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Nymberg, Peter; Drevenhorn, Eva

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PO Box 117  
221 00 Lund  
+46 46-222 00 00

# **Patients' experience of a nurse-led lifestyle clinic at a Swedish health centre**

## **Authors**

Peter Nymberg, MSc, RN, Health Centre Husensjö, Helsingborg, Sweden.

Eva Drevenhorn, PhD, RN, Faculty of Medicine, Department of Health Sciences, University of Lund, Sweden

## **Corresponding author**

Peter Nymberg

Vårdcentralen Husensjö

Skaragatan 102

SE-253 63 Helsingborg

Sweden

Telephone: +46 42 4060500

e-mail: peter.nymberg@skane.se

## ABSTRACT

### **Aim**

The purpose of the study was to explore patients' experiences of visiting a nurse-led lifestyle clinic.

### **Background**

In Sweden 56% of the population aged 16-84 have an unhealthy lifestyle. The primary health care (PHC) has been instructed to offer citizens health promotion and disease-preventive actions. Very few studies have been conducted about how individuals experience interventions from the PHC intended to help them to change lifestyle.

### **Methods**

Patients (n=137), who participated in a screening test at a lifestyle clinic were invited to focus group interviews. Of these, 14 patients agreed to participate. The data were analysed using content analysis.

### **Results**

The patients felt that the visit to the lifestyle clinic gave insight into their habits and diminished their fear of not being healthy. Primary health care was seen as a safe provider in this matter. Disappointment was occasioned by the unfulfilled expectations of blood tests, lack of follow-up visit and inconsistencies of approach during the visit to the lifestyle clinic. Personal chemistry was perceived to be crucial for how the encounter with the public health nurse evolved.

### **Conclusion**

Lifestyle clinics can give patients opportunity to change lifestyle and also to confirm the good habits. It may also be important to have follow-up visits to give the patients' support when changing lifestyle. Nurses counselling patients about lifestyle changes need to have recurrent training in Motivational Interviewing.

### **Key words**

Lifestyle, Prevention, Counselling, Patients' experience, Nurse-led clinic, Public health nurse, Primary health care, Focus groups, Content analysis.

## INTRODUCTION

According to the Swedish National Institute of Public Health (1), 56 per cent of the Swedish population aged 16-84 years have unhealthy habits such as a low intake of fruits and vegetables, a sedentary lifestyle, daily tobacco use, a high alcohol intake, risky gambling behaviour and use of cannabis. Obesity was reported in 14 percent of the Swedish population. The primary health care (PHC) in Sweden has been designated the assignment (2) of preventing illness from different perspectives; both from the perspective of helping the individual to remain healthy, and from a purely economic perspective. The guidelines regarding the financial compensation system state that PHC should be active in providing citizens with health promotion and disease prevention. The guidelines include both primary prevention, with health counselling for healthy groups and groups at risk, and secondary prevention for those already diagnosed with an illness. Primary health nurses (PHN) in Sweden have a special academic education (3) to work with health promotion in a holistic manner including a psychosocial approach.

During the past few years a number of intervention studies have been carried out with the aim of investigating how a changed lifestyle affects the incidence of chronic disease. Most of the studies have shown improvements regarding a lower incidence of diabetes (4,5,6), hypertension (7,8,9,10) and obesity (11,12,13). The studies have shown that patients can get healthier in the experimental setting, but have not examined the patients' views of how to discuss their health problems. Duaso and Cheung (14) investigated patients' recall and perception of lifestyle counselling given by registered nurses in a general practice. The study showed that it is important for PHC to work with lifestyle issues because a number of health risks can be detected and patients can receive guidance to a healthier life. Poskiparta, Kasila and Kiuru (15) argue that it is necessary to have methods that facilitate the discussion of changes of health behaviour with patients and to be able to do this successfully, communication training is required for the staff involved. This was exemplified in a study (16) with patients treated in a patient-centred way by trained nurses at nurse-led hypertension clinics in primary health care. In telephone interviews the patients expressed, more satisfaction with the counselling than patients in the control group did. These studies show that working with lifestyle changes with patients at risk of diseases is important, and this work should be performed from a patient-centered perspective to be successful.

Persson and Friberg conducted a study (17), which aimed to illuminate patients' experiences of health conversations, and found that the patients preferred a patient-centered approach and wanted to be seen as individuals. The way in which the health conversation influenced the patients depended heavily on the patients' previous experiences which Kärner et.al (18) likewise pointed out when investigating how patients' experienced constraining and facilitating factors related to their lifestyle changes. Hardly any studies, however, have focused on patients' experiences of visiting a lifestyle clinic to discuss their health. Therefore this study was conducted with the aim of contributing with further knowledge about patients' views of being counselled about lifestyle factors at a lifestyle clinic.

## AIM

The purpose was to explore patients' experiences of visiting a nurse-led lifestyle clinic.

## METHODS

### Context

At the beginning of 2010 a lifestyle clinic was started at a PHC centre in a prosperous neighbourhood in the south of Sweden to meet the accreditation requirements for an active health promotion. This service was free of charge for the PHC centre patients. The purpose of the lifestyle clinic was to find individuals who were at risk of obesity, hypertension, diabetes, chronic obstructive pulmonary disease (COPD) or mental illness and to prevent illness and promote health among these patients. Visits were offered to patients who were 40, 50 or 60 years of age who did not have a diagnosis of chronic disease. There were also opportunities for other patients to make an appointment and some patients were recommended to visit the lifestyle clinic by the staff of the PHC centre. All questionnaires were developed by PNCs, physicians and a welfare officer at the PHC centre and were tested step by step.

During the visit to the lifestyle clinic patients were screened regarding unhealthy habits in the areas of diet, exercise, tobacco and alcohol, but also from a psychosocial perspective. Together with the invitation, patients received a short questionnaire which they could complete at home and bring to the clinic. This short questionnaire concerned lifestyle habits, heredity, levels of motivation for change and whether or not the patient had any symptoms of diseases caused by an unhealthy lifestyle. At the lifestyle clinic the patients were asked to do all the measurements by themselves with some help from the public health nurse (PHN). The measurements included height, weight, blood pressure, blood glucose, waist circumference, and body mass index (BMI). Smokers also did the breath test COPD-6 (FEV %). When measurements were made the patients filled out a form regarding their self-perceived health, what they wanted to change and what kind of help they expected to be given. Their answers were discussed with the PHN, along with the measured values, in order to find out what was suitable to change, which was then documented. The counselling was based on Motivational Interviewing (MI) (19). If worries about mental unhealth were present, the patient filled out a form to rate their mental health status. Patients who showed abnormal values regarding the different parameters were passed on to other professionals at the health centre according to a developed flow chart.

### Participants

The inclusion of patients in the study started with an invitation to every fifth patient consecutively of those who visited the lifestyle clinic but, but since many refused to participate, all of the patients (n=137) received a letter requesting them to participate in focus group interviews. Fourteen patients agreed to participate (13 women and 1 man). Of these, 10 had been invited and 4 had visited the lifestyle clinic of their own accord. The interviewed patients were 50.5 (md) (40-84) years of age.

### Data collection

Data were collected through focus-group interviews in which the moderator steered the conversation within the aim of the study (20). Four interviews were conducted with a total of 14 respondents (4, 3, 3 and 4 respondents at each interview). The interviews took place approximately one month apart, according to when the invited respondents reported an interest in participating. Each interview started with an open question and then follow-up questions were put in when necessary to keep up the conversation. The focus group interviews lasted between 30 and 60 minutes and were conducted in a neutral conference room. The interviews were recorded and notes were taken by the moderator (PN) during the interviews.

In order to find any flaws that might exist in the interview techniques, and to test the technical equipment, a test interview with a group of six colleagues was conducted.

The reason for using focus-group interviews was to capture the different experience of the respondents (21). Focus-group interviews (22,23) can be described as an interaction between the moderator and the respondents for the purpose of data collection. The idea of focus groups is that the group process may help to develop and clarify the key points of the topic of discussion.

### **Analysis**

Material was analysed using content analysis (24). Interviews were transcribed verbatim including, for example, pauses, laughter and sighs. The interviews and the field notes were read through several times in order to get to know the material, what is called naive reading. After this reading both similarities and differences in the informants' stories were seen and noted in the margins. All text relating to the purpose of the study was extracted and brought together, and these texts were divided into meaning units that were condensed. The condensed meaning units were abstracted and labelled with a code. Codes were sub-classified in order to obtain a broad category that explained the content and responded to the purpose. Both authors sub-classified the codes and gathered them into categories. During the analysis, similarities and differences in subcategories and categories were discussed.

### **Ethics**

The study was approved by the Health Sciences Ethics Committee (VEN 30-11). Information about the voluntariness of participation in the study was given before each interview and confidentiality was assured. Discussion of one's experiences of visiting a lifestyle clinic can give a bad conscience, but can also serve as a reminder to the participants of the need to continue to pursue a healthy lifestyle. Of this reason the moderator of the focus groups was anxious to let all participants of the group to take part in the discussion to not let any person become dominant. Preparations were made to take care of any need that might arise, for physical examination by a physician or psychosocial care by a psychologist in accordance with the local routines at the PHC centre.

## **RESULTS**

Analysis resulted in two categories: sense of security and unfulfilled expectations. These categories are used as headlines in the presentation of the results with the subcategories as subheadings (Table 1). To verify the analysis, the result is presented with quotations.

### **Sense of security**

#### *Seen as being on an equal level*

Some patients felt that the way any particular meeting would turn out depended on the individual PHN they met. It was perceived as positive when the PHN was the same age as they, themselves, were which meant that patients could ask about the nurse's experience of different phenomena.

“ I could ask her (PHN) when did you get hot flashes and how did that feel? Because she knew, she was about my age more or less and could, I felt very close to being able to ask questions.” (Respondent No. 3)

However, there were those who felt that age was irrelevant and thought that it was instead the person's competence that determined whether the meeting would be good or bad. Communication in a direct and straightforward manner without any unnecessary euphemisms was perceived as positive and encouraged patients to understand the effects of poor habits. Through the visit to the lifestyle clinic, and the counselling, many different insights were revealed about how the patients actually lived or what they needed to change.

#### *Control of health*

Fear of not being healthy and not relying upon their own sense of being healthy was the main reason patients visited the lifestyle clinic.

“It was just about finding out about my health, I know I'm fine, but if I get it in writing or if someone can tell me that I'm living in the right way” (Respondent No. 5)

There was also an element of uncertainty about what it was that comprised a healthy way of life. Although the patients had the actual knowledge, they wanted it to be confirmed by the visit to the lifestyle clinic. The patients wanted a health care professional to take responsibility for the correctness of their perception of being healthy and to continue to monitor their health status over time.

#### *The importance of the responsible authority*

Respondents felt that the PHC was a reliable actor which gave the expectation of good quality of care in contrast to that of the occupational health care.

“the way that at least I feel is that you want confidentiality with regard to your employer, I don't want to tell everything to my employer. After all, you're at a disadvantage. So, that's why I think that it will be better for me to go to lifestyle counselling that's given under the authority of Region Skåne. I think I will be able to feel more relaxed about being open than I would in a situation at work.” (Respondent No. 7)

The patients had expectations of better adherence to confidentiality in the management of care by PHC, than in occupational health care or company health services where they felt there was a greater risk that their troubles of a private nature might come to the employer's knowledge and that this could be used in a negative way against them at the workplace.

### **Unfulfilled expectations**

#### *Disappointment*

Patients felt that the invitation to the clinic omitted some information about what would be included in the visit and, because of how the lifestyle clinic was structured. A major area of disappointment was that the PHN was not updated with the patients' past medical history, which the patients perceived strange. The nature of the work at the clinic was also experienced too physically focused with the emphasis placed on the body's constitution and functions. This caused disappointment about not being able to discuss other dimensions

“it was just about the body, like weighing and measuring and taking some small blood samples.” (Respondent No. 3)

The patients felt that the visit to the clinic was very short, even though they did not expect all their problems to be solved during this first visit. However, since there were no planned

follow-up visits much of the disappointment the patients felt was due to their expectations of a motivational follow-up that did not take place.

“making a sort of base inventory, how are you today? Then take some basic tests, this is our starting point, and then from there give a stimulus, this is something you need to think about, then you bring people together (in a follow-up) who have the same basis to work on.”

(Respondent No. 10)

The follow-up was expected to contain motivational aspects for changing lifestyle and to be supported by telephone or, even better, within problem-specific groups, where the group members could give support to each other.

The patients wanted to be prepared for the visit by completing all the questionnaires before the visit so they could get the most out of the counselling. The reason for this was partly because it would provide a greater opportunity for the PHN to assist them in a better way. The patients saw it as wasted time filling out one of the forms on the spot while the PHN just sat beside them watching. This meant that the situation was perceived as stressful and the responses to the form were often oversimplified. On the other hand, there were those who wanted to complete the questionnaire, “Your health profile”, during the actual visit.

“It can be good that you haven’t seen them before, the questions, I mean; it’ll be more spontaneous I think if you fill it in on the spot. At home you think, what’s their ulterior motive with this? That’s how you think when you’ve got more time.” (Respondent No. 6)

The reason was that the questions were easy to respond to and if they had filled them out at home that might have brought up many unnecessary questions and suspicions of any possible ulterior motives behind the various questions.

#### *Missing being seen as an individual*

Patients expected to be intellectually stimulated to make changes in their lifestyle, not to be told exactly what changes to make. They were disappointed about not being helped to get an overall picture of their lifestyle.

“but I felt when I took up things that I had problems with, then she (PHN) began talking about the problems she had and I just mmmhmmm (humming) I’m not interested in that, I mean it felt very odd to me.” (Respondent No. 4)

Patients also expressed disappointment over being given bad advice instead of being encouraged to gain their own insight. This gave them a feeling of a lack of good counselling techniques and an impression that the lifestyle counselling was unprofessionally performed. Some perceived the straightforward approach on purpose as to bring them to insight, as sarcasm.

“she told me to empty my fridge, but you need to have something in the fridge! But then you must have things that are good for the body and not a whole lot of sweets and stuff“ (Respondent No. 8).

Patients experienced that they did not receive enough assistance in putting their knowledge into practice. When the PHN made comparisons between her own experiences and the



patients' concerns, the patients felt that they were not being taken seriously. This, still more, increased their feeling of being unprofessionally treated at the lifestyle clinic.

#### *Physical examination*

The patients expected a thorough traditional physical health examination using objective measurements such as height, weight, blood pressure, lung function tests, as well as extensive blood tests to obtain baseline values.

“I think I'd expected more blood tests as well, it was something like, OK was it only blood sugar.” (Respondent No. 3)

The most frequently missed test that was mentioned was cholesterol. The reason was that this test was strongly associated with lifestyle and could be influenced by changes in one's lifestyle. The patients had knowledge about how high cholesterol affects the incidence of cardiovascular diseases, which created anxiety due to their not knowing what value they had themselves. Furthermore, some uncertainty was brought into the visit by the self-measurement of blood pressure with an automatic blood pressure cuff.

“then it brought on more worry, that was maybe unjustified, because the measurement technique wasn't optimal” (Respondent No. 7)

The patients did not understand the purpose of the nurse sitting beside watching them doing the measurement instead of doing it herself, as is usually done at visits in health care. Furthermore, when the results differed between the two measurements performed, the patients' uncertainty increased.

#### DISCUSSION

It emerged from the focus group interviews about patients' experiences visiting a lifestyle clinic that they gained a sense of security. This sense came partly from being confirmed in arriving at new insights or that the way they were living was healthy. Disappointment was felt when the patients had other expectations of visiting the clinic than what was provided.

The interviewed patients highlighted the importance of personal chemistry with the PHN during the health conversation, but a patient-centred approach might have resulted into a more successful encounter (16,17,18). According to the patients the PHN in our study used an arsenal of different strategies in an effort to help the patients with their struggling for a healthier way of living. The PHN may have used inappropriate strategies towards some of the patients; in some patients it went well but others were upset. This shows the importance of working in a patient-centred way where everyone can benefit from it (25). Patient-centred counselling is obviously an important working model (16,17,18,26) for health conversations if they are to have any impact on the patient. Lack of training can be one barrier to patient-centred lifestyle counselling as shown in a study with GPs and nurses (26). Frequent counselling exercises would not just get a more professional impression but also ensure greater adherence to treatment among the patients (27). Another way to get adherence to given advice could be follow-up visits which also was what the patients expected. This could have resulted in confidence between the PHN and the patient being built up (28). On the other hand patients who visited the life style clinic and had abnormal weight, blood pressure, blood sugar or had any other health problem detected, were either brought back to a follow-up visit or got an appointment with a GP. Why those patients, who were healthy and

objectively did not have any need for a follow-up visit, were disappointed is not clear. But according to Persson and Friberg's findings (17) the visit may nevertheless have affected them but not to the extent that they felt the need of any major lifestyle change. However, the patients received a second opinion about their health and felt reassured when they realised they were healthy and not at risk of diseases related to their way of living.

Another aspect highlighted in the interviews was the degree of integrity, as the respondents compared preventive work organised by occupational health service and the county council. In this comparison they had the opinion that the county council could offer a higher degree of integrity. According to the company health services' professional association in Sweden (29), occupational health service is to be primarily based on the work environment. In the second place, they should act with a desire to optimise the health of the employees so they can stay in production. In contrast, patients experienced PHC as a secure and independent actor in this context to take care of their health check-ups.

Previous experiences may have influenced the patients in a way that led to high expectations which did not match the clinic's intention. This is something Persson and Friberg (17) and Kärner et.al. (18) pointed out as an important factor to take into account. The patients experienced a fixation with their physical condition at the clinic but, at the same time, they would also have preferred a more comprehensive health assessment. One reason for this could possibly be that confidence had not been built up between the nurse and the patient, which might result in greater difficulties in talking about more sensitive things in the patients' lives (30).

Measurements were important for the patients and it is important that they are conducted in an evidence-based way. This is especially important for blood pressure measurement, as there are many sources of errors (31). This means that it would have been better to perform the measurements manually and to utilise the expertise the PHN has about blood pressure measurement so as to avoid false values. Furthermore, this would have made the patients more comfortable as they were familiar with having their blood pressure manually measured by health care personnel. Another very important aspect is that blood pressure measurements should be performed in the same way, regardless of who is performing the measurement (32), especially when follow-up monitoring is performed.

### **Methodological Considerations**

The low response to the invitation to participate in the focus group interviews is a major limitation of this study. Preferably, to make it easier to engage more participants, the interviews should have been performed continuously soon after the patients' visit the lifestyle clinic. Small focus groups (23) are preferable to big ones, because they are easier to handle. However, whether or not three respondents could be classified as a focus group is open to contestation. According to Krueger and Casey (22), the lower limit of mini focus groups is four respondents. The reason for the low number in two of the groups was that some respondents did not show up but, to show respect for those who did, the interviews were conducted anyway.

To ensure validity and reliability the analysis was performed manually in a systematic manner. The co-author was familiar with the material and performed analysis in addition to the first author. The results were compared and discussed between the authors until consensus was reached. This way of working strengthens the results in terms of credibility and

reliability, and also ensures that the results would be transferable to a different lifestyle clinic in a similar context (33).

## CONCLUSIONS

Lifestyle clinics can both give patients opportunity to change their current unhealthy lifestyle and confirm the good habits. Identifying patients' individual needs by using a screening form prior to the visit to a lifestyle clinic might be appropriate. It may also be important to have follow-up visits to provide the patients support when changing lifestyle. Nurses counselling patients about lifestyle changes need to have frequently recurring training in Motivational Interviewing to be able to provide a patient centred holistic approach including somatic, psychological and social aspects. There is a need for further studies focusing on health benefits with a focus on patients' experiences of lifestyle clinics.

## AUTHOR CONTRIBUTIONS

Peter Nymberg and Eva Drevenhorn contributed to the design of the study, analysis of the data and wrote the manuscript; Peter Nymberg was involved in data collection.

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Table 1. Categories in bold with subcategories

<b>Sense of security</b>	<b>Unfulfilled expectations</b>
Seen as being on an equal level	Disappointment
Control of Health	Missing being seen as an individual
The importance of the responsible authority	Physical examination