpose of weight loss. Some of her remarks included "...are coming in with ...better attitudes and they are positive in the whole way they are looking at the whole picture..." She also mentioned how she viewed the surgery as "...a wonderful thing and I admire the people who do it."

Muffin, a nurse in her 30s and actively pursuing a BSN, described herself as being normal weight. She also described caring for bariatric patients dichotomously as reflected by such phrases as "...very manipulative...crude at times ..." However, she described other patient experiences as "...some very nice, good, very sweet patients that are willing to take all the information that you can give them, accept full responsibility for their own care, as well as getting better and doing everything that you are trying to get them to do."

Eddie, a male in his 30s and who described himself as slightly overweight, described a patient who had fallen out of bed as "...a blob on the floor." However, a few sentences earlier Eddie had talked of being "...excited about taking care of the patients."

Love/hate relationship with bariatric patients. A subtheme of having a love/hate relationship was found during participants' descriptions of caring for bariatric patients. Participants told about patients who were cooperative and willing to assist with their care while others were demanding, uncooperative, and acted as though they had no idea what was expected of them. This theme was exemplified by Daisy when she described bariatric patients:

> I admire the people that do it—usually they are the ones who have tried everything that they could and they do come in with the right attitude but, again, go back to the ones who you can detect from the moment they get on the floor—"okay, I can get this done and go home and eat my pizza and do whatever I want" —there are still those.

Alicia, a nurse in her 20s, described her love/hate relationship when caring for bariatric patients this way,

> ...dislike when they need you to help them move constantly...you deal with the moans and groans of not having anything to drink or eat ....they know it is a surgery but until they have it done the realization that they are going to have a lot of pain that is not going to be very comfortable for them to get up and walk...have the dry mouth....it is ...difficult for them to handle.

Conversely, she later revealed how taking care of bariatric patients was a positive experience, "I really enjoy the psychological aspect of it and hearing the stories about how they have struggled...."

Eddie also demonstrated a dichotomous attitude about caring for bariatric patients when he said "in general I think it is a good experience." However, he later described patients as "...not cooperative, not following the game plan to get better."

Muffin described patients who returned about six months after surgery to demonstrate their weight loss when she said "...they look totally different ... it is wonderful! ... A whole new life." However, she also used terms like "challenging" and "...whine and cry and complain about everything" when describing patients.

Importance of social support. Theme number two, found in three of the four interviews, encompassed the importance of having caring people available who were willing to help patients during their recovery period. Muffin discussed families she thought were not supportive of the patient in terms such as "supposed loved ones." She viewed the importance of families and friends in this way,

> ...this kind of surgery, you would need a semi-strong support system. You need lots of encouragement. A lot of obese patients have psychological issues as well...if you don't have a caring family or someone who can ... nurture you as you're recovering then it is going to be really hard –really hard.

Alicia also mentioned social support. She described this support as having a "...husband or friend ... here encouraging them... the family may have already taken

leave from work...to stay with them and be supportive...the support encourages them to get up and do what they have to do..."

Muffin also considered social support important for patients' recovery, especially at home. She discussed a patient who went home with an open wound,

> The husband wanted nothing to do with it. The poor patient was left.... had to have Home Health nurse ...I thought that was so sad...the husband didn't want to come into the room, didn't want to help walk the patient, didn't want to help wash the patient....he just left her to herself...I wondered how that patient turned out once she got home....

She later commented on social support saying "...if you don't have a caring family....kind of watch you and nurture you...then it is going to be really hard."

Conclusions

Several conclusions were drawn from the pilot study data analysis. Nurse participants displayed dichotomous views of caring for bariatric surgery patients by telling both positive and negative stories. They told of frustrations with patients who were demanding and not cooperative in their care. However, caring for bariatric patients was also viewed as rewarding especially when patients willingly participated in their care. Nurse participants also used language that revealed negative attitudes toward this patient population. Using CST I looked at the language used by participants when they discussed caring for this patient population with a critical view of what was being said. I also would replay the audio tapes during the analysis process to get a feel for the tone of the

interviews. During the critique of nurse participants' language I discovered they used negative verbiage such as "moan and groan" and "blob on the floor" when discussing some bariatric patients. Having supportive family and friends was viewed positively by nurse participants as a vital part of patients' success in surgical recovery and in the ultimate goal of weight loss. On the other hand, if nurse participants viewed social support as lacking, they reported patients' recovery as being more difficult.

Critique of the Pilot Study

A rich repertoire of stories was gathered in using hermeneutic phenomenology as a methodology to investigate nurses' lived experience of caring for postoperative bariatric patients. Additionally, using CST as a lens to analyze the language spoken by nurses was an appropriate methodology. Thus, it was found that the methodologies chosen for this study were effective frameworks for understanding the essence of what it was like to care for postoperative bariatric patients.

In reviewing the interviews, it was determined the opening statement "talk to me about what it is like to care for bariatric surgical patients" needed revision in order to have nurse participants tell stories of their experiences rather than tell of the tasks required in the care of bariatric patients. The revised opening statement will be "tell me a story about caring for postoperative bariatric patients." Additionally, probing questions will be asked during the interviews to aide in eliciting in-depth stories of the nurse participants' experiences.

During data analysis it was also revealed that the probing questions used needed modification in order to elicit in-depth experiences from the nurses. *Why* questions were asked during the interviews which resulted in participants giving limited responses. Thus, it was planned that probing questions would be changed by using prompts such as "can you please explain what you mean" or "tell me more about that." It is anticipated these prompts will result in richer data. Leading questions asked by the researcher such as "Do you personally feel like you are prejudiced?" and "Do you think people who have bariatric surgery are different than other surgical patients?" were also found during data analysis. In the future a leading question will be replaced with open-ended questions such as "Please tell me more about that" and "Please explain what you said in a little more detail" in order to elicit more in-depth responses.

Research Process

As a result of the findings of the pilot study the process of the final study was revised. The following discussion explains the changes and gives the rationale for the changes.

The use of Qualrus in the pilot study was cumbersome for me as a novice to this program. Trying to learn how to use Qualrus was challenging and I found it more expedient to use the typed interviews with a highlighter and notes. However, once I am able to become more familiar with this program, it is my intent to use it in other qualitative research projects.

When analyzing the pilot study questions, I discovered many were leading questions. I, therefore, changed my general question from "Tell me, if you will, what it is like to care for postoperative bariatric patients" to "Please tell me a story you will never forget about caring for postoperative bariatric patients." The changed general question led to more in-depth information about how nurses' viewed their experiences of caring for bariatric surgical patients. The probing questions were reworded to exclude any why and leading questions.

The process of Colaizzi's analysis involves final validation of the study findings by returning to the participants for input. This was accomplished by emailing or hand delivering a copy of the findings to 5 different participants and asking for their input. At a later, pre-arranged time and place I met with 4 of the 5 participants to accomplish this task. The 4 participants relayed to me that they found the themes and conclusions to be accurate. During the interviews I found these participants had begun to change how they viewed their experiences of caring for postoperative bariatric patients.

The remaining steps in the research plan remain the same as described in the following chapter. Chapter 4 is an article submitted for publication which describes the study and its' results.

Summary

This chapter outlined the research plan and process of this study. Hermeneutic phenomenology and critical social theory were selected as appropriate for the study of lived experiences of nurses caring for bariatric surgical patients. The design and findings

of the pilot study were presented and critiqued. The research process of the final study was discussed. Selection of participants, study setting, and data collection and analysis were discussed. Protection of human subjects was explained and criteria for methodological rigor were given. The methodology of the final study is discussed in the manuscript found in chapter 4, "Nurses' Lived Experience of Caring for Bariatric Patients."

CHAPTER IV

NURSES' LIVED EXPERIENCES OF CARING FOR BARIATRIC PATIENTS

Abstract

Obesity is increasing worldwide and is so pervasive in the United States as to be classified an epidemic. Obese persons are discriminated against in all aspects of their lives including health care. Although research has demonstrated nurses exhibit prejudicial attitudes toward obese patients, it is not known if this prejudice extends to obese patients who undergo surgery for weight loss. In this hermeneutic phenomenology qualitative study, twelve nurses were interviewed to explore their experiences of caring for postoperative bariatric patients. Data analysis using Colaizzi's model revealed two themes of *getting up for the first time* and *negotiating with families.* Nurses' stories of caring for postoperative bariatric surgery patients revealed the arduous challenges of caring for this patient group. The challenges were related to power struggles between nurses, patients, and families over getting up for the first time and unsupportive family behaviors. Nurses need to be cognizant of power issues and how good communication with patients and families is imperative for positive, effective outcomes. Recommendations are offered for nursing research, education, practice, and social awareness.

Introduction

Obesity is an insidious and complex disease that is at epidemic levels in the United States (U. S.), according to the Surgeon General (2002). Obesity often leads to a variety of diseases such as diabetes, hypertension, sleep apnea, and some cancers which can result in premature mortality (CDC, 2008; NIH, 1998). The increased use of bariatric surgical options, with the likelihood of losing significant amounts of weight and a reduction of living with life-threatening medical conditions, has resulted in large numbers of morbidly obese person scheduling procedures at surgical centers around the country. Consequently nurses are caring for increased numbers of morbidly obese patients on postoperative nursing units. Understanding nurses' views of caring for these patients is important to improving the quality of their health care.

Negative attitudes toward persons who are obese have been documented in the literature. These include views that obese people are lazy, of low intelligence, and unmotivated to change (Drury & Louis, 2002; Myers & Rosen, 1999; Rand & MacGregor, 1990). Negative attitudes toward obese people can affect all aspects of their lives, including health care. For example, patients, particularly women, reported a resistance to referrals for bariatric surgery from their primary care physicians (Kaminsky & Gadaleta, 2002). Nurses seem to share these negative attitudes. Wright (1998) found that nurses expressed discriminatory attitudes toward caring for obese female patients. An early study surveyed 107 Canadian female hospital nurses about their attitudes toward caring for obese patients. Almost one-quarter of the nurses agreed or strongly agreed with

the statement, "Caring for an obese adult usually repulses me" (Bagley et al., 1989, p.954). Other studies that surveyed nurses' attitudes towards caring for obese patients found similar results (Culbertson and Smolen 1999; Mercer & Tessier, 2001; Wright, 1998). Nurses' attitudes can affect the care they provide (Bagley et al.; Brown & Thompson, 2007; Culbertson, & Smolen, 1999l; Garner & Nicol, 1998).

It is not known whether nurses who care for patients after bariatric surgery share these negative views of obese persons. Therefore, the purpose of this critical phenomenological study was to examine nurses' experiences of caring for postoperative bariatric patients. Registered nurses were interviewed and asked to share their stories of caring for this group of patients. This knowledge may enhance understanding of nurses' views about caring for obese patients, resulting in improved treatment and increased patient satisfaction.

Methods

Hermeneutic phenomenology and critical social theory were blended to create the framework guiding this study. Phenomenology is the study of how individuals make sense of their everyday experiences (Holloway & Wheeler, 1996). Phenomenological research is a descriptive methodology by which poorly understood human phenomena are explored through language. We examined the *nature* of the phenomenon of caring for obese patients by analyzing data obtained from nurses who had lived this experience. Hermeneutic phenomenology studies the meaning or *interpretation* of a phenomenon. During data analysis we engaged with the study texts, looked for meanings by examining

the data as a whole, then in parts, and by returning to the whole. In this way we were able to interpret what nurses revealed about their experiences of caring for obese patients after bariatric surgery. Each stage of analysis increased our understanding of the phenomenon as expressed by these nurses who had lived it (Holloway & Wheeler, 1996; Leonard, 1994).

Critical social theory promotes critical analysis of social situations by examining unequal domains of power as they exist within social settings (Sanders, 2003). Using critical social theory as a methodology for research in which participants' language and the social content of their stories were analyzed, we were able to identify underlying power issues that may exist between bariatric surgical patients and the nurses who care for them. Research from a critical theory perspective can also lead to emancipatory change through questioning of a cultures rules, habits, or traditions (Agger, 1999; Fulton, 1997). Asking nurses to reflect on their experiences of caring for patients who are obese could lead to identifying and initiating change in their attitudes toward care of these patients.

The study was conducted in a multi-specialty, central Texas teaching institution. A newly built 40-bed general surgery unit that houses postoperative adult patients provided the setting for recruitment of nurse participants. The rooms were large enough to accommodate equipment that had been appropriately sized to meet the needs of morbidly obese patients. Several had overhead runners that allowed special equipment to be used when necessary to assist in the care of these patients. All rooms had windows

with various views of the surrounding city. Patient families could be accommodated in the patients' rooms 24 hours a day, since the hospital valued family presence as essential to patient recovery.

Recruitment of participants and data collection began after approval for the study was obtained from the Institutional Review Board of the participating institution and by Texas Woman's University. A purposive sample of 11 nurses who had cared for at least three postoperative bariatric patients was recruited through announcement of the study during their bimonthly staff meetings. Audio-taped interviews were scheduled with interested nurses in a place of their choice. After signing a consent form, participants were asked to choose their own pseudonyms. They were then asked, "Tell me a story that you will never forget about what it is like to care for postoperative bariatric patients." Probing questions, such as "What do you think of that?" and "Tell me more of that," were used to better understand and clarify what had been said and to encourage participants to share their thoughts, feelings, and experiences of caring for this patient group. At the time of the interview each participant was asked to fill out a demographic data form created by the researchers with information regarding age, gender, socioeconomic status, marital status, level of education, number of bariatric patients cared for, and each nurse's perception of his or her weight. Participants included nurses who were Asian-American, white, and African-American. Two were male and nine were female; their ages ranged from 20 to 59 years old.

The interview transcripts, transcribed verbatim from the audio-tapes by a professional transcriptionist, comprised the study texts. We analyzed them using Colaizzi's seven step process (Colaizzi, 1978; Sanders, 2003). This process involved reading and rereading the text, reflecting on what was found, extracting significant words and phrases from the text for further analysis, and writing and revising a narrative report of the findings for clarity. Themes were developed from the significant words and phrases found within and between each text. The words and phrases were reinserted into the original interviews to verify the existence of what was revealed. This required us to become immersed in the data by going back and forth between and among individual interviews and reflecting on what was found. The continuous use of critical social theory during data analysis encouraged us to critically analyze participants' words and phrases in order to identify how participants viewed caring for bariatric surgical patients. Data saturation was determined once no new findings were found during ongoing data analysis.

Methodological rigor was met through the trustworthiness and authenticity criteria (Erlandson, Harris, Skipper, & Allen, 1993). Trustworthiness refers to methodological soundness and accuracy of the findings. This was addressed by maintaining an audit trail that consisted of the interview audiotapes, the raw data of the interview transcripts, and a reflective journal that included field notes written after each interview and observations about the research process. Participants were given the opportunity to review and give feedback about their transcripts and the study findings.

The five who responded thought the findings reflected their experiences and acknowledged their changed thought processes concerning caring for bariatric patients. This supports authenticity, which is the assurance that the findings represented the nurses' experiences and that participation in the study brought about changed attitudes or behavior (Erlandson et al.).

Themes

We identified two themes that were present in all interviews and which described these nurses' lived experiences of caring for bariatric patients and the underlying power issues that can exist between nurses and their patients. The two themes were *getting up for the first time* and *negotiating with families*. The following discussion will explore the content of these themes.

Getting Up for the First Time

Postoperative orders for all of these patients included ambulating the day and/or night of surgery. Seasoned and novice nurses described ambulating patients for the first time after surgery as the greatest challenge for nurses and patients. Although not common, a few nurses told of an occasional patient who, soon after surgery, would transfer into bed by climbing off the stretcher without assistance. However, nurses frequently described getting up for the first time as "a difficult challenge...they (patients) don't want to 'pop a stitch,' tear the band aids off, hurt themselves." However, as one nurse phrased it "they don't have a choice. You snooze, you lose."

Conflicts around first ambulation seemed to indicate subtle issues of power. Patients would sometimes not want to ambulate when nurses were able to go with them. The nurses described these instances as patients' attempts to manipulate them. When talking about patients who did not do the things the staff had requested, one nurse said these patients were "trying to beat the system" and "...want to do things their own way..." Another nurse told of patients that "...want control...lose that when they come into the hospital." One nurse described her frustration:

> ...they know they have do it (ambulate) so I get frustrated...there is a difference in patients. There are some you can't walk enough and some you just can't get them up...they spent all this time and they want to lose weight...I would want to follow the rules and guidelines as much as I can...

Fear of falling was a major concern for patients and nurses. One nurse shared the following story about a patient ambulating, reluctantly, for the first time:

> (She) didn't walk very far—wanted to go back to bed and in the process...slipped down...on the floor...getting that patient up and back on the edge of the bed...very difficult, using the Hoyer lift (mechanical device)...four nurses on the extremities and one behind...

Similar experiences were described by other nurses as frightening and anxiety producing.

All participants saw *getting up for the first time* as a challenge for both patients and nurses. Although many described the difficulties motivating patients to ambulate after surgery, one nurse shared how she helped her patients overcome their fears about

getting up for the first time. She would tell them "...the first time you get up is the greatest obstacle." She reassured them that although it would at first hurt to walk, the pain would decrease with each successive walk, and reminded them to use their intravenous pain medicine.

Negotiating with Families

The second theme involved the complexities of *negotiating with families.* Complex family dynamics persist when people are hospitalized. Participants viewed family involvement and support in patient care as essential to recovery and for successful weight loss after bariatric surgery. They described it as supportive or non-supportive. Supportive families helped patients by encouraging them to ambulate and to do as much self-care as they could. Unsupportive families did too much for their family members after surgery. Nurses described these families as "...doting..." and "...doing everything for them..." Nurses defined these dynamics as co-dependence and used terms such as "enablers" and "needy" when discussing some family interactions. One nurse viewed the following behaviors by family members as unsupportive: "hand feeding him, brushing his teeth, washing him." Another nurse described a family whose support was not helpful to the patient's recovery. She said,

> ...they let her not walk. They don't do what you want...I would think that they would be more motivating...more than to let her sit in bed and not do her activities...

Nurses viewed this family behavior as impairing patient recovery, since patients needed to develop independence in order to be successful with weight loss. Nurses also identified families who brought food to the patients' rooms as unsupportive. They described how these families commented to patients on how good the food tasted even when they knew the patient was unable to have food or fluids after surgery. The nurses became frustrated when they were unable to convince family members to go elsewhere to eat.

Nurses did not enjoy negotiating with anxious family members who insisted the nurses call a physician about their concerns when they thought the patient was developing complications. Nurses found this especially challenging when they reassured the family that the patient was progressing normally. The nurses were aware that the resident would probably reiterate to family members what they had already told them. The nurses did not like having their credibility and authority with patients undermined by families' unrealistic postoperative expectations. Nurses described negotiating with families as a complex, multifaceted and intricate aspect of caring for bariatric patients.

Exhaustive Description

The final step in Colaizzi's seven step process is to write an exhaustive description of the phenomenon (Colaizzi, 1979). Nurses' stories of caring for postoperative bariatric surgery patients revealed the arduous challenges of caring for this unique group of patients. The challenges were related to power struggles between nurses, patients, and families over getting up for the first time and unsupportive family behaviors. The nurses frequently described the conflicts they experienced between doing

what they needed to do to prepare patients for discharge and the patients' reluctance to ambulate because of their fear of pain and falling. The nurses thought that some patients did not appreciate how early ambulation reduced their risk for postoperative complications such as blood clots, pneumonia, and poorly controlled pain. The nurses described negotiating with families as a complex challenge and identified conflicts they experienced with families. These conflicts centered on unsupportive family behaviors that nurses felt impaired patients' recovery from surgery. The word challenge itself gives the impression that the nurses, who expected patients and families to follow their instructions, felt their authority was being questioned when patients resisted ambulating or families insisted on speaking to the physician rather than trusting the nurses' clinical judgment.

Discussion

Nurse participants in this study found caring for postoperative bariatric surgery patients to be arduous and challenging. They identified *getting up for the first time* and *negotiating with families* as two challenges of caring for their patients. An aspect of first ambulation supported in the literature was related to fear of injury, a very real concern of these nurses. Studies have reported that risk of injury, particularly back injury increases when caring for patients who are obese (Vieira, 2007). Several studies acknowledged that nurses were reluctant to care for obese patients because of their fears of injuries and the overwhelming demands of caring for them (Bagley et al., 1989; Culbertson & Smolen, 1999; Maroney & Golub, 1992; Zuzelo & Seminara, 2006).

Although not described specifically by the nurses in this study, providing adequate care for these patients can be a challenging experience because they require specialized nursing skills with skin care, bathing, physical assessment, and ambulation (Gallagher, 1997, 1998, 2004). For example, the skin folds in the obese patient require special attention during bathing and daily inspection for signs of skin breakdown and possible infection. Physical assessment of the obese patient is challenging because excess adipose tissue makes physical assessment challenging by limiting the nurse's ability to adequately examine and assess different body systems. Even when they express positive attitudes toward obese patients, nurses may feel overwhelmed with the tasks of caring for them (Zuzelo & Seminara, 2006). Other studies endorse that caring for obese patients in the acute care setting requires special equipment, increased staffing, and specialized nurses who can meet the specific psychosocial needs of these patients (Drake, Dutton, Engelke, McAuliffe & Rose, 2005; Green & Gillett, 1998). Unfortunately, nurses many times work in environments that lack the necessary resources needed to provide adequate care for patients who are obese (Brown, Stride, Psarou, Brewins, & Thompson, 2007).

The nurses who participated in this study identified *negotiating with families* to be a complex challenge. Patients bring their family dynamics with them into the hospital, particularly when families are encouraged to take part in postoperative care as they were on this unit. Persons who are obese experience discrimination from their own family members as exemplified by family members eating in front of patients who were NPO after surgery. Rand and MacGregor (1990) in their study of 57 morbidly obese patients,

confirmed that patients' perceptions of their families' discriminatory behavior decreased significantly after having bariatric surgery with subsequent weight loss. Negotiating with families of patients in acute care settings has been investigated, such as family presence in the emergency room during resuscitation (Duran et al., 2007) and when they have a critically ill relative in the intensive care unit (Eggenberger & Nelms, 2007; Jamerson et al.,1996; Soderstrom, Benzein, & Saveman, 2003). These researchers emphasized the importance of effective communication between families and nurses in patient recovery. They concluded that communication with families alleviated some of the conflicts between family members and nurses as well as gave much needed information and support to families.

The current study also illuminated the power relationships that can exist among nurses, patients, families, and physicians. The lens of critical theory provided a framework for understanding these power relationships as expressed through the two themes of *getting up for the first time* and *negotiating with families*. In her grounded theory study of 65 nurses and patients exploring their views of hospital partnership, Henderson (2003) argued that nurses viewed power as sharing information with patients, but not relinquishing their power for clinical decision-making to patients. The nurses' experiences in the current study demonstrated their dual attitudes of wanting to retain their power with patients and families while having the patients relinquish their dependency on others. For example, nurses encouraged families to assist in patient care such as bathing, but expressed frustration when families did tasks for patients such as

brushing their teeth and feeding them. Nurses wanted the patients to follow the plan of care as established by physicians' orders and yet, they encouraged patients to be independent enough to ambulate on their own and be in charge of their own care rather than their families telling them what to do. The issue of power struggles with families also surfaced when nurses told of families who were either excessively demanding or insisted on a physician being called when the nurse thought it was inappropriate. Thus the issue of power and who possessed it was not directly acknowledged by nurses in this study but was an issue that presented itself in subtle ways through participants' dialogue about their caring experiences for these patients and their families. Nurses need to be cognizant of power issues and how good communication with patients and families is imperative for positive, effective outcomes.

Implications for Practice and Research

Several practice implications can be concluded from this study. First, the necessity of adequate equipment and education in caring for obese patients was emphasized. When nurses have adequate staffing and proper equipment to care for obese patients, the injury rate is decreased (Vieira, 2007). As a result of moving to a newly built, state of the art hospital section, appropriate and adequate equipment for caring for obese patients had become readily accessible. One nurse manager reported there had been no job related injuries of the nursing staff since the move which he felt was a direct result of appropriate equipment. Appropriate equipment and adequate staffing for care of postoperative obese patients can decrease frustrations and physical demands. We also

recommend that nurses receive continuing education about safe nursing practices when caring for obese inpatients including how to advocate for specialized equipment that can aid in protecting them and their patients from injury when ambulating for the first time.

A second recommendation for practice encompasses the importance of enlisting family support by preparing them for what to expect after surgery. Families need instruction about helping patients maintain their postoperative NPO status and how to help them safely ambulate and begin self-care. The nurses in this study emphasized the importance of involving families in patient care as an essential part of patients' surgical recovery and successful weight loss. The structure of the nursing unit should take into account the comfort of families by allowing adequate space for families to stay with patients 24 hours a day.

Nurses seemed to have power struggles with family members as to when and how patient care should be accomplished. We suggest nurses proactively include family members and patients in care by suggesting several scenarios of how patient needs can be accomplished. They can then foster a positive, joint decision between the family and patient as to when the tasks might be completed, fostering a cooperative care environment without power conflicts. This could result in more cooperation from families and patients as well as less frustration for the staff. Educating families could begin by creating a booklet for them outlining what they can expect during the hospital stay. Being hospitalized does not place patients in a cocoon from which they emerge when fully recovered. In reality, patients are discharged while still in the recovery phase of their

hospitalization. Families and support systems are essential in assisting patients during their home recovery. It is ludicrous to not include families in all phases of patients' recovery.

Research investigating nurses and their attitudes toward caring for obese patients has been dominated by quantitative studies in nonsurgical settings (Bagley et al., 1989; Garner & Nicol, 1998; Harvey & Hill, 2001). This study will add to the literature through its qualitative research approach to nurses' experiences of caring for postoperative bariatric surgical patients. Although limited in its scope, this study may add to the existing research about how nurses view caring for patients who are obese. However, further research needs to be done in other settings such as intensive care units and nonsurgical units to learn how nurses view caring for obese patients who are not actively seeking ways to lose weight. Additionally, studies are also needed that investigate the influence of families' attitudes toward patients' surgical recovery and ultimate weight loss. It would be of interest to repeat this study by using focus groups in place of individual interviews to determine what additional information would be revealed. Focus groups could also be used by nurses for brainstorming strategies to improve patient care structured around the topics revealed in this study of first time ambulation and negotiating with families. An advantage of focus groups is that participants concentrate on discussing issues and not on pleasing the researcher (Masvie, 2006). It is hoped that as a result of this study, nurses might begin to explore how to improve care while assisting patients in recovery from bariatric surgery.

Conclusions

Nurses can change their perspectives about caring for patients who are obese. In order to improve patient care, nurses must first be aware of their attitudes about caring for obese patients. Once they acknowledge their attitudes, they can begin to examine how they can be improved. During member checking, it was discovered that nurses had begun reflecting on the interview process which resulted in changing their approach to patient care. As a result of participating in the study, they had begun thinking about how they could address not just the physical needs of these surgical patients, but also how they might help them with the psychological aspects of life changes that result from bariatric surgery. They described their approach to caring for bariatric surgical patients as more holistic than task oriented, as had previously been the case. These findings could be shared with other staff in the hopes awareness of their own attitudes will be explored and improved.

Some participants have requested research information regarding various aspects of the long-term affects of bariatric surgery to assist them in educating patients postoperatively. Although we had anticipated that nurses would express prejudicial views of caring for this patient population, they reported mostly positive, empathic attitudes toward caring for bariatric surgical patients. This positive attitude toward a maligned patient group demonstrates that not all nurses avoid caring for bariatric patients. It is hoped, that as a result of this study, a positive attitude will begin to disseminate to others and result in more positive caring experiences for both nurses and patients.

CHAPTER V

THE EXPERIENCE OF OBESITY: A LITERATURE REVIEW

The literature reports "obese persons are the last acceptable targets of discrimination" (Puhl & Brownell, 2001, p 788). Obesity has been on the rise in the U. S. over the last thirty years despite a society that values thinness. Obesity is a devastating and complicated disease which affects all aspects of a person's life including emotional well being, physical well being, and socio-economical status. Obesity is defined by the National Institutes of Health (NIH, 2005) as having a Body Mass Index (BMI) of 30 or more, which is the equivalent of being 30 pounds above ideal body weight. The NIH defines morbid obesity as those persons who have a BMI over 40. Because more than 60% of the U. S. adult population is classified as being overweight or obese, obesity is now considered an epidemic by the Surgeon General (CDC, 2004; Li, Bowerman, & Heber, 2005; Short, 2004). As obesity levels continue to rise, health care providers will likely be inundated with managing the complex and challenging medical conditions these patients develop as result of their obesity. Nurses, as part of the health care provider network, will be at the center of caring for this group of special needs patients. It is imperative that nurses understand how obese patients experience being in a society obsessed with the image of thinness in order to care for them in a sensitive manner. The

purpose of this article will be to present a picture through the literature of how an obese person is stigmatized today as a member of society, as an individual, and as a recipient of health care.

Social Stigma and Attitudes

Part of the complexity of being obese and the research that investigates obesity is the stigmatization that society at large places on the obese individual. This stigmatization is demonstrated overtly and covertly as seen through limiting access to employment. Klarenbach, Radwal, Chuck, and Jacobs (2006) investigated the relationship of obesity to participation in the workforce. The researchers analyzed pertinent information from the Canadian Community Health Survey of 73,531 persons and concluded that a positive association existed between obesity and work absenteeism, especially with severely obese persons. Although this does not demonstrate stigmatization, it does confirm that employment can be difficult to maintain especially for those who are severely obese. Social and economic factors such as the ability to be employed, maintain employment, and earn an equitable wage are important for one's mental and physical well being.

Attitudes towards obesity are influenced by a variety of factors such as ethnicity, gender, and culture (Kaminsky et al., 2002; Paquette & Raine, 2004; Rand & MacGreggor, 1990). African-American and Latin-American women tend to be more accepting of larger body sizes than white women. They also are more accepting of excess weight in men than in women (Sanchez-Johnsen et al., 2004; White, O'Neil, Kolotkin, & Byrne, 2004). Sanchez-Johnsen et al. (2004) examined the 24-hour dietary recall of 505

weight in men than in women (Sanchez-Johnsen et al., 2004; White, O'Neil, Kolotkin, & Byrne, 2004). Sanchez-Johnsen et al. (2004) examined the 24-hour dietary recall of 505 African-American and Latin-American women, aged 18 to 67 years over a five year period to correlate the effects of dietary intake, body image, and physical activity on levels of obesity. The authors surmised that African-American women more than Latin-American women were accepting of larger body sizes although Latin-American women perceived their body image to be heavier even though they weighed less. White et al. (2004) also deplored the influence of television and a high fat diet on the increased obesity levels of both groups.

Cossrow, Jeffery, and McGuire (2001) conducted a study using male and female focus groups to improve understanding about weight and stigmatization. Females reported more negative occurrences of prejudicial attitudes than males in their encounters with families, friends, co-workers, service oriented people, and health care providers. These negative or prejudicial attitudes included harassment, slurs and insults, negative judgments and assumptions, and discrimination. However, both males and females agreed that there were leaner weight criteria for women than men. Pain and Wiles (2006) interviewed six obese, disabled community persons to explore the effects their limitations had on their lives. They found that participants reported negative attitudes such as resentment, obstructiveness, and insensitivity on the part of health and social staff. These studies reinforce that prejudicial behavior continues to be present in the health care community.

women, aged 20 to 45 years, enrolled in a weight gain prevention program perceived they had been mistreated because of their weight. Mistreatment from a spouse or loved one was reported by 22% of the sample while stranger mistreatment was reported by 27%. The only significant difference found between genders was that women perceived mistreatment from a stranger more often than men. However, mistreatment was reported significantly more often by those participants who were overweight as indicated by a high body mass index (BMI). These findings are a concern for obese patients when they attempt to access health care which is administered by strangers and who rely on loved ones for emotional support.

Rand and MacGregor (1990) conducted a study to explore morbidly obese patients' perceptions of prejudice and discrimination before and after bariatric surgery, which has become the treatment of choice when dietary efforts fail. Results of a nurse administered telephone questionnaire given to 57 morbidly obese patients revealed that the patients experienced prejudice and discrimination prior to surgery from family, friends, and the general public. After losing a significant amount of weight, however, the patients perceived less prejudice and discrimination from the same groups of people. All of these studies demonstrate that obese persons are viewed by others as being undeserving of equal treatment as normal weight people.

Stigma and Negative Perceptions of Health Care

Societal stigma of obese persons occurs in health care. Obese persons will often avoid health care visits and thus put themselves in jeopardy for additional health risks

because of this stigma (NIH, 1998). In order to improve health care delivery to obese patients, health care providers, including nurses, must first understand the experiences of obese patients and appreciate the discriminatory behaviors displayed toward them.

The health care community promotes the concept of preventive medicine through regular check-ups and appropriate screenings. Early detection of such medical conditions as breast and colon cancer, dyslipidemia, hypertension, and diabetes, among others, has been shown to prevent or postpone long-term negative outcomes (NIH, 2005). However, obesity has been demonstrated to be a barrier for persons in accessing regular health care.

Olson, Schumaker, and Yawn (1994) surveyed 310 female health care workers who were mostly obese to determine the reasons participants delayed health care visits. The most common reason for patients to delay health care visits was embarrassment over their weight. Additionally, one-third of the respondents perceived discussions with their physicians regarding their weight as negative. Drury and Louis (2002) surveyed 216 women to explore the association of weight to utilization of health care and surmised that as participants' BMI increased, they tended to delay or avoid health care visits.

Fontaine, Faith, Allison, and Cheskin (1998) investigated the association between BMI and use of medical care services of 6,981 women who were part of the 1992 National Health Interview Survey (NHIS). The researchers concluded there was a direct relationship between BMI and increased physician visits. However, the researchers also found that obese and severely obese women were more likely to delay preventative exams such as breast and gynecologic exams although obtaining mammograms was not

avoided. Avoiding health care because of obesity often complicates the treatment of chronic diseases and can lead to premature death (NIH, 1998).

Bertakis and Azari (2005) also investigated the differences in use of health care services by 509 obese and non-obese patients. Their findings contradicted the studies by Drury and Louis (2002), Fontaine et al. (1998), and Olson et al. (1994). Medical records were used to establish resource usage and charges for one year of all participants. When controlling for socioeconomic status, the authors concluded that as obese patients' health status decreased the number of clinic visits increased especially with specialty clinics and more diagnostic testing was done than their non-obese counterparts. Using the Beck Depression Index, the authors also surmised clinical depression occurred more frequently in obese females than in obese males and non-obese females and males. One limit of this study was that it was conducted in a teaching environment which may have led to increased follow-ups and frequency of diagnostic testing. This study demonstrated that obese people do use health care services but they may be assigned more testing and more negative diagnoses as a result of health care providers not wanting or knowing how to properly assess obese patients.

Once obese persons are being followed in the health care system, many perceive their care by health care providers as inadequate. Wadden et al. (2000) surveyed 259 obese women about their perceptions of physicians' attitudes and practices regarding weight. Although participants were generally satisfied with the medical care they received, 75% did not seek their physicians' assistance when attempting to lose weight.

Obese persons may seek help with weight management outside the health care system that may put them at risk for unhealthy weight loss practices. This can negatively affect their co-morbidities and sabotage their attempts at losing and maintaining weight loss since some weight loss programs can negatively impact their health.

Obese patients' perceptions of the health care they receive are crucial to their satisfaction and acquiescence to a provider's recommendations. In order to eliminate prejudices about obesity, it is necessary to recognize and understand how patients view the health care they receive. Patients' perceptions of care delivered by providers were found to be influenced by the level of obesity, disability, and decisions to have weight loss surgery (Anderson & Wadden, 2004; White et al., 2004). Anderson and Wadden had 105 bariatric surgery patients and 214 patients who chose medical managed weight loss programs complete a questionnaire to assess interactions between physician and patient regarding weight. Both genders were included in the study with females making up the majority of the sample. Females reported more negative experiences regarding their interactions with physicians while fewer bariatric surgical patients reported negative experiences than the nonsurgical obese patients. White et al. investigated how quality of life was impaired for 512 obese male and female patients seeking bariatric surgery by having them complete a quality of life questionnaire. The authors concluded that there was a more negative impact on quality of life as participants' BMIs rose. These studies demonstrate the effects obesity has on peoples' quality of life as well as how obesity

impacts their interactions with physicians, whether or not they are seeking a surgical solution to their weight.

Investigations of how obese patients perceive the medical community's attitudes toward them (Brandsma, 2005; Kaminsky et al., 2002; Zandbelt, Smets, Oort, Godfried & deHaes, 2004), patients' satisfaction of primary care delivered after being diagnosed as obese (Brown, Thompson, Tod & Jones, 2006; Falkner et al., 1999), and views of bariatric patients regarding their physicians' attitudes and practices before and after surgery (Anderson & Wadden, 2004; Rand & MacGregor, 1990) have had mixed results. Brandsma (2005) compared obese patients' perceptions of their physicians' attitudes with the physicians' attitudes about obesity in two outpatient settings. Two different attitude scales were administered to 26 mostly male physicians and 26 mostly female obese patients. Both groups generally reported ambivalent attitudes with physicians showing more positive attitudes toward obese patients than perceived by the patients. The study by Kaminsky and Gadaleta (2002) of 200 patients who had undergone bariatric surgery supported these findings. However, both of these studies contradicted the findings of Zandbelt et al. (2004) who investigated physician and patient satisfaction with an outpatient clinic visit in an academic teaching hospital. The 30 physicians and 330 patients responded to similar satisfaction questionnaires. The researchers found patients were generally more satisfied with the visits than physicians, especially those patients who were older and in better mental health. Patients also reported greater satisfaction with female physicians and with those whom they had had previous visits. Physician

satisfaction was higher with well-educated patients, patients who had better mental health, and those who did not desire a lot of information. The authors concluded that physicians and patients used different criteria to determine their levels of satisfaction. This study emphasizes the need to be aware of the differences in perceptions of obese patients and those who provide their care in order to improve the delivery of health care services.

Patients expect that their health concerns will be addressed at health care visits by their providers. However, when one is obese, this may not always be true. Brown et al. (2006) interviewed a purposive sample of 28 men and women from five general practices to explore their perceptions and experiences during primary care visits. Data analysis revealed five themes as *levels of support, ambivalence and ambiguity, personal responsibility and stigma, attributing all problems to weight,* and *avenues for development.* They concluded that patients demonstrated ambivalence regarding health care providers' support as a result of insensitive or ambiguous communication on the part of the provider while they viewed nurses as being an important aspect in developing a better support program for patients who desire to lose weight through dieting. The participants were found to feel responsible for their obesity and perceived a sense of stigma during their visits which contributed to their reluctance to access health care. The researchers concluded that negative stereotyping and discrimination did not contribute to patients' reluctance in accessing health care; rather a lack of resources such as medically supported weight loss systems was viewed by patients as a reason for avoiding health

care access. This study reinforces the need for patients to have better support for their weight loss attempts but there is also a need to educate primary providers in improving assessment of the obese patient so that obesity is not unnecessarily held liable for all of the patients' physical problems.

Discussion

This review of literature informs nurses about how persons who are obese are "the last acceptable targets of discrimination" (Puhl & Brownell, 2001, p 788). They experience discrimination from strangers, loved ones, and friends that can include slurs, derogatory remarks, and mistreatment (Cossrow et al., 2001). They also describe health care providers as being disrespectful and not helpful in weight loss management (Rand & MacGregor, 1990; Wadden et al., 2000). Patients perceived a lack of appropriately sized equipment, furniture, and clothing in physicians' offices as being discriminatory (Kaminsky & Gadaleta, 2002). As a result of this disrespectful and discriminatory treatment, persons who are obese may delay seeking health care which can put them at increased risk for complications of chronic diseases such as renal failure and strokes from poorly controlled hypertension. Also a lack of regular preventive health care can result in early mortality due to breast and colon cancer (NIH, 2005). Being discriminated against can result in feeling like a second class citizens which can lead to psychological distress, low self esteem, and self recrimination (Friedman et al., 2005; Myers & Rosen, 1999). The findings of this literature review have implications for nursing practice.

Implications for Nursing Practice

The findings from this literature review have many implications for nursing practice. Nurses as part of the health care community are obligated by virtue of the International Code of Ethics for Nurses (ICN, 2005) to promote health and alleviate suffering through caring that reflects dignity and respect for their patients. In order to achieve these goals, nurses must first understand their own attitudes toward maligned patient groups of which obese patients are a part. The literature reports that some nurses feel repulsed by the prospect of caring for obese patients (Bagley, Conklin, Isherwood, Pechiulis, & Watson, 1989; Puhl & Brownell, 2001) and that given a choice they would decline caring for obese patients (Culbertson and Smolen, 1999). In a literature review of nurses' attitudes, Brown (2006) concluded that nurses held similar negative views of obese persons to the general public. In order to examine how their behaviors might be viewed as negative, nurses need to reflect on how their attitudes and behaviors are perceived by others. Reflection of ones' attitudes could be determined by *The Nurses' Attitudes Toward Obese Patients Scale* developed by Bagley et al. (1989). Reflecting on and understanding ones' attitudes and behaviors can initiate self improvement which can manifest itself through improved care of others such as obese patients. Nurse administrators can support exploration of attitudes through nurse support groups and educational opportunities that focus on the complexities of caring for obese patients.

By understanding the experiences of obese persons, nurses can offer more competent and sensitive care. First, nurses need to be knowledgeable about the

differences in caring for patients who are obese (Drake et al., 2005; Green & Gillett, 1998; Grindel & Grindel, 2006; Hahler, 2002). Because of excess adipose tissue different techniques are needed for assessment of the heart and lungs. This includes proper positioning such as moving skin folds to clearly auscultate heart and lung sounds. Skin folds also need careful scrutiny for early identification and treatment of pressure ulcers and candidiasis that are not uncommon in obese patients (Gallagher, 1997, 1998; Gallagher et al., 2004; Hahler, 2002). Because patients who are obese have experienced disrespectful treatment, nurses need to be sensitive and ask permission from them before beginning assessments. Nursing care during hospitalization also includes referrals for dietary counseling to ensure proper nutrition and physical therapy to assist the obese patient in improving and maintaining mobility (Drake et al., 2005; Green & Gillett, 1998). To become knowledgeable about the needs of these patients, it is suggested that nurses begin with the work of Gallagher et al. They can also request that continuing education be offered by nurse experts through their hospital employers.

Nurses can advocate for proper fitting equipment for these patients. This includes toilets that are floor anchored, walk-in showers, adequate beds and furniture, appropriately sized blood pressure cuffs and gowns along with oversized wheelchairs and stretchers that accommodate obese patients (Gallagher, 1998; Gallagher et al., 2004). Nurses report a reluctance to care for obese patients because of increased risks of injuries (Drake et al., 2005). Proper equipment prevents injuries to patients and nurses and improves nurses' attitudes and willingness to care for patients who are obese (Zuzelo &

Seminara, 2006). Educating patients regarding the importance of preventive health care can also be part of patient and nurse interactions (Ahmed, Lemkau, & Birt, 2002). This can be accomplished during the daily care nurses deliver to this patient group using sensitive communication and nursing skills. Understanding the discriminatory treatment that obese people encounter on a daily basis may assist nurses in planning strategies to improve how patients who are obese are treated.

To offer patients sensitive care, nurses must first understand their own attitudes toward maligned patient groups of which obese patients are a part. Although no studies were found that studied perceptions of nurses by obese patients, the literature about nurses' attitudes reports that some nurses feel repulsed by the prospect of caring for obese patients (Bagley et al., 1989; Puhl & Brownell, 2001) and that given a choice they would decline caring for obese patients (Culbertson & Smolen, 1999). In this literature review Brown (2006) concluded that nurses held similar negative views of obese persons as the general public. In order to examine how their behaviors might be viewed as negative by patients, nurses need to become aware of their attitudes towards care of persons who are obese. The work of Bagley et al (1989) provides a survey of attitudes that may inform nurses. Reflecting on and understanding ones' attitudes and behaviors can initiate self improvements which can manifest itself through improved care of others such as obese patients. Nurse administrators can support exploration of attitudes through nurse support groups and educational opportunities that focus on the complexities of caring for obese patients.

Implications for Nursing Research

This review of literature demonstrates that most research has focused on how people viewed being obese within society and how they perceived the treatment they receive from primary care physicians (Brandsma, 2005; Brown et al., 2005) and as participants in bariatric surgery programs (Anderson & Wadden, 2004; Kaminsky & Gadeleta, 2002; Rand & MacGregor, 1990). There is a gap in the literature, however, about how obese persons view the care they receive from nurses when they are hospitalized. Patients see physicians briefly during hospitalizations, but nurses serve as their primary contact with the health care community. In order to improve the interactions between nurses and obese inpatients, it is important to establish how obese persons view their treatment by nurses in all inpatient settings such as intensive care, various medical units, and other surgical units besides bariatric surgery ones. In the literature obese people have reported poor treatment by family, friends, and strangers (Cossrow et al., 2001). Given that inpatient care is delivered by strangers, investigating how obese patients view the nurses who deliver this care is warranted.

Conclusions

Obese persons suffer emotionally, socially, and physically as a result of social stigmatization. Suggestions for nurses have been made to help improve the treatment obese patients receive within the health care community. It is hoped nurses will brainstorm among themselves using these suggestions as a starting point by which they can improve obese patient care and thus change the perception of negativity that is

currently held by this patient population. With the increase of obesity in the U.S. over the last two decades, these issues are becoming more obvious and problematic. The health care community is likely to be inundated with obese patients who are seeking help for their multiple medical and physical problems. It is imperative that the health care community which is comprised primarily of nurses be cognizant of how obese patients view the way they are treated when accessing health care. Improving the care of obese patients cannot be accomplished if it is not known how and when mistreatment occurs. It is important for nurses to reflect on their treatment of obese patients in order to better understand what it is they do that could be viewed as negative by the people they profess to help. Understanding patients' views of nurses and the care they receive is crucial to improving their care.

Table 1

Studies

Author	Aim(s)	Study Design/Methodology	Sample	Main Findings
Anderson & Wadden 2004	Assess obese patient & physician interactions	Randomized controlled trial questionnaire	105 male & female patients in bariatric surgery program; 214 male & female patients medically managed weight loss	Surgery patients more satisfied & had more interactions w/physician
Bertakis & Azari, 2005	Investigate differences in use and costs of health care services between obese and non- obese patients	Patients randomly assigned to medical residents as part of larger study	509 adults	Obesity associated w/ more depression, more primary care visits and diagnostic services
Brandsma, 2005	Examine PCPs and their patients' attitudes toward obesity	Self reported questionnaires	26 MDs and 26 patients	MDs reported more positive attitudes toward obesity than their patients perceived
Brown, Thompson, Tod, & Jones, 2005	To explore obese patients' experiences and perceptions of support in primary care	Semi-structured interviews grounded theory	28 males and females aged 18-75 BM 30-≥40	Participants felt ambivalence about services & resources; good relationships with primary care person and good support ameliorated these effects

Table 1 (Continued)

Studies

Author	Aim(s)	Study Design/Methodology	Sample	Main Findings
Cossrow, Jeffery, & McGuire, 2001	Explore nonclinical adults regarding thoughts & experiences w/weight stigmatization	Focus groups	31 male & females	Participants reported being treated poorly by family, friends, strangers at work, home, & health care settings
Drury & Louis, 2002	Explore obesity stigma effects health care use & accessing health care	Self-administered questionnaire	216 females	As BMI increases so does avoidance of health care
Falkner, French, Jeffery, Neumark-Sztainer, Sherwood, & Morton, 1999	To examine the prevalence and sources of perceived mistreatment of obese people	Self-administered questionnaire longitudinal study	>900 non-clinical males & females aged 20-45 years all obese	22% of females & 17% of males reported mistreatment
Fontaine, Faith, Allison, & Cheskin, 1998	To examine the relationship between BMI and use of medical services in women	Multistage cluster sampling self-reported survey; survey data from National Center for Health Stats	6891 women ≥18 years	Obese women less likely to seek preventive health care services although not a decrease in medical care
Friedman, Reichmann, Costanzo, Zelli, Ashmore, & Musante, 2002	Evaluate relationship of weight related stigmatization experiences & weight-related beliefs	Self-reported questionnaire	93 obese men &women seeking obesity treatment	Weight-based stigma was common & positively associated with depression, psychiatric symptoms, and body image disturbance; negatively associated self-esteem

Table 1 (Continued 2)

Studies

Author	Aim(s)	Study Design/Methodology	Sample	Main Findings
Kaminsky & Gadaleta, 2002	Investigate views of obese persons before, during, & after bariatric surgery	Self-reported questionnaire	40 men & women	Bariatric surgery patients fell misunderstood & mistreated by medical & non-medical people
Klarenbach, Radwal, Chuck, & Jacobs, 2006	Describe relationship of obesity class and work-force participation influence of demographics, SES, and disease states on this relationship	2000-01 Canadian Community Health Survey	73,531 adults aged 20-59 years	As obesity increases, work-force participation decreases
Myers & Rosen, 1999	Examine stigma & coping as related to psychological distress	Self reported questionnaires	209 male & females various levels of obesity	Stigmatization frequency increases as weight increases & affects body image, self-esteem & mental health; coping styles affect psychological adjustment
Olson, Schumake, & Yawn, 1994	Determine if women delay or avoid health care because of weight	Self-administered survey	310 female nurse employees 21.5 – 68 years 121 had BMIs $\geq$ 25	Obese women often delay health care visits due to weight

Table 1 (Continued 3)

Studies

Author	Aim(s)	Study Desig	odology	Sample	Main Findings
Paquette & Raine, 2004	Explore women personal and socio- cultural context influences body image	Naturalistic inquiry using two interviews with each participant		46 females aged 21 to 61 years diverse occupations	Body image is dynamic, fluctuating; classified as external and internal; mediated by relationships
Rand & MacGregor, 1990	Explore morbidly obese patients'perceptions of obesity-related discrimination before & after bariatric surgery	Self-completed 20-item questionnaire		57 patients from a private practice 50% female mean age 33 years mean BMI 62 kg	Preoperatively patients experienced overwhelming prejudice & discrimination Postoperatively reported almost no prejudice or discrimination
Sanchez-Johnson, Fitzgibbon, Martinovich, Stolley, Dyer, & VanHorn, 2004	Examine ethnic women differences in dietary intake, activity, & body image satisfaction	Self-reported questionnaire		271 black 234 Latin-Am	Black women consumed more dietary fat less active higher satisfied w/body image Latin-Am women consumed more carbohydrates & fiber more active less satisfied w/body image
Wadden, Anderson, Foster, Zandbelt, Smets, Oort, Godfried, deHaes, 2004	Examine obese women Compare and explain patients' and MDs' satisfaction	Self-reported questionnaire		259 women330 patients 30 medical MDs	Women reported patient satisfaction higher than MDs determined by self-efficacy in communication and in MD's gender

Table 1 (Continued 4)

Studies

Author	Aim(s)	Study Design/Methodology	Sample	Main Findings
White, O'Neil, Kolotkin, & Byrne, 2004	Examine QOL in obese persons	Self-reported questionnaire	512 men & women	Extreme obesity negatively impacts QOL
Zandbelt, Smets, Oort, Godfried, Hanneke, & deHaes, 2004	Compare patient & MD satisfaction	Self-reported questionnaire	30 MDs 330 patients teaching hospital	Patient satisfaction higher than MDs Satisfaction related to high self-efficacy, female MDs, previous relationship

CHAPTER VI

DISCUSSION AND CONCLUSIONS

The purpose of this critical hermeneutic phenomenological study was to investigate nurses' lived experiences of caring for postoperative bariatric surgical patients. In the literature review I found research that focused on the experiences of being obese, nurses' views of caring for nonsurgical obese patients, and how patients viewed being cared for by health care professionals. However, studies of how nurses viewed caring for obese patients who have had bariatric surgery were missing. This study reports the findings of nurses' conversations regarding their experiences of caring for this unique group of patients.

The initiative for this study came from two sources, patients and nurses. As the bariatric coordinator for an outpatient surgical clinic, I would hear stories from patients about the nursing care they received during their postoperative hospital stay. Some stories were positive while others were not. The nurses who cared for postoperative bariatric patients would tell me about patient issues and problems while I was making hospital rounds. During these conversations some of the language nurses used led me to believe nurses harbored prejudicial attitudes toward these patients. When investigating the literature to establish what issues had been reported regarding caring for obese patients, there was no information about how nurses viewed caring for bariatric surgical patients. It was interesting that other aspects of caring for patients who were obese had been

researched, but investigation of nurses' views of caring for postoperative bariatric patients was an obvious void.

This chapter summarizes this study. Two manuscripts that were products of this research were submitted for publication and are summarized below. The effectiveness of the framework and the accuracy of the assumptions made at the beginning of the study are reported Recommendations are given for nursing practice, nursing education, and nursing research.

Manuscript One: Nurses' Experiences of Caring for Bariatric Patients

This article was submitted to *Bariatric Nursing and Surgical Patient Care*, a peer reviewed journal for nurses and other health care providers interested in the care of bariatric patients. The purpose of this article was to describe the methodology of the study and to report the findings. Analysis of the transcripts using Colaizzi's method revealed two themes of nurses' experiences of caring for bariatric surgical patients. These themes were *getting up for the first time* and *negotiating with families.* Nurses found the greatest challenge of caring for bariatric patients was getting them up for their first ambulation. They reported patients were reluctant to ambulate because of their fear of pain and falling. Nurse participants also viewed families of bariatric patients as sometimes having unrealistic demands and sometimes not being supportive of the patient. Communication issues that involved power dynamics among nurses, patients, and families were found to be an intricate and overwhelming part of caring for this patient group. As a result of this study, I concluded that nurses did not display prejudicial attitudes toward bariatric surgical patients but they do need to educate themselves in how

to care for this patient group in order to avoid injuries to themselves and their patients. I also concluded nurses can improve patient care through awareness of their attitudes toward patients who are obese.

Manuscript Two: The Obese Experience: A Literature Review

The second article was submitted to the peer-reviewed *Surgery for Obesity and Related Diseases* journal. The aim of this article was to give an overview of published research that investigated obese patients' reports of social discrimination and their views of treatment and discrimination within the health care system. The findings illustrated that people who are obese are treated in a discriminatory and negative manner by society, families, and health care providers including nurses. This disrespectful treatment may result in people who are obese to delay seeking health care which can lead to early mortality. Suggestions for nursing practice and research were included. From this review I concluded that nurses offer sensitive care to patients who are obese, but must first understand their own attitudes, educate themselves as to their unique nursing care needs, and advocate for adequate and appropriate equipment for delivering care.

Frameworks

A blend of hermeneutical phenomenology and critical social theory provided a substantial foundation for the philosophical framework of this study. Phenomenology is concerned about the experience of being in the world with the goal of gaining a better understanding of that experience through the gathering and analysis of data from those who have lived the experience. In this study, nurses who cared for postoperative bariatric patients were the population of interest. Critical social theory has a focus of promoting

social change. This theory views language as a method by which one can demonstrate oppression. In this study the lens of critical social theory was used to scrutinize nurses' language during data collection and analysis to establish how or if they their language could be construed to be demeaning or negative. As a result of using hermeneutic phenomenology and critical social theory, participants' experiences, as revealed through their stories, gave meaning and understanding of how they view caring for this group of patients.

Hermeneutics is the investigation, interpretation, and analysis of data while critical social theory explores the language used during the research process in such a way that the researcher becomes one with the data (Leonard, 1994). Integrating hermeneutics with phenomenology and critical social theory allowed me to make sense of the collected data in such a way as to give meaning to nurses' lived experiences of caring for postoperative bariatric patients. Thus, the experiences of nurses who care for postoperative bariatric surgery patients were examined and interpreted to give better insight into how these nurses viewed what they do. In addition, the act of participating in research of this kind allowed nurses to reflect on their experiences which led to some different ways of thinking about this maligned patient group. As a result of reflecting on their research experience nurse participants reported changed views of bariatric surgery patients. During member checking, the nurses told of reflecting on their research experiences and changing bariatric surgery patient care to being more holistic. I, as the researcher, also reflected on what was learned from others and related it to my nursing

role. For example, I am more cognizant of my language and behaviors toward patients who are obese.

Assumptions

At the beginning of the study, I made several assumptions that I discuss in relationship to the study findings. The study findings supported the assumptions that human beings are not always conscious of their own prejudices and their language can reveal prejudices and oppression. A prejudice is a preconceived idea one possesses that is not based on reason or experience (Soanes, 2001). All humans, including nurses, have preconceived ideas regarding some aspect of their lives. It was found in this study that while some nurses seemed to struggle with caring for bariatric surgical patients, in general, their behavior and language did not reveal prejudices. However, it may have been that nurses who participated in the study did not hold preconceived ideas about obesity, while the nurses who did may have not volunteered to be in the study. This study did find a few instances of negative language such as "a blob on the floor" and "couch slugs" interspersed throughout some interviews. As a result of the use of these terms it is concluded that humans do possess prejudices of which they are not always aware that is reflected in the language they use.

The study findings supported the assumption that prejudice can lead to oppressive behavior even when the prejudice is unintentional or unrecognized. Critical social theory has been used in nursing research to identify how oppression can be recognized in patient and nurse groups. Several studies support that oppression often goes unrecognized (Rogge, Greenwald, & Gold, 2004), and that nurses can be both the oppressor and the

oppressed (Fulton, 1997; Giddings, 2005; Roberts, 1983, 2000). The literature espouses the concept that nurses as an oppressed group behave in a subjugated manner which can encourage oppression of others. This can be demonstrated as nurses having power over patients, which can be seen as oppressive behavior toward patients. Part of nurses' power rests in their decision-making regarding nursing care, which they are often unwilling to share with their patients. This was supported in this study by nurses who told of patients who were not willing to ambulate when expected. Oppressive behavior toward patients can be demonstrated as nurses being reluctant and slow to meet obese patient needs in a timely manner such as being slow in responding to their call lights. Additionally, nurses' oppressive behavior can be demonstrated through their unintentional, lack of sensitivity when talking to their patients.

Research participants are the experts in their experiences and therefore what is said by them is assumed to be true. This assumption was supported by the researcher believing what participants said during interviews was what they found to be true for themselves.

The assumption that language reveals prejudices and oppression (Agger, 1998) is demonstrated when language that indicates prejudice was found in the data. The literature has asserted that nurses have negative attitudes toward patients who are obese (Bagley et al., 1989; Culberson & Smolen, 1999). However, although it could be surmised that some nurses held prejudicial attitudes about caring for patients who were obese, this assumption was not readily supported in nurses' stories of their care of bariatric surgery patients.

Limitations of the Study

This study successfully explored nurses' experiences of caring for bariatric surgical patients. Some limits to the study were found. The study was conducted in a state of the art teaching institution with adequate equipment and personnel available to assist in the care of patients who are obese. Such an environment is optimal but not necessarily representational of other institutions. A small, purposive sample in this qualitative study was intentional so rich data could be obtained regarding nurses' experiences but this limits generalizing the findings to other settings. The use of individual interviews might have limited participants' recall that other interview strategies might enhance.

Recommendations

These recommendations are not mutually exclusive, rather they are intended to stimulate readers to reflect on their own areas of expertise and begin reflecting on how they can improve or change their nursing practice. Recommendations for nursing practice, nursing education, and nursing research will be discussed.

Nursing Practice

In order to be effective in all aspects of the care they deliver, nurses need to be skillful in their communication. This study could be used as a springboard for nurses to brainstorm among themselves as to how to improve communication between patients, families, and nurses. Effective verbal and nonverbal communication between patients, families, and nurses might enhance patient satisfaction and lead to a cooperative, team approach that resulted in improved patient care. Power issues in nurses' practice domains need to be recognized and acknowledged by them in order to develop enhancement of

patient care. For example, I recommend nurses begin brainstorming among themselves to develop strategies for motivating patients to participate in self-care such as early ambulation and give them a sense of control. Brainstorming sessions, therefore, need to include ideas from patients. Additionally, knowing their voices were being heard would likely augment nurses' feelings of control within their work environment (Bedini & Henderson, 1995; Hutchinson, Wilson, & Wilson, 1994).

Recommendations for practice include ideas related to discharge planning. In the current environment of health care cost containment, patient hospital stays are as brief as possible. In my NP practice, I begin discharge instructions during the preoperative discussion and give the patient all instructions in a booklet. Hospital nursing staff are informed by me as to the process bariatric patients undergo preoperatively. Pre and postoperative patient education gives patients needed information for positive outcomes while allowing exploration of patients' social settings to enhance patient safety and compliance after discharge. Communication between clinic staff, hospital staff, and patients regarding education allows nurses a sense of control that patients are being well informed while giving patients choices as to how to accomplish their goals of healthy weight loss through surgery. Although the patients in this hospital study all received instructions on postoperative expectations before their surgeries, some patients did not appear motivated to follow those instructions. Continuity of care, an important aspect of positive patient outcomes, could be improved through enhanced communication between the hospital and clinic nursing staff and patients and their support systems. In addition to improved preoperative instructions, I recommend that nurses create ways to accomplish

timely patient tasks through patient and family participation, anticipation of patient needs, and timely patient discharges.

Nursing Education

Nurse educators are trusted to prepare students with accurate and current information while being role models for them. As a result of this study, educators could promote positive, sensitive nursing care by giving students a better understanding of what it is like to care for obese patients. Educators could act as role models for students by projecting a positive attitude toward obese people.

Incorporating the results of this study into the curriculum is another way nurse educators could facilitate student knowledge about the care of obese patients. Although students may learn about such social issues such as prejudice and discrimination in their core curriculum of sociology and psychology, it is up to the nurse educators to apply this information to nursing practice. This study demonstrates that nurses do not necessarily act prejudicially toward obese patients but the literature supports that nurses may hold negative attitudes about caring for these patients (Bagley et al., 1989; Brown et al., 2007; Garner & Nicol, 1998). I recommend educators instruct students about how to project a positive manner when caring for obese patients. Students could also be educated in how to identify others' discriminatory actions so they can perfect their skills as patient advocates. I recommend that curriculum include testing students on their knowledge of the specific needs of obese patients in order to improve patient care. I also recommend that students be instructed on how family dynamics influence patient outcomes.

Educators could also facilitate the process of applying research to practice by having students use the results of this study when caring for obese patients. For instance, nurse educators could have students brainstorm strategies to improve patient care during the process of patient ambulation. Other areas for brainstorming could include a discussion of power issues involving nurses, patients, and families and ways to diminish these conflicts. This discussion might include ways to motivate patients and methods to manage diverse family dynamics for the benefit of patient care. I recommend that all students be taught to be creative in finding solutions to the multiple, complex challenges they will encounter in their profession. I also recommend that nurses in post graduate programs be educated about the complexities of caring for obese patients and their families.

Nursing Research

As a result of this study, further research is needed in several areas. This study included a small group of nurses who cared for patients who were being pro-active in improving their lives. Further studies are needed in other geographical areas with similar nurse groups to determine if findings are similar. Additionally, using focus groups to discuss the same issues of this study might reveal more in-depth information than individual interviews. Other studies are needed to establish if nurses caring for obese patients on medical units such as cardiology, infectious disease, and intensive care units have similar views of caring for patients who are obese using the Nurses' Attitudes Toward Obese Adult Patients developed by Bagley et al. (1989).

This study was conducted in a state of the art institution which had resources many institutions are lacking such as adequate resources to assist in ambulation. Because nurses and patients have been found to have fears of injuries and falling, research conducted in institutions with fewer resources might reach different conclusions than what was found in this study. Additionally, interviewing nurses and the obese patients they care for simultaneously would be of interest to establish if and how perceptions differ. Anecdotal comments made by patients to me in my role as an NP in a bariatric surgery practice during follow-up visits indicate perceptions of nurses and patients might differ.

Although some studies have included how the perception of ones' weight influences attitudes toward obese patients, this subject needs further exploration in the area of nurses caring for postoperative obese patients. The participants in this study sometimes hinted that being obese themselves gave them a better understanding of the struggles their patients' experiences.

There have been some suggestions in the literature that because obese people have experienced discriminatory behavior in society, they expect similar behaviors in other settings such as health care (Brown et al., 2006; Cossrow et al., 2001; Foutaine et al., 1998). For instance, I wonder if obese people perceive negative behaviors during hospitalizations because that is their expectation or do patients report prejudicial behavior of health care workers that actually exists. Research is needed on this subject to better understand patients' views in order to improve their care.

Family dynamics is a complex issue that needs exploration through research as it relates to weight loss surgery. Nurses' stories of family behaviors in this study bring into question what effect family dynamics have on weight loss. Research studies that explore family members' attitudes and understanding of the effect of their behavior on their family member's surgical recovery are needed as are studies of how negative family behaviors can be improved. The literature reports few studies that address the issues of family dynamics and obese people undertaking weight loss surgery. This subject needs more in-depth investigation.

Summary

This chapter began with a review of the study and explained the motivation that prompted the study. Conclusions from data analysis were discussed followed by a discussion of the study frameworks of hermeneutical phenomenology and critical social theory. The study assumptions were then discussed as related to the study. The final section of this chapter gives recommendations for nursing practice, nursing education, and nursing research.

REFERENCES

Agger, B. (1999). *Critical social theories: An introduction.* Boulder, CO: Westview.

Ahmed, S. M., Lemkau, J. P., & Birt, S. L. (2002). Toward sensitive treatment of obese patients. *Family Practice Management, January,* 25-28.

Allison, D. B. & Saunders, S. E. (2000). Obesity in North America: An overview. *Medical Clinics of North America, 84*(2), 305-331.

Anderson, C., Peterson, C. B., Fletcher, L., Mitchell, J. E., Thuras, P., & Crow, S. J. (2001) Weight loss and gender: An examination of physician attitudes.*Obesity Research, 9*(4), 257 -263.

Anderson, D. A., & Wadden, T. A. (2004). Bariatric surgery patients' views of their physicians' weight-related attitudes and practices. *Obesity Research, 12*(10), 587-1595.

Associated Press (2004, October). Americans getting taller, much heavier. Retrieved November 20, 2004, from http://abcnews.go.com/Health.

Bagley, C. R., Conklin, D. N., Isherwood, R. T., Pechulis, D. R., & Watson, L. A. (1989). Attitudes of nurses toward obesity and obese patients. *Perceptual and Motor Skills, 68,* 954.

Baum, C. L. & Ford, W. F. (2002). The wage effects of obesity: A longitudinal study. *Health Economics, 13,* 885-899.

Baxter, J. (2002). Obesity surgery – another unmet need. Retrieved October 14, 2002, from EBSCOhost database.

Bedini, L. A. & Henderson, K. A. (1996). The therapeutic value of the interviewing process in research. *Annual in Therapeutic Recreation, 6*, 55-75.

Bertakis, K. D. & Azari, R. (2005). Obesity and the use of health care services. *Obesity Research, 13*, 372-279.

Boutain, D. M. (1999). Critical nursing scholarship: Exploring critical social theory with African American studies. *Advanced Nursing Science, 21*(4), 37- 47.

Brandsma, L. L. (2005). Physician and patient attitudes toward obesity. *Eating Disorders, 13*, 201-211.

Brown, I. (2006). Nurses' attitudes towards adult patients who are obese: Literature review. *Journal of Advanced Nursing*, 221-232.

Brown, I. Stride, C., Psarou, A., Brewins, L., & Thompson, J. (2007). Management of obesity in primary care: Nurses' practices, beliefs and attitudes. *Journal of Advanced Nursing 59*(4), 329-341.

Brown, I. & Thompson, J. (2007). Primary care nurses' attitudes, beliefs and own body size in relation to obesity management. *Journal of Advanced Nursing 60*(5), 535-543.

Brown, I., Thompson, 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*, 666-672.

Browne, A. J. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research, 32*(2), 35-55.

Cade, J., & O'Connell, S. (1991). Management of weight problem and obesity: Knowledge, attitudes and current practice of general practitioners. *British Journal of General Practice, 41*, 147-150.

Centers for Disease Control and Prevention. (2005). *Chronic disease*. Retrieved May 30, 2005, from http://www.cdc.gov/nccdphp/cdnr/cdnr_winter0503.html

Centers for Disease Control and Prevention. (2004). *Prevalence of overweight and obesity among adults: United States, 1999 – 2002.* Retrieved May 30, 2005, from http://www.cdc.gov/nchs/products/pubs/pubd/hestats/obese/obse99.htm

Chambliss, H. O., Finley, C. E., & Blair, S. N. (2004). Attitudes toward obese individuals among exercise science students. *Medicine and Science in Sports and Exercise,* 468-474.

Conroy, S. A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods, 2*(3), 2-43.

Cossrow, N. H. F., Jeffery, R. W., & McGurie, M. T. (2001). Understanding weight stigmatization: A focus group study. *Journal of Nutrition Education 33*(4), 208-214.

Cranton, P. (1996). Types of Group Learning. In S. Imel (Ed.), *Learning in groups: Exploring fundamental principles, new uses, and emerging opportunities.* San Francisco: Jossey-Bass.

Culbertson, M. J. & Smolen, D. M. (1999). Attitudes of RN students toward obese adult patients. *Journal of Nursing Education, 38*(2), 84-87.

Deitel, M. & Shikora, S. A. (2002). The development of the surgical treatment of morbid obesity. *Journal of the American College of Nutrition, 21*(5), 365-371.

Doherty, C. & Hope, W. (2000). Shared governance – nurses making a difference. *Journal of Nursing Management, 8*, 77-81.

Drake, D., Dutton, K., Engelke, M., McAuliffe, M., & Rose, M. A. (2005). Challenges that nurses face in caring for morbidly obese patients in the acute care setting. *Surgery for Obesity and Related Diseases, 1*(5), 462-466.

Drury, C. A. A. & Louis, M. (2002). Exploring the association between body weight, stigma of obesity, and health care avoidance. *Journal of the American Academy of Nurse Practitioners, 14*(12), 554-561.

Duran, C. R., Oman, K. S., Abel, J. J., Koziel, V. M., & Szymanski, D. (2007). Attitudes toward and beliefs about family presence: A survey of healthcare providers, patients' families, and patients. *American Journal of Critical Care 16*(3), 270-282.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods.* Newbury Park., CA: Sage.

Eggenberger, S. K. & Nelms, T. P. (2007). Being family: The family experience when an adult member is hospitalized with a critical illness. *Journal of Clinical Nursing, 16*, 1618-1628.

Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults (1998).Executive Summary of the Clinical Guidelines on the identification, evaluation, and treatment of overweight and obesity in adults (1998). *Archives of Internal Medicine, 158*, 1855-1867.

Falkner, N. H., French, S. A., Jeffery, R. W., Neumark-Sztainer, D., Sherwood, N. E., & Morton, N. (1999). Mistreatment due to weight: prevalence and sources of perceived mistreatment in women and men. *Obesity Research, 7*(6), 572-576.

Faulkner, K. (2001). Attitudes towards Obesity. Retrieved February 5, 2003, from http://www.hmwsc.edu/psychology/research/psy302/spring96/KevinFaulkner.html

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

Fox, K., & Spence-Jones, G. (2003). Editorial. *Critical Care Nursing Quarterly, 26*(2), 81-82.

Friedman, K. E., Reichmann, S. K., Costanzo, P. R., and Musante, G. J. (2002). Body image partially mediates the relationship between obesity and psychological distress. *Obesity Research 10*(1), 33-40.

Friedman, K. E., Reichmann, S. K., Costanzo, P. R., Zelli, A., Ashmore, J. A., & Musante, G. J. (2005). Weight stigmatization and ideological beliefs: Relation to psychological functioning in obese adults. *Obesity Research, 13*(5), 907-916.

Fulton, Y. (1997). Nurses views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing, 26*, 529-536.

Gallagher, S. M. (1997). Morbid Obesity: a chronic disease with an impact on wounds and related problems. *Ostomy Wound Management, 43*(5), 18-27.

Gallagher, S. M. (1998). Caring for obese patients. *Nursing98, 28*(3), 32hn1-32hn5.

Gallagher, S. M., Arzouman, J., Lacovara, J., Blackett, A., McDonald, P. K., Traver, G., et al. (2004). Criteria-based protocols and the obese patient: Pre-planning care for a high-risk population. *Ostomy Wound Management, 50*(5), 32-42.

Garner, C. M., & Nicol, G. T. (1998). Comparison of male and female nurses' attitudes toward obesity. *Perceptual and Motor Skills, 86*, 1442.

Giddings, L. S. (2005). Health disparities, social injustice, and the culture of nursing. *Nursing Research, 54*(5), 304-312.

Glen, C. V., & Chow, P. (2002). Measurement of attitudes toward obese people among a Canadian sample of men and women. *Psychological Reports, 91*, 627-640.

Green, S. M. & Gillett, A. (1998). Caring for patients with morbid obesity in hospital. *British Journal of Nursing, 7*(13). 785-792.

Greenberg, I., Perna, F., Kaplan, M., & Sullivan, M. A. (2005). Behavioralpsychological factors in the assessment and treatment of obesity surgery patients. *Obesity Research, 13*(2), 244-249.

Grindel, M. E., & Grindel, C. G. (2006). Nursing care of the person having bariatric surgery. *Medsurg Nursing, 15*(3), 129-146.

Grossman, R. J. (2004). Countering a weight crisis. Retrieved March 18, 2004, from http://www.shrm.org/hrmagazine/articles/0604/0604covstory.asp

Hahler, B. (2002). Morbid obesity: A nursing care challenge. *Medsurg Nursing, 11*(2), 85-90.

Harvey, E. L., & Hill, A. J. (2001). Health professionals' views of overweight people and smokers. *International Journal of Obesity, 25*, 1253-1261.

Hebl, M. R., & Xu, J. (2001). Weighing the care: physicians' reactions to the size of a patient. *International Journal of Obesity, 25*, 1246-1252.

Henderson, S. (2003). Power imbalance between nurses and patients: A potential inhibitor of partnership in care. *Journal of Clinical Nursing, 12*(12), 501-508.

Hess, R. G. (2004). From bedside to boardroom- nursing shared governance. *Nursing 2004, 9*(1), 95-107.

Holloway, I., & Wheeler, S. (2002). Phenomenology. In *Qualitative research for nurses* (pp. 170-187). Cambridge, MA: Blackwell Science.

Hoppe, R., & Ogen, J. (1997). Practice nurses' beliefs about obesity and weight related interventions in primary care. *International Journal of Obesity, 21*, 141-146.

Huber, G. L., & Raines, J.W. (2000). Promoting weight loss in the obese patient. *Patient Care, April,* 204 – 218.

Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of participating in research interviews. *IMAGE: Journal of Nursing Scholarship, 26*(2), 161-164.

Ideaworks. (2006) Retrieved October 30, 2005, from www.ideaworks.com

Jamerson, P. A., Scheibmeir, M., Bott, M. J., Crighton, F., Hinton, R., Cobb, A. K. (1996). The experiences of families with a relative in intensive care unit. *Heart & Lung 25*(6), 467-474.

Jeffery, R. W., & French, S. A. (1996). Socioeconomic status and weight control practices among 20- to 45-year-old women. *American Journal of Public Health, 86*(7), 1005-1010.

Kaminsky, J., & Gadaleta, D. (2002). A study of discrimination within the medical community as viewed by obese patients. *Obesity Surgery, 12,* 14-18.

Kettle, J. L. (2004). Factors affecting job satisfaction in the registered nurse. *Journal of Undergraduate Nursing Scholarship, 6*(1). Retrieved September 11, 2005, from http://www.juns.nursing.arizona.edu

Klarenbach, S., Padwal, R., Chuck, A., & Jacobs, P. (2006). Population-based analysis of obesity and workforce participation. *Obesity, 14*(5), 920-927.

Labib, M. (2003. The investigation and management of obesity. *Journal of Clinical Pathology, 56*(1), 17 – 26.

Laferrere, B., Zhu, S., Clarkson, J. R., Yoshioka, M. R. M., Krauskopf, K., Thornton, J. C., et al. (2002). Race, menopause, health-related quality of life, and psychological well-being in obese women. *Obesity Research, 10*(12), 1270-1275.

Latner, J. D., Stunkard, A. J., & Wilson, G. T. (2005). Stigmatized students: Age, sex, and ethnicity effects in the stigmatization of obesity. *Obesity Research, 13*(7), 1226-1231.

Leonard, V. W. (1994) A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), *Interpretive phenomenology* (pp. 43-63). Thousand Oaks, CA: Sage.

Li, Z., Bowerman, S., & Geber, D. (2005). Health ramifications of the obesity epidemic. *The Surgical Clinics of North America, 85*, 681-601.

MacIsaac, D. (1996). The critical theory of Jurgen Habermas. Retrieved December 8, 2003, from http://physicsed.buffalostate.edu/danowne/habcritthy.html

Manias, E., & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry, 7*, 50-60.

Maroney, D., & Golub, G. (1992). Nurses' attitudes toward obese persons and certain ethnic groups. *Perceptual and Motor Skills, 75*, 387-391.

Martin, L. F., Robinson, A., & Moore, B. J. (2000). Socioeconomic issues affecting the treatment of obesity in the new millennium. *Pharmacoeconomics, 18*(4), 335-353.

Melcher, J. (1998). The obese client: Myths, facts, assessment, and intervention. *Journal of Health Social Work, 23*(3), 195 – 202.

Mercer, S. W., & Tessier, S. (2001). A qualitative study of general practitioners' and practice nurses' attitudes to obesity management in primary care. *Health Bulletin, 59*(4), 248-253.

Mill, J. E., Allen, M. N., & Morrow, R. A. (2001). Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research, 33*(2), 109-127.

Murphy, J. I. (2005). How to learn, not what to learn: three strategies that foster lifelong learning in clinical settings. *Annual Review of Nursing Education, 3*, 37-57.

Myers, A., & Rosen, J. C. (1999). Obesity stigmatization and coping: relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity, 23*, 221-230.

National Institutes of Health. (1998). *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults: The evidence report. (NIH Publication* No. 98 – 4083). Washington DC: Author.

National Institutes of Health. (2005). *Institute and center resources*. Retrieved June 18, 2005, from http://health.nih.gov/result.asp/476

National League for Nursing. (2005). *Postion statement: NLN's role in continuing education in nursing.* Retrieved October 8, 2005, from http://www.nln.org/aboutnln/PositionStatements

Office of Surgeon General. (2002). *Overweight and obesity: At a glance*. Retrieved November 7, 2002, from http://www.surgeongeneral.gov

Olson, C. L., Schumaker, H. D., & Yawn, B. P. (1994). Overweight women delay medical care. *Archives of Family Medicine, 3*, 888-892.

Owens, T. M. (2003). Morbid obesity: The disease and comorbidities. *Critical Care Nurse Quarterly, 26*(2), 162-165.

Pain, H., & Wiles, R. (2006). The experience of being disabled and obese. *Disability and Rehabilitation, 28*(19), 1211-1220.

Patton, M. Q. (2002). Variety in qualitative inquiry: Theoretical orientations. *Qualitative Research & Evaluation Methods* (3rd Ed.). Thousand Oaks, CA: Sage.

Paquette, M., & Raine, K. (2004). Sociocultural context of women's body image. *Social Science and Medicine, 59*, 1047-1058.

Price, J. H., Desmond, S. M., Krol, R. A., Synder, F. F., &O'Connell, J. K. (1987). Family practice physicians' beliefs, attitudes and practices regarding obesity. *American Journal of Preventative Medicine, 3*(6), 339-345.

Puhl, R. M., & Bownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research, 9*(12), 788-805.

Rand, C. S. W. & MacGregor, A. M. C. (1990). Morbidly obese patients' perceptions of social discrimination before and after surgery for obesity. *Southern Medical Journal, 83*(12), 1390-1395.

Roberts, S. J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science, 5*(4), 21-30.

Roberts, S. J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science, 22*(4), 71-82.

Roberts, S. J. (2005). Empowerment of nursing leaders: Lessons from oppressed groups. Retrieved September 11, 2005, from http://www.nsweb.nursingspectrum.com

Rogge, M. M., Greenwald, M., & Golden, A. (2004). Obesity, stigma, and civilized oppression. *Advances in Nursing Science, 27*(4), 301-315.

Sanchez-Johnsen, L. A. P., Fitzgibbon, M. L., Martinovich, Z., Stolley, M. R., Dyer, A. R., & Van Horn, L. (2004). Ethnic differences in correlates of obesity between Latin-American and black women. *Obesity Research 12*(4), 652-660.

Sanders, C. (2003). Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse, 14*(3), 292-302.

Schultz, S. (1999). Why we're fat [Electronic version]. *U.S. News & World Report, 127*(18), 82-85.

Schwartz, M. B., Chambliss, H. O., Brownell, K. D., Blair, S. N. & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research, 11*(9), 1033-1039.

Short, J. (2004). Obesity – a public health dilemma. *AORN Journal, 80*(6), 1069-1078.

Soderstrom, I. M., Benzein, E. & Saveman, B. I. (2003). Nurses' experiences of interactions with family members in intensive care units. *Scandinavian Journal of Caring Science, 17*, 185-192.

Spiegelberg, H. (1982). The phenomenological movement: A historical introduction (3rd ed.) The Hague, The Netherlands: Martinus Nijhoff.

Sugerman, H. J., & DeMaria, E. J. (2001). Gastric surgery for morbid obesity. In R. J. Baker & J. E. Fischer (Eds.) *Mastery of surgery: Vol. 1* (pp.1026-1036). Philadelphia: Lippincott Williams & Wilkins.

The International Code of Ethics for Nurses. (2005). Retrieved April 12, 2008, from http://www.icn.ch/ethics.htm

Todres, I. & Wheeler, S. (2001). The complementarity of phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research. *International Journal of Nursing Studies, 38*(1), 1-8.

Vieira, E. R. (2007). Why do nurses have a high incidence of low back disorders, and what can be done to reduce their risk? *Bariatric Nursing and Surgical Patient Care, 2*(2), 141-147.

Virji, A., & Murr, M. M. (2006). Caring for patients after bariatric surgery. *American Family Physician, 73,* 1403-1408.

Wadden, T. A., Anderson, D. A., Foster, G. D., Bennett, A, Steinberg, C., & Sarwer. D. B. (2000). Obese women's perceptions of their physicians' weight management attitudes and practices. *Archives of Family Medicine, 9,* 854-860.

Wechsler, J. G., & Leopold, K. (2003). Medical management of obesity. *Langenbeck's Archives of Surgery, 388*(6), 369-374.

Wee, C. C., Phillips, R. S., Cook, E. F., Haas, J. S., Puopolo, A. L., Brennan, T. A., et al. (2002). Influence of body weight on patients' satisfaction with ambulatory care. *Journal of General Internal Medicine, 17,* 155-159.

White, M. A., O'Neil, P. M., Kolotkin, R. L., & Byrne, T. K. (2004). Gender, race, and obesity-related quality of life at extreme levels of obesity. *Obesity Research, 12*(6), 949-955.

Wiklund, L., Lindholm, L., & Lindstrom, U. A. (2002). Hermeneutics and narration: A way to deal with qualitative data. *Nursing Inquiry, 9*(2), 114-125.

Wilson-Thomas, L. (1995). Applying critical social theory in nursing education to bridge the gap between theory, research and practice. *Journal of Advanced Nursing, 21,* 568-575.

Wright, J. (1998). Female nurses' perceptions of acceptable female body size: An exploratory study. *Journal of Clinical Nursing, 7*(4), 307-315.

Zandbelt, L. C., Smets, E., Oort, F. J., Godfried, M. H., deHaes, H. C. J. M. (2004). Satisfaction with the outpatient encounter: A comparison of patients' and physicians' views. *Journal of General Internal Medicine, 19*, 1088-1095.

Zhang, Q., & Wang, Y. (2004). Trends in the association between obesity and socioeconomic status in U.S. adults: 1971 to 2000. *Obesity Research, 12*(10), 1622-1632.

Zuzelo, P. R., & Seminara, P. (2006). Influence of registered nurses' attitudes toward bariatric patients on educational programming effectiveness. *Journal of Continuing Education in Nursing, 37*(2), 65-73.

APPENDIX A

Interview Guide

Grand Tour Opening Statement:

Tell me a story, if you will, that you will never forget about taking care of a postoperative bariatric patient.

Probing Questions:

1. Would you please elaborate on what you just said?
2. Tell me more about that incident.
3. Is caring for bariatric surgical patients different from caring for other surgical patients? If so, how is it different?
4. What do you like about caring for bariatric surgical patients?
5. What do you not like about caring for bariatric surgical patients?

APPENDIX B

Recruitment Flyer

NEEDED

Registered Nurses who are
Interested in sharing their experiences
of
caring for Postoperative obese patients
for a research study

All information kept confidential

Contact person for more information:
Paulette Whitfield, RN, ANP
Beeper: 1183

APPENDIX C

Demographic Questionnaire

Demographic Questionnaire

Code Name:_____

Age:				
	_____	20-25	_____	26-30
	_____	31-35	_____	36-40
	_____	41-45	_____	46-50
	_____	51-55	_____	56-60
	_____	61-65	_____	66+

Basic Nursing Education/Year of completion (circle correct one):
Associate Degree in Nursing/_____
Bachelor's Degree in Nursing/_____
Master's Degree in Nursing/_____
Other_____

Highest Degree Held/Year of Completion
Diploma_____
Associate Degree in Nursing/_____
Bachelor's Degree in Nursing/_____
Master's Degree in Nursing/_____
Other_____

What shifts do you usually work?

7-3
3-11
11-7
7am – 7 pm
7 pm – 7 am
Weekends only
Other_____

How many bariatric surgical patients have you taken care of (circle answer)

1. 1-5
2. 6-10
3. 11+

What is your perception of **your** body habitus?

1. underweight
2. normal weight
3. overweight
4. obese

APPENDIX D

Scott & White Institutional Review Board Approvals

SCOTT & WHITE

April 17, 2003

Paulette J. Whitfield, RN

PROJECT ID#: 8408

TITLE: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The above referenced study has been **approved by expedited review** procedures of the Institutional Review Board (full IRB review not required under 45 CFR 46.110b(1) category 7). The approved consent form dated April 15,2003 and HIPAA addendum are attached. The approved period starts on April 17, 2003 and ends on April 16, 2004. In order to maintain your project's approved status a progress report should be submitted by **February 27, 2004** to ensure IRB review of your project prior to the end date. You are ultimately responsible for ensuring IRB approval is obtained for the continuation of your project.

Appropriate to the degree of risk, the IRB has also determined this project will be subject to annual review. Changes in the research, during the period approved, may not be initiated without IRB review and approval except where necessary to eliminate apparent immediate hazards to the human subjects. Such urgent changes must be reported to the IRB within five (5) working days. The IRB or its designate may, at any time, observe the consent process and the research to verify no material changes have occurred since review. Any serious or continuing non-compliance by investigators may be reported to the appropriate institutional officials, the Food and Drug Administration and the Office of Human Research Protections.

Unexpected adverse outcomes must be reported to the IRB within five (5) working days of each occurrence. The IRB retains the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects.

Respectfully,

Thomas J. Wincek, M.D., Ph.D.
Chairman, Institutional Review Board

TJW/maf

cc: Grants Administration Office

"Things Are Different Here"

SCOTT & WHITE MEMORIAL HOSPITAL AND SCOTT, SHERWOOD AND BRINDLEY FOUNDATION

INSTITUTIONAL REVIEW BOARD

2401 South 31st St Temple, Texas 76508 254-724-7773

Internet Home Page: http://www.sw.org

SCOTT & WHITE

August 24, 2004

Paulette Whitfield, RN

PROJECT ID#: 8408

TITLE: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The above referenced protocol interim progress report dated February 2, 2004 has been **accepted** by the Institutional Review Board. Please be reminded the Privacy Office has determined you will be unable to use any data on the one subject for which you cannot provide a signed privacy authorization. A copy of the approved consent form dated April 15, 2003 is attached. Appropriate to the degree of risk, the IRB has also determined this project will be subject to annual review. This letter was inadvertently not sent upon resolution on May 6, 2004 of the deferral from March 12, 2004, and the new approved period is **May 6, 2004** to **March 11, 2005.** A progress report should be submitted by **January 28, 2005** to ensure IRB review of your project prior to the end date. You are ultimately responsible for ensuring IRB approval is obtained for the continuation of your project.

Changes in the research, during the period approved, may not be initiated without IRB review and approval except where necessary to eliminate apparent immediate hazards to the human subjects. Such urgent changes must be reported to the IRB within five (5) working days. The IRB or its designate may, at any time, observe the consent process and the research to verify no material changes have occurred since review. Any serious or continuing non-compliance by investigators may be reported to the appropriate institutional officials; the Food and Drug Administration and the Office for Human Research Protections.

Unexpected adverse outcomes must be reported to the IRB within five (5) working days of each occurrence. The IRB retains the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects.

Thank you for submitting this report.

Respectfully,

Stephanie Worley

Stephanie Worley, CIM, CIP
Administrator, Institutional Review Board
Authorized Institutional Review Board Representative

cc: Grants Administration Office

SCOTT & WHITE

May 3, 2005

Paulette Whitfield, RN, ANP

PROJECT ID#: 8408

TITLE: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The completed progress report dated January 21, 2005 for the above referenced study has been **approved by expedited review** procedures of the Institutional Review Board (full IRB review not required under 45 CFR 46.110(b)(1) category (7). The new approved period is May 3, 2005 to May 2, 2006. A progress report should be submitted by **February 24, 2006** to ensure IRB review of your project prior to the end date. You are ultimately responsible for ensuring IRB approval is obtained for the continuation of your project.

Respectfully,

Stephanie Worley

Stephanie Worley, CIM, CIP
Administrator, Institutional Review Board
Authorized Institutional Review Board Representative

cc: Grants Administration Office

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SCOTT & WHITE MEMORIAL HOSPITAL AND SCOTT, SHERWOOD AND BRINDLEY FOUNDATION

INSTITUTIONAL REVIEW BOARD

2401 South 31st St. Temple, Texas 76508 254-724-7773

Internet Home Page: http://www.sw.org

SCOTT & WHITE

March 21, 2006

Paulette Whitfield, RN, MSN

PROJECT ID#: 8408

TITLE: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The interim progress report dated February 1, 2006 for the above referenced study has been **approved by expedited review** procedures of the Institutional Review Board [full IRB review not required under 45 CFR 46.110b(1) category (7)]. A copy of the approved revised consent form dated March 20, 2006 is attached. Appropriate to the degree of risk, the IRB has also determined this project will be subject to annual review. The new approved period is **March 21, 2006** to **February 9, 2007.** A progress report should be submitted by **December 29, 2006** to ensure IRB review of your project prior to the end date. You are ultimately responsible for ensuring IRB approval is obtained for the continuation of your project.

Changes in the research, during the period approved, may not be initiated without IRB review and approval except where necessary to eliminate apparent immediate hazards to the human subjects. Such urgent changes must be reported to the IRB within five (5) working days. The IRB or its designate may, at any time, observe the consent process and the research to verify no material changes have occurred since review. Any serious or continuing non-compliance by investigators may be reported to the appropriate institutional officials, the Food and Drug Administration and the Office for Human Research Protections.

Unexpected adverse outcomes must be reported to the IRB within five (5) working days of each occurrence. The IRB retains the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects.

Respectfully,

Stephanie Worley

Stephanie Worley, CIM, CIP
Administrator, Institutional Review Board
Authorized Institutional Review Board Representative

SW/mr

cc: Grants Administration Office

"Things Are Different Here"

SCOTT & WHITE MEMORIAL HOSPITAL AND SCOTT, SHERWOOD AND BRINDLEY FOUNDATION

INSTITUTIONAL REVIEW BOARD

2401 South 31st St. Temple, Texas 76508 254-724-7773

Internet Home Page: http://www.sw.org

SCOTT & WHITE

November 14, 2006

Paulette Whitfield, RN

PROJECT ID#: 8408

TITLE: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The interim progress report dated November 9, 2006 for the above referenced study has been **approved by expedited review** procedures of the Institutional Review Board [full IRB review not required under 45 CFR 46.110b(1) category 7]. There were no revision requests for the previously approved consent form dated March 20, 2006. Appropriate to the degree of risk, the IRB has also determined this project will be subject to annual review. The new approved period is **November 14, 2006** to **November 13, 2007.** A progress report should be submitted by **September 28, 2007** to ensure IRB review of your project prior to the end date. You are ultimately responsible for ensuring IRB approval is obtained for the continuation of your project.

Changes in the research, during the period approved, may not be initiated without IRB review and approval except where necessary to eliminate apparent immediate hazards to the human subjects. Such urgent changes must be reported to the IRB within five (5) working days. The IRB or its designate may, at any time, observe the consent process and the research to verify no material changes have occurred since review. Any serious or continuing non-compliance by investigators may be reported to the appropriate institutional officials, the Food and Drug Administration and the Office for Human Research Protections.

Unexpected adverse outcomes must be reported to the IRB within five (5) working days of each occurrence. The IRB retains the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects.

Respectfully,

Stephanie Worley

Stephanie Worley, CIM, CIP
Administrator, Institutional Review Board
Authorized Institutional Review Board Representative

SW/mr

"Things Are Different Here"

SCOTT & WHITE MEMORIAL HOSPITAL AND SCOTT, SHERWOOD AND BRINDLEY FOUNDATION

INSTITUTIONAL REVIEW BOARD

2401 South 31st St. Temple, Texas 76508 254-724-7773

Internet Home Page: http://www.sw.org

SCOTT & WHITE

November 2, 2007

Paulette Whitfield, RN, ANP

PROJECT ID#: 8408

TITLE: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The interim progress report dated September 17, 2007 for the above referenced study has been **approved by expedited review** procedures of the Institutional Review Board [full IRB review not required under 45 CFR 46.110b(1) category 7]. There were no suggestions for change to the currently approved consent form dated May 2, 2007. Appropriate to the degree of risk, the IRB has also determined this project will be subject to annual review. The new approved period is **November 2, 2007** to **November 1, 2008.** A progress report should be submitted by **September 26, 2008** to ensure IRB review of your project prior to the end date. You are ultimately responsible for ensuring IRB approval is obtained for the continuation of your project.

Changes in the research, during the period approved, may not be initiated without IRB review and approval except where necessary to eliminate apparent immediate hazards to the human subjects. Such urgent changes must be reported to the IRB within five (5) working days. The IRB or its designate may, at any time, observe the consent process and the research to verify no material changes have occurred since review. Any serious or continuing non-compliance by investigators may be reported to the appropriate institutional officials, the Food and Drug Administration and the Office for Human Research Protections.

Unexpected adverse outcomes must be reported to the IRB within five (5) working days of each occurrence. The IRB retains the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects.

Respectfully,

Stephanie Worley

Stephanie Worley, CIP
Administrator, Institutional Review Board
Authorized Institutional Review Board Representative

APPENDIX E

Texas Woman's University Institutional Review Board Approval

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378 Fax 940-898-3416
e-mail: IRB@twu.edu

April 29, 2003

Ms. Paulette Whitfield
4806 Windbell Dr.
Belton, TX 76513

Social Security # 444-50-9687

Dear Ms. Whitfield:

Re: The Lived Experience of Nurses Caring for Bariatric Surgical Patients

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and has been determined to be exempt from further review because it has been reviewed and approved by an IRB at Scott and White Memorial Hospital and all the subjects will be recruited from this institution.

Another review by the IRB is required if your project changes in any way. If you have any questions, feel free to call the TWU Institutional Review Board at the phone number listed above.

Sincerely,

Dr. Linda Rubin, Chair
Institutional Review Board - Denton

cc. Dr. Carolyn Gunning, College of Nursing
Dr. Tommie Nelms, College of Nursing
Graduate School

Simply the **BEST**

APPENDIX F

Consent Form

CONSENT FORM
AND
INFORMATION ABOUT
The Lived Experience of Nurses Caring for Bariatric Surgical Patients

SCOTT & WHITE CLINIC
SCOTT AND WHITE MEMORIAL HOSPITAL AND
SCOTT, SHERWOOD AND BRINDLEY FOUNDATION
TEMPLE, TEXAS 76508

You are being offered an opportunity to participate in a research study that is supported by SCOTT AND WHITE MEMORIAL HOSPITAL AND SCOTT, SHERWOOD AND BRINDLEY FOUNDATION to evaluate the experiences of nurses who care for postoperative Bariatric surgery patients. Before you agree to volunteer to take part in this research study, it is very important that you understand the purpose of the study and the nature of the tests and procedures you will be asked to undergo.

Purpose and Background
The purpose of this research study is to document and preserve personal accounts of the experiences of nurses who care for postoperative Bariatric surgery patients.

You will be one of approximately 12 subjects in this research study.

Procedures
The investigator will conduct interviews with nurses who currently care for patients who have undergone surgery for weight loss. Face-to-face audiotaped interviews will be conducted at a time and place that are convenient for you.

Length of Study and Number of Visits
It is estimated that participation will involve a maximum of time commitment of two (2) hours and twenty (20) minutes which includes one to two hours for an interview and 20 minutes for follow-up at a later date.

Exclusions
You should not participate in this study if any of the following apply to you:

If you are not a Registered Nurse.

Initialed by Subject _____

Discomfort and Risks
A potential risk of participation is loss of confidentiality. The investigator will attempt to prevent this risk by keeping any identifying information about you in a sealed envelope in a locked file cabinet. Any personal information will be removed from audiotapes and transcripts. Risk of embarrassment is another potential risk of participation. Participation in the study is voluntary. Any private or embarrassing information can be withheld during the interview and the interview can be terminated at any time. There is a possibility that you may not want to be audiotaped. If this is the case, the researcher will take notes during the interview rather than audiotaping. Any identifiable documents or computer discs associated with the study will be destroyed by May 1, 2008.
It is anticipated that the results of the study will be published in the investigator's dissertation as well as in other publications. No names or other identifying information about you will be included in any publications.

Benefits
The only direct benefit of your participation will be a summary of the results at the completion of the study if you desire. These will be mailed to you upon request (see below). An indirect benefit to you will be the opportunity to share your experiences of caring for Bariatric surgical patients.

Alternative Therapies
You have the alternative of not participating in this study.

Confidentiality
Your participation in this research study will be kept confidential in accordance with applicable law. However during the study, representatives from Texas Woman's University as well as Scott and White employees who are involved in this study may have access to records related to this study. Also, the Institutional Review Board (IRB = a group of people who strive to protect the rights of subjects) and representatives of the Food and Drug Administration (FDA) may have access to records which relate to this study. You will not be identified in any publication or presentation of findings resulting from the study.

Cost and Compensation
There are no costs to you for participation in this study.

Compensation or Medical Treatments for Research-Related Adverse Events
In the event of injury or illness resulting from this research procedure, medical care will be available to you. There will be no financial compensation or free medical treatment offered by Scott and White Clinic or Scott and White Memorial Hospital, and Scott, Sherwood and Brindley Foundation.

Initialed by Subject_____

Whom to Contact for Questions or Emergencies
If you have additional questions during the course of this study about your rights as a research subject, you may address them to the Scott and White IRB at (254) 724-4072 or Texas Woman's University Office of Research and Grants at (940) 898-3375 or via email at IRB@twu.edu. If you have questions about the research or in the case of injury or illness resulting from the research, please contact Paultee Whitfield, RN, MSN (investigator) at 724-2628 or her advisor Dr. Jane Grassley at (940) 898-2433. You will be given a copy of this signed and dated consent form to keep.

Participation
Participation in this study is voluntary and refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You are advised to refuse to answer any particular question that you may find embarrassing or offensive.

Right to Withdraw
You may withdraw from participation in the study at any time without penalty or loss of benefits.

New Findings
Any new findings developed during the course of your participation in the study, which may be related to your willingness to participate, will be provided to you.

Patient's Satement
The research study has been explained to me. I have had an opportunity to read the consent form. My questions have been answered, and I understand the statement in this informed consent document. I understand that I am free to ask questions and to leave the study at any time without affecting my medical care. A copy of this compledted consent form will be given to me. I understand that the sponsor or my doctor may withdraw me from the study without my consent. I freely agree to take part in this study.

_____	_____	_____
Name of Subject (please print)	Signature of Subject	Date

Initialed by Subject _____

Investigator/Designee Statement

I have carefully explained to the subject the nature of the study. I hereby certify that to the best of my knowledge the subject signing this consent form understands clearly the nature, demands, risks and benefits involved in participating in this study. A medical problem or language or educational barrier has not prevented a clear understanding of the subject's involvement in this study.

Name of Investigator Or Designee (please print)	Signature of Investigator or Designee	Date

4/07

Initialed by Subject _____

APPENDIX G

Bariatric Nursing and Surgical Patient Care Submission Letter

Dated April 12, 2008

Sent by email

Hello Paulette,

Thank you for your submission. I will send this out for peer review and get back to you with the reviewer comments.

With appreciation....

Lois Gould
Manager, Continuing Education
The Institute for Johns Hopkins Nursing
525 North Wolfe Street, Room 532
Baltimore, MD 21205
(P) 410.614.1978 / (F) 410.614.8972
www.ijhn.jhmi.edu

APPENDIX H

Surgery for Obesity and Related Diseases Submission Letter

>>> SOARD <soard@elsevier.com> 4/30/2008 11:34 AM >>>
Title: The obese experience: a review of the literature Corresponding Author: RN, CBN Paulette Whitfield
Authors: Paulette Whitfield, MSN

Dear RN, CBN Whitfield,

This is to confirm that the above-mentioned manuscript has been received for consideration in Surgery for Obesity and Related Diseases.

You will be able to check on the progress of your manuscript by logging on to the Elsevier Editorial System for Surgery for Obesity and Related Diseases as an author:
http://ees.elsevier.com/soard/
Your username is:
Your password is:

Your paper will be given a manuscript number shortly and you will soon receive an e-mail with this number for your reference.

Thank you for submitting your manuscript to Surgery for Obesity and Related Diseases. Should you have any questions, please feel free to contact our office.

Kind regards,

Harvey Sugerman
Editor-in-Chief
Surgery for Obesity and Related Diseases