

# A qualitative study of GPs' views of treating obesity

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## ABSTRACT

### Background

Due to the increased prevalence of obesity GPs now have a key role in managing obese patients.

### Aim

To explore GPs' views about treating patients with obesity.

### Setting

An inner London primary care trust

### Design of study

A qualitative study using semi-structured interviews.

### Method

Twenty-one GPs working in an inner London primary care trust were interviewed about recent obese patients and obesity in general. An interpretative phenomenological approach was used for data analysis.

### Results

GPs primarily believed that obesity was the responsibility of the patient, rather than a medical problem requiring a medical solution. They also believed that in contrast to this, obese patients wanted to hand responsibility over to their doctor. This contradiction created conflict for the GPs, which was exacerbated by a sense that existing treatment options were ineffective. Further, this conflict was perceived as potentially detrimental to the doctor-patient relationship. GPs described a range of strategies that they used to maintain a good relationship including offering anti-obesity drugs, in which they had little faith, as a means of meeting patients' expectations; listening to the patients' problems, despite not having a solution to them; and offering an understanding of the problems associated with being overweight.

### Conclusion

GPs believe that although patients want them to take responsibility for their weight problems, obesity is not within the GP's professional domain. Until more effective interventions have been developed GPs may remain unconvinced that obesity is a problem requiring their clinical expertise and may continue to resist any government pressure to accept obesity as part of their workload.

### Keywords

obesity; primary healthcare; qualitative research.

## INTRODUCTION

The increase in obesity has been well documented and can be attributed to a range of factors such as changes in eating behaviour and exercise patterns, shifts in food production, and an increasingly obesogenic environment designed to encourage overeating and a sedentary lifestyle.<sup>1-3</sup> The management of obesity is problematic with much research showing that although the most complex interventions may produce weight loss, this reduction in weight is often only short term, with many studies showing that weight returns to baseline levels by follow up.<sup>4-5</sup> In the UK most management of obesity happens in primary care, and yet the primary care approach to obesity has been described as uncoordinated and inconsistent.<sup>6</sup> Further, some medical experts in the clinical field of obesity and professional bodies in medicine are concerned that health professionals, including GPs, are not taking the issue of obesity as seriously as they should.<sup>7</sup> There is also evidence that GPs are negative about their own role in obesity treatment, which, in part, reflects the problematic nature of obesity management. For example, one study of Israeli GPs by Fogelman and colleagues<sup>8</sup> found that although GPs believed it was part of their role to advise obese patients on the health risks of obesity, the majority of doctors thought that they had not made any difference in getting their patients to make long-term changes in lifestyle. Similarly, a Glasgow based study by Mercer and Tessier<sup>9</sup> reported that doctors generally

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had 'little enthusiasm for weight management'. Previous research has also explored GPs' attitudes to individual treatment approaches and have concluded that GPs have reservations about using anti-obesity drugs.<sup>9,10</sup> Surveys show that that only 3% of GPs would refer obese patients for behaviour therapy<sup>11</sup> and that only 23% of primary care physicians would refer morbidly obese patients, who met the criteria for surgery, to a surgeon specialising in surgery for obesity.<sup>12</sup> In addition, research also indicates that GPs and patients hold different models of obesity, which may be detrimental to its successful management.<sup>13</sup>

Research therefore shows that while obesity is on the increase, the effectiveness of available treatments remains low. GPs play a key role in the management of obesity and yet show a range of attitudes towards obesity that may have implications for its management. Previous research exploring GPs' beliefs about obesity, however, has mainly used quantitative methodologies and measures that have been devised and operationalised by researchers. Further, they have tended to explore beliefs in the abstract rather than in the context of the day-to-day management of this problem. In light of this and in line with the current focus on primary care as a potential source of obesity management,<sup>14</sup> the present study used qualitative methods to explore in depth how GPs feel about obesity within the context of their own attempts at management and their own interactions with obese patients.

## METHOD

### *Sampling and recruitment*

All 130 GPs on one inner London primary care trust list (excluding registrars and locums) were invited to participate in the study. Thirty-five GPs were willing to be interviewed. Several doctors replied from some practices, and it was decided to limit the number of participants per practice to two. Twenty-one GPs from 15 different practices were then selected to create a heterogenous sample varying in terms of size of practice, ethnicity, age and sex. There were 10 male and 11 female GPs. They were fairly evenly distributed across the age ranges (30–39 years,  $n = 9$ ; 40–49 years,  $n = 5$ ; 50–59 years,  $n = 5$ ;  $\geq 60$  years,  $n = 2$ ), the majority were white ( $n = 15$ ) although five were Asian and one was black African, nine were trainees and 16 were trained in the UK, while three were trained in India, one in Australia and one in Nigeria. When the last five or six interview transcripts were analysed, it was noted that no new themes were emerging and it was decided that saturation had been reached.

## *How this fits in*

GPs play an increasing role in the management of obesity. Current government recommendations suggest a central role for primary care. GPs have been criticised for offering obesity management which is uncoordinated and inconsistent. GPs believe that obesity is primarily the responsibility of the patient but feel that obese patients want to hand over responsibility to their doctor. This contradiction is exacerbated by a lack of faith in existing treatment options and a desire to maintain a good doctor–patient relationship. GPs sometimes offer treatments that they believe are inappropriate as a means to maintain a good relationship.

### *Design*

In-depth, semi-structured interviews were chosen as the method for the study. The interviews were audiotaped and then transcribed.

### *Interview schedule*

GPs were asked specific questions about recent obese patients and also broader questions about managing obesity in general. In the main, open-ended questions were asked although prompts were added where necessary. The interview schedule is shown in Box 1.

### *Data analysis*

An interpretative phenomenological analysis approach was used that takes a social cognition perspective and assumes that one can find out what a person believes by how he or she discusses a topic.<sup>15</sup> In addition, it acknowledges a role for the researcher's own perspectives and experiences. Initially, a few transcripts were read several times and 'interesting or significant' parts of what the interviewee said were underlined and comments about these put in the left-hand margin of the transcript.<sup>16</sup> The transcripts were then read independently and an initial list of themes and categories, which were then discussed and reorganised to create a coherent picture, was created. Significant comments were underlined

### **Box 1. Interview schedule.**

Think about the last patient that you saw where the patient's obesity was an issue.

- ▶ Can you tell me about the consultation?
- ▶ How did you feel about managing this patient?
- ▶ What did you think the patient expected from you?
- ▶ Did you feel that the consultation was successful?
- ▶ What do you think are the best ways to help patients that are obese?
- ▶ How you feel about psychological/dietary/medical/surgical interventions?

and themes that emerged in association with these were written down.

## RESULTS

GPs primarily described the management of obesity in terms of the issue of responsibility. One GP stated that severe obesity was a medical problem that fell within their professional domain and believed that GPs should take responsibility for its management:

*'There is another group of people who are much more seriously overweight ... who are either encountering medical problems, or at a high risk of medical problems, and actually probably what we should be taking is a more medical medicalised approach.'* (Dr 5.)

The other GPs, however, felt that obesity was ultimately a problem that had both been caused and should also be managed by the patient themselves. For example they described how patients have unhealthy diets:

*'Because of his lifestyle — he was working in the City — his lunch was fast food and so it was a difficult issue for me.'* (Dr 15.)

And:

*'She is a woman who has had a sort of fairly appalling diet, clueless really about ... what a calorie is ...'* (Dr 7.)

GPs also described how patients don't recognise the nature of the problem:

*'What I feel is almost a classic response from women who want to lose weight, but are big, is the sort of "but I only eat a lettuce leaf" approach.'* (Dr 11.)

They also described how patients can be in denial:

*'She often presents asking to be referred to physiotherapy for treatment of her ankle, or the chiropodist to have different shoes to make her feel better, and is really avoiding the real issue.'* (Dr 5.)

The GPs therefore stated that obesity was ultimately the patient's responsibility. In contrast, however, they also described how they felt that the patients did not see the problem in the same way and believed that obesity was the responsibility of the doctor. For example, one GP described how patients want to hand control of their problem to the doctor:

*'He wanted me to magic him lighter.'* (Dr 6.)

And similarly:

*'He was looking to what I was going to do about his weight rather than what he was going to have to do about it.'* (Dr 21.)

They also described how patients were reluctant to accept responsibility for their problem and how some attributed their weight to either a medical cause:

*'Usually patients say, "It's in my genes so we're all overweight — we all eat nothing and we're all overweight."'* (Dr 4.)

Or an external cause:

*'Obesity has become ... into this external problem, it isn't a great deal to do with her anymore in a way, but it is a bit like having a housing problem.'* (Dr 5.)

GPs therefore described the issue of responsibility and although they felt that obesity was ultimately the patient's problem, they felt that patients wanted the doctor to take ownership. This conflict resulted in GPs feeling frustrated with their patients' inability to change their lifestyle. For example, one GP described how suggestions for behaviour change are often met with excuses:

*'People start saying they can't do the exercise, because they can't go to the sessions and ... then you talk about other options ... like going swimming ... just something that would ... get them started and it feels like it's just too much to ask ... And then I end up feeling it isn't possible for them to do it, so I feel annoyed with them for not just doing it.'* (Dr 3.)

Further, although a small minority expressed some faith in the ability to make a difference, for the majority of GPs, this conflict was exacerbated by a general sense that even if they did accept responsibility for a patient's weight, none of the available treatment options were particularly effective. For example, one GP stated:

*'It is a very current major problem and yet as primary care providers we are very ineffective and rather powerless.'* (Dr 18.)

In particular, they were critical of a catalogue of obesity interventions including dietary advice:

*'I'm not a dietician and I don't feel able to monitor their diet properly.'* (Dr 1.)

Comments about anti-obesity drugs included:

*'I think actually, at the moment, that the drugs are only half the story, and that we actually don't have an effective thing to produce weight management.'* (Dr 10.)

One GP was against the option of surgery:

*'Surgery is hugely risky; it gives a really horrible cosmetic effect. It kind of fuels the cosmetic industry. I've never referred anyone for surgery, and I don't think I would.'* (Dr 11.)

The psychological approach was also discussed:

*'Unless they have an eating disorder, I wouldn't really think of involving the psychiatrist or psychologist.'* (Dr 14.)

Living in this state of conflict was particularly uncomfortable for many doctors as they felt that it presented a challenge to their relationship with their obese patients and believed that a good relationship with their patients was central to their role as a GP:

*'I think with any chronic disease ... if there is a good doctor-patient relationship then that definitely will help to overcome not just the problem but other surrounding issues.'* (Dr 15.)

Dr 15 also described how he felt after a consultation with an obese patient that had involved offering advice about behaviour change:

*'I felt happy. I felt at least I had given him knowledge ... and at least I'm here if he needs to come or needs any help on any other issue.'* (Dr 15.)

The GPs also described a range of strategies that they used to preserve this relationship with their patients. At times this involved offering empathy, an awareness of the stigma associated with being overweight and trying to locate the problem of weight in the broader context of the patients' lives:

*'He came to see me, and there was lots of anger he had about the difficulty with his weight, his problems with his sex life, the fact that other people had died, his dad had died the year before. His brother had learning difficulties.'* (Dr 6.)

And similarly:

*'They've got problem of housing, marriage, children, money, so they've got other sorts of problem.'* (Dr 16.)

GPs also described how they sometimes met the patients' expectations by offering them medication even when they believed that it wasn't the solution:

*'So I was quite relieved after about a month that she came to me, and she said, you know, "let's stop this drug", because I didn't think it was the right thing for her.'* (Dr 9.)

## DISCUSSION

### **Summary of main findings**

The results indicate that GPs conceptualise obesity in terms of responsibility and, in general, believe that its management is primarily the responsibility of the patient. They also believe that, in contrast, patients see obesity as a medical problem that should, and can be, managed by the doctor. This contradiction creates a sense of conflict for the GPs, which is exacerbated by their lack of faith in existing treatment options and a desire to maintain a good doctor-patient relationship. A need to resolve this conflict resulted in GPs sometimes offering treatments that they believed were inappropriate and offering support for patients' other associated problems.

### **Strengths and limitations of the study**

The present study used a qualitative design with open-ended questions to encourage GPs to express their own views about treating obesity in the context of their day-to-day care. Such a design emphasises the participants' own perspectives and minimises the impact of the researchers' own agenda. However, the sample size was quite small and limits the generalisability of the results. Further, it is possible that the views and perspectives of the researchers influenced either how the GPs responded to the questions in the interviews, or how the data was interpreted. A larger scale quantitative study of GPs' beliefs would enable a more representative sample to be used and could ask questions in a more neutral environment.

### **Comparison with existing literature**

The results from this study provide support for existing research. The results indicates that GPs believe that obesity is primarily the responsibility of the patients and is line with studies that show that GPs think the primary causes of obesity are factors, such as eating too much, that are within patients' control.<sup>13</sup> The GPs in this study also felt that patients preferred a more medical approach

and want to hand responsibility back to the GP reflecting research which indicates that patients opt for a more medical model of obesity.<sup>13</sup> In addition, the GPs reported feeling sceptical about the success of any available interventions which mirrors the reviews of research indicating that many treatment interventions only have a limited degree of success.<sup>4,5</sup> Finally, the GPs illustrated a desire to maintain a good relationship with the patients, even if this entailed offering treatments in which they had little faith. Previous research has illustrated how central the doctor-patient relationship is to the consultation from both the doctors' and patients' perspectives.<sup>17,18</sup> The results from the present study indicate that this relationship is not only a consequence of patient management, but is also at the forefront of how doctors chose to manage their patients.

#### **Implications for clinical practice and future research**

The government's white paper *Choosing health: making healthy choices easier*<sup>19</sup> and recent obesity documents emphasise the role of primary care in obesity management and suggest that increased resources to facilitate referrals and changes in the quality criteria in the new GP contract could improve the management of this intractable problem.<sup>14</sup> The results from the present study, however, suggest that GPs are not yet convinced that obesity treatment is within their professional domain. Further, even if GPs were to accept obesity management as a legitimate part of their responsibility to patients they remain sceptical of what they can offer. The problem would seem to be one of responsibility and efficacy rather than resources and financial reward. Primarily, managing obesity in primary care requires the development of effective patient interventions in which GPs can have faith. Until such interventions have been developed and are shown to be

effective GPs may remain unconvinced that obesity is a problem requiring their clinical expertise and may continue to resist any government pressure to accept obesity as part of their workload.

#### **Ethics committee**

East London and City Local Research Ethics Committee (P2/04/021)

#### **Competing interests**

None

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