Scandinavian Journal of Primary Health Care

ISSN: 0281-3432 (Print) 1502-7724 (Online) Journal homepage: informahealthcare.com/journals/ipri20

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To cite this article: Kirsti Malterud & Kjersti Ulriksen (2010) Obesity in general practice, Scandinavian Journal of Primary Health Care, 28:4, 205-210, DOI: 10.3109/02813432.2010.526773

To link to this article: https://doi.org/10.3109/02813432.2010.526773

Scandinavian Journal of Primary Health Care, 2010; 28: 205–210

informa
healthcare

ORIGINAL ARTICLE

Obesity in general practice

A focus group study on patient experiences

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Abstract
Objective. To explore obese patients' experiences with GPs' management of their weight problems. *Methods.* Focus-group study with a purposive sample of 13 participants (eight women and five men), aged 30–55 years, with BMI above 40, or BMI above 35 with additional weight-related problems. Two focus-group interviews were conducted, inviting the participants to speak about their health care experiences from general practice. Analysis applied Systematic Text Condensation inspired by Giorgi's approach, searching for issues describing or discussing participants' experiences of GPs' obesity management. *Results.* Obese patients want their GPs to put their weight problems on the agenda. When the patient appears reluctant, it may be a sign of embarrassment rather than rejection of the issue. However, restricted attention to obesity could lead to neglect of patients' problems. Participants complained that GPs often demonstrated insufficient engagement and knowledge regarding service resources for obesity treatment, leaving the responsibility for information on available referral resources to the patient. Finally, considerate attitudes in the GPs are needed for follow-up to be experienced as helpful by the patients. Vulnerable feelings of failure could be reinforced by well-intended advice. Degrading attitudes were perceived as especially subversive when they came from doctors. *Conclusions.* The challenge for the GP is to increase his or her competence in individualized and evidence-based counselling, while acknowledging the efforts needed by the patient to achieve permanent change, and shifting attention from shame to coping.

Key Words: *Doctor–patient relations, focus groups, general practice, obesity, quality of health care, qualitative research*

Population body weight is gradually increasing all round the world [1], and in Norway one in five individuals are obese [2]. Weight reduction and physical exercise can reduce the risk of weigh related health problems [3–5]. General practitioners (GPs) feel responsibility for prevention, treatment, and follow-up of patients with obesity [6]. Nevertheless, only a minority of obese individuals have been offered weight reduction assistance [7]. Patients feel reluctance when presenting with concerns about weight and ambivalence about the services received [8]. Doctors explain their limited engagement by patients' lack of motivation, and lack of successful experiences [6].

From previous research we knew that patients' experiences can contain essential indications on strengths and shortcomings of services [9–11]. As a GP one of the authors experienced almost daily the challenges in talking with patients about their weight problems and providing health-enhancing support. Reading the research literature, both of us were convinced that there is a need to improve care for patients with obesity [12]. We therefore conducted a study where we explored obese patients' experiences with GPs' management of their weight problems.

Material and methods

Participants for a focus-group study [13] were recruited from a Norwegian rehabilitation centre offering lifestyle programmes for obese patients (BMI above 40, or BMI above 35 with additional weight-related problems), in addition to programmes for

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(Received 29 December 2009; accepted 20 September 2010)

ISSN 0281-3432 print/ISSN 1502-7724 online
DOI: 10.3109/02813432.2010.526773

Obese patients have experienced insensitive prejudice from health care providers who ignore or distort their weight problems.

- They hope for GPs' careful assistance to transcend the embarrassment of introducing weight issues in the consultation.
- Nevertheless, attention to medical problems beyond obesity must be maintained by the GP.
- Knowledge of service resources as well as awareness of unintended blame are needed for adequate follow-up of obese patients in general practice.

other medical problems, mainly orthopaedic disorders. Patients were referred to the institution by their GP. We were invited to the daily meeting at the start of one class, announcing the purpose and design of the study, while emphasizing that the study dealt with experiences ahead of their actual admission, not an evaluation of their programme. The study was approved by the regional committee for medical research ethics. Participation was voluntary, with signed informed consent. We established a purposive sample of 13 participants, aged 30–55 years, representing diversity in terms of gender, age, and occupational background (Table I).

Most participants had a lifelong history of considerable overweight. Seven had additional weight-related conditions such as hypertension, diabetes, or sleep disorders, none of them had manifest cardiovascular disease.

Table I. Demographic characteristics of the 13 participants.

Category	Variables	n	Total
Gender	Female	8	
	Male	5	
			13
Age	18–29	0	
	30–39	4	
	40–49	7	
	50–59	2	
	> 60	0	
			13
Civil status	Single	9	
	Married/cohabitant	3	
	Info missing	1	
			13
Work status	At work	7	
	Rehabilitation	3	
	Disability pension	3	
			13
Occupations	Teacher (2), assistant nurse (4), economist (2), technical education (2), administrative background (1), other (2)		13

Two focus-group interviews, each lasting 90 minutes, were conducted in 2008 with gender-separate groups [14]. A moderator (KM) initiated the interviews using an open-ended question inviting the participants to tell us about their own experiences when encountering their GP, calling for experiences perceived by them as good as well as bad. After these two interviews, we found the information gathered to be sufficiently saturated for analysis.

The interviews were audio-recorded and transcribed. Analysis was conducted as collaborative negotiations between the two authors. We applied Systematic Text Condensation inspired by Giorgi's approach [15,16]: (a) reading all the material to obtain an overall impression and bracketing previous preconceptions; (b) identifying units of meaning, representing different aspects of participants' experiences from obesity-related encounters with GPs and coding for these; (c) condensing the contents of each of the coded groups; and (d) summarizing the contents of each code group to generalize descriptions and concepts concerning GPs' obesity management.

Results

Analysis revealed several areas where obese patients called for improved quality of care in general practice. Patients want their GPs to put their weight problems on the agenda. When the patient appears reluctant, it may be a sign of embarrassment rather than rejection of the issue. However, restricted attention to obesity could lead to neglect of patients' problems. Participants complained that GPs often demonstrated insufficient engagement and knowledge about service resources for obesity treatment, leaving the responsibility for information concerning available referral resources to the patient. Finally, considerate attitudes in the GPs are needed for follow-up to be experienced as helpful by the patients. Vulnerable feelings of failure could be reinforced by well-intended advice. Degrading attitudes were perceived as especially subversive when they came from doctors. These findings will be elaborated below.

Patients wish their GP to put obesity on the medical agenda – if it is done with great consideration

A man aged 30, overweight since childhood, increased his weight by 40 kilos in one year. He remarked that his GP, whom he saw regularly during this year, could have intervened. Instead, he imagined the doctor regarding him only as fat and lazy, and not worthy of comment. Similar calls for initiatives were raised by most participants, who had felt too shy to initiate discussions of their body weight with their

GPs. Their own restraints did not mean they did not want to talk about it, they said, but the doctor's silence on these matters had been interpreted as a sign of disapproval. Participants presented stories regarding various ways in which their doctors had introduced the issue of weight in consultations. Some spoke of how they finally came out, but would easily withdraw if they did not get the supportive response they had hoped for. A woman in her forties, actively working as an assistant nurse, sighed:

> *Imagine the feeling when the doctor sits there, asking you: What on earth do you think we can do with this? (Eva)*

A few experiences demonstrated different and affirmative attitudes from the doctor. A man said that he had asked his GP whether anything would be helpful for him, and the doctor responded by asking him whether he was willing to put in great efforts. He said: "Finally, someone stepped forward and took responsibility". One of the female participants encountered a positive attitude – not from her GP, but from her gynaecologist, introducing the weight problem on the medical agenda:

> *It was my first visit with this doctor. After she had measured my height, weight, and blood pressure, she said: "You are pretty tall, I see, although not exactly lean. How about a referral to xx [treatment programme]?" (Eva)*

Patients' worries and diseases can be neglected by restricted attention to obesity

Across the groups, experiences illustrated how doctors might attribute any complaint to obesity, irrespective of the specific cause. A woman, visiting for back problems, had been told that a clinical examination was not necessary, since weight loss in any case would be the solution. She felt she was not allowed to mention that her symptoms had begun long before her weight increased. One of the men, a teacher in his forties, experienced a knee problem after an accident during exercise. He told what happened when he presented the symptoms:

> *It was slippery on the wooden path and I fell and twisted my knee. I saw my doctor because the knee was painful. Before I was given the chance to tell the story, she said – "you are terribly heavy". (Mark)*

We also heard stories of how doctors would dismiss other problems in obese patients, whether these problems might be weight-related or not. One participant consulted his GP for urinary problems. His worries about prostate cancer were not even given the time for discussion, because his problems were interpreted as obesity side effects by the doctor before any history was taken.

GPs' insufficient engagement and knowledge of service resources make patients feel lost

Several stories dealt with unsuccessful lifestyle changes prescribed by the GP. Participants described how their efforts related to diets and exercise did not work without sufficient follow-up schedules. GPs had neither the time nor the enthusiasm for this kind of work, they thought. Follow-up was simply weight measurement, without talking with anyone. Such schedules were not experienced as a treatment plan, especially when appointments for further consultations were left to the patient's initiative. A 32-year-old man explained:

> *For a period, I was enrolled in an activity group where weight reduction was a goal. Afterwards, my GP was expected to provide follow-up, with motivation and weighing. But after a while, she became so busy that she did not have the time to talk with me. I was put into a room on my own with the scale, expected to do the measurements myself. But the room was often unavailable due to lab tests, and I really felt dismissed. (Steven)*

Some participants experienced that when additional weight-related diseases appeared, the GP's awareness seemed to increase. Although doctors had previously suggested weight loss, a treatment programme had never been presented. A woman stated that when her diabetes was diagnosed her eating problems finally caught the attention of the doctor, who quickly referred her to group therapy. One of the male participants in his fifties said:

> *Seven years ago, my diabetes was diagnosed. Then suddenly my GP said that something had to be done, because he was competent on diabetes. I was sent to an education programme, and that was my first achievement. Finally, I received some help. (Michael)*

In different ways, participants explained how their own initiatives and resources had been necessary for developing a treatment plan. One man said that his doctor did not pay him attention until he cried his way, handing over a list of potential institutions for referral. Participants agreed that they felt they always had to keep the leading edge compared with their GP. Never being presented with potential strategies gave them a disturbing feeling that doctors might also lack more substantial medical knowledge regarding obesity.

A few participants reported exceptionally successful collaborations. They spoke of how their GPs gave them a feeling of having the time as well as the knowledge required to develop weight-reduction strategies, one example being this female teacher aged 30:

She said she had observed that I was struggling hard with my weight problem. She told me about another patient whom she had referred to a treatment programme which had been very successful. The other patient had lost a lot of kilos. And she said she would hope for the same for me. In a way, she asked me very carefully and considerately whether I would be interested. And then wrote the referral. (Maria)

Vulnerable feelings of failure can be reinforced by well-intended professional advice

Degrading or moralizing attitudes and messages were reported by participants as especially subversive when they came from doctors, who were expected to mediate between support and compassion. Various stories were told of GPs whose communication was perceived as humiliating. Examples were contemptuous or suspicious comments when vigorous lifestyle efforts from the patient did not lead to the expected results, indicating that the patient was, after all, a lazy or a greedy person who would never be capable of achieving any goals. Participants advised doctors to ask the patient about the underlying causes of the weight problems, instead of blaming the patient for these redundant kilos. Several had met GPs who would not see patients who were smokers or obese.

Some experiences dealt with feelings of not being believed by the doctor when participants had reported their efforts since the last visit. Several of them admitted that although their eating problems represented some level of self-deception, they felt belittled when the doctor dismissed their presentation of programme compliance. A man who had experienced bullying due to his weight over several years, said:

Frequently, they just jump to conclusions: "eat less, move more". But nobody really asked me what I actually was eating and what my daily activities had been. Nobody asks – they just know the answer. (Mark)

Experiences of shame were recurrent issues in the groups. Participants spoke of repeated reminders of being a failure. Realizing that they were not able to cope with significant matters in their own life, they described how this made them vulnerable to negative comments which really hurt. Not being able to conform, problems with finding nice clothes, and appearing attractive were mentioned as inescapable burdens. One participant spoke of having her blood pressure measured, and then hearing the comment "shame on you!". Another woman described her feelings when her 16-year-old son did not want to say hello to her at the bus stop when he was with his friends. In such a context, the impact of a GP who would oppose the cultural disgrace with support was mentioned as crucial by the participants. Participants emphasized the impact of respectful attitudes from the GP, where the patient feels that he or she is recognized as a whole person, not only as a fat person. Different statements from the GP – even well-intended ones – had been perceived as degrading, thereby causing obstructions to shared understanding:

My doctor does not even have a scale with sufficient range for weighing me. I hate that. I have asked her to buy one, but she says I must buy it myself. (Graham)

Discussion

Obesity care can be improved by sensitive initiatives from the GP to introduce patients' obesity to the medical agenda; maintaining medical attention to problems beyond obesity; adequate follow-up and knowledge about service resources; and prevention of unintended blame. Below, we discuss the strengths and limitations of these findings.

The validity of experience

Experience is a subjective phenomenon, obtained by the individual, and transformed by emotions and time. Distortions and elaborations are integral elements of how individuals develop experience over time in order to create meaning, and should therefore not be dismissed by referral to "facts" about what "really" happened. Hence, exploring encounters between doctor and patient from the perspective of one of them – the patient – will not provide access to the motives or attitudes of the other – the doctor. Previous studies including provider perspectives have demonstrated that even well-intended acts may turn out as humiliations [17].

Everyone is somehow affected by the cultural messages concerning body weight, and prejudices and stereotypes are easily internalized by those affected [18]. Among the participants in our study, powerful expectations of being met with degrading attitudes appeared as subjective predictors for what might happen at the GP's office. We therefore regard the stories about unexpectedly positive interaction as especially important data, by transcending participants' preconceptions.

Trust is essential for constructive dialogue. The majority of participants declared their scepticism towards health care, based on previous experiences. The moderator, presenting as a GP, therefore sought to present as a professional in search of service improvement. A lot of critical comments from participants concerning their GP experiences were taken as signs that professional authority did not prevent open exchange. Trust in the interview situation may

also have been enhanced by the fact that none of the researchers is a very lean person.

Our recruitment site was purposefully chosen since we wanted to study experiences among obese people with weight-related health problems, with broad experiences from services. Several participants presented previous positive experiences, and our sample did not include obese people who have resigned their relationships to health care. We consider this kind of background valid for a broad range of obese patients encountering the GP.

Recognition and knowledge may counteract stereotyping humiliation

Regarding obesity as a potentially serious health problem, we became alarmed by observing the broad range of casual, inadequate, and humiliating experiences among participants. Our study is not the first one to report encounters where patients felt that their obesity had been ignored, dismissed, distorted, or attributed as the explanation of all their health problems by providers [8,19,20]. Shortcomings like these can be explained by lack of knowledge or uncertainty among health care providers [6,21]. Insensitive prejudice can take place in the consultation through the well-intended and widespread belief that obesity is believed to be controllable [22].

Our study adds to existing knowledge by identifying specific matters where quality improvement is needed. GPs need to know that obese patients hope for their careful assistance to transcend the embarrassment of introducing weight issues. Avoiding the sensitive question of intervention may protect the doctor from balancing difficult emotions, while the patient feels left alone. Rifkin describes her ambivalence as a doctor when seeing the Fat Lady repeatedly in the hospital without being able to talk to her although her weight was killing her [23]. This is maybe why obesity seems to lead to delay or avoidance of health care, due to patients' fear of being stigmatized or blamed [24]. Our findings demonstrate the subtle nuances between what patients perceive as respectively supportive or derogatory responses.

Our study also revealed problems arising when obesity is the only issue the doctor attends to. Similar situations have been reported for other stigmatizing conditions, such as the lesbian patient complaining of the doctor giving attention only to her sexual orientation [25], or the patient with chronic fatigue syndrome being dismissed from the emergency department with her abdominal complaint [9]. Thesen demonstrated the vital role of stereotyping in the process of unconscious oppression in the health care encounter [26]. To prevent degrading interaction, the GP needs to elaborate the specific competence for particulars required in general practice, where the individual can be approached adequately [27].

We found that obese patients' expectations of follow-up were not especially unreasonable. Although GPs cannot be able to hold a complete overview of service resources, they might pursue such knowledge more vigorously, rather than becoming annoyed [8].

Finally, our study demonstrated the essential role of dignity for obese patients' motivation and collaboration with doctors. Body image is a fundamental element of identity [28]. In our culture, obesity is interpreted as a sign of deficient control of self [29,30], even among health care providers [12,31,32]. Obese persons may feel ashamed of their bodies, demonstrating that they are not able to fulfil the expectations of themselves and their surroundings. Heredity and neuroendocrine regulation mechanisms can explain a substantial part of the individual differences, determining who is most susceptible to weight gain under certain circumstances [33–35]. The doctor who intends to strengthen the motivation of patients must have belief in the project and trust the patient's capacity to cope with the challenges, even though the long-term effects of treatment programmes for weight reduction appear to be limited [36–38]. Boosting shame, the doctor hardly supports the patient's self-assessed health, which is an independent predictor for positive health in longitudinal studies [39].

So what?

The challenge for the GP is to increase his or her competence in individualized and evidence-based counselling, while acknowledging the efforts needed by the patient to achieve permanent change, and shifting attention from shame to coping [40].

Acknowledgements

Sverre Maehlum, MD PhD, and Janne Schioll, PT, provided access to the institution where participants were recruited and gave valuable comments throughout the process.

Sources of funding

Health and Rehabilitation.

Conflict of interest statement

We are aware of no potential, perceived, or real conflicts of interest for each author.

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