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# Clinician resistance to broaching the topic of weight in primary care: Digging deeper into weight management using strong structuration theory

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ABSTRACT

Clinical trials have shown that providing advice and support for people with excess weight can lead to meaningful weight loss. Despite this evidence and guidelines endorsing this approach, provision in real-world clinical settings remains low. We used Strong Structuration Theory (SST) to understand why people are often not offered weight management advice in primary care in England. Data from policy, clinical practice and focus groups were analysed using SST to consider how the interplay between weight stigma and structures of professional responsibilities influenced clinicians to raise (or not) the issue of excess weight with patients. We found that general practitioners (GPs) often accounted for their actions by referring to obesity as a health problem, consistent with policy documents and clinical guidelines. However, they were also aware of weight stigma as a social process that can be internalised by their patients. GPs identified addressing obesity as a priority in their work, but described wanting to care for their patients by avoiding unnecessary suffering, which they were concerned could be caused by talking about weight. We observed tensions between knowledge of clinical guidelines and understanding of the lived experience of their patients. We interpreted that the practice of 'caring by not offering care' produced the outcome of an absence of weight management advice in consultations. There is a risk that this outcome reinforces the external structure of weight stigma as a delicate topic to be avoided, while at the same time denying patients the offer of support to manage their weight.

## 1. Introduction

Worldwide, 39% of adults are clinically recognised as overweight and a further 13% obese and excess weight is now the second largest risk factor for premature death after smoking (WHO, 2021, 2022). Defined as 'abnormal or excessive fat accumulation that may impair health' obesity and overweight are significant public health concerns due to the associated increased prevalence of cardiovascular disease, certain cancers and reduced quality of life (WHO, 2021). Strategies to address obesity include interventions at the individual level (targeting individuals' diet and activity levels) and wider public health or regulatory interventions (such as sugar taxes or advertisement bans). Primary care is the first contact individuals have with the health system, where they can access support for excess weight.

In the UK, national clinical guidelines for obesity are informed by indirect evidence that intervention is beneficial; namely that behavioural weight management programmes lead to greater weight loss than self-directed efforts to lose weight (National Institute for Health and Care Excellence (NICE), 2014). However, a recent systematic review reported clinicians felt inhibited from following guidelines because of what was conceived as a number of barriers, namely: they worried that intervening would take too long, that it would risk causing offence, that they did not know how to intervene, and that they were concerned that intervention was ineffective (Warr et al., 2021). A clinical trial showed that a very brief 30-s intervention (endorse, offer and facilitate a referral to a weight management service) was well-received and effective (high

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uptake of support and weight loss) and was delivered in routine care with only brief training (Aveyard et al., 2016). When accounting for the success of the intervention, clinicians who had taken part in this trial acknowledged that barriers to incorporating routine weight management in clinical practice had been overcome (Kebbe et al., 2022). However, clinicians did not incorporate this intervention into their practice beyond the trial period. It seems unlikely that barriers were somehow removed during the trial period but returned in routine practice, suggesting that a deeper explanation is needed (Checkland et al., 2007).

### 1.1. Obesity discourses

There are multiple perspectives on what Deborah Lupton terms ‘the fat body’, including the notion of obesity as socially or ecologically constructed. From this perspective, the concept of obesity can be understood as an instrument of social control, used to problematise and stigmatise larger bodies (Lupton, 2018). The perceived arbitrariness of body mass index thresholds (BMI) and inconsistency in the epidemiological data linking elevated BMI with adverse health outcomes can be marshalled to support this perspective. Related to this is the body positivity movement, which asserts that an emphasis on body weight can be harmful, and health is a more holistic concept, beyond the measurement of weight (Sastre, 2014). There is concern that focus on thinness and unattainable beauty ideals (problems exacerbated by the increase in social media use) can result in increased risk of eating disorders and poor mental health (Robinson et al., 2017; Rodgers and Melioli, 2016). This perspective draws attention to obesity stigma, which arises from a societal perspective that individuals ‘should’ behave responsibily by living healthily, in this case by eating moderately and being physically active. Stemming from Bourdieu, the concept of habitus implies that individuals acquire this disposition to ‘health’ and by manifestly failing to live up to this experience stigma. By supporting weight management, clinicians are unwittingly partly giving rise to this habitus (Williams, 1995).

In the public health community a socio-ecological perspective is commonplace. This framework considers the interplay between individual, inter-personal, and environmental structures. The Lancet Commission explained obesity largely as a consequence of the macro-level factors including economic policies and social norms. They put particular emphasis on the commerical determinants of health where the food industry, operating within a capitalist paradigm, aims to promote and sell food that returns the highest profit to shareholders, and markets these foods to sell the largest quantities (B. Swinburn et al., 2015; B. A. Swinburn et al., 2019). Micro-environmental circumstances, shape an individuals behaviour and explain the particular vulnerabilities of some communities or households. Proponents of this model argue that tackling obesity will require government intervention to address this market failure.

Biomedical perspectives consider the problem of obesity as arising from a failure in the regulation of energy intake and expenditure, creating a biological susceptibility to obesity. Obesity is highly heritable, and this is manifested in failure of the biological controls to mitigate appetite (Frood et al., 2013). Such controls can be augmented either medically, through pharmacotherapy (Chao et al., 2022), or surgically, though changes in gut-brain signalling from bariatric surgery (O’Brien et al., 2019). From this perspective, obesity is treated as a medical disorder and amenable to clinical treatments.

### 1.2. Clinical interventions

Clinicians rarely receive teaching about obesity or training in how to intervene. As such, they may be more or less aware of these multiple perspectives but are tasked with intervening on obesity with guidelines that aim to change behaviour, without recourse to any underpinning philosophy. Clinicians need to place these guidelines in a person’s specific context when deciding whether, when, and how to intervene on obesity. As Stathi and Blackburn showed, these competing standpoints make intervention with patients problematic for clinicians (Blackburn and Stathi, 2019; Blackburn et al., 2015). For example, if obesity is understood as caused by the interaction between a biologically susceptible individual and the obesogenic environment, then it may seem inappropriate to recommend interventions that aim to support individuals to redouble their self-control efforts to lose weight. Some clinicians feel that intervening on obesity is properly within the domain of society through changes to the environment and that shifting responsibility to individuals is futile. Intervening with individual interventions therefore appears to reinforce the belief that obesity is caused by failure of willpower. Further, clinicians have to reconcile evidence that weight loss reduces cardiometabolic risk, and that behavioural weight management programmes can improve wellbeing in the medium term, with their concerns about the immediate impact of raising the emotive and stigmatising issue of weight with their patient.

### 1.3. Strong structuration theory (SST)

Our study was primarily concerned with understanding why clinicians resist broaching the topic of weight with their patients, and evolved to understand how these multiple perspectives might be known by clinicians and how such perspectives might relate to their clinical care of excess weight. SST is concerned with the process of structuration: how social structures recursively produce and are produced by individuals.

SST was developed by Stones (2005), drawing on Giddens’ (1984) previous work, to investigate empirical examples of structuration. SST is concerned with the process of structuration: how social structures recursively produce and are produced by individuals. SST has four (quadripartite) analytically distinct aspects for studying structuration empirically. These are external social structures (the conditions for action), internal social structures (what actors understand about the external social structures), active agency (what individuals do in the context of external and internal social structures) and lastly outcomes (and how these feedback on the external social structures) (Stones, 2005). These analytical concepts have been used to study a range of health service phenomena including childhood obesity in Hong Kong (Chan et al.), the use of the electronic referral system Choose and Book in UK general practice (Greenhalgh, Swinglehurst and Stones) and email consultations in Danish general practice (Assing Hvidt et al.).

Our analysis of empirical data from primary care allowed us to consider how clinicians intervened, or not, on obesity in relation to the different ways in which they understood the social and medical meanings of obesity (Stones, 2005). Throughout this study we have used the terms ‘obesity’, ‘weight management’, ‘excess weight’, and ‘advice and support’. We realise that these words and phrases have medical connotations and are associated with a clinical understanding of obesity. This arsises because our study is aiming to understand the interaction of the healthcare system with obesity and the language used reflects this. , There is no consensus on the use of this language in the sociological literature and some stakeholders may reject this language and the perspective that is implied by it.

## 2. Research methods and setting

### 2.1. Setting: UK primary care

General practices in the UK operate as independent businesses commissioned by the NHS to provide services agreed in the General

Medical Services (GMS) contract (Beech and Baird, 2020). One main service and income stream in the GMS contract is the achievement of Quality and Outcomes Framework (QOF) indicators which pay GPs for achieving standards for chronic disease management and preventive care. To date, there is only one QOF indicator for obesity, OB002, which states; "[t]he contractor establishes and maintains a register of patients aged 18 years and over with a BMI ≥30 in the preceding 12 months" (National institute for Health and Care Excellence (NICE), 2020). The English and Welsh guideline authority, the *National Institute for Health and Care Excellence* (NICE), recommends a four-tiered weight management service, offering support from simple community weight management programmes through to bariatric surgery (National Institute for Health and Care Excellence (NICE), 2014; Obesity Empowerment Network, 2017). Primary care is the main route of entry into weight management services.

### 2.2. Dataset

To study how clinicians intervene on obesity in primary care, we created a dataset from multiple sources to empirically trace the quadripartite process of structuration. The dataset included policy documents and clinical guidelines, independent reviews, NHS websites, training materials for clinical staff, eight focus groups with practising GPs and 29 recorded consultations between healthcare professionals (HCPs) and patients where obesity was directly clinically relevant to the consultation in primary care settings across England (see Table 1 below).

Policy and practice documents were selected by Joint First Author 1 and Joint First Author 2 between November–December 2021 to understand the context in which clinicians were operating. Our selection of documents entailed repeated cycles of searching, filtering and interpretation across wide-ranging academic sources and grey literature through snowballing and citation tracking, and developed a chronology of documents that was then reviewed by an obesity knowledge and policy expert in the research team. After the focus groups and recorded consultations, the selection was revisited to include any further documents identified by research participants at which point the NHS Eat Well plate (identified by a focus group participant) was added to the dataset. The policy and practice sources included in this study are listed in Table 1. Although many other policy documents refer to obesity, most are focused on prevention, rather than treatment in clinical settings.

There were eight online focus groups of three to six practising GPs. Four groups were conducted with GPs working in affluent areas and four in deprived areas. Inclusion criteria included physicians specialising in primary care with at least a year of practice after qualifying as a GP, and who practised in one of four areas of the UK, sampled for socioeconomic diversity: Esher (Surrey), Knightsbridge (London) as affluent areas, Blackpool (Lancashire) and Jaywick (Essex) as deprived areas. These focus groups were initially planned to be in-person however, due to the COVID-19 pandemic, they were conducted on the video conferencing platform, Microsoft Teams. Each focus group lasted 60–90 min and followed a semi-structured topic guide where participants were asked open-ended questions about their experiences and opinions about obesity management and engaging in conversations about weight management. The focus groups were facilitated by two researchers (a medical sociologist joined by either joint first author 1 or 2). The focus groups were recorded, transcribed, and individual contributions were de-identified. Ethical approval was granted by the University of Oxford Central Ethical Research Committee (reference anonymised for submission).

Recorded consultations took place at five general practices across England. At each practice, consultations with between five and seven patients by one to two HCPs were recorded to a total of 29 consultations involving 29 patients and six HCPs. The consultations were annual reviews of diabetes or hypertension conducted by a practice nurse or healthcare assistant of patients identified by the practice as having overweight or obesity. Inclusion criteria for patients were ≥18 years old, currently registered at the GP practice, with a BMI ≥27.5 (or ≥30 kg/m2 if ethnicity was recorded as White) (National Health Service, 2018). Patients were excluded if they were unable to communicate in English. Written consent was provided by patients for their consultation to be recorded. Inclusion criteria for HCPs was that they were suitably qualified to deliver annual review consultations and were routinely employed by the practice. Consultations were recorded on an external audio device. Ethical approval for this component of the study was granted by the NHS Research Ethics Committee (reference anonymised for submission).

### 2.3. Analysis

Data analysis was completed in linked stages. First the data were categorised by joint first authors 1 and 2, into policy and practice, provider experience, and consultation observation and thematically analysed to gain familiarity with: the clinical and regulatory setting for weight management discussions, GP views on the challenges of weight management in primary care, and the content of a typical consultation. Initial first order findings from the initial three categories were then considered together in relation to the quadripartite framework of SST by joint first authors 1 and 2 and last author who mapped external structures, internal structures, active agency and outcomes. The 3 researchers discussed and interpreted the dynamics between these four components to produce explanations of how structure and agency interacted to prevent weight management being addressed in primary care. These explanations were further tested and refined with the wider team.

Analysis of policy and practice documents was conducted by joint first authors 1 and 2 who independently immersed themselves in the documents, writing detailed notes on how national actors, professional organisations and experts view obesity and weight management. The researchers met regularly to discuss and iteratively refine their findings.

The focus group data was thematically analysed by four researchers (joint first authors 1 and 2, along with two additional co-authors) who

**Table 1**
Outline of the evidence and analysis used.

| Category of data | Dataset | Analysis for first order interpretations | Higher-order theoretical categories |
|---|---|---|---|
| Policy and practice | Four policy and practice sources<br>1. NHS Eat Well Plate<br>*2. Royal College of General Practitioners* (RCGP) online training on weight management<br>*3. National Institute for Health and Care Excellence* (NICE) guideline for weight management<br>*4. Department for Health and Social Care* 'Tackling obesity: empowering adults and children to live healthier lives'. | Analytic memos | 1. External structures<br>2. Internal structures<br>3. Active agency<br>4. Outcomes |
| Provider experience | Eight 1-h focus groups each with three to four GPs | Thematic analysis | |
| Consultation observation | Recorded consultations from five GP practices in England for a total of 29 patients and 6 HCPs. | Analytic memos | |

independently coded the focus group data, meeting regularly to discuss their codes and reduce biased coding. The thematic analysis followed (Braun and Clarke, 2006). Once each researcher had finalised their code list, a medical sociologist co-author synthesised their code lists into five overarching inductive themes. NVivo software was used to organise the data and codes.

The recorded consultations were transcribed by a third-party transcription service analysed by two researchers (joint first authors 1 and 2) who independently listened to the recorded consultations to identify how weight management discussions were initiated (if at all), the language used in the consultation by both the patient and HCPs around the topic of weight, the patient reaction to weight management discussions, and what weight management support was offered. These notes were discussed at regular study meetings between joint first authors 1 and 2.

The analysis of the three groups of data (analytic memos of the policy and practice documents, thematic analysis focus group data and analytic memos of recorded consultations) was used as the foundation of the higher order analysis, using SST. At this stage, three researchers (joint first authors 1 and 2, and last author) discussed and categorised the themes into the different parts of the quadripartite framework. This process was iterative and collaborative, with the three researchers meeting regularly to discuss individual interpretations, returning to raw documents, transcripts and recordings, to refine higher order theoretical findings.

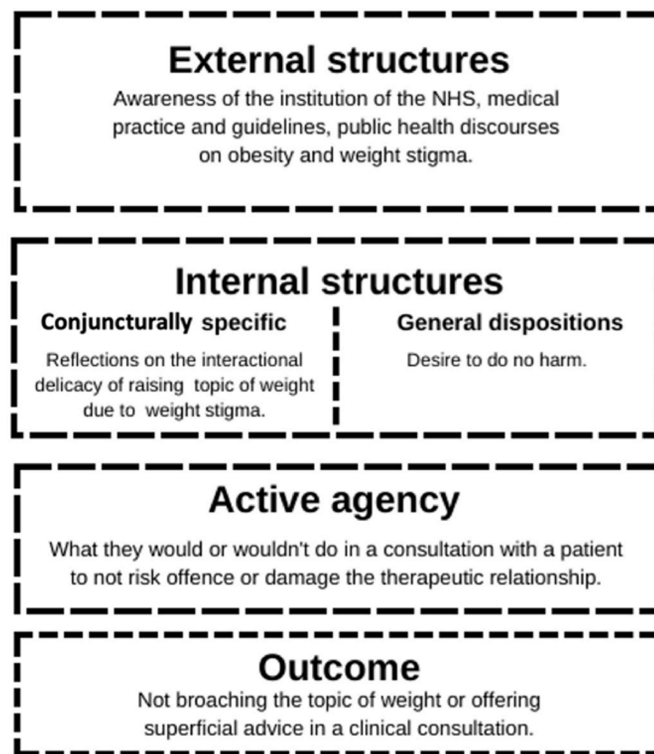
We developed five initial themes to synthesise the reflections shared by GPs during focus groups as to why they were resistant or reluctant to broach the topic of weight in their clinical care of patients living with excess weight. The themes were: mental health and obesity, prioritisation of weight management, personal responsibility, time constraints, and socioeconomic determinants of weight. These themes were consistent with previous studies of GP and nurse perceptions of weight management, systematically reviewed in 2021 (Warr et al., 2021), but did not, in themselves, answer our research question which was to consider how clinicians intervened, or not, on obesity in relation to the different ways in which they understood the social and medical meanings of obesity.

## 3. Findings

### 3.1. Theorisation of resistance and reluctance to broach weight management

We sought to theorise about, and dig deeper into, the commonly reported perceptions and attitudes which amounted to resistance or reluctance on the part of HCPs to offer weight management support. We analysed our empirical findings using Stone's quadripartite framework of structuration to consider the dynamics of external and internal structures, active agency and outcomes (summarised in box 1). This process elicited five higher order theorectical themes, described in detail below, that explain these observations. In outline, these are: weight stigma as an external structure; reconciling multiple perspectives as internal structures; medical disposition to do no harm; decisions about discussing weight; and offering weight management support, or not, and the reproduction of structures of stigma. These themes describe the process of structuration we observed that produces and maintains the absence of weight management discussions in primary care.

**Box 1**
Overarching evidence of structuration organised by Stones' quadripartite framework. Dashed lines indicate fluidity of categories.



### 3.2. *Weight stigma as an external structure*

External structures are the patterns of social arrangements that exist separately to agents and set the conditions for their action (Stones, 2005). External structures that were significant in the analysis of the delivery of weight loss interventions in primary care in the UK based on our data included the institution of the NHS, medical practice and guidelines, public health discourses on obesity, and weight stigma, which can be further traced through internal structures, active agency, and outcomes.

GPs reflected on the organisation of general practice, and how it constrains and enables the type of care they are able to deliver. In the following interaction, we see the difficulty of prioritising prevention in time constrained consultations, and how the QOF can act to drive the integration of preventive care.

Focus group 2

| | |
|---|---|
| GP 2: | "Okay. The context. Preventative care versus acute. I think I feel like I'm firefighting most of the time just to feel like I'm getting through the acute. I feel like if there was more time in the consultation and less pressure on the number of consults staring at you on the screen, I would probably be keen to look at the preventative a bit more. There's a few instances where it comes in as the bread and butter, kind of talking about cholesterol levels, diabetes, osteoporosis. I probably make sure that it's covered. But yeah, as a routine, in the majority of my consultations, I'm focussing on the acute." |
| GP 1: | "It's also, a lot of general practice, sad to say, is QOF driven, so a lot of the preventative controls are QOF driven, so your blood pressure. We all know blood pressure is one of the key ones in preventing stroke. Every single study in the last ten years has shown that if you can get blood pressure under control, even secondary to obesity, then you are well on your way of tackling your stroke rates. Obesity again we know is very much linked to cancer, which is why I was very keen on this study. It's very difficult to do as Hannah said when you're firefighting and you don't really have the carrot of QOF hanging, which was removed this year because of the pandemic, to try and do BP, BMI, to … and all the preventative medicine …" |

In the following interaction, the first respondent shares a lack of knowledge of an external structure (QoF) shaping weight management care. Interestingly, they do recall hypertension incentives and perceive these as being simpler than weight management. The second respondent helped fill the knowledge gap and also recognises the lack of incentivisation of weight management at the time of the focus groups in 2020.

Focus group 5

| | |
|---|---|
| GP 1 | "So, how much is obesity in QOF, I genuinely don't know. It's definitely in hypertension and is something that is easier to do." |
| GP 2 | "QOF says, you need to record the weight, but they don't say you need to achieve a certain weight in public so just say tick the box, record the weight, that's it." |

GPs were aware of recommendations in clinical guidelines, policies and trainings for weight management, which acknowledge the complexity of obesity, while promoting interventions feasible in a clinical interaction. GPs had conflicting views on the effectiveness of these pathways.

Focus group 2

| | |
|---|---|
| GP 1 | "I'm a little bit sceptical about it because if you look at the kind of bariatric and obesity pathways the NHS have … We do have a tier three programme in the CCG, at St Peter's … It should work. It just never does. The outcomes are incredibly poor. There's a 50% dropout rate. 25% of the patients enter with one BMI, two years later have got exactly the same BMI. They may drop it a few but it goes back again. So, I don't think we have found the correct tools as a society." |

In the following excerpt, two respondents had just noted their view that referring patients to NHS service was ineffective obesity management. GP 1 countered arguing that allied health professionals and specific programmes were effective in helping patients manage their weight.

Focus group 3

| | |
|---|---|
| GP 1 | "So, maybe playing devil's advocate, I'm kind of okay with it, because I'm not best placed to give diet advice. I had maybe, I don't know, 4 hours of training in medical school … any time I needed help on the wards, I'd refer to the dietitian. And, they do magic with patients, and I can't do that … I'm really interested in those types of innovations, as I am in Noom, Second Nature, and other innovation which is trying to scale what dietitians do and the super powers they have across broader populations. But I'm okay with others getting involved, be that public-private sector partnerships, as long as its making an impact, that impact is measured, and it's transparent to the rest of the community so we can understand the value of where that NHS pound is being spent." |

Beyond the organisational structure of general practice and its guidelines and policies for weight management, was the public health discourse of obesity and the tension between personal responsibility and social and environmental contributors to the problem of excess weight. GPs commonly expressed views that obesity is a condition brought about through failure of willpower to control energy balance, for example.

Focus group 1

| | |
|---|---|
| GP 3: | "… it has got to be personal choice really. They have got to prioritise and people can help, but if they 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 can do …" |
| GP 2: | "It is very difficult, but 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." |

Some GPs expressed an understanding of obesity that could be framed as a biopsychosocial phenomenon. Situating the individual in the broader contextual factors to take into account the forces that influence individual agency like the built environment with its economic, political, and cultural domains. Doing so, GPs recognised the wider environment, in particular the role of industry that undermines individual agency.

Focus group 6

| | |
|---|---|
| GP 2 | "I think we're emphasising personal responsibility far too much. I think the major problem is industry. We can't blame people for being overweight. As far as I'm concerned, it's the government's fault and it's industry's fault, because they are pushing these foods onto us. These are the foods that are mostly heavily advertised, these are the foods that are mostly discounted and cheap, and what's available. And government is in cahoots with them, because if they really knew … I mean, I once searched for all the stuff on weight loss that there's guidelines on and all the national guidelines mention diet and exercise – not one of them mentioned which is most important. Not one of them. All my colleagues continue to, in a way, blame patients for being overweight and tell them to exercise. They're not going to get anywhere by exercising! It's a complete waste of time." |
| GP 3 | "I think personal responsibility is important but it has to be within the context of your adult life and what is available to you and, sadly, as Dr.X has said, those choices are often just not available to people and that's going to be something that's going to be very difficult to change, unfortunately." |

In keeping with the environmental factors that may influence individual agency, the socioeconomic dimension of patients' lives was

discussed across the focus groups. Half of our focus groups involved GPs who served in areas of deprivation, and half who worked in more affluent regions of the country. One GP who works in practices that serve both demographics, observed.

Focus group 2

| | |
|---|---|
| GP 3 | "… they literally tell me Doctor, this is how much money I get a week, I go to Lidl and from there I can by this. They spell it out for me. Salad, vegetables, will cost me this much and I won't be full, but I can get a KFC bucket on a Tuesday, 10 pieces of chicken for £6.99. How can I argue with that? For £6.99 from Lidl they're going to get a small box of blueberries and a bit of lettuce and tomato. That is not going to fill up my guy that's got a BMI of 35. It's an absolute no-brainer so unfortunately … It's odd because when you think about poverty in the past you think about super skinny people but now I think about obesity. When I work in my other practice in town I don't think I've got more than five people who are overweight. They're all size 6 walking around in their Spandex. They're super fit and super slim." |

Across the focus groups, participants seemed to agree with the clinical relevancy of managing excess weight in their patients while being acutely aware of the interactional delicacy surrounding weight management, due to societal weight stigma. This is a unique feature of weight management that is not present with other similar clinical topics e.g., hyptertension or lipid management. These other clincal areas are subject to similar external structure constraints (the organisational structure of general practice, clinical guidelines and financial incentives) but these topics are routinely discussed in primary care. Therefore, our higher order analysis focussed on weight stigma as the primary external structure restricting weight management discussions in primary care.

Focus group 7

| | |
|---|---|
| GP 2: | "Now obesity has come about probably in the last ten years with the rapid increase in the incidence and prevalence of diabetes … It is something that society does not like, it's a taboo thing. It's seen as a negative thing and people in general find it quite difficult to come and even approach me about it, so it's almost like they have to psych themselves up …" |

Weight stigma was often discussed when GPs reflected on the interplay between mental health and obesity. GPs shared their experience of the negative effect broaching the topic of weight could have on the therapeutic relationship, further explored in internal structures, and active agency.

Focus group 1

| | |
|---|---|
| GP 2: | But, for me, one point I face on a daily basis is mental health and that seems to take over from the obesity side, the diet, the weight loss. If I see someone, I don't want to bring that subject up with them because I then don't have the time to spend with them and I could send them out of my surgery feeling even lower than when they came in and that is a big factor for me. If there are factors in there, I don't know, say they are at risk of diabetes or they have blood tests, but then I am going to approach it but I'm not going to just jump in there without a reason I'm afraid. |

### 3.3. Reconciling multiple perspectives as internal structures

Internal structures are divided by Stones into the conjunctural knowledge of external structures, and general dispositions or habitus (Stones, 2005). Conjunctural knowledge is the way they process their understanding of the external structure; e.g., weight stigma. General dispositions allow us to understand how the agent's values and feelings inform their habitual behaviour; e.g., having a guiding value to do no harm in their clinical practice. Both of these considerations set the stage for appreciating their self-reported behaviour of active agency.

#### 3.3.1. Conjunctural knowledge of external structures

There is a tension between the external structure of clinical guidelines (that obesity can and should be treated) and societal awareness of weight stigma. The following interaction shows clinicians talking about how the tension between body-positive movements to reduce weight stigma clashes with their own views of obesity as a clinical condition. In this focus group, participants did not shy away from pejorative language to express their disdain for what they perceived as the normalisation of obesity. They compare intervening on weight to be akin to being a 'Nazi' and how current trends towards body-positivity may normalise obesity which, for them is a 'ridiculous' concept.

Focus group 8

| | |
|---|---|
| GP 2: | "I personally would like to see them do more, the question is what can they actually do that is going to have a meaningful effect? So government is limited to health policies, we are in an era where you can't criticise people too much, you can't call them out for it, people will get their feelings hurt and then you get sued." |
| GP 1: | "I find it really difficult to figure out how I feel about the whole-body positive movement and people embracing their curves and all this stuff, because it's kind of normalising obesity." |
| GP 2: | "It really has." |
| GP 1: | "I feel like a Nazi for being like no you shouldn't actually be embracing your curves." |
| GP 2: | "I think there's a difference between being slightly overweight and still being healthy and some of these things that they are promoting. I don't care that there is no sense of metabolic syndrome we know you're unhealthy, your joints must be crumbling if you're 300 pounds overweight. This is ridiculous." |

These more extreme and derogatory conversations were not held by all. Across the focus groups, there was an awareness of the interactional delicacy of talking about weight which we attribute to internal and external structures of weight stigma. Weight stigma meant that clinicians framed weight management as a challenge that differed from the management of other risk factors like hypertension. In the next extract, GP 1 points to the stigma around weight that does not appear to accompany hypertension, and a second respondent points to the fact that they often go hand in hand, and, in making his point, struggles to find language that does not appear to blame the patient.

Focus group 7

| | |
|---|---|
| GP 1: | "However, one thing that maybe hasn't been mentioned is that certainly there's a bit of a stigma based around obesity which there isn't with hypertension. So you can walk down the road or walk past someone who's got a systolic of 180 but you wouldn't know; but you can quite easily tell from the outside that someone is BMI 45 … Whereas if you have somebody who has quite significantly high blood pressure I think it's easier to motivate them because there isn't that stigma maybe around that." |
| GP 3: | "But do you not think … I mean this is what I see, I often see hypertension and obesity together and by the time I see the hypertension and I look at them and I think goodness, you could have … not you could have prevented – that's the wrong way of saying it, but in my mind, I'm thinking they've already presented too late to me." |

Another focus group discussed the notion that stigma may motivate individuals to address their obesity. This discussion occurred against the backdrop of concerns around the body-positive movement that was incongruent with 'health' as understood by clinicians.

Focus group 5

(continued on next page)

(*continued*)

| | |
|---|---|
| GP 3: | "We were talking earlier about the campaign to reduce smoking, that actually did create a stigma as I stated with smoking. I'm not suggesting that you should create a stigma, there is already a stigma around obesity but it is interesting that is the way that campaign was successful because it used to be cool to smoke and then it became something disgusting. People's attitudes changed to it and that was why it was successful. I'm not sure that we do that with obesity. I'm not sure that for body positivity, it's a healthy way either." |

### 3.4. Medical disposition to do no harm

A core value that frequently appeared in the clinicians' discussions, was a desire to do no harm. We interpret this as a general disposition, of habitus innate to clinicians as agents. More specifically, clinicians were concerned to do no *net* harm. GPs weighed the potential gains of broaching a conversation on weight against the harm of damaging the GP-patient relationship which they feared could occur by hurting the feelings of the patient by raising the stigmatised topic of weight. For these clinicians', general disposition to care for their patients was perceived to be at odds with proactive weight management care.

Focus group 1

| | |
|---|---|
| GP 2 | "Of course, I see patients who have got really low self-esteem anyway so for me to go in there, with a short amount of time, and tell them that they're obese- I can't even think about the consequences that could happen from that. I would perhaps encourage them to exercise for the mental health and approach it that way and approach that rather than obesity." |

The clinician in the extract above talks about weighing up the general disposition to do no harm with the conjuncturally specific knowledge of a patient with low self-esteem. The decision by the clinician to not conduct appropriate weight management discussions was an active choice, shaped by the dynamics of the external structure of weight stigma, the general disposition to do no harm and the conjuncturally specific knowledge of the low self-esteem of the patient.

Focus group 2

| | |
|---|---|
| GP 2 | "I also think it's not only time, it's also about addressing the issue without insulting the person. I'm sure all obese people know they are obese, and just finding a way to address that subject without making them feel like you're picking on them or alienating them in some way is quite difficult." |

This GP describes the difficulty in navigating the situational tension between the external structures of established clinical guidelines, societal weight stigma and the patient's experience of this. They describe the consequences of not addressing this well, namely alienation. Discussing weight creates a relational risk that is difficult to manage in the context of a primary care consultation.

### 3.5. Decisions about discussing weight

Within SST, active agency is understood as an agent's actions, informed and constrained by internal and external structures. GPs described how their knowledge of external structures (clinical guidelines) was moderated by their internal structures (knowledge of local context) when they explained what they would or would not (their active agency) do in a consultation.

Focus Group 1

| | |
|---|---|
| GP 2: | "Do you exercise? How do you exercise? Do you go walking? Do you go to the gym? Do you go swimming? And it turns out you can't go to the gym and you can't, even around here even though you can potentially go swimming, they can't because the local council can't afford to keep the swimming pool open. So, you try not to approach it directly" |

(*continued on next column*)

(*continued*)

This GP's decision to not routinely discuss weight management was made in relation to their knowledge of the local environment as being lacking in resources that are needed to do achieve weight loss. Guidelines describing what to do practically in a consultation are not always linearly adopted into clinical practice and can be moderated by the environmental and economic situation of the patient, the local community, and the GPs knowledge of these. For these GPs, all of these factors are relevant to the decision about whether to raise the topic of weight, in addition to knowledge of clinical guidelines and protocols that urge individual clinical action to support efforts at weight loss. The subsequent action the GP describes they would take is then outside clinical guidelines, but legitimised by their knowledge of the patient's context. Similarly, GPs in the focus groups described the interplay between weight stigma, their understanding of the effect this had on their patients, and their delivery of weight management advice and referral.

Focus Group 2

| | |
|---|---|
| GP 2: | "I think there's quite a lot of stigma surrounding it as well that it's almost an awkward topic to bring up. It's like you're sat in front of me and I can't help but notice that you're obese. Sometimes it's the elephant in the room and it's how do you open up that discussion and confront them because in my experience most patients are embarrassed. They're shy, defensive. They close up. It feels like a very desperate situation because it has to come from them, and it feels like there's very little we can do to support them. Yes, we can do the exercise referrals and we can suggest that they sign up to Slimming World. Occasionally we might look at tablets but it feels like it's down to them and I guess I've always struggled to make a joint partnership and try to assist them in the process" |

Here, this GP describes the effect that bringing up weight management has on their patients. They become 'shy' 'defensive' and 'embarrassed'. These elicited negative emotions may explain why this GP only occasionally considers further management and struggled to assist the patient. This GP described being caring (sparing the patient from potential negative emotions) as a barrier to offer of weight management support.

### 3.6. Offering weight management support, or not, and the reproduction of structures of stigma

The structure of weight stigma appeared to shape the way in which clinicians raised (or failed to raise) the topic of weight, typically by avoiding the conversation altogether. In turn, this avoidance risks reproducing the stigma of weight as a difficult topic to be avoided in clinical setting. However, in some recorded consultations, weight was raised when it was understood by the clinicians as being directly clinically relevant to the reason for the patient attending, for example HCPs were tasked with discussing weight as part of a routine review. The following quote is taken from a diabetes annual review, a condition strongly associated with obesity.

Practice 2

| | |
|---|---|
| HCP 2, patient 1: | "Your BMI is up to 43 and a half so really do need to look at them things (diet and exercise), you know the things to do, you just told me … You don't need any help where we kind of refer you to an exercise or a diet programme? Do you want me to do anything like that? … At least then there's somewhere to go to and something to aim for. It might just make you think." |

Guidelines suggest the discussion should prompt evidence-based weight management advice and offer of a referral for further support. However, the support which followed was superficial or incomplete. For example.

Practice 1

| | |
|---|---|
| HCP 1, patient 5: Practice 2 HCP 3, Patient 3: | "Your BMI is coming out as 34.84 – what happens is with the BMI is we get certain categories so yours is coming out that you are sort of obese, that you are overweight. Obviously, you have already had conversations about increasing the exercise, about foods to eat, diet, so all of these things whilst reducing that, it will help a huge amount." "Your BMI is 38 and a half … if you follow the advice with your cholesterol, you'll be alright" |

Previous advice given for exercise, diet or raised lipids was often reiterated but further evidence-based weight management advice and referral for support was not explicitly given. We can also see how weight management is overly simplified, and support superficially given; if the patient just increases exercise, is mindful of diet and follows previous advice for lowering cholesterol, the desired outcome will follow-"… it will help a huge amount" and the patient will "… be alright".

When considering how clinicians raised the topic of weight, the choice of language was important, certain words (such as 'obese') were avoided, or attributed in certain ways i.e. to the condition rather than the patient or as being a feature of the clinical system rather than a choice of language by the clinician. In the following interaction, one respondent shares they avoid the term 'obese' altogether. A second participant acknowledged the sensitivity around language, how they will introduce the term obesity as a classification separate from the person.

Focus group 3

| | |
|---|---|
| GP 2: | "I tend to say they are overweight rather than obese; they take it that easily, but obese they would take offence. So, I think I tend to play, as I said, diplomatically, and say well you are …" |
| GP 3: | "I use the word overweight a lot, but then I show them the data, and say, you know, you are in the obese sector. So, we need to move it a bit down to, you know, reasonable levels. But, you know, overweight is the term I use to everybody. And then, then I present the word obese as a secondary word." |

Some HCPs in the recorded consultations used technology to distance themselves from ownership of the diagnosis of obesity. The technology (in this case, the electronic patient record and annual review template), not the individual healthcare practitioner, described the patient as 'obese'.

Practice 1

| | |
|---|---|
| HCP 1, Patient 1: | "I've put your data in and your BMI is 31.44 and according to the drop-down menu here, it categorises you as obese" |

There is a tension here between the diagnostic categorisation of excess weight by BMI, the words used to label the categories as suggested in clinical guidance, and an awareness of the role words play in stigmatisation. This led GPs in our focus groups to describe how they avoided specific words in their consultations and HCPs were observed doing this in the recorded consultations. This avoidance of specific words (typically 'fat', 'obese' or 'obesity') can be understood in this context as another example of the HCP softening the impact of their weight management discussions and by moderating their delivery due to their knowledge of weight stigma and wanting to care for the patient in front of them by not stigmatising them or labelling them.

Stone's quadripartite framework allowed us to systematically consider how GP and HCPs understanding of external structures (clinical guidelines and weight stigma) interacted with their internal structures (personal views on obesity and knowledge of their patient's social, economic and environmental context) in primary care. In this clinical context, HCPs were typically observed to use their active agency to err on the side of caution when broaching the topic of weight with patients. Weight management, although important in the care of patients with hypertension or type 2 diabetes, was either avoided, or incomplete advice was given. The outcome of absence of meaningful weight management discussions may then establish the avoidance of weight management as legitimate clinical practice. Similarly, the negative connotations of weight management, as a difficult topic to be avoided, may reinforce weight stigma in the next round of structuration.

## 4. Discussion

Clinicians had a good knowledge of obesity guidelines and generally thought addressing obesity was an important aspect of holistic primary care. However, evidence from our recorded consultations suggests this rarely happens in practice. A disconnect was observed between focus group discussions about weight management (where obesity was a legitimate clinical problem to be addressed) and the clinical reality (where weight was not discussed). The focus groups were separate discussions, away from the clinical reality of a patient, with their specific environmental constraints and experience of weight stigma. Separated from this reality, clinicians approved of clinical guidance and generally expressed views that intervening for weight management was clinically appropriate. In the recorded consultations, when faced with a specific individual in front of them, with their individual psycho-social context, weight management was generally not discussed. Through applying a SST lens, we suggest that clinicians' awareness of the external structure of weight stigma and an understanding of the impact of this on the patient in front of them, including perceived offence in that clinical encounter, could explain these observations.

Clinicians generally showed an awareness of societal weight stigma, with some showing an understanding of patients' lived experience of excess weight. They described this in terms of patients being visually judged, disadvantaged, and the subsequent effects on mental health, and self-esteem. Some also recognised the association between obesity and deprivation. This led clinicians to err on the side of caution, typically not raising the subject of weight in consultation. In that moment of the clinical encounter, their knowledge of weight stigma, and empathy towards the individual in front of them overruled their knowledge of recommendations to treat obesity. We interpret the decision to not offer one form of care (weight management) as a form of caring (protecting the patient from weight stigma), or caring by not offering care. Clinicians justified this lack of action by describing the avoidance of what they thought could be an encounter where stigma is enacted. They described not wanting to add to an already difficult situation with a complex biopsychosocial aetiology, and were concerned that discussing weight could reduce self-esteem or worsen mental health. The consequences of this were that patients were not offered treatment for excess weight.

Our interpretation of this, using SST, is that situational avoidance may be one process by which weight stigma is maintained and reinforced in subsequent rounds of structuration. Situationally choosing to avoiding the topic of weight, or offering superficial advice and support due its delicacy and risk of jeopardising the therapeutic relationship, reproduces the sensitivity around the condition of excess weight, which can have negative implications for patients who might seek weight-loss support. In the context of obesity, this 'overshooting' in response to concerns about weight stigma may result in people with excess weight not having timely access to treatment that trial evidence suggests some would welcome and benefit from. This could have long term health consequences, such as an increased risk of developing type 2 diabetes or

cardiovascular disease. Calls to avoid weight management discussions to combat weight stigma, may reinforce clinician and patient experiences that weight is a difficult topic and prevent people getting treatment. In addition, the absence of weight management discussions in a clinical context establishes this as acceptable practice, tempering the established clinical guidance that encourage clinicians to address weight.

This phenomenon has been observed in other studies. In the context of weight management in pregnancy, for example, midwives have been reported to avoid weight management discussions despite this being an important risk factor for both adverse maternal and neonatal outcomes. Midwives explained this by wanting to not upset patients or make them feel stigmatised. (Dodd and Briley, 2017; Heslehurst et al., 2007, 2011; Knight-Agarwal et al., 2014). Blackburn and Stathi (2019) showed GPs films of a doctor-patient interaction where the physician either addressed or ignored the patients weight. In their discourse analysis of GPs reflections following the exercise, they found that GPs "… both reproduce and resist moral discourse surrounding body weight ….constructing [ing] obesity as an individual behavioural problem whilst simultaneously drawing on socio-cultural discourse …" which could reinforce societal weight stigma. (Blackburn and Stathi, 2019). This is a problem because evidence has shown that patients generally welcome advice and support for weight management (Keyworth et al., 2020). as long as these interactions are handled sensitively (Talbot et al., 2021) and personalised. (Keyworth et al., 2020; McHale et al., 2019). However, this is not always the case; some patients may not welcome offers of support and GPs also need to recognise this (Amy et al., 2006).

Research shows that clinicians feel ill-equipped to manage these delicate interactions effectively. (Auckburally et al., 2021; Glenister et al., 2017). Options to address this include broadening communication skills training clinicians receive to move beyond concepts of implicit and explicit weight bias (acknowledging that this persists in healthcare) (Bombak et al., 2016)), to directly address avoidance as an expression of weight stigma. Teaching could include evidence from conversation analysis which explores choice of language and association with patient acceptance of weight management support (Keemink et al., 2022; Speer and McPhillips, 2018; Tremblett et al., 2022). We posit that 'caring by not offering care' may have wider utility to understand the interactions between clincians and patients in other stigmatised health conditions.

### 4.1. Strengths and limitations

Our analysis provides empirical evidence from different levels of the network and evidence of structuration 'in situ'. Clinicians were observed 'in practice' by recording consultations so we could hear how obesity interventions were not being offered in primary care. Focus group evidence enabled us to explore how these decisions were weighted up against evidence of effectiveness. A key strength of our analysis is the theoretical development of previously observed phenomena of resistance and reluctance. The use of a video conferencing platform to conduct focus groups has increased in recent years. Research suggests that the benefits in terms of increased accessibility to participate in research and greater representation is likely to outweigh any interactional difficulty. (Keemink et al., 2022). This research was conducted mid-way through the COVID-19 pandemic when the use of such communication was commonplace, likely reducing barriers to participation that might previously have existed. In the context of our research, it enabled GPs from diverse geographical areas and those with caring responsibilities to participate in the focus groups which may have contributed to a more diverse group of participants.

The audio recordings, whilst offering rich speech data, did not capture more subtle aspects of the consultation or its situated and embodied nature which ethnographic work could have generated. For example, body language, eye contact, the layout of the room or size of the chair which may be important in understanding how weight stigma could be enacted. However, direct participant observation of care for obesity can be considered intrusive by patients, with an audio recorder less so. Instead, we used multiple sources of data (accounts told in focus groups, observation in the recorded consultation and written documents) to analyse processes of structuration. We cannot rule out that our pragmatic search for policy and practice documents (using snowballing coupled with expert and clinician input) missed some key policy documents. However, we checked our list of documents against all policy and clinical documents mentioned in the focus groups. This grounds our data corpus in the sources that are known and used in practice by our participants.

## 5. Conclusion

Our work shows that awareness of the external structure of weight stigma reinforces the reluctance to treat obesity. Our data showed that clinicians are aware of weight stigma and its potential repercussions on the therapeutic relationship and mental health of patients. Consequently, this leads them to not routinely offer weight management support to their patients. Most interventions to promote action tell clinicians about the value of intervening but do not directly address stigma. Helping clinicians to address stigma directly in their consultations may increase the ability and willingness of clinicians to support their patients who want to lose weight.

## Credit statement

Anisa Hajizadeh: Conceptualization, methodology, formal analysis, investigation, data curation, writing- original draft, writing-review & editing, visualisation, project administration. Laura Heath: Conceptualization, methodology, formal analysis, investigation, data curation, writing- original draft, writing-review & editing, visualisation, project administration. Aryati Ahmad: Formal analysis, investigation, writing-review & editing. Maryam Kebbe: Conceptualization, writing-review & editing. Susan Anne Jebb: Writing-review & editing, supervision, funding acquisition. Paul Aveyard: Writing- original draft, writing-review & editing, supervision, funding acquisition. Gemma Hughes: Formal analysis, resources, data curation, writing- original draft, writing-review & editing, supervision, project administration.

## Declarations of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Paul Aveyard and Susan Anne Jebb report a relationship with Nestle: non-financial support (donated products to the NHS in support of a separate publicly funded trial they are investigators on).

## Data availability

The data that has been used is confidential.

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## Appendix A. Supplementary data

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