EXPLORING HEALTH PROMOTION THEORY AND NURSING PRACTICE

AUTHOR Stewart Piper, PhD, MSc (HlthEd), PGDE, RGN, is senior lecturer, Homerton School of Health Studies, Anglia Ruskin University, Peterborough.

ABSTRACT Piper, S. (2007) Exploring health promotion theory and nursing practice. Nursing Times; 103: 6, 34–35. This study explored the relationship between hospital nursing and health promotion theory with the aim of developing a conceptual framework for practice. Qualitative data was collected from 32 nurses in an acute hospital. While health promotion was mostly top-down and concerned with information-giving and behaviour change, it also included empowerment and atypical examples of nursing health promotion. A revised health promotion framework was generated for consideration as a tool for clinically focused health promotion. This is a summary: the full paper and reference list can be accessed at nursingtimes.net.

This study was designed to develop a framework to guide nursing practice. The goal was to gain insight into the meaning hospital nurses gave to health education and health promotion and to discover how the findings fit with theory.

METHODS
The study sample comprised 32 nurses from a range of clinical areas in an acute NHS hospital. Data collection was by individual and focus group interviews and the critical incident technique (CIT).

The interview guide was based on a framework of quality indicators (Totten, 1992) that focus on the process and outcomes of health promotion. Participants were asked to:

- Define health education/promotion;
- Give examples from their nursing practice;
- Describe the reasons, motives for and method(s) of intervention;
- Describe the outcomes of practice;
- Describe theory that informs health education and health promotion in nursing.

The CIT used Benner’s (1984) qualitative questionnaire together with interviews to learn more about unique aspects of practice suggested by eight deviant/paradigm case participants during the fieldwork.

DATA ANALYSIS
Interviews were tape-recorded, transcribed, manually coded and analysed to identify:

- Units of general meaning;
- Units of relevant meaning and any redundant data;
- Grouping the units of general meaning;
- Determining themes from the clusters;
- Contextualising the data in relation to Beattie’s (1991) framework.

The process was supplemented by use of computer-assisted qualitative data software (QSR NUD*IST Vivo) to facilitate analysis.

RESULTS
The nurse as informer, behaviour change and empowerment
The theme of the nurse as informer was the central feature of practice. It represented information given by nurses to patients to increase their knowledge and understanding of disease, diagnosis, prognosis and treatment, and assist with decision-making. It underpinned the two sub-themes of behaviour change and empowerment.

Behaviour change aimed to achieve behavioural outcomes based on nursing assessment of patients’ needs and problems. Success was measured by patients’ degree of compliance and self-management. This was achieved through teaching and raising awareness and was based on the assumption that patients were free to choose their health/disease-related behaviour and lifestyle. The tone of this theme is unmistakably paternalistic. For example, nurses described getting patients to:

- Monica: ‘Change their fixed views’;
- Gemma: ‘Take their tablets correctly’;
- Val: ‘Do things our way’.

Empowerment ranged from giving patients information and helping them to understand, cope with and take control of their disease to psychological support, rapport-building, reassurance, empathy and promoting self-esteem. This included facilitating informed choice, developing a more genuine nurse-patient partnership and configuring services around patients. In some cases it included promoting participation in service-user groups and advocacy. Nurses used the following descriptions:

- Louise: ‘People need to be given information to be able to make choices’;
Anne: ‘You have got to let them make the decisions for themselves, you can’t do it for them’.

Gemma: ‘Patients’ autonomy, they keep control of their illness if you like, their routine, you are not taking anything away from them’.

Deviant/paradigm cases

The most surprising findings were the deviant/paradigm cases that emerged from descriptions of atypical intervention. One nurse suggested the title of strategic practice when discussing working at a multidisciplinary and multiagency level. For example, intervention involved: Tracey: ‘Feeding back [to industry about patterns of morbidity]’;

Steve: ‘Working with other agencies’;

Adrian: ‘[Contacting] the local council [in response to an environmental hazard]’.

It also included admission avoidance and involved practitioners from various departments and agencies working together to develop short-term support for those unable to live independently.

Advocacy was not about advocating for patients’ individual needs, helping them with decision-making, fighting on their behalf for therapeutic interventions or resisting the pressure of health professionals for a particular course of action. Brenda suggested it was about ‘representing a patient group… promoting their needs’ and collective empowerment via indirect intervention. Brenda raised the profile, lobbied and advocated on behalf of a disempowered patient population.

DISCUSSION

The individual action perspective and the one-to-one interpersonal intervention aligns behaviour change and empowerment with Beattie’s (1991) models of health persuasion techniques and personal counselling for health. These are concerned with individuals’ health-related knowledge, attitudes, behaviours and skills, and suggest they are key determinants of health status.

However, in operating from different positions on the power continuum, they invoke different aims, methods and outcomes and thus indicators of success. Both behaviour change and health persuasion techniques are top-down and authoritarian. They highlight the relationship between disease, risk factors and lifestyle, emphasise control of lifestyle and highlight the risks of failing to follow advice.

For some, empowerment represented a more patient-centred, holistic and ‘bottom-up’ model but this was still in relation to disease management and helping patients to adapt to changes in health. Where choice was facilitated, this was within available resources. But it overlapped with personal counselling for health, as both involved negotiated, ‘client-centred’ approaches. The focus is on personal control and client choice. Both are ‘participative’ and include the role of practitioner as ‘advocate’ (Beattie, 1991).

The strength of the relationship between the deviant/paradigm cases and the models in Beattie’s framework was less convincing. But when strategic practice and advocacy were compared with Beattie’s legislative action for health and community development for health respectively, it enabled practice to be conceptualised from a macro and micro level. Strategic practice concerns issues at a hospital and departmental level, while legislative action for health represents intervention on legislative, environmental and public health issues, so the partial conceptual fit between these was evident. Advocacy focuses on intervention on an institutional scale, while community development for health represents intervention in the community. However, both reflect interventions that are client-centred and concerned with a form of micro population empowerment.

Both also place the practitioner in the role of advocate and thus also fit at a pragmatic and, in part, a conceptual and philosophical level. The fit between the findings and Beattie’s work are not absolute but are enough to suggest moving towards a modified framework.

IMPLICATIONS FOR PRACTICE

| While the fit between the study findings and Beattie’s (1991) work is not absolute, the links are strong enough to suggest a modified framework for contextualising nursing health promotion practice. |

| Reconfiguring Beattie’s framework enables it to be considered as derived theory where theory from one field of inquiry is modified and synthesised and concepts are redefined and restated so that they fit with, and are meaningful to, the new field of interest. |

| Following this it is possible to advance tentatively a revised framework as a template to help nurses identify, chart and plan clinically focused interventions and strategic, organisational processes that are patient led. |

| This is achieved by articulating clearly the knowledge and power base of the three models of practice identified in the framework in relation to individual and macro/micro patient population interventions. |

REFERENCES


