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Conceptualising lifestyle "choices:" A qualitative study of GP attitudes towards patients living with "obesity" in the UK

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ABSTRACT

As a complex condition that often arises due to numerous social, environmental and political factors, "obesity" can be understood by healthcare providers as a health outcome that is directly linked to issues that are outside of individual control. UK GPs who participated in a series of focus groups examining attitudes about the role of individual responsibility in weight loss often demonstrated contradictory beliefs when asked about the relationship between obesity, personal responsibility and their patients' (in)ability to take individual action. Whilst GPs who practised in affluent areas were more likely to draw connections between poverty and high rates of obesity, GPs who practised in disadvantaged areas were more likely to discuss the need for all patients to assume personal responsibility for their health behaviours regardless of their individual circumstances. This article examines how GPs from both groups conceptualised personal responsibility in relation to their patients' weight and socioeconomic circumstances. We conclude by outlining the need for GPs to demonstrate empathy when engaging in weight-loss discussions with patients and offer practical support for patients who seek it that is mindful of their material circumstances.

1. Introduction

In a study conducted by the Food Foundation in 2019, researchers found that the poorest 10% of UK households would need to spend 74% of their disposable income on food to meet the National Health Service's (NHS) recommended Eatwell Guide costs, compared to the richest 10% of UK households who would need to spend 6% of their disposable income on food (The Food Foundation, 2019). According to health equity expert Michael Marmot, this disparity in the affordability of healthy foods is a key driver of current UK obesity[1] rates, as the regular consumption of nutritious foods (which are often high in price) and its associated health benefits are only available to people who can afford it (Walker, 2022). For people experiencing financial hardship, foods that are relatively inexpensive but low in nutritional value are often the most viable option. As a result, people in this category are significantly more likely to experience nutrition-related ill health than people with a high disposable income and have a higher prevalence of lifestyle-related conditions such as diabetes and hypertension (Garthwaite, 2016; Warin, 2011). Yet despite this finding, UK government initiatives to tackle obesity often promote weight loss through increased activity and a healthy diet, both of which are only available to those who have the means to implement them (Berlant, 2007; Garthwaite, 2016). The most recent initiative, the Tackling Obesity campaign, encourages individual-level change by promoting regular physical activity and healthy eating to achieve weight loss. This campaign's attempt to "empower" individuals to "make healthy choices" by encouraging individual changes (Department of Health & Social Care, 2020, p. 7) overlooks the social and financial constraints that disadvantaged groups

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[1] Terms such as "obesity" and "excess weight" have been widely criticised by self-identified "fat activists" who view these medicalised terms as attempts to pathologise a non-medical issue, and by patient advocacy groups who view them as inherently shaming and/or stigmatising. We use terms such as obesity and excess weight throughout this article to reflect the terminology used by participants. We fully acknowledge the difficulty in finding a conclusive term that represents and respects all viewpoints.

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face when attempting to lose weight. Additionally, because these campaigns often encourage weight loss to reduce the financial burden that obesity poses to the NHS (Department of Health & Social Care, 2020, p. 5), they risk shaming people who might *want* to lose weight but who are unable to do so because they cannot afford to follow NHS-recommended weight-loss advice (Dolezal & Spratt, 2022)..

In a similar way, the "Change4Life" campaign, launched in 2009, aimed to support people to maintain a "healthy weight" by encouraging them to make positive lifestyle changes (Department of Health, 2008). Despite its altruistic and community-oriented approach to weight-loss and overall health improvement, academics working within obesity studies criticised this campaign for its emphasis on personal responsibility and individual action and for its failure to acknowledge the disempowering circumstances that make both considerably more difficult for disadvantaged groups (Mulderrig, 2018). In a 2016 exhibition showcasing posters promoting health equity, sociologist Oli Williams presented one poster that mimicked the "Change4Life" campaign by using the same font, colour scheme and icons, as well as posing the same question and response format that the campaign used. The question posed in this poster - "hands up if you want to live longer?" – features directly above seven human figures, six with their hands raised and one who, despite trying, cannot raise their hands because they are shackled to a heavy brick labelled "poverty" (Williams, 2016). This emphasis on poverty as a restrictive factor that prevents some people from achieving the same health-oriented goals as their more affluent peers demonstrates how calls for individual action often overlook the debilitating effects of poverty and how they drive health inequities in countries like the UK.

In the UK, expectations of individual responsibility, resilience and rational choice making when it comes to food consumption and exercise often drive weight-related shaming and marginalisation (Dolezal & Spratt, 2022) and contribute to negative attitudes about obesity treatments that are funded by the NHS. Those who argue that individual action and accountability are needed to effectively address national obesity rates often bemoan the use of tax-payers' money to fund what they perceive as a self-inflicted condition (Elliott, 2007). Research shows that some health care providers share these negative biases about patients who are living with obesity, viewing it as a condition that is brought about by a lack of will-power and/or self-control (Bocquier et al., 2005; Brown et al., 2006). For some of these providers, any weight-loss guidance and support that they might be able to offer patients is understood as a waste of their medical expertise because it involves intervening in areas that are believed to fall outside of clinical care (i.e. patients' personal lives and individual circumstances) (Blackburn et al., 2015). However, some health care providers also recognise how poverty and inequality directly influence rising obesity rates, therein viewing their patients' disadvantaged circumstances as health-related matters. Because they view obesity as an outcome of material conditions, providers who fall within this category are less likely to blame individual patients for their excess weight and more likely to shift the onus of responsibility onto the state for its failure to address systemic drivers of ill-health (Schrecker and Bambra 2015; Thomas et al., 2020).

In this article we explore the contention between viewing obesity as a matter of individual choice and viewing it as a symptom of systemic drivers of ill health (i.e. poverty) by examining the attitudes and beliefs of UK-based GPs who took part in a series of eight focus groups. These focus groups were divided into two sets, four included GPs who practised in disadvantaged communities and four included GPs who practised in affluent communities. The purpose of this research was to better understand the role that GPs believe personal responsibility plays in obesity management. By examining overarching differences between these two groups in terms of their perceptions of patient agency and control we situate their attitudes and beliefs within a broader framework of "healthism," a form of neoliberal governmentality that "models popular beliefs, which causes a non-political conception of health promotion by situating the problem of health and disease, and its solutions, at the level of the individual" (Jiménez-Loaisa et al., 2020). We then explore how perceptions that are rooted in healthism overlook the limited capacity that disadvantaged groups have when seeking to control their weight-related behaviours through dietary control and exercise regimes. Following that, we discuss how, during the focus groups, some GPs resisted labelling obesity a "disease" because of their understanding of how it diminishes individual responsibility and encourages complacency amongst patients who then feel that obesity is a health condition that they cannot independently manage. We conclude by outlining the need for GPs to demonstrate empathy when engaging in weight-loss discussions with patients and offer practical support for patients who seek it that is mindful of their material circumstances.

2. Methods

Fieldwork for this study consisted of eight online focus groups with GPs who practised in the most affluent and disadvantaged UK communities according to data collected by Public Health England. Each focus group had four to six participants and included GPs who practised in or around the same locations. Twenty-nine GPs participated in this study. Four focus groups included GPs who practised in the most affluent UK communities and four focus groups included GPs who practised in the most disadvantaged UK communities. Participants were recruited through an independent recruitment company who sourced them through local connections and GP practices. To meet the inclusion criteria GPs had to have one or more years of clinical experience and to practise in or near four UK locations: Esher (Surrey), Knightsbridge (London), Blackpool (Lancashire) and Jaywick (Essex). Because it was difficult for the independent recruitment company to recruit participants in some of these areas due to their relatively small population size participants were also recruited from bordering communities with similar demographics. All participants self-identified as either male or female, with 16 males and 13 females. All participants identified their age range as being between 25 and 64, with most identifying as between 25 and 44 years of age (19 participants in total).

All focus groups were conducted through an online platform and were audio-recorded. They were then transcribed verbatim by an independent transcription service. Each focus group lasted between 60 and 90 min, with the average focus group lasting 75 min. Focus groups followed a semi-structured interview guide, whereby participants were asked open-ended questions about the frequency of their conversations about excess weight with patients during GP consultations, and whether they regularly chose to raise the topic of weight or engage in weight-loss conversations with patients. Participants were also asked about their attitudes and beliefs concerning the role that individual responsibility should play in obesity management, and the role of health practitioners in providing patients with weight-loss support.

All focus groups were conducted by the first author and two other members of the research group. The research team consisted of one medical sociologist, two GPs, one nutrition and behaviour scientist, and one researcher who focuses on primary care interventions. Ethical approval for this study was granted by the Combined University of Oxford Research Ethics Committee (CUREC) and all participants gave written informed consent. All participants were given pseudonyms before the data analysis began. All transcripts were independently coded by three leading members of the research team using NVivo 12. In addition, the research team met regularly to discuss key concepts generated by the data to explore interdisciplinary perspectives and inferences. The three researchers responsible for independently coding the focus group transcripts also met regularly to discuss their codes during the initial stages of analysis and discuss the themes they were concurrently developing. The researchers adopted an inductive approach to data analysis, whereby themes were developed from the codes and later conceptualised as patterns of shared meaning (Braun & Clarke, 2021).

Throughout the data analysis the researchers closely followed Braun and Clarke's 'phases of thematic analysis' (Braun & Clarke, 2006) by

initially familiarising themselves with the transcribed data, reading and re-reading the data, and noting initial ideas. We then systemically generated initial codes across the data set and shared them with each other, before independently collating codes into potential themes. At this point we independently reviewed our initial themes by checking if they worked in relation to the coded extracts and met to discuss them. We then proceeded to identify overlapping themes and merged them together by creating a thematic map of our analysis. Following this, we carried out an ongoing analysis to refine each theme, conceptualised the narrative arch of the analysis, and generated definitive names for each theme. Finally, we collectively produced a scholarly report of the analysis (this article) by putting each theme in conversation with each other and relating this analysis back to the research questions and literature.

3. Situating healthism within competing obesity discourses

In her work on obesity, gender and neoliberalism Hannele Harjunen describes healthism as an ideology that conceptualises health as "the primary basic constituent of an individual's life and thus a priority in all one's efforts. Everything done, and every choice made, is evaluated through the lens of its effect (whether real or assumed) on the individual's health … The most notable features of healthism focus on the individual, personal responsibility, and the idea of free choice" (Harjunen, 2017, p. 68). In this way, healthism offers a theoretical understanding of the relationship between personal responsibility, individual action, everyday choices and health outcomes. Freedom of choice is situated within the healthism framework as a justification for the moral judgements imposed by others who primarily perceive and evaluate everyday actions in relation to health. In the case of obesity, moral judgements about food consumption and exercise regimes are generated by the assumption that all individuals have a choice when it comes to both and that those who develop obesity are choosing wrongly (Saguy, 2013; Sanders, 2019; Ulijaszek & Mclennan, 2016). When asked about their understanding of the relationship between personal responsibility and obesity numerous GPs who practised in disadvantaged areas expressed this view, with many arguing that even their most financially precarious patients should exercise a modicum of control over their food choices and assume responsibility for their excess weight:

> Michael: Where we are now, I'd say that half the patients that come in are using food banks because it is a deprived area and they don't mind telling you. They will tell you that we get this or that and will swap it for this with a neighbour. I have said fair enough because a lot of it is tinned food, like tinned carrots, but now they're getting Christmas pudding, pasties and pies and as soon as they get home, that's their tea. So, straight away, they are not eating the correct food again and that is obviously through lack of money and different areas.
>
> I: How do you think personal responsibility plays into that?
>
> Michael: We can mention it to them and we can try and ask them to take responsibility but a lot of them are not interested and they have to take personal responsibility and I don't feel they are at all times
>
> I: Do you think they should be?
>
> Michael: Without a doubt. We know they're deprived [but] we [also] know that a lot of people aren't paying rent and don't know about responsibility.
>
> FG1, [disadvantaged]

For Michael, the precarity of their patients' position as both food insecure and dependent on food banks does not preclude their ability to take personal responsibility or individual action with regards to their food choices. Whilst he acknowledges that his patients are not eating the "correct food" because of financial constraints that prohibit their capacity to have a balanced diet, he simultaneously argues that his patients should exercise control over their eating habits by substituting "puddings, pasties and pies" that they are given by their local food bank for healthier options. In doing so, he overlooks the limited capacity that food bank users have when choosing the food items that they can consume (Garthwaite, 2016) and fails to fully acknowledge the reasons why his patients are unable to adopt the healthy lifestyle practices that he advises to achieve weight-loss. This is furthered by his argument that his patients are "not interested" in following his advice rather than unable to because of their limited food options. When asked if he believes that his patients should take personal responsibility for their food consumption this GP reiterates his belief that they should and suggests that they purposefully choose not to by situating this failure within the context of them failing to take responsibility in other aspects of their lives (i.e. paying rent). In doing so, he directly attributes their failure to assume responsibility for their diet to an overall failure to assume responsibility for their day-to-day lives, thus attributing their obesity to a general lack of self-management and self-care.

GPs who practised in affluent UK communities were more likely to recognise how financial and social restrictions prevent disadvantaged patients from assuming full control over their food intake and lifestyle behaviours. Whilst not all of these GPs agreed that disadvantaged patients had limited means of control, they were more likely to convey an awareness of how living in a poverty-stricken environment contributes to the de-prioritisation of weight-loss by diminishing perceptions of control that are necessary to feel empowered enough to take individual action:

> Lisa: I think being in poverty and the external influence makes you more likely to be obese and makes it a lot harder for you to get in control of it because there are more external factors that you're not able to control that almost makes it harder for you to get in control of your life. Because you're spending so much effort trying to control all those uncontrollables that it's harder to then focus on what is there before you. So many times I say to patients control your own controllables but when there's so much going on externally it's really hard for them to focus on that … a lot of our patients have got the means to do whatever they want with it [weight-loss], but the patients that don't have those means, absolutely it's a really hard battle. It's an uphill struggle.
>
> FG2 [affluent]
>
> James: If their life is so difficult in terms of their mental health, social situation, poverty, it's very difficult to go and prioritise your health when all the other aspects of your life are so chaotic and hard and difficult for them. The last thing on their list is how do I lose these two kilos?
>
> FG2 [affluent]

For Lisa, high obesity rates in underprivileged communities can be explained by a deficit in control that makes it harder for some patients to assume responsibility for their health behaviours than their more affluent counterparts. Because they are simultaneously dealing with numerous uncontrollable issues that arise from conditions of poverty and deprivation (i.e. food insecurity) they are less likely to prioritise weight-loss or to perceive it as an achievable goal than affluent patients who "have the means" to eat healthily and have more available time to exercise. Lisa's practical advice to "control your own controllables" demonstrates an awareness of the need for some degree of autonomy to positively change one's health behaviours (Marmot & Bell, 2012). Moreover, Lisa acknowledges that this is significantly easier for more affluent patients because they can afford to maintain healthy diets and weight-management practices that enable them to control their weight more easily.

Whilst some GPs who practised in disadvantaged communities acknowledged the daily circumstances that made healthy lifestyle

practices more difficult for their patients, they were more likely to attribute blame to patients for eating inexpensive unhealthy foods than GPs who practised in affluent areas:

> Ron: If they [patients] are still going to put bars of chocolate in their mouth when they are double the weight that they should be there is not much we [GPs] can do.
>
> FG1 [disadvantaged]
>
> Joe: I mean it takes effort to cook compared to putting something in an oven or microwave, or buying Kentucky Fried Chicken … which costs £1.99 and you get a full meal. So, you know, it's also the effort of cooking. So if you have a dysfunctional life which is deprived you're less likely to, I think, cook for a couple of hours and do all of the washing up when you've got a lot of other things on your plate to deal with. So feeding your kids fast food is a lot, lot easier.
>
> FG6 [affluent]

For Ron, their patient's decision to "put bars of chocolate in their mouth" when they are already overweight demonstrates a lack of willingness to make positive lifestyle changes that could lead to substantial weight-loss. This, in turn, discourages them from actively intervening by offering weight-loss advice because they perceive those efforts to be futile when the patient fails to take the initial first step. For Joe, their recognition of the additional "effort" required from people who experience disadvantaged circumstances to regularly cook and clean means that they are more sympathetic when it comes to that patient's decision to consume fast food and are less likely to blame them for it. Whilst some GPs who practised in affluent areas argued that food consumption is largely a choice that individuals make, they were more likely than GPs who practised in disadvantaged areas to express nuanced understandings of the capacity that individuals with limited financial and social support have when seeking to make healthy choices:

> Julia: Yes, we say it's a choice, but if your only choices are between buying fresh food from a corner shop, which is often three times the price of a supermarket, and that's the only place you can get to … it's not really a choice then, is it? … a ready meal can often be quite a lot cheaper than preparing a meal from lots of fresh vegetables, it's not necessarily a choice. So personal choice does have a role somewhere in there but I'm not sure it's always as clear cut as that.
>
> FG6 [affluent]

For Julia, choice-making when it comes to buying nutritious food is limited for those who cannot afford to prepare a nutritious meal with "lots of fresh vegetables" and, instead, resort to ready meals that are significantly cheaper. In this way, the onus of responsibility for poor health is placed on wider systemic structures that render healthy food less affordable than unhealthy foods for people with financial constraints.

4. Encouraging empowerment through individual action

Embedded within discourses of empowerment that encourage individual change through individual action is the assumption that the subject is in direct control of behaviours that lead to poor health outcomes (Cairns & Johnston, 2015; Veitch, 2010). As a result, the individual is often held responsible for any negative health outcomes associated with food consumption and/or lack of exercise that are perceived as the direct outcome of the poor behavioural 'choices' that the person has made. By equating empowerment with individual choice, proponents of this idea typically overlook the myriad ways in which one's ability to choose is often precluded by social and financial constraints that prevent some from regularly having access to healthy foods and the time and environmental opportunities required to exercise on a regular basis. As noted by Christopher Mayes in their study of biopolitics, personal responsibility and obesity "[t]he conception of the individual as a free and rational chooser that only requires correct information to choose the healthy choice does not account for the influence of systemic violence on the capacity to *freely* choose" (Mayes, 2016, p. 66). For many GPs who practised in disadvantaged communities, their understanding of the challenges associated with the disempowering circumstances that prevent their most disadvantaged patients from regularly accessing nutritious food and regular exercise directly coincided with their ongoing argument that their patients were able to (and should) assume control over both and were choosing not to. Moreover, for some, labelling these barriers constituted a form of 'excuse making' on behalf of patients that purposefully sought to explain away harmful 'choices' that patients were making with the aim of minimising their responsibility for their excess weight:

> Amrit: There are ways around it, sometimes people just think 'I've got no time, I've got no money, there's nothing I can do.' A simple skipping rope, a pair of shoes to walk around the block, a walk around programme. Walk around the block a couple of times. It's all to do with making that first step and chipping away at it rather than 'I can't do anything so I'm not going to do anything, I'm just going to weigh this forever.' Defeatist attitude.
>
> FG8 [deprived]

For Amrit, his patient's failure to practically implement his advice by undergoing regular exercise is understood as an excuse because of his belief that everyone can use a 'skipping rope, a pair of shoes to walk around the block [and/or join] a walk around programme.' In this way, failing to undergo these common forms of exercise is understood as indicative of the patient's 'defeatist attitude,' which, Amrit infers, is the reason why they remain overweight. This sentiment was echoed by another GP in a different focus group who also practised in a disadvantaged community:

> Michael: The vast majority [of patients] have nothing. If it is the case of making a meal, you can imagine some of them, they don't go starving, but they are just eating rubbish like the local chip shop that has special offers on like buy two get something free. It's not good stuff because you're looking at the takeaways and I've said things like, why don't you try having a week without any takeaways and they just look at you as if you've gone crazy. They are very deprived these people, and it's [about] trying to help them in any way that I can … People have got to take responsibility themselves. The government can spend all this money and put all these things out there but there are already resources for them to take up and use that don't cost a lot of money and are readily available at the moment … there are resources out there if people want to do it. For me, there is help there.
>
> FG1 [deprived]

For Michael, the accessibility of free weight-loss resources (i.e. digital weight-loss apps, walking trails etc.) means that even patients who "have nothing" can, and should, assume responsibility for their weight. By simultaneously acknowledging that limited financial resources significantly restrict food choices whilst arguing that his patients are largely unwilling to heed his weight loss advice, Michael stresses what he perceives to be the futility of his efforts in offering advice to patients who are seemingly unwilling to help themselves. Despite the government's best efforts to promote weight loss advice and make weight loss options accessible, he argues that his patients purposefully choose to ignore the options that are available to them in favour of leading unhealthy lifestyles. In this way, Michael suggests that his patients have everything they need to feel empowered to take control of their weight and engage in sustained weight-loss efforts but choose not to. Whilst similar sentiments were echoed by some GPs who practised in affluent areas, they were more likely to recognise how the disempowering circumstances that patients from disadvantaged backgrounds face can both preclude and de-prioritise weight loss in everyday life:

Rebecca: If you have a much more calm life and you've got a bit more of a comfortable life then yes, you've got a bit more brain space to think about this year I think I want to join the swimming club … but on the other end if you are trying to deal with domestic abuse, alcohol problems, drug problems, honestly they don't have the brain space to think about healthy living, let's say. They just don't have that space. That's what I can see anyway, that's my observation.

FG7 [affluent]

Paul: I think deprivation puts a big challenge on people to manage their diet and manage their lifestyle, because they [are] probably trying to juggle a lot of things in their lives.

FG3 [affluent]

For Rebecca, the extent to which patients' lives are "calm" in terms of social, emotional and financial stability directly influences the degree to which weight-loss is prioritised and, therefore, achieved. The degree of "comfort" that these forms of stability provide creates an environment wherein patients have the "brain space" required to contemplate and execute effective weight-loss strategies (such as joining a swimming club). For those who do not have this required "brain space" because they are dealing with the day-to-day reality of managing issues such as domestic abuse, alcoholism and drug use, healthy living in general (and weight loss in particular) will likely not be viewed as priorities. In a similar way, Paul recognises that the numerous challenges involved in experiencing disempowering circumstances means that it is significantly more difficult for disadvantaged groups to "manage their diet and manage their lifestyle" than more affluent patients. As a result, these groups are significantly less likely to engage in weight-loss efforts and successfully lose weight. By recognising how feeling empowered to take control over one's weight is curtailed by the disempowering circumstances that arise from conditions of poverty and deprivation, GPs who practised in affluent areas were less likely to argue that all patients should assume equal responsibility when it comes to weight management. In this way, these GPs were also less likely to subscribe to the healthism model than GPs who practised in disadvantaged areas because they were more likely to identify how weight-loss is often outside of individual control for disadvantaged groups.

GPs who practised in disadvantaged communities often expressed a need for patients to demonstrate resilience when faced with obstacles such as financial insecurity by undertaking free forms of exercise and maintaining a healthy diet. As noted by three GPs:

Philip: One thing that I try to push with people when they are saying that they can't afford the gym is the couch to 5k app, which is something that I have used personally … Things like that for me help them take some responsibility.

FG1 [disadvantaged]

Peter: If you live in a socially deprived area, and you are socially deprived, and you're living in a family where all the members are obese as well, your predisposition to being obese is going to be greater, so they are inevitably linked. If you're talking about managing obesity … it's no good if people use that excuse as a reason to not change. It's like, "all my family are overweight so I'm just going to be as well" or "I can't afford to be healthy" or whatever. I feel like it shouldn't be a reason to not change.

FG4 [disadvantaged]

Louise: I think these are related to causes of obesity – genetics, or poverty, or all those other things we listed, but they are not an excuse not to lose weight.

FG4 [disadvantaged]

For these GPs, failing to take responsibility for one's excess weight by referring to social, financial and genetic limitations is understood as an excuse because it is assumed that all patients can maintain a healthy lifestyle despite their individual circumstances if they make the decision to do so.

5. Understanding GPs' resistance to recognising obesity as a disease

In countries such as Canada and the US, obesity is commonly referred to as a disease with pathological properties that mark it as an independent indicator of ill health (Hale and Manjoo 2021). Those who argue that obesity should be recognised as a disease often note that understanding it in this way may contribute to a gradual decrease in obesity stigma by shifting the onus of responsibility away from the individual and re-framing it in a way that is similar to how other risk factors and diseases that do not carry the same social or moral judgments are framed (i.e. hypertension and cancer). In this way, the absence of responsibility that this labelling suggests is positively understood as a way to remedy high obesity rates by decreasing negative shame-related health behaviours (such as comfort eating) that can contribute to it. Additionally, those who support labelling obesity a disease often note that it increases the likelihood of obesity receiving medical funding and allows for a clearer treatment pathway (BMJ 2019). Whilst some GPs who practised in affluent areas were sceptical of this approach, many agreed that it is both appropriate and necessary for obesity to be labelled a disease to decrease national obesity rates:

Harrison: I had the same conversation with one of the other clinical leads. They were very keen to call obesity a disease and I can understand why because if you call obesity a disease then that prompts a pathway. You suddenly get, how do you classify that as a disease? What's your treatment protocol? How do you manage it? It's hard to argue against calling it a disease if I'm honest.

FG4 [affluent]

Anita: I feel it [obesity] needs a label to give it something to tackle, to give the patient the focus to be able to work towards, to be able to use the words we can put this into remission.

FG4 [affluent]

Luke: As soon as you do that [label obesity a disease] it becomes something you need to tackle. You can get pathways, criteria, treatment options. It's much easier if you label it a disease to start tackling it.

FG4 [affluent]

GPs who practised in disadvantaged communities were more likely to argue that obesity should not be labelled a disease because of concerns that it would reduce individual efforts to assume responsibility for weight loss. Moreover, many argued that this would be detrimental to ongoing efforts to decrease national obesity rates because individual responsibility must first be assumed to make effective weight-related changes:

Thomas: The government have done so many schemes: they've put the sugar tax on fizzy drinks, they've done all kinds of things to get it moving but people have to take ownership for themselves. By labelling it a disease, you're telling them that it is okay and it's not and it's not something that they can help when it is something that they very much can help. If somebody has a disease, there isn't anything that they can do about it in my eyes. They come to us for treatment. And labelling it [obesity] as a disease, it is just letting people off with what they're doing, and something has to change.

FG1 [disadvantaged]

John: If we are going to call it a disease that takes away that personal choice altogether and it makes life a lot harder … personal choice is

the only way to go forward and calling it a disease takes that away I'm afraid.

FG1 [disadvantaged]

Amrit: I'm not sure how useful it is to classify it as a disease either, because with a lot of things you classify it as a disease and all of a sudden it takes responsibility away from the person. You have that with addictions and alcoholism, "it's a disease, it's not my fault that I like to take heroin."

FG8 [disadvantaged]

Samuel: I think I would steer away from using it as a disease because I think it really takes the responsibility and ownership away from the patient. I think the focus needs to be on them really to do that.

FG8 [disadvantaged]

For these GPs, labelling obesity a disease is counter-productive when encouraging individual weight-loss because it seemingly suggests that patients are not at fault or responsible for their obesity which, they argue, would likely prevent substantial weight-loss. They contend that to achieve weight-loss patients need to first take responsibility for their weight-inducing lifestyle behaviours. By not doing so, they argue, patients are unlikely to change them and are, therefore, unlikely to lose weight. As a result, the onus of responsibility is placed on patients who are presumed to be able to control these contributing factors. In this way, these GPs situate their arguments within a healthist framework that stresses a need for personal responsibility when it comes to practising healthy lifestyle behaviours.

6. Discussion

Throughout the focus groups, GPs who practised in both affluent and disadvantaged areas situated discussions about national obesity rates within conversations about personal responsibility and the limits of, and capacity for, state intervention. There were, at times, overlaps between GPs from both groups who contested the degree to which individual responsibility could (and should) be enacted in relation to state action, with some GPs in each group presenting as outliers when it came to overwhelming opinions expressed by their peers. However, when examining those overarching opinions, the researchers detected a trend that placed both sets of focus groups in conversation with each other. For GPs who practised in affluent areas, a theoretical understanding of the key obstacles and barriers that patients from disadvantaged communities face when trying to lose weight often led to a reduction in blame, with a focus on how they are unable to follow weight-loss advice for reasons that are largely beyond their individual control. Conversely, whilst most GPs who practised in disadvantaged areas acknowledged the practical difficulties their patients faced when trying to lose weight because of their limited access to health-promoting resources, this awareness typically failed to mitigate attitudes concerning the need for personal responsibility when it comes to weight. For these GPs, patients should still exercise a modicum of control over their food "choices" and exercise patterns by "controlling uncontrollables" to the best of their ability.

The first position adopts a public-health oriented approach by acknowledging the myriad factors that can contribute to weight gain and preclude weight loss (i.e. living in an obesogenic environment, having a genetic predisposition to excess weight etc.) (Bambra, 2019; Lupton, 2018). The second position is rooted in a healthist approach that assumes all people are capable of exercising agency over their consumption habits and lifestyle behaviours despite conditions of inequity that drive and motivate those behaviours (Mayes, 2016). Qualitative studies that have examined GP attitudes towards excess weight in primary care patients have found a similar correlation between GPs' recognition of the difficulty in overcoming practical weight-loss barriers and the expectation that patients should assume responsibility for their excess weight. In their 2019 study Maxine Blackburn and Afroditi Stathi found that GPs wanted patients to "take responsibility for being overweight and for changing this through lifestyle change" and that whilst GPs "express[ed] concern about patients feeling judged, responsibility for weight loss remain[ed] with the patient" (Blackburn and Stathi 2019: 170). By simultaneously expressing concerns about conveying weight-related judgment to patients whilst framing weight-loss as an individual matter, these GPs reiterate cultural views that denigrate the use of fat shaming as a motivational tool to encourage weight loss whilst continuing to frame excess weight as an individual issue (Spratt, 2021). This dichotomy does little to reduce moral judgments about excess weight because of its continued emphasis on personal responsibility and the need for people to assume individual control. Additionally, it fails to practically consider the disempowering conditions that preclude substantial weight-loss for those who experience disadvantaged circumstances.

Critics of neoliberal policies and attitudes that advocate for minimal state involvement in everyday life and promote individual accountability when it comes to lifestyle behaviours often note that discourse around the need for resilience when faced with adversity is problematic when expected of vulnerable and/or marginalised groups (Gill & Orgad, 2018). By expecting these groups to demonstrate resilience when faced with adversity, they argue that these neoliberal policies and attitudes fail to account for the material circumstances that often restrict and/or prohibit their use of common resilience strategies (i.e. social engagement). Instead, government policies should aim to redress the inequalities that prevent these groups from being able to enact resilience by following recommended advice when met with obstacles and barriers. As noted by Felicity Thomas and colleagues in their study of responsibility and poverty-related stress, "[g]overnments can facilitate responsibility in citizens when they provide the material and structural resources required for this to become feasible and when they do so in a way that is respectful and emphasises people's self-worth" (Thomas et al., 2020, p. 1135). In this way, responsibility is understood as an outcome that can only be made possible when individuals are materially and structurally supported by their local and/or national governments. Without that support, vulnerable groups cannot always "bounce back" from adversity in the same way that their more affluent peers might by making recommended changes, and therefore should not be expected to demonstrate resilience in the same way.

In their conceptual work on resilience and personal responsibility, Nikolas Rose and Filippa Lentzos positively re-frame resilience by arguing that it is "fundamentally socially embedded: it grows out of caring relationships, high expectations from others, and opportunities for individuals to participate, to take and be given responsibility for others, and to contribute to their communities" (Rose & Lentzos, 2017, p. 41). In doing so, they suggest that when resilience is operationalised within supportive communities it can be a useful strategy to resist negative feelings associated with conditions of vulnerability and precarity that are reinforced by discourses that attribute blame to individuals for lifestyle behaviours that negatively impact health. However, they further argue that this positive re-framing of resilience is only applicable when it does not subsequently blame marginalised groups for their subjugated position. As they note in their discussion about the relationship between personal responsibility, state accountability and obesity: "we know that, all too often, responsibility is imposed in the service of contested norms, by those who wish to deny or escape their own responsibilities, upon those who are not responsible for their condition and do not have causal powers that responsibility attributes to them – as in the attribution of obesity in the poor to their unhealthy lifestyles rather than their obesogenic environment (Rose & Lentzos, 2017, p. 34). The claim made by both authors that responsibility should not be expected of those who do not have the "causal powers" to assume control accurately conveys the limits of resilience narratives that overlook the material consequences of living in precarious circumstances (i.e. not being able to follow a recommended diet)

and, in doing so, argues against discourses of resilience proffered by those GPs who presented weight-loss as a matter of *will* rather than a matter of *opportunity*.

Throughout the focus groups GPs who supported the idea that all patients can and should take responsibility for their weight often noted that patients had the resources they needed to lose weight because many of those resources are "free" (i.e. walking). In this way, they suggested that all patients are empowered to lose weight because they can follow some aspect of recommended weight-loss advice. UK government tactics that aim to encourage individual- and population-level resilience when faced with adversity often rely on similar discourses of empowerment to generate change. In July 2020 the Tackling Obesity campaign, a government-led initiative to curb national obesity rates in response to the threat posed to people living with obesity by COVID-19, emphasised the need to "empower people to make the healthier choices they want to make" by offering additional support in the form of expanding weight management services available through the NHS, banning television advertisements of foods that are high in fat, sugar or salt before 9pm, and introducing "evidence-based tools and apps with advice on how to lose weight and keep it off" (Department of Health & Social Care 2020). By seeking to empower people by providing tools that, if used consistently, could lead to weight-loss, this approach fails to address the needs of those who want to lose weight but do not have the financial means to follow recommended weight-loss advice. In addition, it seeks to promote feelings of empowerment by providing information about foods that are high in nutritional value and by promoting regular exercise, both of which are, arguably, well-known to people already trying to lose weight (Griffin, 2016).

Rather than reiterating well-known advice that overlooks the limitations of those who are unable to follow it because of financial and/or social constraints, efforts should be made to remedy existing inequalities that prevent disadvantaged groups from making healthier choices. As noted by Michael Marmot in his discussion of how social gradients influence health outcomes, "[b]eing at the wrong end of inequality is disempowering, it deprives people of control over their lives. Their health is damaged as a result. And the effect is graded – the greater the disadvantage the worse the health" (Marmot, 2016: 7). By presenting socio-economic disadvantage as inherently disempowering, Marmot demonstrates how successfully rectifying population-level health issues like obesity is dependent on efforts to redress inequalities that reduce the capacity of members from disadvantaged groups to exercise full control over their lives and everyday choices. In doing so, Marmot offers an alternative view of what it means to empower people to make healthy choices than the one typically promoted by government-led strategies that conceptualise empowerment as a feeling that can be enacted if individuals practically implement appropriate advice. This difference was reflected in the disparate responses that GPs gave when asked about their understanding of the relationship between individual responsibility and national obesity rates. For GPs who conceptualised empowerment as an act that is driven by knowledge and advice, perceptions of individual accountability and patient blame largely came from the understanding that everyone has access to weight-management tools and weight-loss advice and, when patients fail to use those resources, it is because they are *choosing* not to. For GPs whose approach was similar to Marmot's, individuals living with obesity were typically not understood to be at fault for their condition because of a broader recognition of how systemic factors (i.e. poverty) that are largely outside of individual control contribute to current obesity rates.

During the focus groups many GPs who practised in affluent areas emphasised the need for patients to feel *in control* of their lives to feel empowered enough to lose weight. Their recognition of the disempowering conditions that preclude government-recommended action (i.e. experiencing poverty, witnessing violence, drug addiction etc.) coincides with the work of mental health advocates who argue that greater attention needs to be paid to the well-established links between mental ill health and obesity when seeking to reduce national obesity rates (Berlant, 2007). As noted by one GP, "if somebody's got depression they might be comfort-eating. Someone might have binge-eating disorder or compulsive eating disorder, and unless you identify and address those problems you're never going to manage the condition properly." However, for many GPs their recognition of the link between mental ill health and obesity did not prevent them from arguing that patients need to assume personal responsibility for their weight. For GPs who felt powerless to effectively address this link during consultations because of time constraints and/or emotional fatigue, their failure to empathise with patients who are living with obesity could be seen to reflect the restrictive conditions in which they are practising rather than their individual unwillingness to meaningfully engage with their patients' experiences.

When seeking to understand the overarching differences between these two focus groups in terms of their understanding of the relationship between personal responsibility, lifestyle behaviours and obesity it is important to note how practising in each environment could impact their emotive responses. For example, this distinction could be explained by a difference in a *practical* and a *theoretical* approach to these challenges. Because GPs who practise in disadvantaged areas are more likely to witness repeated exposure to those circumstances and how they impact patients, they are arguably more likely to experience empathy fatigue in ways that decrease their sensitivity to the everyday challenges their patients face. This, in turn, can generate feelings of apathy. In this way, GPs who practise in affluent areas could be more likely to demonstrate empathy than their peers because they do not routinely witness these hardships first hand. This difference in attitudes could also be attributed to a difference in common attitudes in each group's local community, with GPs reiterating popular local assumptions about the role of individual responsibility in weight loss.

Additionally, because they are not tasked with offering weight-loss support to patients who cannot practically implement their advice, GPs who practise in affluent areas could be seen to have greater clarity when it comes to recognising the myriad factors that contribute to weight gain that are largely outside of individual control. This clarity could, in turn, decrease their likelihood of attributing blame to the individual because of their recognition of the need for state accountability and state action when it comes to promoting public health. For GPs practising in disadvantaged communities who felt powerless to help their patients lose weight because of the various barriers that prohibit weight loss, blaming patients for their excess weight could also reflect an unwillingness to admit feelings of perceived failure. Because they are unable to offer their patients effective weight-loss interventions that work alongside the root causes of weight gain (i.e. limited access to healthy foods and exercise opportunities) they may feel frustrated by their inability to carry out their clinical role, which could result in them blaming patients for not intervening in an area that they are perceived to be able to more readily control.

7. Conclusion

In this paper we have examined the problematic assumptions underlying the popular argument that, for people who are living with obesity, weight-loss is a matter of individual responsibility and self-control rather than a condition that is often shaped by social, political, and financial circumstances.

Whilst GPs who practised in disadvantaged areas largely acknowledged the disempowering circumstances that made weight-loss more challenging for their patients, their continued expectation that patients demonstrate resilience by losing weight through independent means (i.e. weight-loss apps and free forms of exercise) conveys a limited understanding of the degree to which patients are able to assume control over their lifestyle behaviours. Digital weight-loss applications, for example, are only available to those who have access to digital technology and, as noted by many GPs who practised in affluent communities, living in poverty means that substantial weight-loss is neither

easily achievable nor necessarily prioritised. Individuals who cannot fully control their lifestyle behaviours should not be held accountable for their subsequent weight gain, and efforts should be made to practically recognise these challenges and offer appropriate support for patients who request it. More research is needed to further understand the relationship between empathy fatigue and GP attitudes towards lifestyle behaviours that can lead to ill health, particularly as it relates to obesity and perceptions of individual blame.

Detailed information about individual contributions to the work

Tanisha Jemma Rose Spratt: conceptualisation (equal), writing – original draft (lead), writing – review and editing (lead), project administration (lead), investigation (lead), data curation (equal), formal analysis (equal)

Anisa Hajizadeh: formal analysis (equal), conceptualisation (equal), investigation (supporting), data curation (equal)

Laura Heath: formal analysis (equal), conceptualisation (equal), investigation (supporting), data curation (equal)

Maryam Kebbe: conceptualisation (equal), project administration (supporting), writing review and editing (supporting)

Paul Aveyard: Supervision (supporting), investigation (supporting), funding acquisition (lead)

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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