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People with weight-related long-term conditions want support from GPs: A qualitative interview study

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Summary

Two-thirds of UK adults do not have an up-to-date weight record in primary care. Some studies suggest that doctors do not raise the topic of weight management for fear of causing embarrassment or offence, or are doubtful whether people will make changes. However, for people with weight-related long-term conditions, conversations with general practitioners (GPs) can be crucial. Our study explores how people with long-term conditions associated with overweight recall and interpret conversations about weight in British primary care. An experienced qualitative researcher interviewed 41 people aged ≤ 42 years with long-term conditions associated with overweight. A maximum variation sample was sought, and transcribed interviews were analysed thematically. We revealed that patients with weight-related long-term conditions have different experiences and expectations about the role of GPs in supporting weight management. If a GP did not raise weight management in the context of the long-term condition patients formed the impression that their overweight was not seen as “doctorable” that is, as an appropriate topic for the consultation, rather than a personal or “lifestyle” concern. This was explained in multiple ways, which are captured in two themes; perceiving weight as “doctorable”; and weight doctoring in primary care. The findings highlight the need for increased attention on weight-related long-term conditions in primary care. Interventions from GPs would be welcome if conducted in a sensitive, non-judgmental manner and based on sound evidence about what works.

KEYWORDS

comorbidity, long-term conditions, primary care, qualitative research, weight management

1 | INTRODUCTION

Living with overweight is associated with the development of many long-term conditions, including some cancers, Type 2 diabetes, high blood pressure, sleep apnoea, several heart conditions, and for those with obesity (BMI ≥ 30), overall increased morbidity

and mortality.^{3,4} UK National guidelines encourage health professionals to use clinical judgement to decide when to measure and record someone's weight.^{5,6} Yet, only one-third of UK adults have their weight recorded in primary care in any given year.¹

In the UK, GPs are the first point of contact for all health care⁷ and deliver most of the formal weight management care.^{8,9}

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However, in a recent survey of people with overweight, only 20% of the 1309 participants had sought GP care in relation to their weight.⁷ There are many potential reasons why this is the case, including the possibility that patients do not regard weight-management as a “doctorable” problem.¹⁰ Patients may also be reluctant to engage in conversations about weight if they anticipate that it will involve stigmatizing language and be over-focused on diet and lifestyle change.¹¹ Despite evidence of effectiveness,¹² GPs do not routinely engage in weight-management discussions.¹ Health professionals report embarrassment and concern about offending patients who are overweight, and some are unconvinced that people who are overweight will successfully make changes.^{8,11,13} A recent review concluded that discussions about weight management are not a high priority for GPs.¹⁴ However, surely GPs should not feel reluctant to raise the topic when the patient has a known, weight-related long-term health condition? It is this specific group that is the focus of the interview study reported here.

1.1 | Is overweight seen as a “doctorable” issue?

Some patients whose weight is not monitored regularly conclude that GPs cannot consider weight a serious medical problem; instead, they believe that GPs view overweight as a “lifestyle” issue within the patient's sphere of responsibility.^{2,15,16} By contrast “doctorable” problems are those that are “worthy of medical attention, worthy of evaluation as a potentially significant medical condition, and worthy of advice and, where necessary, medical treatment.”¹⁰ Weight management may occupy a more liminal space between a lifestyle/personal issue and one that is, “worthy of medical attention.” Social comparison theory suggests that overweight is not seen as a legitimate reason to consult a doctor because in modern western society there has been increased normalization of overweight body types.¹¹ However, the growing population of people with long-term conditions associated with overweight need to be offered support to lose weight, especially since certain biological and social determinants can make it difficult for them to manage or lose weight on their own.¹⁷ Some long-term conditions require medications, such as calcium channel blockers, some beta-blockers, and insulin therapies which can contribute to weight retention or weight gain.^{18,19} Without support, weight gain could exacerbate existing condition or lead to other health problems, and self-management alone is not enough to help people manage their weight.¹

The experiences of people with long-term conditions associated with overweight have attracted little interest in the literature. We aim to fill this gap and make suggestions for GP practice by exploring how people with long-term conditions associated with overweight recount and interpret GP conversations. While we focus on people's experiences with GPs, we also reference the wider multidisciplinary team (e.g., nurses, dieticians) who are involved in primary care weight management.

What is already known about this subject?

- There is increasing pressure on primary care to deliver weight-management interventions; yet, two-thirds of UK adults do not have an up-to-date weight record.^{1,2}
- For people with weight-related long-term conditions, support for weight management can be crucial.
- The experiences of people with long-term conditions associated with overweight in relation to GP care have attracted little interest in the literature.

What this study adds?

- This qualitative interview study included people with weight-related long-term conditions to explore how weight conversations with GPs are recalled and interpreted.
- Those whose excess weight did not seem to be a priority to their GP reinforced the idea that weight-management is not a “doctorable” problem.
- GPs may want to consider offering increased, sensitive, and evidence-based weight intervention support for people with weight-related long-term conditions to underline the message that weight is a priority and that treatment and support are available.

2 | METHOD

2.1 | Recruitment

As authorized by the NHS National Research Ethics Committee South Central-Berkshire (Reference: 12/SC/0495), all participants were recruited through GPs, weight-loss clinics, community services, and snowball sampling and approached by telephone, mail, and email. The study aimed for a maximum variation sample.²⁰ We made efforts to recruit people from different parts of the country, social and ethnic minority background, and history of weight gain, loss, or maintenance. Experiences of weight and long-term conditions are likely to change over time. Thus, we recruited people whose long-term conditions had been diagnosed recently as well as those who had lived with their conditions for many years.

Participants were provided with information sheets and consent forms explaining the research and given time to decide whether they wanted to take part. These documents introduced MS (name, gender, job role, institution) and explained the reasons for this research. MS, a professional salaried researcher was funded to conduct this research to improve understanding of the experiences of people with long-term conditions associated with overweight and use this understanding to develop resources for information and support. Neither she, nor any of the co-authors, had a prior relationship with any of the participants.

2.2 | Interviews

In-depth qualitative interviews were conducted with 28 women and 13 men about their experiences of a weight-related long-term condition by an experienced qualitative researcher (MS, a middle-aged woman with a PhD). One interviewee dropped out due to time commitments. Interviews were conducted in 2018 across the UK in locations chosen by the participants, usually their own homes, although some interviews were conducted in community centres, hotels, or private interview rooms at the University of Oxford. The interviews had two parts:

1. An unstructured narrative where participants described their own experiences, thoughts, and important moments, with minimal interruption, of having a long-term condition associated with overweight; and
2. A series of specific topic questions asked by the researcher to explore issues already raised and potentially salient issues that had not yet been discussed. This section included questions about experiences of using British primary care for weight services and messages for clinicians working with long-term conditions associated with overweight.

With informed consent, interviews were audio-recorded for transcription. Interviews lasted between 1 and 2 h and 25 min. The average (mean) length of interview was 1 h and 35 min. Field notes were taken during and after interviews for reflexivity and to underline important moments for analysis.

After completion of 16 interviews, the study team consulted with an advisory panel. The panel included a patient representative, health professionals, social scientists, health researchers, a Diabetes UK representative, and members of the host research team, NDPCHS University of Oxford. The advisory panel contributed to ideas about sampling and recruitment, suggested further topics to explore in interviews and reflected on initial interview quotes and analysis.

2.3 | Sample

Forty-one people with 36 weight-related long-term conditions were represented in the sample. Recruitment continued until the analytic themes appeared to be fully saturated, and new interviews were no longer adding categories to the analysis.²¹ Conditions included arthritis ($n = 3$), irritable bowel syndrome ($n = 1$), Type 2 diabetes ($n = 17$), cancers ($n = 3$), epilepsy ($n = 1$), fibromyalgia ($n = 1$), high blood pressure ($n = 5$), sleep apnoea ($n = 6$), multiple sclerosis ($n = 1$), osteoarthritis ($n = 6$), and heart conditions ($n = 8$). Some participants had multiple long-term health conditions. Sixteen participants perceived themselves to be experiencing weight-gain at the time of the interview, with 6 reporting weight-maintenance and 15 reporting weight-loss. Two participants did not disclose whether they were in a weight gain, loss, or maintenance stage, and two participants felt that they were plateauing with their weight loss. Nine participants were from

the English midlands, 9 from the South of England, 20 from the North of England, and 3 from Scotland.

2.4 | Analysis

The interviews were transcribed verbatim and returned to participants to give them an opportunity to revise or remove any sections that they did not want to be used in the analysis. Any such sections were removed before the authors accessed the interviews. Data were then coded by MS using NVivo12.²² Initial analysis was informed by modified grounded theory which involved using line by line coding and constant comparison to develop themes from the whole data set and the context of each participant's interview.^{23,24} Further analyses and hundreds of interview clips from the collection can be seen at the public-facing website healthtalk.org/weight-change-associated-health-problems/overview.

AT and CA used the OSOP technique²⁵ to mind map themes and develop new inductive themes to answer a new question: how do people with long-term conditions associated with overweight recall and interpret conversations about weight with their GP? AT took an outsider's position not having worked in weight before, with CA who has interests in weight contributing knowledge based on previous research. Themes were developed through discussion and with advice from SZ.

3 | RESULTS

Our analysis suggests inconsistencies in how GPs support people with weight-related long-term conditions to manage their weight. This was explained in multiple ways, which are captured in two themes; perceiving weight as "doctorable"; and weight doctoring in primary care. Anonymised excerpts are presented to illustrate these themes.

3.1 | Perceiving weight as doctorable

Patients decide which of the health issues they face may be amenable to treatment by their GP—those issues that are considered appropriate to discuss have been described as "doctorable."²⁶ In many of the accounts, participants mentioned that GPs rarely discussed weight-management despite its connection with the long-term conditions that they were experiencing. Many participants struggled to make sense of this absence. A male with sleep apnoea, which he knew was related to his overweight, commented that his GP had never raised the possibility of weight loss: "*But coming back to the issue of sleep apnoea, nothing came. There was no suggestions about diets or how I might lose weight. Of course, I was aware sleep apnoea applies frequently to men who are overweight.*" (P02, M, Sleep, Apnoea).

Similarly, some participants said they were surprised that their GP had not mentioned their overweight before they developed their weight-related long-term condition. A woman with Type 2 diabetes,

for example, explained that her husband was confused about why her GP had not mentioned her overweight. From her husband's point of view, her weight only became doctorable once she had a diabetes diagnosis: *"When my periods ceased, I thought, 'Oh it's menopausal,' and I went (to the GP), there was never a comment (about my weight). My husband said to me on a couple of occasions, 'Did they mention your weight?' Not one of them (GPs) had ever mentioned my weight until the diabetes."* (P18, F, Type 2 diabetes).

The lack of expected doctoring for weight was variously interpreted; patients primarily suspected that GPs were uninterested, embarrassed, and/or were more interested in treating other conditions rather than overweight: *"I have to go to the GP quite a lot, and they don't seem to be interested in my weight... They just say, 'Oh, we'll treat this or that, do not worry about weight. I think they're embarrassed because I'm obviously very big and they don't know what to say.'" (P07, F, multimorbidity).* This had significant implications for some of our participants. A woman with arthritis and fibromyalgia said her conditions were exhausting and made it feel impossible to self-manage her weight. In other cases, people described how even low-intensity exercise would cause pain, causing them to live more sedentary lifestyles: *"If I could walk without pain (that) would be wonderful... there is no choice I cannot walk at all. And if we are going anywhere we take a wheelchair with us."* (P04, F, Multimorbidity).

Many of our participants emphasized the need for GPs to acknowledge and help treat their overweight. A man with heart failure perceived a nurse had been unhelpful, rude, and dismissive of the bereavement that triggered his weight gain: *"the weight gain started 12 months after my wife died. I was so worried about it. I went to see the GP, and the practice nurse was really quite rude... She told me, 'You'll lose weight if you keep that shut' (Gestures to mouth)... She did not give me any advice on how I should change my diet"* (P25, M, heart failure).

Even when GPs did discuss weight management, some participants reported dissatisfaction. A woman who went to see her GP for a non-weight-related condition described her interaction as *"one of the most unsatisfactory experiences"* due to the doctor treating her overweight in a *"tokenistic way."* She explained that the GP asked her only a couple of weight-related questions, which she suspected was to make a good example to a trainee doctor in the room. What stood out to the participant was that the doctoring consisted of dietary advice, despite her expressing that she generally eats healthily other than when she lacked time: *"I went (to the GP) with a different problem, she mentioned my weight, and it was one of the most unsatisfactory experiences... she had a trainee doctor in the room, and I felt she'd just put that question into our consultation as an example of good practice. I explained that I did eat well, but time was a factor sometimes... She said to me, 'If you make a small change like take a salad to work,' I felt quite insulted. I just felt it was tokenistic, really."* (P10, F, multimorbidity).

Although relatively few participants described positive doctoring for weight in the context of their long-term condition, many suggested that discussion of weight was most beneficial when GPs took time to listen and offer person-centred support based on sound evidence about what works. One participant with multimorbidities described his GP's technique as listening and adapting interventions

based on his experience. He perceived his GP's advice as *"straight"* and *"sound."* A woman with impaired mobility described her experiences as *"outstanding."* She emphasized that getting the right GP is essential to successful weight doctoring: *"My GPs have been outstanding for me... Getting the right GP is the most important because they're your first point of call. We (GP and I) delved into (my condition) and started to find out there were more things wrong with me than I anticipated. But having him... being able to call and say, 'Can you ask the doctor to call me?'... And then they do call. It's just nice"* (P37, F, impaired mobility). A few participants spoke of success with self-management, mainly discovering what worked through trial and error. For these participants, adhering to self-management techniques involved having the right mind-set or great personal motivation to lose weight: *"It's all in the mind. Your attitude does have to change if you want to lose weight"*. (P09, F, clogged artery). Most of our participants described having this mind-set. However, as described earlier, they often lacked the means to engage with these techniques because of the symptoms associated with their long-term condition.

3.2 | Weight doctoring in primary care

The people we talked to wanted different approaches from primary care staff in relation to their overweight: Some wanted overt attention to their weight, whereas others said that weight-management consultations were difficult. However, few participants appreciated simple advice based on *"eating less and moving more."* A participant with joint hypermobility syndrome said that it was a conversation with a nurse while she was being weighed that caused her to rethink whether she really wanted to have bariatric surgery: *"She (the nurse) was weighing me and talking about diet, and it definitely helped. She said if you want to go ahead and get bariatric surgery, you've reached that point. But then I thought, 'Nah, it's not for me.'" (P04, F, joint hypermobility syndrome).* Diet and lifestyle advice is readily available, as this participant notes: *"They sent me to a dietician. She was lovely, I knew all that she was telling me, it's all on the television now... she was very good with me, but it wasn't what I needed. I needed counselling."* (P07, F, multimorbidity).

A participant with multimorbidity had been following dietary advice for some time but thought other issues prevented her from losing weight which she wanted her GP to explain: *"If you've had prolonged (weight difficulties)... and you feel you've been living healthily and nothing's changing then I think it should be looked at in the same way that you would look at my heart... 'Well can we look and see what's happening with my weight if I tell you, keep my food diary, and I show you what I eat? Where am I going wrong?'" (P35, F, multimorbidity).* In her experience, health professionals sounded like they were reading a script and not considering non-dietary weight management advice: *"Every time you see a health professional if you are overweight, they'll always tell you, 'You've got to lose weight,' and, and that's it... It's like a mantra of, 'You've got to lose weight. Eat more veg and more fruit. Less carbs, less fat,' which is what I do and if I say, 'Well, I do that already,' and they say, 'Well, you're not doing it enough.' There's no alternatives. I think they are given a script..."* (P35, F, multimorbidity).

This lack of attention to the patient's weight was echoed several times in our participants' accounts, with some suggesting that their GPs were not doing a key part of their job. A man with Type 2 diabetes explained: *'I was lucky, or unlucky I'd got a really nice group of doctors who never made a big deal about it (his weight).'*' (P39, M, Type 2 diabetes). However, later in his account, he emphasized that he needed a doctor to stress the importance of him losing weight: *"If you've got somebody who came up and says, 'You're eating too much.' That's different. It might not make any difference, but you would take note. Whereas if they say, 'Maybe you should try losing a wee bit of weight,' like maybe it was an option. It's not an option. Be brutal and ruthless."* This idea of doctors being brutal when discussing overweight was also mentioned by another participant with Type 2 diabetes. This participant suggested that if her doctor had been more direct about her overweight, she would have taken measures to avoid it: *"They'd say, 'well, you're a wee bit chubby,' and I was at the time... They never said, 'You're pre-diabetic'... If the doctor had stressed that I would have done something about it... They have to be more brutal."* (P08, F, Type 2 diabetes). These last perspectives were atypical, divergent, and cases in our data, and we should note that people may not appreciate 'brutal' communication from their GP in actual consultations.

Most of our participants spoke about wanting increased weight doctoring from their GP, expressed in a sensitive and non-judgemental manner. One participant highlighted the importance of considering the diversity of patients' needs. In the context of overweight and comorbidities, this means understanding that certain advice and interventions may work for one person but not another: *"Listen without prejudice... We can label people. We can put them into pigeon holes... Don't treat it like he wants too much, he's a nuisance."* (P20, M, multimorbidity). Another woman with Type 2 diabetes identified how different living situations can affect weight-management which, in her view, means that GPs should deliver person-centred advice, rather than assuming that dietary and lifestyle changes work for everyone: *"It needs to be more personal... I think you need to really understand the person's problems and lifestyle because what will fit one, won't fit the other.... I live alone; what suits me won't suit somebody who's got three small children"* (P32, F, Type 2 diabetes).

4 | DISCUSSION

4.1 | Summary

This study found that GPs in UK primary care are not perceived to prioritize weight-management discussions even with people with weight-related long-term conditions, a group who could clearly benefit from support in losing weight. Several meanings were attached to why this may be, including perceptions that GPs were embarrassed, uninterested, or more interested in managing symptoms. This puzzled participants who viewed their weight as "doctorable" and knew that their long-term condition was weight-related. They expected weight-management advice and treatment but instead said they received mixed messages about the importance of managing their weight from

GPs, who rarely spoke about it or offered treatment. Micro-level interactions within consultations, for example, when GPs simply offered diet and lifestyle advice, were also reported to reinforce notions that weight-management is not doctorable. Some felt that their weight was treated in a tokenistic way or that their other conditions were viewed as more doctorable. Those who described positive experiences said their GPs took time to listen and offer person-centred support based on sound evidence about what works and were willing to make adjustments to the treatment/ medicines for the associated long-term conditions.

4.2 | Where this fits with other literature

Our findings that GPs may appear to overlook overweight when associated with a long-term condition are supported by a quantitative study of weight measured in electronic health records in the UK¹ and a systematic review of perspectives of people with overweight.¹⁶ Our participants' observation that GPs do not appear to prioritize discussion of overweight is also congruent with several qualitative studies on the views of GPs about weight-management conversations with people who are overweight.^{2,8,27} The Awareness, Care, and Treatment In Obesity Management International Observation (ACTION-IO) survey, for example, found that healthcare professionals assumed that people with obesity were not interested or motivated to lose weight.²⁸ People with obesity, on the other hand, thought that they were making serious efforts to lose weight on their own but were having limited success and needed support and guidance from their GP.²⁸ However, none of these studies has focussed on weight-related long-term conditions. A recent review of qualitative studies with primary care staff¹⁴ found mixed views about whether there was enough evidence to support GPs to advise people who are overweight (there is). Even among those who did see it as "part of the job" to advise weight-management, some suggested that limited time in the consultation meant that staff prioritized other, more effective, discussions.¹⁴

A recent systematic review of behaviour change conversations in GP consultations also suggests that people can respond negatively to unilateral advice-giving and prefer a collaborative, personalized approach linked to something important to them.²⁹ The existing literature has highlighted that weight-management conversations should be helpful and supportive, rather than present 'worst-case scenarios'.³⁰

Our findings may be transferable to Canadian and American primary care settings where guidelines also encourage GPs to view overweight when associated with a comorbidity as doctorable.³¹ A recent Canadian study on patient perspectives on the role of primary care in overweight management, for example, highlighted how patients expect GPs to doctor their weight sensitively.³² Like our study, they suggest that simplistic dietary and lifestyle advice will not work for everyone,³² especially in the context of a long-term condition. They recommend GPs engage in the 5A framework for weight management (Ask-Ask-Assess-Advise-Agree-Assist) as it is associated with increased patient motivation to manage and lose weight.³³

4.3 | Strengths and limitations

The use of relatively unstructured interviews conducted in a home environment has highlighted the mixed messages that people with weight-related long-term conditions receive when GPs do not offer support. People feel confused, and some found it hard to follow general advice to change to diet and activity in the context of their long-term condition. Therefore, our data highlight the importance of GPs viewing overweight in the context of an associated long-term condition as a doctorable issue, rather than one that will respond to general unspecific advice to eat less and move more.

A limitation of the study is that because it is based on interviews with people, not observations of clinics, we do not know whether the participants' accounts reflect what happened in the consultations described. GPs might be interviewed on the same matter to identify similarities and differences in perspectives and help improve weight-management consultations for people with long-term weight-related conditions. The youngest participant in the study was 42, and there were few from ethnic minority backgrounds (two were Afro-Caribbean). Young people and ethnic minorities may have additional difficulties related to weight-management in the context of a long-term condition.

4.4 | Implications for practice

Our findings suggest that people with weight-related long-term conditions need more attention in primary care consultations. Increasing emphasis on weight management in clinical training and continuing professional development could start to address this. By engaging in weight-loss discussions with people with weight-related long-term conditions, GPs can actively support this seldom-heard group. GPs may want to consider offering increased, sensitive and evidence-based weight intervention support for people with weight-related long-term conditions to underline the message that weight is a priority and that treatment and support are available. GPs will also recognize that what works for one patient might not necessarily work for another. For example, some people want overt attention to their weight, whereas others find weight-management consultations difficult.¹⁶ In these cases, GPs may wish to engage with the 5A element “ask”, meaning to ask for the patient's permission to doctor their weight.³²

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CONFLICT OF INTERESTS

None of the authors have conflicts to declare.

AUTHOR CONTRIBUTIONS

Amelia Talbot was the lead author for this article, and Maria Salinas was the sole data collector. Maria Salinas and Sue Ziebland were involved in study design, advisory panel, and the initial analyses for the Healthtalk project. All authors were involved in analysis and writing the article and had final approval of the submitted and published versions.

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