**TITLE:**

Nurses as role models in health promotion: piloting the acceptability of a social marketing campaign.

**ABSTRACT**

**Aim**

To pilot the acceptability to practising nurses of the concept of being healthy role models as regards obesity and weight.

**Background**

Nursing standards expect nurses to act as role models of professionalism, including maintaining a healthy lifestyle. Many healthcare employers wish to instigate values and social norms about professional behaviour in staff.

**Methods**

A mixed methods study comprising two stages. In Stage One, an online survey was used to develop an intervention, which was then evaluated by a rapid intercept survey with open-ended questions. Insights from 71 obese nurses, recruited at a 2016 nursing conference, were used to develop a social marketing campaign encouraging a social norm around professional behaviour as regards healthy lifestyles and obesity, with the message that “first impressions count” in staff-patient encounters. The campaign was tested with 79 nurses at three English hospitals.

**Results**

In Stage One, 58% agreed that nurses should be role models and 48% that being obese made the public less likely to trust their public health messages. In Stage Two, the campaign concept of “first impressions count” was widely understood and accepted, but nurses found the introduction of a professional expectation around personal behaviours unacceptable.

**Conclusion**

Nurses accept an expectation that they are healthy role models but refute its value when confronted with real-life scenarios. Other aspects of identity were privileged to avoid engaging with the healthy role model message. Personal health behaviour was seen as part of a private domain and not part of their public presentation in professional life.

(250 words)

**Keywords**

Health behaviour; health promotion; nurses; role model; social identity; social marketing; social norms; social identification

**SUMMARY STATEMENT**

1. **Why is this research or review needed?**

* There is an expectation that nurses should be healthy role models, including maintaining a healthy weight, and the nursing profession itself has suggested that nurses have a professional duty to lead healthy lifestyles.
* Nurses have a strong professional and social identity derived from their work values and public image that has been well explored.
* Appealing to nurses’ professional identities to highlight discrepancies between personal unhealthy behaviours and professional expectations may help to emphasise a healthy lifestyle as a value of the nursing profession.

1. **What are the key findings?**

* Nurses accept an expectation to be healthy role models, including maintaining a healthy weight, but refute the value of this expectation when confronted with real-life scenarios.
* Nurses privilege other aspects of their identity to avoid engaging with the message of being a healthy role model.
* Nurses view their personal health behaviour as part of a private domain of behaviour and not part of their public presentation in professional life.

1. **How should the findings be used to influence Policy/ practice/ research /education?**

* The study provides important insights into why being a healthy role model is not accepted as a reasonable expectation by practising nurses.
* It adds to the body of work that explores the social identity of nursing and acceptable professional behaviours.

**Introduction**

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health (World Health Organisation, 2016). The Body Mass Index (BMI) is a common method of classifying overweight and obesity in adults, where a BMI between 18.5–24.9 indicates a normal range, and a BMI ≥30 indicates obesity (World Health Organisation, 2015). Globally, nurses evidence a poor health profile (Lobelo & de Quevedo, 2016), and previous studies in the UK, Australia, New Zealand, and the US have estimated that between 52%- 69% of nurses are overweight and obese, a level consistent with prevalence rates in the general population (Bogossian et al., 2012; Kyle et al., 2017; Kyle, Neall, & Atherton, 2016; Zapka, Lemon, Magner, & Hale, 2009).

Aside from caring for nurses’ health as individuals, obesity in nurses is concerning as a contributor to both musculoskeletal disorders and mental health conditions (Anandacoomarasamy, Caterson, Sambrook, Fransen, & March, 2008; Scott et al., 2008) and because of its impact on the nurse’s role as a public health messenger. Nurses who engage in unhealthy behaviours may be less willing to intervene and offer health promotion advice for fear of criticism or appearing hypocritical (Aranda & McGreevy, 2014; Beletsioti-Stika & Scriven, 2006; González, Bennasar, Pericàs, Seguí, & De Pedro, 2009; Sejr & Osler, 2002; Sekijima, Seki, & Suzuki, 2005), and patients appear less likely to follow advice given by unhealthy nurses (Hicks et al., 2008; Kelly, Wills, Jester, & Speller, 2017; Kelly, Wills, & Sykes, 2017). Obesity is a visibly unhealthy behaviour and is frequently referred to in the discourse around nurses being healthy role models (e.g. Aranda & McGreevy, 2014; Naish, 2012; While, 2015).

The nursing profession itself has suggested that leading a healthy lifestyle is a duty of nurses that is socially expected of them by virtue of their professional role (While, 2014). As the UK regulator, the Nursing and Midwifery Council (NMC) includes an expectation for nurses to role model health-promoting behaviours as a competency for registration (NMC, 2010) and the Chief Nursing Officer for England has stated that nurses should "be a positive role model for a healthier diet and active lifestyle and encourage others. This benefits individual wellbeing and resilience, and can reduce staff absence rates" (Cummings, 2016, p. 45). This expectation is emphasised further in professional nursing journals, which advise that nurses are obliged to behave in ways that do not jeopardise the image of the profession or place undue demand on the health system (Orr, 2014; Orr, McGrouther, & McCaig, 2014; While, 2014).

Encouraging and supporting nurses to achieve and maintain a healthy lifestyle therefore adds value in two evidence-based ways; it has an impact on workforce efficiency by reducing the costs associated with sickness absence and presenteeism, and it supports the health promotion initiatives and messages of health services (American Nurses Association, 2012; International Council of Nurses, 2010). One way of understanding individual nurses’ preparedness to live by these ideals is by considering the way these requirements form part of personal and social identities.

**Background**

The expectation that nurses should be healthy role models as part of their professional behaviours can be illuminated by reference to Social Identity Theory (Tajfel & Turner, 1986) which argues that organisations depend on their employees to go beyond simply enacting their job descriptions to establishing and maintaining social norms – usually in the form of agreed-upon expectations and values. These norms guide staff behaviour and shape their interactions with other employees and the wider public (Haslam, 2003). For example, several NHS Trusts in England have developed campaigns to encourage common values and behaviours: Moorfields Eye Hospital NHS Trust describes four expected commitments for staff in the “Moorfields Way” (Moorfields Eye Hospital NHS Foundation Trust, n.d.), and the Leeds Teaching Hospitals NHS Trust has “the Leeds way” which is used to guide staff as to ‘how we do things here’ (The Leeds Teaching Hospitals NHS Trust, n.d.). These establish desired attributes of employees and conduct values with the implicit assumption that if many others perform the same behaviours, those practices become accepted and ‘normal’, and social pressure becomes both an enabler of and a deterrent from different behaviours. By reinforcing the desired social norms through professional and social identities, individuals might be motivated to remain normative so as to maintain the positive psychological benefits of group membership. Those who do not conform to social norms are likely to experience cognitive dissonance (the discomfort caused by inconsistency between beliefs and behaviours, for example by being obese or a smoker whilst believing these behaviours to be wrong; see Festinger & Carlsmith, 1959).

Nursing is a profession with a strong associated social identity - promoted through a long period of education, a professional code of practice, a public image and an organisational identity (Ten Hoeve, Jansen, & Roodbol, 2014). Extensive studies have explored the construction of nurses’ professional identity and recently, the contribution of values to that identity (Baillie & Black, 2014). Nurses themselves perceive a professional expectation to be healthy role models (Hensel, 2011), which has been conceptualised as being caring, trustworthy, knowledgeable, self-confident, professional, having a deep sense of self, as well as being an exemplar and champion of wellness (Darch, Baillie, & Gillison, 2017). Emphasising a healthy lifestyle as a value of the nursing profession can be seen as an appeal to nurses’ professional identities and also a prescriptive social norm (i.e. a socially held expectation about how a group member should behave, see Cialdini, Reno & Kallgren, 1990), where being unhealthy as a nurse is seen as an unacceptable and anti-normative behaviour.

Despite the evidence highlighting the importance of social identity for the nursing profession, little research has been done to describe how group norms and motivations help to define the performance of nurses’ professional identity and belongingness (Willetts & Clarke, 2014). This is particularly the case in terms of nurses’ preparedness to have a healthy lifestyle.

**The study**

**Aim**

The aim of the study was to (i) explore the extent to which having a healthy lifestyle is part (or not) of the social norms associated with being a nurse and (ii) introduce a social norm to encourage nurses to achieve and maintain a healthy lifestyle in relation to obesity and weight. By reinforcing the message that ‘first impressions count’, the study aimed to highlight the discrepancy between personal unhealthy behaviours such as obesity and a professional expectation to maintain a healthy lifestyle as a nurse.

**Design**

The study was conducted as a two-stage process. In the first stage, the views of obese nurses were gathered to explore how important is being a healthy role model and to refine the concept before pilot testing. In the second stage, the insights from these nurses were used to develop and deploy a social marketing campaign, which was then evaluated through a rapid intercept survey in three hospitals.

**Ethical considerations**

A university ethics committee granted ethical approval for the study in June 2016 (UREC 1616). Participants were given a study information sheet and informed that completing the survey indicated their consent for data to be used in this study. They were informed that they were free to refuse to participate or to withdraw from the survey at any time. Participants provided oral consent before completing the survey. All survey data were anonymised at the analysis stage.

**Stage One**

**Participants**

Convenience sampling was used to recruit nurses from a volunteer panel of 200 nurses who had expressed interest in contributing to the design of interventions as part of the Healthy Weight Initiative for Nurses (WIN), after taking part in a survey conducted at a national nursing conference in June 2016. Nurses’ eligibility for the panel was based on being visually identified as obese by trained researchers aided by a validated visual rating scale (Harris, Bradlyn, Coffman, Gunel, & Cottrell, 2008). To confirm the visual identification, potential participants were asked if they had ever worn clothes sized XXL or size 18 and above.

**Data Collection**

Participants were invited by email to consent to and complete an online survey. The survey aimed to investigate if nurses thought they should be healthy role models and why this might matter. Nurses were asked to agree/disagree with five statements related to whether nurses should be a healthy weight and reasons why; whether a patient would trust advice from an obese nurse, whether ‘practising what you preach’ was important and whether a nurse should act as a role model for healthy lifestyles.

**Data analysis**

The survey data were downloaded securely from the web-based survey tool into a Microsoft Excel spreadsheet. Frequencies were calculated to summarise respondents’ characteristics and responses.

**Results of Stage One**

Seventy-one nurses (35.5% of the volunteer panel) completed the online survey. Further detail on participants is given in Table 1 below.

INSERT TABLE 1 HERE

Table 2 shows participants’ responses to the statements related to whether nurses should be a healthy weight and why.

INSERT TABLE 2 HERE

The reasons given why nurses should be healthy role models were: to set a good example to patients (N= 41, 58%); to meet the physical demands of the job (N= 15, 21%); to look after their own health as individuals (N= 14, 20%); to be seen as a credible source of health education (N= 11, 16%); and to maintain the professionalism and protecting the image of the nursing profession (N= 5, 7%).

The analysis of the responses of Stage One led to the development of a social marketing campaign in the second stage. Stage One revealed a strong social norm for nurses about being a role model, both as a professional but more importantly, to be seen to support the public health messages given to patients and 90% of nurse participants in Stage One supported the simple concept of ‘practising what you preach’. The participants were divided about the importance of trust and credibility in delivering health promotion advice. This may reflect the desire of those with observably less healthy behaviour (i.e. who may be seen as less credible public health messengers) to emphasise empathy over trustworthiness, reputation and expertise (Kelly et al 2017) and thus reduce or avoid cognitive dissonance. The survey did not point to any adverse consequences that might arise from not practising what you preach. However, that there was so little disagreement or reflection suggests that nurses would be motivated to maintain a healthy lifestyle to ensure they were adhering to a norm to ‘practise what they preach’, in particular to the extent that violating this norm was perceived as reducing the impact of health advice given to patients. As such, these aspects of Stage One formed the basis of the intervention developed and tested in Stage Two.

**Stage Two**

**Design of the pilot campaign**

As the adoption or otherwise of a healthy lifestyle or being a healthy role model is observable, it was decided to adopt a message about ‘first impressions’ to reinforce that unhealthy behaviours are observable and impact on patients, and to encourage the individual nurse to consider how they appear to those in their care. The message was framed as:

“First Impressions Count: Yours is the most important voice patients will hear. Get healthy and show them that lifestyle change is possible”.

The phrase “First impressions count” phrasing was intended to piggyback on the influence of a recent national initiative to “Make every contact count”, which encourages all healthcare employees to promote health improvement at every opportunity (Public Health England, NHS England, & Health Education England, 2016). The phrase “Yours is the most important voice patients will hear” was included to emphasise the nurse-patient relationship, as nurses have more direct contact with patients than any other practitioners. The campaign aimed to elicit an emotional response from the viewer in three scenarios (two focusing on weight, and one on smoking). Ironic contrast was used by combining the written message with video and still images in which a nurse visibly displays discrepant behaviour (due to their weight or by smoking) against the professionally accepted public health messages verbally given to the patient about losing weight for the benefit of their health. The humorous stimulus was the violation of that social situation by the visible dissonance between the nurse’s own health and what is said (Veatch, 1998). This approach was used as humour can lessen any defensiveness that nurses might have experienced when receiving an evaluation that threatens their self-integrity (Sherman & Cohen, 2006).

The campaign was promoted using two channels over a four-week period in three NHS Trusts in England. First, a two-minute film was produced by university staff and actors, which ran on microsites within the NHS Trusts’ intranets where workforce roles are considered, including Human Resources, Occupational Health and training for new starters. The film is available to view at [https://vimeo.com/165554642.](https://vimeo.com/165554642.n) Because the film ran on an intranet, it was not possible to obtain figures on the number of views. Secondly, a series of three posters were produced from the film stills, which were displayed in offices, staffrooms, corridors and the hospital canteen.

**Stage Two evaluation**

**Participants**

One month after the campaign was deployed, two researchers attended each Trust site to evaluate the campaign. Over a one-hour period, a “street intercept” survey method was used to recruit nurses leaving the canteen (Bush & Hair, 1985). 130 nurses were approached and invited to respond to the campaign. Both obese and non-obese nurses were eligible to participate. Participants gave oral consent to be interviewed.

**Data collection**

Street intercept is an efficient method when time may be limited and participants may be harder to recruit. It offers the added advantages of easily ascertaining eligibility by the uniform worn and response rates. Participants were asked to view the video and poster series (if they had not previously done so) and to complete a short, structured interview, hosted on a tablet computer. In recognition that staff often get less than 20-minutes break, the survey was intentionally short and comprised three open questions;

* Their understanding of the message “First Impressions Count”;
* The extent of their agreement with the principle that “First Impressions Count”; and
* Whether staff should “get healthy and show that lifestyle change is possible”.

No demographic data were collected, as such questions would have added to the length of the rapid intercept interview (Sperry, Burris, & Dumbaugh, 2012). Responses were audio recorded and transcribed by the researcher.

**Data analysis**

Interview data were analysed and described by frequency according to the three questions. Given the nature of the street intercept method, responses and the segments of text were often very short, which precluded any open coding following a formal thematic analysis (Braun & Clarke, 2006). Rather, all responses were given an initial coding based on content. When this had been completed for all responses, every statement was analysed and coded as representing agreement or disagreement for nurses being role models. Each response was revisited and two researchers coded the whole dataset identifying semantic themes.

**Rigour**

Two researchers discussed the codes being used after the rater had completed the initial coding. As the dataset was small, they then considered all the statements appearing within each code. A record of codes attached to each quote was retained in the dataset. All authors have considered the role that their professional background may have played on their interpretation (none had a professional nursing background, but all had a research background which included behaviour in health settings, broadly defined). During the process of data analysis, one of the team cross-checked the coding strategies and interpretation of data by the two researchers.

**Results of Stage Two**

Seventy-nine nurses completed the evaluation of the social marketing campaign (61%) and their responses are shown in Table 3. Illustrative quotes are presented alongside the results in Table 4. No identifying information is included with the quotes given.

**INSERT TABLE 3 HERE**

**INSERT TABLE 4 HERE**

**What does the message “First Impressions Count” mean to you?**

Most responses (52% N=41) indicated a shared understanding about the message of the campaign which was seen as nurses appearing to act in ways congruent with their role as public health messengers. A range of idioms was used, reflecting this common understanding: “putting your own house in order”, “practising what you preach”, “acting what you say”, “setting a good example”.

**Do first impressions matter as a nurse?**

The majority of participants (74% N=58) at this stage agreed that “first impressions” matter and 30% (N=26) mentioned that nurses should try to be healthy role models because that was part of being professional. Many nurses (48%; N=38) said they found the message thought provoking and a third (N=26) found it amusing. Most of these participants laughed aloud viewing the film and several used the word ‘hilarious’. All of the participants chose to make an observation about the perspective of the nurse or the patient in the health encounter:

“I felt that the patient had every right to question the nurse’s obesity, when she was trying to help them address theirs.”

Several participants used the term ‘hypocrisy’ to describe health messages given by a visibly unhealthy nurse:

“Hypocrites. If I had a nurse who was stuffing her face with crisps and giving me advice I'd think "Well really? Take your own advice".

**Do healthy lifestyles matter as a nurse?**

This sample of nurses, having viewed the campaign materials about whether being a role model and “practising what you preach’ is important, were much more equivocal than those in Stage One. The responses reflected a difference between being a professional and acting professionally. The majority of nurses felt that looking healthy was part of being a professional (74% N=58) but 24% of participants (N=19) felt that acting professionally or how a nurse relates to patients and their communication skills (16%) were more important than how a nurse appeared.

Ten participants became quite vehement and strongly opposed the campaign’s aims, refuting that the organisation should have any expectations of their personal health behaviours. Six participants used the terms ‘body-shaming’ or ‘fat-shaming’ to refer to the core message of the campaign, implying that this was not an appropriate message as an expectation to be a healthy weight put too much pressure on staff. Several participants felt that a positively framed message would be more effective and the organisation itself should enable staff to adopt healthier lifestyles.

**Discussion**

Having a healthy workforce is important for nurses’ own health, the organisation they work for, and also to reinforce the credibility of public health messages. Existing interventions and campaigns to encourage healthier lifestyles among NHS staff are positively framed and stress the benefits of a healthy lifestyle by presenting examples of healthy actions adopted by staff (Blake & Chambers, 2012; Dean, 2014). These present socially normative behaviour, but do not make explicit use of strategies that would encourage community members to emulate others in the community and behave similarly to them and do not serve to prompt individuals to actively reflect on how much they embody these ideals themselves. This is an important limitation, as group members often see themselves as more prototypical of the group norm (e.g. being an exemplar or a healthy role model) than they actually are - and thus less motivated to change their behaviour (Giguère, Lalonde, & Taylor, 2014; Turner, Oakes, Haslam, & McGarty, 1994).

This pilot study tested whether a social marketing campaign that emphasised a professional expectation of nurses as credible public health messengers could encourage social conformity amongst nurses to demonstrate healthier lifestyles. Although there is little evidence that patients actually reject messages from staff who may be obese or smokers (Kelly, Wills, & Sykes, 2017), it is an accepted assumption that health care staff should “practise what they preach” (Kelly, Wills, Jester, et al., 2017). Stage One of the present study showed that most nurses accepted this proposition (i.e. it was socially normative), even if they did not evidence a healthy lifestyle themselves. The campaign developed in Stage Two attempted to expose the incongruence between nurses’ own visibly unhealthy behaviours and their delivery of public health messages, and how that might impact on patients. When presented with real-life scenarios, many participants no longer accepted the previously attractive proposition of being a role model, and asserted that nurses’ competence and skill were more important. They argued strongly that it is possible to give professional advice about health behaviours that they did not engage in personally.

Traditional perspectives on social comparison suggest that individuals will find it uncomfortable to disagree with a group of which they wish to be a part (Festinger, 1954). After viewing the social marketing campaign, the nurses in Stage Two easily detected the presence of a discrepancy between being a role model and the behaviours shown in the campaign materials. It appears that they personally compared themselves with the nurses shown in the campaign and engaged in various strategies for reducing the cognitive dissonance between the personal health behaviour observed, their own behaviours and the professional expectation to be a healthy role model (Stone & Cooper, 2000). First, many staff reduced the importance of the original cognition about the importance of being a healthy role model by appealing to their professional competence and standards over personal health behaviours. Thus a ‘good nurse’ role model became seen as one who is compassionate rather than necessarily upholding personal standards of behaviour. Secondly, staff added new cognitions to support the conflicting behaviour (Festinger, 1962) so when asked if “staff should get healthy and show that lifestyle change is possible” most of the participants emphasised that personal health behaviours were a private domain, and rejected any relationship to their public presentation in professional life. Thirdly, staff emphasised the impossibility of becoming a healthy role model because of numerous organisational barriers such as lack of access to healthy food or lack of breaks. This placed responsibility at the feet of employers rather than the individual. The means of reducing cognitive dissonance seen in this project were for individuals to deny that the message applies to them, to deny that there is any impact on patients from staff unhealthy behaviours, and to suggest that other aspects of professional behaviour matter more such as communication skills. Such strategies of self-affirmation via an increased emphasis on alternative dimensions of worth has been observed in various other populations whose identities are threatened, but has not been recorded amongst nurses before (see e.g. Steele, 1988 and Sherman et al., 2007).

**Limitations**

The numbers responding to the scoping stage were small, and that of obese nurses who might be less likely to agree that nurses should be healthy role models. There are limits to how far the concept was tested due to budgetary constraints and the nature of the campaign and its limited reach. Following from other work in this area (Kelly, Wills, Jester, et al., 2017; Kelly, Wills, & Sykes, 2017) however, it does seem there is a lack of acceptance that nurses should be role models and resistance to this concept being promoted as a realistic expectation of nurses.

**Conclusion**

This pilot project aimed to explore the extent to which having a healthy lifestyle was seen as social normative amongst the nursing profession and also to pilot an intervention to use such norms to generate healthy behaviour change amongst nurses. Taken together, the findings suggest that although the belief that health care professionals have a special obligation with regard to their health behaviours is normatively accepted, its implementation is devalued in the challenging working life of a nurse. When shown campaign materials highlighting how unhealthy behaviours might look in the real-life scenarios (and the effect this could have on the impact of health advice delivered to patients), nurses became pragmatic and engaged in self-affirmation via increasing emphasis on other dimensions of the nursing identity- being a ‘good nurse’ or health care professional. This was expressed in part by re-conceptualising healthy behaviours as a private matter of individual choice.

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Table 1 Participant characteristics

|  |  |
| --- | --- |
| Demographic characteristic | N (%) |
| Gender | |
| Male | 4 (6%) |
| Female | 67 (94%) |
| Age group | |
| 21 to 30 | 4 (6%) |
| 31 to 40 | 12 (17%) |
| 41 to 50 | 20 (28%) |
| 51 to 60 | 28 (39%) |
| 60 or older | 7 (10%) |
| Obesity and weight | |
| Currently wore a size 18 or above or XXL, or reported a BMI greater than 30 | 56 (79%) |
| Previously wore a size 18 or above or XXL, or reported a BMI greater than 30 but had since lost weight | 15 (21%) |
| Work setting | |
| Hospital | 20 (28%) |
| Primary care | 19 (27%) |
| Community | 13 (18%) |
| Other | 19 (27%) |

Table 2 Participants' responses to statements on nurses as healthy role models

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | Agree | | Disagree | |
| N | % | N | % |
| Should nurses act as healthy role models? | 67 | 94% | 4 | 6% |
| Do you think a patient would take public health advice about nutrition, diet or physical activity from nurses who are obese themselves? | 35 | 49% | 34 | 48% |
| Do you believe all nurses should be a healthy weight? | 51 | 72% | 17 | 24% |
| Do you believe that practising what you preach about healthy weight is important for public trust? | 64 | 90% | 4 | 6% |
| Does it matter if nurses are obese? | 59 | 83% | 12 | 17% |

Table 3 Results from Stage Two: evaluation of the intervention

|  |  |  |  |
| --- | --- | --- | --- |
|  | Agree | Disagree | Don’t know or unsure |
| Understanding that appearance “first impressions) matter in professional life | 52% (N=41) |  | 48% (N=38) |
| Agreement that “first impressions’ matter when talking to patients | 74% (N=58) | 26% (N=21) |  |
| Agreement whether nurses’ lifestyles matter | 36% (N=28) | 44% (N=35) | 20% (N=16) |

Table 4 Results from Stage 2: Codes and indicative quotes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Reasonable: Being congruent with a public health message | Reasonable: Being professional | Unreasonable: Acting professionally | Unreasonable: Personal domain | Unreasonable:  Organisational domain |
| “You need to ‘practise what you preach’, examine your own lifestyle before dishing out advice to others”. | “Definitely staff should be not giving the wrong message by doing those things themselves. It looks like staff are just going through the motions otherwise” | “It barely matters what staff look like” | “I give enough to this place, so what I eat and look like is my business” | “Staff should be inspired, not expected, to be healthy – to feel better, to get more out of life, for it to be enjoyable in its own right.” |
| “Staff should be a good example. What they do should be congruent with what they're advising” | “As a diabetic I'm often left baffled when nurses the size of houses attempt to advise me on a healthy diet... On one particularly glorious occasion the obese nurse noticed I’d lost weight and as a diabetic herself asked me for some slimming advice. I said cutting out fatty food to which she replied ‘Oh no, I couldn’t do that – I’m a very tasty lady ‘” | “It’s how I talk to patients that matters” | “This is so unfair, I can’t be expected to add looking good to my job” | “It's an organisation thing more than an individual thing. Practise what you preach has to come from the organisation so good advocacy becomes a social norm. Staff can't do that themselves.” |
| “We should act what we say” | “It's blatantly obvious: that the staff are not practising what they are saying. And from the patient point of view it's like the woman in labour who asks the midwife if they have children i.e. do they know what they're talking about? I mean the patient would be thinking ...yeah, right!” | “Actually, being told to lose weight by a thin person is not very motivating- patients think you don't understand. They can be motivated equally well by someone who takes a pragmatic approach and recognises that we all have our unhealthy behaviours.“ |  |  |