

Esthetic Knowing with a Hospitalized Morbidly Obese Patient

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Abstract

This article demonstrates the combined use of Johnson's Behavioral Systems theory and various patterns of knowing to care for a patient with complex needs. The authors emphasize the usefulness of esthetic knowing, which helped them extend their care beyond the physical dimension to effectively communicate with the patient through verbal and nonverbal approaches.

Case

Ms. D is a morbidly obese 67 year old female, 240 lbs, 5'2" with type II diabetes mellitus. She was transferred from a nursing home to the hospital for pneumonia, but also suffers from congestive heart disease, sleep apnea, psoriasis, and osteoarthritis. She has a weak but productive cough with tonsil suction, and she was on breathing treatments with Albuterol. Her skin is very dry and thin with several lesions and yeast infections, and the deep folds of her lower abdomen bled during the bed bath. She did not want to wear her breathing mask at night and refused to get out of bed. She cried when encouraged to use the bathroom or to move her legs. She expressed great fear of returning to the nursing home.

From the outset, we realized that Ms. D needed care beyond physical therapy and treatment for pneumonia; we realized that her obesity and refusal to participate in her health care expressed important patterns of her life. Morbid obesity does not happen overnight; it is a progressive pattern associated with activity levels, diet, and self-care practices, as well as other possible physiological and psychosocial dimensions. Johnson's (1980) Behavioral System Model, which outlines seven behavioral subsystems, was helpful in providing a perspective of the complexity of Ms. D's health needs. We also assessed that Ms. D lacked confidence in taking care of herself (reflecting the *achievement subsystem*) and lacked a sense of family support from her two sons (*affiliative subsystem*). Her fear of returning to the nursing home coupled with her need for ongoing care challenged her sense of interdependency as addressed in Johnson's *dependency subsystem*.

We used *empirical* sources of knowledge to inform our care of her skin, yeast infection, and pain. For example, in addition to certain medications, we knew that research indicated physical touch promotes physical comfort, emotional comfort and mind and body comfort (Chang, 2001). But the *esthetic* pattern of knowing was particularly useful to us. Esthetic knowledge involves translating the what and why of treatment into the how, right in the moment. We had to use our knowledge of Ms. D's mood and needs at the moment to communicate effectively with her. In addition to use of touch, this included but was not limited to our voice pitch, facial expressions, hand gestures and word choices while explaining nursing procedures and providing encouragement to her.

Personal knowing, in terms of regarding her as a person not as an object, in relationship with us, was also helpful in our approach. It allowed us to be assertive in our interactions and help to meet needs of affiliation, interdependency, and achievement and through these approaches, help Ms. D overcome her child-like and resistive behaviors during nursing care.

In conclusion, we discovered that if the patient is not willing to contribute or support her care plan, nursing efforts would be in vain. Although we had the best intentions, without her participation we were unable to facilitate her recovery and obtain the desired results. Applying knowledge from Johnson's (1980) nursing model and from various patterns of knowing (Carper, 1978) helped us learn about the complexities of nursing care in working with a patient who had complex health needs.

References

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