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The experiences of people with overweight in GP consultations – a qualitative study

ORIGINAL ARTICLE

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BACKGROUND
Overweight and obesity are increasing in the Norwegian population. GPs can play an important role in preventing weight gain and increased health risks in patients with overweight. The aim of this study was to obtain greater insight and a deeper understanding of the experiences of patients with overweight in consultations with their GP.

MATERIAL AND METHOD
Eight individual interviews with patients with overweight in the age group 20 - 48 years were analysed using systematic text condensation.

RESULTS
A key finding in the study was that the informants reported that their GP did not raise the subject of overweight. The informants wanted their GP to take the initiative to talk to them about their weight and regarded their GP as an important agent in connection with challenges of overweight. The GP could function as a 'wake-up call' to make them aware of the health risk and of poor lifestyle choices. The GP was also highlighted as an important source of support in a change process.

INTERPRETATION
The informants wanted their GP to take a more active role in talking about the health challenges connected with overweight.

Main findings

The informants reported that their GP did not raise the subject of overweight.

Several wanted their GP to initiate a discussion about their weight, also in consultations about other matters.

The GP was described as an important agent in connection with individualised preventive health care in the area of overweight.

Several informants believed that GPs could make patients aware of unhealthy behaviours and lifestyle choices and provide support in the change process.

The prevalence of overweight and obesity in the Norwegian population is rising dramatically (1). There is therefore a need in society to prevent this through a concerted and strengthened effort (1–3). One of the goals of the Coordination Reform is for GPs to be more active in the prevention of lifestyle diseases (2).

Greater efforts to prevent weight gain and the associated health risks in people who are overweight can have a major impact on the individual, and can also benefit society considerably (1, 4). For many patients, getting support and help from their GP at an early stage will be crucial for avoiding negative weight development (5, 6).

In previous research, *overweight* has mainly been used as a generic term for overweight and obesity. The conditions differ from each other in terms of prognosis and treatment (1). Being overweight is not associated with the same degree of health risk, but for some it can be a precursor to obesity and a significantly increased health risk (1). Studies from the UK and the United States show that few doctors talk to their patients about overweight and obesity (7, 8), despite patients wanting and expecting this (5, 9–11). Doctors may be reluctant to discuss overweight for fear of causing offence (12), and this can lead to the subject only being raised once medical complications have arisen (12, 13).

We have little empirical knowledge about how GPs can introduce the subject at an early stage with a view to preventing weight gain and the associated health risks in people who are overweight (1). In order to equip themselves to provide individualised preventive health care for people who are overweight, the first step for GPs is to learn more about the patient's perspective of the situation. We therefore conducted a study where the aim was to explore and describe the experiences of people who are overweight in GP consultations.

Material and method

We interviewed eight people in the age group 20–48 years; five women and three men, in the period February–June 2021. Informants were recruited through notices (see the appendix) posted at educational institutions, training centres, GPs' offices and private agencies working with lifestyle changes. To secure young participants for the study, snowball sampling via informants' networks was also used (14).

At the time of interview, all informants had a body mass index (BMI) that is classified as overweight according to the World Health Organization (25–30 kg/m^2); six were at the high end of the overweight index, while two were at the lower end. The informants had become overweight at a relatively young age, from their mid-teens and as young adults. Three of the informants had developed obesity as a young adult and had lost weight in the last 5–7 years, subsequently maintaining a stable weight. Various rural and urban areas throughout Norway were represented in the sample. The patients had contacted their GP for various physical and mental health issues, such as back and joint pain, sleep problems, lack of energy and other specific challenges. Some contacted their GP specifically about a problem with their weight.

The interview guide had an overall theme and suggestions for follow-up questions. All interviews started with the introductory question 'Can you describe your experiences with the subject of overweight in GP consultations?' This gave the informants the opportunity to tell their story and discuss topics that helped shed light on the issue. Follow-up questions were asked about their situation in relation to health, lifestyle and work – currently and in the future – and their thoughts on discussing overweight with their GP.

The interviews lasted 45–90 minutes. The interviewer actively encouraged the informants to express and expand on their own narratives. For the sake of variety, the interviewer asked follow-up questions about whether there were other situations in which the informants had had a different experience (14). Questions and words such as 'Can you tell me more?', 'What did you think?', 'How?' and 'In what way?' were used to gain a greater understanding. For the theme on how the informants wanted their GP to communicate with them, the interviewer used elements from role play ('If I were you and you were the doctor, how would you have proceeded?'). This produced concrete examples of situations and resulted in rich data on the topic and satisfactory information power for the sample (14).

The interview was recorded digitally and transcribed immediately afterwards so that the social and emotional tone remained fresh in the interviewer's mind. The transcribed material amounted to 162 single-spaced A4 pages of data. We analysed the material using systematic text condensation (14). Everything was thoroughly read first to get an overall impression. Meaning units were then identified and sorted into groups with similar content. Finally, we synthesised the material into an analytical text, with quotations illustrating each category. We used this method to describe the most relevant pages, common features and variations in the material. The categories were given new headings that summarised their content.

In qualitative research, there is a strong requirement for reflexivity in which researchers recognise their preconceptions and acknowledge their role in the research. All the authors are nurses and researchers, two with experience in the field. The study was approved by the Regional Committees for Medical and Health Research Ethics (reference number 203664) and the Norwegian Centre for Research Data. All the informants gave written informed consent. The material was anonymised before publication.

Results

Through the analysis, we developed four categories: 1) 'My GP does not raise the subject of overweight', 2) The GP's responsibility for prevention, 3) The GP can initiate a discussion about weight, and 4) The GP as a 'wake-up call' and source of support in a change process.

'My GP does not raise the subject of overweight'

All the informants found that their GP did not raise the subject of overweight. Some GPs acknowledged or mentioned overweight – sometimes causal links were mentioned – without inviting further discussion or an exchange of information. An informant in his 20s was found to have high blood pressure. In the first consultation, blood pressure medication was prescribed and the patient was informed that weight could affect blood pressure. There was no further discussion of the challenges involved, either at the consultation or at annual check-ups. In another informant's consultation with their GP, overweight was mentioned together with back pain on their medical certificate, despite not being discussed in the consultation.

'I panicked. I thought that my employer got the same information that I could see … that they could see that it said overweight on the sick note. I know that I'm too … yeah, too fat. But it was still a bit of a shock to see it on the sick note. We haven't talked about it … we could've done that.' (Informant 1)
Several of the informants wanted to talk about their weight with their GP, but found that the doctor ignored the subject or oversimplified the problem. This led to the informants themselves ignoring the subject. The informants felt unable to raise the subject of overweight, partly due to the limited time available in consultations. An 18-year-old informant had asked for 'diet pills' and had been prescribed them without further follow-up on the issue. Several of the informants reported implying to their GP that they had a weight problem, but that the doctor did not take the hint.

Overweight was a sensitive issue, regardless of a patient's BMI. The informants described how they felt they were in a vulnerable position in their interaction with their GP, and often interpreted the GP's words and actions negatively. Some felt that their GP was not aware of their discomfort during the consultation. Several described a feeling of shame and sense of defeat at not managing to do anything about their problem.

The GP's responsibility for prevention

Several informants had an expectation that the GP would take responsibility for talking about their weight, with the aim of establishing a picture of the situation and providing information, support and further follow-up. Several participants believed that their GP has a duty to help them prevent negative weight development.

'Preventing excess weight gain must be as obvious a topic for discussion with the doctor as preventing other health issues.' (Informant 6)
One informant used a car analogy to convey the message:

'If the doctor thinks that I may be at risk of developing health problems, I expect him to address it with me. If my car is at the garage and they notice that my brakes are a bit worn, but still drivable, then yes, I expect them to tell me that, and also mention what the consequences might be if I don't do something about it.' (Informant 2)I
At the same time, a picture emerged in which the informants themselves also had responsibility for their own health, while society at large had an obligation to help prevent overweight and obesity. For many, it was important not to be perceived as lacking self-control. The informants described how they expected the doctors to be knowledgeable about overweight and measures for weight regulation and weight reduction. They also wanted information about health risks. Several of the informants also said that the doctor should not be afraid of how the patients might react.

Young informants found it difficult to have expectations of their GP when they themselves had no knowledge of how a GP can and should work. Bringing up the subject was described as challenging when only one health issue could be raised per consultation. Several found it difficult to book an appointment with their GP for weight issues.

The GP can initiate a discussion about weight

The informants wished that their GP would take the initiative to talk about overweight, also when they were there to discuss other health issues. Several important points would need to be included in order for the conversation to be effective. The GP would have to explain why he was bringing up the subject of weight in a consultation. It would be easy to think that the doctor might be basing the discussion about weight on the patient's appearance. One informant gave an example of how GPs could explain this:

'If only they (the GPs) had explained, for example, that for some, being overweight can be a precursor to obesity, that some can be at risk of that ... without mentioning appearance, just focusing on the risks of being too big ... and why it might be a good idea to work on keeping your weight stable.' (Informant 5)

The informants found that it would have been easier to open up if the GP had initiated such a conversation. The limited time available would force a natural conclusion to the conversation, but the GP would also need to bring it up again at a later date. The informants emphasised the importance of their GP's positivity and of giving them realistic objectives. The conversation could come to an abrupt halt when the doctor suggested oversimplified solutions.

'Simplifications are the worst: "Just eat less and move more." It doesn't exactly boost your self-confidence when everything is supposedly so simple. Why haven't I figured it out myself? Test out what I can manage, what I think myself. What is the pattern of behaviour I have that prevents me from putting a stop to it?' (Informant 6)

Being shown empathy was a prerequisite for trust and a determining factor for further cooperation. Another condition was that the doctor checked what knowledge they had. Good communication was highlighted as particularly important in this regard. Good relations during the consultation were more important than already being acquainted with the GP. One informant describes it as follows when he talks about how he wanted to discuss his weight with the doctor:

'It's about being pleasant and a bit flexible in how you word it. Show respect. Nothing major, just be pleasant.' (Informant 6)

Regardless of whether they already knew the doctor, timing was essential with regard to being receptive to the information.

The GP as a 'wake-up call' and source of support in a change process

The expectation of a conversation about weight is rooted in a desire for help to change. The informants were of the opinion that GPs can and should draw attention to poor lifestyle choices that hinder weight regulation, particularly if the patient is inattentive to their own behaviour. The informants wanted their GP to help them identify their habits in order to bring to light any negative aspects of their behaviour. Several informants suggested that their GP could function as a 'wake-up call'.

'You don't always see it yourself. It wouldn't have mattered if the GP had talked to me about weight… if I had to stand on the scales and find out my BMI. If he (the doctor) had asked me about my habits, I would've answered. I see now that I could have discovered things… goodies on Saturday maybe, not Monday, Tuesday, Wednesday… (laughter). I think I might have understood the seriousness if the doctor had brought it up. He had to explain things to me … properly.' (Informant 4)

Several of the informants reflected on how there was an eventuality linked to the prevention of weight gain if the GP made them aware of the problem at an early stage. They saw the GP as a professional they would have listened to, but acknowledge that they would initially have shown resistance.

'I might have gone home and been a bit annoyed, but so what! It might have woken me up a bit. Maybe I wouldn't have let it get this badd…' (Informant 2)

In general, the informants with no experience of weight reduction believed that their GP could support them in changing their behaviours and lifestyle. The informants with experience drew a slightly different picture. They wanted their GP to guide them in the direction of people with the competence to help them change. They did not have the same confidence in GPs' ability to help them make long-term changes in their behaviours and lifestyle. Nevertheless, they did not want their GP to drop the subject from future consultations, but to continue talking about weight and boosting motivation. The GPs could feed their motivation in all stages of change.

Discussion

A key finding was that informants reported that their GP did not raise the subject of overweight. The general perception was that it was fine if the GP initiated conversations about weight, also during consultations regarding other issues. The informants believed that GPs play an important role in preventive health care in the area of overweight. GPs can act as a 'wake-up call' by making patients aware of their own behaviours and the consequences of these, and they can provide support in a change process.

Weight – a non-topic

Previous international research shows that few doctors talk to patients with a high BMI about overweight and obesity (7, 8). The subject was only brought up in the case of comorbidity (12, 13). There is reason to believe that GPs are even less likely to raise the subject with people who are overweight if they have a lower risk of health problems and complications.

This can partly be explained by the fact that GPs are unable to identify the weight status of patients. Healthcare professionals and people in general underestimate body weight (15, 16). The average body size has increased in society over the years and there has been a recalibration in which larger bodies are perceived as the 'new normal', in accordance with visual normalisation theory (16). Some of the informants found that their GP did identify their weight status as they mentioned overweight. The lack of thorough research on the subject, however, may indicate that it has become a topic that needs to be

approached with caution and restraint. GPs use 'golden moments' to talk about lifestyle changes (17). Communication on sensitive issues is a difficult art to master. In the patient-centred method, doctors are advised to ask for permission when they wish to discuss sensitive issues (18).

A British study found that GPs are reluctant to talk about overweight for fear of causing offence (12). It is natural that GPs are afraid of triggering negative thoughts and behaviours in a patient by bringing up the subject with otherwise healthy people. It can affect a person's self-esteem, as weight and body image are important components of this (19). Dissatisfaction with appearance in connection with an eating disorder can also have this effect. The GP has to make professional and ethical judgments within a short timeframe during consultations. If the doctor misperceives the patient and regards them as not very motivated to change their lifestyle this can also be a barrier to talking about weight, or they may lack knowledge about genetic factors (10, 11).

The GP as an agent for preventive health care

The perception of the GP's role is in line with what the authorities, through regulations and reports, have expressed in terms of expectations for health promotion and preventive work in general practice. However, there is currently a gap between what is expected and the actual work of GPs (20). When the GP service was introduced, the intention was to strengthen individualised preventive health care (18). Financial prudence can guide which services GPs should prioritise, and it therefore makes sense to prioritise individualised preventive health care. This can be done by stimulating use of preventive procedures (21). Through individualised work in consultations, GPs have an important function as a practitioner of preventive health care (20). Almost 70 % of the population see their GP at least once a year, which underlines the GP's key role as an agent in individualised health care for preventing excess weight gain (5).

The informants wanted their GP to initiate a conversation about weight, also in consultations about other issues. This has also been found in several other studies (5, 9–11). Few informants said that they would be offended, as is also seen in international research on obesity (10). Obesity is linked to a risk of health problems and comorbidity (1). If GPs wait until a health problem has arisen before they raise the subject of weight, it will be too late, and weight gain and obesity will already have become a reality that is difficult to reverse (22). The consumerist nature of modern-day society and the complex causality of obesity make it difficult to prevent overweight (1). The aim must be to encourage health behaviours that promote weight stabilisation.

The findings on sensitivity, expectations, timing and communication reflect the difficulties faced by GPs in mastering the art of thematising obesity, and opinions can differ on whether the subject has been raised at all. A broader discussion relates to whether GPs can be expected to raise the subject in consultations, and whether they should do so regardless of the reason for the consultation.

Supportive conversations promote motivation

The study finds that GPs can function as a 'wake-up call' by making patients aware of their own behaviours and the consequences of these, and they can provide support in a change process. Supportive conversations about weight promote health motivation and patient compliance. Conversely, a stigmatising conversation about weight has a negative impact (6). The informants felt that talking about overweight was a sensitive issue. Studies also show that patients are sensitive to how GPs express themselves in discussions about weight (5). The GP's mode of expression and communication can affect patient's cooperation and their motivation to change their lifestyle (23–25).

The informants' wish for a discussion with their GP about weight is rooted in a desire to change. Motivational interviewing is a recommended counselling approach for encouraging behavioural change (26). This method can potentially be used to help patients in primary health care to lose weight (27). Doctors could also be pragmatic and use their own experiences with this technique instead of an evidence-based approach (28). Based on experience, GPs can also have lower expectations of what lifestyle changes patients can actually achieve (29). The informants highlighted the importance of a knowledge-based approach and of not withholding information from them. The ability of GPs to coach patients and recognise their problems is considered important (30).

Strengths and weaknesses of the study

The rich and varied data material and the fact that it was able to shed light on several aspects of the research problem was a strength of the study (14). In addition, the study used a well-tested analysis method with which the authors have experience. In order to strengthen reliability, we set out in detail how we drew conclusions about the subject from the material, enabling the reader to follow the analytical path that forms the basis for the interpretation and conclusion.

The findings from the interviews cannot be generalised to everyone who is overweight, but they provide insight into our informants' experiences with their GP. Other people who are overweight, other researchers and other qualitative methods will produce other findings (14), but that does not diminish the importance of our findings.

Conclusion

A key finding was that overweight was not perceived as being thematised by GPs. The GP is regarded as an important agent in connection with preventive health care in the area of overweight. The informants wanted their GPs to initiate a discussion about their weight, make them aware of their own poor lifestyle choices and provide support in a process of change.

The article has been peer-reviewed.

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