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Manuscript title: Talking about overweight and obesity in rural Australian general practice

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Talking about overweight and obesity in rural Australian general practice

Abstract

As many patients' sole point of contact with the health care system, primary health care physicians (general practitioners (GPs) in Australia) are often positioned as key players in responding to rates of overweight and obesity in dominant public discourse. However, research from Western industrialised countries suggests that GPs may not be prepared for, or confident in, having conversations about overweight and obesity with patients. Little attention has been given to this topic in Australia, particularly in the context of rural health. The aim of this study was to understand how GPs in two rural settings in Victoria, Australia talk about overweight and obesity with patients. Working from a multidisciplinary perspective, a qualitative study design was adopted, and semi-structured interviews were conducted with seven GPs and seven GP patients living in two rural communities between January and April, 2016. Data was coded manually and thematic analysis was used to explore the data. The findings of this study support the argument that, in contrast to dominant messages within public health discourses, GPs may not be best placed to act as the primary actors in responding to overweight and obesity as they are constructed in epidemiological terms. In fact, the perspectives of GP study participants suggest that to do so would compromise important dimensions of general medical practice that make it simultaneously a humane practice. Instead, more balanced, holistic approaches to discussing and responding to overweight and obesity with patients could be taken up in local, interdisciplinary collaborations between different health professionals and patients, which utilise broader social supports. Focussing on long-term, incremental programs that consider the whole person within their particular socio-cultural environment would be a productive means of

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working with the complexities of overweight and obesity. However, structural level changes are required to ensure such initiatives are sustainable in rural practice.
Key words: overweight, obesity, talk, rural, GPs, patients

What is known about this topic?

- Primary health care physicians are often understood as the central actors responding to overweight and obesity.
- Current evidence suggests that overweight and obesity are rarely discussed during primary health care consultations.
- The body of knowledge regarding how Australian primary health care providers/GPs, talk about overweight and obesity with patients is limited.

What this paper adds

- Rurally-based GP participants treated weight as a complex matter requiring considered and nuanced approaches.
- In contrast to dominant portrayals, GPs may not be best placed to act as the primary actors in responding to overweight and obesity.
- In rural contexts, interdisciplinary, long-term, and, importantly, sustainable programs that consider the whole person within their particular socio-cultural environment are recommended.

Introduction

Given their frequent contact with patients who are considered overweight or obese (Heintze et al., 2010; Laidlaw, McHale, Locke, & Cecil, 2015; Peters et al., 2013; Swift, Choi, Puhl, & Glazebrook, 2013), primary health care physicians (GPs in Australia) are often identified in dominant discourse as the central actors in responding to rates of overweight and obesity (Heintze et al., 2010; Laidlaw et al., 2015; Peters et al., 2013). Consequently, GPs increasingly receive explicit directives from overseeing bodies to work intensively with patients around overweight and obesity (Alexander et al., 2007; Laidlaw et al., 2015). However, currently available evidence suggests that discussions about overweight and obesity between a patient and their primary health care professional are uncommon (Turner, Harris, & Mazza, 2015). International literature has found that primary health care physicians are unlikely to discuss weight-related issues – specifically, weight management and weight loss (Alexander et al., 2007; Laidlaw et al., 2015). Some evidence suggests a decline rather than an increase in these discussions over the last twenty years (Laidlaw et al., 2015).

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Existing international research has identified several key issues constraining doctor-patient communication about overweight and obesity from physicians' perspectives. These include: lack of time (Alexander et al., 2007; Chisholm, Hart, Lam, & Peters, 2012; Peters et al., 2013); disbelief in patients' commitment to losing weight (Alexander et al., 2007); 'pessimism about long term success', and frustration 'due to low patient compliance' (Peters et al., 2013, p. 4); and a lack of appropriate training in how to have weight-related discussions (Alexander et al., 2007; Chisholm et al., 2012; Peters et al., 2013). Relatedly, while medical trainees may feel confident in their abilities to have these conversations, this confidence is likely to be overestimated as trainees have been found to have insufficient communication skills with which to approach discussions related to behavioural change and be less competent than they perceive in using evidence-informed techniques to encourage behavioural change in patients (Peters et al., 2013). This may explain why this confidence lowers once they are practicing physicians (National Institute for Health and Clinical Excellence, 2006). This concurs with research (Peters et al., 2013; Puhl & Brownell, 2001) finding that GPs' low self-efficacy and doubt in their ability to 'treat' overweight and obesity are key obstacles to engaging patients in discussions about weight. Other studies have also found that GPs avoid discussions about overweight with their patients because of a concern that such discussions may cause offence and/or provoke a negative reaction (Hansson, Rasmussen, & Ahlstrom, 2011; Michie, 2007; Pedersen & Ketcham, 2009).

Another critical issue raised in current international literature is the dominant attitude towards people who are considered overweight or obese: they are often stigmatised, subject to blaming discourses and encounter prejudice and bias in their daily lives (Puhl & Brownell, 2001; Puhl & Heuer, 2009). The medical profession is not immune to these prevailing attitudes. Student doctors have been found to hold negative views about people considered overweight or obese (Peters et al., 2013), as have practicing health care practitioners, including those who specialise in obesity (Swift et al., 2013). This makes respectful and empathetic communication, identified as important for facilitating behavioural change (Lindner, 2001; Swift et al., 2013), difficult to achieve.

Alexander et al. (2007) identified several ways in which GPs initiate discussions about weight with their patients. Some wait for their patient to raise the issue, others 'go through the back door' by linking to comorbidities (Alexander et al., 2007, pp. 499-500). It should be noted that patients have often been found to be reticent about bringing up their weight with doctors (Tham & Young, 2008; Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008).

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GPs in Laidlaw et al.'s (2015, p. 313) study were more likely to initiate a discussion about weight than patients, but these discussions were rarely successful and patients frequently 'reduced space' (defined by Laidlaw et al. (2015, p. 311) as 'using behaviours that are not facilitative for discussing weight, such as blocking or reducing scope for further discussion or changing the topic of discussion') for these conversations. Patient-initiated discussions were 'more likely to result in a weight-related outcome' (Laidlaw et al., 2015, p. 313). However, if patients attempted to raise the issue of weight towards the end of the consultation, GPs frequently 'blocked' the discussion, which suggests that time constraints may encourage blocking behaviours and that weight discussions are understood as time consuming (Laidlaw et al., 2015, p. 313).

Overall, there is an expectation that GPs act as key agents in responding to overweight and obesity in many Western industrialised countries. Simultaneously, research is consistent in highlighting an under-preparedness and lack of confidence in many GPs about how to have discussions with their patients about overweight and obesity (Campbell et al., 2000; Chisholm et al., 2012; Michie, 2007). International scholars agree that there is a research gap in relation to how GPs and patients talk about overweight and obesity (Alexander et al., 2007; Laidlaw et al., 2015; Webb, 2009, 2013). In Australia particularly, little attention has been given to this topic. This knowledge gap is significant because if these discussions do not take place, or are poorly managed, behavioural change, recognised as the most effective option to initiate weight loss (Marteau, Dieppe, Foy, Kinmonth, & Schneiderman, 2006), is unlikely to occur.

This incongruence and the issues it raises were highlighted in a local, regional Australian context when, in 2014, a community health survey was undertaken in four regional areas of Victoria (Ervin et al., 2015). Respondents were asked a comprehensive range of questions including, 'Have you ever been advised to lose weight by a health professional?' and 'Have you had a diagnosis of obesity?', and their weight and height. Based on self-reported height and weight, 69.3% of respondents across the four sites had, according to current guidelines, body mass indices (BMI) corresponding to overweight (39.7%) or obese (29.6%). Yet few (22%) participants reported having been advised to lose weight by a health professional. Such findings indicated a reluctance amongst local health professionals to have explicit conversations with patients about what their weight means in the context of current clinical guidelines. Thus, the aim of this study was to gain a deeper understanding of how GPs in

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these rural areas talk about overweight and obesity with their patients. The specific barriers to effective conversations between GPs and GP patients that this study identified have been outlined elsewhere (Glenister, Malatzky, & Wright, 2017). In this paper, we explore rurally-based Australian GPs' perspectives on overweight and obesity and analyse how these practitioners approach overweight and obesity in their everyday practices. We use this analysis to consider whether GPs are well-positioned to directly address overweight and obesity in their practice and relatedly, how alternative ways of understanding and responding to overweight and obesity can be taken up and promoted in rural communities.

Methods

The researchers/authors who conducted this study are two academics working in rural health; one biomedical scientist with a focus on chronic illness in rural communities and one sociologist with a focus on cultural inclusion in rural health care. This study was thus an exercise in multidisciplinarity; the two researchers worked together, drawing on different bodies of knowledge and interpretative lenses to design the study, collect and analyse data and present findings to different audiences (Choi & Pak, 2006). This involved researchers sharing different knowledges; the biomedical scientist drew on knowledge pertaining to clinical guidelines and the physiological relationships between health and overweight and obesity, and the sociologist of knowledge pertaining to qualitative inquiry, and a particular social constructionist approach to conceiving the social world and human interaction (Foucault, 1972; Holstein & Gubrium, 2011). Through this collaborative approach to the methodology, it is clear to both researchers that their individual positionalities, including their disciplinary and personal locations inform how research is conducted; and specifically how the data in this study was analysed and interpreted (Mauthner & Doucet, 2003; Ramazanoglu & Holland, 2002). Thus, the researchers recognise that '[r]epresentation…is always self-presentation' (Denzin, 1994, p. 503) in the research process.

In approaching the study, a qualitative design was adopted because researchers were interested in developing an understanding of what particular GPs do in their everyday practice (how they talk about overweight and obesity with their patients) and why; that is, the meanings GPs associated with their particular practices (see Erickson, 2011). In order to gather localised accounts of how GPs talk about overweight and obesity with their patients, researchers chose to conduct semi-structured one-on-one, face-to-face interviews (see Perakyla & Ruusuvuori, 2011) with both GPs and GP patients who had some experience in talking (or not) about overweight and/or obesity with their own GP. Interview data were

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collected in two of the four sites of the community health survey referenced above. To recruit GPs, a plain language statement summarising the project was sent via email to all GP clinics in the two sites. Interested GPs then contacted the researchers directly. Patients were recruited by displaying a simple flyer outlining the project and asking for participants who had experience of a GP discussing weight with them in several public places including gymnasiums, health clinics and public service noticeboards. A total of seven GPs and seven patients across the two sites participated in individual, one-on-one interviews between January and April, 2016. Both researchers conducted interviews, one with only GP participants and the other with two GP participants and the GP patient participants. The richness of the data generated from this sample was adequate for researchers to explore the key questions articulated in the aims of the research (Gaskell, 2000; Kuzel, 1992; Marshall, 1996; O'Reilly & Parker, 2012). While the sample is small, researchers had limited resources at their disposal to support the analysis of larger numbers of participant data (Gaskell, 2000; O'Reilly & Parker, 2012) and, as is highlighted in the discussion of the research's findings, this topic is ripe for further exploration (Morse, 1995; O'Reilly & Parker, 2012).

GP participants were asked various questions about their interest areas and client group before central questions about how often they raise the issue of weight with their patients who fall into the categories of overweight or obese; how they go about initiating and progressing these conversations; what kinds of advice or guidance they offer patients about how to lose weight; what, from their perspectives, makes it difficult for GPs to have conversations about weight with their patients; what factors they see as being most relevant in explaining why the patients they see are overweight or obese; and what could be done to better support GPs in their efforts to respond to rates of overweight and obesity in the population.

GP patient participants were asked some initial questions about themselves and their community and social contexts and whether they had a regular GP in the local area before central questions about the kinds of issues that usually take them to the doctors; how often their GP/s raise the issue of weight with them during consultations; how their GP/s have gone about initiating these conversations; the kinds of advice or guidance received and its utility; what, from their perspectives, makes it difficult for GPs to have conversations about weight with their patients; what have been the most significant challenges to managing weight in their lives; and what, from their perspectives, could be done to help improve the way GPs approach the topic of weight with their patients. The University of Melbourne's Human

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Research Ethics Advisory Group granted approval for this project (identification number 1545331). Written consent was received from each participant and all interviews were audio-recorded with participants' permission.

The researchers used broad, prompting questions including 'what strikes you?' (Creswell, 2007, p. 153) and 'what do I see going on here?' (Emerson, Fretz, & Shaw, 1995, p. 146) to assist with drawing out and deepening the meanings interpreted from the interview data as they independently coded these data. These interpretations were then shared and discussed before consecutive rounds of coding were undertaken to refine codes and identify patterns within and across data sets (individual interviews) (Charmaz, 2006). The resulting patterns were then drawn together into broad themes (Saldana, 2009), the most dominant of which are outlined below. While recognising that the interpretation of data is inescapably the researchers' construction (Charmaz, 2006; Ramazanoglu & Holland, 2002), substantive extracts from participants' responses are included to provide some justification for how researchers arrived at their particular interpretations (Finlay, 2006).

Findings

The GPs interviewed were experienced rural practitioners who reported that, according to current guidelines, a high proportion of their patients (more than half in each instance) fell into either the overweight or obese category. Participants considered this reflected contemporary norms rather than a peculiarity. However, GP participants were cognisant of prevailing political concerns pertaining to weight trends in Australia (Lupton, 2013) and, in some cases, within their particular rural locality. The way in which GP participants described approaching the topic of weight with patients did not emulate the kind of popularised rhetoric often associated with dominant health narratives which, using a language of moral panic, constructs fatness as both an individual-level 'problem' and 'epidemic' (Boero, 2007; Lupton, 2013).

The complexities of overweight

Based on their experiences, some patient participants indicated that GPs 'seem to dismiss' (GP patient participant 5) weight as a complicated issue. However, GP participants emphasised the complex nature of 'weight issues'. In fact, some GPs expressed that the degree of complexity involved in explaining overweight and obesity can often be under-estimated in dominant public discourses. One GP described how 'a lot of people think it's a

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very straightforward issue and I would say it's way, way more complex than people ever give it credit' (GP participant 1). This particular participant pointed to:

> …how feelings drive behaviours and how hard it is for any of us to change any behaviour: you think, well, we just have to eat less. Well actually [some laughter], actually, we all have barriers to simple change and really, because they stem from a million other things, not just one factor.

As this GP expressed, '…there are a lot of things out of the medical work to be considering…' in conversations about overweight and obesity. Indeed, some GPs challenged the notion that additional weight (to the 'scientific' definitions of 'normal' weight ranges) is necessarily problematic in and of itself (Monaghan, 2005). In this context, GPs articulated that additional weight is an 'issue' that needs to be measured by its impact on other conditions:

> …we know that a certain amount of weight is potentially, makes you unwell, but also *there's lots of very healthy obese people*…obesity or whatever is an interesting thing but you can be overweight or fat and very healthy, you can be skinny and very unhealthy… (GP participant 4)

> It's difficult, isn't it, because, to be honest, in my head it comes under people in whom weight is a problem…it therefore relates to the fact that you've got arthritic knees and a problem from that so your weight matters, because I do believe there are some people who are overweight and still remarkably healthy and actually their weight *isn't really an issue that I need to be too concerned about*…it comes under what problem they are presenting and therefore, is weight something that I think is a contributing factor to either their current condition or something that will cause future problems?... (GP participant 1)

These understandings informed how conversations about overweight and obesity were conducted with patients. That is, the recognition of the complexities of overweight by these GPs translated into nuanced approaches to weight-related issues.

GPs' sensitivities to the social stigma of being overweight or obese and how it affects people's mental wellbeing (Farrell, Warin, Moore, & Street, 2016; Lupton, 2013) also informed GPs' approaches. GPs highlighted how the social stigma surrounding overweight and obesity in countries like Australia makes the language surrounding overweight, including 'obese' and 'fat', highly problematic and destructive.

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> Weight is such a political statement, isn't it? It's such a loaded thing. We say someone is fat – that can mean such a terrible thing to call someone fat. It can be such a critical, nasty comment, we can actually pull someone down just by using the word 'fat'. Yet all it is, is just adipose tissue on a person… (GP participant 3)

GPs were highly conscious that conversations about overweight or obesity are likely to be difficult or potentially upsetting for patients and it was in this context that the importance of relationships and rapport in general practice was emphasised. GPs expressed that a good rapport or an established relationship can make it 'easier' (GP participant 1) to venture into sensitive areas with patients. While one GP participant acknowledged that having a familiar relationship with a patient could make it 'harder' (GP participant 1) to initiate such conversations, it was also relayed that a level of familiarity can make conversation/s more impactful.

The importance of the therapeutic relationship was also emphasised in patients' narratives. Reflecting on the relationships they have or have had with their GPs, patients expressed that they were more likely to feel confident and have productive conservations about weight in situations where the therapeutic relationship had developed over a period time. For these participants, a GP's familiarity with their 'track record', being able to 'say anything…tell [the GP] anything' and having 'continuity' with a particular practitioner were important to ensuring that conversations about weight were comfortable and safe (GP patient participant 7).

Having conversations about overweight and obesity

In recognition of the complex nature of overweight, GPs indicated that their conversations with patients about weight are careful and considered matters involving assessments of context and relevance. GPs spoke about the importance of 'targeting' (GP participant 4) particular patients who are 'kind of ripe and ready not just, continuous, "here's what I think you should do" [laughter]' (GP participant 1), which some patient participants had experienced. The GPs interviewed considered it important that conversations with patients about overweight or obesity occurred at particular times, when the patient was ready, and this requires preparation by both GP and patient. In this context, 'preparation for change' was described as:

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> actually having an idea of the context – what is going on, in their life, what's their, what's the social situation, and therefore getting people to kind of consider, well, at some point I'd like to do more about this or address it and then, when is it ever going to be a good time? When's the right time and what's it going to take to make you actually consider that change or indeed, does it matter to you? (GP participant 1)

GPs spoke about how important it is to tailor care related to weight changes, including the conversations and the advice given to individual patients:

> I tailor to individual people because I know my patients well, I know that some like a different way of handling that and some, and so you can't generalise this problem, you have to really, really individualise (GP participant 2).

This perspective was mirrored in the accounts of patients.

Patient participants emphasised that, in order to seriously take into account the multitude of relevant concerns, including mobility issues, comorbidities, age, personal preferences and financial circumstances, and be effective, weight loss programs need to be individualised. However, some patient participants reported that they had rarely, if ever, been weighed by their GPs and when they had been weighed, the results were not necessarily discussed. Other professionals, such as personal trainers, were more likely to have weighed patient participants than their GPs and to monitor weight changes. Patient participants who had received weight loss advice from their GP expressed that the advice given had been too general to be useful, practical or achievable. These participants wanted 'specifics' rather than what [they] already knew:

> [the GP] said, you've got to be aware of what you eat...[GP] didn't give me specifics, no saying eat A, B, C to lose this much weight (GP patient participant 4).

Most patients expressed that a lack of time during consultations made both the initiation and depth of conversation about overweight and obesity difficult. These patients described how restrictive consultation timeslots can result in the dismissal or downplaying of weight-related issues by doctors. This was articulated in patient comments such as:

> I said 'I wouldn't mind having a chat with someone about my weight', and she [GP] said 'we'll talk about it later', because everything's always rushed (GP patient participant 1).

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These reflections were consistent with those of GP participants who also considered a lack of time during consultations constrained their ability to have in-depth, singularly focused, conversations about weight.

> It's not a small subject, it is related to everything in their life…You cannot explain this in a ten minute appointment (GP participant 1).

GPs spoke about how time is needed to provide holistic care and specific weight loss advice. It was stressed that GPs work under tight time constraints, especially those in bulk-billing practices[1], which restricts their ability to engage extensively in weight-related discussions. The role of nurses was particularly emphasised in this context, although not all attempts to share care had been successful. For example, some GP practices had been unable to sustain, financially, intensive nurse-led clinics, despite the success of these clinics in supporting patients to lose weight. Some GP participants stressed that long-term, time-intensive initiatives are what is needed to assist patients with changing their weight and that rurally-based GPs need better support from system-level structures (often, to enable shared-care with nurses).

GPs largely rejected what could be coined 'direct approaches' to conversations about overweight and obesity with patients. Most GP participants expressed that such approaches are insensitive to individual patient contexts and can be quite harmful. For example, one participant described how:

> …probably five years ago when I read my magazines it was saying, 'OK it's time to start telling patients they're obese, just come out with it, say the word'. That was the thing about five years ago and I remember thinking, 'No, I'm not doing that'…you'll read some articles and they'll say, 'Oh, GPs would just pussyfoot around', we don't actually come right out with it, we sort of say, 'You've got a little bit of weight on' and yet they might have 30 kilos on top and we'll be saying words like, 'You've got a bit of weight on', but that's life though. I don't think you need to be too, you don't know what baggage people are carrying, you don't want to tip someone over the edge, you've got to be kind…they might comfort eat a lot and that's the only thing that's keeping them going, so we've got to be really careful (GP participant 3).

[1] Australia's national health insurance scheme, Medicare, has a fixed fee schedule for medical services. However, medical professionals are allowed to set their own fees; patients pay the 'gap'. Bulk-billing is when a GP sets their fee at the same rate as the Medicare schedule and the practice directly retrieves this fee from Medicare.

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Thus, while from a patient perspective there can be a perception that '[GPs] shy away from it [discussions about weight]' and 'don't seem to take it seriously' (GP patient participant 5), it is possible that sometimes GPs in these circumstances can be taking weight very seriously but this may not be communicated effectively to patients who may be in a place to engage in weight-related discussions (Heintze et al., 2010).

Congruent with these critiques of direct approaches, most of the GPs described raising the topic of weight in indirect, subtle and sensitive ways in order to assess patients' receptiveness and begin to build into a conversation about weight loss for those in whom it may be relevant. GP participants described initiating conversations about weight 'in very sort of roundabout way[s]' (GP participant 2) and 'bring[ing] it up a little bit and just play[ing] it by ear' (GP participant 3). One participant described using:

> permissive phrases like, you know, 'Do you think there's anything that's contributing to your sore knees or are there areas of your health that you're concerned about?' or um, 'Do you feel that your weight has changed?'

Rather than:

> purely [going for], 'You're overweight but has there been a change in your weight?' and try and do a softening up question before jumping in with, 'Don't you think you're a bit fat?' [laughter] which, I don't use that, I don't use that, but yeah, that kind of lead-in question to see if they seem receptive to it or start a look to the scales or something that makes you think, 'OK we can move on here' [emphasis added] (GP participant 5).

One GP particularly stressed the aim or ideal when it comes to conversations about weight within the therapeutic relationship is for patients to initiate the conversation. This was described as a gradual process that involved preparing the patient and choosing the right time for this process.

Once conversations were underway with patients, GPs stressed the importance of being realistic about what to encourage patients to do to lose weight and how much weight to lose. This included being realistic about the patient's ability, within their context, to lose weight. One GP connected this with having respect for the patient:

> …You can be quite fixed up by the standards that are expected and then the reality of what human beings should and can do, and as a GP I think, well, my view is that you

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> want to have people doing their best they can for themselves within what they are able to do…I think we have to respect, and I think that comes with experience, really. You've got to grow in your own practice to work out what kind of person you are and what are my priorities as trying to be a good GP, which will be different to [others]…but we should all be looking at helping the patient, not beating them up over lifestyle issues. Occasionally, we'll beat them up and that's good, but only occasionally [humorous tone and some laughter]. Some people do need that and they'll say that…the reason I lost weight was because I scared them and they knew they were coming back to see me so that, that's just a different skillset, you can play that role of sort of the more parent-child relationship rather than the adult-adult one, and some people are happy with that and can respond to that. So, if that works, then great, but it mustn't be the only one you use (GP participant 5).

These views were consistent with patient perspectives. Some patients said they appreciated doctors speaking to them in clear, unambiguous ways about weight, even to the point of being blunt, while others recalled times when the direct approach taken by practitioners in relation to talking about their weight had been offensive and, ultimately, ineffective:

> I remember this one explicitly [10 years ago]. The anaesthesiologist, she was quite rude about my weight, she said I was lazy. I didn't even know this person, I don't see why she had the right to even start commenting (GP patient participant 5).

Sometimes, this kind of direct approach was associated with medical authoritarianism where practitioners 'make a statement, it's not a discussion' (GP patient participant 4). Regardless of preferred approach-styles, mutual trust and respect were of high importance for patients when receiving weight loss advice from practitioners. This was echoed in GP participants' general discourses about patients and their practice as health care professionals, which strongly emphasised respect for the patient.

Discussion

Clinical guidelines related to the management of overweight and obesity in Australia recommend that primary health care providers 'routinely during standard care and regularly during active management' assess and record patient weight, height and BMI calculations and initiate discussions about these measures with patients (National Health and Medical Research Council, 2013, p. 14). The findings of this study, however, suggest that the way in which these guidelines are enacted in practice can be quite different to the manner in which

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such guidelines suggest these processes should unfold in primary health care settings. It is possible to interpret such discrepancies as essentially poor practice, with doctors failing to act on information pertinent to the current and future health of their patients (National Health and Medical Research Council, 2013). However, the accounts of participants in this study go some way in deconstructing and contextualising the complexities involved in enacting clinical guidelines, with patients in practice.

Existing research has highlighted how an established doctor-patient relationship is likely to lead to overly optimistic prognoses (Fallowfield & Jenkins, 2004). However, this research has also highlighted the importance of 'understanding what is important to patients' in determining how the communication of potentially upsetting or difficult-to-hear information is 'best done' (Fallowfield & Jenkins, 2004, p. 313). For rurally-based GPs, and for GPs in general, establishing a mutually respectful relationship with their patients is an essential component of their practice; it is, in some ways, the ultimate goal and the most sacred element in the clinical encounter (Kearley, Freeman, & Heath, 2001). From this position, the GP participants in this study rationalised their often indirect approaches to raising the issue of overweight and obesity with patients through a prism of patient-centeredness – they made careful assessments about patient-readiness and what was going to be the most meaningful and relevant to patients in their life contexts. These are inevitably subjective assessments, but medical practice is, despite dominant portrayals of neutrality and objectivity, a human social practice embedded within a broader social, historical and cultural context (Beagan, 2003; Foucault, 2004; Levesque & Li, 2014; Malatzky & Bourke, 2017). Thus, GPs may not always make assessments in the most useful way, as the findings of this study indicate, they can strive to practice in ways that are mindful of the broader social and cultural contexts in which they are practicing, and develop skills in different approaches to communicating about difficult topics with their patients (Fallowfield & Jenkins, 2004).

Contrary to the directives of dominant biomedical discourses that pathologise overweight and obesity (Jutel, 2006), the GPs in this study approached weight as a complex matter requiring considered and nuanced approaches. Importantly, most GP perspectives pertaining to the obesity 'problem' were not framed within pessimistic or frustrated narratives, nor within a language of 'patient non-compliance' (Peters et al., 2013). Rather, many of these participants rejected the simplification of weight-related issues (Boero, 2007; Farrell et al., 2016) and understood such phenomena as embedded within social structures and relations rather than solely clinical or medical diagnoses. In fact, some GP participants expressed that overweight

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did not necessarily signify poor health. Correspondingly, the stigmatisation associated with overweight and obesity (Bissell, Peacock, Blackburn, & Smith, 2016; Lupton, 2013) was taken seriously by most GPs in this study. While a related cautiousness in approaching the topic of overweight can be seen to hinder conversations between primary health care physicians and patients (Hansson et al., 2011; Michie, 2007; Pedersen & Ketcham, 2009), most of the GPs in this study prioritised the creation of safe, inclusive environments for patients. The focus for these practitioners was on the contexts and needs of their individual patients.

Relatedly, and consistent with previous research (Laidlaw et al., 2015), both GP and patient participants highlighted the importance of quality therapeutic relationships built over time between patient and health care professional in enabling safe conversations pertaining to weight and ensuring that such conversations lead to meaningful outcomes. In these accounts, respect for the patient in their particular circumstances was highlighted. It should be acknowledged that all the GPs interviewed had been practicing for many years and were thus highly experienced at developing and gauging the development of their professional relationships with patients, something that may be a struggle for less experienced practitioners (National Institute for Health and Clinical Excellence, 2006; Peters et al., 2013).

The GP participants in this study rejected the use of direct language in discussions about overweight and obesity with their patients (e.g., the use of the word ‘fat’), which some government officials in the United Kingdom have advised physicians to use in order to shock patients into weight loss (Martin, 2010). Instead, GP participants preferred to use more discursive language to approach the topic of weight with their patients, which is consistent with the preferences of primary health care providers in the United Kingdom and the United States (Tailor & Ogden, 2009). It also concurs with the views of patient participants who recognised, like GPs, that direct approaches are sometimes appropriate, but emphasised that this is not always the case. GPs need multiple tools (approaches) in their toolbox and should not solely rely on direct styles.

Both GP and patient participants indicated that a lack of time during consultations may make either initiating conversations or having in-depth conversations related to weight difficult. In discussing time restrictions, many GPs highlighted notions of readiness and timing and pointed to the important contribution of nurses in providing holistic, client-centred clinics to complement the care GPs provide to patients. From patient perspectives, lack of time during

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GP consultations could lead to feelings of dismissal or the downplaying of weight-related issues. However, the extent to which the allocation of more time leads to more or deeper discussions about overweight has been questioned (Laidlaw et al., 2015) and some of the GP participants in this study emphasised that other health professionals, most specifically nurses, may be better positioned to engage with patients over the many facets of weight loss (Phillips, Wood, & Kinnersley, 2014). This transition to more intensive nurse engagement with the issues of overweight and obesity could be managed by GP referral to clinic/GP practice-based nurses. However, as the findings of this study indicated, a means to increase the financial sustainability of nurses' involvement in weight management with patients is needed.

Both GPs and patients discussed a lack of referral or complementary service options and pointed to the need for tailored rather than 'one size fits all' approaches to weight loss advice (Grima & Dixon, 2013). However, consistent with other research (Evans, 1999; Simkin-Silverman et al., 2005), generalised rather than more specific advice was most commonly reported, something that some patients indicate is inadequate (Hart, Yelland, Mallinson, Hussain, & Peters, 2016). Specialist weight management clinics are not widely available, particularly in rural areas (Grima & Dixon, 2013), leaving rural GPs with limited support. This points to the potential of mobilising other health professionals, including nurses, and social supports to respond collaboratively, where relevant, to overweight and obesity in rural areas.

Conclusion

This study has contributed to current understandings of how Australian GPs, specifically those based outside of metropolitan areas, conceptualise and approach discussion about overweight and obesity with their patients. The small number of participants involved in this study means that we must be cautious about the conclusions that can be drawn. However, by focusing on the perspectives of both GPs and GP patients, the complexities involved in responding to overweight and obesity during GP consultations have been highlighted. The perspectives on overweight and obesity expressed by the GPs in this study emphasise a critical mindfulness about the socio-cultural dimensions of, and realities that produce, such phenomena. From these perspectives, overweight and obesity, as they are constructed in epidemiological terms, are not issues that GPs are well-positioned to directly address in their practice. In fact, the narratives of many GPs interviewed suggest that to do so would

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compromise important dimensions of general medical practice that make it simultaneously a human practice. This contrasts with dominant portrayals of GPs as the main actors in these matters and points to the need for further exploratory research into how overweight and obesity can be best approached within primary health care, specifically in rural settings, and the role of GPs in this work.

Most GP participants used their autonomy as medical practitioners to promote balanced, holistic approaches to discussing and responding to overweight and obesity with patients. We suggest that these approaches be taken up by local community initiatives to focus on the creation of collaborative, interdisciplinary, long-term, and incremental programs that consider and respect the whole person within their particular socio-cultural environment. However, there are currently few such options available in rural communities, as rural practices can struggle to make them financially viable. These constraints, coupled with the need for more guidance and support emphasised by patients, point to the need for structural-level changes to the Australian health care system to enable such initiatives and ensure they are sustainable in rural practice.

References

Alexander, S. C., Østbye, T., Pollak, K. I., Gradison, M., Bastian, L. A., & Namenek Brouwer, R. J. (2007). Physicians' beliefs about discussing obesity: Results from focus groups. American Journal of Health Promotion, 21(6), 498-500.

Beagan, B. L. (2003). Teaching social and cultural awareness to medical students: 'It's all very nice to talk about it in theory, but ultimately it makes no difference'. Academic Medicine, 78(6), 605-614.

Bissell, P., Peacock, M., Blackburn, J., & Smith, C. (2016). The discordant pleasures of everyday eating: Reflections on the social gradient in obesity under neo-liberalism. Social Science & Medicine, 159(159), 14-21. doi:10.1016/j.socscimed.2016.04.026

Boero, N. (2007). All the news that's fat to print: The American "obesity epidemic" and the media. Qualitative Sociology, 30(1), 41-60. doi:10.1007/s11133-006-9010-4

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D., & Tyrer, P. (2000). Framework for design and evaluation of complex interventions to improve health. British Medical Journal, 321(7262), 694-696.

Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. London: Sage Publications.

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Author Manuscript

Chisholm, A., Hart, J., Lam, V., & Peters, S. (2012). Provider perspectives: Current challenges of behavior change talk for medical professionals and trainees. Patient Educ Couns, 87(3), 389-394. doi:10.1016/j.pec.2011.12.001

Choi, B. C. K., & Pak, A. W. P. (2006). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. Clinical And Investigative Medicine. Medecine Clinique Et Experimentale, 29(6), 351-364.

Creswell, J. (2007). Qualitative inquiry and research design: Choosing among five approaches (2nd ed.). Thousand Oaks, California: Sage publications.

Denzin, N. (1994). The art and politics of interpretation. In N. Denzin & Y. Lincoln (Eds.), Handbook of qualitative research. London: Sage.

Emerson, R., Fretz, R., & Shaw, L. (1995). Writing ethnographic fieldnotes. Chicago: University of Chicago Press.

Erickson, F. (2011). A history of qualitative inquiry in social and educational research. In N. K. Denzin & Y. S. Lincoln (Eds.), The sage handbook of qualitative research (pp. 43-59). United States of America: Sage Publications.

Ervin, K., Pallant, J., Terry, D., Bourke, L., Pierce, D., & Glenister, K. (2015). A descriptive study of health, lifestyle and sociodemographic characteristics and their relationship to known dementia risk factors in rural Victorian communities. AIMS Medical Science, 2(3), 246-260. doi:10.3934/medsci.2015.3.246

Evans, E. (1999). Why should obesity be managed? The obese individual's perspective. International Journal of Obesity and Related Metabolic Disorders: Journal of the International Association for the Study of Obesity, 23(Suppl 4), S3-5; discussion S6.

Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. Lancet(9405), 312-319.

Farrell, L. C., Warin, M. J., Moore, V. M., & Street, J. M. (2016). Emotion in obesity discourse: Understanding public attitudes towards regulations for obesity prevention. Sociology of Health & Illness, 38(4), 543-558. doi:10.1111/1467-9566.12378

Finlay, L. (2006). 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. BRITISH JOURNAL OF OCCUPATIONAL THERAPY, 69(7), 319-326.

Foucault, M. (1972). The archaeology of knowledge and the discourse on language. New York: Pantheon Books.

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Foucault, M. (2004). The crisis of medicine or the crisis of antimedicine? Foucault Studies (1), 5-19.

Gaskell, G. (2000). Individual and group interviewing. In M. Bauer & G. Gaskell (Eds.), Qualitative researching with text, image and sound (pp. 38-56). London: Sage.

Glenister, K., Malatzky, C., & Wright, J. (2017). Barriers to effective conversations regarding overweight and obesity in regional Victoria. Australian family physician, 46(10), 769-773.

Grima, M., & Dixon, J. (2013). Obesity: Recommendations for management in general practice and beyond. Australian family physician, 42(8), 532-541.

Hansson, L. M., Rasmussen, F., & Ahlstrom, G. I. (2011). General practitioners' and district nurses' conceptions of the encounter with obese patients in primary health care. BMC Family Practice, 12(7), 7-7. doi:10.1186/1471-2296-12-7

Hart, J., Yelland, S., Mallinson, A., Hussain, Z., & Peters, S. (2016). When is it ok to tell patients they are overweight? General public's views of the role of doctors in supporting patients' dieting and weight management. Journal of health psychology, 21(9), 2098-2107. doi:10.1177/1359105315571974

Heintze, C., Metz, U., Hahn, D., Niewöhner, J., Schwantes, U., Wiesner, J., & Braun, V. (2010). Communication study: Counseling overweight in primary care: An analysis of patient–physician encounters. Patient Educ Couns, 80(1), 71-75. doi:10.1016/j.pec.2009.10.016

Holstein, J., & Gubrium, J. (2011). The constructionist analytics of interpretive practice. In N. K. Denzin & Y. S. Lincoln (Eds.), The sage handbook of qualitative research (pp. 341-357). Thousand Oaks, California: Sage Publications.

Jutel, A. (2006). The emergence of overweight as a disease entity: Measuring up normality. Social Science & Medicine, 63(9), 2268-2276. doi:10.1016/j.socscimed.2006.05.028

Kearley, K. E., Freeman, G. K., & Heath, A. (2001). An exploration of the value of the personal doctor-patient relationship in general practice. British Journal of General Practice, 51(470), 712-718.

Kuzel, A. (1992). Sampling in qualitative inquiry. In B. Crabtree & W. Miller (Eds.), Doing qualitative research (pp. 31-44). Thousand Oaks: Sage.

Laidlaw, A., McHale, C., Locke, H., & Cecil, J. (2015). Talk weight: An observational study of communication about patient weight in primary care consultations. Primary Health Care Research & Development, 16(3), 309-315. doi:10.1017/S1463423614000279

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Author Manuscript

Levesque, A., & Li, H. Z. (2014). The relationship between culture, health conceptions, and health practices: A qualitative-quantitative approach. Journal of Cross-Cultural Psychology, 45(4), 628-645.

Lindner, L. (2001). Broach the subject: Talking to patients about weight. Nutrition in Clinical Care, 4(5), 233-234. doi:10.1046/j.1523-5408.2001.00002.x

Lupton, D. (2013). Fat. Milton Park, Abingdon, Oxon: Routledge.

Malatzky, C., & Bourke, L. (2017). When the social meets health in rural Australia: Confronting the disconnect. Health Sociology Review, 26(2), 190-203. doi:10.1080/14461242.2016.1275978

Marshall, M. (1996). Sampling for qualitative research. Family Practice, 13(6), 522-525.

Marteau, T., Dieppe, P., Foy, R., Kinmonth, A.-L., & Schneiderman, N. (2006). Behavioural medicine: Changing our behaviour: A growing body of evidence shows how to make behavioural interventions effective. British Medical Journal, 332(7539), 437-438.

Martin, D. (2010). Obese? Just call them fat: Plain-speaking doctors will jolt people into losing weight, says minister. The Daily Mail. Retrieved from http://www.dailymail.co.uk/news/article-1298394/Call-overweight-people-fat-instead-obese-says-health-minister.html

Mauthner, N. S., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. Sociology, 37(3), 413-431.

Michie, S. (2007). Talking to primary care patients about weight: A study of GPs and practice nurses in the UK. Psychology, Health & Medicine, 12(5), 521-525.

Monaghan, L. (2005). Discussion piece: A critical take on the obesity debate. Social Theory & Health, 3(4), 302-314.

Morse, J. (1995). The significance of saturation. Qualitative Health Research, 5(2), 147-149.

National Health and Medical Research Council. (2013). Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia. Retrieved from Melbourne: http://www.dannysplace.com.au/wp-content/uploads/2016/02/NRMHC_guidelines_Guidelines_ver1.pdf

National Institute for Health and Clinical Excellence. (2006). Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. Retrieved from http://www.nice.org.uk/guidance/CG43

O'Reilly, M., & Parker, N. (2012). 'Unsatisfactory saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. Qualitative Research, 13(2), 190-197.

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Pedersen, P. J., & Ketcham, P. L. (2009). Exploring the climate for overweight and obese students in a student health setting. Journal of American College Health, 57(4), 465-480.

Perakyla, A., & Ruusuvuori, J. (2011). Analyzing text and talk. In N. K. Denzin & Y. S. Lincoln (Eds.), The sage handbook of qualitative research (pp. 529-543). United States of America: Sage Publications.

Peters, S., Bird, L., Ashraf, H., Ahmed, S., McNamee, P., Ng, C., & Hart, J. (2013). Medical undergraduates' use of behaviour change talk: The example of facilitating weight management. BMC Medical Education, 13(7), 1-12.

Phillips, K., Wood, F., & Kinnersley, P. (2014). Tackling obesity: The challenge of obesity management for practice nurses in primary care. Family Practice, 31(1), 51-59.

Puhl, R., & Brownell, K. D. (2001). Bias, discrimination, and obesity. Obesity Research, 9(12), 788-805.

Puhl, R., & Heuer, C. A. (2009). Stigma of obesity: A review and update. Obesity, 17(5), 941-964.

Ramazanoglu, C., & Holland, J. (2002). Feminist methodology: Challenges and choices. Thousand Oaks, California: Sage Publications.

Saldana, J. (2009). The coding manual for qualitative researchers. London: SAGE publications.

Simkin-Silverman, L. R., Gleason, K. A., King, W. C., Weissfeld, L. A., Buhari, A., Boraz, M. A., & Wing, R. R. (2005). Predictors of weight control advice in primary care practices: Patient health and psychosocial characteristics. Prev Med, 40(1), 71-82. doi:10.1016/j.ypmed.2004.05.012

Swift, J. A., Choi, E., Puhl, R. M., & Glazebrook, C. (2013). Communication study: Talking about obesity with clients: Preferred terms and communication styles of UK pre-registration dieticians, doctors, and nurses. Patient Educ Couns, 91(2), 186-191. doi:10.1016/j.pec.2012.12.008

Tailor, A., & Ogden, J. (2009). Avoiding the term 'obesity': An experimental study of the impact of doctors' language on patients' beliefs. Patient Education Counseling, 76(2), 260-264. doi:10.1016/j.pec.2008.12.016

Tham, M., & Young, D. (2008). The role of the General Practitioner in weight management in primary care: A cross sectional study in General Practice. BMC Family Practice, 9(66), 1-7.

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Thomas, S. L., Hyde, J., Karunaratne, A., Herbert, D., & Komesaroff, P. A. (2008). Being 'fat' in today's world: A qualitative study of the lived experiences of people with obesity in Australia. Health Expectations, 11(4), 321-330.

Turner, L. R., Harris, M. F., & Mazza, D. (2015). Obesity management in general practice: Does current practice match guideline recommendations? Med J Aust, 202(7), 370-372.

Webb, H. (2009). 'I've put weight on cos I've bin inactive, cos I've 'ad me knee done': Moral work in the obesity clinic. Sociology of Health & Illness, 31(6), 854-871. doi:10.1111/j.1467-9566.2009.01188.x

Webb, H. (2013). Naturally occurring interactions and guidance codifications in healthcare communication analysis: The case of praising obese patients. International Review of Social Research, 3(2), 29-50. doi:10.1515/irsr-2013-0009

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