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An identification and critical analysis of barriers to raising the topic of weight in general practice

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"Neither the life of an individual nor the history of a society can be understood without understanding both" C.Wright Mills

Abstract

In light of the increasing prevalence of obesity in the UK, health professionals working within general practice are urged to initiate discussion about weight with overweight and obese patients. Despite such appeals, evidence suggests that only a minority of health professionals routinely talk to patients about weight loss.

To understand more about the barriers to raising the topic of weight in general practice, three empirical studies guided by qualitative research design were carried out. The first two studies draw on psychological theory to identify barriers to raising the topic of weight. Semi-structured interviews were conducted with 17 GPs and 17 primary care nurses. The third study conducted with 20 GPs is underpinned by discourse analysis and uses trigger film interviews to capture and critically analyse the discursive production of, and macro-discourses shaping, barriers.

In study 1 and 2, three main themes summarise barriers identified from GP and primary care nurse perspectives: limited understanding about obesity care, concern about negative consequences and limited time to raise a sensitive topic. In study 3, four discursive frameworks were identified as underpinning constructions about the barriers to broaching discussion about obesity: medical-reductionist, medical-holistic, moral and ethical. Findings extend understanding about the ways in which obesity is constructed as both a medical and non-medical issue.

The findings have implications for health professional education, policy and research including the need to expose and challenge dominant understandings of obesity as a behavioural problem, to address barriers operating at the socio-cultural as well as the individual-level, and to enhance understanding about the socially embedded and pernicious effects of obesity stigma in the consultation and beyond.

Chapter 1: Introduction

1.1 Introduction to the chapter

This thesis is about the challenges that health professionals, general practitioners (GPs) and primary care nurses, encounter when starting conversations about excess weight in general practice. To introduce and contextualise the thesis in the broader research field, the chapter will begin with some background information about obesity and will look at the role of general practice in contributing to the public health goal of lowering rates of obesity and overweight in the population. By drawing attention to the unresolved issues and conflicting findings in the knowledge base, I hope to make clear why this research is required. After justifying the conduct of the thesis, I will clarify the focus of the research and discuss the approach taken including the overall aim and individual objectives of the thesis. Before concluding the chapter, I will provide a roadmap of the thesis through specifying the content of each chapter and overall structure of the research.

1.2 Background to the research area

1.2.1 Prevalence and costs of obesity

Obesity is a clinical term used to describe excess body fat and is most commonly measured by calculating an individual's body mass index (BMI), calculated by dividing a person's weight measurement (in kilograms) by the square of their height (in metres). To be classified as obese, an individual must have a BMI of 30kg/m² or above and to be classified as overweight, a BMI of 25.0 – 29.9 kg/m². In England the prevalence rate has more than doubled in the last twenty five years; in 1993 around 15% of adults were obese compared to 2013 when the figure was closer to 25% with 26% of men and 24% of women in England being classified as obese (Health and Social Care Information Centre [HSCIC], 2015). In 2007, the Foresight report run by the Government Office for Science, predicted that by 2050 the prevalence of obesity would affect 60% of adult men and 50% of adult women (Butland et al, 2007). England also has a high prevalence of overweight adults. The latest figures reveal that 41% of men and 33% of women are overweight (HSCIC, 2015). There are also clear health inequalities with regard to obesity (Department of Health [DOH], 2011). Rates of obesity are increasing most among

those from poorer backgrounds, particularly so for females, and when socioeconomic position is measured by education (HSCIC, 2015). Currently, 15 – 18% of women (aged 20-60) in the highest social class (social class I) are obese compared to 26 - 33% of women in the lowest social class (social class V) (HSCIC, 2015). The Foresight report estimates that in 2050, obesity prevalence among women social class I will be 15%, in contrast to 62% for women in social class V. For men, the Foresight report estimates that a modest social class gradient will persist into the future, with 52% of social class I men predicted to be obese by 2050, compared to 60% in other classes (Butland et al, 2007).

Obesity can result in major adverse consequences for health, wellbeing, work output and life expectation (Butland et al, 2007). Being obese is associated with an increased risk of a number of conditions including diabetes, cardiovascular disease (CVD), musculoskeletal disease, infertility, obstructive sleep apnoea, asthma, disability, dementia, and premature mortality (Abdullah, Peeters, de Courten & Stoelwinder, 2010; Berrington et al, 2010; World Health Organization [WHO], 2000). More recently, there are recognised associations with several cancers, alzheimer's disease and renal failure (Profenno, Porsteinsson, & Faraone, 2010). In addition, obesity has social and psychological consequences at an individual level such as stigmatisation, reduced quality of life and low self-esteem (Puhl & Heuer, 2009). There is increasing evidence that obesity is associated with depression (de Wit et al., 2010; Faith et al, 2011; Luppino et al., 2010), anxiety (Gariepy, Nitka, & Schmitz, 2010; Scott et al, 2008) and other mental health disorders such as agoraphobia (Simon et al, 2006). Furthermore there is evidence that obesity is linked to adverse neurocognitive outcomes, including reduced cognitive functioning (Cserjési, Luminet, Poncelet, & Lénárd, 2009; Gunstad et al., 2007). As well as having an adverse effect on the individual concerned, comorbidities and associated problems, add to the complexity of treating this chronic and disabling condition. To give an example of the extent of this problem, an audit carried out in England found that 74% of obese patients had one or more comorbid conditions, almost half had two or more, and weight loss was less in those with comorbidities such as diabetes and arthritis (McQuigg et al, 2005).

The clinical burden of obesity is therefore a central concern to governments and medical leaders, as well as broader society (Dietz et al, 2015; Withrow & Alter, 2011). Recently, increased attention has been given to the direct economic cost of

obesity in England. It is estimated that £5 billion per year is spent on dealing with the consequences of obesity (Royal College of Physicians [RCP], 2013). The economic burden of obesity has been acknowledged around the world and a systematic review concluded that the medical costs attributed to obese individuals were approximately 30% greater than their normal weight peers (Withrow & Alter, 2009). The financial and economic costs of obesity were recently estimated to be 2 trillion dollars annually which equates to 2.8 percent of global gross domestic product (GDP) (McKinsey Global Institute, 2014).

As a result of the consequences and costs of obesity, there have been great efforts to develop interventions and/or preventative strategies to curtail what is often described as the 'obesity epidemic' (Gortmaker et al, 2011). Much attention has been given to the role that health professionals can play, particularly in primary health care given the continuous contact and long-term relationships that health professionals have with patients. I will now summarise the government and medical reports concerning obesity and draw attention to how they have urged GPs and nurses to 'tackle' obesity in general practice.

1.2.2 Policy documents and medical reports concerning obesity

The latest white paper, "*Healthy lives, Healthy people: A call to action on obesity in England*" emphasised that effective action on obesity calls for a range of approaches and treatment interventions, asserting that "preventing and tackling overweight and obesity is everybody's business" (DOH, 2011 p. 49). The paper prioritises a collective effort to encourage healthy weight in adults and states that effective and tailored support for the more than 60% of adults who are already overweight and obese is essential. Drawing strongly on the analysis carried out in 2007 by the Government Office for Science's Foresight programme "*Tackling obesities: Future choices*", the report recognises the wide range of issues that have contributed to the increase in obesity and acknowledges the complex ways factors interrelate and reinforce each other as demonstrated in the 'systems map' produced by Foresight (Butland, 2007).

Despite acknowledging that obesity is "driven by a complex web of environmental, physiological and behavioural factors" (DOH, 2011, p. 19), the report firmly asserts that the solutions lie in individual behaviour change and emphasises the need for individuals to reduce their overall energy intake. Personal choice, responsibility and a voluntary approach to change are consistent themes

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throughout the document. Susan Jebb, a leading obesity researcher and science advisor for the Foresight report, has labelled this approach "liberal paternalism" (Jebb, 2013, p. 44).

Health professionals are thus expected to contribute to the goal of lowering energy intake within society by promoting values of personal choice and responsibility when engaging with patients. A specific role for GP practices is the "identification, provision of brief advice, medical management and onward referral of overweight and obese individuals" (DOH, 2011, p. 31). The paper also asserts that health professionals will be supported in raising the issue of overweight and obesity with their patients and recognises that "broaching the issue and engaging people can be difficult" (DOH, 2011, p. 39).

One of the most influential policy documents to be published regarding obesity was the 2007 Foresight report *"Foresight Tackling Obesities: Future Choices Project".* The report was commissioned to determine how a sustainable response could be developed to tackle obesity over the subsequent 40 years.   The report puts an emphasis on complexity, describing obesity as a "complex, multifaceted condition that has no easy or obvious solution" (Butland, 2007, p. 61). Furthermore, the authors recognise and warn against disagreement from stakeholders on the individual determinants of a complex issue due to the contribution it will make to the "marginalisation of a multiple approach to change" (Butland, 2007, p. 126).

Whilst acknowledging that many of the levers of change lie outside the traditional health area and control of government, the report advocates for health professional involvement in the prevention and treatment of obesity. Referring to the specific role that health professionals are required and expected to contribute, it states:

> "To meet the increased demand, every health professional will need to be trained to identify those at risk from increasing body weight and be skilled in the initial management of the condition. For strategies to be effective, they must start in general practice and be linked to local expertise in acute NHS trusts. They will need to be adequately resourced and linked to local strategic partnerships, thereby engaging professionals outside the immediate remit of health. Ready access for psychological referral and

surgery, where appropriate, will also be important. Local initiatives should engage commercial weight loss organisations with evidence-based programmes for effective weight loss". (Foresight report, 2007, p. 123)

Along with government reports highlighting the need to improve the management of obesity in primary care, two recent reports authored by medical professional bodies have been produced. In January 2013, the Royal College of Physicians (RCP) produced a report titled "*Action on obesity*" followed by a report published in February 2013 by the Academy of Medical Royal Colleges (AoMRC) named "*Measuring up: the medical profession's prescription for the nation's obesity crisis*". Both reports emphasise the increase in prevalence rates of obesity and advocate for increased health professional awareness, training and engagement in tackling obesity in primary care.

Several of the aforementioned reports also discuss the need to operationalise the 'making every contact count' policy in which health professionals are recommended to routinely offer brief opportunistic advice about lifestyle including but not exclusive to behaviours related to weight (NHS Future Forum, 2012). The making every contact count policy, although not exclusive to general practice, was operationalised in 2012 and emphasises that:

"Every health professional should "make every contact count": use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, in particular targeting the four main lifestyle risk factors: diet, physical activity, alcohol and tobacco- whatever their speciality or the purpose of the contact". (NHS Future Forum, p.11).

The Making every contact count policy thus emphasises the responsibility of health professionals to put health prevention efforts at the centre of their consultations. Clinical guidelines have also clearly outlined the roles and responsibilities of health professionals and these will now be summarised.

1.2.3 Clinical guidelines

Recommendations on how to provide high quality and evidence-based health care are made directly to health professionals through guidelines issued by the National Institute for Health and Care Excellence (NICE). The overriding purpose of clinical guidelines is to improve the quality of care patients receive by

describing appropriate care based on the best available scientific evidence and broad consensus, while promoting efficient use of resources (Feder, Eccles, Grol, Griffiths, & Grimshaw, 1999). Clinical guidelines on obesity were issued by NICE in 2006 and updated in 2014, offering practical recommendations around the prevention, identification, assessment and management of overweight and obesity (NICE, 2006, 2014, cg43). According to the guidelines, primary care physicians in England should identify people with obesity and offer clinical management (NICE, 2014, cg 43). Since these guidelines were published, numerous other NICE guidelines have been issued which describe the role health professionals can play in promoting a healthy weight for patients. These guidelines include "*Managing overweight and obesity in adults - lifestyle weight management services*" (NICE, 2014, ph 53), "*Physical activity: brief advice for adults in primary care*" (NICE, 2013, cg 44), "*Obesity: working with local communities*" (NICE, 2012, cg 42), "*Four commonly used methods to increase physical activity*" (NICE, 2006, cg 2), "*Preventing type 2 diabetes: risk identification and interventions for individuals at high risk*" (NICE, 2012, ph 38), "*Behaviour change: the principles for effective interventions*" (NICE, 2007, ph 6). In addition, NICE guidelines on eating disorders (NICE, 2004, cg 9), are advised to be read alongside the 2014 obesity specific clinical guidance.

Despite the numerous guidelines published, there is limited detail regarding how health professionals should broach the issue of overweight or obesity with patients. In the 2006 guidelines, health professionals are instructed to: "use their clinical judgment to decide when to measure a person's height and weight" (NICE, 2006 cg 43 p. 35), followed by advice on how to classify the degree of overweight or obesity, how to make a clinical assessment and the range of interventions that can be offered. Thus, guidance is mainly concerned with the measurement, assessment and treatment of obesity but fails to provide insight into how health professionals should approach patients before the subsequent measurement and assessment takes place.

However recent guidance, "*Managing overweight and obesity in adults - lifestyle weight management services*"(NICE 2014, ph 53), has included advice around the need for sensitive communication advocating that GP practices and other health care professionals who give advice about, or refer people to lifestyle weight management programmes, should "raise the issue of weight loss in a

respectful and non-judgemental way" (NICE 2014, ph 53, p. 4), "ensure the tone and content of all communications is respectful and non-judgemental" (NICE 2014, ph 53, p. 4), and "the terminology used to describe someone's condition should respect how they would like to be described" (NICE 2014, ph 53, p. 5). I will now look at how the focus on promoting weight loss has come to reside with general practice clinicians.

1.2.4 General Practice as a suitable location to prevent and manage obesity

General Practice is seen as the optimal context to deliver care for people with long term-conditions due to its accessibility, efficiency and ability to offer continuity of care (Chew-Graham et al, 2013). Every year, over 80% of the UK's population visit their general practice (Walker, Maher, Coulthard, Goodard, & Thomas 2000) and on average, each patient has around five-and-a-half consultations within the year (Hippisley-Cox & Vinogradova, 2009). Research also suggests that patients with obesity compared to patients without obesity have almost one and half times more visits to primary health care services (Twells, Bridger, Knight, Alaghehbandan, & Barrett, 2012) thus it is suggested that primary care practitioners are in an ideal position to address and treat obesity.

It is important to recognise that general practice is located in a historical and social context and that political and socio-cultural factors shape interactions between health professionals and patients and, importantly for this thesis, clinician behaviour. I will now summarise some of the contextual factors that shape GP and nurse behaviour and discuss the changing role of general practice in regards to population health.

Since the 1970s, health service reforms in the 1990s and continual changes to government policy have resulted in a greater emphasis on primary care being efficient, measurable and amenable to external regulation. In 2004, a new contract was introduced into the NHS.   This General Medical Services (GMS) contract introduced major changes to the operation of general practice.   Previous to this, GPs operated as independent contractors to the NHS. However, with the introduction of the GMS came a shift in this independence and the introduction of performance management, audit and inspection by local primary care organisations (primary care trusts and clinical commissioning groups). There has thus been a shift from individual self-regulation by GPs based on their professional knowledge and skills to regulation by clinical and non-clinical administrative bodies (McDonald,

Campbell & Lester, 2009; Waring, 2007). The GMS brought in performance indicators, financial incentives and increased measurement and regulation of clinical work (Roland, 2004). The Quality and Outcomes framework (QOF) is one such example of the introduction of targets. The QOF ensures that the quality of care delivered in practice is measured against patients' experience and clinical and organisational levels of care, with practices being paid for approximately 150 indicators.

Another major change occurred in April 2013. Primary care trusts were no longer responsible for negotiating contracts with commercial companies which they had previously carried out in order to commission services for GPs, or in supporting quality improvement efforts in general practice. Instead power was handed to Clinical Commissioning Groups (CCGs), groups of GPs located in similar geographical areas. These CCGs were given responsibility for approximately two thirds of the NHS budget (Naylor et al, 2013). In addition, CCGs gained responsibility for performance monitoring, negotiating contracts and supporting quality improvement work in practices. At the same time, these reforms saw the shift of public health into local authorities (Phillips & Green, 2015).

1.2.5 The role of GPs and nurses in obesity management

As has been discussed, health professionals have been positioned as apt to raise awareness of their patient's weight status. The push from policy makers has been supported by evidence that a significant proportion of overweight individuals do not recognise that they are overweight. Studies for example have demonstrated that some overweight individuals underestimate their weight status (Kuchler & Variyam, 2003; Standley, Sullivan & Wardle, 2009). It is assumed that if people are not aware that excess weight is a risk factor, they will have little motivation to change their behaviours in order to lose weight (Duncan et al, 2011; Johnson et al, 2008).

As well as being encouraged to raise awareness of weight status, health professionals are also expected to play a role in supporting patients to lose weight. Research has demonstrated that health professional advice can influence patients' self-efficacy (Kant & Miner, 2007), weight loss efforts (Galuska, Will, Serdula, & Ford, 1999; Sciamanna, Tate, Lang, & Wing, 2000) and motivation (Rose, Poynter, Anderson, Noar, & Conigliaro 2013). The possibilities health professionals have to prevent and treat adult obesity include counselling to induce lifestyle change which

includes a focus on diet, physical activity and behaviour change; pharmacotherapy; and, bariatric surgery (NICE, 2014, cg43). It is important to emphasise that the first line of therapy recommended and supported by evidence is lifestyle intervention which includes dietary restriction, increased physical activity and behavioural management (NICE, 2014, cg43). Therefore, health professionals are expected to routinely encourage patients to lose weight through increasing healthy eating and physical activity via behaviour change. Guidance suggests that health professionals should work with patients to achieve a 5-10% weight loss since this can elicit substantial health benefit (NICE, 2014, cg43).

In addition to contributing towards the treatment of obesity, primary care providers are also being asked to prevent obesity through raising awareness of adiposity which can be categorised as 'overweight'. A 2010 report produced by the Royal College of Physicians about the training needs of health professionals, emphasised the need for all health-care professionals to identify those at risk of obesity as well as to manage and treat those patients already presenting with obesity (RCP, 2010). Recognising that health professionals are poorly equipped to meet demands from the clinical impact of obesity, the report lays out training needs and clearly asserts a role for all front-line health professionals in contributing to the prevention and treatment of obesity.

In line with increasing pressure on general practice to address excess body weight with patients, there has been a greater emphasis on promoting behaviour change. Current public health policy has put increasing emphasis on the role that health professionals can play in promoting changes to individual behaviour in order to improve population health (Wanless, 2004; NHS forum, 2012). Clinicians are encouraged to intervene to change health behaviours during routine contact with patients (Butler et al, 2013). Given the high rates of the population consulting in general practice every year, this approach is able to reach the majority of the population thus removing the need for setting up an intervention programme in addition to routine care. Amongst the benefits of interventions delivered at the point of care is that clinicians have contact with disadvantaged populations who are at greater risk of chronic disease yet are least likely to meet current guidelines for healthy lifestyles (Buck & Frosini, 2012). Health behaviours such as smoking, excessive alcohol consumption, lack of exercise, and consumption of an unhealthy diet are framed within health policy as some of the most important modifiable

causes of premature morbidity and mortality in the developed world (Goldstein, Whitlock & DePue, 2004). There is increasing concern that health care services will be unable to cope with rises in lifestyle-related illness if preventative measures are not implemented (Tsou, Mackie & Sim, 2006) and much focus has been directed towards the contribution that health professionals can make within their consultations. As well as being tasked to promote behaviour change, reports also emphasise that health care professionals need to work with other specialists to prevent and manage obesity reflecting a change towards a greater interdisciplinary model of working (Dietz, Lee, Weschsler, Malepati, & Sherry, 2007; RCP, 2010).

Finally, GP practices are incentivized to play a role in obesity management through the QOF. GP practices are rewarded if they produce a register of obese patients aged 16 years and older. However, given that the number of QOF points assigned to this is less than 1%, many have argued that it continues to have a negligible influence on practice (Haslam, 2014). It is also interesting that despite the focus on behaviour change taken in other reports and within NICE guidelines, the QOF only rewards practices for measuring and recording BMI rather than offering any further intervention such as behaviour change advice.

As this section has illustrated, there is a clear increase in expectation and responsibility for primary care health professionals to contribute towards helping patients lose weight. Although there are signs that the complexity of obesity is being recognised, there is continued emphasis on individual-level behaviour change which continues to be a dominant force in how health professionals are expected to help patients.

1.2.6 Effectiveness of weight loss interventions in primary care

There is currently variable evidence supporting the effectiveness of weight loss interventions delivered in primary care. For weight loss interventions to be judged as effective within health care settings, patients much achieve 5% weight loss, a criterion considered to yield significant health benefits (Douketis et al, 2005). Since lifestyle interventions are considered to be the most cost effective means of treatment and prevention for individuals with obesity and overweight (although not for severe obese), and are recommended as a first-line approach for the prevention and treatment of obesity in the NICE guidelines, I will now summarise the variability that exists in the evidence base regarding the effectiveness of these interventions.

It is first important to note that there is good evidence that behavioural interventions that focus on changing behaviours related to eating and physical activity are effective in inducing clinically significant weight loss (Avenell et al, 2004; Dombrowski, Avenell & Sniehotta, 2010). However, there remains limited evidence about the effectiveness of interventions that promote long-term weight loss maintenance (Dombrowski et al, 2014; Wing & Phelan, 2005; Gilman & Murphy, 2015) with most people regaining weight within 5 years (Avenell et al, 2004; Dombrowski et al, 2010). In addition, when applied to the primary care setting, it remains unclear whether behavioural interventions can yield clinically significant weight loss.

A recent systematic review and meta-analysis which estimated the effect of behavioural interventions delivered in primary care reported that lifestyle interventions result in small reductions in body weight which are unlikely to be clinically significant (Booth, Prevost, Wright, & Gulliford, 2014). However, it is interesting to note that within the review, the study using the highest number of behaviour change techniques and based on behaviour change theory, demonstrated the greatest weight loss at 12 and 24 months (Apell et al, 2011). Unfortunately poor study reporting prohibited assessment of the behavioural science components in each intervention, preventing understanding into the mechanisms of effective weight management interventions. In a similar vein, others have noted that the majority of interventions have not been influenced by psychological theory (Sniehotta et al, 2014). It is thus important to note that there is no conclusive evidence about the components and behaviour change techniques required for interventions that support long-term weight loss. Although researchers argue that interventions informed by theories of behaviour change offer great potential to support effective weight loss maintenance, the research is still in its early stages (Sniehotta et al, 2014).

Another systematic review which points to the limited evidence around interventions delivered in primary care comes from the US. Tsai and colleagues examined randomised control trails of weight loss interventions in adults where counselling was provided by a physician in primary care. Ten trials met the inclusion criteria in total and the authors concluded the review that low- and moderate-intensity behavioural counselling alone (counselling occurring on a monthly basis or less) did not result in clinically significant weight loss (Tsai et al, 2009). Such

findings confirm a more recent systematic review reporting that although behavioural counselling can induce clinically significant weight loss, there remains few studies including primary care professionals providing intensive behavioural counselling (which the authors define as 14 in-person sessions delivered over 6 months) and as such limited evidence that health professional intervention is effective (Wadden et al, 2014).

Whilst such findings paint a bleak picture, it is important to consider research findings which suggest that behavioural interventions delivered in primary care can result in effective weight loss (Le Blanc et al, 2011). In their review of 58 trials, Le Blanc and colleagues reported that behavioural interventions resulted in 3kg greater weight loss in intervention than control participants after 12 -18 months (Le Blanc et al, 2011). However, as Booth and colleagues argue, the review included trails carried out in settings such as academic institutions and specialist hospitals which differ in important ways from those conducted in primary care in the UK (for example, interventions in these settings are more intensive and the study population is unlikely to be representative of the general population). Never the less, the finding that behavioural interventions can be effective are in line with the findings from interventions delivered in primary care such as the Counterweight programme (Counterweight Project Team, 2008b). Counterweight was launched in 2000 and was the most widely adopted primary care led weight management programme in the UK with 58 practices in the UK being randomised to implement the programme. Primary care practitioners delivering weight loss treatment were provided with intensive training and support and it was recommended that clinicians have at least six appointments or group sessions with patients in the first 3 months and follow-up every 3 months. The final five-year evaluation of the programme reported that of those participants attending a minimum of 24 months, 31.9% of the sample achieved ≥ 5% weight loss (Counterweight Project Team, 2008b). Whilst these findings are promising, the programme was an uncontrolled trial thus limiting the conclusions that can be drawn and it should be noted that the reported outcomes were achieved through a variety of treatments including lifestyle interventions during individual consultations, group interventions and prescribed medication. Analyses were not conducted to determine which components of the programme contributed to weight loss limiting the conclusions that can be drawn.

There is also growing evidence that referral to commercial providers such as Weight watchers and Slimming World, programmes which draw on behavioural interventions for weight management, can result in significant weight loss (Jolly et al, 2011; Jebb et al, 2011; Dixon et al, 2012). For example, in the randomised control trail carried out by Jolly and colleagues in which participants were allocated to one of five groups including two commercial programmes as well as one programme delivered by primary care practitioners in primary care settings, almost one third of the people allocated to the commercial groups achieved a 5% reduction of body weight at one year follow-up. Interestingly, there were no clinically significant benefits from the primary care programme despite the primary care practitioners delivering the programme being trained in weight management counselling. As the authors note, this could suggest that there is a problem with supporting behaviour change in primary care and is an area of research warranting further investigation (Jolly et al, 2011). This is in line with the urgent calls for research to develop new and more effective approaches to managing obesity in primary care and the questions raised about whether primary care is the most effective place to prevent obesity at the population level (Fildes et al, 2015).

To summarise then, it seems that there is insufficient evidence regarding the effectiveness of weight loss interventions delivered in primary care although there is evidence that behavioural interventions can lead to clinically significant weight loss (Avenell et al, 2004; Dombrowski, Avenell & Sniehotta, 2010). There is also limited evidence that behavioural interventions can promote weight loss maintenance (Dombrowski et al, 2014) and this is an acknowledged gap in the research field (Sniehotta et al, 2014). As has been argued, the majority of interventions have lacked psychological or behavioural theory which researchers suggest impede our understanding of the 'active ingredients' in interventions and may account for the current lack of evidence base for interventions (Michie & Johnston, 2012). Whilst advances in behavioural science may improve the effectiveness of future interventions delivered in primary care, behavioural interventions predominantly target determinants of behaviour at the individual level. Many researchers argue this approach does not tackle the multi-factorial and multi-level drivers of obesity, particularly the social and environmental determinants (Chan, Deave & Greenhalgh, 2010; Kleinert & Horton, 2015) or the complexity of a condition such as obesity (Cohn, Clinch, Bunn & Stronge, 2013; Hafekost et al,

2013). This tension between individual and societal interventions for weight loss is a theme that will be explored further throughout the thesis.

1.2.7 Obesity continues to be under-addressed in primary care

Multiple studies have provided evidence that obesity is not raised with a substantial proportion of patients in primary care. Evidence, typically from patient surveys, suggest that less than half of obese patients are advised by their physicians to lose weight (Abid et al, 2005; Jackson et al, 2013; Kirk et al, 2012). Recently in Great Britain, a cross-sectional survey of 810 overweight or obese adults found that only 17% of overweight and 42% of obese respondents recalled ever receiving health professional advice to lose weight (Jackson et al, 2013). In the US, cross-sectional surveys have suggested that despite the increase in obesity, the proportion of obese people who reported being counselled by a healthcare professional has declined (Abid et al, 2005). Galuska and colleagues analysed telephone survey data in the US and found that less than half of obese adults were advised by physicians to lose weight. Women, the middle aged, individuals with higher BMIs, and those with diabetes were more likely to receive advice (Galuska et al, 1999). Research from Canada also suggests that physician advice is low. Using data from a survey on weight management which included 2004 respondents, only 30% of overweight and obese respondents reported that their physician advised them to lose weight without them specifically asking (Kirk, 2012).

Numerous sources, including patient surveys and observational studies and survey research with health professionals suggest that obesity and overweight are infrequently addressed in primary care. An observational study investigating doctor patient communication through video-recording consultations, reported that weight was rarely mentioned (Laidlaw et al, 2015). Another observational study looking at doctor-patient communication around weight control found that excess weight was only mentioned in 17% of encounters with obese and overweight patients and provision of weight loss counselling was even lower (Scott et al, 2004). Several survey studies undertaken with health professionals also suggest lower than optimal levels of weight loss discussion or advice in general practice, suggesting missed opportunities to address weight with patients (Bramlage et al, 2004; Michie, 2007).

Although comparable research has not been conducted in the UK, studies looking at the epidemiology of weight counselling in the US have demonstrated that the majority of weight loss counselling is provided by a minority of clinicians (Kraschnewski et al, 2013) and that diagnosis occurs with only a third of obese patients and weight loss counselling occurs with only a fifth of patients (Bleich, Pickett-Blakely & Cooper, 2011). In the UK, a recent study analysed primary care electronic health records and found that between 2005 and 2012, the use of weight management interventions for the treatment of overweight and obesity were infrequent, for example 60% of men and 58% of women with morbid obesity (a BMI of 40, or 35 to 40 with significant medical problems caused by or made worse by weight) did not have any record of receiving weight management in primary care (Booth, Prevost, & Gulliford, 2015). Although this does not tell us whether the issue of weight was raised or not (i.e. it may have been acknowledged in the consultation but not documented), it does highlight that there is low implementation of weight management guidelines and warrants further investigation.

As well as evidence suggesting that the treatment of obesity is limited, there is also indication that the prevention of obesity is problematic. Although there is general consensus that general practice is a suitable location to treat obesity and associated problems, there is less agreement regarding the preventative role that health professionals should take. Whilst it is argued that preventative medicine is a key part of a primary care practitioner's role (Aveyard & Raw, 2012), in practice it seems that overweight and obese patients who have not developed a disease or complication related to obesity, are less likely to receive health professional intervention than those who have (Michie, 2007; Rodondi et al, 2006; Sciammana et al, 2000). In light of the increasing prevalence of obesity, the reluctance to talk to patients about weight in a preventative manner in general practice warrants further research.

1.2.8 Current knowledge about barriers to clinician engagement

The majority of research investigating health professional weight management practice can be divided into four broad areas. First, research has investigated health professional beliefs about the causes and/or solutions of obesity, factors which are themselves subject to ongoing debate (Kirk et al, 2014). Whilst the majority of this research has used quantitative methods such as cross-sectional surveys, more recent research has included the views of health

professionals with other stake holders such as the general public and policy makers (Greener et al, 2010; Kirk et al, 2014). Researchers have emphasised the importance of looking at health professional beliefs about the causes and solutions of obesity because of the effects these beliefs can have on opinions about individual responsibility which may translate into negative attitudes towards patients with obesity (Brown & Flint, 2013; Puhl & Brownell, 2003). In addition, if health professionals do not believe obesity to be a 'medical problem' but instead see it as a 'social problem', there may be less acceptance that obesity falls within their professional domain (Henderson, 2015). Studies have reported that health professionals are ambivalent and conflicted about obesity and attribute the causes and solutions to patients, viewing obesity as a matter of individual responsibility (Ogden et al, 2001; Ogden & Flannagan, 2008). Of the qualitative research that has been conducted, findings suggest that although health professionals recognise the societal drivers of obesity (e.g. Greener et al, 2010; Kirk et al, 2014), they continue to attribute solutions to patients and look to individual behaviour change rather than medical intervention or structural change.

Second, research has focused on health professional views about treating patients with obesity and views about obesity more generally. Surveys and interview studies have highlighted that clinicians feel ineffective at delivering obesity care to patients (Brown, Stride, Psarou, Brewins, & Thompson, 2007; Epstein & Ogden, 2005; Nolan, Deehan, Wylie, & Jones, 2012); are concerned about damaging rapport with patients (Epstein & Ogden, 2005; Keyworth et al, 2012; Nolan et al, 2012); and lack the knowledge, expertise and resources to treat obesity (Epling, Morley, & Ploutz-Snyder, 2011; Brown et al, 2007). The majority of this research was conducted before the recent service provision of weight management interventions in general practice and it is important to note that health professionals are now able to refer patients to commercial weight loss providers, schemes in the community such as exercise on referral and there is increasing provision for bariatric care (NICE, 2014, ph 53).

Third, research has looked at communication between health professionals and patients. A variety of methods have been used including surveys, interviews and observation. Studies looking at communication about public health topics (including obesity) have been particularly insightful. These studies have demonstrated a lack of shared understanding about obesity and highlighted that

shame and power are barriers to effective communication (Abildsnes, Walseth, Flottorp & Stensland, 2012; Guassora, Reventlow & Malterud, 2014; Throsby, 2007; Webb, 2009). However the majority of these studies were conducted in secondary care and are not specific to weight.

The fourth area of research includes those studies looking at stigma and prejudice. This research has tended to take a psychological or sociological approach, the former mainly using quantitative and experimental studies to identify attitudes and behaviours of health professionals (Teachman & Brownell, 2001; Sabin, Marini & Nosek, 2012; Schwartz et al, 2003) and the latter including interviews with health professionals and patients, and ethnographic methods in medical settings (Grønning et al, 2012; Throsby, 2007). Although taking different perspectives around what stigma actually is, these studies have clearly identified that stigma exists within health care settings either as stigmatising beliefs or as a process. Other than a literature review on nurses' attitudes towards patients with obesity, which reported that attitudes were complex and warranted further investigation (Brown, 2006), there remains a lack of qualitative insight into the views and attitudes of general practice clinicians towards the role they play in obesity prevention and management. Given that relationships are so important in general practice, understanding whether and how stigma affects health professional engagement in the topic seems worthy.

1.2.9 Divergent views around obesity as a medical problem

There are a number of tensions in the research literature including whether or not obesity is a medical issue which relate to debates about the causes and consequences of obesity.

Whilst there are numerous ways to frame obesity, in the research field it is possible to identify that researchers often use a biomedical or a socio-ecological framework. Drawing on the work of Goffman, a frame came be defined as "a cultural set of meanings which give a cause, effect and response to a recognised problem" (Greener et al, 2010, p. 1043) thus recognising the importance of social and cultural meanings which come to be ascribed to problems. The way a problem is framed shapes how it is understood and how people believe it should be responded to. Framing obesity using a biomedical frame of reference means it is understood and treated as a behavioural or biological problem with interventions focused on the individual and the collective task being to motivate people to make

better and healthier choices (Kwan, 2009). If obesity is framed within a socio-ecological or systemic framework there is a greater focus on the environment and how the conditions of modern life shape behaviour and reinforce ways of living that lead to weight gain (Egger & Swinburn, 1997; Lang & Raynor, 2007).

Although views on interventions and policies seem to be in flux, perhaps due to the high profile that obesity has gained in recent times, researchers criticise public health and medical bodies for their tendency to promote a biomedical and individual level view of obesity (Greener et al, 2010). Whilst in recent years there has been greater acknowledgement that obesity is a complex health issue (Butland et al, 2007), engrained beliefs that obesity is under the personal control of the individual endure (Kirk & Penney, 2010). It is argued that this focus on individual responsibility leads to victim-blaming and stigma (Adler & Stewart, 2009). Research has identified that the emphasis on personal responsibility for obesity is evident (and problematic) in society and within healthcare systems (Puhl & Heuer, 2009).

A more extreme position has been taken up by critical researchers. These researchers object to obesity being defined as a medical condition in need of treatment pointing to 'fabricated' knowledge in the field (Campos, 2004; Gard & Wright, 2005; Monaghan, 2005), the harmful consequences of the current technocratic/biomedical approach to weight management (Rich & Evans, 2005; Evans & Coll, 2009; Rothblum, Solovay & Wann, 2009) and the lack of recognition biomedical researchers give to the stigmatising nature of framing obesity in a medicalised way (Aphramor, 2005; Saguy & Gruys, 2010). Rather than viewing obesity as a medical problem, these researchers fight for 'size acceptance' arguing that 'obesity' is a medicalised and pejorative term for fatness, affirming that fatness is a part of identity (Saguy & Riley, 2005).

Researchers have emphasised that health professionals and lay people hold different views about the causes and solutions of obesity. Studies, mainly using survey methods, report that obesity continues to be attributed to individual level factors such as overconsumption of food (Bleich et al, 2012; Foster et al, 2003; Ogden and Flanagan, 2008). Several qualitative studies have reported that health professionals acknowledge the social and environmental causes of obesity yet tend to support individually-oriented weight management interventions as solutions to obesity (Greener et al, 2010; Kirk et al, 2014). A recent qualitative study reported

that health professionals used conflicting discourses of individual, environmental and social causes and solutions of obesity (Kirk et al, 2014) suggesting multiple rather than one single narrative around obesity. However, the authors point out that blame, frustration and disappointment permeate discourse used by health professionals, suggesting that obesity is predominantly viewed as an individual problem (Kirk et al, 2014).

To conclude this section, the importance of considering the framing of obesity concerns the impact it has for those involved. In the context of health care it may determine whether and how health professionals intervene and may result in blame being attributed to individuals. Health professionals may be placed in a difficult position in this respect; there is clearly a balance to strike between empowering patients to take individual responsibility yet there is a need to consider the influence of the social structures and entrenched routines driving behaviour. Rather than thinking in a dichotomous way, researchers suggest we need to recognise that both individuals and environmental factors play a role in the causes and treatment of obesity (Moffat, 2010; Roberto et al, 2015). Whilst a discussion of the causes and solutions of obesity is beyond the scope of this thesis, it is important to note that to attribute weight gain and failure to lose weight to individual preference or choice is too simplistic and fails to account for the reciprocal relationship between the individual and their environment (Roberto et al, 2015).

1.3 The gap in the knowledge

Given the low proportions of patients who receive weight loss advice or intervention from their health care provider in general practice (Booth et al, 2015; Laidlaw, 2015), it is vital to understand more about why health professionals do not talk to patients about weight. By providing an overview of the research problem and literature conducted to date, I have highlighted that there remains limited understanding about health professional engagement in obesity prevention and management practices. There has been little theoretically informed or in-depth qualitative research seeking to understand why health professionals are reluctant to discuss excess weight and to my knowledge, there is a lack of research focused specifically on views around starting conversations with patients about weight. Interestingly, in the area of smoking and alcohol there has been focused research exploring why health professionals do not initiate discussions about these health problems (Coleman, Murphy, Cheater, 2000; Pilnick & Coleman, 2003; Beich,

Gannik, & Malterud, 2002; Rapley et al, 2006). Given the lack of research specifically focusing on views towards excess weight, to date it is still not clear whether there is anything unique to obesity or weight that contributes to it remaining unacknowledged in general practice. Given the changing landscape in health care, with health professionals increasingly being able to refer patients to other providers and the increased emphasis on the provision of brief advice, it seems timely to explore the barriers to the initiation of weight loss discussions in general practice.

A further need for this research relates to the framing of obesity. Despite the growing recognition of the complexity of causes and solutions to obesity and the subsequent need for multidisciplinary teams and collaborative weight management (Butland et al, 2007; RCP, 2013, AoMRC, 2013) there has been a dearth of studies investigating whether this insight is reflected in health professional education or understanding. In addition, in the UK there has been little in-depth research with GPs or nurses to look at how obesity is constructed and framed and why it is or is not framed as a medical problem. There has also been little qualitative research looking at obesity stigma and whether this is a barrier to discussions about weight in general practice. This is an important gap given the potential for patients to feel blamed for their obesity. In addition, it seems plausible that stigma may explain health professional disengagement and the lack of shared understanding about obesity consistently reported in previous literature.

As the summary of the research area demonstrates, the majority of researchers have approached the problem from a psychological orientation (i.e. looking at psychological constructs of individual health professionals to explain the research problem). The few studies that report that broaching the issue is a problem have been survey methods excluding exploration into why such findings exists (Michie, 2007). This precludes an understanding of how obesity is constructed by health professionals as well as how theoretical concepts such as stigma and power impact on this area of care. Research has increasingly documented that the social and medical elements of obesity are intertwined (Spence-Jones, 2003; Townend, 2009) and thus qualitative methods that facilitate the opening up of an in-depth problem by capturing a broad range of subjective perceptions, would undoubtedly make great contribution to this area of research.

To summarise, it is essential to understand more about why health professionals working in general practice fail to talk routinely to patients about weight loss given

the rising prevalence of obesity in society which has consequences for quality of life and is costly to the health service and wider society. There is evidence to suggest that patients are reluctant to approach their health professional about weight concerns (Tham & Young, 2008; Ahern, Boyland, Jebb, & Cohn, 2013) and given the chronic and relapsing nature of obesity, there is a need for individuals to receive comprehensive and ongoing support (Dietz et al, 2015). Researchers also point out that if obesity is ignored, both health professionals and patients will experience frustration and it is possible that patients will suffer from increasing comorbidities (Kirk & Penney, 2010; Sainsbury et al, 2014). Furthermore, there is research to suggest that people with obesity may delay treatment for other health conditions due to embarrassment and experiences of disrespectful treatment (Mitchell, Padwall, Chuck, Klarenbach, 2008; Wee, McCarthy, Davis, & Phillips, 2000) aligning with health professional concerns. If we are to improve the care available for patients in this area, it is clearly vital to explore why health professionals are reluctant to talk about weight.

1.4 Research problem and approach

In this thesis, I present a qualitative study of barriers to raising the topic of weight in general practice by exploring the views of General Practitioners (GP) and primary care nurses. As the chapter has demonstrated, this is a relatively unexplored area of research despite the rapid increase in obesity and associated costs evident across society. Although research has identified that broaching the topic of obesity, along with other public health problems viewed as requiring lifestyle change, is often problematic (Chisholm, Hart, Lam, & Peters, 2012), there remains a lack of understanding into why this is or how this area of practice can be improved. Research to date has mainly looked at views about the causes and solutions of obesity, or barriers to providing advice or counselling for obesity. Whilst these studies have generated important findings, with the provision of weight management services and bariatric surgery as well as the recent emphasis on the need for collaborative weight management and multidisciplinary team work, it is important to understand more about the barriers to raising the topic of weight in general practice.

The overall aim of the thesis is therefore to use qualitative research methods to understand more about GP and nurse barriers to initiating discussion about weight with overweight and obese patients in general practice. More specifically, I aim to

identify GP and nurse barriers, and then critically analyse GP barriers, by drawing on psychological and sociological theory.

The objectives of the research are as follows:

1. To identify and describe GPs' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice
2. To identify and describe primary care nurses' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice
3. To explore the discursive power relations that shape how GPs talk about obesity with patients by:
   > 3.1 identifying the micro-political processes at play when GPs talk about the challenges of raising the topic of weight in general practice
   > 3.2 relating the micro-political discourses inherent in doctor-patient encounters about weight with macro-discourses surrounding obesity and general practice

In order to achieve the objectives outlined above, in this thesis I seek to answer the following research questions:

1. What are GPs' views and attitudes about raising the topic of weight with overweight and obese patients in general practice?
2. What are primary care nurses' views and attitudes about raising the topic of weight with overweight and obese patients in general practice?
3. How do GPs discursively construct the challenges of raising the topic of weight whilst reflecting on trigger films of doctor-patient encounters?
4. What discourses shape GPs accounts of raising the topic of weight in general practice using trigger films to spark reflections?

To answer the research questions, two different study designs and methods will be used. The first two empirical studies will be conducted within a realist epistemological framework, drawing on a validated framework, the Theoretical Domains Framework (TDF) (Michie et al, 2005), to understand why practice diverges from evidence-based guidelines. The TDF originates from health psychology and sits within a growing field of implementation research. The final

empirical study (study 3) is located within a social constructionist epistemological framework. The study uses findings from study 1 and 2 to produce trigger films which are used to stimulate dialogue and debate in study 3. The resulting data were analysed using a discourse analytic approach, drawing on the theoretical contribution of Michel Foucault.

1.5 Roadmap: the structure of the thesis

The thesis consists of six more chapters, beginning with a literature review. This chapter starts by describing the multiple knowledge frameworks that researchers have identified as shaping general practice medicine. The literature review then describes the ways in which obesity has been conceptualised and studied by researchers and explores the multitude of ways obesity has been framed and understood depending on the stance of the researcher. This section of the chapter demonstrates that obesity cannot be assumed to be a value-free or objective medical problem but also a social construction which has moral, political and ethical dimensions. By looking at how obesity is framed by researchers and paying attention to those studies emphasising the socially constructed nature of obesity, as well as those studies which are situated within a biomedical framework and fail to question the power dimensions underlying the research problem, I aim to demonstrate the dichotomy which characterises the research field and illuminate the multidisciplinary nature of the research. Toward the end of the chapter, in reviewing the empirical research, I illustrate that the majority of research has looked to individual and typically psychological constructs to explain why health professionals are disengaged with obesity. In doing so, I demonstrate the need for research which goes beyond individual beliefs and looks at the socio-political and cultural context. In addition, the review of empirical studies demonstrates that whilst it is clearly established that health professionals fail to broach the issue of obesity, there has been little focused research, particularly of a qualitative nature to explore this finding. I end the literature review chapter with a clear research gap which the thesis goes on to address.

Following the literature review chapter, I describe the two methodological frameworks which underpin the three empirical studies making up the thesis. The chapter starts with an outline of the theoretical framework, developed within the field of health psychology, informing study 1 and 2. The chapter then goes on to describe how these findings informed and enabled the construction of an innovative

research tool- a collection of trigger films, which were used in the design of study 3. Finally, the chapter describes the discourse analytic approach underpinning study 3 and justifies the move to a method informed by a social constructionist epistemology.

The following three chapters report the methods and findings of each of the three empirical studies. Chapter 4 identifies the barriers to raising the topic of weight for GPs and chapter 5, identifies equivalent barriers for primary care nurses. Both studies are strongly informed and guided by the TDF (Michie et al, 2005) and thus the findings are situated and reported within this framework. Whilst these studies were useful in identifying a broad and specific range of barriers, including those at the contextual level, findings are limited given the prescriptive nature of the psychological framework and the underlying assumptions which correspond to an epistemology rooted in positivism. Findings from using the TDF then do not go 'beyond the knowing subject' to account for power relations. To counter such limitations, the following chapter takes a discourse analytic approach, incorporating Foucauldian theory to illuminate the contradictions and tensions in GP accounts. These accounts were generated from interviews using trigger films of doctor-patient consultations. The chapter takes a critical focus by describing how the construction of obesity is contributing to barriers to talking about weight and brings to light the moral and ethical dimensions of obesity, problematizing the idea that obesity is ever just a medical issue.

Finally, the thesis brings the two competing methodological approaches together by summarising the findings of each and describing how they both point to the uncertainty and ambiguity of the medicalised nature of obesity and demonstrate that only once the social dimension of obesity is appreciated, can progress be made in this area. Implications for practice, education and future research are summarised before the chapter, and the thesis, concludes.

Chapter 2: Literature review

2.1 Introduction to the chapter

In this chapter, I begin by outlining the competing knowledge frameworks in general practice. The purpose of this is to demonstrate that what counts as medical knowledge and subsequently a medical problem is contested. This is important because knowledge frameworks shape how obesity is approached and determine when, whether and how it is seen as a medical problem. Next, I will describe the different positions that can be taken in regards to researching obesity, demonstrating that the social scientific literature surrounding obesity is characterised by debate, tensions and controversy. One of the main problems appears to be that there is no agreed upon way to define or research obesity. Such divergent opinions and criticisms are revealing since they provide insight into the limitations characteristic of a large proportion of the research findings reported in this area. I initially draw on a social constructionist approach to demonstrate the ways in which obesity can be ontologically and epistemologically defined and how such framing shapes the way obesity is both researched and negotiated in practice. I then go on to report the empirical literature which has mainly been carried out from a biomedical perspective and highlight how these empirical findings reflect tensions which the social constructionist stance illuminates. I end the review by specifying the research questions the thesis will go on to address.

2.2 Competing knowledges in general practice

Just as there is not any one way to view medical problems, there is also not a singular 'medical model' of obesity. Although biomedical knowledge has dominated medical understanding and practice since the middle of the 20th Century, general practice has fought to demonstrate itself as distinct to secondary care medicine and thus researchers have developed epistemological frameworks which better suit the complexity of its needs (Armstrong, 1979; Checkland, Harrison, McDonald et al, 2008). The chapter will now go on to describe the competing knowledges within general practice and how they oscillate between biomedical, technocratic styles of medicine as well as more person-centred, holistic styles of medicine.

Although biomedical knowledge dominated and was readily accepted into hospital medicine, it has been a problematic concept to apply within general

practice. Within the biomedical model there is an assumed causal relationship between disease and illness and along with other assumptions including mind-body dualism and a focus on pathology, it has been criticised as a reductionist way to categorise illness (Cantor, 2000; Jewson, 2009). The idea of 'patient-centred care' emerged during the 1960s and 70s with its application in general practice being promoted by researchers such as Michael Balint and more recently advocated within the patient-centred care movement (May & Mead, 1999; Stewart et al, 2001). Balint proposed that the medical gaze should be directed at the patient's biography and environment, rather than at the 'silent interior of the body' (Armstrong, 1979, p. 5) and attention should be given to the patient's underlying social and personal problems. During the late 1950s, whilst hospital and biomedical medicine took the view of symptoms as indicators of pathology, general practice shifted the ontological status of symptoms to being part of the pathology itself, indicating that subjective patient experiences were central rather than organic pathology (Armstrong, 1979). Patient-centred care places an emphasis on caring for the patient rather than the practice of 'a science' (Stewart et al, 2001). As opposed to hospital medicine, which prioritises a view of medicine as a science and the patient as a subject, patient-centred care aspires to understand patients as unique human beings (Balint, 1957).

Patient-centred care draws on a 'biopsychosocial' model of medicine, theorised by the psychiatrist George Engel to resolve the differences between hospital medicine and its application to general practice (Engel, 1977, 1981). Engel was critical of the narrow focus that biomedical research and practice favoured which he asserted led clinicians to view patients as objects and as such was dehumanising and disempowering of patients. Engel was also critical of the way biomedical knowledge viewed the subjective experience of the patient as unamenable to scientific study.   Rather than focusing on just the biological factors of disease, Engel proposed that doctors should incorporate a wider view of cultural, social and psychological factors shaping patients health and illness experience, whilst continuing to value biological factors. Engel asserted that by attending simultaneously to the biological, psychological, and social dimensions of illness, patients would be more likely to feel understood and it would allow doctors to understand and respond adequately to patients' suffering (Engel, 1977). Engel developed 'the biopsychosocial model' as a philosophy of care and a practical clinical guide (Borrell-Carrió, Suchman, & Epstein 2004), which offered a holistic,

as well as more empathetic and compassionate alterative, to the biomedical knowledge dominating industrialised societies since the mid-20th Century. Although some researchers have questioned whether the biopsychosocial model is more rhetoric than reality given the pragmatic barriers of general practice such as time constraints (Dowrick, May, Richardson, & Bundred, 1996), it has gained considerable support as a model of medical practice.

A shift in how knowledge was used in practice came with the introduction of evidence-based medicine (EBM) (Sackett et al, 1996). Attempting to improve diagnosis and clinical decision making, EBM acknowledges the value and need for external research evidence to be integrated with clinical expertise in clinical decision making (Sackett et al, 1996). In recognising that the scientific knowledge base of health and illness was constantly expanding, it was asserted that health professionals needed support in keeping up to date with the latest scientific knowledge. EBM is defined as the "conscientious, explicit, judicious use of current best evidence in making clinical decisions about the care of individual patients" (Sackett et al, 1996, p. 71). Best evidence is that which is 'clinically relevant', with emphasis placed on the approaches of clinical epidemiology and randomised controlled trials (Reeve, 2010; Sackett et al 1996).

This emphasis on methods of Western science means that EBM is grounded in the philosophy of positivist science (Marks, 2002). It draws on knowledge developed within the disease-oriented setting of specialist secondary care (Reeve, 2010). EBM uses the approach of 'hierarchies' of evidence, a model which has been contested and criticised for privileging knowledge from a narrow perspective (Marks, 2002). Harrison and colleagues describes the EBM movement as "scientific bureaucratic medicine" (Harrison, Moran, & Wood, 2002, p. 1). Evidence based medical knowledge led to the creation of guidelines for clinical decision making which continue to be experienced as constraining and promoting protocol-driven care (Mant, 2008). Although EBM is recognised as the ideal of practice and evidence-informed decision making is supported by researchers and clinicians, problems have arisen in the implementation of EBM guidelines (Reeve, 2010). Researchers and clinicians working within general practice have been critical of the implementation of EBM, recognising that it is developed within the setting of secondary care and asserting that generalist practice is "more than disease-focused care delivered in a community setting" (Reeve, 2010, p. 1). It is argued

that the current model of EBM is contributing to the shift away from generalist principles to a more disease focused model of care (Reeve, 2010; Stange, 2009; Checkland et al, 2008).

Recently, interpretive and narrative approaches to general practice medicine have been proposed by researchers who assert that the interpretation of illness rather than the identification of disease should be the focus of general practice consultations (Reeve, 2009). Interpretive medicine can be defined as "the critical, thoughtful, professional use of an appropriate range of knowledges in the dynamic, shared exploration and interpretation of individual illness experience, in order to support the creative capacity of individuals in maintaining their daily lives" (Reeve, 2010, p. 88). This shifts the focus from a 'true' diagnosis to a co-constructed diagnosis and the construction of knowledge or a narrative which supports rather than undermines a patient's agency (Reeve, 2010). Importantly, the patient's own explanatory account is central to the consultation. Taking a perspective rooted in postmodernism, interpretive medicine exhibits distrust in any single theoretical view of the world as 'truth'. According to authors supporting this model, biomedicine is just one (of many) accounts of illness and not always suited to general practice which is characterised by complexity and uncertainty (Mathers & Rowland, 1997).

This summary of competing knowledge frameworks in general practice demonstrates that there has been a shift in the medical gaze over time from prioritising symptoms as indicators of underlying pathology to prioritising the patient and patient-defined problems. It also points to a discourse about the ways of understanding and approaching medical problems in general practice which are multiple and in flux.

2.3 Obesity as a social construction

Researchers who take a social constructionist perspective toward the study of obesity assert that the ways obesity is talked about, understood and acted on is the result of the specific space and time we live in, and they tend to take a critical stance towards obesity as a medical problem (Lupton, 2013). Whilst some social constructionist researchers doubt the existence of obesity as a biological condition, others reserve judgment about the existence of the condition and the health effects but focus on the way claim-makers construct obesity as a problem (Moffat, 2010; Patterson & Johnston, 2012; Warin, 2014). Their concern is with the consequences of these constructions for obesity treatment and how constructions impact on how

obesity is 'enacted in practice' between health professionals and patients or talked about in wider society.

Sociologists have long been interested in how the medical profession have the power and authority to define (and create) medical problems (Brown,1995; Friedson, 1970). Researchers assert that the use of measurement and quantification plays a key role in the medicalization of obesity (Sobal, 1995). For example, the BMI, a calculation of an individual's weight in kilograms divided by height in metres squared (kg/m), is currently seen as the 'gold standard' of defining obesity. Labelling a patient 'obese' transforms excess body weight from a visual category into an 'objective' and 'medical' fact (Jutel, 2006). However, as medical sociologists assert, the BMI is a measure which originated as a product of the situational and historical context, in this case from epidemiology in the 1960s (Hacking, 2007), and continues to be used despite growing criticism about its validity as an indicator of health (Bacon & Aphramor, 2011). Thus the measurement tool that has the power to transform excess weight to 'obesity', exists due to ease of use and cheapness, rather than always existing as a neutral and objective instrument (Lupton, 2013).

As well as pointing out that obesity has been constructed and thus continues to be discussed as a medical problem, sociologists, along with critical researchers, have emphasised the way obesity is a moral construction. Researchers discuss the existence of a 'moral model' of obesity (Webb, 2009) in which individuals are held responsible for their body weight and related behaviour. In this moral model, obesity is primarily caused by overconsumption or greed and obese individuals are viewed as a drain on society. Obesity is thus treated as 'badness' compared to 'sickness' (Grønning, Scambler & Tjora, 2012). As researchers taking a social constructionist position point out, the medical and moral model of obesity tend to overlap and obesity may also be treated as deviance (Grønning et al, 2012; Webb, 2010). A key study that has looked at how the construction of obesity has changed as a medical category, and thus is a moral as well as a medical issue, is that by Chang and Christakis (2002). These researchers conducted a content analysis on the framing of obesity in a core US medical text book from 1927 until 2000. The researchers focused on two things: the proposed explanation of obesity and the framing of social accountability for obesity. They highlight the discursive work that underlies the representation of obesity by tracing the transformation of its

(biomedical) representation. By looking at the changes in the definition of obesity over seven decades, the researchers suggest that over time, less personal responsibility has been assigned to individuals. The study concluded with the suggestion that obesity has shifted from being something that individuals do to something they experience (Chang & Christakis, 2002).This is an interesting finding in light of other research which suggests responsibility and thus stigma around obesity may be increasing (Tomiyama et al, 2015; Trainer, Brewis, Hruschka & Williams, 2015), however it aligns with the ways in which the understanding of obesity is constantly changing and how the complexity of obesity is increasingly being recognised in government documents such as the Foresight report.

One of the major contributions made to the study of obesity by social constructionists is the work on stigma. Ervine Goffman, Bruce Link and Jo Phelan, and Graham Scambler have made many important contributions to the theory of stigma and many social constructionists have used their ideas in studies of obesity. This work differs to that of researchers who approach obesity from an uncritical and biomedical stance, since rather than trying to detect stigmatising beliefs and cognitions from health professionals, stigma is theorised as a qualitative phenomenon, a "relationship between attribute and stereotype" (Goffman, 1963, p. 4), and a social process embedded within wider social and cultural systems (Parker & Aggleton, 2003).   Studies of stigma relate to an important topic of debate in the research literature: whether obesity is a disease or a social identity. The answer to this question has implications for the construction of obesity as a medical problem or not, and thus has implications for how obesity is treated in policy and practice.

Two empirical studies which have approached their research concerning the medical management of obesity from a sociological perspective, and relate closely to the thesis, will now be summarised to provide an example of the sociological contribution to the field. Most recently Karen Throsby carried out ethnographic work in an obesity surgery, observing 153 consultations between surgeons and patients. The work highlighted the moral dimension of interactions. Patients felt a moral responsibility for their weight, making confessional statements and worrying about the legitimacy of claims to resources (Throsby, 2012). As Throsby concluded, when obesity is enacted in the clinic, there is more than health at stake. Interactions are imbued with morality- morality that even medicine cannot deny (Throsby, 2012). Throsby summarises the 'inextricable' relationship between the medical and moral

aspects of obesity by asserting that "the lived, complex realities of obesity mean that it is impossible to insulate the rationalised and purposefully non-judgmental obesity that is enacted in the clinic from the profoundly moralised and shameful obesity that is constantly reiterated and reproduced in the wider social context" (Throsby, 2012, p 9 -10). Such findings emphasise that general practice consultations about weight are also embedded in a wider social and cultural context in which there issignificant vigilance about the increasing number of people with obesity and the related costs- what some describe as a 'war on obesity' (Evans, 2010).

The second study that is useful to consider concerns video recorded observations of a secondary care National Health Service weight management clinic, which used conversation analysis to capture how clinicians and patients 'do' obesity talk (Webb, 2009). The study found that through references to agency i.e. claiming efforts to lose weight, patients perform moral work and construct failure of weight loss as blameworthy. Thus it is not just clinicians who attribute labels to patients as normatively good or bad, patients have a role to play. Drawing on Parson's classic typology of the sick role (Parsons, 1951), Webb demonstrates how patients attend to the sick role requirements by attempting to lose weight. However, since obesity is viewed as a 'lifestyle' condition in which individuals have caused their own ill health, patients do not have the privilege of escaping responsibility and thus lack of medical progress is seen as further evidence of deviant behaviour. This study exemplifies that moral work is jointly accomplished by clinician and patient through a process of collaboration and negotiation and that issues of responsibility are central to this moral work (Webb, 2009).

As these two studies demonstrate, a sociological understanding of obesity adds to an understanding of how wider societal views contribute towards obesity being enacted as a moral as well as medical condition in practice. These studies also demonstrate that stigma, which much of the medical and psychological literature has paid attention to, typically viewing it as an attitude (and thus a psychological construct), can be conceptualised in a different way and that patients, along with health professionals construct obesity as a moral phenomenon.

2.4 Obesity as a political and ethical issue

Researchers who emphasise the inequalities, power relations, corporate interests and adverse consequences of obesity research and practice tend to construct obesity as a political and ethical issue. Critical researchers, feminists and activists tend to present obesity in this way. These researchers aim to encourage health professionals and policy makers to question dominant understandings of obesity. Critical researchers have tended to study obesity as a constructed phenomenon, which sits at the opposite end of the pole to research which studies obesity as a biomedical fact and is situated in a realist framework. I will now summarise and review arguments which typically challenge the construction, seek social justice and challenge hegemonic understandings of obesity and its treatment.

First, researchers raise awareness of the dominant (negative) framings of obesity and ways to 'tackle' population levels of obesity, and to the potential negative consequences of these constructions for individuals. Critical researchers speak of an 'obesity discourse' that circulates in society, and in particular within media, medical and public health framings of the issue which present obesity as a biomedical 'health concern' and emphasise risk and morality (Rich & Evans, 2005). Used in this way, critical researchers speak of 'obesity discourse' to refer to public representations of obesity. This discourse is dominated by scientific issues, claiming certainty over what causes obesity and how best to address it; presents obesity as an epidemic; is dominated by a biomedical narrative which excludes or marginalises the influence of social structure on the causes and solutions of obesity; conceptualises weight loss as energy-in-energy-out and represents the body as a machine; stereotypes 'fatness'; promotes universal values about the desirable thin body which normalise and reinforce this body type; and emphasises personal responsibility and individualistic approaches to weight loss (Gard & Wright, 2005; Rich & Evans, 2005). According to critical researchers, these discourses reinforce a 'rational ascetic' (attitudes which subject the body to a systematic regime and expects bodies to behave in methodical and regular ways) rather than produce humanistic approaches to the body and health, produce feelings of guilt and shame, and demand that all individuals should participate in an endeavour to lose weight since it will improve health (Rich & Evans, 2005). The authors' note that there is a failure on the part of these governing bodies to recognise that their demands may have damaging implications for people's self-esteem and embodied identities (Evans, Rich, Davies & Alwood, 2008).

A prominent feature of the obesity discourse is the individualising frame it uses to represent the causes and solutions to obesity. The discourse promulgates the idea that the individual who is affected by obesity is responsible for causing and thus solving obesity (Lawrence, 2004). Researchers assert the importance of considering the culture of 'healthism' (Crawford, 1980) that characterises western society and in which a moral obligation is placed on an individual to achieve health. A moral responsibility is placed on individuals to make good lifestyle 'choices' around eating and physical activity with little regard for the structural and cultural constraints which make these choices problematic and even impossible for some. Critical researchers are also concerned that with its emphasis on risk and morality, obesity discourse creates a shame-based narrative and may impact on the social identities and lives of individuals (Rich & Evans, 2005; Evans & Coll, 2009). Others assert that constructing fat bodies as a medical problem is a source of stigma and contributes to the marginalisation of individuals (Braziel & LeBesco, 2001; Rothblum, Solovay & Wann, 2009).

Critical researchers acknowledge that they have a political aim to raise awareness of the moral dimension of obesity discourse. They are particularly critical of the discourses operationalised by those promoting weight-loss such as health professionals, educators and parents who they assert "may be ill-equipped to adopt a more cautious attitude towards the ways in which weight and health are represented" (Rich & Evans, 2005 p. 355). Researchers point out that the labelling of overweight/obesity may itself be a source of poor health, particularly for those experiencing inequalities and discrimination (Monoghan, 2005), yet this is an issue receiving little attention due to the panic to 'treat' and prevent what is typically labelled an 'epidemic'.

Critical researchers are particularly opposed to the idea that there is a correlation between being overweight and ill-health and that losing weight will 'cure' associated disease (Gard & Wright, 2005). Despite this, they assert that overweight and obesity are presented as a definite 'threat' to health which will be cured by weight loss. These researchers claim that there is now an excessive fear of body fat due to what they frame as questionable scientific research and public health/media reports of obesity as an epidemic (Gard & Wright, 2005). Whilst acknowledging that if weight is at the extreme there is a correlation with ill health (Campos, 2004) critical researchers assert that scientists are unclear as to the

precise point at which weight threatens health yet this uncertainty is rarely acknowledged (Brownell & Fairburn, 1995). They also assert that it is because researchers and practitioners have taken a simplistic and reductionist approach to health and weight, with a mechanistic view of the body and the universalising premise that the body will respond in the same way if less calories are consumed and more calories expended, that has led treatment programmes to be 95% unsuccessful (Aphramor, 2005). They claim that such simplicity ignores factors such as culture, class, lifestyles, economics and differences in metabolism and genetics.

Researchers are also critical about the exclusive focus on weight loss rather than health behaviours. They raise awareness of the universal promotion of weight loss despite the fact that individuals can derive benefits from physical activity and a nutritious diet independent of weight loss (Gaesser & Blair, 2011). Writing from America, Paul Campos and colleagues are particularly critical of the medical profession for its focus on body weight and framing of fatness as synonymous with ill-health (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). They claim that a shift is needed so that positive health behaviours are promoted rather than the reductionist focus on weight loss. Campos also criticises medical research for predominantly studying the ill-health effects of obesity which he claims justifies and reinforces pre-existing cultural notions that fatness is bad (Campos, 2004). Other researchers are critical of what they view as the emphasis on dieting which has resulted in a focus on weight loss, which they claim can lead to weight-cycling and harmful consequences (Aphramor, 2005; Ernsberger & Koletsky, 1999).

There has also been strong criticisms from researchers about the little focus given to wider socio-cultural or socio-economic factors. Health promotion strategies have been criticised for failing to consider factors, other than those at an individual level, that determine health inequalities. Despite evidence that mortality risk is primarily determined by social factors (e.g., Marmot, 2005), social inequalities, forms of discrimination and psychosocial stress are rarely considered in research or forms of health promotion (Monaghan, 2005).

It is also useful to consider feminist and activist contributions to obesity research. A brief summary of the research from a feminist and activist perspective will be presented since such authors are important contributors to the research debate about obesity and are central to modern day framings of obesity. The

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emergence of activists groups is useful to be aware of since they form part of the social and political context in which understandings about obesity and interactions between health professionals and patients take place.

Feminists and activists are particularly critical of the 'obesity epidemic' which they state has been constructed due to negative cultural values towards fatness rather than concerns about ill health. They are critical about how the 'obesity epidemic' is connected to powerful interests and cultural values about fatness that they claim are historically rooted and socially constructed (Campos, 2004; Orbach, 2006; Saguy & Almeling, 2008; Rothblum, Solovay & Wann, 2009). The media, the diet and weight loss industry, beauty companies, and public health agencies are claimed to be instrumental in shaping the way obesity is understood (Orbach, 2006; Saguy & Almeling, 2008; Kwan, 2009). As well as being viewed as a feminist issue (Bordo; 1993; Orbach, 1978), more widely, what has been termed 'the war on fat' (Campos et al, 2006) is viewed to be a deeply political issue.

There has also been a growth of fat acceptance groups including the health at every size paradigm in the UK. Activists typically view fatness as a natural and largely inevitable form of diversity, much like diversity based on race, ethnicity, or sexual preference. Fatness is seen as part of identity and activists are resistant towards medical intervention and the use of the word 'obesity' which they see as a medicalised and pejorative term for fatness. Much like political groups such as the civil rights and gay rights movements, fat acceptance/body diversity groups have built on anti-discrimination and rights claims and have for example, reclaimed the word 'fat' (Saguy & Riley, 2005). Many activists assert that weight is outside of personal control and draw on evidence which suggests that weight loss and particularly weight loss maintenance is unsuccessful for the majority of the population (Aphramor, 2005). Given the view that weight loss is outside personal control, they recommend 'size acceptance' and therefore criticise the public health and medical emphasis on health risks and economic costs, asserting that it promotes 'fat phobia' and stigmatisation.

To summarise this section there is much debate around obesity and how or if it should be 'treated' and a lack of common understanding about what obesity is (Moffat, 2010; Patterson & Johnston, 2012). There has been a call for collaboration by researchers who voice their concern that "the tensions produced by the credibility struggles … may actually undermine the creation of a synthesis that

combines the insights from two competing perspectives" (Saguy & Riley, 2005 p. 874).

As the brief summary of the literature highlights, moral and ethical concerns are at the heart of those concerns raised by critical researchers who warn that the current framing of obesity as a medical and public health problem may reproduce stigmatising practices. Critical researchers make consistent reference to the 'obesity discourse' which aligns with a reductionist, biomedical framing of obesity and is used to take a critical view towards current medical understandings of obesity. These researchers claim that individuals are left vulnerable to internalise the dominant and shameful constructions surrounding obesity and are critical of biomedical research for continuing to reproduce individualising and 'scientifically questionable' understandings of obesity (Gard & Wright, 2005). Obesity (or fatness) is a contested and political issue with several groups of researchers and claim-makers demonstrating critical perspectives on medicalised and dominant understandings of obesity. Research from these groups is helpful to contextualise the empirical research that will be conducted in the remainder of the thesis and to foster critical and alternative understandings about overweight and obesity, clearly raising questions about the ontological and epistemological nature of obesity in medical encounters.

Finally it is important to point out that it is not only critical and feminist researchers who point to the ethical and political dimensions of efforts to prevent obesity. Researchers who continue to conceptualise obesity as a medical problem also raise attention to the ethics of obesity prevention and treatment efforts. Recently, researchers from public health and medical ethics communities have outlined the ethical issues that obesity can raise and researchers have designed an ethical framework for those public health and medical clinicians working in the field (ten Have, De Beaufort, Teixeira, Mackenbach, & van der Heide, 2011; ten Have, 2014). This research has been published relatively recently and is currently minimal, suggesting that the ethical and political issues arising from obesity prevention and treatment efforts arean emerging field for medical and public health research. Interestingly, despite the concern exhibited around medical ethics, there is on-going dialogue within the wider research community about whether stigma might be used as a strategy to reduce levels of obesity (Bayer, 2008; Burris, 2008), which I take up further in chapter 6 of the thesis.

The chapter has so far demonstrated the tensions in the obesity research literature which demonstrate that there is disagreement over how obesity should be viewed and how it should be treated, if at all. It has also provided some background into the public health and medical response to obesity, and the competing epistemological frameworks between primary and secondary care. I will now narrow the scope of the chapter by reviewing the empirical research concerned with health professional prevention and management of obesity which has mainly approached the research from a psychological rather than sociological approach.

2.5 Literature review of health professional prevention and management of obesity
2.5.1 An introduction to the review

The subsequent findings are a summary of the current research literature on GPs' and nurses views and experiences of the prevention and management of adult obesity with emphasis on the barriers to intervening about weight. Given that limited research has been conducted in the UK, specifically around the management of adult obesity in general practice, research from other Western countries such as the US, Australia and Europe will be included. Research documenting the medical management of obesity in secondary care, and research exploring clinician views towards lifestyle change will also be included where it contributes to knowledge around the barriers of obesity prevention and management. However, to keep the review focused I have excluded studies focusing on the prevention and management of childhood obesity.

Searches for literature began as the thesis commenced (January 2012) and continued until writing up was complete (August 2015). A search of electronic databases was supplemented with hand searching of references. The following databases were searched: PubMed, PsychINFO, SCOPUS, Web of knowledge, Embase, OVID and Cochrane Library. Search terms were built around obesity (and related terms), health provider (GPs, practice nurse and related terms) and terms such as practice, behaviour, attitudes, knowledge, views, beliefs, skills, emotion, self-efficacy, barriers and enablers.

2.5.2 Beliefs about the causes and solutions of obesity

A number of studies have been carried out specifically to look at GP perceptions about the causes of and solutions to obesity (Bleich et al, 2012; Ogden et al, 2001; Ogden & Flanagan, 2008). Researchers working in the field have

expressed concern about clinician beliefs that obesity is caused by individual behaviour (Brown & Flint, 2013) because beliefs that obesity is under individual control can lead to blame for failure to lose weight and thus result in stigmatisation (Weiner, 1985; Crandall & Biernatt, 1990). It is therefore of relevance to review the empirical studies identifying GP and nurse beliefs about the causes and solutions of obesity. However, since there has no research to specifically investigate the outcomes of such beliefs, it is not possible to confirm the effects on patient care within this literature reviews.

Studies have mainly taken a quantitative design. Most recently a survey carried out in the US evaluated physician perspectives on the causes of obesity, competence in treating obese patients and views about treating obesity (Bleich et al, 2012). This study found that individual behavioural factors, including insufficient physical activity, overconsumption of food and lack of will power, were the most commonly reported causes of obesity. This supports the findings of an earlier cross-sectional survey of 73 GPs and 311 lay people in the UK which reported that GPs and patients differ in their views about the causes of overweight and counselling expectations (Ogden & Flanagan, 2008). GPs reported that they tended to stress the importance of behaviour-related factors whilst patients ascribe weight to biomedical determinants. In a similar study, Ogden and colleagues found that GPs and patients hold different views about the causes, consequences and solutions to obesity with GPs mainly attributing obesity to internal, controllable factors whilst patients attributed their obesity to internal, incontrollable factors and solutions were attributed to external factors (Ogden et al, 2001). While such findings are important, perhaps owing to the quantitative design of the studies there has been no exploration around how such beliefs influence practice or where these beliefs originate from. For instance, the finding that GPs and patients hold different explanatory models for obesity suggests that there may be tension within the consultation and difficulty in achieving a shared understanding.

Several qualitative studies have demonstrated the tension that arises due to clinician beliefs that weight management lies with the individual (Greener et al, 2010; Kirk et al, 2014). Greener and colleagues carried out semi-structured interviews with 20 health professionals , 34 lay people self-identifying as being overweight and 9 health professionals. This study distinguished between biomedical interventions for obesity (those interventions at the individual level which

draw on health care resources to support individuals to change weight) and socio-ecological interventions (which focuses on multidisciplinary policy interventions to sustain population behaviour change). Health professionals saw obesity as both an individual and wider social issue yet tended to reinforce a biomedical and individual-level intervention for patients. The authors suggest that greater awareness about the socio-ecological causes and solutions of obesity may reduce the negative feelings experienced by people with obesity who tend to blame themselves for their weight (Greener et al, 2010). A more recent study, conducted in Canada, employed a qualitative research design underpinned by feminist poststructuralism to capture health professional discourses. This revealed frustrations and contradictions in experiences of obesity management, with health professionals questioning whether obesity was a disease and admitted to blaming the obese for their excess weight suggesting they also locate the causes of, and solutions to obesity with the individual (Kirk et al, 2014). Whilst these studies generated useful insight concerning health professional views, the focus of the studies were on comparing perceptions between different stakeholders rather than looking in depth at health professional beliefs and as such both studies included a small sample of health professionals. In addition, the focus on perceptions about causes and solutions of obesity in the study by Greener and colleagues did not capture other important beliefs about obesity, thus potentially missing nuanced understanding about the phenomenon.

2.5.3 Views and attitudes towards the prevention and treatment of obesity

A number of studies, both quantitative and qualitative, have been carried out to look at specific beliefs related to the management of obesity. Studies adopting a cross-sectional survey design have pointed to concern about damaging the doctor-patient or nurse-patient relationship and worry about offending patients by talking about weight (Brown & Psarou, 2007; Michie, 2007). A study which is particularly insightful to consider in relation to the current thesis operationalised a cross-sectional survey design and included the views of GPs and Nurses (Michie, 2007). The study asked participants how often they introduced the subject of weight with overweight patients, how they did it and whether they had concerns about talking about weight. The study reported that GPs and nurses were most concerned about patients reacting emotionally to their intervention as well as impairing the doctor-patient relationship (Michie, 2007). In addition, findings suggested that weight issues are more likely to be tackled when a patient has a

related medical condition but even then intervention is sub-optimal. For example, 38% of GPs and 14% of nurses reported raising the issue on less than 50% of occasions when a patient presented without a related medical condition. Although the response rate was low (26%) with just 40 GPs and 47 practice nurses participating, this study was insightful due to its focus upon investigating a specific behaviour i.e., raising the issue of weight and highlighting that this behaviour is a problem for clinicians. Interestingly Michie ended the article suggesting that future studies should go beyond looking at psychological constructs to understand the complexities of raising the topic of weight in general practice.

Another insightful study employed in the UK is a qualitative study involving interviews with twenty-one GPs about their recent experiences of managing obesity and views about obesity in general (Epstein & Ogden, 2005). This study reported that GPs discussed the strain that obesity had on the doctor-patient relationship which the authors suggested was due to conflicting views (between GPs and patients) about the causes of and solutions to obesity. Giving insight into the concerns that GPs have, the study reported that GPs consider their future relationship with patients as central. The study also described the strategies GPs report using to preserve their relationships with patients which included offering empathy and an awareness of the stigma associated with being overweight. Whilst this study provided rich insight into GP's concerns, a criticism of the study is the focus on individual-level experiences in-line with the interpretive phenomenological analysis design it employed.

As well as research focused on weight management, studies which look at views towards lifestyle or behaviour change have also generated useful findings. A qualitative study employing a grounded theory methodology used interviews with medical professionals and trainees to capture views around behaviour change talk. Amongst other reasons, interviewees asserted that prioritizing the doctor-patient relationship explained why they avoided behaviour change talk with patients (Chisholm, 2012). In-depth interviews were carried out with doctors of various specialities including GPs. Talking about lifestyle change was viewed as a highly sensitive topic with potential to offend patients. Doctors discussed the potential to evoke emotional reactions in patients as well as discussing their own emotions such as feeling awkward and many reported choosing to prioritize maintaining the doctor-patient relationship over talking about behaviour change. Some interviewees

viewed lifestyle change as being a patient's personal choice which they had no moral right to address whilst others believed obesity should be addressed by politicians and at a society level (Chisholm, 2012). This study is interesting since it demonstrates that other public health 'problems' such as smoking and alcohol consumption are perceived as difficult to broach for similar reasons. In addition, the study suggests there may be something about behaviour change that is difficult to carry out with patients rather than just the condition/medical problem itself.

A number of studies with nurses only have also documented concern about upsetting patients although findings have been mixed. In a recent study, in-depth interviews were conducted with student nurses to understand perceptions of obesity and potential barriers to successful weight management (Keyworth et al, 2012). This study suggested that there was a fear amongst students that raising the issue of weight may affect the relationship they had with the patient. Respondents reported avoiding discussing weight management to prevent offending or embarrassing patients and also themselves if they were overweight (Keyworth et al, 2012). An interview study including 15 practice nurses also supports these findings, with the authors reporting that in every interview nurses perceived obesity to be a potentially awkward, difficult, sensitive and uncomfortable issue to address with patients (Brown & Thompson, 2007). However other studies do not corroborate these findings. In a cross-sectional study, most nurses reported that they did not find obesity an awkward or sensitive issue to discuss with patients (Brown et al, 2007). Furthermore, in a more recent qualitative study which included interviews with 22 practice nurses, concern about the nurse-patient relationship did not emerge as a factor affecting the role adequacy or legitimacy of nurses (Nolan et al, 2012). These conflicting findings suggest that further research is needed to clarify the extent to which nurses and other health professionals find broaching the topic of weight difficult and if so, to look at explanations for why this is the case.

As well as suggesting that clinician concern about patient reactions and relational factors are barriers to delivering weight management, study findings have also consistently demonstrated that health professionals feel ineffective in this area of care. This finding has been documented in numerous studies using a cross-sectional survey design (Bleich et al, 2012; Brown et al, 2007; Campbell et al, 2000; Foster et al, 2003) and extended on by authors employing interviews and focus-groups (Claridge et al, 2014; Leverence et al, 2007; Nolan et al, 2012; Teixeira,

Pais-Ribeiro, & Maia 2015). Those operationalising a qualitative design have provided some insight into why health professionals feel ineffective in this area. In the study by Nolan and colleagues, several nurses did not believe that their communication about weight had much of an impact and success was seen as rare (Nolan et al, 2012). These nurses did not attribute their lack of success to their communication skills, rather they considered low patient motivation, patient denial or the patient's personal circumstances responsible (Nolan et al, 2012). Another recent study found that whilst GPs acknowledged the importance of their role in obesity management, they doubted their ability to help patients make long-term behaviour change and blamed patients for being unmotivated and non-compliant (Teixeira et al, 2015). These studies bring to light the embedded beliefs that the solutions to obesity lie in individual behaviour change. They also support the findings of other studies which have highlighted that clinicians hold perceptions that patients do not lose weight due to low motivation and that such views may act as barriers to effective clinician engagement in obesity care (Alexander et al, 2007; Befort et al, 2006; Mercer & Tessier, 2001; Sonntag, Brink, Renneberg, Braun, & Heintze, 2012).

Concern about patient reactions and feeling ineffective relate to another consistent finding in the literature, clinician ambivalence and mixed views about whether obesity is a medical condition. In a recent UK study which described the barriers to implementing NICE's guidelines on obesity, GPs and practice nurses' did not believe it was their responsibility to manage obese patients (Gunther, Guo, Sinfield, Rogers, & Baker, 2012). Research from the UK suggests that GPs are unconvinced that obesity is within their professional domain and believe it should be managed outside primary care showing concerns about medicalising the problem (Counterweight Project Team, 2008; Epstein & Ogden, 2005). However the lack of research conducted in this area warrants further investigation. Due to the increasing number of individuals affected by obesity and the frequent visits that obese patients have to general practice, health professionals may increasingly come to view treating (and possibly preventing) obesity as one of their tasks (Truswell, Hiddink, Green, Roberts, & van Weel, 2012). However, perceptions that obesity should be treated at the societal level may also be increasing since the complexity of obesity is increasingly being acknowledged (for example, within the Foresight report). Although there remains a paucity of research around this point, several studies demonstrate physicians believe that obesity is a significant problem

that they needed to address, yet recognise it requires intervention at the societal level (Alexander et al, 2007; Greener et al, 2010; Sussman et al, 2006). Clinicians seem to hold conflicting viewpoints; on the one hand recognising their role and the importance of treating obesity and on the other, feeling ineffective and resistant to treat such a complex, societal problem (Henderson, 2015; Teixiera et al, 2015).

There is also evidence to suggest that personal identity may influence attitudes and behaviours towards obesity. A systematic review of 9 cross-sectional surveys examining the relationship between doctor's and nurse's weight status and practice behaviours, reported that doctors and nurses who self-identified as being normal weight were more likely than those who identified as overweight or obese to provide overweight and obese patients with advice and to use strategies to prevent obesity in patients (Zhu, Norman, & While, 2011). These findings were supported by a study by Bleich and colleagues who carried out a cross-sectional survey with 500 primary care physicians in the US and reported that a greater number of normal weight than overweight and obese physicians engaged patients in discussion about weight loss and felt more confident doing so (Bleich, Bennett, Gudzune, & Cooper, 2012). Qualitative research also gives further insight into how health professional body weight may act as a barrier to providing obesity care. A particularly insightful study documented nurse understandings and experiences of having a high body weight (Aranda & McGreevy, 2014). As well as reporting that nurses felt subjected to stigma and derogatory stereotypes, they also made the important observation that nurses "reinforce the dominant and damaging individualising" understandings of obesity (Aranda & McGreevy, 2014, p. 30). Another interview study of student nurses reported that those who were overweight themselves were more likely to avoid discussing weight management (Keyworth et al, 2012). The small number of studies which have looked at clinician views about own body weight as a factor affecting their practice in obesity management suggests that this is an area worthy of further investigation.

The context of a medical consultation has also been highlighted as a barrier to weight management practice. A lack of time, resources and competing demands have been cited as problematic (Huang et al, 2004; King et al, 2007; Nelson, Adamson, & Moore, 2006; Walker, Strong, Atchinson, Saunders, & Abbott, 2007). A mixed-method study carried out by Sussman & colleagues is particularly insightful around how the environmental context affects health professional decision making

around obesity (Sussman, Williams, Leverence, Gloyd, & Crabtree, 2006). The organisational structure of the practice and awareness of the presence/absence of resources in the community and the suitability of these resources for a given patient, were factors found to affect clinical decision-making to engage in preventive counselling (Sussman et al, 2006). Practice conditions at the time of the visit such as patients waiting to be seen, the office staff present, and the time of day influenced the delivery of counselling. Interestingly, in this study compared to the majority of other research conducted, availability of time rarely came up as a determinant of whether to address the topic. The authors of this study argue that decision-making in primary care is particularly challenging to research due to the complexity of dynamic and situational factors. They criticise the linear, cause and effect models which commonly inform intervention efforts by isolating and manipulating one or a few components of intervention delivery. According to the authors, these models do not adequately incorporate the complexity of the brief primary care encounter or acknowledge the full range of competing demands that affect clinicians and patients (Sussman et al, 2006).

Research with nurses also demonstrates how the organisational and environmental context affects beliefs and practice behaviours. In the interview study by Nolan and colleagues, nurses did not prioritise dealing with obesity in the practice and many were unsure whether the practice had an obesity register or if anyone in the practice had a special interest (Nolan et al, 2012). Although the nurses felt they had more time to manage obese patients than GPs, lack of time available and a competing workload were discussed as barriers to managing obesity. In terms of referral options, nurses discussed the lack of clear protocols on referral between GP and practice nurse within practices and most were unaware of community-based lifestyle programmes but were familiar with dieticians and local exercise on referral programmes. A lack of supportive framework for a nurse's role in obesity prevention and management was a prominent theme in this study. In an earlier cross-sectional survey, primary care nurses also indicated that the organisational support was not very well developed (Brown et al, 2007). Most nurses were unaware of a specific clinical protocol in relation to managing obesity and could not identify a lead clinician in relation to managing obesity. Furthermore, only 13.6% of respondents agreed or strongly agreed that their practice had a well-developed programme of support for obese patients (Brown et al, 2007).

It is important to point out that whilst the contextual barriers to obesity management have been identified, researchers have tended to focus on perceptions of environmental constraints rather than capture social and cultural contextual barriers (such as norms and power relations) that may be beyond individual perception. A research approach that can capture these barriers would thus be useful to extend current insight into the social-cultural context that GPs and nurses operate in and that may hinder weight management practice.

In addition to those studies looking at clinician views towards obesity management, a small number of studies have looked at views towards obesity prevention. These studies have also suggested mixed attitudes towards whether primary care can or should help with obesity prevention (Aucott et al, 2011). GP trainers and registrars practicing in Scotland mostly agreed that obesity and its prevention were important but GP registrars (doctors in their final year of specialist training) were more likely to agree that obesity can and should be prevented in primary care than GP trainers which the authors suggest may illustrate that the experience of working with obese patients may reduce beliefs about succeeding with patients (Aucott et al, 2011). In another study, focus groups explored attitudes of thirty-six GPs towards adopting a population approach to lifestyle advice. GPs discussed their belief that lifestyle advice often annoyed patients and affected the doctor-patient relationship and this was especially so when the advice was unrelated to the patients presenting complaint (Lawlor et al, 2000). In this study, GPs discussed feeling more comfortable providing lifestyle advice when it was directly relevant to a patient's medical condition and attributed a population approach as being 'victim blaming', especially with deprived groups of patients.

Given the multitude of barriers reported in the literature, researchers have tended to conclude that GPs and nurses need to undertake training and education specifically around the management and communication of obesity (Alexander, 2007; Brown & Thompson 2007; Bocquier et al, 2005; Jay, 2008). Several studies have reported that a large proportion of clinicians do not feel qualified or competent to treat obesity (Bleich et al, 2012; Foster et al, 2003; Gunther et al, 2012) and others suggest health professionals do not feel confident to talk about weight (Gunther et al, 2012; Moorhead et al, 2013), lack insight into how to counsel patients to change physical activity and dietary behaviours (Nolan et al, 2012;

Philips, Wood & Kinnersley, 2013) or undertake general counselling around lifestyle change (Chisholm et al, 2012; Melin et al, 2005).

2.5.4 Communication about obesity

A number of studies have looked at communication between clinicians and patients, either directly using observation, or indirectly, using interviews or surveys to identify clinician beliefs about their communication and practice. Findings of such studies are relevant since they demonstrate the complexity of introducing and negotiating the topic of body weight in medical consultations. Studies of health professional-patient communication tend to rationalise the need for such investigation given the evidence that the communication style a clinician adopts can significantly impact upon patient compliance (Vermeire, Hearnshaw, Van Royen, & Denekens, 2001), patient satisfaction (Little et al, 2001; Street, Gordon, & Haidet, 2007) and potentially weight loss (Pollak et al, 2010). A recent observational study using video analysis in Scotland, investigated the prevalence of weight discussion in general practice and reported that weight was rarely mentioned, even when patients consulted with problems known to be exacerbated by excess weight (such as musculoskeletal pain and cardiovascular issues). Other findings were that GPs more often than patients introduced the topic of weight and when GPs did raise the issue, it was often unsuccessful due to patients reducing the space for weight loss discussions to occur (Laidlaw et al, 2015). The authors conclude that GPs need additional training to help them counteract patient barriers to weight management discussion. A limitation of this study is the small sample (just 3 GPs and 46 patients were included in the study) precluding the generalisation of findings. Other studies recording doctor-patient consultations have reported that shared decision making and the use of motivational interviewing skills which focus on the patient's understanding of obesity, are infrequent (Heintze et al, 2010; Sonntag et al, 2012) suggesting that clinicians need training in how they communicate and counsel about weight loss. These studies were conducted in Germany thus it is not clear if findings extend to GPs in the UK.

The findings of these studies are interesting in light of research emphasising that power and shame in consultations about obesity and other lifestyle issues can act as barriers to effective communication (Abildsnes et al, 2012; Guassora et al, 2014; Walseth, Abildsnes, & Schei, 2011). In one study exploring lifestyle counselling, focus group studies elicited GP narratives to analyse power and

powerlessness (Abildsnes et al, 2012). A proportion of GPs claimed to use a paternalistic approach when discussing lifestyle change and rarely elicited patients' wishes and expectations. The authors suggest that when patients' resist their doctors advice to change lifestyle, this may be due to powerlessness related to difficulties to change lifestyle (rather than autonomy and power). Interestingly, GPs discussed previous clinical encounters in which they had responded to patient resistance with a confrontational attitude, an action the authors deem as one likely to elicit distrust rather than facilitate change as is well documented in the communication literature (Van Denburg & Kiesler, 2002; Francis, Rollnick, McCambridge et al, 2005). This study raises awareness of the potential for unintended consequences inherent in clinical communication such as the elicitation and reinforcement of guilt and shame (Malterud & Thesen, 2008). Viewed in this light, clinician concern about how patients will react to communication about weight loss is understandable - although a health professional has the opportunity to empower patients there is always the potential to reinforce powerlessness and conflict. It has been suggested that GPs require training in counselling techniques that respond adequately (and non-confrontationally) to patient resistance (Abildsnes et al, 2012; Rollnick et al, 2005).

A study which video-recorded consultations to analyse social interactions when lifestyle issues (physical active, diet, smoking and weight) were being negotiated also gives interesting insight into health professional-patient communication. The study authors suggest that when consultations involve discussion of lifestyle issues, it is the doctor rather than the patient (as is usually the case) who introduces the topic (Guassora et al, 2014). In addition, within these consultations patients constantly try to present themselves as responsible individuals and when unsuccessful at changing lifestyle issues, they speak about themselves with self-depreciation and shame. Interestingly, the role of the GP was reported to be 'subtle', an interpretation the researchers make based on the observation that patients' presented themselves (either taking responsibility or expressing shame) in ways which were often not linked to their GPs approach. The authors suggest that moral complexities are embedded in all medical consultations and are particularly apparent in consultations about lifestyle which have an impact on identity, values and emotions. Drawing on the theoretical work of Scheff, the study concludes with the suggestion that unrecognised shame in consultations can lead to alienation and hostility and can affect interpersonal relationships and thus

suggest that GPs should acknowledge shame in order to strengthen bonds (Scheff, 2000).

Finally, a cross-sectional survey conducted with 382 primary care and community-based health professionals (including 46 GPs and 103 practice nurses) across Ireland (Moorhead et al, 2013). Whilst the majority of respondents felt they had an important role in providing patients who presented with obesity with advice, 81% of the sample acknowledged that they found the communication complex and challenging and 27% reported difficulty in sensitively addressing the topic of weight/obesity. Like other studies, the authors recommend that health professionals undergo training to learn communication that is acceptable to patients (Moorhead et al, 2013). As this section of the literature review has demonstrated, communication and practice relating to body weight is fraught with moral complexity which authors suggest may relate to the nature of consultations about obesity, which like other lifestyle issues, relies on patients to change behaviour and typically involves the health professional to raise the issue.

2.5.5 Stigmatising beliefs towards patients

Obesity is a stigmatised condition thus stigma is an important topic to consider in this review of GP and nurse views and practice regarding weight management. There has been substantial research documenting that health professionals hold negative attitudes towards people with obesity reflecting societal prejudice. Researchers emphasise the importance of identifying and trying to change such attitudes since they are likely to undermine the quality of the support that can be offered to patients (Brown & Flint, 2013). As revealed by several systematic reviews in this area (Puhl & Brownell, 2001; Puhl & Heuer, 2009; Puhl & Latner, 2007), there is evidence that weight bias and stigma towards overweight and obese patients extends to primary health care however most of this research has been carried out in the US and the extent to which this can be generalised to the UK context is unknown. Studies have tended to look at both self-reported and implicit beliefs and have demonstrated that even if unintentional, discriminatory behaviour may occur as result of negative feelings and views towards people with obesity. A fairly recent study undertaken in the US included examining implicit and explicit attitudes about weight among 2,284 medical doctors (Sabin et al, 2012). Doctors had high rates of both types of attitudes and these were comparable to the general public (Sabin et al, 2012). These findings support other cross-sectional

surveys. For example, in another study conducted in the US, 45% of physicians from internal medicine, paediatrics and psychiatry self-reported a negative reaction towards obese patients (Jay et al, 2009). Foster and colleagues found that more than 50% of a large sample of primary care physicians viewed obese patients as awkward, unattractive, ugly and non-compliant and one-third perceived obese patients as weak-willed, sloppy, and lazy (Foster, 2003). In France, 30% of 600 GPs surveyed viewed overweight and obese patients to be lazier and more self-indulgent than normal-weight people (Bocquier et al, 2005).

A limited number of studies have attempted to assess negative attitudes that GPs and nurses may hold in the UK. In a study conducted over 20 years ago, 27% of GPs (N = 299) agreed with the statement that 'overweight people tend to be more lazy and over-indulgent than normal weight people' in a postal survey (Cade & O'Connell, 1991). More recently, although still over a decade ago, Harvey & Hill compared the views of health professionals in two health districts in the north of England (204 GPs and 51 clinical psychologists), on their beliefs about overweight people and smokers (Harvey & Hill, 2001). GPs perceived overweight people to have reduced self-esteem, sexual attractiveness and were significantly more likely than clinical psychologists to believe that overweight and smoking were due to a lack of will power and personality (Harvey & Hill, 2001). Research looking at whether nurses in the UK hold stigmatising beliefs are also sparse. In a cross-sectional survey, a small proportion of nurses agreed to negative stereotypical statements about obese people and there was a spread of attitudes on the scale of negative views about obesity indicating that at least some nurses self-report bias towards obese patients (Brown et al, 2007). Interestingly nurses with lower BMIs expressed more negative views of obesity. The authors of this study note that it is unhelpful to view stigma in a reductionist way i.e. by simply looking at whether it exists or not since this precludes an understanding of the complex nature of nurse views towards obesity, particularly that nurses also hold positive attitudes towards patients with obesity, a finding demonstrated in an interview study by the same lead author (Brown & Thompson, 2006). In relation to this point, whilst it is not always clear whether studies are looking at prejudice or stigma, are one way stigma can be understood is as "a pervasive, probably impossible to avoid psycho-social phenomenon affecting all interactions with patients" (Brown & Flint, 2013, p. 334) whereas prejudice is an observable, consequence of stigma. Indeed, recent work illustrates how social institutions may legitimise and structurally perpetuate stigma

(Bos, Pryor, Reeder, & Stutterheim, 2013) thus stigma is viewed as an elusive and powerful force in a medical consultation rather than a belief held by a health professional.

Other research in this area documenting the existence of stigma and negative stereotypes in health professionals comes from experimental research, some of which has used the Implicit Association Test (IAT) and more recently digital technology (Hebl & Xu, 2001; Persky & Eccleston, 2010; Schwarz et al, 2003; Teachman & Brownell, 2001). Whilst these studies have given useful findings they are clearly limited since the experimental nature of the design precludes an analysis of how the context of health care shapes the process of stigmatisation. As well as research undertaken with health professionals, studies carried out with lay people and users of health care have also suggested that health professionals have negative attitudes towards obesity and obese people and this will be discussed next.

2.5.6 Patient views about obesity being addressed in general practice

There has been very little research investigating patient views or experiences of having weight addressed in general practice. One study in Norway included a focus-group with 13 individuals with a BMI above 40 or with a BMI above 35 with additional weight-related problems (Malterud & Ulriksen, 2010). The study concluded that obese patients want their GP to introduce the topic of weight into the consultation and patients expressed frustration and feelings of being worthless when health professionals ignored the issue. Along with findings reported by other studies, patients felt doctors attributed nearly any complaints to obesity without investigating the specific causes (Brown, Thompson, Tod, & Jones, 2006; Merrill & Grassley, 2008; Russell & Carryer, 2013). This raises an important ethical tension since it may suggest that patients with obesity are not receiving a thorough investigation by medical professionals. An exclusive focus of weight without an exploration of a patient's medical history or perceptions about the medical problem may lead health professionals to discount an underlying problem (Malterud & Ulriksen, 2010). Another finding is that patients present with expectations that their GP will be disapproving and judgmental towards them (Guassora et al, 2014; Malterud & Ulriksen, 2010) which supports evidence suggesting some individuals with obesity compromise going to general practice for other health needs due to

fear of being negatively evaluated by health professionals (Drury, Aramburu & Louis, 2005; Wee et al, 2000).

Several reviews have synthesised qualitative studies looking at patient experiences of obesity and have suggested that in a health care context stigma is often enacted with increased ambivalence and discomfort from both health professionals and patients and tensions exist regarding responsibility and attribution (Brown & Gould, 2011; Malterud & Ulriksen, 2011). Another review has demonstrated that obesity stigma impacts negatively on the relationship between health professional and patient (Mold & Forbes, 2011). Whilst experiences of stigma are beyond the scope of this thesis, these findings are useful to consider since they may act as a barrier to GP and nurse engagement in obesity care.

Studies employing cross-sectional survey designs have also reported that patients want their doctors to talk to them about weight (Potter, Vu & Croughan-Minihane, 2001; Tan, Zwar, Dennis, & Vagholkar, 2006) yet another suggests patients would prefer a health professional other than the GP to talk to them about obesity management (Tham & Young, 2008). Whilst the disparity in findings is interesting to note, these studies have all been carried out outside the UK and all are several years old thus further research is needed in this area before it is possible to conclude how patients view weight-loss communication from health professionals.

2.5.7 Summary of literature and research gap

As this review has demonstrated there are a plethora of barriers hindering GP and nurse engagement of obesity management yet there appears to be a lack of research carrying out in-depth or theoretical investigation into GP and nurse views about their role in obesity prevention and management in the UK. The research that has been conducted suggests that addressing obesity is a sensitive matter, is difficult to negotiate in practice without eliciting and reinforcing negative emotions, and that health professionals avoid raising the issue in order to prevent upsetting patients or disrupting rapport in the consultation, particularly given strong beliefs that interventions will be ineffective. Given that there may be negative consequences if clinicians either ignore the issue (e.g. for patients, it may result in beliefs that weight is unimportant or feelings of being ignored) or indeed raise the issue, it seems that more research to understand views about raising the topic of weight is needed. As the review demonstrated, to the authors knowledge there is

currently a lack of qualitative research specifically focused on understanding GP and nurse views towards initiating the topic of weight in general practice.

The review also demonstrated that health professional views about the causes and solutions of obesity are important to consider. Views that obesity is within an individual's control, a matter of individual behaviour and thus an individual's responsibility may translate to negative beliefs and feelings towards patients (Brown & Flint, 2013). With the increasing emphasis on costs in the health system (Monoghan, 2005), some researchers have suggested that weight stigma may increase (Tomiyama et al, 2015; Trainer, Brewis, Hruschka & Williams, 2015). It thus seems important to consider the assumptions that health professionals make about patients and capture the range of views and feelings that health professionals have towards raising the topic of body weight with patients. As the review demonstrated, studies on stigma and prejudice have mainly been carried out in the US and it is not clear if, or to what extent, the findings are an artefact of the method used. In addition, whilst there seems to be a proliferation of research suggesting that health professionals hold negative beliefs towards obese patients, there is subsequently good evidence that health professionals are worried about causing patients upset and damaging relations (Chisholm et al, 2012; Michie, 2007). It is not clear how these seemingly contradictory attitudes interact but as asserted in a literature review documenting nurse attitudes toward obese patients in the UK, it seems likely that health professionals hold a complex mix of attitudes towards patients (Brown, 2006) although there has been little exploration of this phenomenon.

Since the majority of studies conducted to date have investigated physician counselling or another intervention which requires time and knowledge on behalf of the physician, and given that health professionals now have a greater role in referring patients to others providers and thus do not necessarily need to deliver time-consuming and complex interventions themselves, research focused on raising the topic seems timely. It also seems relevant to understand more about when and why GPs and nurses find raising the topic difficult given that quantitative studies consistently report that weight loss advice is more likely to be given to patients who have comorbidities or have weight-related problems (Aucott et al, 2011; Michie, 2007). No qualitative studies have explored why this is suggesting a clear need for qualitative understanding.

Finally, the literature review suggests that there are discordant beliefs between doctors and patients in regards to the causes and solutions of obesity (Ogden et al, 2001; Ogden & Flanagan, 2008) and the potential for patient resistance and the elicitation of shame and blame (Guassora et al, 2014; Malterud et al, 2010), which may cause tension in the consultation. In 2007, the Foresight report clearly asserted that obesity was a highly, complex and multifaceted condition. In addition, NICE guidelines assert that preventing and managing overweight and obesity "are complex problems, with no easy answers" (NICE, 2014, cg. 43 p. 6) and offer practical advice to help professionals deal with this complexity. It is not clear if these guidelines have punctuated the consciousness of GPs and nurses or are viewed as a useful resource in interactions which patients where issues of responsibility and blame are often at stake (Brown & Flint, 2013).

2.6 Chapter conclusion

I began the chapter by providing the reader with contextual information about the ontological and epistemological frameworks operating in general practice. I then described sociological and critical perspectives about obesity research and prevention/management in general practice. This served to emphasise the divergent and contested views towards obesity. The chapter finished by providing a review of the empirical literature around the prevention and management of obesity in medical settings and justified the need for further qualitative research which explores views around the challenges of raising the issue of weight in general practice and builds on previous scholarly work that has documented complex and contradictory attitudes towards obesity and weight management. The next chapter will lay out the methodological underpinnings and philosophical frameworks of the empirical studies in chapters 4, 5 and 6 of the thesis.

Chapter 3: Methodology

3.1 Introduction

The purpose of this chapter is to inform the reader of the methodological underpinnings of the research and make explicit those concepts that have informed the three empirical studies that make up the thesis. I will initially remind the reader of the broader research objectives and research questions guiding the thesis. I will then discuss the design of each empirical study, drawing attention to the methodological assumptions underpinnings, in order to locate the research ontologically and epistemologically. This chapter will also explain the role and creation of a set of trigger films which were used as a research tool for study 3. Since reflexivity is central to qualitative research, I will end the chapter with a discussion of my own place in the research process and subsequent implications.

3.2 Research aim and objectives

The aim of the thesis is to use qualitative research methods to understand more about GP and nurse barriers to initiating discussion about weight with overweight and obese patients in general practice. As well as identifying barriers to raising the topic through analysis of GP and nurse perspectives, I aim to critically disrupt these barriers through performing a discourse analysis of GP accounts of raising the topic of weight.

The three objectives of the research are:

1. To identify and describe GPs' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice
2. To identify and describe primary care nurses' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice
3. To explore the discursive power relations that shape how GPs talk about obesity with patients by:
   3.1 identifying the micro-political processes at play when GPs talk about the challenges of raising the topic of weight in general practice

3.2 relating the micro-political discourses inherent in doctor-patient encounters about weight with macro-discourses surrounding obesity and general practice

3.3 Research questions

In order to achieve the objectives outlined above, this thesis seeks to answer the following research questions:

1. What are GPs' views and attitudes about raising the topic of weight with overweight and obese patients in general practice?
2. What are primary care nurses' views and attitudes about raising the topic of weight with overweight and obese patients in general practice?
3. How do GPs discursively construct the challenges of raising the topic of weight whilst reflecting on trigger films of doctor-patient encounters?
4. What discourses shape GPs accounts of raising the topic of weight in general practice using trigger films to spark reflections?

3.4 An introduction to the methodological approach

The first two empirical studies of the thesis are situated within the discipline of health psychology. A review of the literature around how to understand the behaviour of health professionals and the role they play in obesity prevention and treatment, suggested accumulating evidence that psychological theory drawn from health behaviour literature is useful to aid understanding of health professional behaviour (Eccles et al, 2006; Hrisos et al, 2008). I expand on the models offered by health psychology, review the growing body of research in the field and offer a justification for taking this approach after I briefly explain the change in methodology adopted for study 3.

As I became aware of the growing movement of researchers who question the dominant methods associated with the discipline of health psychology and after completing study 1 and 2 of the thesis, I sought a change in methodological approach. Following researchers situated within the field of social psychology, sociology and medical sociology who suggest that a critical stance towards research is required, the third empirical study adopts discourse analysis. A major

limitation of much research carried out in health psychology is its lack of reflexivity and application of theory to highlight that health is a moral phenomenon and a site of power relations (Crossley, 2001; Lupton, 1992). As such, there is a requirement for a research approach able to incorporate the socio-political and cultural factors that shape views, experiences and practices towards health. One methodology which meets these requirements is discourse analysis. Discourse analysis can be applied to health research to show how taken-for-granted assumptions and views of the world can be challenged to obtain a more reflexive and critical stance (Lupton, 1992; Morgan, 2010). This approach, which informs the final empirical study of the thesis, shifts the research to a social constructionist theoretical orientation. I will now explain the theoretical foundations and methodological assumptions of the studies.

3.5 Study 1 and 2

3.5.1 Epistemology and theoretical perspective

The design of study 1 and 2 was informed by the Theoretical Domains Framework (TDF) (Michie et al, 2005; Cane, O'Connor & Michie, 2012) and used content and thematic analysis to analyse the interview data (Hsieh & Shannon, 2005; Braun & Clarke, 2006). The TDF originated from social psychology thus I will discuss the ontological and epistemological underpinnings of the paradigm of social psychology before looking specifically at content and thematic analysis as approaches to qualitative analysis.

It is first important to outline what ontology and epistemology are, given the importance of these factors in how research problems are viewed and findings arrived at within qualitative research (Caelli, Ray & Mill, 2008; Thorne, Joachim, Paterson, & Canam, 2008). Furthermore, within and between methods that are considered qualitative, there is a wide range of epistemological and ontological variations (Carter & Little, 2007). It is also useful to outline the historical context and disciplinary orientation from which the theoretical approach emerged since these factors play an important role in specifying what is considered relevant, which bodies of knowledge should be drawn on, how one ought to approach a research problem and what the point of gaining new knowledge is (Thorne et al, 2008).

Ontology is a term encompassing assumptions about what the social world consists of, what units make it up, and how these units interrelate to each other

(Stainton Rogers, 2011). Epistemology relates to what constitutes valid knowledge about the social world and ways to go about gaining it (Stainton Rogers, 2011). The TDF consists largely of socio-cognitive models, originating from general cognitive theory and based on experimental social psychology. These models regard the social world as external to and separate from human action (Stainton Rogers, 2011) and thus take up an ontological position aligning with realism (Blaikie, 2007; Ritchie, Lewis, Nichols, & Ormston, 2013). Social psychologists aim to discover universal laws by which the social world 'works'. Broadly speaking, social psychology is based on positivism, an epistemological orientation which prioritises the discovery of reliable, factual knowledge about the reality of the social world (Breen & Darlaston-Jones, 2010). Application of the scientific model is thus a goal, so that through systematic collection and analysis, reality can be revealed. Positivism aims to describe, predict, control and explain in its quest to produce universal laws (Leahey, 1992).

As noted, socio-cognitive models arose from general cognitive theory thus it is also important to summarise assumptions inherent in cognitive models of behaviour. These models posit that the way people perceive, understand and interact with the world is a product of them both taking in and interpreting information, with the latter process being facilitated through using their stored knowledge (Stainton Rogers, 2011). Socio-cognitive models arose as a reaction by researchers against machine-like and passive models of the person put forward by social learning theory and information processing approaches. Important assumptions within socio-cognitive models are that people have agency, purpose and the capacity to interpret the world actively and attribute meaning to things based on their stored knowledge and prior experience (Stainton-Rogers, 2011). Although these models recognise that people interpret external stimuli, it is still assumed that there is an objective reality 'out there'.

The TDF is thus based on theories originating from an ontological approach which aligns with realism and an epistemological approach reflecting positivism. Interestingly however, the researchers do not reflect on this within the development of the framework which is surprising since there is a push in the field of qualitative health research for authors to explicitly state the philosophical and theoretical approach of studies (Caelli et al, 2003). It is also useful to reflect that the TDF has been developed to understand, predict and influence behaviour yet has also been

deemed useful as a qualitative research tool (Francis, O'Connor & Curran, 2012; Phillips et al, 2015). When the TDF is used as a qualitative research method and theoretical framework, findings are of a descriptive nature and the goal of researchers is often to generate hypotheses which can be tested in future quantitative research designs. Researchers who use the TDF thus strive to produce objective, reliable and valid knowledge, criteria related to the scientific method and an approach in line with the positivist paradigm that the constitutive theories originate from. However, as well as being a tool to generate new knowledge to add to the field of behavioural science, it is also important to note that the TDF has been designed as a tool for use within the field of applied health research and for use by a multidisciplinary audience including researchers and public health practitioners (Francis et al, 2012). Seen in this light, the TDF aims to produce knowledge for application to clinical practice and is thus a pragmatic tool.

Given the philosophical background and assumptions of the TDF, I designed and conducted studies 1 and 2 using an approach similar to that advocated by Jane Ritchie and Liz Spencer who developed framework analysis for use within social policy research (Ritchie & Spencer, 1994). In a position akin to realism and drawing on understanding from socio-cognitive models, I took the perspective that reality exists independently of those who observe it, but that this reality is only accessible through the views and interpretations of the individuals who observe it. Again similar to framework analysis and in line with the goals of pragmatism, the emphasis was on producing findings to answer a specific research question rather than prioritising the epistemological stance of the method (Ritchie & Spencer, 1994).

Content analysis was used to code the interview data and map codes onto the TDF. Hsieh and Shannon define content analysis as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278). Researchers using content analysis typically aim towards systematic analysis of data and seek to achieve criterion such as validity, reliability, objectivity and generalizability (Hsieh & Shannon, 2005). Content analysis reflects the methodological underpinnings of the positivist paradigm (Yardley & Marks, 2003). In addition, researchers argue that content analysis is not as advanced as methods such as grounded theory or phenomenology which go beyond content analysis by developing theories and nuanced understanding of

lived experiences. Whereas these approaches require a higher level of interpretive work from the researcher, there is less transformation of data by using content and thematic analysis which rely more on description and less on interpretation (Sandelowski & Barroso, 2003).

During analysis, both the manifest and latent content of the data was examined. This means that both what was said by participants and meanings of what was said, as inferred by the lead researcher (MB) who had spent significant time in the research field, was coded as relevant data i.e. that judged as providing insight into the research problem. Explicit explanations rely on participants' own accounts of their intentions, beliefs and circumstances that explain why they carry out actions. In this study explicit explanations were built on to form implicit explanations. The decision to include implicit explanations was made because only coding the manifest content or explicit explanations offered by participants did not explain the full variations and patterns in the data. As my knowledge of the research area increased, it also became clear that coding of latent content was required to get a more complete picture of the data. Following the coding of the data, segments of the text identified as barriers were mapped to the TDF.

Thematic analysis (Braun & Clarke, 2006) was also drawn on within studies 1 and 2 in order to synthesise codes into themes. Thematic analysis involves the search for and identification of common threads that manifest throughout the whole set of interviews (DeSanti & Noel Ugarrize, 2000). It is a flexible approach which can be conducted within a realist paradigm and thus was considered to be a suitable approach aligning with the TDF and content analysis which reflect the methodological underpinnings of a positivist paradigm. Researchers have called this the 'factist' perspective which assumes that data is more or less accurate, 'truthful' and corresponds to 'reality' (Sandelowski, 2010). The methodological instruments drawn on for study 1 and 2 thus aimed to identify attitudes and motives of GPs and nurses, a methodological approach that differs radically to the one employed in study 3 as I will go on to explain later in the chapter.

3.5.2 Development of the TDF and justification of use for study 1 and 2

The TDF is a tool that has emerged due to the gap between evidence and practice in health care. Many patients do not receive care according to current scientific evidence and it is predicted that about 20-25% of the care that is provided is not required or potentially harmful (Grol, 2001). One way to increase the

implementation of evidence-based practice is through changing health professional behaviour through intervention. The TDF emerged from a growing body of behaviour change and implementation research demonstrating that scientific theories of behaviour and behaviour change can assist our understanding of health professional behaviour (Hrisos et al, 2008). In support of the applicability of theoretical models of individual behaviour to health professional practice, a systematic review reported consistent and strong relationships between intention and clinical behaviours of healthcare professionals (Eccles et al, 2006). Due to a large number of overlapping theories of behaviour, including psychological, organisational and motivational theories, the selection of theoretical models or constructs became difficult for researchers seeking to apply these theories (Michie et al, 2005). For instance, a recent review reported 83 evidence-based theories in total (Davis, Campbell, Hildon, Hobbs, & Michie, 2014). In order to make the task easier for researchers, Michie and colleagues identified and grouped 128 theoretical constructs derived from 33 theories of behaviour change into 12 theoretical domains which could be used for implementation research i.e. that seeking to understand and potentially change health professional behaviour (Michie et al, 2005). The framework was developed, refined and validated by health psychology theorists, with input from health service researchers and health psychologists attending a national health psychology conference. This framework was named the theoretical domains framework (TDF) (see table 1).

Table 1

Theoretical domains and constructs in original TDF

Theoretical domain	Constructs
Knowledge	Knowledge about condition/scientific rationale; Schemas, mindsets and illness representations; Procedural knowledge
Skills	Competence/ability/skill assessment; Practice/skills development; Interpersonal skills; Coping strategies
Social/Professional Role and Identity	Identity; Professional identity/boundaries/role; Group/social identity; Social/group norms; Alienation/organisational commitment
Beliefs about capabilities	Self-efficacy; Control- of behaviour and material and social environment; Perceived competence; Self-confidence/professional confidence; Empowerment; Self-esteem; Perceived behavioural control; Optimism/pessimism
Beliefs about consequences	Outcome expectancies; Anticipated regret; Appraisal/evaluation/review; Consequents; Attitudes; Contingencies;

	Reinforcement/punishment/consequences; Incentives/rewards; Beliefs; Unrealistic optimism; Salient events/sensitisation/critical incidents; Characteristics of outcome expectancies- physical, social, emotional; Sanctions/rewards, proximal/distal; valued/not valued; probable/improbable, salient/not salient, perceived risk/threat
Motivations and goals (intentions)	Intention- stability of intention/certainty of intention; Goals (autonomous, controlled); Goals target/setting; Goal priority; Intrinsic motivation; Commitment; Distal and proximal goals; Transtheoretical model and stages of change.
Memory, attention and decision processes	Memory; Attention; Attention control; Decision making
Environmental context and resources	Resources/material resources (availability and management); Environmental stressors; Person x environment interaction; knowledge of task environment
Social influences (Norms)	Social support; Social/group norms; Organisational development; Leadership; Team working; Group conformity; Organisational climate/culture; Social pressure; Power/hierarchy; Professional boundaries/roles; Management commitment; Supervision; Inter-group conflict; Champions; Social comparisons; Identity, group/social identity; Organisational commitment/alienation; Feedback; Conflict- competing demands, conflicting roles; Change management; Crew resource management; Negotiation; Social support: personal/professional/organisational, intra/interpersonal, society/community; Social/group norms- subjective, descriptive, injunctive norms; Learning and modelling
Emotion	Affect; Stress; Anticipated regret; Fear; Burn-out; Cognitive overload/tiredness; Threat; Postive/negative affect; Anxiety/depression
Behavioural regulation	Goal/target setting; Implementation intention; Action planning; Self-monitoring; Goal priority; Generating alternatives; Feedback; Moderators of intention-behaviour gap; Project management; Barriers and facilitators
Nature of the behaviours	Routine/automatic/habit; Breaking habit; Direct experience/past behaviour; Representation of tasks; Stages of change model

Note. Reproduced from Michie et al (2005)

The TDF draws on theories belonging to different traditions, which define behaviour in different ways and which have diverse intended applications. For example, theories include social cognitive theory (Bandura,1986), self-determination theory (Deci & Ryan, 2000), effort-reward imbalance (Siegrist, 1996) and social identity theory (Tajfel,1982) thus it is an inter-disciplinary theoretical tool. Disciplines such as psychology, sociology, anthropology, communications, nursing, economics, and marketing which have contributed to behavioural science theory,

are represented. The theories also vary in their emphasis: some focus on motivation and propose that motivation determines behaviour, others place emphasis on factors that are necessary to predict behaviour in people who are already motivated to change and yet others emphasise that predictors of behaviour are different for people at different stages of change (Bonetti et al, 2006). Interestingly all theories have been rigorously evaluated with patients or healthy individuals but not health professionals. The authors of the TDF emphasise that the domains were not designed to maintain the explanatory and causal mechanism that the individual constructs bring from their original theory. Instead the "12 domains identify key constructs but not the causal processes that link theoretical constructs in a coherent explanation of behavioural regulation or behavioural change" (Michie et al, 2005, p. 31). The TDF intends to broadly cover the full range of current scientific explanations for human behaviour hypothesised in current behaviour change theories (Cane et al, 2012; Michie et al, 2005). The TDF is thus a pragmatic framework designed to be used for exploratory purposes. It is also important to note that the aim of the TDF is to make "psychological theory useful to researchers from a variety of disciplinary backgrounds internationally, to investigate a wide range of behaviours in various healthcare settings" (Francis et al, 2012, p. 2).

Examples of how this framework has been used previously include an investigation into the perceived implementation difficulties of midwives providing smoking-cessation advice to pregnant women (Beenstock et al, 2012), an investigation into clinicians' behaviour in relation to blood transfusions (Francis et al, 2009), an assessment of implementation difficulties in tobacco use prevention and cessation counselling among dental providers (Amemori, Korhonen, Kinnunen, Michie, & Murtomaa, 2011) and to explore the factors that influence doctors' prescribing behaviour (Cullinan et al, 2015; Duncan et al, 2012). More recently the TDF has also been used to understand the behaviour of those individuals involved in behaviour change interventions (Atkins et al, 2013; Penn et al, 2013) thus it is not exclusive in its application to health professional behaviour.

The TDF contributes to current thinking about the development of complex interventions to improve health (Francis et al, 2009). The framework has been designed to identify the factors that influence decision making and/or behaviour and

to help researchers select interventions that will increase the likelihood of success of an intervention for a specific behaviour (Bonetti et al, 2006).

Since the development of the original framework, attempts have been made to improve the validity of the framework. Cane and colleagues used a card sorting methodology to examine the content validity of the TDF (Cane et al, 2012). As a result of this process, a refined framework was put forward consisting of 14 domains and 84 component constructs (these are theoretical "constructs" or component parts of theory that relate to behaviour change). In the process of the validation exercise, the authors point out the links the TDF makes between theories of behaviour change and behaviour change techniques to address implementation problems (Cane et al, 2012). After barriers have been identified and mapped to the relevant domains of the TDF, behaviour change techniques based on expert consensus about effectiveness for behaviour change can inform a future intervention (Michie, Johnston, Francis, & Eccles, 2008). Since the refinement of the TDF, it has been used flexibly by researchers, with some researchers continuing to use the original 12 domains, others using the 14 domains, and the majority modifying the framework by drawing on the original and refined frameworks, selecting domains depending on the context and the implementation problem i.e. using it pragmatically.

3.5.3 Reliability and validity

Reliability refers to how likely it would be for another researcher to repeat the study and arrive at similar findings (Seale, Gobo, Gubrium, & Silverman, 2004). Whilst criteria such as reliability and validity are contested within the qualitative research field (Murphy et al, 1998), some authors argue that for applied health and policy research producing findings within a scientific context, is important for researchers to make attempts to produce reliable findings (Ritchie et al, 2013). It is argued that one way to do this in qualitative research is to explicitly and transparently communicate the procedures that lead to the specific findings and conclusions (Seale et al, 2004). In line with this standard, throughout the thesis I have made attempts to provide a detailed and honest description of the methodical approach, both throughout this chapter and in chapters 4 and 5. During all parts of the research process, including the initial design, data collection and analysis, I have tried to achieve what other researchers call "emphatic neutrality" (Ritchie et al, 2014, p. 22), that is I attempted to avoid bias and retain a neutral position in

regards to the research. Whilst I acknowledge such neutrality is impossible, I tried to be explicit about my own views and opinions towards the research by using strategies such as memo writing (Charmaz, 1990) and keeping a reflective journal, to minimise potential sources of bias.

Validity relates to whether findings accurately reflect the phenomenon being studied (Ritchie et al, 1994). I ensured validity of findings in various ways during both the analysis and reporting of findings. During the analysis of interview data, a selection of the transcripts were coded by a second coder with expertise in health psychology (Dr Afroditi Stathi). In addition, data analysis and the implications of the data were discussed and any difficulties resolved at frequent supervisor team meetings, with all of the research team having expertise and experience in psychological research. I also ensured findings were valid in a more applied sense. A visiting researcher within the department for health (Dr Paul Bennett), who had previously worked as a GP and thus had extensive knowledge of the research problem, also reviewed my analysis and reporting of the data, providing me with the opportunity to further reflect on the empirical data within context rather than focus too much on theory. During the reporting of the research, I presented preliminary findings to a Nutrition Group representing practising GPs interested in improving clinician education and training of obesity. Whilst I was mindful that the GPs did not approach my findings in an unbiased way and were not trained in applied health research, it proved a useful exercise in encouraging me to return to the data to ensure that the analysis was robust.

3.5.4 Strengths and limitations of the methodological approach

In regards to the limitations of the methods used, it is important to note that there are several limitations to the deductive use of theory and content analysis. First, a researcher's familiarity with the theoretical framework means that the data collection and analysis is approached with an informed but potentially strong bias (Hsieh & Shannon, 2005). Second, social desirability may have influenced responses. That is, in answering questions relating to specific domains, interviewees may have felt inclined to answer in a socially acceptable way (Krefting, 1991). Third, it could be argued that as a researcher predisposed to the theoretical domains framework, it was more likely that I would find supportive rather than non-supportive evidence aligning to the framework. Fourth, it has been noted that an overemphasis on the theoretical framework can blind researchers to contextual

aspects of the phenomenon (Hsieh & Shannon, 2005). Finally in regards to content analysis, researchers have critiqued this approach which involves only a low level of interpretation and more focus on description and validity, as being inadequate for studying the social and cultural objects of a text or shining light on the historical, political and social processes which produce these socio-cultural dimensions (Dieronitou, 2014).

There are also a number of limitations specifically relating to the application of the TDF. Using it as a form of qualitative research, researchers have noted that it pays less attention to idiosyncrasies that characterise much of qualitative research (Lipworth, Taylor, & Braithwaite, 2013). The purpose of qualitative research is to map the range and diversity of perspectives and experiences of individuals, to describe a phenomenon in rich and authentic detail and to help readers of research develop more sophisticated understandings of the phenomenon (Ritchie et al, 2013). However, by focusing on specific beliefs as the unit of analysis, the TDF distils the complexity of the phenomenon allowing a comprehensive assessment of barriers but less focus on depth or dimensions of barriers. Another major limitation of the TDF is that it does not specify relationships between each of the domains. Furthermore the domains are not mutually exclusive, that is, barriers can be mapped to more than one domain. However, it should be noted that the purpose of the TDF is to act as a step to identify barriers and map these barriers to behavioural domains so that researchers can choose a relevant theory to explore associations between domains in more detail. As noted by other researchers using the framework, this may be a strength of the framework since the TDF is a tool for practical use and thus definitions do not need to be precise and mutually exclusive (Lipworth et al, 2013).

In regards to the methodological orientation of the study, it is important to consider that the TDF is heavily orientated towards the paradigm of health psychology and thus it is useful to briefly reflect on the underlying assumptions of this paradigm. Health psychology formally developed 40 years ago, naming itself as a distinct field of psychology in the 1970s. Within the field there is an emphasis on the relationship between attitudes/cognitions and behaviour (Murray, 2014). The discipline promotes a biopsychosocial model of illness, supporting medicine's focus on mind-body dualism and paying less attention to the role of social issues (Murray, 2014). Health psychology is concerned with individual behaviour change

and the promotion of individual behaviour strategies. In terms of the methods used in the field, priority has been given to the application of objective methods, particularly measurement of variables and statistical analyses (Murray, 2014). Qualitative research which searches for universal laws of behaviour mirrors the goal of researchers applying statistical analysis. Critiques of the field argue that the importance of the broader social and political context is underplayed due to the focus on the individual and concern with individual change (Crossley, 2001).

These limitations should be viewed in consideration of the strengths of using a valid theoretical framework to analyse the data. The strength of the TDF relates to its application which allows a systematic and comprehensive mapping of barriers. Using the TDF to inform the interview schedule and analysis of data helps to ensure that no important domain is overlooked. Barriers can then be mapped to theoretical behavioural domains and targeted in a future intervention (French et al, 2012) thus aligning with the recommendations of the Medical Research Council (MRC) for theoretically-informed interventions (Campbell et al, 2000). Behaviour change techniques and methods, originating from a strong field of scientific evidence (French et al, 2012), can then be selected.

A further strength of the TDF, particularly in comparison to other psychological theories, is that it includes organisational theories which explain change at a higher order social and systems level (Walker et al, 2003). Although the TDF can only identify barriers that are psychological and thus precludes barriers that are physical in nature or that relate to legislation, the authors claim that these are likely to be mediated by psychological processes represented by the domain list of the TDF (Michie et al, 2005). Researchers also note that the TDF has made an otherwise inaccessible method understandable to the users of research, particularly health care professionals and policy makers (Lipworth et al, 2013).

3.6 Alternative approaches to studying the behaviour of health professionals

Given the limitations of the dominant theoretical approach taken to study health professional behaviour, social psychologists have found alternative ways to study psycho-social phenomena. Recognising the shortcomings of dominant psychological models which often take little account of the variability of human

thought and action (Potter, Edwards & Wetherell, 1993) and "bolster a spurious model of thinking as uniform, rational, and classifiable into equal-interval categories" (Burman & Parker, 1993, p. 8), researchers turned to discourse. Turning to discourse prioritises the function of discourse over underlying, stable dispositions. In this approach, talk is seen as the function of context (Burman & Parker, 1993).

Whilst the TDF offered a useful exploratory tool for data collection in studies 1 and 2, the failure to account for the social and political context, which emerged as central to the research problem, led me to adopt a discourse analytic methodology for study 3. Before outlining the ontological and epistemological underpinnings of study 3, I will discuss the trigger films produced from the findings of studies 1 and 2. These trigger films were used as stimuli in study 3 and as such connect the three empirical studies.

3.7 Trigger films

3.7.1 Rationale for the use of trigger films

To build on the knowledge generated in studies 1 and 2, and overcome the limitations of using self-report data, it would have been useful to directly observe doctor-patient interactions. This technique has been used by other researchers concerned with health professional-patient communication around obesity (Throsby, 2012; Webb, 2009; Wiggins, 2009), although to my knowledge, there is a paucity of observational research concerning opportunistic discussions about obesity or weight in general practice. Due to pragmatic constraints such as a lack of time and the ethical implications required to undertake such research, it was not possible to carry out this kind of study. Therefore several alternative methods were considered.

A review of the literature demonstrated that due to the difficulties of conducting ethnographic research in the medical setting, elicitation methods have been used including paper and visual vignettes (Hillen, van Vliet, de Haes, & Smets, 2013). It was during this exploration of the use of vignettes in medical research and education that I learned about 'trigger films', a term first used by Alroy and Ber in 1982 to describe short situational films (Alroy & Ber, 1982).

Trigger films came into use as a method of studying the doctor-patient relationship due to the challenge of teaching and studying a relationship which is inherently complex with films being used as a method to expose medical students to clinical experiences that are difficult to teach in situ. Topics such as the doctor-patient relationship, ethical issues and professionalism have been explored using the method (Bel & Alroy, 2001; Johnston & Chan, 2012). An advantage of this approach for medical students is the exposure it gives to difficult ethical dilemmas in a safe environment, allowing students their own capacity for managing difficult cases such as breaking bad news and facing dying patients with the guidance of a teacher. Films are often used to encourage reflection, particularly when there is not an obvious answer or direction required (Blasco, Mônaco, De Benedetto, Moreto, & Levites 2010).

Although trigger films have been used as a teaching device rather than a research tool, visual methods such as video staged consultations are increasingly being used in the field of medicine and medical education (Hillen et al, 2013). There is also an increasing use of visual vignettes and other visual methods in the social sciences (Prosser & Loxley, 2008). Further discussion with my academic supervisors and a small number of medical professionals about the use of such a method, suggested that trigger films were an acceptable and pragmatic data collection tool to be used when researching GPs and trying to understand provider-patient relationships. A key advantage of using trigger films as a research tool is that they may trigger more issues than initially anticipated (Rabinowitz, Melzer-Geva, & Ber, 2002), leading to rich and diverse discussion with interviewees. In addition, it is suggested that trigger films are helpful in facilitating understanding the cultural and social elements of the clinical encounter (Rabinowitz et al, 2002).

3.7.2 Designing and producing the trigger films

In line with the general principles of trigger film production (Alroy & Ber, 1982), each film was based on a simple case history, formulated into a written script, and designed to present one or two main points as a stimulus for discussion. New trigger points were expected to emerge. Each scripted scenario was composed to represent a consultation that a doctor may face in actual practice. Scripts centred on: the problem that the patient was consulting with; the doctor and patient characteristics; and, the trigger point the film was designed to explore (see Table 2). A review of the previous literature, findings of the first two studies of the thesis,

conversations with a wide range of health professionals in the field, and consultation with the Healthy Living Panel at the University of Bath informed the objectives of each film clip and the narrative, both central to the development of the script. Although the scripts were written in advance of the filming, they were expected to evolve during the production process.

Several experts were consulted to ensure the script represented a believable clinical scenario. Advice was sought from health care professionals, academics from within and outside the University with experience of producing videoed consultations, and the University Healthy Living Panel group made up of members of the public. These experts advised on the ecological validity of the communicative behaviour and the context. Several GPs advised on the appropriate medical language to use and the nature of the clinical examination to enhance viewers' perception of reality. The professional film maker involved in the project advised on the fluidity of the scripts. The films were made in an actual general practice consultation room to enhance realism and incorporate contextual factors

Table 2

The objectives and trigger points of each film

	Trigger film 1	Trigger film 2	Trigger film 3
Plot	Paul consults with knee pain	Eleanor consults with heel pain (Plantar Fasiitis)	Pauline consults with ear ache
Objective	To explore GP 'avoidance'	To explore patient reaction	To explore a 'health promotion' approach to raising the topic

Trigger point	GP avoids raising the topic	Patient does not want to talk about weight	GP asks patient if she wants to talk about smoking, alcohol consumption, diet or fitness

A decision was made to include a segment of the consultation, rather than the whole consultation, in each film clip. Although some researchers argue that an abridged version of a consultation may come at the expense of ecological validity (Hillen et al, 2013), short film clips (i.e. approximately 2 minutes in length) were considered to be pragmatically suitable since they maintain viewers' attention and reduce time needed with research participants during data collection.

A decision was made to use professional actors in the films rather than qualified health professionals or lay people to represent the doctor and three patients. This decision was made because studies have reported that is often difficult for health professionals to adhere strictly to, and repeatedly play several slightly different versions of a script, and portray different styles of consultation behaviour (Hillen et al, 2013). Actors were selected based on personal characteristics that matched the character they were supposed to portray in the films. Given the nature of the research question and the purpose of the films, the appearance of the characters were important. A casting agency were briefed on the characteristics of the actors required which included actors with a BMI above 30 kg/m², two female characters and one male character, and a range of ages. Four actors in total were selected from a shortlist of actors who matched the selection criteria. Patients differed in age and gender to allow for a greater variety of patient characteristics to spark discussion and to reflect the diversity of patients that practitioners consult with in clinical practice. Given that the trigger films were about a potentially sensitive topic, the casting agency were asked to send all actors an information leaflet about the content of the films prior to signing up.

In order to convert the scripts into film clips, the lead researcher collaborated with Therapeutic Media, a local professional film company. The company had experience of working with the University and had filmed a range of other health and wellbeing topics. The actors were directed by the lead researcher (MB) and

drew on the expertise of the video company to produce cinematic effects in-line with the objectives of each of the trigger films. In particular, camera perspective, shot emphasis, camera movement and stylistic approach were discussed with the video company.

3.7.3 Piloting the trigger films

Due to the novelty of using trigger films, extensive piloting was essential. Potential participants, peer researchers and members of Wiltshire Public Health were involved in piloting the trigger films. The purpose of piloting the trigger films was to investigate legitimacy (i.e. if people saw the videos as representing a believable clinical scenario) and to provide an opportunity to refine the interview questions and my interviewing technique. Initially, the films were viewed by a group of health professionals attending a motivational interviewing seminar at the University of Bath. Pilot interviews were then carried out with five GPs. The films were also viewed and discussed with my academic supervisors, peer researchers and two members of Wiltshire Public Health team.

Piloting the film clips indicated that three trigger films were appropriate for each interview, generating adequate depth of discussion whilst allowing for a broad range of topics to be discussed. Interview questions were also tweaked to reflect emergent themes and to ensure flexible and smooth use of the videos for future interviews.

3.7.4 Strengths and limitations of using trigger films

A key strength of using trigger films within interview studies is that they represent novel stimuli, particularly to psychological research. Psychology has been criticised historically for the limited exploration of the visual, with researchers recognising that it closes off a whole range of questions and topics that may improve our understanding of everyday social life (Beloff, 1997). Visual research allows a greater engagement with 'multi-modal' forms of communication in order to further understanding of social and psychological phenomena (Reavey & Johnson, 2008).

In regards to the limitations of using trigger films, the study may have been less appealing to those GPs unfamiliar with video methods for researching and/or teaching. However, videos of consultations are increasingly used in medical education (De Leng, Dolmans, Van de Wiel, Muijtjens, & Van Der Vleuten, 2007)

thus it was not considered to exclude a substantial number of GPs. Another limitation is around representation and how images are interpreted. The meanings that people derive from the images are varied (Collier & Collier, 1986) and visual data has been criticised as being 'ambiguous' (Frith, Riley, Archer, & Gleeson, 2005). However the films were not being used as an interpretative tool concerned with the 'truth'. Rather they were being used to trigger 'discourse' within a study situated within a social constructionist epistemological framework which as I will go on to discuss which is interested in multiple realities, wider societal and cultural discourse and the co-constructed nature of research (Burr, 2003). Therefore remaining transparent and reflexive when conducting and reporting the use of the trigger films, particularly about the co-constructed nature of the findings, was considered essential.

3.7.5 Access to the trigger films

Stills from the three trigger films are shown in figures 1 to 3 below:

Figure 1: Trigger film of Paul consulting with knee pain

Figure 2: Trigger film of Eleanor consulting with heel pain

Figure 3: Trigger film of Pauline consulting with ear ache

To access the set of trigger films, use the following link:

http://doi.org/10.15125/BATH-00162

3.8 Study 3
3.8.1 Epistemology and theoretical perspective

Social constructionism informs the theoretical perspective of study 3. As was discussed earlier, several commentators from within and outside psychology argue that in order to capture the complexities and contexts of psychological phenomena, there is a need to look beyond positivism (Gergen, 1999; Lincoln & Guba, 2000; Riggs, 2004). In regards to epistemology, social constructionism assumes that meaning is constructed not discovered and that this meaning is constructed in different ways by different people regarding the same object or phenomena (Crotty, 1998). It therefore presents a challenge to the objective basis of conventional knowledge (Gergen, 1985). Rather than searching for objective truth, studies informed by social constructionism are concerned with exploring the processes that construct the object. As Crotty affirms "what constructionism drives home unambiguously is that there is no true or valid interpretation" (Crotty, 1998, p. 47). He goes on to assert:

> "There are useful interpretations, to be sure, and these stand over against interpretations that appear to serve no useful purpose. There are liberating forms of interpretation too; they contrast sharply with interpretations that prove oppressive. There are even interpretations that may be judged fulfilling or rewarding- in contradistinction to interpretations that impoverish human existence and stunt human growth. 'Useful', 'liberating', 'fulfilling', 'rewarding' interpretations, yes. 'True' or 'valid' interpretations, no". (Crotty, 1998, p. 47-48).

By rejecting the notion that knowledge is objective and that there is one truth, and by taking a research approach which examines the variation in how objects and subjects are understood by different people, social constructionism opens up possibilities for alternative ways of understanding (Berger & Luckman, 1966; Bury, 1986).

The underlying assumptions of social constructionism alter the focus of research concerning how we understand people and social action. Rather than trying to elicit cognitions and motivation which would imply that the knowledge in an individual's mind will enable us to understand behaviour, attention is turned to inter-subjectivity and the social construction of knowledge and meaning (Crotty, 1998). Traditionally psychology has been focused on measuring and predicting pre-

defined variables such as 'attitudes' and 'knowledge'. As a discipline, it is underpinned by an essentialist theoretical stance which suggests that there is a pre-determined nature of the world or people (Crossley, 2001). However, social constructionism asserts that these categories are constructions which produce a certain kind of subjectivity and creates divisions which could have been otherwise. Psychology presents only one way of seeing the world and this is partial rather than the 'truth' (Burr, 2003; Crossley, 2001). Social constructionism thus warrants a move away from the 'psyche' and instead encourages a focus on the constructive nature of language and explanations that reside in the social situation (Burr, 2003). Meanings are socially created and socially shared thus there is a need to go beyond the individual. Social constructionism relocates problems away from the individual to the social practices and interactions that individuals engage in (Burr, 2003). Knowledge becomes what people do, it is fabricated in every day interactions, rather than what they have (Burr, 2003). In the case of obesity and the problematic nature of raising the topic, it can be seen as a construction that emerges through the interaction between patient and health professional embedded within a wider socio-political and cultural context.

Social constructionism also encourages us to look at the particular social and economic arrangements that prevail in our culture and shape how we view human behaviour (Burr, 2003). Ways of understanding are particular to specific cultures and periods of history and therefore we should not assume that our ways of understanding will bring us nearer to the truth than other ways, and we should extend our research focus from the individual to the social, political and economic realms of social problems (Burr, 2003). Consideration is given to the social origins of taken-for-granted assumptions and "the social, moral, political and economic institutions that sustain and are supported by current assumptions about human activity" (Gergen, 1985 p. 2672).

Another underlying assumption of social constructionism is that institutions, social structures and practices limit and constrict the free flow of discourse (Hook et al, 2001). The discursive powers of disciplines like medicine and psychology constrain what can be said, written and known about a phenomenon or subject. As Cheek asserts:

"According to the prevailing discourse in 'power', 'truth' status is achieved. In contemporary healthcare, the truth status of medical/scientific discursive

frames has shaped dominant taken-for-granted understandings of what is appropriate and authoritative practice (....) At any time in history, certain discourses will operate in such a way to marginalise or even exclude others. Which discursive frame is afforded presence is a consequence of the effect of power relations". (Cheek, 2004, p. 1143).

Social constructionism encourages deconstruction to achieve alternative ways of understanding: by disrupting and destabilizing boundaries, new ways of thinking and knowing can be achieved (Gergen, 1999).

Since social constructionism takes the view that knowledge is constructed between people, language is of great interest. Language is the site through which meaning is made, maintained and contested and provides a framework of meaning for people to think within (Burr, 2003). The view taken of language within social constructionism differs to that taken by researchers in traditional psychology who tend to hold the "tacit assumption that language is a more or less straightforward expression of thought, rather than a pre-condition of it" (Burr, 2003, p. 8). Social constructionism disputes the proposition that language is just descriptive and asserts that its use is influenced by and influences wider society. A fuller explanation of this will be provided further in the chapter.

It is important to point out that although social constructionism views reality as being socially constructed, it is not asserting that it is not real. Things can be socially constructed in that they often exist because of 'the rules of the game' and are at the same time real (Crotty, 1998). Social constructionism then is realist in the sense that it does not confine meanings to only those in the mind, however it does deny that our knowledge is a direct perception of reality and asserts that all knowledge is derived from looking at the world from a certain position (Burr, 2003). It also takes a relativist stance – it views phenomena as being interpreted within historical and cultural conditions, rather than taking the view that eternal truths exist. This demonstrates that interpretations of the same phenomena are likely to be highly divergent in different time periods and in different locations (Crotty, 1998). Different individuals inhabit different worlds and these worlds constitute "diverse ways of knowing, distinguishable sets of meanings, separate realities" (Crotty, 1998, p. 64). A social constructionist's concern is thus with reading representations of the world rather than gaining access to reality.

3.8.2 Language

Social constructionism views language as constantly changing and varied in its meaning. Throughout a text, meaning weaves in and out of it. Similar to a post-structural stance, the thesis takes the view that language provides people with a way of structuring their experience of the world. The concepts we use are made possible by the available language and are the way we come to understand ourselves (Burr, 2003).   In an effort to make sense of things, the categories and concepts existing in our cultural milieu and which divide up the world are impossible to escape and have implications for how we understand experience. These categories and concepts are linked with the type of society we live in and thus are revealing about the cultural context people inhabit. Language is of such importance to social constructionism because it is viewed as the locus at which identities are constructed between people in interaction. The focus is thus on the social realm rather than at the level of the individual. This implies that meaning is never fixed, is always contestable and language therefore becomes the site of potential disagreement and conflict regarding meaning (Burr, 2003). The focus on language in social constructionism then reinforces that what is said about an object and the way language represents such objects in certain ways, has implications.

3.8.3 Discourse and morality

A social constructionist position considers how 'obesity' (the medical label attributed to certain body sizes) and related social practices are constructed through discourse. According to Ian Parker, things can be endowed with three types of existence: ontological, epistemological and moral/political (Parker, 1990). Ontological existence refers to the existence of objects without thought processes and/or language. Investigating the discursive construction of things with ontological existence takes a view that the discursive is conveyed through material difficulties. Epistemological existence refers to those things which have been given meaning by discourse (Burr, 1995). 'Overweight' and 'obesity', at least within a medical framework, have become known as a 'health threat' or a 'risk factor' due to medical discourse positioning body weight in this way and thus, certainly for health professionals, this is likely to be the meaning they attribute to large bodies. This meaning is relative to the current time and culture we live in. Third, moral/political existence is a classification that refers to those things that have been constructed through discourse and through this construction are seen to be real. Things with moral/political existence may be treated as if they have the same kind of reality as

things with ontological status (Burr, 1995). For example, the dangers of obesity, and obesity as a 'global epidemic', have come to be seen as concrete reality. Viewing obesity as a social problem comes to be seen as the truth and other ways of viewing it are closed down. Biomedical and social scientific literature often construct people with obesity as at 'high risk' and as being a drain on the NHS, shaping views that these ways of regarding obesity are the only reality. Once objects are constructed by discourses in this way, it is very difficult to refer to them as anything but real (Parker, 1990). Social construction helps us recognise that the categorisation of obese people requiring medical intervention is not natural. Whilst not denying the ontological existence of the associated health risks with obesity, 'obesity' is constructed as an epistemological and moral/political reality and it is these constructions which are important when trying to understand the thesis research question.

Social constructionism helps us see that language has a performative role operating within a moral framework i.e. within "the sets of rules and conventions about right and wrong and correct behaviour within which the person is currently operating" (Burr, 2003, p. 135). When people account for their/other people's behaviour they do so not to explain reality but to justify, offer explanations, give excuses, appropriate blame and accuse (Burr, 2003). Individuals operate in a moral universe and concern themselves with maintaining a credible and creditable position (Burr, 2003). An assumption of discourse analysis is that people draw on 'discursive repertoires' which relieve them of a moral responsibility for action and validate the status quo (Wetherell & Potter, 1998). Another assumption of the approach is that people construct things in particular ways, not to communicate their internal state but to represent themselves in a positive and beneficial way.

Finally in relation to morality, discourse analysis identifies the subject positions that discourse make possible (Davies & Harré, 1999). A subject position can be defined as "a location for persons within the structure of rights and duties for those who use that repertoire" (Davies & Harré, 1999, p. 35). Subject positions bring with them a structure of rights and obligations, and legitimise what a person can or cannot say and do i.e. prescribes a set of moral codes. Subject positions allocate what is possible or not possible for us to do, what is right and appropriate and what is inappropriate (Burr, 2003). This is relevant for a study including GPs

who abide by or resist the moral code inherent in their position of medical expertise and also position 'patients' in particular ways.

3.8.4 Subjectivity

According to social constructionism, subjectivity (our subjective experience) is governed by the wider social structures in which we are embedded. In this way, social structures speak through people, "it is as if we internalise the ways of representing human life present in discourses (…) and our subjective experience flows from that" (Burr, 2003, p. 119). This is an important point of departure from traditional perspectives in psychology. Burr (2003) sums this up nicely:

"Social constructionism, then, replaces the self-contained, pre-social and unitary individual with a fragmented and changing, socially produced phenomenon who comes into existence and is maintained not inside the skull but in social life". (Burr, 2003, p. 104)

Social constructionism then is proposing that discourses, ideologies and institutional practices constitute individual identity (Danaher et al, 2000) and that entities such as 'attitudes' and 'personality' have been brought into being through language with no concrete existence. In Western societies we take up a discourse of individuality (Burr, 2003) which has certain possibilities for what it means to be a person. Although this view appears deterministic, the possibility of agency exists. Discourses are constraining to the extent that they are powerful forces yet individuals are able to negotiate their identity within the available discursive resources. Individuals thus experience a tension between constructing their own reality and having it constructed for them (Potter & Wetherell, 1987). An important goal for researchers using discourse analysis is to identify the points of rupture and opportunities for alternative constructions.

The concept of subjectivity in the current thesis is relevant to the way that identities of both health professionals and patients are attributed by speakers. Identity is constructed out of the discourses culturally available, it is a "subtle weaving of many different threads" (Burr, 2003, p. 106).   Willig (1999) raises awareness of the way discourse constrains and the limited possibilities it provides: "individuals are constrained by available discourses because discursive positions pre-exist the individual whose sense of 'self' (subjectivity) and range of experience are circumscribed by available discourses" (Willig, 1999, p. 111). Put another way,

people come to understand their behaviour and to experience themselves in the way that discourse prescribes (Gillies, 1999).

Since discourses represent people in particular ways, it is helpful to look at how people with obesity have been represented by the discourses prevailing in Western society. Researchers have identified a common perception and hence prevailing discourses that 'obesity' is caused by individuals simply eating too much unhealthy food (LeBesco, 2011), biomedical discourses that position obesity as a health risk (Campos, 2004; Gard & Wright, 2005) and discourses which represent body weight as a consequence of lifestyle and thus as an individual's personal responsibility (Saguy & Riley, 2005; Throsby, 2007). Critical obesity researchers (those researchers who challenge medical constructions of obesity) argue that there is a dominant discourse or 'collective knowingness' about people with obesity which categorises and frames these individuals as lazy and unwilling to change (Murray, 2005) thus they ('obese people' who are typically grouped into a uniform category) have become morally reprehensible. Interestingly, discourses opposing such harmful representations are increasing, taking up broad, liberal humanistic principles (e.g. Aphramor, 2005; Bacon & Aphramor, 2011; Tischner & Malson, 2012) thus demonstrating resistance in the research field around how obesity is constructed. This leads us onto the idea of power, which along with knowledge is the focus of the next section.

3.8.5 Power and knowledge

Discourses regulate our knowledge of the world thus it is important to consider what we mean by knowledge. According to social constructionism, knowledge refers to "the particular construction or version of a phenomenon that has received the stamp of truth in our society" (Burr, 2003, p. 68). For Foucault, knowledge is intimately bound up with power. This is because knowledge brings with it implications for acting in one way or another and the potential for marginalising certain ways of behaving. Power can be exercised by drawing upon discourses which explain our actions in an acceptable light. Power is thus an effect of discourse. As Burr points out, knowledge is constantly changing because there are always multiple 'versions of events' or discourses around an object.

> "Given that there are always a number of discourses surrounding an event, each offering an alternative view, each bringing with it different possibilities for action, it follows that the dominant or prevailing discourse, or common

sense, is continually subject to contestation and resistance." (Burr, 2003, p. 67)

Power relations are thus a key concern to researchers using a methodological approach informed by social constructionism. Challenging dominant constructions and questioning the related social practices are two functions of the methodological approach. The identification of resistance within discourse is also important since it signals that the power implicit in another discourse is apparent. An implication of discourse analysis is that there is always the opportunity for new discourses to dislodge current prevailing discourses from their position of truth.

3.8.6 The implications of constructions/discourse

A social constructionist position promotes an investigation into the consequences of the current meanings imbued in discourse. When meanings come to be ascribed to particular categorisations, there are implications for social practice. Discourses which produce knowledge, bring with them possibilities for acting in the world and thus have material effects on people's lives and reproduce or resist established power relations and institutions (Willig, 2001). In relation to this thesis, discourses used to construct obesity and the practice of talking to patients about weight will have implications for how people with obesity (and health professionals themselves) are positioned as subjects with rights and obligations that influence their health care as well as what can be done to them.

Researchers espousing a social constructionist perspective bring some hope for change. Findings of their studies can help those in positions of power to recognise the potential implications of the discourses they adopt in their talk about health and illness. A discourse analytic approach is able to capture the dilemmas that health professionals face and researchers can suggest ways for actors to escape the dominant discourses which shape health professional-patient interaction. Foucault discussed 'consciousness raising' which could be achieved by the opening up of marginalised discourses to reveal alternative possibilities. Discourse analysis is also useful for revealing assumptions and as the thesis will go on to discuss, in the case of obesity, these assumptions can have damaging consequences.

3.8.7 Discourse analysis

Study 3 will use discourse analysis as the methodological framework underpinning the study. More specifically, the type of discourse analysis used relates to macro social constructionism and the emphasis will be on "the way that the forms of language available to us set limits upon, or at least strongly channel, not only what we can think and say, but also what we can do or what can be done to us" (Burr, 2003, p. 63). This approach is influenced by Michel Foucault and thus is a type of Foucauldian discourse analysis. The approach involves identifying discourses, a discourse being defined as "practices which form the objects of which they speak" (Foucault, 1972, p. 49). By referring to "a set of meanings, metaphors, representations, images, stories and so on" (Burr, 2003, p. 64), discourses represent objects and subjects in certain ways and paints a particular picture of the phenomenon. The focus will shift from identifying individual attitudes and motivations to the shared discursive resources that are used to construct obesity.

The approach to discourse analysis used in this thesis will be informed by Ian Parker (1992) and Carla Willig (2001). The ways in which power relations are produced and reproduced through discourse will be a key focus and attention will be paid to the role of the discursive in constructing obesity in particular ways which have important implications, including effects on patient care.

3.8.8 The design of Study 3

The approach taken to conduct the discourse analysis was informed by Ian Parker's text *Discourse dynamics, Critical analysis for Social and Individual Psycholog*y (Parker, 1992). The seven criteria laid out for identifying a discourse ensured the analysis was conducted in a systematic and rigorous way. In the table below, I have summarised each of the criteria provided by Parker and which informed the methodological approach taken:

Table 3

Overview of Parker's criteria for distinguishing discourses

Criteria	Summary
A discourse is realised in texts	Objects of study are texts, described and put into words. A discourse is at work in texts, it is doing something and thus there is a need to explore inferences, allusions and implications

	that the texts evoke. Texts are defined by Parker as "delimited tissues of meaning reproduced in any form that can be given an interpretative gloss" (Parker, 1992, p. 6).
A discourse is about objects	A discourse represents an object through previous uses of discourse and by drawing on/alluding to other discourses. Many of the objects referred to and defined by discourse do not exist in a realm outside discourse. Therefore the analysis asked what objects were referred to and how they were described i.e. it unpicked the ways in which objects were talked about.
A discourse contains subjects	Parker asserts that "we cannot avoid the perceptions of ourselves and others that discourses invite" (Parker, 1992, p. 8). Discourses address us in particular ways and allow us to perceive ourselves in certain roles. When an individual adopts a particular subject position, which might have been assigned to them by others, their identity becomes shaped since limitations are imposed upon their possibilities for seeing and thus acting in the world. Therefore in using discourse analysis I sought to identify the rights and obligations of subjects within participant's accounts.
A discourse is a coherent system of meanings	Discourse consists of a group of statements that present a particular picture of the world. The analyst should map this world including the rules and boundaries.
A discourse refers to other discourses	"Discourses embed, entail and presuppose other discourses" (Parker, 1992, p. 13). To disentangle discourses, it is useful to look at different ways of speaking about an object by comparing and contrasting them. The interrelationships between discourses are thus important.

A discourse reflects on its own way of speaking	By reflecting on the terminology used and the other texts used to elaborate, it is possible to attend to different levels of meaning particularly the implicit meaning which is rarely voiced but is part of the way of thinking about things. This entails the analysts taking a moral and political stance on issues involved in discourses.
A discourse is historically located	By exploring how discourses emerge, are embedded in history and how these discourses have changed over time, it is possible to reveal what present allusions refer to. The analyst is thus looking at how discourses change and tell a story. Rather than making assumptions about what a person means to express, it is necessary to look underneath the text to the historical and cultural discourses that shape the way in which the research participant is able to communicate about the topic.

Note. Adapted from "Discourse Dynamics Critical Analysis for Social and Individual Psychology" by Ian Parker, 1992, p. 3 – 22 and Shaw & Greenhalgh, 2008.

3.8.9 Justification for undertaking a discourse analytic approach

In a review on the use of discourse analysis in health care research, discourse analysis is described as a powerful way to "bring to light the operation of taken-for-granted practices in healthcare delivery that sometimes work to the disadvantage of patients or professionals themselves" (Traynor, 2006, p. 70). This points to the potential that discourse analysis has to explore the power relations inherent in all aspects of health care. It also points to how discourse analysis works to reveal taken for granted and hidden aspects of health care.

Through analysing how discourse shapes and influences behaviour, and provides ways to construct and give meaning to the world, it is possible to read the text for implicit values and power relations. Discourse analysis presents a challenge to dominant knowledge about a social problem like obesity, in order to demonstrate that things could be different and that there are a diverse plurality of

understandings surrounding the topic. In this sense, the analysis raises awareness of conflicting discourses and opens the issue up to political debate (Gee, 2004; Murray & Campbell, 2003). Another reason to undertake discourse analysis is the 'three dimensional' approach it takes to research by connecting the text to historical and social contexts, revealing the complexities of the problem, rather than concealing them (Fairclough, 1992). Discourse analysis gives a rich and nuanced picture within a particular setting, by moving beyond the individual (and their words) and instead takes the view that what is said draws on and thus reflects part of a wider, shared cultural context (Crowe, 2005). It is this wider shared cultural context which is important to learn more about since it shapes and thus reinforces social practices.

Although discourse analysis is not seeking answers, it does look for meanings that contribute to a particular view. For this thesis it contributes insight into how GPs have come to construct 'obesity' in the way they have and allows us to learn more about how their constructions contribute to making weight a 'problematic' topic to talk about. The way GPs talk about obesity, the way their words invoke powerful imagery and narratives creates shared identities and thus shapes their social practice.

Discourse analysis seems to be a particularly useful approach to apply to the thesis for two reasons. Firstly, whilst studies have explored GPs views on practice in the area of obesity, the majority of studies have approached the topic from a traditional psychological perspective. By doing so they assume that language is reflective of reality and do not question how the reality respondents talk about is mediated by powerful socio-political discourses in the cultural context they inhabit. In addition, they endorse the view that people are driven by cognitive factors such as attitudes and motivations thus assuming a 'psychologised' subject (Rose, 1990) and all related assumptions. I would argue that this has limited the research to date and in order to contribute new knowledge to the debate, there is a need to question such assumptions and start from a different perspective. As the limited studies in the area have demonstrated, a social constructionist perspective enables us to see that 'obesity' is more than a linguistic term to describe a bio-medical condition, rather how obesity is understood is mediated by powerful social and moral meanings which enable and constrain how it is talked and thought about (Throsby, 2007; Kirk, 2014). Second, there is nascent scholarship in the area which has

demonstrated the multitude of discourses surrounding obesity. This includes discourses of obesity which are dominant and generally oppressive circulating in the media (Rich, 2011), social policy (Evans, 2006; Piggin & Lee, 2011; Townend, 2009), educational settings (Evans, Davies, & Rich, 2008) as well as the medical and public health arena (Bell, McNaughton, & Salmon, 2009; Warin, Turner, Moore, & Davies, 2008). To contribute to this debate, and to allow this specific area of research to reap the benefits from the broader research debate, discourse analysis was judged to be an appropriate research approach.

3.8.10 Limitations of discourse analysis

It is important to acknowledge two characteristics of discourse analysis which impacts on how readers understand this research. First, since discourse analysis draws on social constructionism, it is important to acknowledge that the study design is unable to escape the critique that the findings of the study are just one way of accounting for a social phenomenon and are themselves a product of social construction. It is thus important for me to account for my own contribution to the discourse in the interaction with research participants. I endeavour to be transparent about my involvement in the study and thus readers should bear in mind that I am merely giving my reading of the text rather than claiming truth and that my involvement in the study will have implications on the findings I produce. It can be expected that another researcher would produce both different interview data and a different reading of the texts.

Secondly, as a researcher it is problematic to escape the limitations and constraints on thinking that also effect participants. Although social constructionism relies on researchers taking a critical approach toward 'taken for granted' knowledge, as a researcher situated in an institution (i.e. the Department for Health at the University of Bath), I am limited in the extent to which I can comprehend the world in a different way to the framework which structures my thinking. Deconstruction and reinterpretation are thus constrained by my position embedded within an institution. As Fish (1980) asserts:

> "The mental operations we can perform are limited by the institutions in which we are already embedded. These institutions precede us, and it is only by inhabiting them, or being inhabited by them, that we have access to the public and conventional senses they make". (Fish, 1980, p. 331-332)

3.9 Ethical NHS and Research and Design approvals

During the PhD I submitted ethical and NHS R&D applications on two occasions. The first was approved in November 2012 for study 1 and 2 (Ref: EP 12/13 1) and the second was approved in January 2014 for study 3 (Ref: EP 13/14 43). On each occasion ethical approval was granted from the Department for health and the Department of Psychology at the University of Bath.

For studies 1 and 2, R&D approval was gained on behalf of NHS Wiltshire (Ref: 2012/065). For study 3, R&D approval was gained on behalf of NHS Wiltshire CCG, Bath & North East Somerset CCG and Swindon CCG (Ref: 2013/074). The R&D approvals confirmed that the studies met nationally agreed research governance criteria.

3.10 Reflexivity

Reflexivity refers to paying attention and making explicit the ways in which I, as a researcher, have contributed to the data collected and to exploring how my own a priori assumptions have shaped the data analysis (Murphy et al, 1998). Findings of research are inevitably shaped and constituted as objects by the research process (Henwood & Pidgeon, 1992), it is thus necessary to reflect on the theoretical assumptions and tools used to generate the data. Furthermore, the social relationships embedded in the interview situation, can never be separated from the resultant data, thus as a researcher I am obliged to reflect on my impact on the setting and interviewees (Altheide & Johnson, 1994). I will now discuss my own position in the research, particularly in relation to the GPs and nurses I interviewed and the strategies I used to maintain reflexivity throughout the research timeline.

In relation to my position in the research process, it is highly relevant to acknowledge that this changed quite profoundly over the period of the PhD. As is obvious from the chronological order of the empirical studies, as a researcher I began with a theoretical orientation similar to the so-called medical model using theory from the field of health psychology which was well suited to my own educational background which included an Undergraduate Degree in Psychology and a Masters Degree in Organisational Psychology. I had thus never been exposed to a critical or sociological orientation to research. Discourse analysis was an approach first suggested by my supervisor in light of my frustration resulting from

using a methodological approach which I felt was inadequate to capture the complexity of the data. This transition has been both challenging yet worthwhile since it has enabled me to capture new dimensions in the research findings and recognise limitations in previous attempts at understanding GP and nurse behaviour in this area which are predominantly based on qualitative methods subscribing to the medical model (Murphy, 1998) which fail to take account of multiple realities, power dimensions and the constructive nature of talk. However it has also raised my awareness to the co-constructed nature of my research findings and I no longer claim to reveal the truth but to provide an account of my own readings of data produced to investigate a research problem specified by a range of people including myself, supervisory team and the funders of the research.

It is also necessary to comment on my position as a student researcher with no clinical or other work experience in general practice, undertaking a PhD sponsored by the local public health team. I explained this to the GPs and nurses I was interviewing, who on the whole were positive about research being conductied in an important area of their practice. Over the time period that the research was carried out, obesity became a 'hot topic' in the media (Saguy & Gruys, 2010), with particular emphasis on the financial cost of obesity to the NHS. It also appears to be a topic of growing importance for medical bodies such as the RCGP and RCP (Pryke et al, 2015; RCP, 2010). Whilst at times feeling disadvantaged about my lack of clinical experience, particularly during interviews when I had to occasionally ask interviewees to expand on their use of clinical terms or inferences, at other times I believe my non-clinical background was beneficial. For example, there were instances during data collection when clinicians discussed their lack of expertise or ambivalent feelings towards obesity, in which case I felt it was more useful to retain neutrality in the sense of non-judgement and to employ facilitative strategies to encourage clinicians to discuss their own professional or personal struggles with obesity which may have been more difficult to do with a researcher who also occupied a clinical position and was caught up in the power dynamics of medicine. I am also aware, both from my time in the research field and from my personal life, that there is some frustration from NHS clinicians about the government and the apparent lack of government involvement in obesity reduction efforts. As the thesis goes on to describe, obesity is a very political topic. It should be borne in mind that many clinicians may have decided not to take part in the research due to awareness that the research was sponsored by Public Health Wiltshire and those that did, gave

accounts fully informed that findings would be fed back to the sponsor. Finally, the focus of the PhD relates to both my own interests and emerged in collaboration with Wiltshire public health team who expressed a need for this research. Perhaps like many researchers who decide to conduct applied health research, I came to the field with a desire to produce findings which would help people in society and had a curiosity about 'obesity' although little real insight into the condition. Whilst I now take a more critical view on this endeavour, I continue to find the area of health research, albeit that with a societal rather than psychological orientation, both fascinating and a worthy pursuit.

In regards to the strategies used to monitor my impact on the setting, I followed the advice of health technology guidelines which suggest the use of peer-debriefing. This strategy provides an opportunity for discussion about the circumstances of the data collection with others not closely involved in the day-to-day research (Guba, 1981). I also took opportunities to present my research to other students and staff within the Department for Health at the University of Bath, including to audiences of researchers with qualitative expertise. I also used supervisory meetings to discuss any concerns, challenges and confusions I had about the data analysis process. A particularly memorable period of reflection occurred during a supervisory meeting and was around the ethical implications of publishing given my recognition of the limitations of the study design of study 1 and 2. This was an important part of my research training since I learnt the value of making my personal and theoretical biases explicit in the reporting of research, aligning with best practice in qualitative research (Marshall, 1985). It was also as a result of reflecting on my use of the TDF for study 1 and 2 during supervisor meetings that I changed the focus of study 3 to use discourse analysis rather than another qualitative method aligning more towards realism than constructionism. Thus constant reflection as data collection continued allowed me to use reflexivity to enhance the use of research findings within the thesis.

Finally, it is important to acknowledge that I have positioned myself in a very different way in study 3 compared to studies 1 and 2, and as such make different claims about the research findings. This is largely an outcome of the different methodological approaches used. Whilst I claim that the research findings are valid and reliable in studies 1 and 2, and made attempts to improve these criterion (such as asking another member of the research team to code the data), in study 3 my

aim is to provide a subjective reading of the text and as such I am not claiming to be revealing the truth or findings which can be generalised.

3.11 Conclusion

The aim of this chapter was to outline the methodological approaches taken in the thesis. The chapter began with an outline of the aims of the thesis and in chronological order, discussed the three empirical studies. I described the ontological and epistemological assumptions grounding the two methodological approaches and theoretical concepts used to structure and interpret the empirical data.   The stimuli created from findings of studies 1 and 2, and used as a data-collection tool in study 3, was also described. The following empirical chapters will give greater insight into the methods employed and describe the subsequent findings.

Chapter 4: Identifying barriers to raising the topic of weight in general practice: the perspectives of GPs

4.1 Introduction

Having laid out the methodological underpinnings of the thesis in the last chapter, I will now report the findings of the first empirical study. This chapter describes a qualitative study which involved conducting semi-structured interviews with 17 GPs about their views on broaching the topic of weight in general practice consultations. The study was underpinned by behaviour change theory with the TDF being used to inform the interview schedule and guide analysis of the data. The TDF allows exploration of the full range of barriers that may hinder GPs from initiating discussions about weight and demonstrates barriers that warrant further investigation. The findings are presented in relation to behaviour change theory and at the end of the chapter, I outline the implications for practice and suggest future research directions. It should be noted that the findings of this study have been combined with study 2 and peer-reviewed and published in the BMJ online. A copy of the published manuscript is included within the appendices (Appendix A).

4.2 Background to the study and research question

Studies report that less than half of obese patients are advised by primary care health professionals to lose weight (Abid et al, 2005; Kirk et al, 2012). This is despite evidence-based guidelines recommending that primary care clinicians should identify, classify and offer clinical management for overweight and obesity (NICE, 2014, cg 189). Researchers have sought to understand why GPs are reluctant to offer weight management interventions and have concluded that lack of time, limited training, worry of offending patients and low expectations of success contribute to their low engagement (Epstein & Ogden, 2005; Michie et al, 2007; Teixeira et al, 2015). Whilst several studies have suggested that one of the barriers to offering weight management in primary care is raising the issue in the first place, that is, initiating discussion in the consultation (Chisholm et al, 2012; Michie, 2007; Scott et al, 2004), there is a paucity of research which gives insight into this phenomenon. Given the complexity of primary care consultations, many researchers suggest qualitative investigation which is able to capture the nuance and dynamic nature of those factors influencing doctor-patient encounters and individual behaviour is needed (Sussman et al, 2006). Thus in order to learn more

about the full range of factors that impede GPs from talking to patients about weight in general practice, a research method capable of generating qualitative insight into the research problem was sought.

One way that researchers have generated knowledge on implementation problems, that is when there is a gap between health professional practice and evidence, is through the application of theoretical models. One such model is the theoretical domains framework (TDF) (Michie et al, 2005) which is based on theories of human behaviour and behaviour change. The TDF is a conceptual tool developed to identify the causes of health professional behaviour(s) which deviate from evidence-based practice by focusing on individuals' perceptions of the determinants of their behaviour. Application of the framework facilitates understanding about how to change behaviour in future interventions through identifying domains of behaviour (potential mediators of change) that can be targeted in future interventions. The TDF was deemed to be suitable for this research seeking to identify clinician beliefs that relate to raising the topic of weight for several reasons. First, the TDF is an overarching theoretical framework which combines 128 constructs from 33 theories of behaviour change thus increasingly the likelihood that the model will include the full range of factors influencing behaviour. There is therefore no need for researchers to decide and rely on a single theory which increases the risk that important influences on behaviour will be missed (Cullinan et al, 2014). There is evidence that the use of the TDF captures barriers that would not otherwise be identified (Dyson, Lawton, Jackson, Cheater, 2011). Second, there is a growing body of research documenting the use of the TDF in qualitative studies with GPs (Mazza, Chapman & Michie, 2013; McSherry, et al, 2012; Murphy et al, 2014) suggesting the TDF is a useful tool to generate findings with this sample. Third, the TDF is apt to use for research focused on exploration of views and when little is known about the implementation problem. As outlined, to my knowledge little research has focused on the barriers to raising the topic of weight or used behaviour change theory to generate insights which can be used in future intervention studies. There is evidence that interventions based on theory are more effective than those based on intuition (French et al, 2012; Cane et al, 2012) thus the TDF serves a valuable purpose for implementation researchers.

Given the lack of research which gives insight into raising the topic of weight from the perspectives of GPs, the study sought to identify and describe GPs' beliefs and attitudes regarding barriers to raising the issue of weight in general practice. The identification of barriers was facilitated by drawing on the TDF given the suitability of the framework to include a broad and comprehensive range of determinants of health professional behaviour. The research question was: What are the barriers to raising the topic of weight in general practice identified from the views and perceptions of GPs?

4.3 Methods

4.3.1 Design

This was a qualitative study underpinned by the theoretical domains framework and drawing on content and thematic analysis. Semi-structured interviews guided by the TDF were carried out with 17 GPs. The original 12 domain TDF was used (Michie et al, 2005) given its application in many other implementation studies (Duncan et al, 2012; Pitt, O'Connor & Green, 2008; Amemori et al, 2011). In addition, when used to inform the interview schedule, 14 domains were judged to generate an impractical number of interview questions. However, it should be noted that the TDF was used flexibly and insight from both the 12 and 14 domain framework informed the study design.

4.3.2 Participant selection and recruitment

Ethical approval was sought prior to any recruitment or interviews being carried out. Approval was granted by the Research Ethics Approval Committee for Health (REACH) at the University of Bath (EP 12/13 1) and from the Department of Psychology. NHS Research and development (R&D) approval was also sought (2012/065). Purposive sampling and snowballing techniques were used to recruit a heterogeneous sample of GPs. The study adopted a multi-faceted recruitment approach. GPs working within one primary health care authority were invited to participate in the study. The researcher attended two practice manager meetings and included a flyer in the Primary Care Trust's monthly newsletter. An email was circulated to all practice managers in Wiltshire which included 58 practices (See appendix B). Snowballing techniques were used simultaneously- GPs and nurses who had already been interviewed or were known to the research team were asked to identify other people they knew who fit the selection criteria.

Participants were recruited until no new information and understanding from the interviews occurred. In order to establish data saturation, guidelines recommended for theory-based interview studies were followed (Francis et al, 2010). Firstly, a minimum sample size for initial analysis was specified: in this case 10 GPs. Secondly, a stopping criterion (i.e. how many more interviews will be conducted without new ideas emerging) of 3 was specified. These criteria were based on the methods sections of other theoretical based research involving interviews with health professionals (McSherry et al, 2012; Duncan et al, 2012) and general recommendations on sample size for interview studies (Guest, Bunce & Johnson, 2006). This resulted in a total of 17 GPs participating in the study.

4.3.3 Data collection

A semi-structured topic guide (appendix C) was developed based on the TDF and a literature review (see chapter 2).   Interview questions were based on factors that might influence beliefs about raising the issue of weight and were designed to explore the domains of the TDF while allowing participants to speak about topics important to them. The topic guide thus served as a framework for questioning. Prior to the interviews, the questions were piloted with three GPs (and one retired GP) to assess clarity and focus, and refine as appropriate. The interview schedule was used flexibly, tending to begin by asking participants the factors that triggered them to broach discussion of weight loss and then focusing on each of the 12 theoretical domains.

Face-to-face interviews were conducted by MB at a time and place to suit the participant. Interview locations included GP practice rooms, a University room and participants houses. At the start of each interview, participants were asked to confirm they had read the study information sheet (appendix D) and to sign a consent form (appendix E). They were also asked to complete a demographic form which included identifying their height and weight. Interviews were digitally audio-taped and transcribed verbatim into Microsoft Word. The interviewer transcribed 50% of the interviews, with the remainder being transcribed by an external transcription company. This was mainly a pragmatic decision due to time constraints.

4.3.4 Data management and analysis

Transcriptions were uploaded to NVivo (Version 10) for coding and data organisation. The analytic approach drew on other studies using the TDF which

adopt a two-phase approach to content analysis in which conventional analysis is used initially (familiarisation with transcripts and initial coding) followed by directed content analysis (texts are coded to a pre-defined list of domains) (Cullinan et al, 2015; Duncan et al, 2012).

The process of analysis included first becoming familiar with the data through reading and re-reading the transcripts to gain an overview of the entire data set, and then using a deductive approach to data coding. The accuracy of initial themes derived from a subset of the data, were reviewed by another member of the research team (Dr Afroditi Stathi) which helped guide the indexing of the remaining transcripts. Findings were also discussed with all three supervisors during monthly meetings.

Coding involved identifying a priori themes directed by the interview topic guide, unexpected emergent themes and recurring viewpoints. Both manifest and latent content was coded. Coding proceeded until all of the data that was deemed to be relevant to the research question had been coded. The unit of analysis (amount of data that was coded) included specific beliefs which were identified as barriers to raising the topic of weight. Coded data was allocated to the appropriate domains.

The thematic structure of the TDF was used as a framework to organise and locate the coded data. The TDF coding framework developed by Heslehurst et al (2014) was used to ensure code names were matched to the appropriate domains (appendix F). The framework was useful since it provided some rules around the categories or domains of the TDF including an operationalization of what the domain concerns. Barriers were identified and mapped to the domains if identified by at least two clinicians (i.e. two GPs or one GP and one nurse since analysis was conducted in parallel with study 2).

After coding and thematic mapping to the TDF domains, the lower-order themes were charted and organised into three salient higher-order themes that captured the range of experiences and views reported and which were manifested within the whole data set (Braun & Clarke, 2006). The TDF provided an analytic tool from which emergent concepts could be identified. The process of thematic analysis was carried out by combining study 1 and study 2 data thus the themes are evident in the findings of both studies.

4.4 Findings

4.4.1 Characteristics of GPs

Of the 17 GPs interviewed, 5 were partners, 6 were salaried (1 of whom was a GP assistant) and 6 were locums. Respondents came from rural, semirural and urban practices. Additional demographic data are presented in table 4.

Table 4

Demographic details reported by participants in study 1

		Number of participants
Sex:		
	Male	6
	Female	11
Age:		
	30-39	7
	40-49	3
	50-59	6
	60-69	1
Experience as GP/nurse in General Practice:		
	0-9 years	7
	10-19 years	3
	20-29 years	7
Weight status:		
	Normal (BMI 18.5-24.9 kg/m²)	9
	Overweight (BMI 25-29.9 kg/m²)	7
	Obese (BMI 30 kg/m² and above)	
	Not specified	1

4.4.2 Barriers mapped to the TDF and thematic analysis

Data analysis resulted in the identification of 24 barriers which were then mapped to 10 domains of the TDF (see table 5). It should be noted that a decision was made to split the 'motivation and goals' domain into two domains, 'motivation' and 'competing goals' which diverges from the original TDF framework (Michie et al, 2005). This decision was made during the analysis stage when domains were synthesised into themes. Although these barriers were judged to interact with one another, the empirical data suggested they were distinct barriers and splitting them into separate domains and subsequently themes, was judged to better reflect the data.   Thematic analysis resulted in the following three themes: Limited

understanding about obesity care, concern about negative consequences, and, lacking time and resources to raise a sensitive topic (see figure 4).

Table 5

Barriers mapped to the domains of the theoretical domains framework, derived from GP perspectives

Behavioural domain	Barrier
Knowledge	Lacking content knowledge of guidelines Not recognising obesity as a complex medical problem Uncertainty about raising the topic routinely
Skills	Uncertainty about how to raise the topic sensitively Uncertainty about how to raise the topic when patient is not consulting with related problem
Beliefs about consequences	Potential to damage the doctor-patient relationship Concern that patient will feel alienated and disengage from healthcare Beliefs about negative responses Potential to open a can of worms
Beliefs about capabilities	Feeling ineffective at helping patients with weight loss
Motivation	Desire to maintain a positive, non-judgmental relationship with patient
Competing goals	Prioritising other areas of patient care
Emotion	Fear of upsetting patients Feeling awkward/uncomfortable raising the issue Hopelessness Frustration
Professional role and identification	Threat to professional reputation Impact of own weight status Personal feelings about advocating weight loss
GP Practice and available resources	Having time to open up a sensitive issue Feeling like there's nothing to offer patients No continuity of care with patients
Social influences	Adhering to the patients agenda Perceptions about patient receptiveness to advice

Figure 4. GP barriers to raising the topic of weight synthesised into three analytic themes

Note. Reproduced and modified from Blackburn, Stathi, Keogh and Eccleston (2015).

4.5 Limited understanding about obesity care

The first theme synthesises barriers linked to two domains of the TDF: Knowledge and skills. GPs demonstrated that their knowledge was inconsistent with guidelines about when and how to raise the topic and they perceived themselves to lack the skills to raise the topic sensitively, suggesting limited understanding of how to raise the topic in line with the evidence base around delivering obesity care.

4.5.1 Knowledge

4.5.1.1 Lacking content knowledge of guidelines

Whilst the majority of GPs were aware of the existence of guidelines for obesity, the majority had little insight into the content of these guidelines or perceived that they were irrelevant to raising the topic. At least six interviewees lacked insight into the content of the guidance. As well as individuals explicitly stating that they were unaware of the guidelines, it was evident that familiarity with the guidelines was low.

> "*I know there was some guidance that was put round at about two or three years ago, which was to say that you're raising the issue because of health reasons, and I did take snippets from that and that's why I do things the way I do. But I can't honestly say that I know where it came from or that I refer to it regularly, no.*" (GP 2, Female, Locum)

4.5.1.2 Not recognising obesity as a complex medical problem

A minority of GPs questioned whether obesity was a medical problem and the role they had to play in helping patients to address weight. Obesity was framed as a social problem and respondents questioned whether solutions would be better attributed to sources other than the GP. Despite this, these GPs still viewed raising the issue as an important task for all health professionals to carry out in general practice, suggesting ambivalence. These views also suggest lack of insight into the NICE guidelines which frame obesity as a health concern that warrants medical intervention.

> "*I don't always know whether it's the GPs role erm a lot of patients seem to blame lots of problems on their weight and I don't know whether it's actually a social problem now rather than a GPs problem*" (GP 9)

There was an assumption that the solutions to obesity resided in solutions at the societal level such as making changes to the food industry. The following excerpt demonstrates a GP making the assumption that obesity is due to people consuming too much food, reflecting beliefs that obesity is an issue in need of societal and individual level change rather than medical intervention.

"With obesity, actually have we got much of a role really? That really has to come from other sources of... like making food expensive, things like that, you know, all sorts of ways, but I mean, it's phenomenally cheap at the moment, 9% of people's salaries go on food, don't they? In 1951 or something it was 50%. It's phenomenally cheap. So just, you know, nobody's short of food anymore." (GP 8)

4.5.1.3 Uncertainty about raising the topic routinely

There was uncertainty and a diversity of views around whether the topic of weight should be raised routinely (i.e. with all overweight and obese patients) or only with those at greater risk (i.e. patients with higher BMIs and/or comorbidities). The majority of clinicians prioritised raising the topic for patients consulting with a weight related problem. Several GPs were opposed to talking about weight in every consultation unless it was having medical implications. A minority of GPs advocated broaching the topic whenever they had the opportunity and thus doing some 'health promotion'. A third group of GPs were not clear about when they should raise the topic, suggesting uncertainty about raising the topic routinely, as advocated by guidelines. It was also possible to detect conflicting views from GPs who felt raising the topic was important due to the health implications of obesity but on the other, did not feel the topic should be raised routinely, often due to the negative implications of doing so.

"You don't want to raise it every single time but if it's having a direct impact on their health it should be mentioned." (GP11, Female, Locum)

Another GP explains how he decides whether to raise the issue and again demonstrates low intention to raise the topic unless it is clinically relevant:

"if you look at the ethical framework of whether you should actually tackle people cold about it, if somebody comes in and they haven't come about this

problem then there are pros and cons for sort of raising it with them … if as doctors we challenge everybody who is mild to moderately overweight then it's likely that, you know my concern is that it will have a counterproductive effect on the doctor patient relationship and will change the way people actually use the service and come and talk to us." (GP 6, Male, Partner)

In contrast, one GP acknowledged that raising the topic routinely was becoming more important, demonstrating awareness of the focus for health promotion in general practice which implies that public health topics including obesity should be broached routinely with patients.

"*I mean it's getting more important because I just think that we are, general practice as a whole should be moving from an illness-treatment service to a health-promotion service, we should be moving, our jobs should be to help people keep healthy rather than patching them up when they've become unwell and so anything, all the things that promote better health should be part of that.*" (GP10, Male, Partner).

4.5.2 Skills

4.5.2.1 Uncertainty about how to raise the topic sensitively

There was consensus that good communication skills were needed to talk to patients about weight. The topic was framed as an area of a patient's life which was typically emotive and challenging for the patient to discuss and thus for the doctor to broach. The following excerpt demonstrates that patients are predicted to react defensively or feel accused when the issue of weight is raised. The caution that the GP speaks with suggests that skills around how to talk about weight, particularly when it cannot be linked to a medical condition, are lacking.

"*they (patients) can be really quite defensive about it and as I say if the if the feeling a patient has got is that you're being judgmental or that you're not on their side and you can't make that link then it can be very very difficult.*" (GP 6)

Since obesity was viewed as a condition often associated with emotion and complexity, several GPs discussed the benefit of additional skills to help them raise the topic within a medical consultation.

"I think because of the challenging emotional connotations of raising the issue of weight, any consultation skills that have been proven to be effective with regard to weight would be really interesting to hear about" (GP 1)

There was variability in confidence levels of raising the topic. Another GP was confident that she could broach the topic sensitively and discussed the importance of knowing when to raise the topic and how to communicate about it to maintain engagement. As the GP discusses, she starts with the patient and takes into account multiple factors, including diverse areas of the patient's life, in order to broach the topic 'sensitively'. The GP also talks about weight as being associated with blame and thus takes this into account when discussing how she negotiates broaching the topic:

"you've got to do it at a time when they can take it on board and not sort of be… you don't (want them) to feel they're being nagged or accused of gluttony. I mean, most of those people are worried anyway about their weight, and if they've got masses of other worries, you've just got to take things at a step that they can cope with and not fling everything at them at once." (GP 7)

4.5.2.2 Uncertainty about how to raise the topic when patient is not consulting with related problem

GPs discussed the difficulty of raising the topic when patients were not consulting with a related medical problem or comorbidity suggesting a lack of skills to talk directly about weight. The following excerpt demonstrates that a minority of GPs were uncertain about the appropriate language and terminology to use when discussing obesity with patients.

"Just bringing it up….how do you bring it up, when they've come in about a cold? It's really difficult isn't it because you know we've all got to be very PC and people get very hurt even with medical terms like obesity or overweight, it can be really challenging" (GP13)

4.6 Concern about negative consequences

The second theme incorporates six behavioural domain of the TDF: beliefs about consequences, beliefs about capabilities, emotion, professional role and

identification, motivation and social influences. These domains have been synthesised together since all barriers and domains relate to the concern GPs express about broaching the topic of weight with patients. According to behaviour change theory, this concern is likely to be contributing to lack of GP motivation to raise the topic of weight.

4.6.1 Beliefs about consequences

4.6.1.1 Potential to damage the doctor-patient relationship

When discussing concerns about raising the topic, the potential for damage to the doctor-patient relationship was central to the accounts provided by many GPs. Trust was a key attribute that GPs were concerned they may lose by raising the topic. This appeared to be related to the negative social construction around weight with associations of judgment and blame. The majority of GPs expressed that discussions about obesity were often emotionally-laden, difficult for patients to talk about and a personal topic in which to address. GPs expressed concern that rapport would breakdown and patients would be less likely to consult with them in the future. This barrier was most likely to be discussed in relation to raising the topic when a patient was consulting with a complaint unrelated to obesity:

> "*patients can be a bit defensive and they can be a bit peeved that you've brought it up and I think that definitely applies with weight … it is a risk to the doctor-patient relationship and I think that there's a risk that the patient doesn't realise they you're not saying it in the way like 'I don't like your hair' you're just saying it for health reasons and trying to explain that can be misconstrued or just not heard in the blitz of ooo the doctor said I'm overweight/obese*" (GP 2)

4.6.1.2 Concern that patients will feel alienated and disengage from healthcare

A broader concern expressed by several GPs was about putting patients off from the medical profession as a whole. The prospect of health professionals routinely talking to patients about their weight at the expense of their other health concerns was conveyed as a threat to maintaining patient engagement:

> "(the concern is) *to have them disengaged with the medical profession and think that I'm not going to bother going to see the doctor because I'm just going to get nagged about my weight.*" (GP 1)

4.6.1.3 Beliefs about negative responses

Broaching the topic of weight was associated with a number of undesirable patient responses such as feelings of confrontation, judgment, blame, anger, defensiveness and sadness. Raising the topic was thus considered a risk to the consultation:

"people often feel very judged, erm people often get angry, people feel blamed, erm sometimes people take offense and don't want to come back and see you, it can kind of, if something doesn't go well then it ruins the whole consultation you might have lost any positive things you've been talking about it any other areas, any advice you were trying to give them so that can be difficult" (GP 12)

4.6.1.4 Potential to open a can of worms

Several GPs used the metaphor "can of worms" to explain why they might not initiate a conversation about weight. This appeared to relate to the belief that obesity might be reflective of complex problems thus raising the topic of weight posed the risk of opening up a difficult issue.

"We may not want to go there as well because you just suspect that something is going to happen and if we start talking about this we may get a whole outpour of stuff that erm we might not be able to or want to deal with just at that moment and the entry to that moment might be talking about their weight for certain patients because you never know what's going to happen." (GP10)

However, in contrast to not wanting to open up a personal and potentially overwhelming issue, other GPs acknowledged the importance of addressing weight in order to facilitate holistic care of the patient. A minority of GPs viewed raising the topic as an enabler of delivering holistic care to the patient. These GPs felt that by talking to patients about being overweight, they could explore other attributes of a patient's health:

"I mean I think it can be a really good opportunity to explore wider stuff around what's going on with the patient's life, so you can end up finding out all sorts of stuff about sort of their working pattern or their home life or whatever." (GP 15)

4.6.2 Beliefs about capabilities

4.6.2.1 Feeling ineffective at helping patients with weight loss

Due to the perceived complexities of weight loss, some GPs questioned the usefulness of their intervention. There was a feeling of inadequacy and of only being able to raise awareness of obesity rather than truly support patients with weight loss:

"you can say, 'You're overweight', but I can't do anything about it, you know, that I don't have a magic wand you know. So it's hard, it's hard for people to lose weight so I guess that's the thing, you know. You can say, 'You need to lose weight', and I'm not much help other than that, even the referrals and things we can do now, you know, it's still hard isn't it." (GP 16)

In contrast to this perspective, other GPs discussed their belief that initiating a conversation about weight loss was likely to act as a trigger for change. Seeing obesity as something that is modifiable and a problem that discussion could help with, seemed to be an enabler of raising the issue:

"It's something that's modifiable so you know, that's why it's important because we can change it. There's no point in measuring something and saying that's a bad thing and not being able to change it… so if you bring it up with 10 people, one of them might do something about it and you've adjusted things a little bit." (GP 11)

"Sometimes being told something pretty bluntly but in a nice way, can be a very…can be what tips you over into changing." (GP 10)

4.6.3 Emotion

4.6.3.1 Fear of upsetting patients

In relation to a GP's own emotions, interviewees talked about fearing a patient's reaction. Anticipated reactions included provoking anger and a feeling of judgement. Some GPs talked about reactions as being out of their control due to a patient's own interpretive stance:

"I guess I'm slightly concerned about making people angry and aggressive erm but mainly I think some people know, however tactfully your, however

sort of factually you try and make it they'll take it as a criticism and judgement of them." (GP 12)

4.6.3.2 Feeling awkward/uncomfortable raising the topic

The potential for patients to interpret a conversation about weight as a judgment related to aesthetics and thus an insult toward personal identity was a concern expressed by GPs, some of whom discussed feeling awkward when raising the topic.

"*I think potentially, it is an issue that's very sensitive erm its very personal erm I think it can be quite, it can make I think the clinician feel quite awkward because if you feel you've got to raise it for a clinically relevant reason and the patient doesn't want to it can feel very rude and quite disrespectful because your commenting on a person's appearance, there's all that sort of overlay of it is not just a health issue, there's overlay about appearance issues and that can be quite a fine line to tread erm which is, going back to the sort of, less raised BMIs, probably part of the reason that I don't raise it is because if there isn't clear evidence that it is clinically relevant who am I to comment on what someone looks like.*" (GP 15)

4.6.3.3 Hopelessness

A minority of GPs discussed feeling hopeless about initiating conversations around weight loss. This barrier links with feeling ineffective in the area:

"*Some days you do sort of, it feels like a losing battle, you just get erm feel negative about it before you even start.*" (GP 12)

"*Well when people are very very large it's difficult to not feel a bit disheartened by it, it can have a certain euwww when someone's very overweight and when you examine people sometimes it has an effect on the condition of their skin.*" (GP 4)

4.6.3.4 Frustration

Some GPs talked frankly about feeling frustrated in this area of practice. Interviewees explained their frustration in relation to the lack of weight loss witnessed in patients. As the following excerpt demonstrates, there were assumptions that patients fail to 'do anything about their weight' and remain unaware or unconcerned about of the health consequences of obesity. GPs also

expressed frustration that the needs of patients with obesity are beyond the contributions that a GP can make:

"Occasionally there would be frustration if weight is a huge reason or contributor for why a patient is seeing you on a regular occasion, it seems to be their failing to address that or its very hard to address that erm if they're still seeing you really regularly erm perhaps frustration where you feel you've perhaps tried almost everything that's at our disposal to try and help people with their weight reduction and to no avail erm perhaps again frustration if there's a complete dismissal from the patient about their weight and erm again a constant denial from them that it's having any effect on their health erm and then perhaps a frustration on a personal level that it is challenging to help these people, these patients when there's a health need there and it's frustrating not to help them with that so perhaps frustration would be one of the main emotions when trying to help people with weight problems and being unsuccessful". (GP 1)

4.6.4 Professional role and identification

4.6.4.1 Threat to professional reputation

Due to the perceived judgment associated with obesity, some GPs felt that raising the topic of weight posed a risk to their professional reputation and discussed protecting this rather than talking about weight. Again this illustrates the importance of patient expectations:

"I think patients having confidence that they can come and talk to their GP about anything and they won't be judged … if I have to not talk about something or talk about something very sort of gently in order to preserve my reputation as being non-judgmental then I will do that." (GP 15)

4.6.4.2 Impact of own weight status

A minority of GPs felt uncomfortable about talking to patients about a 'problem' that they themselves did not have. Several GPs talked about previous experiences of negative reactions from patients which centred around GPs not being able to empathise with them:

"I suppose there is a slight feeling of feeling a bit uncomfortable at… I don't know. I don't know how to explain this. Yes, feeling a bit uncomfortable to

be telling people they've got a problem, but then I don't have that problem with diabetics saying, 'You've got diabetes but I haven't.' That's interesting. Sorry, I'm stumbling here because I don't really know why I feel a bit uncomfortable about it." (GP 3)

"You can get that sort of response from them you know, 'how would you know, you've never been there?' erm so you can feel quite vulnerable in that sense." (GP 13)

Several GPs with BMI's in the overweight range also talked about feeling more comfortable raising the topic:

"I feel being slightly overweight, it's something that is a positive, its easier to kind of enthuse sympathy and empathy with people who are overweight where as if you are very stick thin they might think you don't understand" (GP 12)

Another GP reported finding it easier to raise the topic due to self-identifying as having a healthy weight:

"Well to me I can say it thinking well I'm not lying, you can have a healthy habit, lifestyle, you can eat sensibly and you can control your weight erm because you know I have, my friends have, my family have, my husband has, you can do it erm but erm I know that patients probably think that I've got fast metabolism or something" (GP 9)

4.6.4.3 Personal views on advocating weight loss

A minority of GPs talked about personal experience of weight management in self and others which they perceived may influence raising the topic:

"my sister in-law is obese and I've seen the struggle that she's gone through and I do think there is obviously a genetic element there and some people are very disadvantaged and she's tried every single sort of medication available to her so I can see the frustration in that and equally as I said previously you know I had a friend at University who had, in first year probably over-indulged, put on quiet a lot of weight and then went completely the other way and she was hospitalised for anorexia and bulimia and yeah probably all of those things at a personal level effect how I discuss things and what I feel about it." (GP 13)

4.6.5 Motivation

4.6.5.1 Desire to maintain a positive, non-judgmental relationship with a patient

GPs explained that one of their main goals in a consultation was to maintain a positive relationship with a patient. Raising the topic of weight was perceived as a threat to this goal since it was assumed to be doctor-driven rather than patient-driven and a personal topic with pejorative status in wider society. Talking about weight had the power to spoil the consultation and cast judgement. GPs talked about prioritising their main goal of having a non-judgmental, harmonious relationship with patients.

> *"In any consultation you don't want in any way to be confrontational and, you know, you don't want to bring up the point of, something which might actually just put a negative vibe on the whole discussion. 'The doctor is more interested in my weight than he...,' you know, you're always hearing people say that these days. 'Oh the doctor's more interested in filling in his computer than asking me about my problem'. You know, 'taking my blood pressure or finding out whether I've had a cervical smear rather than what I came with'. So I think you've got to get that balance".* (GP 8)

4.6.6 Social influences

4.6.6.1 Adhering to the patient's agenda

The majority of GPs discussed the difficulties of starting a conversation about weight with patients who were not perceived to be attending with a desire to discuss weight loss. Most GPs said that patients were unlikely to visit them especially to talk about weight. As the following excerpt illustrates, the purpose of the visit could act as a barrier to talking about weight. Patient expectations seem to be an important consideration for GPs who have a desire to satisfy patients and avoid negative consequences.

> *"They also need you to address the problem they've come about, because patients will be sitting in the waiting room rehearsing their stories about what they want to say and what they want from the consultation, so they'll have an expectation of what they want the doctor to do. And if you go off on a tangent and start talking about something that they're not keen to talk about*

then that risks jeopardising the relationship because it takes the agenda away from them and onto you, or it can be perceived in that way. So I think that that's the element of getting that balance right that really is tricky". (GP2)

4.6.6.2 Perceptions about patient receptiveness to advice

GPs made assumptions about whether patients wanted to discuss weight with the majority of interviewees, asserting that generally patients did not want them to raise the topic unless they had specifically made an appointment to discuss weight. There was also an assumption that patients were aware of their overweight and expectations that patients would react negatively if it was brought up by the GP:

"If they wanted to come in to discuss that, they would of come in to discuss it. They're not here about that, they don't want to talk about that. They know it's an issue and I suppose from my experience, that's probably why I don't tend to go there" (GP 13)

In contrast to assumptions that patients would not be receptive to discussion about weight, other GPs discussed giving patient's permission to talk about weight. These GPs took the view that patients may feel embarrassed or unable to raise the topic of weight themselves and therefore felt it was their role to raise the topic and allow the discussion to occur:

"Often you know it's something that the patients are very aware that they have a weight issue and if you bring it up then that gives them permission to talk about it, they might feel a bit embarrassed to mention it themselves so that can be a positive". (GP 12)

4.7 Lacking time and resources to deal with a sensitive issue

The final theme incorporates two behavioural domains of the TDF: GP practice and available resources, and, competing goals. It demonstrates how structural barriers limit the opportunity for GPs to discuss a topic which has to be negotiated and discussed with sensitivity and has the potential to evoke emotions. The majority of GPs expressed the view that rather than just raise the topic, they had an obligation to explore the issue with the patient, thus it was a time-consuming task.

4.7.1 GP Practice and resources

4.7.1.1 Having time to open up a sensitive issue

The majority of GPs felt that they needed adequate time to sensitively and constructively broach obesity. It was felt that many consultations did not allow the time needed.

> "*I mean I think even 10 minutes is probably under-selling the time it takes to address weight with a patient …to explain that it does take a few minutes especially if the patients upset and shocked by the fact that they weigh more than they realised or that they're outside of that normal range and then I would like to look into why they're overweight.*" (GP2)

4.7.1.2 Feeling like there's nothing to offer

Some GPs felt they had little to offer patients which would help with weight loss after a discussion about weight had been initiated.

> "*If you're going to raise it as an issue then you need to know where you're going to go with that... I can totally understand why a lot of GPs will just leave it because there's nothing to offer anyway*." (GP 17)

However, contrary to this view, other GPs felt confident about the referrals they could make and felt equipped and able to support patients:

> "*Now that we've got some tools, in that we've got the referral to the gym and to weightwatchers, doctors like giving people stuff, so that's why we've got prescriptions because we feel like we've done something useful and when it was drugs that didn't work or nothing, you did feel like well what is the point in me saying this cause there's nothing I can do to assist you anyway whereas now when people are saying 'yes but' you can say 'a har yes but I can offer you this, this and this' so its back on to them to do something about it.*" (GP 11)

4.7.1.3 No continuity of care

Having an established relationship and being able to maintain continuity of care with patients was viewed as being necessary to raising the topic of weight due to the subject being so sensitive and difficult for patients to confront.

"You need to build a relationship with a person before you can start driving them down a road that they've demonstrably found it difficult to go down, the rest of a life that they've lived so far they've been overweight." (GP 17)

Continuity of care was also perceived as useful since it allows follow up of patients about their weight during future consultations. One GP reflected that she was aware that a discussion about weight did not have to be conducted all in a single consultation but noted that due to the nature of her role as a locum, she could not guarantee that she would consult with patients in the future:

"I think what I've learnt is that it doesn't have to all be done in that one consultation and I think that's why it is harder as a locum because you really just have to sow the seed and maybe the patient will do the rest…I hope so but ideally you'll be able to follow it through and check that things were going ok." (GP 2)

4.7.2 Competing demands

4.7.2.1 Prioritising other areas of patient care

Interviewees explained that a patient's other health needs often acted as a barrier to raising the topic since they were perceived to be of greater risk than being overweight and thus GPs would intentionally avoid raising the topic.

"You may deliberately you know decide to, try to park erm you know weight related things because it's a lower magnitude of risk for them and its likely to be counterproductive to the whole exercise to try and do everything all in one go and you may well not do it if the consultation itself is emotive, if you've had a consultation about depression, if they've had a recent bereavement there's lots of reasons why you might not tackle it in any given single consultation." (GP 6)

4.8 Discussion

4.8.1 Summary of findings

The aim of the study was to systematically map the perspectives of GP to the TDF in order to identify and elicit a theoretical understanding of the barriers to raising the topic of weight in general practice. Twenty-four barriers across 10 theoretical domains were identified and synthesised into three main themes. I will

now go on to discuss these themes in relation to the findings of current research in the field.

4.8.1.1 Limited understanding about obesity care

The first theme, 'Limited understanding about obesity care' integrates barriers from two domains of the TDF: Knowledge and skills. In regards to the knowledge domain, findings suggest that there is uncertainty and varied opinions about raising the topic of weight amongst GPs. That opinions were dominating the judgment around when to raise the issue suggest there is uncertainty in this area and lack of knowledge about guidelines. In line with previous research, the majority of GPs took a 'treatment' rather than a 'preventative' approach to raising the issue and reported only broaching the issue when weight was judged to be having a clear impact on a patient's health (Counterweight Project Team, 2004; Sonntag et al, 2012; Teixeira et al, 2015). Also in support of previous research, there appeared to be some ambivalence about obesity being a medical issue that needed to be prevented and treated in general practice (Epstein & Ogden, 2005; Walker et al, 2007; Sonntag et al, 2012). Whilst all GPs acknowledged the health risks of obesity, a proportion of GPs also framed obesity as a social problem and proposed that solutions would be better lying in the wider social environment rather than in general practice. Views towards obesity as a medical condition were therefore variable and at times contradictory. Such findings demonstrate that GPs recognise the health consequences of high body weight yet do not view obesity as a multifactorial chronic condition in need of long-term follow-up (Ogden & Flanagan, 2008; Thuan & Avignon, 2005).

Within this theme it is also of relevance that some GPs discussed the difficulty of sensitive communication about weight, which they attributed to the association of weight with appearance, self-esteem and complex emotions. Several clinicians also discussed the resistance they had experienced from patients when they had attempted to broach weight and emphasised care needed to be taken when integrating discussion about weight into consultations. This was judged to be particularly problematic when patients presented without medical problems that related to weight. In summary then, many clinicians appear to lack the skills to discuss weight in a way that is acceptable to patients.

4.8.1.2 Concern about negative consequences

The second theme, 'Concern about negative consequences', is a synthesis of barriers from six domains of the TDF: beliefs about consequences, beliefs about capabilities, emotion, social influences, professional role and identification, and motivation. Barriers categorised as belonging to the 'beliefs about consequences' domain appeared to be particularly salient. Concern about damaging the doctor-patient relationship was frequently discussed and is a barrier that has been identified in several other studies (Alexander et al, 2007; Epstein & Ogden, 2005; Michie, 2007). Concerns included the potential for patients to feel judged, lose trust, feel victimised and fail to seek future medical care. An interesting finding to emerge from this study was the concern GPs had that however they broached the topic, patients would interpret their intervention negatively. GPs generally attributed this to the negative status of obesity in today's society.

The Beliefs about Consequences domain seemed to be particularly relevant given a GPs motivation to maintain a positive, non-judgmental relationship with patients and protect their professional reputation. It seems that the motivation to maintain a harmonious relationship with patients is currently acting as a barrier to raising the topic. It is interesting that another barrier identified was around adhering to the patient's agenda. These findings may suggest that GPs do not perceive raising the topic of weight to be in line with patient-centred care (Chew-Graham et al, 2013; Maisey et al, 2008).

The finding that practitioner emotions may be acting as a barrier to raising the issue of weight is an important one. Emotions include fear of upsetting patients, feeling awkward talking about weight, and frustration. Other research has found that medical professionals find talking about lifestyle change as socially and emotionally uncomfortable (Chisholm et al, 2012; Guassora et al, 2014) and are concerned about eliciting emotional reactions from patients when they discuss weight (Michie, 2007). These medical professionals also expressed frustration about their lack of success in this area of practice which seems to relate to feeling ineffective, a barrier relevant to many of the GPs in the current study. This supports other research highlighting that clinicians may feel discouraged and overwhelmed by the complexity of obesity (Frood, Johnston, Matteson, & Finegood, 2013) and perceive efforts to intervene as frustrating and ineffective (Ferrente et al, 2009; Foster et al, 2003; Sonntag et al, 2012). Perceived ineffectiveness may relate to

the expectations GPs have about what effective weight loss is. Several studies have emphasised the importance of educating GPs about the chronic and relapsing nature of obesity and to prioritise outcomes other than weight loss (Davis et al, 2008; Thuan & Avignon, 2005) since unrealistic expectations may lead to frustration and disappointment with weight loss attempts. GPs also play an important role in communicating realistic and achievable expectations to patients (NICE, 2014, cg 189) who may share these high expectations about weight loss (Foster, Wadden, Vogt, & Brewer, 1997).

A GP's own weight status and personal beliefs about raising the topic have also been reported as barriers in previous research (Bleich et al, 2012; Steeves, Liu, Willis, Lee, & Smith, 2014; Zhu et al, 2011). Although no GPs with a BMI in the obese category were recruited to the study, the majority of those classified as normal weight and overweight perceived that their weight had an influence on raising the topic. For these clinicians, weight could make them feel uncomfortable due to appearing to lack empathy and being judgemental. Interestingly, some GPs expressed feeling more confident when they perceived themselves to be slightly overweight, which they explained helped them appear more understanding. This finding conflicts with previous studies which have typically taken a cross-sectional survey design and reported that clinicians with BMIs in the normal range are more likely to feel confident at initiating and providing weight loss communication than clinicians with a BMI in the overweight or obese range (Bleich et al, 2012; Steeves et al, 2014; Zhu et al, 2011). However, there is a lack of qualitative research identifying how a GPs own weight influences weight management beliefs and practice, thus findings suggest the picture is more complex and further qualitative research is warranted. The finding that GPs with a BMI in the normal range perceive their weight to act as a barrier aligns with the findings of a qualitative study in the UK that investigated how primary care nurses own body weight relates to giving advice about obesity. The study authors, Brown & Thompson (2007), report that a proportion of nurses with low BMI find it difficult to offer patients weight management advice due to concern about how patients will receive their intervention (Brown & Thompson, 2007). Another qualitative study of primary care nurses also reported that having a BMI in the obese range can act as a barrier to weight management behaviours due to the difficulty of maintaining impressions of being a credible role model whilst delivering weight loss advice (Aranda &

McGreevy, 2014). Further research to determine if findings extend to GPs thus seems fruitful.

4.8.1.3 Lacking time and resources to raise a sensitive topic

The final theme, 'lacking time and resources to raise a sensitive topic' integrates barriers from two domains of the TDF: GP practice and available resources, and, competing goals. The lack of opportunity GPs have to raise the topic of weight, largely due to the time constraints of medical consultations has been identified as an important barrier in many previous studies (Campbell et al, 2000; Leverence et al, 2007; Sonntag et al, 2012; Teixiera et al, 2015). This study found that in line with GPs perceptions that weight is an emotive topic to broach and a complex issue to help resolve, the time constraints of a routine consultation were felt to be particularly detrimental to facilitating a constructive dialogue about weight loss. A strong view from some GPs in the study was that if they were to broach the topic of weight, there needed to be adequate time in the consultation to explore an emotional and complex issue. These GPs felt that just raising awareness of the topic was insufficient and not reflective of good patient care. A minority of GPs also expressed their reluctance to refer patients to external providers due to their limited knowledge about the services. These are relatively new findings given that there is little other research looking specifically at raising the topic. It also has implications since it points to the importance that clinicians give to their interactions with patients and demonstrates that rather than focusing on isolated health risks they approach a patient's holistic wellbeing and consider how acceptable their interventions will be to patients. Whilst it may be assumed that the ability for clinicians to refer patients to other providers will be sufficient to overcome barriers in this area, it demonstrates that as the integrators/coordinators of care for patients, GPs need sufficient time at the point of contact and knowledge of how safe and effective interventions are, for them to initiate discussions about weight loss.

4.8.2 Implications for research and practice

These findings suggest that GPs require knowledge and skills about how and when to raise the topic of weight with patients as well as specific education about the complex aetiology and nature of obesity including the chronic, relapsing and multi-faceted nature of the condition. Although the outcomes of such training are unclear, it may modify the knowledge and attitudes of clinicians so that obesity is perceived as a complex medical condition rather than a lifestyle choice. Other

scholars have emphasised the importance of communicating the myriad of causes of obesity to clinicians and the public as a means of lowering the stigma currently surrounding obesity (Beeken & Wardle, 2013; O'Brien, Puhl, Latner, Mir, & Hunter 2010; Puhl & Brownell, 2003). GPs may also be able to communicate the complexity of obesity to patients, with the aim of reducing the burden of guilt and self-blame that often accompanies living with obesity (Conradt et al, 2009). Such training could also encourage GPs to develop realistic expectations about their treatment approaches and resolve their frustration around their perceived inefficacy in the area.

Given that GPs are predominantly concerned about their relationship with patients, education about how to raise the topic in a patient-centred and constructive way that is deemed acceptable and supportive by patients, is required. The lack of insight into the patient or lay perspectives in the research literature is striking and there is a clear need for research to understand these (Malterud & Tonstad, 2009). These perspectives could also be integrated into clinical guidelines. Although as this study found low engagement with guidelines, this method alone is not likely to be adequate to ensure clinicians are equipped with the knowledge and skills. As has been noted by authors concerned with developing holistic, multi-behavioural complex interventions for practitioners, the challenge lies in developing interventions that GPs are willing to learn, find enjoyable and usable, and which are effective and acceptable to patients (Butler, 2013).

Patient resistance to raising the topic of weight is an interesting barrier in light of recent observational research reporting that GP's attempts to initiate discussion about weight in routine consultations were often blocked by patients (Laidlow et al, 2015). The current consensus in the field is for health professionals to be trained in motivational interviewing skills, a training intervention aimed at improving health professional competence in communicating about behaviour change (Rollnick et al, 2005). Such training provides clinicians with a greater understanding of patient motivation, facilitates patient-centred communication and helps clinicians prevent patient resistance or at least respond to this resistance in a constructive rather than confrontational way (Pollak et al, 2011; Rollnick et al, 2008). Education and training to address GP concerns about offending and alienating patients may also be useful. Raising GPs awareness of the dimensions of power and stigma involved in consultations about obesity and lifestyle change,

given that the presence and implications of these constructs "are not always visible and comprehensible" (Abildsnes et al, 2012 p.e165) may facilitate practice that enhances health and avoids unintentionally eliciting guilt and shame.

The study has provided impetus for further research into barriers, particularly a GP's own weight and personal opinions. Whilst findings reveal new insight into how GPs' weight status and personal beliefs about weight may act as barrier to raising the topic of weight, further research would be aid understanding about 'normal' or 'under' weight as barriers to talking about weight. Although this study did not include the perspectives of GPs with a BMI classified as obese, other research suggests that this can act as a barrier to weight management practices (Bleich et al, 2012; Zhu et al, 2011). As researchers have pointed out, for any future research or interventions targeted at clinicians, there is a need for sensitivity to ensure that such practices do not increase obesity stigma (Bleich et al, 2012). Encouraging clinicians to improve their overall wellbeing and take up healthy behaviours may therefore be more beneficial than targeting overweight clinicians in isolation.

Finally, given that competing demands and time constraints in routine general practice consultations hinder the opportunity of GPs to raise the topic of weight, government and medical bodies pressurising GPs to raise the topic at every contact (such as within the 'Making every contact count' policy) should recognise such limitations. This study suggested that GPs are resistant to raising the topic unless it can be integrated into the consultation and is demand-led (i.e. relates to the purpose of the visit or is raised in reactance to a health need) rather than being pre-determined. It may be that settings other than general practice consultations (which function to resolve the problems that patients bring to the appointment and thus leave little scope for other topics to be broached) are more suitable and/or effective for preventing and treating obesity at the population-level. A final implication is that a team-oriented rather than a GP-only oriented model of care is likely to be needed for an effective approach to manage obesity given the complexity of the condition (Sonntag et al, 2012; Teixiera et al, 2015).

4.9 Conclusion

This chapter has identified and described barriers to raising the topic of weight from the perspectives of GPs. Interviews were based on, and analysis was

underpinned by, a validated theoretical framework incorporating constructs from behavioural science. Barriers were mapped to ten domains of the TDF suggesting potential determinants of GP behaviour in this area (initiating discussion about weight) that could be targeted in future research or interventions seeking to change GP behaviour. Synthesising the barriers into three main themes has illustrated that GPs feel under equipped in this area of practice - in terms of their own competency and the available time and resources, and express concern about the consequences of raising the topic. Reflections on the use of the TDF and the limitations of the study will be discussed in chapter 5, which documents the barriers to raising the topic of weight from the perspectives of primary care nurses.

Chapter 5: Barriers to raising the topic of weight in general practice: perspectives of primary care nurses

5.1 Introduction to the chapter

This chapter proceeds in a similar way to the previous one. This is the second empirical study of the thesis and includes the findings of interviews with 17 primary care nurses. The design of the study is the same as study 1 with the main difference being the sample of health professionals interviewed and the findings and conclusions. This chapter also includes a discussion of the barriers unique to GPs and nurses and the limitations of using the TDF to inform and guide the analysis of the data. In describing these limitations and reflecting on the use of the TDF, I also justify my decision to change the epistemological orientation in the subsequent and final empirical study of the thesis.

5.2 Background to the study and research question

Primary care nurses have a central role to play in promoting and supporting weight management, both during routine clinics and in delivering specialist primary care services such as diabetes and chronic disease management (Department of Health, 2002). In addition, GPs may refer patients to nurses who are increasingly expected to have expertise in weight management. In addition to these expectations, clinical guidance recommends that nurses identify overweight and obesity and support patients with weight loss (NICE, cg 43). However, for many patients presenting in general practice, weight is not addressed (Jackson et al, 2013; Scott et al, 2004). Researchers have identified that nurses experience a number of barriers that hinder their weight management practice, such as perceived lack of effective intervention, mixed feelings about whose role it is to provide weight prevention and management interventions, frustration, not feeling like a credible role model due to own body weight (Brown & Thompson, 2007; Mercer & Tessier, 2001; Nolan et al, 2012) and has suggestions that nurses hold negative judgments towards obese patients which may influence their clinical behaviour (Brown, 2006). Studies also report that discussing weight management is perceived as challenging due to the sensitivity of the issue (Keyworth et al, 2012; Michie, 2007; Moorhead et al, 2013) suggesting that initially talking about weight might also be problematic. However, there has been no qualitative or exploratory investigation specifically

concerned with factors that prevent nurses from broaching weight loss conversations in primary care. Without such research it remains unclear how this area of practice can be improved.

The TDF has been applied in several studies to identify the theoretical determinants of nurse behaviour(s). This includes a study in primary care which sought to identify the factors that influence human papillomavirus screening (McSherry et al, 2012). Another study with a range of clinicians, including 13 nurses, investigated the factors that influence the management of brain injury in the emergency department (Tavendar et al, 2014). As described in chapters 3 and 4 of the thesis, the TDF is a validated framework which incorporates a comprehensive range of barriers which can be linked to domains to identify potential mediators of behaviour change. The application of such a framework may identify new barriers given the inclusion of a wide range of theories and provides insight into the pathways of change that are likely to influence the target behaviour (raising the issue).

In light of establishing that the TDF is a unique tool to identify the barriers that prevent nurses initiating discussion about weight, this study sought to identify and describe primary care nurses beliefs and attitudes regarding barriers to raising the issue of weight in general practice. The research question was: What are the barriers to raising the topic of weight in general practice identified from the views and perceptions of primary care nurses?

5.3 Methods

5.3.1 Design

Semi-structured interviews guided by the TDF were carried out with 17 Primary care nurses. Further details about the research design are provided in chapter 4, section 4.3.

5.3.2 Participant selection and recruitment

Ethical approval was sought prior to any recruitment or interviews being carried out. Approval was granted by the Research Ethics Approval Committee for Health (REACH) at the University of Bath (EP 12/13 1) and from the Department of Psychology. NHS Research and development (R&D) approval was also sought (2012/065). Purposive sampling and snowballing techniques were used to recruit a heterogeneous sample of primary care nurses. The study adopted a multi-faceted

recruitment approach. Primary care nurses working within one primary health care authority were invited to participate in the study. The researcher attended two practice manager meetings and included a flyer in the Primary Care Trust's monthly newsletter. An email was circulated to all practice managers in Wiltshire which included 58 practices. Snowballing techniques were used simultaneously- GPs and nurses who had already been interviewed or were known to the research team were asked to identify other people they knew who fit the selection criteria.

Participants were recruited until no new information and understanding from the interviews occurred. In order to establish data saturation, guidelines recommended for theory-based interview studies were followed (Francis et al, 2010). Firstly, a minimum sample size for initial analysis was specified: in this case 10 primary care nurses. Secondly, a stopping criterion (i.e. how many more interviews will be conducted without new ideas emerging) of 3 was specified. These criteria were based on the methods sections of other theoretical based research involving interviews with health professionals (McSherry et al, 2012; Duncan et al, 2012) and general recommendations on sample size for interview studies (Guest et al, 2006). This resulted in a total of 17 primary care nurses participating in the study.

5.3.3 Data collection

A semi-structured topic guide (appendix C) was developed based on the TDF and a literature review. Interview questions were based on factors that might influence beliefs about raising the issue of weight and were designed to explore the domains of the TDF while allowing participants to speak about topics important to them. The topic guide thus served as a framework for questioning. Prior to the final interviews, the questions were piloted with two primary and two secondary care nurses to assess clarity and focus, and refine as appropriate. The interview schedule was used flexibly, tending to begin by asking participants the factors that triggered them to broach discussion of weight loss and then focusing on each of the 12 theoretical domains.

Face-to-face interviews were conducted by MB at a time and place to suit the participant. Interview locations included GP practice rooms, a University room and participants homes. At the start of each interview, participants were asked to confirm they had read the study information sheet (appendix D) and to sign a consent form (appendix E). Interviews were digitally audio-taped and transcribed

verbatim into Microsoft Word. The interviewer transcribed 50% of the interviews, with the remainder being transcribed by an external transcription company. This was mainly a pragmatic decision due to time constraints.

5.3.4 Data management and analysis

Transcriptions were uploaded to NVivo (version 10) for coding and data organisation. The lead researcher coded the majority of the transcripts. The accuracy of initial themes derived from a subset of the data, were reviewed by another member of the research team (Dr Afroditi Stathi) which helped guide the indexing of the remaining transcripts. Findings were also discussed with all three supervisors during monthly meetings.

The process of analysis included first becoming familiar with the data through reading and re-reading the transcripts to gain an overview of the entire data set, and then using a deductive approach to data coding. Coding involved identifying a priori themes directed by the interview topic guide, unexpected emergent themes and recurring viewpoints. Both manifest and latent content was coded. Coding proceeded until all of the data that was deemed to be relevant to the research question had been coded. The unit of analysis (amount of data that was coded) included specific beliefs which were identified as barriers to raising the topic of weight. Coded data was allocated to the appropriate domains.

The thematic structure of the TDF was used as a framework to organise and locate the coded data. The TDF coding framework developed by Heslehurst et al (2014) was used to ensure code names were matched to the appropriate domains. The framework was useful since it provided some rules around the categories or domains of the TDF including an operationalization of what the domain concerns.

Barriers were identified and mapped to the domains if identified by at least two clinicians (i.e. two nurses or one nurse and one GP since analysis was conducted in parallel with study 1).

After coding and thematic mapping to the TDF domains, the lower-order themes were charted and organised into three salient higher-order themes that captured the range of experiences and views reported and which were manifested within the whole data set (Braun & Clarke, 2006). The TDF provided an analytic tool from which emergent concepts could be identified.

5.4 Findings

5.4.1 Characteristics of nurses

Of the 17 nurses interviewed, three were nurse practitioners. Nursing roles varied widely: six nurses specialised in diabetes care (three of whom also carried out general practice nurse duties), three nurses specialised in COPD and asthma (two of whom also carried out general practice nurse duties), and four nurses worked in emergency and minor illness roles (one of whom also carried out general practice nurse duties) and four nurses identified as having a generalist practice nurse role. Respondents came from rural, semi-rural and urban practices. Additional demographic data are presented in table 6.

Table 6

Demographic details reported by participants in study 2

	Number of participants
Sex:	
Male	0
Female	17
Age:	
30-39	1
40-49	7
50-59	5
60-69	4
Experience as nurse in General Practice:	
0-9 years	7
10-19 years	6
20-29 years	4
Weight status:	
Normal (BMI 18.5-24.9 kg/m²)	9
Overweight (BMI 25-29.9 kg/m²)	4
Obese (BMI 30 kg/m² and above)	4
Not specified	

5.4.2 Barriers mapped to the TDF and thematic analysis

Data analysis resulted in the identification of 22 barriers which were then mapped to 9 domains of the TDF (see table 7). Thematic analysis resulted in the following three themes: Limited understanding about obesity care, concern about negative consequences, and, lacking time and resources to raise a sensitive topic (see figure 4).

Table 7

Barriers mapped to the domains of the theoretical domains framework, derived from nurse perspectives

Behavioural domain	Barrier
Knowledge	Lacking content knowledge of guidelines Not recognising obesity as a complex medical problem Uncertainty about raising the topic routinely
Skills	Uncertainty about how to raise the topic sensitively Uncertainty about how to raise the topic when patient is not consulting with related problem
Beliefs about consequences	Concern that patient will feel alienated and disengage from healthcare Beliefs about negative responses Potential to open a can of worms
Beliefs about capabilities	Feeling ineffective at helping patients with weight loss
Conflicting demands	Prioritising other areas of patient care Prioritising other public health concerns
Emotion	Fear of upsetting patients Feeling awkward/uncomfortable raising the issue Hopelessness Frustration
Professional role and identification	Impact of own weight status Personal feelings about advocating weight loss
GP Practice and available resources	Having time to open up a sensitive issue Feeling like there's nothing to offer patients No continuity of care with patients
Social influences	Perceptions about patient receptiveness to advice

5.5 Limited understanding about obesity care

The first theme synthesises barriers linked to two domains of the TDF: Knowledge and Skills. Analysis demonstrated nurses lack knowledge about raising the topic of weight and the skills to raise the topic sensitively, suggesting limited understanding of how to raise the topic in line with NICE guidelines (NICE, 2014, cg 43).

5.5.1 Knowledge

5.5.1.1 Lacking content knowledge of guidelines

In regards to awareness of guidelines on obesity, only those nurses working in the area of diabetes talked about protocols for managing a patient's excess weight. For the majority of nurses, there was a perception that there were no guidelines available. As the nurses pointed out, there are no national guidelines focused specifically on raising the topic of weight. Of the nurses who talked about being

aware of the clinical guidelines on obesity, some nurses lacked insight into the content of these guidelines:

"I think there are some nurse guidelines I think somewhere but no, I don't know. I think they're like a lot of guidelines and things; they're there and they sit on a computer or they sit somewhere and I don't know that we're necessarily that good with them." (Nurse 11)

Several nurses expressed their belief that guidelines would be useful. In particular guidance on who, when and how to approach the issue was consider to be useful.

"Everybody's individual and it's difficult to know when to approach the subject. Whether there could be any guidance in how and when, I don't know." (Nurse 16)

5.5.1.2 Not recognising obesity as a complex medical problem

Several nurses explicitly asserted that they did not consider obesity to be a medical problem. Whilst these nurses recognised that obesity could cause medical problems, they questioned whether it was a problem that required medical intervention and they questioned whether they were best placed to raise the topic. The nurses who expressed this view felt that help from outside the NHS would be more appropriate for obese patients. As the following quotations illustrate, this barrier also relates to role beliefs:

"I don't agree that it should be a medicalised problem. Yes if you're overweight it can lead to medical problems but I'm a really highly trained nurse with 21 years' experience, 22 years, and I'm seeing people about weight management, which actually is it really my role? Is it a doctor's role with all their experience and qualifications?" (Nurse 3)

Despite NICE guidelines and policy documents which define obesity as a medical problem (RCP, 2010) and outline the role that all health professionals should play, as the following quotations illustrate, personal opinion differs from the evidence thus obesity is not seen as a legitimate medical problem:

"Is obesity a medical problem? It has medical implications, I don't think necessarily it's a medical problem, and I think sometimes it's better being dealt with outside the NHS, you know, because it has a lot of, there are a lot

of other factors that cause people to be heavier than perhaps they need to come to a medical practice for". (Nurse 8)

The same nurse questions the efficacy of the medical role in helping patients with obesity:

"I don't consider – my personal feeling – I do not consider obesity as a medical problem in isolation and so that's why I say there's a lot of other people that could be more effective at helping people to reduce weight than the nurse". (Nurse 8)

As well as explicitly questioning whether obesity was a medical problem, through the corpus of data it was possible to detect that nurses did not consistently recognise the complexity of obesity and at times positioned it in a simplistic way, suggesting a lack of understanding into obesity care. For example, several nurses discussed information being available for patients, who failed to act on it, positioning the problem of obesity as a knowledge deficit.

Interestingly all nurses emphasised the importance of talking to patients about obesity and weight loss yet there was clearly ambivalence as to whether obesity was a medical or social problem. This barrier seems to link to the barrier 'uncertainty about raising the topic routinely'. Nurses said they were more likely to raise the topic when patients were consulting with a medical problem that could be related to obesity suggesting that obesity in itself is not seen as a medical problem in need of intervention.

5.5.1.3 Uncertainty about raising the topic routinely

For those primary care nurses who did not have a specialist role linked to weight management (such as diabetes care), there was uncertainty about raising the topic in every consultation. The majority of nurses took the view that they only had the opportunity and intention to raise the topic if patients presented with a problem that weight was having an impact on or on occasions when patients started the conversation about weight themselves. Importantly, nurses seemed to lack the knowledge that it was their role to talk to patients about weight at every opportunity:

"You've got to remember I'm seeing people in minor illness, not a routine appointment. I think that question would be better asked of the clinicians that see them in a routine appointment. My concern is their immediate problem

– and that's not their weight. That's part of their problem, possibly, but not the immediate problem." (Nurse 6)

However there were a diversity of opinions, with one general practice nurse particularly assured about raising the topic at every opportunity:

"I'm trying to raise it with all of them, so anybody who comes in. You get to know your patients sometimes and if – well, not even if they are struggling, if they haven't got a weight recorded I'm trying to record their weights now. It's a bit like smoking status. We would ask them their smoking status every two years, and if patients, even if they've been at the practice for a long time, if we haven't got a weight recorded, I'm saying, 'Would you like to be weighed while you are here?" (Nurse 13)

5.5.2 Skills

5.5.2.1 Uncertainty about how to raise the topic sensitively

All nurses acknowledged that good communication skills were required to have a discussion about weight which was typically emotive and challenging. Whilst the majority of nurses said they felt confident to raise the topic sensitively, some nurses felt this was difficult and others talked about raising the topic indirectly:

"It's difficult to raise it directly at that person for me so that's a barrier but when you've just met somebody and you don't know them… you don't know what the psychology around the feeling of their weight is so they could have been battling with it for years because we can't see that in our records can we…I mean text books would tell you to try and get a history from them around their weight but I just don't have time" (Nurse 1)

Language seemed to be particularly problematic. Knowing how to frame the conversation in a way that avoided judgment was considered a skill that some nurses felt they lacked. In the following excerpt a nurse discusses the words she uses to open the conversation and demonstrates a lack of competence in communicating about excess weight:

"A bit overweight', I might use. I think it's... I don't want to sound like condescending or as though I know better than they do, they're the people that are in charge of their lives, and I think... you know, I think if I use

certain language I feel as though I'm judging them in some way and I don't like that very much. It is, I think, difficult."(Nurse 8)

Other nurses discussed the difficulty of engaging patients and the care needed to deliver the message so patients would return:

"If they're very negative and don't want to talk to you, then you've got to be careful how you do it. Sometimes if you raise the subject, you know, they just don't want to know and then they won't come back.... You have to do it in a roundabout way, maybe". (Nurse 7)

5.5.2.2 Uncertainty about how to raise the topic when patient is not consulting with a related problem

As has been explained, the majority of nurses reported little intention to raise the topic unless patients were consulting with a related medical problem. This seems to be due to a lack of skills to talk about weight without having a medical problem to relate the conversation to. Raising a topic as an 'add-on' rather than because of a health need or in reaction to a medical problem seems to diverge from the usual conventions of medical consultations:

"I think it would be difficult for me to go in blind, and if there was a patient with me that was in for a totally unrelated problem to their weight, I don't think I would find it comfortable saying, "Oh, by the way, you need to lose weight" if it's not actually attributed to why they're in front of me". (Nurse 6)

5.6 Concern about negative consequences

The next set of barriers relate to five domains of the TDF: beliefs about consequences, beliefs about capabilities, emotion, professional role and identification, and social influences. According to behaviour change theory, the majority of these barriers impede clinician motivation to raise the topic.

5.6.1 Beliefs about consequences

5.6.1.1 Concern that patient will feel alienated and disengage from healthcare

Beliefs about the negative consequences of talking to patients were particularly salient from the interviews with nurses. Whilst only a minority of nurses

were worried about alienating patients by talking to them about weight, all nurses raised the possibility of this consequence. Several of the nurses were mindful that patients might repeatedly have their weight broached by health professionals and they did not want to contribute to any marginalisation a patient may feel:

> "*For fear of putting the patient off coming forward, really, because there is this perception that, "Oh, the doctor's going to blame my weight. The nurse is going to blame my weight. Whatever's wrong with me, it's going to be my weight." And it's not always – it' is sometimes, but it's not always. And I think we don't want to drum on too much.*" (Nurse 4)

Many of the nurses emphasised the unknown consequences of raising the topic with a major concern being that patients would not return:

> "*Not knowing how that information is going to sit with the patient, whether you're going to upset them, you know really you know I understand how tough it is for them and I want them to come back…I just don't want to offend them.*" (Nurse 1)

A patient's other medical problems and broader social circumstances were also taken into account and could act as a barrier to raising the topic for nurses who did not want to 'burden' patients if they had other priorities. The following quotation demonstrates a perception that the context of a general practice consultation is not always conducive to opportunistic discussion about a topic which is likely to elicit an emotional response:

> "*Yes, I think you're conscious that you don't want to make somebody's life any worse potentially than it already is at that point because if they've come to the doctors very often, you know, there may well be some other issue going on, so you certainly don't want to make the burden on them any greater.*" (Nurse 17)

5.6.1.2 Concern about negative responses

Nurses discussed the possibility of a range of negative consequences as a result of a patient's weight being broached in the consultation. These consequences included patients going home to comfort eat, the reinforcement of low self-esteem, patients feeling judged and despondency. The potential for patient to feel judged was a central concern for many nurses.

"Then they just think, 'Oh, she thinks I'm fat,' or, 'She sees me as a big person.' That is what people think and people worry about. I would just hate to upset them even – I would just hate them to think that I'm judging them because I'm not. You are not judging someone in that you are not saying, 'You are a bad person because you are overweight.' But it's the whole judgment thing really." (Nurse 15)

Nurses also raised the possibility of evoking an angry reaction from patients. However, not all nurses saw an angry reaction as a barrier to raising the topic, as the following excerpt illustrates:

"Patients can get angry sometimes, they don't want to know. So, in that case you, sort of, crawl under the table and think, "Well, I wish I hadn't bothered." But there's always a reason and you should always ask, you know, I might get head bitten off but at least I've tried. So the disadvantages basically are upsetting people sometimes." (Nurse 16)

5.6.1.3 Potential to open a can of worms

Although only a minority of nurses raised the 'potential to open a can of worms' as a barrier, obesity and weight were viewed as topics that took time to explore and which related to a web of factors, and thus some nurses explained that they were reluctant to broach the topic. The lack of support and resources for managing a complex problem like obesity seemed to contribute to nurses feeling unwilling to raise the topic:

"Are you going to open up a can of worms and not be able to deal with it or provide support because there's no…well as far as I'm aware there's nowhere really where we can send them." (Nurse 1)

5.6.2 Beliefs about capabilities

5.6.2.1 Feeling ineffective at helping patients with weight loss

It was clear that the feeling of being ineffective at helping patients achieve weight loss, was a major barrier for some nurses. One nurse explained feeling less able to influence obesity than acute problems, thus consultations about obesity were less likely to have a positive outcome:

"Just the whole kind of thing: actually am I going to be successful here? At least with somebody's wound you've got a fair chance of actually getting

them better. And I like that sort of consultation, that sort of thing: you see patient, you identify the problem, you sort the problem out, brilliant off they go on their merry way; you've got a happy outcome. Whereas actually obesity management you very rarely have that happy outcome. You know, it's just an on-going thing." (Nurse 3)

This notion of obesity as an on-going, chronic problem was also emphasised in another interview from a nurse who was less confident about helping patients with sustained weight-loss:

"My feeling is possibly that you possibly have an impact at that point in time but how long that impact is sustained after they shut the door and walk out the surgery, that's the issue, isn't it?" (Nurse 17)

However, this was an area of divergent views and many nurses were confident that they could help trigger change by initiating a discussion about weight. Nurses discussed being able to offer encouragement, instigate change through their rapport with patients and helping patients with weight maintenance at the very least. Some nurses raised the possibility of patients wanting to talk about weight but not doing so due to a lack of confidence. In such cases raising the topic was likely to be effective since patients were likely to already be motivated to lose weight.

"Well, you might just get somebody who actually has been meaning to raise it for ages and hasn't done because they're embarrassed about the whole thing, and if you raise it then they can say, 'Oh yes, I would like to do something', and, you know, you've got them".(Nurse 10)

Interestingly, those nurses who had participated in training or research studies and who felt they had advice to offer patients, reported feeling competent at being able to support patients with weight loss:

"I don't find it that difficult any more. I think I may be used to but I think again because we took part in the power study and things I think I find it a bit easier. I think I find it easier in the fact that before - it's okay to raise a patient's issue of weight, but if you've not got any advice to give them then what's the point? If you can't help them or do something then… It's okay saying "Eat less" but if you can't give them any help and advice then what's the point in raising it,

I think. So yeah, so I don't mind so much now because at least I can sort of steer them, give them a bit of advice". (Nurse 11)

5.6.3 Emotion

5.6.3.1 Fear of upsetting patients

Although many nurses discussed feeling comfortable dealing with patient emotions, there was a worry that patients were being targeted by other clinicians to lose weight and so some nurses were conscious about how hard it might be for patients to hear from another practitioner that their weight was a problem. Again there was worry that patients would feel judged about their weight:

"It's just my worry that it's not going to sit well cause it must be the hardest thing cause I know that possibly most people are already conscious of their weight so to be told by every single practitioner they see about their weight is a bit negative isn't it". (Nurse 1)

As the following excerpt demonstrates, there is fear in this area about how patients will react and respond. In addition, personal opinions and experience contribute to beliefs that talking about weight will be upsetting for patients:

"A fear of upsetting people I suppose; it's quite personal and I would not like it if my doctor said to me "Your BMI is creeping up". I would hate it and I hate being weighed at the doctor's. So I think "Well, if I feel like that if you're five kilo or ten kilograms heavier than me how must you feel?" (Nurse 3)

5.6.3.2 Feeling awkward/uncomfortable raising the topic

A minority of nurses expressed discomfort and feelings of awkwardness about talking to patients about weight. This was mainly linked to judgment and overlaps with other barriers such as beliefs about negative responses and lacking skills to raise the topic sensitively. Other nurses expressed a general feeling of confidence to raise the topic but noted factors that made the task more difficult such as patient emotions:

"I couldn't say it's always very comfortable, definitely, because sometimes the patient's very embarrassed about their weight, so I suppose that might make me feel slightly less confident if I've got a sense that that person was very embarrassed about it". (Nurse 17)

This feeling of awkwardness contrasted with feeling comfortable with different types of reactions and responses:

"I think I'm quite good at picking up on peoples body language and I'm quite comfortable about people saying to me, I don't wish to discuss it' and I'm quite comfortable saying 'that's fine, it's your body' type of thing. I don't have a problem with that". (Nurse 9)

Another nurse talked about how she had to ask 'awkward' questions regularly in her role as a nurse and that experience had helped her see it as part of a normal duty:

"I don't mind, I'm so used to it now. It's another awkward question, well there's hundreds of awkward questions we ask all the time. And if I'm not awkward about it, hopefully they're not, you know, it's just a normal conversation." (Nurse 10)

Experience of raising the topic appeared to make the task easier to do as well as learning ways to react to patient responses and feeling equipped to support patients:

"I find it very easy to raise it and I'm very sensitive to the responses I get, and I've learnt ways to... Like I've said to you, if somebody says, "Oh no, no, I can't bear to see it," I say, "Well don't look, I'll take the numbers". So they don't look, I take the numbers but they are invariably interested and ask what it is. That then leads on to saying, you know, the things that we can do."(Nurse 14)

5.6.3.3 Hopelessness

There was a sense of disengagement for those nurses who felt ineffective in the area. As was evident from other barriers, the long-term and chronic nature of obesity seems to present difficultly for nurses who feel unable to help patients:

"I know it's necessary erm but when you know that somebodys doing their very best is hopelessness for me really as well that I can't help someone or can't make a change for them you know some people say they don't want to see a dietician again because they've seen one in the past and it wasn't helpful or they don't want to go on our course that we run the newly

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diagnosed diabetics coz they've heard it all before so it is despondent that we can't find a way to help." (Nurse 1)

Some nurses drew on their experience to demonstrate that whilst they had felt a sense of optimism, they now felt pessimistic about being able to help patients. Interestingly nurses attributed lack of success to patients not abiding by their advice suggesting that a proportion of nurses lack awareness of the complexity of obesity and have expectations that obesity is within the control of an individual. Rather than recognise the chronic nature of obesity, some nurses seem to talk about obesity as if it were an acute medical problem, capable of being 'fixed' if patients take up their advice.

Whilst illustrating that a proportion of nurses felt hopeless it is however important to recognise that other nurses were extremely optimistic about being able to support patients with weight loss. Again this is an area of divergent views.

5.6.3.4 Frustration

There seemed to be a sense of frustration as well as hopelessness from a minority of nurses who were familiar with patients failing to lose weight. This frustration seemed to relate to beliefs that patients do not adhere to advice and the societal contributors to high prevalence rates of obesity:

"Dismay, despair, because, as I say, you don't tend to get success with it. In the past I was quite "Oh yes, great, I'm going to do this" and I was much up for it. But I think now I'm more despondent because, as I say, I don't find that people do what they should be doing to lose more weight in obesity management clinics, and I've tried to sort of talk to other people and find out what they find helpful – people not just from this practice, from other practices – and I get the impression that we're all a bit the same. And, as I say, I just feel that we're fighting society." (Nurse 3)

5.6.4 Professional role and identification

5.6.4.1 Impact of own weight status

Nurses talked about their own weight as a factor which they considered made it more difficult or easier to start a discussion about weight. Both 'overweight' and 'normal' weight nurses believed that their own weight made it difficult to broach the topic and support patients with weight loss. Thus, there did not appear to be a straightforward relationship between weight status and feeling uncomfortable about

raising the topic with both overweight and normal weight nurses feeling aware of their weight and how it may be judged by patients when discussing weight:

"I've found it quite difficult because I'm overweight myself, so I find it difficult talking to others about weight issues when I'm overweight myself, so. Because it's very difficult to lose weight. But I know it's my job and I know I have to, so I do, you know. You know, I suppose some patients look at me and say, "Well, why are you talking about weight when you're overweight yourself?" But it's my job, it's what I do." (Nurse 16)

Some nurses who categorised themselves as 'normal' weight believed patients would see them as lacking empathy:

"If I was overweight I would find it easier to bring up the weight loss for someone because you could almost recognise with them, you could almost say, 'I've been there. It's bloody hard work.' I struggle with my own weight but if I said that to a patient they would look at me, someone that is not overweight, and, 'Of course you don't." (Nurse 15)

5.6.4.2 Personal feelings about advocating weight loss

It was evident that nurses had personal perspectives on raising the topic of weight. These beliefs may act as barriers to raising the topic.

"My own children that had anorexia so I quite like the idea of bigger people. I don't feel that I want to get fixed on weight, I think there are a lot of other as important issues...My own personal emotional feeling is that smoking has a much bigger impact on ill health than obesity does, that's my own belief, I don't know whether that's right." (Nurse 8)

Several nurses commented that they would not like their doctor or nurse to broach the topic of weight, or use certain language with them, suggesting that personal opinions are important in this area of practice:

"There are some people that say 'urgh I don't want to be told I'm obese' that does happen but it's a technical term but I wouldn't like it, I'm virtually, verging on the, well I'm certainly in the overweight category personally so I know it feels uncomfortable." (Nurse 9)

5.6.5 Social influences

5.6.5.1 Perceptions about patient receptiveness to advice

In terms of the influence of important others on raising the topic, the views of patients were considered of vital importance. The following excerpt suggests nurses predict how patients will react to their weight loss intervention and will bring the issue up if it is considered acceptable and wanted by patients. Talking about weight can be considered to be intrusive and stepping into the private realm of a patient's life and thus the judgement of whether to raise it or not seems to lie on a prediction of how receptive the patient will be to the intervention:

"In my consultations I try to focus on what the patient wants to bring, so if they don't mention it because they don't want to then I won't because I would feel that an intrusion. But when you're kind of going through the examination bit there may be an opportunity there and you just see how they react to actually being weighed or not wanting to be weighed or whatever to see if there is an opportunity to discuss." (Nurse 8)

5.7 Lacking time and resources to deal with a sensitive issue

The final theme incorporates two behavioural domains of the TDF: GP practice and available resources, and, Competing goals. It demonstrates how structural barriers limit the opportunity for nurses to discuss a topic which has to be negotiated and discussed with sensitivity and has the potential to evoke emotions. This barrier emerged for nurses whose appointments were 10 minutes as well as for those with longer appointments (e.g. 20 minutes) although it seemed to be particularly salient for those with shorter time frames and who were more focused on dealing with a patient's presenting problem.

5.7.1 GP Practice and available resources:

5.7.1.1 Having time to open up a sensitive issue

Due to the sensitivity of obesity and weight loss discussions, nurses discussed how adequate time was needed in which the issue could be explored with the patient. This barrier was relevant for all nurses but was particularly salient to those nurses who worked in a role with shorter consultation times. As the following excerpt demonstrates, if a sensitive topic is raised, there must be time to explore that issue and currently the consultation prevents such an exploration of the topic:

"My main problem is trying to work within this incredibly stressed time frames in which we work in which is sometimes I just don't have time. I don't want to raise it because I haven't got time to talk about it and so I can't and it's as simple as that so it would be more to do with time pressures than anything else because there's not point raising a topic if you can't then tackle it or deal with it". (Nurse 9)

Having time to offer support rather than just raise awareness of the topic then was considered essential in the process of raising the issue. Some nurses considered that exploring the issue with a patient and offering advice was part of their role when raising the issue. Thus for many nurses raising the issue of weight is not a single or isolated behaviour but consists of multiple behaviours associated and interactive with other behaviours (such as exploring the issue and offering advice):

"I don't think it takes long to raise the issue; it then takes a long time to deal with the issue. But raising it doesn't take long for you to just say to somebody 'We've done these measurements and actually you're a bit overweight and your BMI is this; have you considered doping anything about it?' That bit doesn't take long. Then it's what you're going to do about it that takes the time." (Nurse 11)

The issue of lack of time relates to the difficulty of raising the topic of weight when it does not relate to the medical problem a patient consults with. Again this emphasises that within some general practice consultations (for example those concerned with minor illness) there is a perceived lack of opportunity for broaching other issues:

"The issue for me is that I have a very, very short amount of time to see people for what they're presenting with here and now. And, yes, if I had ample time then, yes, part of the consultation could be leading on to other things, like their weight and their smoking and things like that, but the simple fact of life is we don't get that long in minor illness to see people – and there's usually a queue– so it's just getting on with it and doing the job as quickly as possible." (Nurse 6)

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5.7.1.2 Feeling like there's nothing to offer patients

Some nurses felt unable to offer patients any good quality help for weight loss. Whilst most nurses were aware of weight management referral options, some predicted these would be unsuccessful:

"Now we can do Weightwatchers and Slimming World, I offer them that, but I think, to be honest, I personally, and it is a personal thing, feel that all these diet things in the diet industry is not the way we should be going because I think it just doesn't work because people yo-yo all the time." (Nurse 2)

Other nurses discussed lacking anything to give patients who wanted help with weight loss. Nurses felt lacking is this area yet good resources and referral options are required given the restrictions nurses are under:

"A lot of patients come in and say, "Can I have a diet sheet?" or "Can I have...?" They obviously want something to take away. And when you're constricted with time having something to give to somebody is a good idea, I think, and I haven't found anything that I've ever thought was a really good resource to be able to hand to somebody." (Nurse 17)

5.7.1.3 No continuity of care

The majority of nurses felt that continuity of care was important for raising the topic of weight and whilst most saw the continuity of care their role afforded as an enabler to raising the topic, a minority of nurses did not have roles that facilitated future consultations with patients (e.g. those in minor illness roles). Continuity of care thus seems to be an important factor determining whether weight will be raised and the quotation below is from a general practice nurse with concerns about continuity of care becoming a barrier to raising the issue in the future:

"If the surgery becomes really busy, I can almost see that they might turn around and tell me as a registered nurse that I haven't got time to see these patients and that the healthcare support worker needs to see them. And that would then decrease my job satisfaction. …if I start a consultation a lot of it is about continuity with the same person. You are the one that has initiated the conversation and built the trust and got to know somebody" (Nurse 12)

5.7.2 Competing demands

5.7.2.1 Prioritising other areas of patient care

Nurses talked about the requirement for it to be 'the right time' to raise the issue and this depended on a patients other health needs. As well as considering the purpose of the visit, nurses discussed the patient's broader health needs which were often ongoing.   If patients were judged to be suffering from anxiety and depression, nurses discussed dealing with these problems before talking to patients about weight:

"*Well clearly if someone's really, really depressed and that does happen sometimes, in fact I saw someone just yesterday who I know is a very depressed lady, she is overweight, she knows she's very overweight that was the last thing that I would of brought up with her because she, we need to keep her coming in because of various things we need to do err so you simply wouldn't raise the issue with her, not at this time, possibly never*." (Nurse 9)

Nurses endorsed a patient-centred approach by raising the topic if they judged it to be in the best interests of the patient at the time. Nurses thus make a judgment about when to raise the topic of weight and one consideration is a patient's other medical conditions, broader social context and whether weight loss is likely to be helpful in comparison to other issues which could be targeted.

"*If there were other things going on that were important as well and that was actually just one of three or four things, all the other three or four being in the end at that point in their lives more important, then I'm not going to frighten somebody off because they think I'm going to nag them every time they walk through the door. And that would be the same with a lot of things; you have to get your priorities right, what's important for them at this moment. So there may be times when I don't say a lot because it's not going to help them at that point*." (Nurse 10)

5.7.2.2 Prioritising other public health concerns

More specifically, the requirement to raise other public health concerns such as smoking and alcohol consumption could act as a barrier within each consultation to talk about weight. Pressure to raise topics such as smoking and blood pressure

in line with the QOF requirements sometimes acted as a barrier to talking about weight:

"That's the trouble isn't it, it's the conflict of time for all the other things that we're supposed to do in a ten minute consultation, of which probably smoking cessation comes quite high on the sort of health promotion thing... and alcohol, of course, that's another." (Nurse 17)

5.8 Discussion

5.8.1 Summary of findings and comparison with previous literature

The aim of the study was to systematically map the perspectives of primary care nurses to the TDF in order to identify and elicit a theoretical understanding of the barriers to raising the topic of weight in general practice. Twenty-two barriers across 9 theoretical domains were identified and synthesised into three main themes: limited understanding about obesity care; beliefs about consequences; and, lacking time and resources to raise a sensitive topic. I will now go on to discuss these themes in relation to wider research findings in the field. In considering the findings, it is important to emphasise the diversity of views expressed by nurses which can be partly attributed to the heterogeneous sample of primary care nurses included in the study. Nursing roles ranged from generalist practice nurse to specialist areas such as diabetes and chronic obstructive pulmonary disease (COPD).

5.8.1.1 Limited understanding about obesity care

The first theme, 'limited understanding about obesity care*'*, reflects the finding that nurses lacked the skills and knowledge to talk to patients about weight loss during routine appointments as suggested by guidelines and policy documents. The majority of nurses were not aware or familiar with the content of any guidelines around weight management. It was also possible to detect that nurses had a low understanding about the complexity of obesity particularly the chronic and relapsing nature of the condition. This finding suggests a lack of engagement with NICE guidelines (and the current evidence-base regarding obesity care) and has been reported in other research (Kable et al, 2015; Turner et al, 2009). It remains to be determined whether familiarity with the guidelines will increase nurse knowledge about the complexity of obesity or that overweight and obesity can be considered legitimate medical concerns requiring health professional support.

Knowledge and skills are important theoretical domains to consider in terms of mediators to behaviour change. Interestingly those nurses who reported feeling more confident attributed this to training in weight management and/or having a role in which weight management was a key part. In addition, nurses involved in obesity research studies suggested this had a positive influence on their knowledge of obesity care and thus confidence. This aligns with research that has reported that nurses who run weight loss clinics feel more positive about their effectiveness and confidence when working with patients to achieve weight loss (Hoppe & Ogden, 1997; Nolan et al, 2012). However, it should be noted that one participant specialising in diabetes care (and thus weight management was central to her role) reported feeling discomfort, awkwardness and fear about raising the topic of weight. Whilst this may be more related to diabetes than obesity, and/or the individual clinician, caution should be taken in assuming that training and involvement in weight loss clinics/research is enough to overcome barriers to providing obesity care. Further research is thus needed to establish the relationship between increased knowledge of evidence-based obesity care and clinician behaviour.

Whilst many nurses reported they had the communication skills to sensitively raise the topic of weight with patients, several nurses in the current study felt they lacked these skills. There are mixed findings from other studies. A recent qualitative study reported that nurses do feel confident that they have the required communication skills to talk to patient about obesity (Nolan et al, 2012), yet other studies report that nurses feel ill-equipped and require training specifically around how to broach and communicate about weight and obesity (Keyworth et al, 2012; Moorhead et al, 2013). Aligning with the finding that nurses require further training, this study found that pejorative understandings about obesity in wider society contribute to the difficulty for nurses to broach the topic with nurses feeling concerned about causing offense and appearing judgemental. This finding suggests an opportunity to support nurses to develop skills to broach weight in a non-judgmental and non-stigmatising way.

This study also identified that the majority of nurses found it difficult to raise the topic of weight without being able to link the discussion with the purpose of the patient's visit or a weight-related medical problem/condition. Other research has highlighted that nurses perform their weight management and health promotion roles using an expert-led and medical approach (Nolan et al, 2012) and tend to put

excessive emphasis on the health risks of obesity (Brown et al, 2007). The lack of knowledge and skills to talk about obesity in a preventative manner or in the absence of other medical problems may thus be contributing to the perceived difficulties. The study also found that some nurses did not believe it was appropriate to raise the topic of weight in a preventative manner (e.g. with patients who were overweight or obese with no symptoms or comorbidities), again suggesting limited understanding that obesity and overweight are legitimate health concerns in their own right that patients should be offered support for. This aligns with other studies which report that nurses are more likely to raise the topic when patients present with comorbidities (Brown & Psarou, 2007; Counterweight Project Team, 2004; Mercer & Tessier, 2001).

The ambivalence towards obesity as a medical problem, including lack of insight into obesity as a complex medical problem, was considered an important finding. This finding had been classified as corresponding to the 'knowledge' domain since it shows a lack of knowledge of guidelines which clearly demarcate obesity as a medical condition and as part of a nurse's role. It also aligns to the coding framework used by Heslehurst et al, which incorporates knowledge of the condition and 'schemas, mind sets and illness representations' (Heslehurst et al, 2014). However this barrier could also sit within the domain 'Professional role and identification' since it suggests nurses feel conflicted about obesity as their responsibility despite acknowledging that obesity is important. This finding aligns with other research reporting ambivalence about obesity as a medical problem (Brown & Thompson, 2007; Brown et al, 2007; Mercer & Tessier, 2001) and mixed opinion about whether it is the nurses role and duty to deliver obesity care (Keyworth et al, 2012).

In relation to identifying that nurses hold variable views as to where obesity is a legitimate and complex medical condition, it is interesting that the majority of nurses emphasised individual behaviour and personal responsibility when discussing their views on obesity and raising the topic of weight. Whilst it is not clear what the effects of holding such assumptions are, the findings suggest a lack of understanding about the long-term and multi-disciplinary support that many patients with obesity require. These assumptions also demonstrate the complexity of nurse attitudes and suggest that nurses do not simply have attitudes which reflect wider cultural stereotypes (as has been suggested by some studies such as Budd,

Mariotti, Graff, & Falkenstein, 2011; Puhl & Heuer, 2009). However beliefs about personal responsibility underpin negative attitudes towards obesity (Puhl & Brownell, 2003) thus it is important for future research to look more at nurse's understandings of obesity including views on responsibility.

5.8.1.2 Beliefs about consequences

The second theme, 'Beliefs about consequences' includes barriers from five domains of the TDF: beliefs about consequences, beliefs about capabilities, emotion, professional role and identification, and social influences. These barriers were synthesised since they all relate to the potential outcomes of initiating discussion about weight loss.

Adding to the previous research, the study identified that nurses are worried about patients feeling judged, embarrassed and alienated if they broach the topic of weight (Keyworth et al, 2014; Michie, 2007; Phillips et al, 2013). Nurses also demonstrated concern that patients would feel all problems were being attributed to excess weight. Interestingly, research has highlighted that health professionals are in danger of overstating the risks of obesity (Brown et al, 2007; Monaghan, 2005). Whilst concerned about appearing judgmental, the majority of nurses emphasised that they felt well positioned to support patients with their emotional reactions. Unlike some other studies (Phillips et al, 2013), in the current study nurses did not emphasise their worry of damaging their relationship with patients although the majority of nurses identified that patients could feel judged as a result of raising the issue and strove to avoid this. Despite it not being referred to explicitly, many nurses seemed to recognise the stigma of obesity and wished to avoid perpetuating any negative emotions experienced by patients. Given that nearly all nurses reported that addressing obesity in general practice was important, nurses appear to hold conflicting attitudes about broaching weight.   These findings resonate with other studies suggesting attitudes about obesity are complex and conflicting (Aranda & McGreevy, 2014; Brown et al, 2007).

Nurse emotions identified in this study include fear, awkwardness, hopelessness and frustration. These are important findings since studies have shown that patients are able to detect health professional awkwardness and ambivalence and these feelings may perpetuate stigma and feelings of shame (Merrill & Grassley, 2008; Mold & Forbes, 2011). It is also interesting to note that whilst nurses did not explicitly express stigmatising attitudes, the frustration and

assumption that patients should lose weight and that obesity was due to a lack of motivation/self-control suggests a complex composition of attitudes. The hopelessness and frustration expressed by clinicians seemed to link with views about a nurse's perception of their efficacy to help patients achieve weight loss. Whilst establishing how the barriers relate was not an aim of this study, future research may wish to look into the relationship between these two barriers. Other research points out that clinician expectations about weight loss may be too ambitious (i.e. more than the recommended 5-10%), and suggest that the relapsing and chronic nature of obesity should be recognised and outcomes other than weight (e.g. disease risk reduction and quality of life) should be valued (Brown et al, 2007; Harvey, Glenny, Kirk, & Summerbell, 2001). It should be noted that whilst many nurses were optimistic about raising the topic of weight and expressed beliefs that weight was modifiable, many of these nurses simultaneously expressed doubt about the efficacy of weight loss interventions.

Another important finding of the study is that a nurse's own weight status and personal opinions around weight loss are important factors influencing beliefs about raising the topic of weight. Own weight status related to emotions, such as feeling uncomfortable/awkward talking about weight and concern that patients would feel judged. This is important in light of other studies which have reported that nurses are conscious of their own weight during medical consultations (Aranda & McGreevy, 2014; Brown et al, 2007). Similar to the qualitative study by Brown and Thompson (2007), several nurses with a BMI classified in the normal range discussed their concerns that patients would feel judged and perceive them to lack empathy. However, a diversity of views was given on this matter, with several nurses classified as normal weight describing their weight as an enabler since they felt like credible role models. A diversity of views was also evident for those nurses with BMIs classified as overweight or obese. Whilst excess weight was perceived to facilitate empathy with patients and allowed practitioners to disclose their weight loss efforts, others found it a very 'awkward' and personal issue to raise which contributed to feelings of being an inadequate role model. Findings thus demonstrate a complex relationship between own weight status and weight management practice. Although a systematic review concluded that doctors and nurses identifying as normal weight were more likely than those identifying as overweight or obese to provide advice about weight loss (Zhu et al, 2011), it seems that further research is needed to clarify the relationship between weight status and

health professional behaviour. Identifying as 'normal weight' may also be an important barrier for nurses (Brown & Thompson, 2007).

Personal opinions about weight loss were also identified as barriers to broaching the topic. Given that weight is highly intertwined with identity and self-esteem (Schwartz & Brownell, 2004; Miller & Downey, 1999) and that the incidence of eating disorders is increasing in society (Micali et al, 2013), this is an important finding. There is a lack of research looking into how health professional personal views and attitudes about weight/weight loss contribute to beliefs and practice, thus it is an area apt for future research.

Finally, it is interesting to discuss barriers related to the social influences domain of the TDF. Beliefs about patient receptiveness to advice was identified as a potential barrier, which contributes to findings that nurses make assumptions about how motivated patients are (Brown et al, 2007; Mercer & Tessier, 2001). Beliefs that weight should only be broached with 'receptive' patients may miss one of the points of raising the issue which is to start a process of change with patients and to avoid eliciting resistance (Rollnick et al, 2005) and also suggests nurses are categorising patients. It may be that nurses are lacking skills in lifestyle counselling and dealing with behaviour change, tasks which differ to those involved in many other medical problems (Chisholm et al, 2012; Kable et al, 2015; Keyworth et al, 2012).

5.8.1.3 Lacking time and resources to raise a sensitive topic

The final theme was 'Lacking time and resources to raise a sensitive topic'. The finding that most nurses working within the constraints of a 10 minute appointment found it difficult to raise the topic of weight confirm that time in the consultation is an important determinant of behaviour related to weight management (Michie, 2007; Shay, Shobert, Seibert, & Thomas, 2009). The shortage of time appeared to be an important issue due to the emotive nature of communication about obesity and the challenges of unpicking a complex problem. Nurses thus expressed reluctance to raise an issue which they perceived they did not have time to provide advice for or could refer to a specialist provider. Interestingly even nurses with longer appointment times raised time as a barrier due to competing goals in the consultation. These findings demonstrate the importance of considering a nurses role given that time in consultations, the nature of the medical problems, and ability to follow-up is so diverse.

5.8.2 Implications for research and practice

Findings demonstrate that knowledge and skills around how and when to communicate about excess weight are inconsistent with clinical guidelines on obesity (NICE, 2014 cg 43). As advocated by other researchers in the field, there is a need for advanced communication skills training for nurses (Keyworth et al, 2012; Moorhead et al, 2013) including education on how to address sensitive topics (Miller et al, 2008). Given the range and complexity of attitudes about obesity, training should empower clinicians with knowledge about stigma and demonstrate how stigma can influence the clinical encounter (Brown & Flint, 2013). Such education could also equip those clinicians who are concerned about patients feeling judged and/or alienated by raising the topic with the skills to discuss weight in a non-judgmental and non-harmful way. In addition, findings suggest that the complexity of obesity as a chronic and relapsing condition is not fully recognised by nurses who voice frustration about patient's lack of success at weight loss. Whilst clear that education and training is required to ensure nurses understand more about the complex nature of obesity and learn the skills to facilitate behaviour change with patients, it should be noted that the evidence base of how best to deliver this type of training is limited (Chisholm, 2012; Keyworth et al, 2012).

Training around motivational interviewing may also be useful to consider for nurses, particularly since this study suggested a lack of understanding about motivation. Equipping nurses with the skills to raise the topic of weight in a non-confrontational manner and to recognise ambivalence rather than lack of motivation, might overcome barriers related to emotions and beliefs about consequences. Whilst there is evidence that motivational interviewing is effective for weight loss, there remains limited evidence that it can be delivered effectively within the ten minute consultation (National Obesity Observatory, 2011). However, as a patient-centred approach, it may offer solutions to many of the barriers nurses experience and lead to other important outputs such as maintaining a strong therapeutic relationship and patient satisfaction.

Future research is needed to enhance understanding about how a nurses own weight status impacts on beliefs and behaviours about broaching the topic of weight and providing weight loss-support. This study has identified emotions (frustration, awkwardness) that nurses may experience as a result of working with patients to lose weight. It is important for research to look at whether the constant

pressure on health professionals to address the topic of weight and act as role models to patients is impacting negatively on their own health as well as their practice with patients. Previous studies have suggested that nurses feel anxious about being judged by patients, and suffer from inner conflict particularly due to not being good role models (Aranda & McGreevy, 2014). There are also implications for practice. Policy makers and medical authorities urging clinicians to talk to patients about weight need to be mindful that nurses are subject to the negative effects of stigma and that feelings of ambivalence are likely to continue if feelings of dissonance, guilt, prejudice and detachment are not addressed (Aranda & McGreevy, 2014; Brown et al, 2007). An approach in which impression management could be studied, such as conversational analysis, might also be a fruitful area of further study.

In regards to the barriers related to time and resources, considering that these barriers were more salient for those nurses in 10 minute consultations, it is important for policy makers/medical institutions to recognise that discussions about weight require time to enable sensitive communication and to facilitate the exploration of emotions. Diversity in nursing roles should also be considered since factors related to nurse role such as length of consultation, purpose of the visit and ability to follow-up will limit the opportunity for nurses to raise the topic. Any interventions then should be sensitive to the time and resource pressures facing nurses which will differ depending on the specific role of the nurse.

5.9 Comparison of GP and nurse barriers

In chapter 4, the analysis of GP barriers resulted in 24 barriers mapped onto 10 behavioural domains. In this study, 21 barriers were identified and mapped onto 9 behavioural domains. Four barriers identified from GP perspectives were not identified in nurse perspectives and one barrier identified from nurse's perspectives were unique to nurses.

First, nurses appeared to place less emphasis on their fear of damaging their relationship with patients. This differs to other research which demonstrates that nurses are also concerned about their relationship with patients breaking down (Keyworth et al, 2012). In the current study, although nurses expressed concern about patients feeling judged and alienated, there was less emphasis on the relationship. The third difference is the finding that GPs' view raising the issue as a threat to their professional reputation, a barrier that was not identified for nurses.

Closely related to this barrier is that GPs put emphasis on adhering to their patient's agenda which again did not seem to be the case by nurses. That these barriers are unique to GPs, highlights the importance of the relationship between doctor and patient. Research has highlighted that the relationship between doctor and patient can be elevated to a position that results in collusion (Chew-Graham, May & Roland, 2004). However, it might also demonstrate how powerful the stigma around weight is which prevents it being discussed even between two individuals with a long-term relationship. GPs were particularly concerned about losing patient trust, which is central to the doctor-patient relationship again highlighting perceptions about the negative construction of weight in society and its ability to offend people if spoken about.

One barrier, prioritising public health concerns, was unique to nurses. This barrier highlights that for any single consultation, a nurse has multiple competing goals thus may lack the opportunity to discuss weight with patients. A possible explanation for this finding is that nurses have a well-defined role in achieving public health targets and so as well as talking to patients about weight, are also talking to patients about smoking, alcohol, checking blood pressure etc. It is interesting that nurses said they often prioritised raising the topic of smoking over weight given the low QOF points attributed to recording a BMI (8 points out of a maximum of 900 points) compared to the QOF points for recording that a patient smokes and offering patients who smoke support to stop (25 points can be achieved for identifying a smoker and 25 points for offering support). Research has highlighted that whilst those areas of care associated with financial incentives have improved, these improvements have been at the expense of small detrimental effects on those areas of care not incentivised (Doran et al, 2011). When compared to GPs it may demonstrate that nurses are already engaged in preventative and public health tasks whereas GPs are dealing with acute problems, although this is a speculative explanation and requires further research.

Finally, it should be noted that four of the nurses interviewed had a BMI in the obese range, whereas only GPs classified as normal and overweight were included in the study so it is not possible to determine if identifying as obese is a barrier that extends to GPs. This gap also reflects previous literature since no study in the UK has identified the perception and views of overweight and obese GPs towards their own weight status. That research has only been carried out with

nurses may be reflective of the high levels of obesity reported in nurses as an occupational group (Bogossian et al, 2012; Miller, 2008). Nurses and GPs may be vulnerable to the societal stigma that patients are (Aranda & McGreevy, 2014) and may be subject to additional stigma from their own occupational group, thus further research including GPs who identify as obese would be helpful.

5.10 Limitations to study 1 and 2

There are several limitations to the first two empirical studies of the thesis that need to be considered. The first relates to the heterogeneous sample of nurses involved in the study including practice nurses and more specialist nurses ranging from diabetes nurses to those specialising in asthma and COPD, as well as Duty nurses looking after acute conditions during emergency appointments. The nature of the sample resulted in a broad range of barriers and there were a diversity of views expressed by nurses in regards to each of the interview topics prohibiting insight into those barriers specific to certain nursing roles due to low numbers in each role. However, the sample could also be considered a strength because it ensured that a broad range of views and barriers were captured and is arguably reflective of the nature of general practice today in which nurses occupy a variety of roles and the profession becoming more specialist and fragmented. This limitation and/or strength can also be applied to the sample of GPs recruited into study 1. The inclusion of locum GPs resulted in barriers which were specific to locum GPs rather than all GPs (for example lack of continuity of care).

A second limitation relates to the opportunities that nurses have to refer patients to weight management support, which differs by role. Whilst some nurses could refer patients (nurse practitioners), others could not or were not aware of being able to. Again this could also be considered a strength because it illuminated differences in beliefs about capabilities and emotions between those nurses who could refer and those who couldn't. Interestingly in the context of study 2 it demonstrated that even those nurses who could refer patients still expressed their belief that there was nothing to offer suggesting that the ability to refer patients does not overcome barriers related to beliefs about efficacy. The third limitation relates to the time GPs and nurses had available for the interviews which ranged from 30 minutes to 90 minutes. This relates to the limited time clinicians can give for interviews and demonstrates the practical challenges of conducting research in a busy clinical setting.

Finally, it is important to consider that those who agreed to be interviewed in the study may have a greater interest in weight management and thus be more enthusiastic about raising the topic and that all respondents were recruited from one geographical area. In addition, participants were made aware that the research was being sponsored by Wiltshire Public Health which may have influenced how respondents answered the interview questions, particularly given that there was some frustration about the lack of government intervention into obesity prevention. Although all participants were employed in general practices in Wiltshire, the sampling framework ensured participants were selected from practices in diverse settings (rural, urban and mixed) and of varied practice size.

5.11 Reflections of using the TDF

There were a number of strengths and limitations to using the TDF to inform the research design for study 1 and 2. In regards to strengths, the TDF ensured that a comprehensive and wide range of potential influences on behaviour were taken into consideration. Using the TDF thus prompts the identification of determinants of behaviour that might otherwise have been disregarded in research trying to understand health professional behaviour (Francis et al, 2012). Another strength is the efficiency with which the data can be coded since the TDF facilitates a focused analysis. Furthermore, the findings of this study can be used to inform a future study seeking to validate the findings which in turn could be used to inform a complex, evidence-based intervention. From a research perspective, using the TDF ensures the use of a common language for specifying target domains for behaviour change and contributes to the accumulating field of implementation science (Michie et al, 2011).

There were also several limitations to using the TDF. The first limitation relates to approaching the data with an informed but potentially constrained view (Hsieh & Shannon, 2005). It is important to consider that the TDF was used to inform the interview schedule and the analysis thus there was little scope to explore topics in addition to those specified by the theoretical framework. Whilst focusing the interviews, it may have excluded diverse perspectives outside of the predetermined domains to emerge. In the future it seems advisable to bring the theoretical framework in at a later date during the analysis process to ensure theoretical concepts are brought in that match the data and to ensure the detailed richness of the data is not lost. In study 1 and 2, the TDF was used to inform the

interviews resulting in a focused interview at the expense of exploration and new insight. It should be noted that to account for the limitation outlined, a number of processes were put in place. For example, as the analysis proceeded, the initial coding scheme was continually revisited and refined. Audio recordings and transcripts were continually revisited to look for disconfirming data and to ensure participants' accounts were central to the analysis.

Another and related limitation is that the findings do not reflect the richness and depth of the phenomenon. As an approach to qualitative research, it can be argued that using a framework does not elicit the idiosyncrasies that qualitative research is capable of achieving. By systematically mapping the barriers, the TDF distils the complexity of the data (Lipworth, 2013) and provides a comprehensive assessment of barriers at the cost of less focus on the depth of individual barriers. It is also relevant to note that similar to framework analysis, the TDF is not aligned with a particular epistemological, philosophical or theoretical approach perhaps reflecting its goal to "make psychological theory useful" (Francis et al, 2012, p. 2). Situating qualitative research in an epistemological and theoretical paradigm is considered highly important (Caelli et al, 2008) and, whilst this is a contested issue amongst qualitative researchers themselves (Thorne et al, 2008), it can be concluded that the TDF prioritises pragmatism at the expense of producing the rich understanding that qualitative research is capable of. Whilst it is claimed that using the TDF overcomes many problems within implementation studies which produce pragmatic rather than theoretically informed solutions to research problems (French et al, 2012), it is questionable whether the use of theory per se is enough to ensure that findings become anything more than pragmatic if the theoretical underpinnings of qualitative research is ignored.

Another important limitation of using the TDF, which has been discussed by several other authors, is that the framework does not specify relationships between each of the domains (Francis et al, 2009). However, it should be noted that the purpose of the TDF is to act as a step which involves the identification of barriers and then the mapping of these barriers to behavioural domains so that researchers can choose a relevant theory to explore associations between domains in more detail (French et al, 2012). In addition, given that the framework is relatively new in the field, future research may specify links between domains to improve the value of using the framework (Duncan et al, 2012). It should also be noted that domains

are not mutually exclusive. In some cases, barriers can be mapped to more than one domain which adds to the challenge of coding the data. However, as noted by Lipworth and colleagues comment, this may be a strength of the framework since the TDF is a tool for practical use and thus definitions do not need to be precise and mutually exclusive (Lipworth et al, 2013). Another advantage which comes from my own experience of coding barriers in the current study is that when difficulties arise in mapping barriers to codes, it is a good opportunity to discuss barriers at team meetings thus increasing insight into both the theoretical constructs within the domains and the actual data.

Finally, although the TDF was developed to represent theories of social and organisational behaviour, the experience of using the TDF suggests that the focus remains on individual cognitions and motivations and fails to adequately capture the complexity of the broader drivers of behaviours, a limitation recognised by other authors using the framework (Francis et al, 2012).

5.12 Conclusion

This chapter has identified and described barriers to raising the topic of weight from the perspectives of primary care nurses as well as comparing these barriers to those identified from the attitudes and views of GPs (study 1) and outlining the limitations to the methodological approach taken in study 1 and 2. By using the TDF it is clear that barriers operate across multiple domains of behaviour, and seem to be operating on multiple levels- both at an individual level and at the organisational level of general practice. Similar to GPs, nurses also lack understanding of obesity care thus require training and education and are concerned about patients' feeling judged and alienated suggesting that obesity stigma is contributing towards barriers to broaching the topic of weight with patients. The limitations of the TDF, particularly that it does not provide rich insight into barriers or incorporate theoretical concepts such as stigma and power, has prompted a change to a different theoretical approach to the study of health professional behaviour. As noted in the previous chapter, the findings of this study have been combined with study 1 and published in the BMJ online. A copy of the published manuscript is included within the appendices (appendix A). The next chapter seeks to focus on selected barriers that were identified as salient to the research problem during study 1 and 2, and to unravel how obesity is constructed in general practice. Given that GPs identified their relationship with patients as

contributing to their reluctance to raise the topic of weight, and since relationships are central to general practice care, a decision was made to focus the final empirical study on GPs. Therefore only the views of GPs are included in study 3, which is where the thesis will now turn.

Chapter 6: A critical analysis of barriers to raising the topic of weight in general practice: a turn to discourse

6.1 Introduction

In this chapter, I first provide a rationale for using trigger films to facilitate interviews with 20 GPs. The aim of this third and final empirical study is to trace how weight has come to be a problematic subject to negotiate and reach a common understanding about in general practice. This study differs to the previous two studies in important ways, both through the introduction of the trigger films, which represent a novel methodological approach, and given the discourse analytic approach underpinning the study signifying a shift to social constructionism. As the findings demonstrate I identify four discursive frameworks that GPs draw on to construct obesity and describe the ways GPs position themselves and patients within their constructions. After describing these frameworks and relating them to social theory, I briefly discuss and point to the implications of such discursive constructions.

6.2 Background to the study and research questions

This study involved the creation and use of trigger films (full details can be found in chapter 3, section 3.7). Trigger films are short scenes (video clips) depicting a typical clinical scenario (Ber & Alroy, 2001) often used in medical education and research to explore views on 'sensitive' issues such as breaking bad news and those issues which are ethically problematic (Blasco et al, 2010; Johnston & Chan, 2012). There are several benefits to using trigger films as an interview tool. Trigger films generate unique insight since they allow researchers to explore the dominant, shared understandings that the scene elicits and the less dominant ones that may emerge from showing the same set of stimuli to several practitioners (O'Dell, Crafter, de Abreu, & Cline, 2012). Trigger films can also be useful to generate rich data on subjective perceptions, feelings and experiences particularly if they recreate an authentic clinical scenario and thus act as an anchor to clinician's practice and experience (O'Dell et al, 2012). Films can also be useful to explore taken for granted assumptions (Garfinkel, 1967) and prompt clinicians to discuss details of the consultation and related feelings that they would otherwise fail to recall

in interviews. In addition, the films may prompt interviewees to talk about issues they consider important that the researcher has failed to capture in the films. In summary, trigger films have shown to be an effective and suitable research tool for use with health professionals and can generate rich and novel data around clinical problems. Using a visual methodology within this thesis was deemed to be particularly useful since interaction around obesity in healthcare is often complicated by the stigmatised nature and high visibility of the condition (Brown et al., 2006; Puhl & Heuer, 2009) and as was established in study 1 and 2, is a topic which generates assumptions as well as contradictory and complex attitudes.

In comparison to the previous studies in this thesis, this study adopted a different theoretical orientation. The shift to social constructionism and discourse analysis makes an important contribution to the field given the paucity of studies which have used this approach to understand socio-political and cultural influences on GP views and interactions regarding obesity prevention and management. There are many contested discourses surrounding obesity (Evans et al, 2008; Malson & Burns, 2009; Throsby, 2007) suggesting that power is an important theoretical concept to include in a study investigating barriers to raising the topic of weight. In addition, an approach which questions the knowledge and taken for granted assumptions surrounding obesity and doctor-patient communication is considered important.

Given the lack of research focused on a critical analysis barriers to raising the topic of weight in general practice, this study sought to explore the discursive power relations that shape how GPs understand and talk about obesity with patients by:

1. identifying the micro-political processes at play when GPs talk about the challenges of raising the topic of weight in general practice
2. relating the micro-political discourses identified in GP accounts about weight with macro-discourses surrounding obesity and general practice

To achieve these objectives, this study sought to answer the following research questions:

1. How do GPs discursively construct the challenges of raising the topic of weight whilst reflecting on trigger films of doctor-patient encounters?

2. What discourses shape GPs accounts of raising the topic of weight in general practice using trigger films to spark reflections?

6.3 Method

6.3.1 Design

This was a qualitative study using a discourse analytic approach informed by Michel Foucault. Trigger film interviews (see chapter 3, section 3.7 and 6.3.2) were carried out with 20 GPs.

6.3.2 Design and production of the trigger films

Each trigger film was designed based on insight from study 1 and 2. It is important to acknowledge that many other clinical scenarios could have been represented within trigger films but the following were designed to investigate salient barriers identified in study 1 and 2 and in the research literature. The first trigger film (figure 1) was designed to further explore reluctance to raising the issue of weight and to generate discussion about not raising the topic of weight when patients consult with a weight related problem. In study 1 and 2 the majority of clinicians claimed that their decision about whether to broach the topic of weight was based on whether patients had developed a weight related problem, with the majority asserting that they would talk about weight if patients had developed such problems. I made the decision to produce a trigger film whereby the doctor does not raise the issue of weight when a patient presents with a related problem to provoke views from clinicians about the duty of doctors to talk to patients about weight and to see if this was considered unusual (or usual) to GPs. By including this trigger film I aimed to stimulate discussion about the silence around obesity even in situations when there appears to be clear agreement from multiple stakeholders (e.g. public health, researchers and clinicians), that it is a Doctor's ethical duty to initiate discussion about weight.

The second trigger film (figure 2) was designed to (a) further explore views on when it is appropriate to raise the issue and (b) generate discussion about how patients react or respond when their doctor raises the issue. It was not clear from the data generated in study 1 and 2 which problems or symptoms are related to obesity by GPs and how such views differ. However, it was clear that there was likely to be a multitude of views on this so I chose to include a medical problem

which could be related to weight although not indefinitely. In the film the patient consulted with planta fasciitus, which I was aware from discussions with several GPs and internet research into medical problems, is a problem attributed to excess weight as well as a multitude of other factors. This film also included an encounter in which the patient became upset when their doctor asked them if they wanted to talk about weight. This related to the central finding in study 1 and 2 that clinicians are concerned about the negative consequences of raising the topic of weight and fear how patients will react to their intervention.

In the final trigger film (figure 3), the design was based on objectives to (a) generate discussion about raising the topic when a patient does not consult about weight (b) generate discussion about patients reacting in an affirmative/agreeable way and (c) generate discussion about taking a health promotion/motivational approach to raising the issue i.e. not asking patients directly about weight but asking patients if they have concerns about a multitude of health problems. My decision to construct the films in this way was based on study 1 and 2 in which I identified that GPs and nurses were uncertain about raising the topic of weight routinely (a barrier classified as aligning with knowledge in the TDF) and were uncertain about how to raise the topic of weight when patients were consulting with an unrelated problem (a barrier classified under skills in the TDF). I also wanted to explore views on a possible solution to clinician worry about offending patients and thus included an approach whereby weight was raised but not directly. An approach suggested in much of the motivational interviewing literature as well as the 5As approach to talking about obesity (Christie & Channon, 2014; Vallis et al, 2013) is to ask patients if they have concerns about their weight and other public health problems thereby giving patients greater autonomy and choice over the discussion.

After the content of the films was decided, a script was designed and refined through discussion with clinicians (e.g. Dr Paul Bennett and Dr Rachel Pryke commented on the initial scripts). These scripts were sent to Therapeutic media (a team with experience of designing films) and it was agreed that they were realistic and feasible to turn from screen play to film.

The trigger films were produced over one and a half days. On the initial half day, the lead researcher, actors and therapeutic media met at the University of Bath to talk through the scripts and rehearse the clinical scenarios. On the second full day, all members of the production and acting team assembled at a medical surgery

to record the trigger films. Following filming, therapeutic media edited and produced final versions of the three trigger films to be used as a tool within interviews.

6.3.3 Piloting the trigger films

Prior to conducting trigger film interviews with GPs, the films were piloted in several different ways. Initially, the films were presented to two groups of medical professionals who were completing motivational interviewing training at the University of Bath. The aim of this exercise was to (a) assess reactions of the medical professionals and ascertain whether they were conceived as realistic and generated discussion and (b) to pilot interview questions to facilitate discussion of the films. Secondly the trigger films were piloted in interviews with five GPs. The aim of these pilots were to further test interview questions and to enhance my interview technique. This piloting confirmed that the trigger films generated discussion and were viewed as realistic in the sense that GPs could refer to their own practice and experiences of interacting about obesity when watching the films.

6.3.4 Participant selection and recruitment

GPs in three CCGs in the south west of England were eligible to participate in the study.   A flyer outlining the study was emailed to 58 practices in Wiltshire local authority and to a network of general practitioners in the three CCGs. The flyer outlined that the study related to obesity research and required GPs' views on raising the topic of weight in general practice through reflecting on video clips of doctor-patient communication (appendix G). It also informed participants that they would receive £50 Amazon vouchers for their participation in the research. Twenty two GPs expressed their interest in the study via email, of which twenty agreed to be interviewed after receiving full details of the study. The final sample consisted of Twenty GPs.

6.3.5 Data collection

Trigger film interviews were carried out with participating GPs. At the start of each interview, participants were asked to confirm they had read the study information sheet (appendix H) and to sign a consent form (appendix I).   All participants watched three trigger films depicting doctor-patient consultations (see chapter 3, section 3.6).   After each trigger film, GPs were questioned about their views on raising the topic of weight during general practice consultations, the

barriers and challenges they face in raising the topic of weight and their views on the efficacy of raising the topic. Interviews lasted between 30 to 95 minutes. They were undertaken at the University, in participant's home or in a General Practice surgery depending on preference. All interviews were audio-recorded.

An interview schedule was used to guide the interviews (appendix J). This provided a set of prompts within interviews. The schedule was used flexibly, often to start the interview which would then be taken in the direction favoured by the participant.

All interviews were transcribed by the lead researcher. Audio recordings were transcribed for words and punctuation only. This choice was made because excessive detail in a transcript may distract the researcher from the readability of the text (Potter & Wetherell, 1987) and was in line with the underpinning theoretical framework viewing interviews as a constructive practice, thus with less of an interest in representing what is really there (Parker, 2002).

6.3.6 Data management and analysis

Transcriptions were uploaded to NVivo (version 10) for coding and data organisation. Analysis involved using a macro-discourse analytic approach drawing on social theory including the work of Michel Foucault, to understand the micro and macro politics inherent in consultations concerning obesity. In line with the approach, the focus of the analysis was not on the cognitions and motivations of individual GPs but on the work GPs were doing with the explanatory accounts they provided and on how these accounts related to the shared, cultural available discourses in society.

Initial analyses involved becoming familiar with the text by repeatedly reading and re-reading the transcripts and extracting sections of the text judged to be important to the research question. This process allowed a manageable data set which could be analysed in greater detail. Given that I was interested in identifying how broader discourses were shaping what GPs were saying within the interviews, I was attentive to, and selected, extracts that cohered around specific ways of talking and thinking about obesity i.e. systematic ways of talking about obesity and raising the topic of weight, and which seemed to be being operationalised for specific purposes. The process of identifying discursive constructions which relate to wider discourse was made easier given my familiarity

and insight into the research area. For example, I was familiar and could easily identify constructions which related to broader moral discourses related to obesity. The approach taken was informed by Ian Parker's criteria for identifying discourses (see table 3, section 3.8.8). It should be noted that analysis did not occur in a linear manner or in clear sequential steps, rather the process was iterative, steps merged together and varied, and the interpretive process involved continuous reflexivity and engagement with the empirical data and wider social theory.

The selected extracts were grouped into thematic categories within a coding table. Those themes cohering around hypothesised discourses were grouped together and the discursive content and devices that appeared to be operating within the text were analysed and noted (for example, subject positions made available through the discourses were identified). These micro-constructions were then linked to 'macro-level discourses' of obesity and medicine. Themes were compared and contrasted, examined for variation and alternative interpretations were proposed. Decisions around coding, including how the data cohered around discursive frameworks, were discussed and debated at regular supervisory meetings. Analysis proceeded over several months and allowed insight from social theory to be incorporated into the analytic process. In order to ensure that GPs talk was analysed in a contextualised way, i.e. in a way that took account of the fact that what was said at any one time emerged within an interview situation in response to a specific interview question or prompt, and in which other ways of speaking were also evident, I constantly referred back to the complete interview transcript.

Initially I judged the data to cohere around three discursive frameworks: a medical, moral and ethical framework. However following extensive reading of the wider literature and discussion with the research team, it was possible to identify (and judged to be more reflective of the research problem), two medical discursive frameworks rather than a singular one. Thus the final analysis resulted in four frameworks: a medical-reductionist model, a medical-holistic model, a moral model and an ethical model. It should be noted that the interpretation of the discourses presented below constitute only one way of interpreting the text and that other ways are possible (Potter and Wetherell, 1987). A representative selection of extracts with an explanation of how the data were read is included in the subsequent sections of the chapter so that the interpretation can be assessed.

6.4 Findings

6.4.1 Characteristics of GPs
Table 8

Demographic details reported by participants

		Number of participants
Sex:		
	Male	8
	Female	12
Age:		
	21-30	3
	31-40	12
	41-50	4
	51-60	1
Experience as GP in General Practice:		
	0-5 years	11
	5-10 years	5
	11-15 years	2
	16-20 years	1
	20-25 years	1

6.4.2 Discursive frameworks identified within GP accounts

My reading of the data suggests that GPs structure their talk around four main discursive frameworks. These frameworks are: a medical-reductionist framework, a medical-holistic framework, a moral-cultural framework and an ethical framework (see figure 5 below). The interwoven meanings running through these frameworks and connections with existing literature will now be discussed.

Medical-reductionist framework → **Difficulty in achieving a shared understanding** → **Opening up a can of worms** → **Finding a way in**

Medical-holistic framework → **Co-constructing the problem with patients**

Moral framework → **Walking a fine-line** → **Patient's think we're calling them fat** → **They think it's alright for you**

Ethical framework → **Blaming everything on weight** → **Reinforcing shame and blame** → **Feeling as helpless as patient's**

Figure 5. Four discursive frameworks underpinning GPs' talk about barriers to raising the topic of weight

6.5 Medical-reductionist framework

When discussing the challenges of broaching the topic of a patient's weight, GPs often draw upon a medicalised discourse. I have termed these constructions a medical-reductionist framework. This discourse relates to a reliance on biomedical and evidence-based knowledge and seeing this as the 'truth', rather than appreciating other knowledge such as patient narratives. It relates to what critical researchers have called the 'obesity discourse' (e.g. Monoghan, Colls & Evans; Rich & Evans, 2005). I will now go on to describe three micro-discourses within the medical-reductionist framework that were evident among accounts and relate these to wider social theory.

6.5.1 Difficulty in achieving a shared understanding

A number of GPs talked about how difficult they found it when patients said they did not eat or drink much, assuming that the source of the 'obesity problem' lay in individual behaviour. By disregarding the patient's knowledge and ignoring the social context in which patient's live their lives, GPs prioritise their own individualised notions of obesity, regarding their understandings as the 'truth'. In the following account there is evident tension due to a GP feeling unable to challenge those patients who do not subscribe to the medicalised understanding of obesity where overweight and obesity is caused by individual behaviour:

"Most say 'oh I don't drink fizzy drinks, I don't drink that' but we know, we know that people's perception in obesity is … their ability to recognise what they're eating and how much they're eating is just sort of presumably is one of the you know neurotransmitters or something isn't it or whatever appetite or I don't know the science behind it but but that seems to happen that people don't, so you can't have a discussion, that's why people come in and say 'I don't eat very much' and you and it's very difficult cause to say 'well actually you must be' because for them it's true …and food diaries don't really work, people under-report so actually it's very difficult." (GPK)

Another GP talks about the difficulty in believing patients and thus achieving a shared understanding about obesity. As this account demonstrates, the medicalised discourse is also laden with moral assumptions for example that patients should confess that they 'stuff their face':

"I think it's easy, if you see someone erm whose overweight and you ask them why they think their overweight and they admit that they stuff their face the whole time then that's that's much more easy to do. With the difficult people to deal with, not necessarily the people who deny that they're overweight but the people who deny that they eat a lot and they say that they eat small amounts and yet they're still overweight and they can't understand why they're piling on the weight, those are the patients that are more challenging because I, I don't really know whether to believe them or not, I don't know whether they're in denial about how much they're eating or whether they really are eating in, not eating that much and gaining weight." (GP M)

The next extract again demonstrates an instance when the GP's knowledge of obesity is prioritised over a patient's. According to the GP, the patient 'blames' their excess weight on medical factors. This is interesting because although the GP is prioritising her medicalised knowledge over the patients, the account suggests that she does not see obesity as having medical causes and she questions the legitimacy of obesity as a medical problem. She goes on to describe tensions between maintaining a good doctor-patient relationship and minimising blame by 'going along with it' to be 'understanding'. Again this account demonstrates issues that fit within a moral framework such as the attribution of blame and the requirement for patients to take responsibility:

"if they're trying to blame it on something else, like the tablets or there must be some medical problem because I've tried to lose weight, I hardly eat anything yet I'm still, however many stone and they want us to do bloods and stuff like that errrr looking to a medical cause and where we know full well that it's, it's not that and actually if they kept a food diary you'd see exactly what. But you don't want to sort of… you almost have to go along with it in a way to be understanding and say ok well we'll do thyroid function and nothing else and if that's normal then we probably got to look at what you are consuming on a daily basis and stuff like that so, it is difficult because you don't really want to go down the medical route cause you know it's not really eeeerm but you almost don't want to blame the patient I suppose errr you don't want to seem as if you're blaming them so if they feel like you are, or they're trying to shift the blame onto something else that can be quite difficult cause really it's the patients responsibility we feel and they don't want to take responsibility sometimes and that can be hard to try and shift that around yeah, don't want to get into a fight about it." (GP R)

The final extract demonstrates how a GP labels patients as 'amazing' when they go off and lose weight whilst those patients who don't lose weight are talked about as coming back with 'excuses'. Again this suggests that the doctor's medical knowledge of obesity is prioritised over the patient's and there is a moral judgment attributed to the patient:

"There are people who are amazing and they go away and they really take on board what you've said and they really lose weight erm and I, that really helps urmm there are other people who ermmm come back with just excuses

as to why they've not been able to, or reasons as to why they've not been able to." (GP Q)

These micro-constructions can be better understood if we link them with the existing social theory around medicalised discourse. Much has been theorised on the prioritisation of expert medical knowledge over the patients' knowledge. Tuckett and colleagues (1985) suggested that differences in language, expectations and culture between doctors and patients could lead to dissonance since, as he asserted, doctors did not know the details of what patients were thinking and thus there was little dialogue and sharing of ideas (Tuckett, Boulton, & Olson, 1985). Mishler was particularly influential with his research which suggested that doctors talk in the 'voice of medicine' whilst patients talk in the 'voice of the world view', and it is these disparate voices which cause dissonance (Mishler, 1984). The extracts above suggest discrepancy between doctor's and patient's understanding of obesity.

Another important conclusion that can be drawn from these accounts is that obesity is being treated as a lifestyle choice rather than being viewed as a legitimate medical condition which warrants the patient with the rights and obligations of the sick role (Parsons, 1951). Thus whilst obesity is approached by clinicians using a paternalistic, standardised and universal discourse reflecting medical power, responsibility remains with the individual and in these ways obesity is pushed to the margins of medicine. The medical-reductionist model of obesity then constructs obesity as a problem of individual behaviour and deviance, reflecting a tension between medicine and the complexities presented by a chronic condition.

As the accounts demonstrate, doctors rely on normative assumptions that patients are eating too much. By constructing patients as consuming excessive calories and as being dishonest, accounts are echoing what Karen Throsby describes as the "considerable suspicion within obesity medicine of the readings of the body" (Throsby, 2007, p. 1565). Although there is evidence that shame and guilt might inhibit full disclosure of consumption (Heitman et al, 2000; Muhlheim et al, 1998) within medical discourses there is a tendency to position obese individuals as 'misconstruing' information about their food intake. As was written by leading anti-obesity researchers in a journal article in the BMI, "obese people tend to provide biased diet records and habitually eat more than they claim" (Prentice & Jebb, 1995, p. 437) which they describe as "Doctor, it's my metabolism syndrome"

(Prentice & Jebb, 1995, p.437). This view fails to take into account people's lived experiences and beliefs about their bodies, which include beliefs that one's own body responds uniquely to food (Throsby, 2007) and the accumulating evidence that energy input is determined by sociocultural, biomedical, psychological and iatrogenic factors (Sharma & Padwal, 2010) thus being much more complex than both doctors and a proportion of researchers seem to assume.

6.5.2 Opening up a can of worms

Another discursive theme identified across interviews was the way that GPs talked about raising the issue of weight as being like opening a can of worms, a place that GPs said they often 'wouldn't go'. They described choosing to address obesity with a patient as 'tackling' an issue that was 'more than' the problem it was believed to be causing (such as knee pain) and being about 'more than excess weight'. In this way obesity was described as an ever expanding issue which could take an infinite amount of time (and emotional resources) to explore once broached. The following account demonstrates a GP rationalising his reluctance to raise the topic which he does by emphasising the difficulty of initiating a discussion about obesity compared to other problems. His description of obesity as deviating from 'normal' and associated with 'baggage' suggest both preconceptions and fear about the unknown.

> "*When I say a can of worms … sometimes there'll be abuse, in the past, self-harm, extreme depression, which is causing low energy, low self-esteem, erm hopelessness, so motivation just feels like a challenge, so often it does seem to be multi-faceted more so probably than other issues… so actually, you feel like you're not just addressing obesity, you're addressing, it becomes, rather than just a consultation about a foot, it becomes a consultation about obesity and then it's going to become a consultation about depression or mental health or child abuse or you know, something like that erm which can become very complex and so I guess that's maybe why, cause you know, you could slip in an extra issue if didn't seem, if it was more normal and didn't seem to have as much baggage associated with it.*" (GP J)

Another GP talks about a multitude of barriers that contribute to obesity often being 'side-lined'. She describes obesity as being difficult to bring up and offer advice for in contrast to smoking which is more 'black and white'. The complexity

of obesity incorporates moral and social elements since it is related to personally critical attitudes and may include asking people to change a lifestyle they take pleasure from. The complexity and 'scope' of obesity does not seem to fit within the parameters of a medical framework which involves quickly offering 'effective advice or intervention'. Instead, raising the issue of weight necessitates the difficult and laborious task of helping patients with emotional and social elements related to their obesity.

> *"I think sometimes the, the scope of what we're trying to deal with in those few minutes with that one person is almost just so massive that you have to just kind of pick and choose what you tackle that day and I think unfortunately obesity often gets side-lined because it is kind of easier to say to someone 'oh well do you smoke' and you know the intervention there seems more concise, it seems sort of a black and white thing, most people on the whole who do smoke, don't want to smoke so you know, it's kind of, it seems to be less emotion involved, less, less personally critical … I honestly think that many GPs don't talk or don't tackle the weight issue because it is just so massive and its really quite hard to you know to, to quickly bring up and to quickly kind of offer effective advice or intervention it's a kind of big topic."* (GP C)

In contrast, another GP constructs her role as being about offering 'moral support' for the social and emotional issues attached to obesity which may 'surface' when the topic is broached. She resists a medical-reductionist discourse which is only interested in 'fixing' problems and depicts her role as dealing with the holistic elements of obesity with less emphasis on measurable outcomes. Within her account, the GP constructs obesity as a problem of the psyche situated in a broader social context. Although this discursive construction appears to be resistant to the medical-reductionist framing of obesity, there continues to be an emphasis on fixing the problem (albeit over time) and thus obesity continues to be a problem located and requiring support at the individual-level.

> *"At the end of that consultation it looked like there were a whole load of social and emotional issues, probably just below the surface so if you'd really started to explore the weight then you might get a whole load of, you know it's the can of worms kind of thing, you might get a whole load of issues coming out because you know all the self-esteem and the emotional problems that might be related to obesity even the cycle or just the way, the self-esteem and the*

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way they feel about themselves and in all likelihood there's a whole load of social issues and problems within that whole, their, you know their you know their personal circumstances, their context and of course you can't sort all that out in a consultation but it might be a good thing if some of those are actually just brought to the surface erm so that you can offer some at least some moral support at that time." (GP B)

Despite offering an account to suggest she would 'open the can of worms', as was the case for nearly all GPs, tension was evident between helping with the emotional and psychological elements of obesity and the time-limited nature of the consultations. The ability to properly explore issues was talked about as being constrained by the medical system and it was up to the GP to be 'very careful and very precise' when questioning patients within the consultation.

"Always at the back of your mind, you don't have an infinite amount of time so you have to be very careful about how much time you use because erm you know your job really isn't necessarily to sit there for 45 minutes sort of listening to the complete life history and sort of doing CBT and trying to sort of do that because actually that's done by a counsellor or a psychologist and it, yeah you just have to be very careful and very precise about the questions you're asking to try and get the information you need safely and erm and you know and then sort of refer them appropriately basically that's the sort of role of the GP I think." (GP S)

As this theme suggests, obesity is constructed as a problem that when broached in a time and resource limited consultation, can lead to a boundless interaction concerning emotional, psychological, social and moral elements. This uneasiness about engaging with 'the obese subject' suggests that obesity is a condition full of mystique and assumed to be emotionally and psychologically complex. This can be related to the work of Susan Sontag who wrote about the societal response to disease, the language used to describe these diseases and the implications for those who suffer from these diseases (Sontag, 1977). Sontag looks historically at how both Cancer and Tuberculosis (TB) were associated with personal and psychological traits because at the time, Cancer and TB had causes that were multiple and misunderstood. Sontag's concern was that since diseases were viewed as expressing character, for example cancer was viewed as passion repressed, this may also be reversed so that character is seen to express disease,

for example 'a cancer personality'. These constructions lead to a 'blame the victim' stance in regards to illness and disease. The metaphor used to describe initiating a conversation about weight loss with an obese patient as being like 'opening a can of worms' and the association of obesity with social and psychological elements apparent in my empirical research, suggests that obesity is being associated with personal and psychological traits similarly to how TB and Cancer were described in the 19th and 20th Century, reflecting societal and cultural ways of thinking. Sontag writes that "the most truthful way of regarding illness- and the healthiest way of being ill- is one most purified, most resistant to metaphoric thinking" (Sontag, 1977 p. 3). As well as referring to the pathological dimensions of weight for individuals, it should be noted that GPs also talk about the wider social, contextual factors such as the difficulty of being physically active in modern lifestyles, suggesting a recognition that obesity does not lie purely with the individual and thus lies outside the medical remit. In this way 'opening a can of worms' may refer to starting a conversation in which doctors are powerless to help due to the solutions lying outside the realms of medicine.

These findings can also be related to the theoretical concept of 'medicalization'. Medicalisation is "the process whereby an object or a condition becomes defined by society at large as an illness…and is thereby moved into the sphere of control of the medical profession" (Miller & Findlay, 1994, p. 276). Medicalisation is not limited to physicians' power to define what is illness or disease but also involves the collaboration of patients (Riessman, 2003). Applied to this study, both doctors and patients play a role in constructing obesity as both a medical and non-medical problem.

Western medicine has been criticised for being dominated by ideologies of science and objectivity, focusing on cause and cure and taking a prescriptive, individualised, dualistic, authoritarian, patriarchal and doctor-centred approach to illness and disease (Conrad & Schneider, 1980; Conrad, 1992; Thomas-MacLean, 2004). Medicalised discourse depicts illness and disease as a measurable and objective condition in contrast to patient-centred medicine, which draws on a humanistic, biopsychosocial perspective. Conventional medicine is dominated by a positivist-realist epistemology (Bensing, 2000) with a focus on the disease rather than the individual. With the growth of evidence-based medicine, it can be argued that this focus on science and objectivity has increased (Reeve, 2010). Evidence-

based medicine has grown in the last 20 years due to the need to reduce inequalities, use resources effectively, disseminate information and improve the quality of health care (Sackett et al, 1996) and is claimed to be part of the population health movement which standardises individuals (Hart, 2008). The increasing reliance on guidelines and protocols and the Quality and Outcomes Framework demonstrates this evidence-based medicine movement (Taylor, 2009).

The metaphor 'opening a can of worms' may reflect the incongruity between the complexity of obesity (a condition which is often chronic and relapsing, caused and maintained by a multitude of intertwining factors) and a biomedical approach to care. It is argued that, largely due to the scientific nature of medicine, that which is "untidy and indeterminate is undesirable" (Thomas-MacLean & Stoppard, 2004, p. 287). Empirical research in other areas of health care demonstrates this point. For example, physicians construct depression within a medicalised framework despite their experiences of treating depression which suggest that the framework does not encompass complex, lived-experiences (Thomas-MacLean & Stoppard, 2004). This leads to tensions, on the one hand conceiving depression to be a medical disorder and on the other understanding depression as being related to the conditions of a person's life (Thomas-MacLean & Stoppard, 2004). This study is helpful to apply to my research since it suggests that the awareness of the relationship between social contextual influences and conditions such as obesity or depression are in contradiction to medicalised (and thus individualised) descriptions of the condition leading to unresolved tensions in physicians understandings. Like in the current study, those physicians managing depression felt powerless to help patients due to the recognition of social and contextual factors. This micro-discourse, which I have coded as 'feeling powerless' to help patients, is expanded on within my explanation of the ethical discourses that GPs draw on. Other researchers have asserted that the current medicalised approach to obesity does not encompass the complexity of the condition and suggests that medicine needs to change the ontological focus to recognise that there are a multiplicity of obesities rather than a singular obesity (Throsby, 2012).

6.5.3 Finding a way in

A common difficulty encountered by GPs was 'finding a way in', a justification used to explain the difficulty of raising the issue when a patient was not presenting with a problem that could be attributed to their weight (i.e. when the problem was not

caused or exacerbated by the patient's obesity). In these conditions raising the issue was described as 'tricky' because it was considered difficult to 'put a medical slant on it'. This problem suggests that GPs operate from a medical-reductionist model in terms of the diagnosis of obesity, with their role being to communicate medical risk to patients and offer cures for medical problems. It also illustrates that GPs find it difficult to talk about subjects which sit outside the traditional realms of medical (problem-based) care. This theme suggests that Doctors only feel able to broach the topic of weight when it has developed into a pathological condition or when it can be discussed as an established risk factor for a medical condition that patients are likely to want to avoid, rather than be brought up proactively and in a constructive and positive way. It is evident from GPs' accounts that patients are positioned as unaccepting of obesity being broached when it is not yet causing additional problems and thus not yet a legitimate medical condition which allows GPs to intervene.

> *"The problem occurs I think in patients that don't come up very, obese patients that don't have a problem so that have a long-standing illness they don't come in with knee pain, so dealing with them is much more difficult because you know how do you sort of approach the problem, when you've got something to hang it on like you know, 'you will become diabetic like your mother unless you lose some weight', that's, you can almost put a medical slant on it which is obviously well within our comfort zone, if you're just looking at someone whose otherwise completely well, hasn't come about their weight, tackling it at that stage is probably a bit more difficult."* (GP P)

Another quote from the same GP suggests that one of the reasons she feels more comfortable raising the issue when it is related to medical pathology, allowing her to feel 'sure of her ground' is due to the visual element involved in identifying obesity. She, like many other GPs describe it as being equivalent to looking at a patient and calling them fat. This clearly links to moral-cultural discourses on obesity and can be linked to the analytic theme 'walking a fine line'. Some GPs also talked about 'blaming the computer' (referring to QOF indicators) and telling patients they had been instructed to raise the issue to avoid patients feeling subjected to their visual evaluation.

> *"I would do it in the sort of a context of a health check and have you thought about blood pressure and have you got a family … it's a way in without actually saying well looking at you to be honest, you look fat and I think you need to*

do something about it which is much more directive I understand, but more likely to get their backs up." (GP P)

Another GP talks about her frustration of feeling like she is 'treading on egg shells'. She talks about wanting to take a directive approach (medico-reductionist discourse) and associates obesity with a patient's identity and moral judgment. The way raising the issue is constructed as an 'effort' reinforces the idea that obesity is 'a can of worms' that doctors do not want to open.

"Yeah I do think it's important, at the end of the day that's what the problem is, I feel like I wish we didn't have to tread on egg shells so much and I wish we could just you know, say what the problem is and say what they need to do about it but it is so much more complex than that because people are sensitive and cause its part of image and stuff erm and so that takes more time cause you're having to skirt around it a little bit, you have to try and drag it out of the patient and it does require a lot more effort I suppose." (GP R)

Patient-centred care advocates that a role of the doctor is to pick up on psychological and social issues as well as traditional biological problems (Balint et al, 1957; Mead & Bower, 2000). However, research suggests that GPs find it more difficult to discuss subjects which are not linked to illness (Arborelius & Österberg, 1995; Verhaak & Wennink, 1990) suggesting that they work within a biomedical framework in regards to diagnosis. This biomedical framework may be perceived to be more acceptable by patients and is a technique to maintain harmony in the consultation. The function of this medical-reductionist framing then seems to be to maintain politeness and restrict talk to topics which are morally neutral. As Strong asserted "by sticking with the more biological side of medical practice, doctors can avoid many of those topics which might threaten the surface gentility of the proceedings" (Strong, 1979, p.211).

As the empirical quotes demonstrate, identifying obesity is problematic largely due to the visual element involved in the process of diagnosing obesity. For clinicians, appearance is important in many health encounters with many illnesses being detected through vision. There is a tension in visually diagnosing obesity due to the clash with cultural norms of appearance and thus the task involves 'moral work' (Webb, 2009). The visual nature of identifying obesity has been explored by critical researchers who point out the important role that external appearance plays

in appraising health (Jutel & Buetow, 2007). Dating back to the renaissance, there has been a link between beauty and goodness and appearance continues to be linked with important symbolic meanings, seemingly offering insight to a person's true nature (Jutel & Buetow, 2007). Contemporary media, markets and health practices have promoted the discourse that to be healthy is to be beautiful thus health has become dependent on, and indicative of beauty and moral goodness (Jutel & Buetow, 2007).

Researchers have called for more scrutiny of the visual diagnosis involved in clinical decision-making. Although an important first step, visual diagnosis can lead to anchoring bias, or a tendency to focus on a first impression and prematurely close diagnostic options (Croskerry, 2002). A study by Kreuter and colleagues (1997) reported that clinicians use "imperfect heuristics" and rely on corpulence to prompt advice about physical activity and diet. The implications of this are that patients who do not look unhealthy but who engage in unhealthy practices, are ignored. Jutel and Buetow (2007) suggest that clinicians should reflect on the assumptions underpinning the recommendations they make and acknowledge how appearance influences practice. My research shows that many clinicians are aware that a visual assessment of a patient's fatness prompts them to consider raising the issue but, for the sake of maintaining harmony in the doctor-patient relationship, they reserve talking to patients about weight.

6.6 Medical-holistic model

As expanded on above, although GP's construct obesity by drawing on a 'medical-reductionist' framework, most notably by prioritising their largely biomedical knowledge of obesity over the knowledge of their patients, and discount psycho-social knowledge (by not opening the can of worms), GPs also step outside this medicalised discourse. Throughout accounts, resistance to a reductionist medicalised construction of obesity was evident. It should be noted that whilst some GPs drew on 'patient-centeredness' and a holistic model of medicine to justify why they did not discuss weight with patients, others used these same discourses to justify why they do raise the topic.

6.6.1 Co-constructing the problem with patients

Many GPs took a critical stance to raising the topic routinely with patients constructing it as the 'doctor's agenda'. In order to create a shared understanding of obesity, GPs talked about 'negotiation', 'matching up agendas' and 'agreeing a way

forward'. Through their talk about the broader social context of patients' lives, including competing health concerns, and the disparate and inconsistent nature of obesity to cause medical problems, GPs justified the need to take an idiosyncratic approach to raising the topic by considering body weight within the unique context of a patient's life.

> "*discussing weight that's the kind of doctor agenda… about how you introduce the topic it's matching up agendas isn't it, it's like what's the patients agenda in this consultation, what's your agenda and you've got to marry them up because otherwise that leads to dissatisfaction from the consultation for both parties, so you don't get anywhere if you can't, if you can't come together and agree a way forward on whatever issue it is or negotiate, you kind of negotiate this kind of thing well, well I will bring it up this time because its gonna keer into their knee pain or their heel pain but I'm not gonna bring it up this time because she's bursting into tears because her husband's left her and or one of their children is getting bullied at school or whatever it may be you know, she's lost her job, so you don't want to start piling in about 'oh you ought to lose weight' you know.*" (GP N)

As well as demonstrating resistance to taking a standardised, population approach to raising the issue of weight, GPs were also antagonistic toward taking a simplistic, authoritative approach to addressing obesity. The complex lives that patients with obesity were often reported to lead resulted in GPs constructing obesity as a holistic problem and there was an emphasis on the need for patients to feel 'understood'.

> "*So just telling somebody "right you need to lose weight" is the wrong, complete wrong way of doing it, you can't do that, they'll just go, "how dare you, you don't understand me" so that's you know, for me, that's the reaction, there's more to it than just the weight, there's all sorts of emotions and lifestyle and relationships and everything, it's a holistic problem.*" (GP E)

This is an area of practice in which GPs are reliant on patients to change their lifestyle and behaviour. This is exemplified by GPs asserting 'I can't do it for them' and 'they've got to want to change' reinforcing the need for GPs to co-construct the problem with the patient rather than raise the issue paternalistically. However, it is interesting to note that whilst GPs claim to be co-constructing the problem with

patients (suggesting equality in the relationship), excess weight has already been constructed as a problem by the GP and the task of the doctor is to convince patients of this. In this light, Doctors appear to be agents of social control, with their interventions encouraging patients to internalise the norms, values and behaviours determined by medicine.

> "*It's about saying, it's about finding a way in, it's about finding an approach where they, the patient themselves can begin to understand or realise that their weight is a problem, not about us telling them about, the patient understanding themselves that there is a problem and when they begin to appreciate themselves that there's a problem that means you can then have a shared understanding of it and a shared agreement of how to take it forward if it's me being a parent and them being a child and saying you know 'you're overweight, you need to do something about it' what you need to do is talk about it adult to adult level so saying we can see there is a problem, what can we do about it together.*" (GP P)

Our understanding of these constructions can be facilitated by situating them within social theory. Although there is a dichotomy between the medicalised-reductionist approach (with its reliance on biomedical knowledge and mechanistic thinking) and the medical-holistic approach (which recognises the patients 'story' and takes an idiosyncratic approach to raising the topic by considering a patients wider contextual factors), accounts suggest that GPs draw on both of these approaches when accounting for the problematic nature of raising the issue.

In order to better understand the holistic health movement it is useful to look at the theoretical contributions to the doctor-patient relationship overtime and the change in power relations. Traditionally, doctor-patient interactions were doctor-centred, paternalistic and directive (Byrne & Long, 1976). Over the last fifty years, there has been a growth towards the promotion of egalitarian, patient-centred and informed models of patient care (Pendleton et al, 1991; Taylor, 2009). This change has been driven by a number of changes in society including the shift towards a more consumerist and 'market-driven' model of health care (Coulter & Magee, 2003; Goode et al, 2004), a questioning of authority in all areas of public service (Lupton, 1997; Taylor, 2009), increased access to information about health care (Hardey, 2001; Lupton, 1997), and encouragement on greater self-care and thus less reliance on the state by government (Fitzpatrick & Derbyshire, 2001). This has

resulted in greater responsibility for health care on behalf of the patient (Coulter, 1999), and a greater emphasis placed on patient autonomy (Charles et al, 1997; Balint & Shelton, 1996). Alongside these changes, 'patient-centred care' has emerged as an aspirational model of medical practice. Patient-centred medicine is based on an ontological perspective which takes a humanistic, biopsychosocial focus rather than the conventional, positivist focus of biomedicine (Bensing, 2000). However it is also argued that patient-centred medicine can incorporate both models of care (thus drawing on both ontological perspectives) so long as both doctor and patient agree to behave in this way (put another way, are willing to engage in negotiation) (Charles et al, 1999).

It is important to note that the literature has pointed to a conflict between the emergence of evidence-based medicine and holistic medicine (May, Rapley, Moreira, Finch & Heaven, 2006; Rogers, 2002). Clinical guidelines, such as those developed by NICE advocate routine application to whole classes of patients which critics claim demonstrate similarity to 'scientific-bureaucratic medicine' (Harrison, 2002). It is argued that the population-based approach of clinical guidelines "corresponds to the abstraction of disease implicit in the biomedical model" (Checkland, 2008, p. 792). The Quality and Outcomes Framework (QOF) introduced in 2004 with the GMC, also reinforces a biomedical approach to practice and thus conflicts with holistic medical care.

Applying these ideas to my research, it seems that GPs are resistant to take a population approach to raising the issue of weight (as suggested by NICE guidelines and endorsed by public health) and draw on arguments related to holistic medicine to justify their position. The change in power relations between doctors and patients, particularly the increase of discourses reinforcing patient autonomy, helps us to understand justifications related to competing agendas.

By using these conceptual models of medicalised discourse, it again brings to light the ways in which obesity does not fit neatly into a traditional medical framework and is not conducive to the medical system whereby the doctor is expert with the goal of treating or curing a patient's problem. Instead obesity is constructed as a 'holistic problem' requiring 'holistic care' requiring a personalised and idiosyncratic approach. Working within this model of care also means there is a greater emphasis on patient autonomy and thus responsibility. Although the holistic model of medical care suggests GPs will expand their jurisdiction to the personal and social nature of

patients' lives (Armstrong, 1995), there is a tension given the emphasis on patient autonomy which implies that people have the right to live their life in line with their own wishes and values. In practice it seems that GPs prioritise patient autonomy over intrusion into the social and psychological areas of patient's lives, particularly as such intrusion raises moral and ethical issues which will now be explored.

6.7 Moral model

A broader discourse, linked to morality and culture, was evident in the accounts of all interviewees. Although medical and public health discourses frame obesity as an objective, measurable 'condition' the empirical findings from interviews with GPs demonstrate that talk about obesity can be problematic for example it can lead to resistance and evoke feelings of moral accountability. In this section, my aim is to demonstrate how obesity has come to be imbued with morality by linking GP accounts with social theory. This will illustrate the problematic nature of discussing body weight in the doctor-patient encounter and will shed light on how obesity is much more than an objective measurement that can lead to ill health.

6.7.1 Walking a fine line

GPs demonstrate caution about raising the issue, again suggesting obesity is a topic they fear getting involved with or opening up. Obesity was constantly talked about as a 'sensitive topic', related to judgment and assumptions. The discussion of obesity carried with it the potential to upset patients which was deemed problematic, particularly if patients were consulting for another problem suggesting that GPs are aware of and constrained by the powerful discourses surrounding obesity. GPs positioned themselves as conflicted, on the one hand wanting to help patients with their medical problems but on the other not wanting to upset them by raising awareness of their devalued social status.

Although weight loss was described as a 'long-term' and 'difficult' accomplishment for patients, suggesting a sense of powerlessness for both doctor and patient, there remained a silence around the lack of help available for patients. Instead GPs were mainly concerned about maintaining a non-judgmental relationship with their patients. The following extract demonstrates the focus GPs give toward ensuring they do not upset patients:

"*You worry about being kind of judgmental and coming across as judgmental and unsympathetic cause weight loss is such a sort of long-term*

difficult thing for a lot of people, you don't want to, you know make them upset when they've already come with another problem but then that doesn't make sense because by helping them with their weight then potentially will, wouldn't have these problems so much as well so it is quite complicated isn't it the kind of desire to help people as a GP but also then you don't want to upset them." (GP N)

Another GP talked about only raising the topic of weight when there was complete certainty that a medical condition or problem could be attributed to weight. In these cases it was deemed to be 'appropriate' and 'correct' and allowed the GP to stay on 'safe ground'. In the following extract, the GP explains that it is only appropriate to raise the topic of weight when there is a cause and effect relationship between excess weight and the medical condition. As she explains, in these instances it is 'entirely correct' to raise the topic of weight and she justifies that her caution is due to patients being 'very, very sensitive'. Arguments such as these suggest that GPs are drawing on discourses which construct obesity as a moral failing and infuse obesity with blame. The GP positions herself as wishing to mitigate the consequences of raising such a 'loaded' topic. This construction allows GPs to justify raising the topic in restricted circumstances only i.e. when weight is causing medical symptoms.

"I think in general you have to be careful, well not just in general practice, you have to be careful about unnecessarily attributing something to weight if it isn't because patients are very very sensitive about it so when you're sure of your ground then it's absolutely correct so if someone develops diabetes or something like that erm and you've looked at all the lifestyle things and they still haven't lost weight then that's absolutely appropriate, when someone's got bad arthritis in their knees and you know that you, that is entirely correct to sort of bring it up because that is a direct cause and effect, it's attributing something, I mean this man, this pain he's got is very acute, it's quite painful it may be nothing to do with his weight and therefore to associate the two at this stage you're more likely to get patients backs up because they are very, very sensitive about it and you have to tread carefully." (GP P)

GPs position themselves then as walking a fine line between the discussion of a medical topic and a moral topic. As accounts suggest, attributions of blame

are central to discussions about obesity. The following quotation suggests that doctors are aware of discourses circulating in the general public around their practices in the realm of obesity and are thus cautious to activate these stereotypes.

> "*They think well they're just going to tell me to lose weight and I know that and I can't do anything about that and a feeling of being kind of disempowered and out of control and feeling useless and judged and and therefore they might not seek help either for that or for other things erm because they might think well the doctors going to tell me it's all about my weight and you hear people, people on buses and in public say things like that, people say 'ohrrr they're just going to tell me to lose weight', and you want to avoid that.*" (GP Q)

In order to understand the moral evaluation of the fat body in today's society, Throsby (2012) argues that a key assumption underpinning the 'war on obesity' needs to be understood. Obesity has been constructed as a medical, financial and social problem, threatening the well-being of individuals, communities and society on a global scale (WHO, 2000). Individuals are called upon to take preventative action against obesity, in order to counteract the assumed perceived risk of future health problems (Gard & Wright, 2005; Lupton, 1994; Throsby, 2007). Therefore it is the assumption that obesity is a medical, financial and social problem and discourses of epidemic, crisis and individual responsibility that lead to negative moral evaluations (Throsby, 2007).

These discourses on judgment may also be better understood in relation to social theory on the body. In today's society and culture, the outward body has come to demonstrate inner worthiness of the self (Lupton, 2013). We are living in a culture which focuses on improving the body so it looks as attractive as possible, which authors refer to as "the cosmetic gaze" (Wegenstein & Ruck, 2011, p. 27). Lupton and other researchers discuss the 'project of the self' in which "the body is viewed as malleable and unfinished, requiring constant maintenance and work" (Lupton, 2013, p 70; Bordo, 1993; Featherstone, 2010; Shilling, 1993). In her book *Fat,* Lupton explains how maintaining a thin body has come to be viewed as a disciplining desire, an association that is rooted in the Judeo-Christian ethic of self-denial in pursuit of spirituality, and achieving an appearance which conforms to the normative ideals of beauty (Lupton, 2013). This relationship between outward bodily appearance and the moral worth of a person suggests that talking to patients

about body weight implies a judgment of one's identity and thus personal worth, an effect that GPs are not immune to.

Overweight bodies are also evaluated negatively in a neoliberal society in which governments encourage greater self-care and less reliance on the state (Fitzpatrick, 2001), implying greater responsibility on behalf of the individual (Coulter, 1999). Those individuals who partake in 'the practices of the self' (Foucault, 1988) by conducting the way they live their lives and work on their bodies, to achieve an 'entrepreneurial self', are privileged. Achieving a body weight that lies within the 'norm' is associated with the ideal of being a 'good', 'productive' and 'healthy' citizen (Lupton, 2013). Conversely, individuals with adiposity are viewed as being irresponsible and an economic drain on society in need of intervention to regulate, normalise and discipline to ensure they become more productive (Lupton, 2013). Free choice is also a dominant concept within these neoliberal discourses implying that individuals are rational and make decisions based on costs and benefits (Petersen, 1997). Other ethical values and social interests are effaced in light of the (assumed) rational quest of individuals to become "entrepreneurs of the self" (Hamann, 2009 p. 38). In the context of increased pressure to consume, individuals are expected to both consume and use their self-discipline and 'free choice' to limit consumption. Neoliberalism can thus help us to understand how obese individuals have come to be discursively produced with such negative and morally-laden meanings and how this impacts on clinician discussion about obesity (Guthman, 2009; Leggett, 2014).

It is also useful to draw on social theory which suggests that obese bodies are subject to the 'disciplinary gaze' and surveillance of public health and medical institutions which attempt to normalise and control bodies. These bodies are constructed as being out of control and excessive. Lupton (2013) draws on a Foucauldian perspective in arguing that doctors subject patients to the disciplinary gaze by asking them to confess about lifestyle choices or their failure to conform to medical guidelines to achieve weight loss. The highly visible nature of obesity makes it difficult for patients to avoid interrogation (Lupton, 2013). This suggests that doctors are positioned in a role to monitor and judge bodies in order to normalise and discipline. This aligns with the extended role that medicine has taken up since the early twentieth century in which surveillance of normal populations at risk have resulted in the blurring of boundaries between health and illness

(Armstrong, 1995). As interviewee accounts demonstrate however, doctors are aware of the power they hold to judge patients but are resistant and/or aware they need to take care in how they exercise discipline. There is much at stake for GPs considering raising a topic with such poignant moral connotations, most importantly the long-term doctor-patient relationship.

There is also an uncertainty in diagnosing overweight and obesity. Reflected in the accounts of interviewees is the view that excess weight does not necessarily cause pathology and the recognition that individuals are able to live with obesity symptom-free. Although it is mainly studies taking a critical perspective that emphasise that an individual can have a high body weight with no accompanying medical problems (e.g. Campos, 2004; Aphramor, 2005), several scholars taking a biomedical approach to the study of obesity have demonstrated that the relationship between overweight and health is not straight forward and have called for more sensitive measures of pathological body weight (Lee, Blair & Jackson, 1999; Sharma & Kushner, 2009). This seems to support the suggestion that there are multiple obesities and that one label to describe excess weight and one standardised approach to prevent and manage obesity is reductionist (Throsby, 2012). However, it also draws attention to the contested discourses surrounding obesity as a medical problem. Unlike in the case of many other medical problems where doctors and patients co-operate and achieve a shared understanding about an illness or condition, being labelled as 'obese' and in need of an intervention may be contested by patients as with other socially constructed medical problems or risk factors such as alcohol consumption (Strong, 1980). As many scholars assert, individuals have a right to view their weight as unproblematic and in a way that deviates from clinical, reductionist categories (Warin et al, 2008). These contestations around the definition of obesity demonstrate that the body is "the ultimate site of political and ideological control, surveillance and regulation" (Lupton, 2003, p. 25). The government and the institute of medicine predefine obesity as a medical problem and use their authority to categorise people and label them in need of intervention.

6.7.2 Patients think we're calling them fat

GPs frequently used the word 'fat' and 'fatness' during interviews. Through expressing their concern that patients would interpret attempts to talk about weight as being attributed with the label 'fat', GPs were able to justify their silence around

the topic. Fat was constructed as a more powerful discourse associated with negative meanings and associations than weight or obesity. That fatness can also be contested is evident in the ways in which GPs discuss the instances that patients refuse to construct their fatness as medically problematic.

"I know kind of there'll be situations where kind of nurse colleagues have had a relationship that completely broke down with a patient for trying to address the issue of weight and them going well you said I was fat and that's really rude kind of thing so I think it's just this really sensitive issue for a lot of people and something that's harder and they probably know about it and have tried to address it to some extent already and think that they've failed or that there's no point or…but whether those are my issues rather than the patients issues and I'm projecting them onto the patient you know in anticipation that if I talk to them about it, they're going to go, oh you know "you think I'm fat, I think I'm fine." (GP H)

The following two quotations illustrate the experience of broaching the topic by two GPs. Such reactions point to the moral and cultural discourses surrounding obesity.

"I eventually said you know and I've been seeing her for about two years this is not a new relationship, this is a very well-developed relationship, very established and I felt at that stage to say you know, 'one of the things I think that's contributing to this that we haven't talked about is your weight' and she went absolutely off the deep end you know, well you're calling me fat and you're calling me greed, you're just saying I'm greedy aren't you' and you know I approached it in the gentlest way possible so you know the, patients really are incredibly sensitive about their weight." (GP P)

"I deliberately didn't use the word fat erm in fact I actually just said look you know, I, in fact I think the phrase I used was you know erm, you're, you know you're carrying a few extra pounds erm that does put you at a risk and according to this you are very overweight and I purposely didn't say obese and I didn't even say fat and I thought it was quite interesting in the fact that you know, quite a pejorative term fat had been replaced by very careful language because it sort of meant that the patient, it sort of implied that the

patient wasn't actually listening to the words, they were just taking the meaning of that." (GP S)

It is first interesting to reflect on the use of the word fatness in GPs accounts since it is suggested that "the absence of an appropriate biomedical label (…) works to reduce the importance of certain conditions, and allows practitioners to delegate responsibility" (Charles-Jones et al, 2003, p. 77). Discursive constructions of obesity as fatness thus demonstrate how the condition is situated outside normative constructions of medical problems. Many of the accounts provided by GPs have also demonstrated that broaching the issue of weight, however it is done, has consequences in the consultation room. Interviewees referred to patients reacting and responding in a way that is viewed as 'defensive', 'in denial', 'dishonest' and 'delusional' and described 'raising the issue of weight' as leading to a 'relationship breakdown'. These discursive constructions of patient resistance emphasise the importance of power in doctor-patient encounters about obesity. It is thus helpful to look at how Foucault conceptualised power and resistance before looking at how resistance to the dominant obesity discourse has been understood in the wider sociological literature.

In Foucault's theorising about power, he argued that where there is power there is also resistance. Individuals do not necessarily submit to the exercise of power (Foucault, 1975). That is, bodies are not necessarily passive, malleable and docile. Foucault argued that physical bodies are subjugated and made to behave in certain ways by 'bio-power' (Foucault, 1991), which refers to the "governance and regulation of individuals and populations through practices associated with the body" (Wright, 2009, p. 2). Medical knowledge and discourse is one of the most dominant discourses that attempts to exert power on individuals and define what is normal and what is pathological or deviant. Although doctors are argued to be agents of social control who function to influence people's thinking, behaviour and lifestyle (Freidson, 1970; Parsons, 1951), power can only be exercised on people who are willing to be placed in that position (Oliver, 2010). Others have referred to the negative construction of obesity in society to argue that patients are unwilling to subjugate themselves to a system that has already marginalised and excluded them (Wachs & Chase, 2013). The medical (reductionist) model of obesity can be seen as a 'body of knowledge' that defines obesity and obese individuals as a challenge to the norms of society and thus deviant and in need of social control.

Patients who react negatively or 'misconstrue' their doctor's words as being a moral insult, may be viewed as resisting against knowledge which constitutes them as deviant, blameworthy and 'bad citizens'. Wider neoliberal discourses circulating in society which promote the idea that to be a successful human being one should be an 'entrepreneur of the self' and that 'ill health is your fault' (LeBesco, 2011), reinforce the construction of overweight and obesity as a morally loaded or 'sensitive' topic to discuss in the consultation. This demonstrates that the medical model of obesity is bound up and inseparable from the wider, societal (moralised) notions of obesity.

Foucault's writing on power and resistance is also useful to draw on since he asserted that "power is everywhere", diffuse, a network of relationships and embodied in discourse (Foucault, 1998, p. 63). According to the wider literature, patients have increasing autonomy in the doctor-patient relationship, one of the reasons being that we are living in a postmodern society where individuals are well equipped to challenge state (and doctor's) decisions (Fairhurst & May, 1995). Resistance to interventions which aim to change patient lifestyles, demonstrate that individuals are autonomous rather than passive and reinforce the idea that power is not simply exercised by a central, hierarchical, authority figure (such as doctors) but flows and is in constant flux and negotiation. Discourses of resistance may also suggest a counter-discourse to medicalised notions of what it means to be a 'healthy' or 'normal' weight and how to live a lifestyle which adheres to the normative ideals of a 'good citizen'. Other forms of knowledge, such as embodied knowledge or other ways of depicting what a good citizen is (than one whom strives for good health or normal weight), may be deemed a higher priority for those individuals with a high body weight (Rail, Holmes & Murray, 2010).

Another way to view the patient 'denial' that GPs report is that of patients making justifications and explanations for weight gain to mediate against accusations of blame, which are central to discussions about obesity. For example, in their empirical research investigating the experiences of managing identities in a sample of Norwegian individuals, Grønning and colleagues draw on the sociological work of Ervine Goffman to demonstrate that unlike many other health conditions or markers of identity, obesity cannot be hidden backstage (Grønning, Scambler & Tjora, 2013). Although individuals can attempt 'covering', that is, downplaying their stigmatising attribute, if a doctor does start a conversation about

weight it is the doctor who has the power to draw attention to obesity and make it a topic for conversation. In an attempt to 'cope' or manage their stigmatised identity, people tend to downplay or excuse their obesity (Grønning, Scambler & Tjora, 2013) suggesting that patients deploy strategies to protect their self-identity.

Some authors have gone on to explain resistance to obesity discourse as 'rationalised resistance' (Monoghan, 2007). In an ethnographic study of a slimming club for males, Monoghan reported that some men resisted the attribution of health risks and problems to their 'excess weight' despite continuing to try to lose weight in line with their wish to 'fit in socially'. Not all males in the club who failed to achieve or maintain weight loss offered a confession of excess consumption or attempted "remedial work" (Monoghan, 2007, p. 601) but resisted the attempts of the slimming club workforce to attribute the failure to lose weight as being due to dishonesty and over-consumption. It is thus important for researchers to consider the function of what GP's and medical researchers tend to label as 'denial'.

6.7.3 They think it's alright for you

A moral framework was evident when GPs positioned themselves as the object of their patient's gaze and positioned patients as judgmental toward their doctor's own body size and thus life style. Several GPs described patients as judging their weight and making inferences that GPs lack empathy due to their 'nice and slim' bodies:

> *"Patients have said back to me about colleagues of mine, have said so and so brought it up and I don't know what they're talking about you know because, they won't, they won't say doctor so and so's fat but they will give you the look and the other thing, the other way round you get it is 'it's alright for you' which is the reverse on its head, it's alright for you to talk about my weight because you're really nice and slim…. and so it's like, you don't know, you don't know my life sort of thing, you don't know my issues type reply so it's, it's both ways. They do, do see you as a role model so I think one should, doctors should reflect erm what they're telling patients."* (GP P)

Conversely, one GP talked about it being easier to raise the topic when she was slightly overweight due to 'sitting on the same side of the fence' as the patient. This seems to be related to the moral judgment associated with talking about weight which may become more pronounced if body sizes differ markedly. The GP uses a

dichotomy of language to describe body weight such as 'super-fit skinny person' and 'frightfully obese' which serves to magnify the distance between the two body shapes:

> "*I must admit I find it easier to raise the subject with people because I'm slightly overweight myself whereas in the past when I was younger and skinnier I probably would of found it harder because I could of almost like join people on the same side of the fence … if you're kind of sitting there as some super-fit skinny person saying well frankly mr so and so you know you're frightfully obese and you've only got yourself to blame for your knee pain because if you weren't so overweight then I mean obviously that's a bit crass but but I think that is I think that is the what you potentially feel as a doctor broaching it with people, is you don't want to upset them.*" (GP N)

GPs thus operationalise discourse which suggests that they have come to self-govern their own weight and body size in order to construct themselves as 'role models' for patients. It is useful to draw on Foucault's ideas related to Bentham's model of the Panoptican to understand such 'technologies of the self' (Foucault, 1988; Rose, 1998). Writing in discipline and punishment, Foucault (1977) draws on the idea of Bentham's model of the Panoptican, a plan for a prison which created the illusion that inmates were being constantly watched. Just as all prisoners feel constantly surveilled by the gaze of the central guard who may or may not be present, individuals discipline themselves in order to meet society's demands of having a healthy, normalised body (Foucault, 1977). In society, there is a constant possibility of being subjected to a 'normalising and regulating gaze', thus individuals start watching or disciplining themselves, ensuring that they fit normative rules, being ever aware that someone may see them and judge them. Being continuously visible acts as a discipline-mechanism of normalisation, thus visibility is closely linked to discipline and power. It may be that the medical analytic gaze has been turned inwards in the case for the GPs who talk about themselves as feeling the need to 'preach what they practice'. To continue with the idea of Bentham's Panoptican, doctors seem to be both acting as guards, subjecting patients to the 'medical gaze' and 'inmates', themselves being the object of their patients' and thus society's regulating gaze.

Recent policy documents issued by medical bodies such as the Royal College of Physicians and the Academy of Medical Royal Colleges, have made

reference to the need for health professionals to maintain a healthy weight and act as role models for patients (AoMRC, 2013; RCP, 2013) suggesting that the 'medical gaze' which serves to discipline and exert surveillance is indeed operating at the level of health professionals. Both the medical profession and patients serve as 'instruments of power' which discipline GPs to self-monitor and regulate their weight/behaviour. Again, this idea illustrates that power relations are not unidirectional; rather they operate in a regulating network. They also exemplify the idea that norms become so embedded that they are beyond perception, causing health professionals (and patients) to discipline themselves without any direct coercion from others (Foucault, 1971).

These discourses emphasise the close association between the visible slim body with notions of being a 'good' and 'responsible' citizen, or in this case, a good health professional. In talking about how patients view their health professionals' body size, GPs make associations between the visible body and lifestyle, rearticulating societal views that body size signals different living patterns depending on if it is slim or overweight. Just as slim bodies signal self-control in wider society, slim doctors signal good doctors and just as overweight bodies signal self-indulgence and a lack of control in wider society, overweight doctors signal 'bad doctors' in the consultation. Again the link between body weight and consumption of food is assumed as self-evident (Peterson & Lupton, 1996). However, another and seemingly contradictory discourse drawn on by GPs was that being slim meant that patients would judge them as lacking empathy and there were claims that it was harder to stay on side with patients. This may demonstrate how powerful the obesity discourse is in creating dichotomies between 'fat' and 'thin' with associated moral evaluations.

Finally, the references to 'working hard' and making a 'choice' to be a healthy weight demonstrate assumptions that being overweight is associated with bad choices and is a matter of overconsumption (Lupton, 1996) reflecting a reductionist understanding about the causes of obesity in line with the prevailing obesity discourse. From a sociological perspective the body has become a personal resource reflecting a person's self-identity and true nature, and has become a project since it can be reconstructed (Shilling, 2012). The influence of living in a neoliberal society, which positions individuals as responsible for making self-interested choices in order to advance their own well-being and contribute towards

a productive society (Guthman & DuPuis, 2006) also seem to be reflected in accounts of obesity as a lifestyle choice.

6.8 Ethical model

Finally an ethical discursive framework was drawn on. Ethical arguments for and against raising the issue were peppered throughout GP accounts. These will now be discussed by linking themes to medical ethics, stigma and ideas discussed in the work of critical researchers.

6.8.1 Becoming yet another person blaming everything on weight:

GPs constructed patients as being aware of their obesity and requirement to lose weight and positioned these patients as receiving pressure to lose weight from other family members and health professionals. They used these arguments to justify their cautiousness about raising the issue which might further marginalise patients. GPs were resistant towards simply 'telling people to lose weight' which threatened to reinforce blame and shame, particularly for those with complex and messy lives. It was thus evident that GPs recognised the social context of their patient's lives and did not just rely on a medicalised discourse in discussing experiences of obesity in the consultation:

> *"I've got patients who tell me about their self-esteem, their err their grandchildren saying that their arms wobble cause their so fat erm they don't undress in front of their partner, they get you know thrush under their folds of fat, there's all the, I mean there's so much you know and actually …..people I mean with the best will in the world, if you're very overweight you must know that you are very overweight erm to some extent so but facing up to that fact and the implications and how it makes you feel and the reality that maybe you can't do anything about it and its all your fault and you know and blah blah blah and you've got a bit of a crap life anyway, and a lot of people enjoy eating cause actually you've got crap lives so you know, some people take drugs, some people eat, some people smoke erm do you know what I mean so you can't just make somebody change there's lots of reasons why people do things."* (GP E)

GPs demonstrated their awareness of obesity stigma in wider society and the pressure individuals were under to lose weight. By drawing on discourses of stigma, GPs argued that they did not want to contribute further to such

marginalisation by offering what they framed as 'well-meant helpful advice'. By discussing their concern that patients would not consult with other health problems in the future, would lose trust and thus would feel alienated, GPs justified their lack of intervention. In taking a critical approach towards raising the issue, the GP below refers to the short-comings of taking an approach which aligns with a reductionist medical model of obesity:

> *"You've got a situation where overweight and obese people already kind of, already a very sort of put up on group in society and they do get a lot of bias and prejudice about their weight and a lot of nagging, a lot of well-meant helpful advice, trying to get them to, you know telling them to eat less, exercise more, lose weight, I don't want to be just one more person doing that."* (GP I)

Several GPs retold patient experiences of secondary care, in which patients had felt blamed and inadequately cared for due to being overweight. Reflections on discussions they had had with patients led interviewees to question the ethical implications of a medical (reductionist) approach to obesity which includes advising patients to lose weight. These GPs positioned themselves against the dominant medical construction of obesity as a risk factor and a threat to health, and instead aligned themselves to a patient-centred model of care and constructed patients as typically presenting with multiple other health problems that needed addressing:

> *"In our eyes, to us as medical professionals they are one and the same issue, you know he's got back pain because he's sat on a chair all day not moving and he's horribly overweight but erm yeah that was interesting so he'd lost complete faith in any of the, the medical professionals he'd come into contact with because he thought they were obsessed about his weight so maybe we do sometimes stigmatise people and almost give them, I don't know, I mean you can almost give the impression to somebody well this is your, well not your fault but this is a result of you being overweight."* (GP C)

In addition to the quotes presented above, there was constant reference to 'nagging GPs', patients being 'picked on' and anecdotes of patients outside the surgery constructing GPs as 'blaming everything on weight'. In this way, people with obesity are positioned as victims with the doctor being positioned as a powerful agent fixated on weight. The challenge for the GP then is to raise the topic of

weight without blaming the patient. This illustrates that medical professionals are working on the intersection between societal views and patient experience, and are in a position in which they are expected to empower patients to take control through behaviour change yet avoid blaming patients (Adler & Stewart, 2009).

Several GPs constructed patient's weight as beyond 'their business' unless patients had come to see them specifically about weight loss, or in situations when excess weight was judged to be causing problems for the patient. Although acknowledging that excess weight may become a problem in the 'longer term', if excess weight was not affecting a patient at the time, to raise the issue was viewed as going beyond the role of the doctor (or outside the domain of medicine). Due to the wider context of obesity as a blameworthy condition, GPs positioned themselves as resistant to routinely raising the topic due to ethical concerns. As well as drawing on an ethical discourse, it is possible to see how obesity is constructed as a personal and non-medical issue.

> *"I think that any time you take on the role of, you know, going beyond the role of what they came to see you about and getting into 'you should do this thing in your life differently' you risking coming across as more of a busy body which to be fair is probably a fair thing for someone to think in that situation, if I go and see a doctor about my sore throat I don't need them telling me about how I should be living my life differently or whatever but erm you know this is also happening in a context of of erm you know society having this big prejudice against overweight people and you know these are people who've probably already faced massive prejudice, this thing that your raising and you know a lot of put downs a lot of nagging a lot of 'oh yes, don't you think you should do something about your weight' which really gets people down and you know just being one more person that does that really it is not my business anyway."* (GP I)

Those doctors who mobilised ethical arguments to justify the challenging nature of raising the issue positioned their patients as being unable to simply 'eat less and move more' and in some cases having tried to lose weight for years. Thus the dominant medical model of obesity was taken to be too simplistic in its unremitting focus on weight loss and reductionist approach (Evans, Evans & Rich, 2003). Whilst it has been argued earlier in the chapter that GPs draw on moral discourses of obesity which constructs obesity as the result of individual behaviour,

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it is also evident that GPs draw on discourses which demonstrate resistance towards the one-size fits all and largely 'reductionist' approach taken toward obesity evident in public health and medical discourse. This resistance suggests tension for GPs who are working within a system and being equipped with solutions that fail to take into account the lived realities of being obese and the contextualised and embodied narratives that patients bring to the consultation (Roberts, 2009).

It is often argued by critical obesity researchers that the prevailing assumption in society is that obesity is preventable and treatable leading to solutions being advocated which reduce weight loss to the simple physics of energy input and output: "eat less" and "exercise more". It is argued that this presumed simplicity of weight loss results in those who are categorised as obese as vulnerable to moral evaluations (Throsby, 2007). It is within this context of circulating negative and moralising discourses about obesity, that GPs have the task of raising the issue of weight. As accounts illustrate, GPs position themselves as being worried about furthering the blame attributed to obesity i.e. furthering stigmatisation. Stigma is thus a concept central to consider in any encounter concerning obesity and is where the focus of the discussion will now turn.

From a social constructionist perspective, the source of stigma is not the disease itself but the social imputation of a negative connotation (Freund, McGuire & Podhurst, 2003). Medical sociologists have pointed out that the stigma of illness may be worse than the condition itself (Schneider & Conrad, 1980). As Guttman and Salmon assert:

> "Once stereotypes and stigma are established, they can result in individuals being feared, avoided, regarded as deviant, and even blamed for engaging in the immoral behaviours that must have elicited the 'punishment' of their affliction (….) This type of social climate can be devastating to members of vulnerable populations who suffer from stigmatised medical conditions since it can result in the internalization of self-blame and destruction of self-esteem." (Guttman & Salmon, 2004, p. 547)

The work of Ervine Goffman and Graham Scambler contributes to a sociological understanding of obesity and is helpful to consider. In Goffman's account of stigma, shame and stigma relations are typically reproduced rather than produced during face-to-face encounters reflecting GP concerns about 'being yet

another person' commenting on weight (Goffman, 1963). Scambler adds to Goffman's work by describing stigma as both enacted and felt. Felt stigma refers to the fear of enacted stigma, which in turn refers to "instances of discrimination against people on the grounds of their perceived unacceptability or inferiority" and can include active shaming (Scambler & Hopkins, 1986, p. 33). Felt stigma refers to internalised feelings of shame and blame and the fear of being subject to discriminatory attitudes (Scambler & Hopkins, 1986). GPs demonstrate concern about 'blaming' and 'picking on' patients as well as reinforcing marginalisation reflecting 'felt stigma' which proceeds rather than results from episodes of enacted stigma (Hopkins & Goffman, 1986).

In light of the description of stigma, it is important to note that the very activity of intervening in obesity i.e. raising the issue, which means categorising patients as overweight or obese, can be viewed as inherently stigmatising. This has been pointed out by other researchers interested in the ethical implications of obesity interventions. For example, a report commissioned by Foresight to explore the ethical implications of obesity interventions reported that "given that obesity is a stigmatised condition, being identified as being at risk of obesity may amount to or produce stigma" (Holm, 2007, p. 208). Stigma and prejudice then can be seen as a consequence of forms of categorization rather than an attitude or belief (Stainton-Rogers, 2011). This is highly relevant to consider, since there are also counter-claims that stigmatisation should be used as a tool to encourage people with obesity to lose weight (Callahan, 2013).

Despite the proliferation of texts on stigma and the damage it may cause, there are debates from wider public health, about whether stigma should be used as a tool to promote public health (Bayer, 2008; Burris, 2008). Those against argue that a liberal society should not shame its citizens and view the use of evoking stigma as being at odds with equality and dignity (Nussbaum, 2004). In line with this view, Scott Burris writes "Stigma can without exaggeration be considered a barbarous and unacceptable form of regulation that a humane society must reject" (Burris, 2002, p.187). Against this strong opposition Ronald Bayer argues that "there may be circumstances when public health efforts that unavoidably or even intentionally stigmatise are morally defensible" (Bayer, 2008, p. 471). Using the argument that stigma helped reduce the levels of smoking through de-normalisation and marginalisation, with society coming to view smoking as an undesirable and

antisocial behaviour, Bayer is drawing on a utilitarian argument to suggest that stigma may be a useful method of changing norms and behaviours in society (Bayer, 2008). However as Burris argues, the meaning of stigma (and its reinforcement) is subject to negotiation. If, as is the case for smoking, reinforcing stigma equates to negative social marketing and a variety of behavioural interventions aimed at marginalising unhealthy behaviours then this, according to Burris, may be acceptable. However if this means inculcating a sense of spoiled identity, it is unlikely that it will lead people to adopt healthier behaviours (Burris, 2008). Using the case of smoking he argues:

> "The ethical practitioner is watching for any sign that people who smoke are becoming a pariah group, are being stereotyped, are suffering status loss, or are beginning to shamefully punish themselves. The practitioner is particularly careful of the risk that public health efforts will add fuel to existing stigmas of, for example, minority group or class" (Burris, 2008, p. 475).

Burris takes an ethical stance in claiming stigmas cruelty lies in its ability to turn people against themselves, in other words to internalise blame and shame. This resonates with Foucault's work on care of the self, in which people come to self-govern and turn the gaze upon themselves (Foucault, 1988). Indeed techniques such as social marketing and behaviour change, which have the predetermined goal of changing behaviours and at times invoking fear or social disapproval of behaviours (thus potentially promoting stigma), are increasingly being challenged as ethically acceptable by critical researchers (Crawshaw, 2012; Evans, Colls, & Hoerschelmann, 2011; Lupton, 2014). Interestingly, this alternative discourse seems to remain silenced in policy or dominant medical and public health research fields.

It is beyond the scope of this thesis to expand further on this ethical tension evident in the wider fields of public health and medicine. However, it is important to acknowledge that there are discourses debating the ethics of using stigma as a public health tool to engender change in the population in order to reduce levels of obesity. It is also highly relevant to consider that a proportion of GPs are arguing against routinely talking to patients about weight loss since they consider patients with obesity to be a stigmatised group in society and are resistant to exacerbate this existing stigma.

Finally, the finding that GPs rely on patients to start conversations about weight demonstrates assumptions that patients will raise the issue of weight if it is deemed problematic (and ignores the possibility of patients feeling unable to raise the issue). By drawing on discourses of stigma, GPs position themselves as ethical practitioners who wish to protect their patients from the distress that may result from talking about weight. That GPs position and assume patients can and will raise the topic of weight neglects to consider that stigma may be a barrier for patients to initiate discussion about weight. Interestingly, in contrast to drawing on ethical arguments to support not raising the topic of weight, a minority of GPs positioned themselves as having a responsibility to talk about excess weight, as to not to do so, would be ignoring their professional duty. This illustrates that GPs draw on broader ethical discourses to support and justify their stance on the matter. The diverse views on the issue, as demonstrated in GP accounts, appear to be reflective of debates in wider society and amongst the research community, whereby there are strong and often polarised views about obesity (Moffat, 2010; Roberto et al, 2015).

  Finally, it was interesting to note instances when GPs justified not raising the issue of weight (and thus not medicalising it) by arguing that the task is not their 'business'. Such a construction suggests,   GPs view obesity as a personal and private (and thus problematic) issue to open up or discuss and one that they are hesitant to get involved in. Thus drawing on discourses of stigma can serve several functions.

6.8.2 Reinforcing shame and blame

Another way GPs justified their lack of weight loss discussion was through demonstrating their worry that they would reinforce negative emotions associated with being overweight such as anxiety, depression, low self-esteem and guilt. There was a recognition that interventions had consequences which could cause or reinforce negative emotions.

"I've got a few patients I can think of who say you know 'part of my problem is my weight and I hate the fact that I'm overweight like this and urrm you know, I wish I was slimmer' and so therefore in those situations, bringing up the issue of weight when they're aware of it kind of feels really insensitive as if you're reinforcing that …you worry about kind of reinforcing their, their

feelings of low self-esteem and weight being an issue, feeling out of control and worrying about that." (GP Q)

The same GP commented on the second video (in which a patient tells the GPs she does not want to talk about her weight) explaining that it is difficult to know how to avoid making patients feeling 'guilty' or 'judged':

"*It is difficult when patients respond similarly to how to how she did, knowing then where to go with that erm because obviously you can't just just leave it like that and obviously she did have a erm a an issue with her weight erm so then it would be knowing where you go with it from there without making her feel kind of guilty or judged… so I would feel really bad, I'd of been like 'oh no, she already feels bad about her weight and I've made her feel worst about it and to blame for her weight problems' erm but but I think you've got to realise that professionally it's not that and and it's more about raising it and then supporting her with something that she's obviously struggling.*" (GP Q)

Another GP described the potential consequences of raising the issue as being like a 'vicious circle' whereby patients feel more marginalised and alienated due to their doctors intervention:

"*They think we're saying they're fat I suppose errrm which you know we would never say in black and white but I guess that is sort of what you're saying that they've got a problem with their weight and they need help or they need to do something about it and that is probably offensive to some people that are self-conscious and I guess a lot of overweight people can be self-conscious … they may not want to come and see you again and they might not want to talk about it, you might make the issue worst cause they might then go home and comfort eat and it could be a bit of a vicious circle.*" (GP S)

Concern about reinforcing feelings of guilt demonstrate that GPs recognise the social and psychological aspects of obesity and are acutely aware of the internalised feelings of shame and blame that obese individuals may experience. The challenge of talking about body weight without reinforcing self-destructive emotions relate to "the very limited vocabulary through which fatness can be intelligibly discussed and accounted for" with dominant discourses tending to locate

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obesity as a matter of personal responsibility (Throsby, 2007, p. 1507). For those patients who construct their body weight in a way that mirrors dominant constructions of obesity, i.e. focusing on individual responsibility whilst discounting structural factors in the causation and maintenance of obesity, are likely to be vulnerable to effects of felt-stigma (Scambler, 2007). These constructions limit the opportunity for individuals to think about body weight or possibilities for change in any other way. GPs fear of 'reproducing' and 'reinforcing' negative and blameworthy ideas about obesity and even contributing to a 'viscous circle' in those obese individuals also experiencing anxiety and depression, suggest that there are limited ways to talk about obesity outside the dominant, individualised model embedded in society today.

It is helpful to turn to discourses around the stigmatisation of obesity in order to understand more about reluctance to broach the topic of weight due to fear of reinforcing negative emotions. Over the last twenty years, a strong evidence base has built up to demonstrate that particularly strong negative associations for obesity are related to beliefs about personal responsibility for body size (Crandall & Biernett, 1990; Crandall & Resser, 2005; Weiner, 1985). Since obesity is perceived to be within an individual's control it is judged more harshly than conditions constructed as less controllable (Brown & Flint, 2013; Puhl & Brownell, 2001; Puhl & Heuer, 2009). The dominant assumptions prevailing in wider society, and to some extent being reinforced through medical discourse, is that obesity is both an individual's responsibility and is controllable (Puhl & Heuer, 2009; Sabin, Marini & Nosek, 2012).

There seems to be a tension between the emphasis from health professionals and wider policy documents which encourage patients to 'take responsibility' (reflecting wider neoliberal discourses) and the likelihood of stigma to be produced and reinforced as a result of believing that obesity is controllable. For example NICE guidelines recommend that health professionals implement individual level interventions by encouraging individuals to change their lifestyle through an increase in physical activity and healthy eating practices thus reinforcing the idea that obesity is within an individual's control. Attributing obesity to personal responsibility has consequences: on the one hand it has been shown to predict stronger beliefs that weight is controllable (Crandall & Reser, 2005; Klaczynski, Goold, & Mudry, 2004), which may be beneficial since it is proposed to strengthen

self-efficacy among overweight individuals (Burnette, 2010; Burnette & Finkel, 2012). On the other hand, researchers suggest that personal responsibility can become associated with a failure in personal will-power, particularly when people fail to lower their weight (Adler & Stewart, 2009; Brownell, 1991). Both health professionals supporting patients, and individuals trying to lose weight, who subscribe to the notion that obesity is within personal control, may experience negative emotions such as frustration and guilt, when weight loss is problematic. Therefore GPs' discourse which demonstrates concern about making patients feeling 'guilty' or 'judged' and 'not knowing where to go from there' may be a result of interactions in which both clinician and patient have constructed obesity as under personal control which requires 'motivation' and 'will power'.

Scambler extends understanding around how stigma can be transmuted into blame, something that is more likely to occur within a neoliberal society promoting the philosophy of personal responsibility (Scambler, 2007). Stigma relates to the view that the stigmatised individual has no control of the "shameful" characteristic. Deviance on the other hand, renders the individual to blame and the individual is felt to be in control of the 'condition' or 'character deficit'. In other words, the individual is held to be accountable and morally culpable. Scambler theorises that the philosophy of personal responsibility accentuates an 'ontology of deviance' and thus locates obesity as a morally reprehensible construct rather than a stigmatised one (Grønning et al, 2012). This insight is important to consider since GPs' and patients are situated within a socio-cultural context in which obesity is predominantly assumed to be a lifestyle choice. Again it is evident that societal notions that hold obese individuals culpable of their condition are powerful and shape doctor-patient interactions about obesity reinforcing the moral nature of such encounters.

6.8.3 Feeling as helpless as patients

There was a tension between problematizing excess weight and lacking solutions or evidence-based interventions with which to help patients. This meant 'opening a can of worms' to which GPs could not help with particularly in the constraints of a ten minute consultation:

> *"It's a can of worms though I mean because it's such a difficult thing because actually… ok there are weight reduction services out there but non with really good evidence at two years so actually on the one hand you're saying could*

you do something about it and on the other you're saying well there's no great evidence, do you see what I mean so errr yeah so I always partly feel like are you now opening a can of worms if you, if you raise this topic or they'll then talk about, having discussions about, it's just time isn't it, time in the clinic, you're pressured and you don't always have a lot of time." (GP K)

Another GP talked about her role as a locum GP constraining her ability to offer patients continuity of care. Although acknowledging she could refer patients to a practice nurse, she refers to one particular nurse who considers providing weight loss advice as futile and unenjoyable. Given that GPs are reliant on nurses and other health professionals to care for patients whom they refer, this illustrates an ethical tension. GPs who wish to support patients with weight loss face structural constraints including the inability to refer patients to other members of the health team who are able or willing to care for patients with obesity.

"I've got a, a practice locally that I locum for and I know that the practice nurse is lovely but she just doesn't like to, she doesn't like erm talking about weight, she just feels like it's a bit pointless and she hasn't had any sort of real success stories so it's a kind of self-enforcing vicious circle erm and so you do say to people 'well pop back and you know, talk to the practice nurse in more detail, can look at your diet and exercise" but actually I have less faith in that being successful at that practice." (GP L)

GPs also demonstrated a tension in their role when they positioned themselves as lacking knowledge and expertise about how to help patients lose weight, particularly those patients unable to undertake current physical activity recommendations. GPs described their current knowledge of weight loss as simplistic reflecting the medical-reductionist (mechanical) approach to weight loss 'eat less, move more'.

"I do think that as GPs you kind of, sometimes you kind of lack the…the knowledge of what you would actually advise people to do about losing weight bar the really kind of simple you know you need to eat less and exercise more obviously he can't exercise more." (GP N)

Another GP talked about the holistic nature of obesity, often leading patients to perceive they were unable to carry out exercise, as a source of tension. There was recognition that weight loss was beneficial for a patient's medical problem whilst

paradoxically recognising the constraints patients face in losing weight. Again the intervention of telling patients to exercise more was judged to be insufficient to change behaviour and patients demonstrated resistance to this kind of advice. Interestingly the GP continues to feel that weight loss is the 'best thing for the patient':

> "*they can say things like ohrrr I can't exercise at the moment erm often I think that's, that can be difficult because it kind of brings into, it kind of raises all sorts of issues when people perhaps feel that you don't understand where they're coming from and it's then about trying to understand where they're coming from so people either say things like 'ohhh you know, how can, you know, how can you expect me to exercise when I'm in so much pain' erm is often something that you get and and that's really difficult because you know they are in a lot of pain and you really want to, to help them erm with that …it is difficult because if if patients say to you how do you expect me to exercise erm I'm at work all day, I work shifts, I come home, I'm a single mum, I'm looking after my three children, I'm then exhausted by the time I go to bed, erm then that's, its, you can, you hear that and you think yes and erm still the best thing for them would be to lose weight and to help him with his knee problem or whatever*". (GP Q)

Time limits of the consultation were talked about as constraining interventions and meaning that issues could only be raised simplistically and in a reductionist fashion. Some clinicians advocated that the complexity of obesity (including the lived experience of obesity and the difficulty of helping patients with weight loss), meant that initiating discussions about obesity had to allow for some exploration of the problem and time to allow patients to react and respond (and contribute) to the intervention. This was seen as a patients 'right' and contributed to resistance to just raising awareness of issues taking a population (governmental) approach:

> "*I don't feel you can bring something up that, bring it up and then just completely drop it kind of thing.*" (GP M)

> "*The difficulty is with the government instilling so many things that we need to bring up during every consultation, you know according to them we need to be asking patients how much they're drinking in every consultation, you know if they're smokers, if there this that and the*

other, patients will not give you a yes, no answer normally, they will expand and rightly so, you know and they're not robots and there is no way you can cover all of that and write up a consultation and solve the problem and prescribe in ten minutes it's just not possible." (GP L)

Within these accounts, GPs position themselves as powerless recognising the constraints of only being able to tell patients to 'eat less' and 'move more'. GPs face the consequences of being equipped with this reductionist approach to weight management in which time and resources are also limited. The potential implications of these material difficulties echoed in GPs' discourse is that obesity continues to be constructed as an overwhelming issue with tension building for both doctor and patient (Vallis, Currie, Lawlor & Ransom, 2007). For example, research which includes the views of individuals with obesity suggests that patients resent the lack of support clinicians can give them and health providers find their lack of expertise in obesity care, and the fact that patients do not change what they view to be within personal control, as extremely frustrating and a source of tension (Vallis, Currie, Lawlor & Ransom, 2007). Other research has reported that health professionals experience hopelessness and feel unsupported by the health system, yet continue to recommend weight loss and simplistic solutions to patients (Kirk et al, 2014). In positioning themselves as powerless, GPs resemble doctors referred to in previous research literature who label and categorise patients perceived as beyond help as 'heart sink' patients (O'Dowd, 1986). This group of patients arouse negative feelings of unprofessionalism, cause puzzlement, frustration and disappointment (O'Dowd, 1986).

6.9 Discussion

6.9.1 Summary of main findings and implications

Confirming previous research findings, this study has identified and described multiple barriers to initiating discussion about weight in general practice. In an attempt to extend the previous literature, the study has focused on exploring the construction of these barriers and in doing so has captured new dimensions of the research problem. The discourse analysis has provided insight into the discursive frameworks around which GPs construct talking to patients about weight. There are important implications to constructing obesity in particular ways which will form the focus of the discussion. It should be noted that most of the GPs drew upon several of the discursive frameworks during their interviews demonstrating

how understandings of obesity and barriers are dynamic and woven out of different discourses. It also reflects how GPs draw on different discourses throughout their interviews in order to *do* different things.

GPs constructed barriers to raising the topic through both drawing on medical-reductionist and medical-holistic discourses. It is perhaps not surprising that GPs draw on this medical-reductionist discourse given their pre-dominantly biomedical training (Thomas-MacLean & Stoppard, 2004) and the dominance of the 'obesity discourse' (Evans, Davies & Rich, 2008; Gard & Wright, 2005). However, there are important implications for GPs predominantly drawing on medical-reductionist discourses to frame obesity and discussion about weight loss. That practitioners found it difficult to achieve a shared understanding of obesity is important since shared understandings are one element of being able to deliver patient-centred care which requires genuine personal engagement and emotional involvement rather than a mechanical application of skills (Levinson, Lesser, & Epstein, 2010). A shared understanding of medical problems is also fundamental to the doctor-patient relationship (Elwyn et al, 2010; Frosh et al, 2012) and as findings demonstrate is a cause of tension in medical consultations concerning obesity. This study suggests two sources of tension in understandings about obesity between GPs and patients: firstly whether obesity is judged to be problematic and secondly, what the causes of obesity are and what needs to be done. According to GPs in this study, some patients contest that their body weight is a medical problem in need of change. This lack of congruence between 'lay' and 'medical' models of obesity, a finding evident in other health conditions such as medically unexplained symptoms and chronic pain (May et al, 2004) as well as with other public health topics which are 'face threatening' and involve lifestyle change such as smoking and alcohol consumption (Butler, Rollnick & Stott; 1996; Pilnick & Coleman, 2003) provides insight into the power relations at work in consultations about obesity. As others have emphasised, it cannot be assumed that doctors and patients agree on models of pathology or on outcomes (May et al, 2004). In regards to outcomes, other empirical research reports that patients and doctors attribute the causes of obesity to different sources (e.g. genetics versus individual behaviour) (Ogden & Flannagan, 2008) and findings of the current study suggest that GPs continue to attribute the causes (and solutions) of obesity to individual behaviour and lifestyle.

One of the most salient examples of how GPs constructed obesity in line with biomedical discourses, was in their comparison of raising the topic of weight to 'opening a can of worms'. Whilst my findings demonstrate that short consultation lengths are constructed as a barrier by GPs who position themselves as unable to explore a patient's subjective experience and weight loss history, considering that this problem is evident in many other areas of patient care (e.g. medically unexplained symptoms, depression and chronic pain), GPs discourse suggests that the 'messiness' of obesity and unpredictability of patient reactions evokes discomfort. As other authors have pointed out there is limited evidence that GPs have the desire to hear the often emotional and complicated realities of people's lives (e.g. Dorwick, 1995; May et al, 1996; May & Mead, 1999) or in this case, weight loss trajectories. Whilst drawing on medical-reductionist discourses allows doctors to withdraw their responsibility from the complex and messy reality of their patients' lives (Salmon & Hall, 2003), this finding is of concern because obesity is a chronic and relapsing condition which requires on-going support and engagement from health professionals (Kirk et al, 2014). As discourse analysis looks at the function of what is said, it seems that not 'opening a can of worms' may allow GPs to exert greater control of the consultation, prioritise patient satisfaction by focusing on their patient's agenda, and to remain detached from their patient's subjective experience (and thus protect themselves from the burden of sharing the emotional and social consequences of obesity). Again it is important to remember that GPs are working within the constraints of the medical system in which there is little time to explore personal and emotional problems which may contribute to feelings of powerlessness for GPs and reinforces the importance they place on controlling the consultation. The consequences of these constraints for patients is that they are denied the opportunity to 'tell their story' and receive medical and social support for their obesity. May, Dorwich and Richardson summarise this tension in their discussion about chronic medical problems akin to obesity which have no straightforward answer and are thus time-consuming and difficult to deal with: "the dilemma for the doctor is not diagnosis, but disposal- of how best to advise the patient to proceed to resolve personal problems that relate to troubled life histories rather than pathology" (1999, p. 20).

GPs do not just construct barriers to raising the issue within a medical-reductionist discursive framework, as was evident by the use of a medical-holistic

framework. This finding has implications for critical researchers who typically put forward and critique a singular medical model (e.g. Gard & Wright, 2005). Given that GPs interact with patients on a day-to-day basis and potentially over several decades, they have insight into the lived and complex realities of people's lives and thus construct obesity as a complex and holistic health problem. In constructing weight loss as a 'struggle', findings support other research suggesting that health professionals, in their interactions with patients, experience the frustration and struggles of their patient's weight loss attempts (Brown & Thompson, 2007; Greener et al, 2010; Kirk et al, 2014). However, it is also important to consider the functions of constructing obesity using psychosocial discourses. May and Mead (1999) point out that these discourses serve to legitimise the expansion of medicine into patients' personalities and psychosocial lives and importantly, come with expectations that patients will be prepared to change their behaviour to prevent or manage disease if required (May & Mead, 1999; Salmon & Hall, 2003). It was also noticeable that GPs drew on patient-centred discourse to explain the tension inherent in asserting their agenda over their patients. This is an interesting finding given the increased criticism of the epistemological authority of medicine and the emphasis on prioritising patient views and patient satisfaction, values which are inherent in 'marketised' and consumer-driven models of health care (Lupton, 1997). Thus considering that patient trust in GPs is no longer something that can be taken for granted but must be continuously earned and worked at, challenging patients understanding of excess weight becomes extremely problematic (Lupton, 1997). An implication of this finding then is that the change in the power dynamics of doctors and patients should be taken into consideration for interventions trying to change GP behaviour, bearing in mind that the increase in power that the 'patient voice' has garnered adds to the challenge of broaching topics that evoke strong emotions and resistance.

The moral discursive framework which GPs draw on in constructing obesity and raising the topic, points to the ways in which dominant discourses of obesity shape GP views and experiences of discussions about obesity. The wider cultural discourses positioning obesity as a moral failure were reflected within GP's talk. Raising a topic that is inextricably moral is constructed as a risk to an on-going doctor-patient relationship and, importantly to GPs since their on-going work relies on it, their professional reputation. However GPs also reflected on the societal and cultural construction of obesity as deviance, a construction GPs sought to avoid

reproducing but that not all felt confident that they could avoid.   An important finding then is that GPs may ignore obesity because they have not developed the discursive resources to talk about weight in a supportive, constructive and caring way and one that prevents reinforcing stigma.

The moral framework also demonstrates that GPs construct obesity as a lifestyle choice caused by individual behaviour. Whilst this is a view dominant within society, this study confirms that it is also one shared by GPs. Other researchers have also identified the collective misunderstanding about obesity in which the complex array of causes and solutions are located with the individual whilst effacing the complex entanglement of social, psychological, biological factors which also contribute to weight gain and make weight loss difficult (Kirk et al, 2014; Sharma & Padwal, 2010).   Beliefs that obesity is caused by behaviour and lifestyle choices may lead to beliefs that body weight is under individual control which subsequently may lead to the perpetuation of stigma (Brown & Flint, 2013).   Discourses can be modified and the challenge of researchers and policy makers may be to change the discourses that understandings of obesity are embedded within so that blame and shame are evaded. This view effaces the complex causes of obesity. It seems vital that GPs are fully educated about the complexity of obesity.

A final point to make about the moral framework evident in GP accounts is that it illuminates the personal dimensions of interactions about body weight for GPs who are subjected to the moral imperative to maintain a healthy weight and whose bodies are also open to the 'gaze' and thus moral judgement from patients. Research with nurses who identify as obese have found that nurses internalise pejorative understandings of obesity and suffer the burden of impression management on a daily basis (Aranda & McGreevy, 2014). Health professionals themselves then are subjected to the medical and moral discourses surrounding obesity and further research should look at how clinicians can be protected from internalising hegemonic discourses surrounding obesity which generate shame and blame.

The fourth framework identified, the ethical framework, demonstrates how health professionals draw on discourses of stigma to justify their reluctance to broach weight. This finding has important implications for public health and medical bodies exerting increasing pressure on GPs to talk to patients about weight loss since their efforts seem to be generating resistance from clinicians. Importantly,

GPs are concerned that talking to patients about weight will reinforce stigma and/or alienate patients. The potential for doctors to 'do harm' by talking about weight is an important finding particularly since there has been a paucity of research to identify outcomes, other than weight loss, of public health interventions around obesity. However, public health efforts which use techniques to change behaviour, including those that evoke fear or social disapproval, are increasingly being challenged by critical researchers as ethically unacceptable (Crawshaw, 2012; Evans, Colls & Hoerschelmann, 2011; Lupton, 2014). Future research investigating the outcomes of broaching weight is therefore needed. Other implications of the ethical discourse is the need for public health and medical institutions to recognise the tension that clinicians experience given the current uncertainty about medical solutions to obesity. As other researchers have pointed out, health care systems are not yet designed to deal with the clinical complexity of obesity, being more aligned to treat acute conditions (Frank, 1998; Kirk et al, 2014). However a good start might be for the multifaceted, complex and chronic nature of obesity to be recognised and reinforced by clinical guidelines and policy documents so that GPs recognise that patients require on-going support and can play a role in articulating the complexity of obesity and potentially alleviating blame.

Finally, resistance to a medical-reductionist framing of obesity has been an important finding in this thesis. As Foucault suggests resistance to discourse, in this case medical obesity discourse, may suggest that opposing ways to talk about, enact and treat obesity are needed:

"Discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart". (Foucault, 1998, p. 100-1)

To conclude this discussion, it is apparent that raising the topic of weight is governed less by clinical guidelines (or QOF indicators) and more by what GP's believe is appropriate professional behaviour including beliefs about what a medical problem is and assumptions about what patients want, views which in turn are mediated by the medical, moral and ethical discourses surrounding obesity and prevailing in our current society. Importantly, GPs position themselves as powerless to prevent reproducing blame about obesity, demonstrating the

dominance of the moral discourses surrounding the condition. Yet at times clinicians reproduce a moral understanding of obesity through associating it with individual responsibility and choice. GPs fear and powerlessness about opening up a complex issue demonstrates the tension between dealing with the lived experience of obesity and being situated within a reductionist medical system. This study also demonstrates that GPs believe addressing weight within medical consultations has the potential to stigmatise and alienate patients and thus suggest public health interventions imposed on general practice require critical scrutiny. Further debate and research is thus needed around how and when GPs should be talking to patients about excess weight and uncertainties in the evidence base acknowledged.

6.9.2 Reflections of the study

The implications of carrying out a discourse analytic study informed by Foucauldian theory is that I (as the researcher) cannot be separated from the discursive formations and macro-discourses that were identified in the study. It is important to acknowledge that the findings of this study are my readings of the text and that I play an inextricable part in the production of these findings. I am also aware that the research I carry out may have an impact on the way that knowledge is framed and have been cautious not to produce or reproduce discourses which marginalise or have negative consequences for individuals living with obesity.

A difficulty I experienced while conducting the discourse analysis was the requirement to recognise hidden assumptions and practices forming the rules of discourse formation. This is a challenge because I myself am embedded within and shaped by discourses. The following reflection about discourse analysis illustrates this point whilst also demonstrating how this limitation can be used constructively: "each of us – academics, policy makers, politicians – tends to think within a discourse. But we do need not to be imprisoned within it. Moreover, being made aware of what we have been taking for granted (…) can be liberating, academically and politically" (Hidding, Needham & Wisserhof, 2000, p. 129).

An important reason for carrying out discourse analysis then is for critical reflexivity focused on the examination of assumptions, beliefs and consequences that are ignored or invisible to health professionals or politicians who are not familiar with looking at problems from a critical and social way (Timmermans, 2013).

There were a number of limitations to the study. First is the inclusion of GP voices only. Throughout their accounts GPs discussed the way patients' resisted

their attempts to talk about weight however this may not align with accounts from patients themselves or be evident if consultations were observed. The way that patients act in the consultation and reflect on and position health professionals is of interest and would add to these findings. Related to this limitation is that within interviews GPs are likely to have been offering a specific and limited version of their views on obesity and raising the topic which differ to how they speak to colleagues or patients about the topic (Potter & Wetherell, 1987). Thus, identifying discourses by observing an actual doctor-patient consultation would be useful to identify the discourses that shape talk between doctor and patient. However, since there are limitations to observational research, particularly observer effects, a combination of methods would be useful to give a fuller picture of the discursive practices being operationalised within general practice consultations.

The second limitation relates to my involvement in the construction of the trigger films and the interview schedule, which are themselves a discursive practice representing only one way of constructing obesity and barriers to raising the issue of weight. These prompts and questions should be viewed as active and constructive, contributing to the functional context for the answers respondents gave (Potter & Wetherell, 1987). The findings of the study cannot be separated from the way I have represented obesity and raising the topic in the videos and the interview encounter. In this way, findings should be viewed as the product and co-construction of a trigger film interview with myself, rather than as how GPs actually construct and thus view obesity. It is also important to point out that it was evident within interviews that GPs do talk to patients about weight despite the common representation that they consistently ignore the issue. It could be argued that I myself am guilty of constructing and reproducing the idea that GPs do not talk to patients about weight. However this is more a reflection of the thesis goal being to identify and look critically at barriers rather than identify whether or how often GPs are raising the issue. Nevertheless my study has given important insight in that it seems GPs do raise the issue and encounter patient resistance, as has been noted in other research (e.g.Laidlaw et al, 2015) rather than remain silent about the matter. Future researchers and policy makers may do well to focus more on supporting health professionals to raise weight constructively and compassionately rather than assuming they don't do it or know that they should be doing it.

The final limitation relates to the methodology of discourse analysis. Given the focus on discourse rather than anything real residing beneath layers of constructed meaning, it can be argued that the methodology is reductionist (Taylor & Ussher, 2001). People's realities and the material world are reduced to a narrative or a cultural construction which negates consideration of how the discursive and material interact and produce real-life consequences. However, the focus on capturing discourse rather than going into the realm of interpretation can also be considered a strength of Foucauldian analysis, since it produces unique findings in comparison to other qualitative methodologies which take a unified approach to analysis, thus extending and opening up new directions in research fields.

6.10 Conclusion

This chapter has described the third and final empirical study of the thesis. Through the use of discourse analysis I have identified four discursive frameworks that GPs draw on when discussing their views around raising the topic of weight in general practice. A critical focus was taken towards understanding barriers to raising the topic in order to capture the discourses that shape and reinforce the ways that GPs construct these barriers and position themselves and 'obese' patients. Describing the work that discursive constructions do and identifying underlying assumptions is important since they shape understandings of body weight/obesity and as such have real consequences. The implications of the findings were laid out in the discussion of the chapter before I reflected on the strengths and limitations of the study.

Chapter 7: Discussion

7.1 Introduction

In this chapter, I will first summarise the key findings from the three empirical studies of the PhD. Findings will be discussed in light of the current literature around the prevention and management of obesity in general practice and new insights highlighted. The implications that can be drawn from these findings will then be summarised and the limitations outlined. Next, I will discuss the two theoretical orientations underlying the study. The chapter will end by outlining the conclusions that can be drawn from the research.

7.2 The research aims and objectives

In this thesis I aimed to contribute knowledge about the barriers to raising the topic of weight in general practice. Through using qualitative methodology and drawing on psychological and social theory, I aimed to identify barriers from the perspectives of GPs and nurses, and then critically analyse barriers by performing a discourses analysis of GP talk about raising the topic generated during trigger film interviews.

I sought to achieve the following objectives:

1. To systematically identify and describe GPs' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice

2. To systematically identify and describe primary care nurses' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice

3. To explore the discursive power relations that shape how GPs talk about obesity with patients by:

    3.1 identifying the micro-political processes at play when GPs talk about the challenges of raising the topic of weight in general practice

    3.2 relating the micro-political discourses inherent in doctor-patient encounters about weight with macro-discourses surrounding obesity and general practice

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7.3 The methodological approaches taken within the thesis

The thesis is formed of three empirical studies. The first two studies identify and describe barriers to raising the topic of weight by eliciting clinician views. This allowed an identification of the determinants driving clinician behaviour. The framework underpinning these studies is informed by health behaviour change theory and is focused on the cognitive, motivational and contextual precursors of behaviour. Due to the limitations of imposing a psychological framework to understand health professional behaviour in study 1 and 2, I began questioning how accounts related to reality. The theoretical orientation of the third empirical study is discourse analysis. In this study, I aimed to deconstruct clinician accounts to capture embedded meanings and norms reflective of the dominant culturally available discourse, and to consider how discourse produces, shapes and reinforces rather than reflects reality (Lupton, 1997; Parker, 1992; Rose, 2007). This approach does not deny the existence of obesity but takes the view that 'obesity' is a social construction shaped by social interactions, shifting frameworks of knowledge, shared cultural meanings and power (Conrad & Barker, 2010). Throughout study 3, I examine the assumptions implicit in accounts and reflect on the possible effects and consequences of such assumptions. This critical stance toward taken-for-granted knowledge reveals that the prevailing cultural, economic and social conditions play a major role in the formation of 'the barriers' to initiating discussions about obesity. Rather than trying to understand human behaviour by examining attitudes, motivations and cognitions, I shift the focus of enquiry to look at the social practices and wider culture which medical interactions about body weight take place and are embedded within (Burr, 2003).

The two methodological approaches are underpinned by different epistemological and philosophical orientations. Whilst this makes a synthesis of the findings challenging and remains the subject of great debate within the field of qualitative research (Barbour, 1999; Blaikie, 1991; Perlesz & Lindsay, 2003), in line with those researchers operating within paradigms such as a pragmatism and critical realism (Greene, 2008; McEvoy & Richards, 2004), I argue that research findings, including both quantitative and qualitative, can be triangulated to produce a rich and more rounded picture of the phenomenon (Kidder & Fine, 1987; Mason, 1994). In addition, it can be argued that by using multiple research methodologies I have avoided an "all-or-nothing commitment to a philosophical position" which is considered "unwise for practising social researchers" (Seale, 1999, p. 57). The two

methodological approaches have allowed me to reveal different facets of the research problem and to examine reality from different perspectives giving a deeper and more complete understanding of the problem (McEvoy & Richards, 2004).

Given that the findings from all three empirical studies have contributed to the understanding of the research problem reached within the thesis, it is necessary to recognise how the study findings cohere. Since the studies were carried out separately and judged according to their underpinning epistemological and philosophical paradigms, I will first discuss the findings from study 1 and 2 which give insight into the beliefs, attitudes and motivations of clinicians, and then I will discuss the findings of study 3, in which I identify the discourses drawn on and constructed in clinician accounts. Finally, I will discuss the findings from all three studies in relation to previous literature. It can be argued that using research approaches with different methodological orientations captures unique dimensions of the research problem and can be synthesised to produce a more complex and meaningful view of the phenomenon adding both depth and breadth (Perlesz & Lindsay, 2003; Seale, 1999). It is important to note that I am not combining findings in the belief that there is a singular and fixed reality that can be determined objectively through the use of methodological triangulation but that I recognise that the research problem can be viewed in different ways and that each of these perspectives contributes to an understanding of the problematic nature of talking to patients about weight in general practice.

7.4 Themes highlighted in study 1 and 2

The three main themes synthesising the barriers from study 1 and 2 were: limited understanding about obesity care, concern about negative consequences and lacking time and resources to raise a sensitive topic. Each theme will now be discussed in relation to previous literature.

7.4.1 Limited understanding about obesity care

Although comprehensive guidelines have been published to facilitate health professional prevention and management of obesity (NICE, 2014, cg 43), study 1 and 2 suggested that engagement with these guidelines remains low. An important finding of these studies emerged when a minority of health professionals explicitly questioned whether obesity was a medical problem that should be treated within primary care. It was also possible to detect from analysis of the latent content of

interviews that clinicians had a limited understanding about the complexity of the causes and solutions to obesity. These findings align with much of the previous literature which suggest that health professionals rely on individual behavioural factors to explain the causes of obesity (Bleich et al, 2012; Epstein & Ogden, 2005; Ogden et al, 2001); feel unprepared to support patients with obesity (Jay et al, 2008), doubt whether obesity is a medical condition and instead frame it as a social problem (Epstein & Ogden, 2005; Mercer & Tessier, 2001; Henderson, 2015), and lack sufficient obesity-specific training (Bleich et al, 2012; Mercer & Tessier, 2001; Turner, Shield & Salisbury, 2009).

The complexity of how to initiate discussions about overweight and obesity was another salient barrier identified from GP and nurse perspectives. Clinicians appeared to lack the skills and knowledge about how to raise the topic in a sensitive and acceptable manner. The studies highlighted the difficulty of raising the topic when overweight or obesity were not causing any other medical problems. There was also considerable uncertainty about whether to raise the topic in these circumstances, suggesting that overweight and obesity are not in themselves considered to be a medical problem. As well as demonstrating knowledge gaps, the skills needed to initiate discussions about weight appear to be a key barrier.

Findings thus support other research reporting that clinicians are less likely to advise or counsel patients about weight loss if they do not present with comorbidities or weight-related problems (Aucott et al, 2011; Michie, 2007). There has been little investigation into why clinicians fail to intervene when patients are overweight or obese without related medical problems so the finding that clinician knowledge and skills deviate from best practice guidelines is of interest. Other research has emphasised the complex endeavour inherent in discussions about weight loss (Jebb, Lang, & Penrose, 2003; Moorhead et al, 2013) and has pointed out that guidelines do not give adequate attention to the complexity of communicating about weight in their recommendations for practice (Webb, 2009). Thus whilst guidelines suggest clinicians "raise the issue of weight loss in a respectful and non-judgemental way" (NICE 2014, ph 53, pg 7), there is little explanation about how practitioners can operationalise this in practice particularly given the 'face-threatening' manner of such discussions. The first two empirical studies thus confirm that knowledge about the nature of obesity as a medical problem and uncertainty/divergent opinions about when to raise the topic and how are barriers to raising the topic of weight.

7.4.2 Concern about negative consequences

Clinician engagement with obesity care and motivation to raise the topic of weight appear to be influenced by a wide range of barriers including beliefs about negative consequences, beliefs about low self-efficacy to help patients lose weight, emotions such as fear and frustration, beliefs about own weight status, and the desire to maintain a non-judgmental and harmonious relationship with patients. Again these findings largely support other research seeking to explain why health professionals do not advise or counsel patients about weight loss (Brown et al, 2007; Kirk et al, 2014; Michie, 2007; Sonntag et al, 2012) and bring to light how central beliefs about negative consequences are for clinicians. Worry about judging, disengaging and alienating patients, consequences which are counter to the values and goals of the drive for patient-centred care, were evident throughout the interviews. Feeling unable to help patients with weight loss particularly within the constraints of a 10 minute consultation seemed to add to this resistance to raise the topic and worry about 'doing more harm than good'.

In comparison to other research, the study confirmed that clinicians worry about evoking emotional reactions from patients (Chisholm et al, 2012; Michie, 2007) and emphasised the centrality that clinicians put on maintaining good relationships with patients (Epstein & Ogden, 2005). However, the findings differ somewhat to the burgeoning literature on stigma which suggests that health professionals hold prejudiced attitudes towards patients (Pantenburg et al, 2012; Puhl, Luedicke, & Grilo, 2014; Sabin et al, 2012). Instead this study demonstrated that clinicians were concerned about activating stigma during interactions with patients. Nevertheless, frustration and ambivalence were evident in GP and nurse accounts suggesting diverse and conflicting views and feelings towards this area of care.

7.4.3 Lacking time and resources to raise a sensitive topic

The final theme demonstrated that the time constraints are an important barrier to starting discussions about weight loss. Clinicians emphasised that weight was unique as a topic to discuss with patients in that it typically evoked emotional reactions and may be related to other areas of the patient's life, thus requiring time to 'explore' and 'unpick'. Recent guidelines emphasise that when identifying that patients are overweight and obese, health professionals should "ensure there is

adequate time in the consultation to provide information and answer questions" (NICE, 2014, cg 189, p. 18). In line with this recommendation, clinicians emphasised that it was unfair to raise a topic without adequate time to discuss treatment options and forms of support with patients. However they also highlighted emotional reactions and the inextricable social and emotional elements typically accompanying obesity, which the guidelines fail to acknowledge. Clinicians also expressed beliefs that they had little to offer patients. This is perhaps reflective of the patchy provision of weight loss services for primary care (Pryke et al, 2015) and aligns with much research suggesting that health professionals feel unable to help and are overwhelmed by the difficulty of treating obesity (Teixeira et al, 2015). Finally, in relation to this theme, clinicians also discussed the importance of considering a patient's other medical needs, particularly the purpose of the visit. This finding highlights the importance of considering context in analysis of barriers and demonstrates the limitations of raising the topic of weight routinely in general practice when patients are likely to be suffering from illness or other health problems and thus could be considered to be in a vulnerable position to be 'tackled' about their weight.

7.4.4 Differences between GPs and nurses

A comparison of barriers identified in study 1 and 2 demonstrated that GPs are particularly concerned about damaging their relationship with patients, prioritise maintaining a positive non-judgmental relationship with patients, view raising the topic as a threat to their professional reputation and view abiding by their patient's agenda as a high priority. These factors seem to be acting as barriers for GPs but not nurses. Nurses on the other hand, emphasised that talking about other public health topics such as alcohol consumption and smoking could act as a barrier to raising the topic. There were also differences in enablers, with nurses emphasising that training and involvement in research studies helped them to feel greater efficacy when raising the topic and in their role supporting patients with weight loss. Although the enablers of raising the topic of weight and the differences in views and attitudes between GPs and nurses was not a focus of this study, further research would be useful to further explore similarities and differences between the two professional groups as well as how they work together given the focus on multidisciplinary team work for the management of obesity in primary care. Given the lack of literature exploring views of obesity prevention and management which

include both GPs and nurses, future research is certainly warranted. Given that concern about damaging the doctor-patient relationship was central to the accounts of GPs, I explore this barrier in more detail later in the chapter.

7.5 Findings from study 3

7.5.1 A critical analysis of barriers

Study 3 reported that GPs use four discursive frameworks to talk about the challenges of raising the topic of weight: a medical-reductionist framework, a medical-holistic framework, a moral-cultural framework and an ethical framework. This study highlighted that obesity is constructed in a variety of ways by GPs, and most importantly not only using a medical-reductionist discursive framework (underpinned by a biomedical epistemology) as many critical scholars suggest. The study also emphasised that to understand more about GPs knowledge of obesity and the problematic nature of raising the topic of weight in a medical consultation we must look beyond the individual, to incorporate medical, cultural, societal and political discourses that mediate understandings of obesity and shape practice. Most saliently, the discourse analysis brought to light a number of tensions inherent in the current medical approach to obesity. Of importance is that obesity does not conform to a traditional medical model. Despite the shift to a biopsychosocial epistemology and a focus on patient-centred care, the current medicalised approach to obesity continues to be reductionist and driven by biomedicine- a site of power and culture and fostering conditions which create and reinforce stigmatisation. I will first outline constructions of obesity from the micro-discourse analysis then summarise the most important macro-discourses which shape GP understanding of obesity before describing the tensions that the medical approach to treating obesity create. This should make visible why, in order to better understand the research problem, we need to look beyond GPs who are 'caught up' in a difficult political and societal challenge, to the conditions which create and shape health care practice.

7.5.2 Medical constructions of obesity

One way GPs talk about obesity is through drawing on a medical-reductionist discursive framework, thus talking in the 'voice of medicine' (Mishler, 1984). This medicalised discourse is based within a biomedical epistemology, draws on the rhetoric of 'evidence-based medicine', is couched in the language of risk, and positions patients in need of intervention. Importantly, this medical-reductionist

discourse frames obesity as a lifestyle choice in need of behaviour change and is under-pinned by the notion that patients should take personal responsibility for health. These medical discourses produce a medical-reductionist model of obesity which is concerned with the clinically relevant and objective nature of obesity rather than the social and emotional elements. It is important to consider that GPs' understandings of obesity are mediated by medical discourses which focus less on the personal and social elements of obesity and more on objective and biomedical criteria thus causing tension within the consultation when clinicians are faced with the complexity of the lived experience of obesity.

When drawing on this medical-reductionist discourse clinicians appear to doubt the honesty of their patients and as a consequence find it difficult to achieve a shared understanding around weight loss with patients. The mythical and uncertain nature of obesity is also evident from GP accounts (e.g. there is much use of metaphorical language) perhaps reflecting the lack of a medicalised, technocratic 'fix' for obesity. A consequence of drawing on medical-reductionist notions of obesity is that clinicians may inadvertently efface the psycho-social dimensions of obesity whilst reinforcing a biomedical and reductionist understanding of obesity which is again likely to contribute to the lack of shared understanding of obesity between doctors and patients and ignores important social and emotional elements of a patient's health. This framework can also help us understand why discussion about weight is only likely to be initiated by doctors if a patient's weight is pathological i.e. it is judged to be having a 'demonstrable' clinical impact on a patient's physical health, since it draws on reductionist and biomedical conceptualisations of medical problems. Paradoxically, when using a medical model, obesity is positioned both outside the boundaries of the medical model (i.e. when GPs deny that the causes of obesity are 'medical') and within it (i.e. when GPs relate obesity to medical symptoms to ensure patients find their intervention acceptable), suggesting that obesity, perhaps due to the inextricable social dimensions of the condition, does not fit neatly into the medical model yet it is not completely denied either since it enables GPs to carry out other areas of their work.

However as I emphasised, GPs also draw on a psychosocial discourse to construct obesity as a holistic medical problem. This medical-holistic model, informed by biopsychosocial and patient-centred care discourses, prioritises patient rights and autonomy, recognises the emotional and personal dimensions of obesity and the wider societal causes of obesity. However, similar to the medical-

reductionist approach, obesity continues to be constructed as a problem in need of intervention, patients are expected to take responsibility, and obesity is constructed as a problem requiring individual motivation and lifestyle change. Thus whilst this discourse extends the medical remit to include the social dimensions of obesity, it retains a focus on individual solutions to obesity. In this way obesity continues to be constructed in a way which aligns with the medical-reductionist model. It is also relevant to mention that although the medical-holistic model pays attention to the psychological and social dimensions of disease, the biological is still prioritised (Armstrong, 1987). Furthermore it is questionable whether given the practical constraints of medicine and within general practice (i.e. 10 minute appointments, limited budgets, demands on clinicians to improve efficiency and productivity) which are more aligned with biomedical than psycho-social problems, that the holistic approach is achievable, particularly when routinely raising the topic of weight (Mercer, Watt & Reilly, 2001).

7.5.3 The moral dimensions of raising the topic

Obesity and the work it produces for health professionals is not strictly clinical (Webb, 2009; Seale, Rivas, Al-Sarraj, Webb, & Kelly, 2013). Consultations in which obesity is or is not discussed are embedded within a wider moral context, and as the discourse analysis demonstrated it is these social dimensions that contribute to answering the research question underpinning the thesis. Firstly it is important to consider the social condemnation of fat (De Vries, 2007). Given the importance of the body in relation to demonstrating self-care during a time of neoliberal rule (Fitzpatrick & Derbyshire, 2001; Foucault, 1988), the centrality of one's 'body identity' (Giddens, 1991; Shilling, 2012) and the social pressure to achieve an appearance which conforms to the normative ideals of beauty (Lupton, 2013), talking to patients about weight in the clinical encounter is a moral endeavour. It can be argued that GPs are positioned in a governmental role, subjecting bodies to the 'disciplinary gaze' (Lupton, 2013). Obesity is a condition which carries with it a visible stigma or "an attribute that is significantly discrediting" (Goffman, 1990, p. 13). Yet it is more than the visible nature of obesity which positions obesity in the moral sphere. The condition requires health professionals to take on a role and interact with patients in a way that differs from other medical conditions, particularly those of an acute nature or without social stigma. When initiating discussions about obesity, health professionals are creating 'patients' who are expected to undertake self-management behaviours through lifestyle change to

lose weight. Patients are coerced into carrying out 'technologies of the self' in which they begin to police their 'selves' in society (Foucault, 1988). A medical approach to obesity carries with it the expectation that patients see obesity as an undesirable state and thus want to be treated. However, as the thesis has found, according to health professionals, not all individuals with obesity are willing to take on this role or become subject to medical intervention. In taking a medical approach, GPs draw on moral discourses which situate obesity as a self-inflicted, lifestyle choice in need of intervention. Moral discourses were also evident in accounts when GPs discussed their own ability to maintain (or not) a healthy weight. Just as there are prevailing discourses that we live in a meritocratic society and that those individuals living in poverty and disadvantage have created their conditions through poor self-management (Gillies, 2005), there was an assumption that if GPs themselves could maintain a healthy weight, then their patients should be able to, promoting a moral discourse that assumes that overweight and obesity is due to lack of will power. Again this discourse obscures structural causes of overweight and obesity and reinforces a distinct view of subject-hood (Rose, 1999) i.e. people with obesity are seen as failing to self-govern.

7.5.4 The ethical dimensions of raising the topic

Interacting with a range of patients on a day-to-day basis gives GPs an insight into the harsh realities of life for many individuals. Recognising the complexity of the lived experience of obesity and aware of the pressure from public health to measure, intervene and monitor in line with guidelines and protocols, some GPs were resistant to the idea that raising the topic of weight could be done routinely or that it was a case of 'telling patients what to do'. The public health focus on obesity appears to align with a medical-reductionist discourse in its focus on the construction of obesity as a health risk and its emphasis on individual responsibility and lifestyle change. GP resistance also points to the paternalistic, disease-centred approach of guidelines which are not always considered to be in the best interest of patients and which conflict with patient-centred care. Furthermore, GPs draw on discourses of stigma to justify their reluctance to broach weight routinely, demonstrating caution about further marginalising patients or contributing to a patient's illness burden by creating weight into a medical problem. Constructions of obesity as posing an ethical dilemma for GPs aligns with arguments put forward by critical scholars who contend that the stigma of obesity may be worse than the

condition itself and argue against stigma on the grounds of social justice and human rights.

7.5.5 Tensions of taking a medicalised approach to obesity

As will be demonstrated there are tensions in the discourses circulating around obesity and the delivery of health care which reveal the complex and embedded nature of the problem. This reminds us that health professionals do not practice in a vacuum and points to the importance of shifting the analytic gaze to the socio-cultural and political landscape to achieve a fuller understanding of the research problem.

The first tension relates to discourses of personal responsibility in health care, whereby policy focuses on the roles of health professionals to encourage patients to self-manage, particularly in relation to chronic conditions (DOH, 2010; Wanless, 2004). There is an emphasis on agency and encouraging people to exercise self-control (DOH, 2010). The rationale for encouraging self-management is achieved by couching the need for self-management of chronic disease in the language of risk (Morden et al, 2012). This is reflective of neoliberal health policy which encourages individuals to take "responsibility for their own health and not rely passively on the state" (Joyce, 2001, p. 598). This is problematic in relation to obesity, a condition which is complex and where there is uncertainty and debate around how health services should respond to the increasing number of patients presenting with excess weight (Frood et al, 2013). Obesity is a condition often attributed to a lack of responsibility on behalf of the person with the condition particularly in the media which shapes public understanding (Malterud et al, 2011). As I have discussed throughout the thesis, beliefs that obesity is under personal control and an issue of 'personal responsibility' have been linked with stigma (Puhl & Brownell, 2003; Brown & Flint, 2013). Thus health professionals are in a difficult position. Through encouraging patients to self-manage and change their behaviour, they may be unwittingly implying that obesity is under personal control, obligating patients to take responsibility for a condition despite evidence suggesting that many significant contributors to obesity are beyond the control of individuals (Puhl & Heuer, 2010; Sharma & Padwal, 2010). The dilemma is that this medicalised approach frames and shapes understanding that obesity is within person control and thus may be unwittingly reinforcing stigma. Although there is no empirical research to support this claim, there is a clear need for future research to investigate the possibility of such a consequence.

The second tension relates to the subjective experience of overweight and obesity and the fact that excess weight, whilst problematic from a medical perspective, may not be constructed as problematic by patients. The current emphasis on person-centred care and biographical medicine prioritises the patient's agenda and doctor as witness to their patient's story (May & Mead, 1999; Stewart, 2001). This approach to health care means that addressing a topic routinely or as a reaction to an objective 'risk factor' becomes difficult. It demonstrates that guidelines, which are disease-centred and seek standardised rather than individualised care are in tension with patient-centred medicine (Bensing, 2000). Obesity like other public health topics such as smoking and alcohol consumption are constructed as problematic for the government and medical institutions, yet may not cause illness or resonate with a patient's experience. This becomes a practical problem within the consultation because unlike many medical problems whereby patients are motivated to comply with medical instructions (Parsons, 1951), for some illnesses or conditions the rules are broken and patient co-operation is problematic (Strong, 1980). Interestingly, topics that tend to be problematic to negotiate in practice often have a personal and social dimension and are assumed to be preventable based on a patient exercising their agency (Strong, 1980). Recently a small observational study in general practice demonstrated that some patients were resistant to attempts by their clinician to talk about weight loss (Laidlaw et al, 2015) and although reasons for this remain unclear, it may be that being 'overweight' or 'obese' does not equate to a subjective illness experience. Interestingly, an article narrated from a patient perspective was recently published in the British Medical Journal (BMJ) and demonstrated that the consistent pursuit of weight loss can be more detrimental to health in terms of lowering self-esteem than living with a body weight considered problematic by doctors yet with no other physical symptoms (Lewis, 2015).In addition to those patients who are overweight or obese and do not accept that they have a medical problem, many patients may wish to lose weight but feel the reductionist response from medical practitioners is unacceptable or feel frustration at the simplistic solutions presented to them which reinforce a lack of understanding into the lived experience of obesity (Lewis et al, 2011; Owen-Smith, Donovan & Coast, 2016). This tension suggests that if obesity is to be treated within a medical framework it requires an approach which incorporates more than a one-dimensional, biomedical view of obesity. A shared model of care needs to incorporate both health

professional and patient views, allowing the two actors to come to a co-constructed understanding of obesity, and which incorporates meaning and lived experiences. However, it should be noted that whilst this may mean a more harmonious interaction between health professional and patient, it will not necessary lead to weight loss for patients (Bisson, May & Noyce, 2004).

It is important to consider that policies and guidelines currently lack this alternative and embodied view of obesity (Morden et al, 2012). It is also important to consider that health professional and patient resistance to talking about weight in general practice could reflect the voice of critical researchers and stigma researchers, suggesting that weight has become a civil rights issue. It may also demonstrate resistance against 'medicalisation' (Moynihan & Smith, 2002) in which the boundaries between normal and abnormal/health and illness are becoming ever smaller given the rise of surveillance medicine (Armstrong, 1995).

It is important to recognise that as well as individuals purportedly contesting that obesity is a problem (or resisting in other ways), patients may also suffer from feelings of shame and blame. And herein lies the next tension. The culturally shared knowledge that health professionals and patients draw on to construct obesity is likely to resemble the moral model and thus construct obesity in a pejorative way i.e. as a matter of personal choice, a burden on the NHS etc. It is critical that clinicians do not reinforce these feelings of shame and blame and thus reproduce stigma (which they may do if they continue to see obesity as a matter of lifestyle choice), emphasising the need for education which helps clinicians and patients recognise that obesity is a complex, multifaceted condition beyond individual control and requiring support. The tensions then reveal an opportunity: a new non-harmful discourse around obesity could be co-constructed between health professional and patient. Given the lack of effective interventions, there may be a 'shared hopelessness' about obesity, so re-framing the issue is likely to continue to be a challenge.

Finally, the ten minute appointment, reflective of the medical approach to problems, is clearly more suitable for acute problems rather than chronic conditions such as obesity. In addition, there are likely to be many competing demands in the consultation such as dealing with a patient's presenting problem(s) which places limits on health professionals to raise additional issues. This model creates tensions for GPs who are likely to have limited opportunity to explore the psycho-social elements of obesity. GPs are constrained in their agency to explore feelings

and this finding thus points to the need for structural change not just individual change. As has been widely discussed in the research literature, 10 minute appointments are a key constraint for both doctors and patients and limit the extent to which patient-centred care can be delivered (Pollock, 2002).

7.6 Important findings and comparison with previous literature

7.6.1 Obesity sits outside the boundaries of medicine

A central argument of the thesis is that obesity represents unique challenges for general practice teams largely due to the social dimensions inherent in the medical prevention and treatment of obesity which position the condition on the boundaries of medicine. Since the majority of research in the field has not been approached from a social constructionist theoretical orientation, this study has added unique knowledge by demonstrating the ways in which GPs construct obesity as sitting outside a strictly medical or clinical problem. This finding adds to other research which has mainly been approached from a socio-cognitive perspective reporting that health professionals feel ambivalent towards obesity prevention (Aucott et al, 2011) and obesity treatment (Mercer & Tessier, 2001; Sonntag et al, 2012), doubt whether it is their professional responsibility or duty to treat obesity (Epstein & Ogden, 2005; Ogden & Flanagan, 2008; Gunther et al, 2012) and hold a different model of obesity to their patients, with more emphasis on the role of individual behaviour as a solution to obesity (Ogden & Flanagan, 2008). Findings also support studies looking at communication between health professionals and patients which reveal that the moral dimensions of obesity are prominent in interactions between health professionals and patients (Guassivora et al, 2014; Throsby, 2012; Webb et al, 2009). I have suggested that the construction of obesity as a lifestyle choice requiring individual behaviour change contributes to obesity residing outside the boundaries of medicine. Interestingly, research into alcohol consumption and smoking, other public health priorities, also suggest ambivalence from health professionals and resistance from patients who may both position the topic outside the boundaries of medicine given the personal and social nature of these problems and as such interactions breach the rules of typical medical consultations (Deehan, Marshall & Strang, 1998; Pilnick & Coleman, 2003; Strong, 1980).

Findings also contribute toward research exploring differences in perceptions and understandings of obesity between health professionals and

patients. A recent study carried out in Canada describing the social construction of obesity by health professionals and individuals with obesity found differences in the expectations and experiences between health professionals and patients which created tensions in the therapeutic relationship (Price, Aston, Rehman, Lyons, & Kirk, 2015). Similar research involving a range of stake holders have identified discrepancy in social constructions of obesity (Greener et al, 2010; Kirk et al, 2014). Interestingly, some of the GPs interviewed in the thesis did not think patients constructed obesity as a medical problem and used this to justify their lack of intervention. Given the limited research looking at how individuals with obesity socially construct their condition or the type of assistance individuals want from their health professionals, it is not possible to say to what extent GPs perceptions align with that of their patients. However, given that some previous research has found that individuals do want medical support, as long as it is non-judgmental and respectful (Kirk et al, 2014; Price et al, 2015) and that patients often feel misunderstood by their clinician given that their repeated attempts to lose weight and their emotional distress related to obesity (Lewis et al, 2011; Owen-Smith, Donovan & Coast, 2016), it may be that GPs assumptions about patient perceptions are incorrect. Research thus needs to focus on the acceptability of raising the topic from the patient's perspective, identifying from a patient perspective how clinicians can demonstrate a better understanding of the lived experience of obesity.

To conclude this section, the social construction of obesity is highly relevant in it being positioned as non-medical and thus may contribute to obesity being ignored or overlooked in consultations.

7.6.2 Responsibility is central to interactions about obesity

In line with the findings of several other studies (Alexander et al, 2007; Epstein & Ogden, 2005; Malterud & Ultiksen, 2011), I have confirmed that the issue of responsibility is central in communication and interaction about obesity. Although not intended to be a focus of the thesis, obesity was constructed as a lifestyle choice requiring behaviour change. Inevitably such framings point to issues of responsibility which are likely to account for the moral dimensions of consultations about obesity (Webb, 2009). Such constructions are likely to be related to dominant framings of obesity in society, particularly reinforced by the media, which gloss over the role of the social determinants of obesity and emphasise the role of individual agency. Although researchers point out the importance of understanding the

framing of obesity, for example a recent article in the Lancet confirmed that the way obesity is framed underlines dichotomous thinking about the causes and solutions of obesity and thus acts as a barrier to progress in the area (Roberto et al, 2015), few empirical studies involving the views of health professionals have considered that obesity is a socially constructed medical problem and that critical reflection about the medical framing of obesity contributes to understanding the difficulties of health professional-patient interaction. The thesis thus contributes unique findings, demonstrating that GP constructions and thus understandings of obesity are mediated by broader societal and political discourses.

Much contribution to understanding the medical and public health framing of obesity comes from critical researchers who point to the way obesity is framed as a homogenous, pathological, controllable condition attributable to individual behaviour (Saguy & Riley, 2005; Jutel, 2006; Throsby, 2007) and that this framing results in a moral panic and blame for what might be better conceptualised as a societal issue (Crossley, 2004; Guard & Wright, 2004). Whilst the discourse analysis in study 3 identified that obesity is constructed as a 'lifestyle choice' thus as a moral problem, it also revealed that GPs, through their daily interaction with patients in which they observe the embodied and lived experiences of obesity, have insight into the complexity of obesity. GPs frame obesity in a multitude of ways as they take up different discourses, including viewing obesity as a holistic problem, thus the 'medical framing' of obesity referred to by critical scholars is more nuanced and multifaceted than they acknowledge.

Researchers have pointed out that responsibility cannot be ignored in consultations concerning problems related to lifestyle choices (such as obesity, alcohol consumption and smoking) because the two (the problem and responsibility) are so tightly intertwined (Strong, 1980; Webb, 2009). In such consultations, health professionals are dependent on patients to acknowledge the problematic nature of obesity and to change their behaviour to lose weight. Thus obesity is unique to many other problems that medical professionals encounter due to variable acceptance that obesity is a medical problem and because solutions lie with patients. Both these features are at odds with the conventional, paternalistic medical approach to treatment.

7.6.3 Obesity stigma as a barrier to raising the topic of weight

This thesis has confirmed that stigma is central to the challenges GPs and nurses face in initiating discussions about weight during general practice

consultations. I would like to argue that this is because social stigma contributes to the perceived risk of disrupting relations, particularly the doctor-patient relationship. Social stigma prohibits constructive discussions about weight and given that research suggests that social stigma is inextricable from the lived experience of obesity (Lewis et al, 2011; Ogden & Clementi, 2010), it is essential to incorporate stigma theory into any understanding of health professional views and experiences around obesity prevention and management. Drawing on theory on stigma thus extends findings of previous research which has identified that concern about damaging the doctor-patient relationship prevents medical intervention.

Given that the doctor-patient relationship is central to general practice medicine and that care is purportedly delivered through and enhanced by this relationship (Balint, 1957; May & Mead, 1999), it is vital to understand more about this barrier. By relating findings to stigma theory, I have suggested that the stigma of obesity is powerful to the extent that it can erode trust and mutual understanding between health professional and patient, which are core dimensions of the doctor-patient relationship and contribute to its therapeutic effect (Scott, 2008).

Although it is beyond the scope of this thesis to discuss findings through the lens of stigma theory, I will extend my discussion to two barriers which relate to stigma since they were salient barriers that could be identified within all three empirical studies. The first barrier relates to GP and nurse concern about disengaging, alienating and burdening patients by identifying and initiating discussions about obesity. As discussed in the previous chapter, stigma is more often reproduced than produced in health care settings (Goffman, 1963; Scambler, 2007) and given the status of obesity in society, living with high body weight can bring with it a sense of personal shame and anticipation of rejection or 'felt stigma' (Grønning et al, 2012; Scambler & Hopkins, 1986) thus there is a risk that clinicians may activate and reinforce internalised blame and shame. Other research has identified clinician concern about disrupting the doctor-patient relationship and causing offence, however findings of the thesis are novel in illustrating that clinicians are concerned about extending and reinforcing stigma and importantly feel powerless to prevent this, which they fear will result in a range of negative consequences including alienating patients from health care. This finding also differs from the dominant perspective reported by researchers who emphasise the high level of stigmatising attitudes demonstrated by health professionals. Whilst I have reported assumptions and frustration from clinicians in my empirical work, it

is important that the research community present a balanced picture and raise awareness that clinicians also demonstrate worry about 'doing more harm than good' thus demonstrating attitudes are complex and in constant flux. It is also necessary to consider that health professional beliefs and behaviours, as well as the broader discourses they draw on, relate to underlying social structures (which limit and constrain thought and action) and to the social networks in which social actors are embedded (Williams, 2003).

Stigma can also help us to understand other barriers to raising the topic of weight, namely those barriers relating to patient resistance and contestations about receiving a diagnosis of obesity and weight being framed as a medical condition in need of intervention. In the third empirical study, I described how health professionals frame patients as 'in denial' and/or as 'defensive'. Theory on stigma and power can aid our understanding of this phenomenon. As alluded to in the previous chapter, individuals may use stigma reducing techniques to distance themselves from a spoiled identity. Sociologists discuss this phenomenon as a "refusal to accept enacted stigma without falling prey to felt stigma" (Scambler, 2003, p. 5) and view this resistance as a powerful resource in the fight back against oppression (Parker & Aggleton, 2003). Whilst outside the realms of this thesis, the recent backlash against the medical and public health quest to 'tackle obesity' by movements such as Health at every size (Bacon & Aphamor, 2011), reinforce that power and stigma are central to obesity and thus medical discussions about obesity. Interestingly, little empirical research eliciting health professional views has identified that patient resistance or unacceptance of medical intervention is a barrier to raising the topic. However, this is a well-documented finding in areas such as smoking (Bell, Bowers, McCullough, & Bell, 2012; Butler et al, 1998; Pilnick & Coleman et al, 2004) and alcohol consumption (Rapley, May & Kaner, 2006; Strong, 1980).

As has been discussed, the findings of the thesis suggest that obesity stigma is a barrier to initiating discussions about weight in general practice specifically because it contributes to perceptions that discussion of obesity will damage the doctor-patient relationship. Given that the doctor-patient relationship is often considered the cornerstone of primary care medicine, stigma becomes a central conceptual tool in helping us understand the research problem. Ways to incorporate stigma theory into similar research in the future include a focus on the

social, institutional and political conditions in which the process of stigmatisation takes place. This will be discussed further in the implications section of the chapter.

7.6.4 Lack of effective interventions continue to be a challenge to raising the topic

In line with much other research, the thesis indicates that health professionals have low expectations about raising the topic of weight and question whether discussing weight with patients will result in weight loss (Brown et al, 2007; Epstein & Ogden, 2005; Nolan et al, 2012; Teixeira et al, 2015). In addition, feelings of hopelessness and frustration were identified throughout the empirical studies, findings which also align with previous research (Teixeira et al, 2015) and may reflect the current limited evidence base. There remains variable evidence to suggest that behavioural interventions delivered at the level of primary care can facilitate clinically effective or long-term weight loss (Booth et al, 2014; Fildes et al, 2015). There is also little evidence on a wider scale about how to achieve population wide weight loss through individual interventions (Roberto et al, 2015). These findings may highlight the tension of working within a medical framework which typically seeks to cure and fix. In the case of obesity, clinicians are unable to achieve such goals due to the nature of the condition as a chronic, relapsing condition. The ten minute consultation also seems to prohibit engagement with patients in a way other than the technocratic-medical approach. For example, time constraints limit discussion about lived experience of obesity. Such findings suggest an uncomfortable position for clinicians who are being pressurised to talk to patients about obesity yet are working within a system more conducive to acute conditions. Few other studies have pointed to this tension (with the exception of Kirk et al, 2014) yet research into chronic disease management suggests a new model of care is needed to overcome the limitations of the traditional medical approach to problems (Bodenheimer, Lorig, Holman, & Grumbach, 2002).

The sociological literature can also help us to understand this barrier. An assumption of conventional medical consultations is that clinicians have a high degree of technical expertise (Strong, 1980). The lack of cure or even effective treatment approach, including brief intervention that GPs and nurses can use for obesity, makes bringing up the issue problematic. Currently only bariatric surgery promises an effective long-term weight loss solution (Arterburn & Courcoulas, 2014). The lack of clinical expertise evident in GP and nurse accounts seem to reflect medicines current failure to 'cure' obesity. In this light we can see that

solutions outside of the clinic such as commercial weight loss programmes may only to serve to reinforce obesity as a non-medical problem. Finally, obesity is reported to be associated with anxiety and depression (Luppino et al, 2010; Simon et al, 2006) and social stigma (Puhl & Brownell, 2009). GPs admitted to sometimes ignoring the psychological, social and emotional elements of obesity suggesting these elements of obesity sit outside the expertise of clinicians and again demonstrate that consultations about obesity diverge from the norms of conventional medical consultations.

It is also useful to reflect on the intense societal debate currently focused around ways to 'tackle' what is framed as a global 'obesity epidemic'. Critics stress the need for population-wide prevention policies, such as the tackling of 'big food' and disagree that general practice should be used for health promotion attributing this to political agendas. This resistance is not unique to interventions around obesity, for example the NHS health checks have been criticised by a proportion of researchers and clinicians who suggest that they are ineffective, cost inefficient and harmful (Capewell, McCartney, & Holland, 2015).

Whilst there remains a lack of evidence around how clinicians can support patients to achieve effective weight loss, it is interesting to reflect that other outcomes of talking to patients about weight have received little attention. Researchers have called for a change of focus in relation to intervention in primary care, suggesting that new primary outcomes be incorporated into the structures governing general practice consultations such as guidelines and QOF (Booth et al, 2015).

7.6.5 Limited engagement with the social and emotional dimensions of obesity

The reluctance of clinicians, particularly GPs, to explore the emotional and social dimensions of obesity is an important finding given the evidence that obesity is associated with a range of psychological consequences including depression and anxiety (Luppino et al, 2010; Simon et al, 2006) and that those who experience obesity experience lower self-esteem (Miller & Downey, 1999), body image disturbance (Schwartz & Brownell, 2004) and reduced quality of life (Ul-Haq, Mackay, Fenwick, & Pell, 2013). Some clinicians discussed their reluctance to discuss weight since it required engagement with difficult emotions and a complex biography, an unpractical task given the constraints of time and a clinician's own

emotional resources. Thus there was a tension in accepting the multifaceted nature of obesity, particularly those dimensions of the condition diverging from biomedical criteria. This barrier indicates that it is not only weight that is being ignored in the case of obesity, but emotional and social health needs that are inextricable to the condition. This is relatively unexplored in other research thus a novel finding of the study. Further research should clarify if the social and emotional dimensions of obesity are acting as a barrier to raising the topic of weight and look at ways GPs can be supported with such an unarguably complex task. The literature on emotional labour (e.g. Hochschild, 1983) may be useful given that some GPs acknowledged how exploring the relational and historical elements of obesity impacted on their energy levels for future consultations.

7.7 Limitations of the thesis

This investigation has limits. In relation to study 1 and 2, the deductive and theoretical design of the study could be considered a limitation since it may have precluded the research team from identifying and presenting barriers in a way that deviate from the theoretical domains framework. The framework is based on the dominant behaviour and behaviour change theories prevalent and accepted in the field of implementation science at the current time, with the majority of theories underlying the framework belonging to social cognition models. The epistemological and ontological assumptions underlying the study determine, shape and limit the research. The constraints of the framework, particularly the focus on the individual as the unit of analysis, as well as the lack of attention paid to the socio-cultural meanings attached to obesity contributed to my decision to use a new research design for study 3.

Study 3 also has methodological limitations that are important to bear in mind. First the trigger films used to generate discussion were novel methodology designed as part of the PhD and had not been validated. However, it is important to remind readers that the design of the study was informed by a social constructionist paradigm rather than a realist paradigm, therefore the focus was on exploring the constructed nature of barriers and representations of consultations about obesity rather than to produce valid and reliable interpretations of GPs beliefs and behaviour. The trigger films were constructed purposefully by the researcher to trigger discourse and thus generate rich and novel insight into barriers. A further limitation of study 3 relates to the use of discourse analysis, an approach unable to

generate explanation into how structure and agency interact i.e. how the structures of health systems interact with individual behaviour. Furthermore the focus on socio-cultural discourses prevailing in society rather than the individual, can be criticised for being deterministic and limited by only looking at the wider context. Finally the sample of participants mainly came from one clinical commissioning group (CCG) within the UK and participants self-selected to be in the study, details which should be considered in relation to the transferability of findings.

Beyond methodological limitations of the current studies, the thesis could have benefited from the inclusion of a study documenting a patient/lay perspective. This absence was due to pragmatic reasons, particularly time and research focus and a decision to focus on gaining greater insight into GP constructions of obesity and barriers to talking about weight. However, as the findings of the thesis point towards, raising the issue of weight is a relational phenomenon, and the inclusion of voices other than medical professionals is clearly needed to understand the research problem. It is perhaps more conducive to think about the co-construction of raising the topic of weight and the associated barriers. The thesis is thus limited due to only representing the perspectives and discourses drawn on by one half of what is a relational duality.

7.8 Implications

7.8.1 Implications for Practice

Findings confirm that there is a need for training and education around obesity which is well recognised in policy texts. In 2010, the Royal College of Physicians released a report providing a detailed outline of the educational and training needs of health professionals (RCP, 2010). Amongst the recommendations, the report included the aim "to enhance awareness and understanding of obesity as a significant medical condition" and for health professionals "to recognise the social stigma and personal values and attitudes towards obesity" are interesting given the findings of the thesis (RCP, 2010, p.24). Although findings of this thesis suggest that the complexity of obesity and weight loss are recognised by many health professionals, obesity is still framed as a lifestyle choice and thus constructed as within individual control and a matter of individual responsibility. Encounters about obesity thus become moral encounters. Despite reports such as the Foresight report documenting the multifactorial and interactive causes of obesity, there seems to be awareness yet inconsistent

understanding amongst GPs and nurses about the complexity of obesity, with patients continuing to be positioned as lacking motivation. Whilst other scholars in the field suggest that education may help reduce weight bias evident amongst health professionals (Dietz et al, 2015), if obesity continues to be framed as a lifestyle choice, assumptions and thus weight bias may remain.

Training and education may also wish to acknowledge the limited evidence and uncertainty that currently exists about the medical treatment/care for patients with obesity (Brauer et al, 2015; Griffiths, Green, & Tsouroufli, 2005), particularly around how patients can be supported to maintain long-term weight loss. Although this may exacerbate clinician beliefs about the challenging nature of managing obesity in consultations, it may also reduce frustration which may build up if patients do not lose weight or relapse. This may prevent patients being labelled as 'unmotivated' and thus deviant and reduce the moral tone of consultations.

Since stigma and power relations were major themes throughout the thesis, it is important that any education and training applies theoretical insights from these research fields and seeks to raise clinician consciousness about how such phenomena might constrain any communication. It may be useful to inform clinicians about how the social and cultural meanings of obesity in wider society impact on the medical encounter. For example, clinicians could be educated about the pejorative representations of people with obesity evident in society and how obesity is often framed as an economic 'burden' which contributes to the social stigmatisation of obesity. It is important that clinicians are aware of how these constructions may be internalised by both themselves and patients, and come to shape and frame their interactions. Since the overarching concern of clinicians is to maintain a good relationship with patients and to ensure patients are not alienated if discussion about weight is broached, it is imperative that any training and education is directed at appeasing these concerns. Training around the sociological dimensions of stigma may be helpful, particularly training which looks at internalised stigma and stigma reproduction which could be responsible for unintended consequences. Furthermore, since patient resistance was a prominent theme, clinicians could be informed of the stigma management techniques that people use to 'cope' with obesity (Monaghan, 2007), which may be interpreted as 'denial' or 'dishonesty'. Interestingly, the RCPs training guidance suggests that health professionals should be able to prevent resistance when sensitively raising the topic of weight (RCP, 2010) yet offers little guidance about how health

professionals can achieve this outcome during clinical encounters. Recently, research has suggested that clinicians should be aware of the tacit shame that patients often feel about conditions represented as lifestyle choices (Guassora et al, 2014), thus theory on shame could also be incorporated into training and education. To date, stigma reduction efforts have largely been based on individual level interventions (Kushner et al, 2014; Swift et al, 2013) which provide only limited evidence that long-term attitude change and weight bias reduction can be achieved by such interventions. In Canada, a novel intervention has been implemented by researchers using stage drama to demonstrate the tensions inherent in medical encounters about obesity with the aim being to educate and provoke constructive dialogue to address these tensions (Kirk, 2015), which may be a promising avenue to replicate in the UK. Whilst I advocate for training and educating at an individual level, there is a clear need for further research to determine how stigma can be reduced during medical consultations about obesity given that stigma is produced from the social structures and social networks that actors are embedded within. Thus any intervention to reduce stigma needs to target both individual actors and social structures since either approach alone is unlikely to be sufficient and at worst may inadvertently increase stigma, demonstrating the urgency of further research in this area.

As has been suggested widely in the literature, clinicians need a better understanding about how to help patients change behaviours related to obesity (Dietz et al, 2015; RCP, 2010). Whilst behaviour change theory underpins the current approach to changing patient behaviour and is recommended in clinical guidelines (NICE, 2007, cg 6), there remains limited focus on the social context or on biological influences, and perhaps most importantly the interaction between the two, that shape behaviour (Glass & McAtee, 2006; McKinlay & Marceau, 2000) thus research is still needed to explore whether there are unintended consequences of using behaviour change theory. For example, these theories do not account for the social causes of behaviours despite epidemiological evidence demonstrating that behaviours related to obesity are socially patterned, thus they may unintentionally put greater emphasis on patient agency and controllability of obesity and, paradoxically, reinforce social inequality (Frohlich & Potvin, 2008).

Future research may wish to scrutinise behaviour change theory and the field of behaviourism to look at the effects of this potentially reductionist conceptualisation of human behaviour. Raising the topic of weight is similar to

raising topics such as smoking and alcohol consumption in that there is a reliance on patient behaviour change. However, behaviour change theory, although central to current health care policy, is open to criticism due to the emphasis it puts on individual agency and the little acknowledgement attributed to social structures or determinants that drive behaviour (Baum & Fisher, 2014; Cohn, 2014; Nettleton & Green, 2014).

My position on this matter then is for training and education to inform clinicians about the limitations of behaviour change theory when applied to obesity given that the causes of obesity include contributors beyond the control of individuals (Puhl & Heur, 2010). Until the knowledge base increases (for example, social practice theory is a promising area), behaviour change theory is likely to be the dominant way of educating health professionals since there are no other evidence-based approaches to behaviour change which can be included in clinical guidelines. However, since the thesis has revealed that issues of responsibility and choice are central to discussion about obesity, health professionals could be educated on the complexity of choice in human behaviour and how factors like social inequality, ethnicity and gender intersect and shape choice. In conjunction, health professionals could be educated about neoliberal discourses which position individuals as agentic individuals capable of changing their conditions by making the right choices and expending enough effort. Despite a strong body of evidence demonstrating the complexity of obesity, it is still framed as a lifestyle choice and it is important that health professionals understand the mechanisms maintaining such representations which are likely to lead to blame and shame in the medical encounter. Rather than frame behaviour change as a panacea for the treatment of obesity, it is important that clinicians are aware that behavioural interventions are only one part of an array of solutions that are required. As was pointed out in a recent Lancet article, changes to the environment and food industry are needed to produce change at a population level and behavioural change alone is not likely to be enough for an individual to maintain weight loss (Roberto et al, 2015). The important point is that if health professionals (and patients) believe behaviour change is the solution for weight loss, in the common scenario that an individual does not lose weight, there is likely to be frustration and other emotions which hinder relations and future efforts at weight loss (Kirk et al, 2014).

Whilst advocating for further training for GPs and nurses to facilitate provision of obesity care, there are obvious constraints on clinician time and

resources and thus there needs to be further clarification about the role that GPs and nurses are expected to play. It may be that obesity care responsibilities can be shared with other members of the care team for example dieticians and psychologists so that GPs feel supported rather than overwhelmed by such a complex and relapsing condition.

7.8.2 Implications for Theory and Research

The limitations of the first two empirical studies of the thesis demonstrate that an understanding of health professional behaviour may be enhanced by going beyond psychological constructs. Dominant models of psychology have a number of underlying assumptions which limit and constrain the knowledge that can be produced. In study 1 and 2 I identified several underlying assumptions of the TDF which often remain invisible yet are problematic since they do not reveal important dimensions of the research problem. First, the majority of theories derive from socio-cognitive models and hold a particular ontology of personhood. People are conceptualised as being driven and cognitively motivated as individuals (Horrocks & Johnson, 2014). The framework thus makes it difficult to include and pay attention to data which does not fit into the dominant theorised drivers of behaviour. These models of behaviour are also limited since they do not look critically at the accounts people give, taking what is said to be an account of reality and assuming that language is simply a vehicle to communicate thoughts (Burr, 2003). I suggest that researchers developing and applying models of behaviour look critically at this notion of personhood built into their models and recognise that as a body of knowledge, psychology represents just one, albeit a powerful, way to understand human behaviour and that the underlying values of the discipline require critical scrutiny.

In regards to this point, it is important to point out that much of the previous research literature has embarked on research looking at health professional management of obesity using psychological theory or has at least focused on the views and beliefs of health professionals as the main unit of inquiry. By using this approach to social enquiry the discourse of science and psychology has been used to construct findings as 'knowledge' or 'truth' (Holmes et al, 2006). These studies pay little attention to the importance of language or discourse including meanings which go beyond what is said, ignoring how language is performative and constructive. I would like to argue that this approach is not sufficient since it misses out on the actual construction of knowledge and by implication, power. Such

studies can be criticised as 'decontextualised' constructions of the research problem. Of the studies that have looked at the negotiation of obesity from a sociological perspective (Grønning et al, 2012; Throsby, 2007; Webb, 2009), they have demonstrated that obesity is far from a value-free 'medical condition' and that the moral constructions of obesity are central to understanding the nature of medical encounters between health professional and patients presenting with excess weight.

Whilst I have suggested ways to improve the TDF i.e. by incorporating the socially constructed nature of obesity into the model and considering theories on stigma and power, it can be argued that the empiricism and positivism underlying psychological models of behaviour require a paradigm shift to prevent reproducing the assumptions of human behaviour which are embedded in these models (Baum, MacDougall, & Smith, 2014; Cohn, 2014; Shove, 2010). Although there is a need to look beyond the dominant paradigm of psychology in understanding health professional behaviour/health care interaction by including sociological theory and remaining aware that there is a risk of embodying and reproducing the dominant models of behaviour by continuing to use psychological theories of behaviour change (Shove, 2010), it remains unclear how a model like the TDF can incorporate the idea that obesity is socially constructed. As Shove (2010) points out, there is a need for researchers to consider "how competing theories of social change become embedded in, and excluded from, policy and practice" (Shove, 2010, p. 1281). Although moving away from individual behaviour change is problematic since there are political interests at stake, for a full understanding of the problem, this may be necessary.

Another implication for theory around how to understand and change health professional behaviour relates to the underlying premise in psychological models that behaviour is unitary in character and as such can be easily identified. There is no consideration given to how the meanings of specific behaviours vary across the range of contexts and settings in which they take place or that behaviours rarely take place in isolation. As has been argued in relation to health behaviour, there is a need to reconceptualise behaviour to incorporate the meaning and importance granted to actions by wider social practices (Mielewczyk & Willig, 2007). In addition, by viewing behaviour as a unitary action, it is not reflective of the nature of health care practice which is complex, dynamic and interactive (Plsek & Greenhalgh, 2001). The TDF then could be improved by modifying the model to look at the

interactive nature of health professional behaviour and focusing on 'practices' as the unit of analysis rather than discrete behaviours (Greenhalgh & Swinglehurst, 2011; Reckwitz, 2002).

The second implication for theory and research is the need to go beyond individual health professional beliefs and attitudes to understand obesity stigma as a social process. Findings of the thesis draw attention to the possibility that patients with obesity in general practice experience internalised stigma and the dilemma this presents for health professionals who may, despite good intentions, reinforce stigma. As has been pointed out by others, research into obesity stigma has been dominated by psychological perspectives and has tended to maintain a focus at the individual level (Brown & Flint, 2013; Parker & Aggleton, 2003). There has been a particular focus on revealing the enduring negative attitudes of health professionals. This approach is reductionist, providing only a limited view of obesity stigma, which may be better described as a complex and nuanced social phenomenon. Since stigma relations are part of a nexus of social structures (Scambler, 2009), sociologists have called for future research and education/training to account for structures, including social and cultural factors, in addition to the individuals operating within these frameworks. As Scambler asserts "studies of health-related stigma can no longer afford (…) to neglect the social structural underpinnings of cultural norms and individual choice" (Scambler, 2009 p. 453). In other words it is necessary to empirically expose social structures which are necessary for stigma to be activated in interaction (Scambler & Paoli, 2008). Scambler also asserts that there is a need to pay attention to the broader social forces influencing the practices of health professionals and reminds us that stigma is a bi-product of these social structures (Scambler, 2006). Whilst it was not within the scope of this thesis to perform a sociological analysis of how stigma is a barrier to constructive discussion about obesity, it has highlighted the requirement for future research to consider that in any attempts to combat and reduce stigma, there is a need to incorporate more than the attitudes, cognitions and motivations of individual health professionals. For example, it is essential to consider that norms of shame and blame are embedded in social structures and seemingly 'natural' forms of social order (Scambler, 2006). There is a requirement then for future research to look at the contexts and conditions within which the process of stigmatisation takes place (Parker & Aggleton, 2003). A highly significant point is that stigma occurs within specific contexts of culture and power (Parker & Aggleton, 2003). Researchers thus

emphasise the importance of focusing on "the political economy of stigmatisation" (Parker & Aggleton, 2003, p. 17) and the functions of social exclusion. Foucault's work on power for example, reveals how regimes of power embedded in knowledge systems (such as biomedicine) function as a form of social control over individual and social bodies (Foucault, 1977). Thus there is a need for researchers to consider stigma as a social process that can only be understood in relation to broader notions of power and control. In addition, stigma is linked to the dynamics of social inequality requiring researchers to consider how specific contexts create and reinforce exclusion of certain groups (Parker & Aggleton, 2003). Importantly, any attempts to prevent or reduce stigma need to target both individual-level and structural level factors which cause and maintain the blame and shame related to obesity.

It is also important to consider that people can feel stigmatised in the absence of any direct discrimination, again suggesting future research/theory development into obesity stigma needs to go beyond health professional attitudes and motivations. There is a tendency for researchers to brush over the internalised shame and blame that people with obesity are at risk of experiencing and even a tendency for researchers to draw on two small, US-based studies to suggest patients find interventions about weight acceptable (researchers typically refer to a study by Tan et al, (2006) and a study by Potter et al, (2001)). This failure to acknowledge that GP and nurses have legitimate and rational grounds for concern that they will upset patients by talking to them about weight, seems to be ignoring the harmful effects of interventions on patients and attributes the problem and solution to individual health professionals with little acknowledgement of the socio-cultural context and dimensions of the problem. As has been argued throughout the chapter then, in order to understand and reduce the stigma which hinders health professional and patient communication about obesity, both individual-level and structural-level factors which cause and maintain the shame and blame related to obesity need to be considered, either approach alone will not suffice.

Finally, I suggest that further research should be conducted to extend insight into how a health professional's own weight status is an important factor in discussions about weight in general practice. In study 1 and 2, a health professional's own weight status was identified as a potential barrier to raising the topic of weight. In study 3, in my discussion of the moral discourse of obesity, I identified that health professionals who were overweight or obese were framed as

illegitimate role models by their colleagues. Whilst it was considered beyond the scope of the thesis to look at this barrier, psychoanalytic theory on 'othering' may help future researchers understand this I/Other split and the marking of difference as significant (Shapiro et al, 2008). Since one of the social goals of modern medicine is to demarcate the sick from the well (Cassell, 1998), it may be that the more medicalised society becomes, the greater the importance of difference between the 'ill' and the 'healthy' (Marks, 1997). Research on scapegoating may also be useful to incorporate since it gives insight into extreme othering in which people are rejected, distanced and separated to avoid contamination (Wear, Aultman, Varley, & Zarconi, 2006). This relates back to blame and thus reiterates that sociological theory of stigma is essential to include in any attempt to understand views and practice around obesity.

7.8.3 Implications for Policy

Given the concern expressed by clinicians about disengaging, alienating and damaging relationships with patients, there is a need for policy to remain mindful of the unintended consequences of public health efforts to lower rates of obesity. Whilst policies such as "*Making every count*" (NHS Forum, 2012) advocate for health professionals to raise topics during every contact, findings demonstrate that health professionals view a blanket approach to talking about weight (i.e. talking about weight loss at every appointment) as a threat to person-centred medicine. Raising the topic of weight opportunistically, when the conversation is prompted and linked to the content of the proceeding consultation however, does seem to be more acceptable to clinicians. Research to find out patient perspectives on this matter is needed to confirm when discussion about weight loss is acceptable for patients. The majority of clinicians were also resistant about taking a preventative approach to weight loss discussions demonstrating the power struggle between public health and general practice, a well-recognised phenomenon but one which policy may do well to consider. It seems particularly important that health professionals do not feel coerced into raising topics and have the freedom to exercise clinical judgment. The limits to health promotion were summed up in a BMJ editorial:

> "Doctors with a public health orientation can be quick to say what general practitioners should be doing on the basis of population data. Yet doctors and nurses in general practice face the frustration of being bribed or bullied

by governments to achieve targets that many patients are not ready to accept for personal and social reasons. Nothing is more likely to reduce the likelihood of long-term 'success'. Coercion may in the short-term achieve apparent health gain targets, but at what cost to relationships and the professionals' feelings of integrity and self-respect? The opportunity costs are still unevaluated". (Stott, Kinnersley & Rollnick, 1994, p. 971)

Findings suggest that clinicians need support to introduce and talk about the topic of weight loss in a patient-centred or co-constructed way. Including the views of people with obesity in guidelines, training and communication could help doctors and nurses to understand more about the lived experience of obesity and the type of support and communication required by patients. However, as the discourse analysis demonstrated, there is a need to consider how the experience of obesity is affected by political, economic and cultural as well as biomedical factors, and that patients may have internalised blame and shame. It remains an empirical question whether and how clinicians could play a role in reducing a patient's burden of living with a stigmatised condition such as obesity, nevertheless clinicians need to take care to reduce rather than reinforce felt stigma. Guidelines and training, which currently include little detailed reference to stigma or shame and blame, could incorporate such detail and emphasise the role health professionals have in supporting (rather than curing) patients. In conjunction with interventions aimed at the level of health professionals, action is needed to combat institutionalised stigma and to scrutinise the conditions which give rise to stigmatisation. Given the moral and ethical implications of weight loss discussions in medical encounters, guidelines should recognise the complexity that raising the topic of weight presents for health professionals and thus provide more detailed and supportive guidance.

Policy makers may also wish to take into account social movements which relate to the findings of the thesis such as the 'Health at every size' movement which look at the harms of a medical approach to obesity. Rather than seeing such movements as threatening, policy makers could learn from how this type of collective action may influence public opinion around what is acceptable in health care. Another example of collective action is the 'preventing overdiagnosis' movement made up of clinicians and/or researches who recognise the expansion of medicine and the 'pathologising' of everyday life (Moynihan et al, 2013). This may help policy makers understand more about clinician resistance to raise public

health topics during every consultation and take action to ensure that policy recommendations minimise the potential for harms. However, it should be noted that the discourse produced from groups such as the 'health at every size' movement and critical obesity researchers have important and potentially harmful implications in a similar way to medical discourses. Future research which analyses the discourses surrounding such a movement would make a valuable contribution to the research field.

Another implication for health policy is the need to recognise the limitations of general practice as a location for the promotion of weight loss discussions. The structural constraints of primary care consultations, particularly time restrictions, hinder the opportunities for health professionals and patients to engage in constructive discussion about weight loss. There is also a need to consider the high proportion of patients presenting in general practice with other illnesses or medical complaints, something that is likely to make raising the topic less appropriate or acceptable to patients. Resistance from health professionals to raise the topic of weight in a tokenistic manner demonstrates intentions to take a patient-centred and ethical approach to raising the topic. Given that opportunities to raise the topic of weight are therefore likely to be limited, policy makers may wish to consider alternative venues for weight loss discussions to be initiated. In addition, the limited evidence base to suggest that primary care obesity prevention and treatment interventions are effective (Booth et al, 2014) should be acknowledged by policies, particularly given the potential for negative consequences. Much may be learnt from the multifaceted approach that has been taken to lowering population rates of smoking, demonstrating that national-level as well as primary care-level support is a requirement for a problem which is as much societal as medical.

Finally, it is important for policy, public health and medical institutions to remain aware of the way they frame any communication about obesity and remain mindful to the potential for unintended consequences, particularly given the potential for stigma reproduction (Parker & Aggleton, 2003). With the current policy and research focus on the health consequences of obesity, the construction of obesity as a health risk (Armstrong, 1995; Lupton, 1995) and the framing of obesity as a 'burden to the NHS' (Hilton, Patterson, & Teyhan, 2012), such framings may contribute to a reductionist, negative discourse around obesity and shape the discomfort health professionals express in relation to discussing weight with

patients. The moral tone used to frame obesity in policy documents is also important to consider in relation to health professionals who are also being urged to lose weight in various policy documents and interestingly engendering some resistance from those targeted (McCartney et al, 2014). These documents tend to ignore the complexity of obesity and provide little information about how health professionals can go on to lose weight. Trying to reduce the incidence of obesity amongst health professionals by approaching obesity as a matter of lifestyle choice may reinforce reductionist thinking about obesity.

7.9 Future research

There is a clear need for any future research is this area to include the voices of patients. There is a dearth of research from the perspective of lay people to elicit their perspectives about weight being discussed in general practice consultations. Given the thesis has described how 'obesity' and 'raising the topic of weight' is socially constructed by health professionals, research is needed to understand how patients construct both, including how broader discourses shape their experience of obesity. Research which allows patients to talk about their experience of negotiating the health care system from their own perspective and narrative, rather than through the lens of a psychological theoretical framework, would add insight to the findings of the thesis. As has already been alluded to, these views and narratives could be fed back to clinicians through education, training and guidelines to support a person-centred approach to initiating discussion about weight loss.

Given that patients may internalise shame and blame and are likely to be unaware of the societal discourses which maintain their position as a marginalised individual, future research should incorporate theory around stigma and power to look at the ways shame and blame can be minimised in general practice consultations. Since shame is a relational concept (Scheff, 2003), studies which include the practices and/or views of both health professionals and patients are required. A related research direction includes working with health professionals and patients to raise consciousness about the moral and oppressive discourses surrounding obesity (Friere, 1968) and to facilitate the co-construction of a supportive and collaborative discourse. Making space for new dialogue on health professional support for obesity could be facilitated by a study adopting a participatory action research design (Baum et al, 2006). Research should also

explore institutionalised stigma and focus on the context and conditions in which consultations about weight loss take place, since stigma is a multi-level and multi-faceted social process.

Given the aforementioned requirements, a research approach which can capture important theoretical concepts such as stigma, power and tacit knowledge is needed for future research. Ethnographic methods which allow the observation of consultations may be particularly useful since stigma may be internalised and both health professionals and patients may lack understanding of stigma and/or the linguistic resources to communicate this during interviews. Since much health professional practice draws on tacit knowledge which is difficult to capture and untangle during an interview, an approach such as ethnography that captures tacit knowledge and social practice make it a particularly suitable method to use (Greenhalgh & Swinglehurst, 2011; Savage, 2000).

Since concern about alienating patients was a major theme in this thesis, future research could explore this further. It is not clear how or when initiating discussion about weight could cause harm to patients but given the concern expressed by GPs and nurses, a systematic investigation into the effects of raising the topic would be worthwhile. This aligns with a call for more research to look into the unintended consequences of medical intervention (Cundy 2012; Moynihan et al, 2013). Training could then incorporate these insights to reduce the likelihood that health professionals will unintentionally alienate patients and damage relations with patients. Many clinicians voiced their uncertainty about raising the topic of weight when patients presented with depression and anxiety. There is little research looking at the type of support patients need in these cases and given the association of these problems with obesity (Luppino et al, 2010; Simon et al, 2006), further research is needed to clarify whether raising weight loss is likely to be beneficial and if so how health professionals can best support patients.

Future research investigating the negative consequences of interventions may also be well placed to explore the negative consequences of the current focus and approach to behaviour change advocated by guidelines (NICE, 2007, cg7; NICE, 2004, cg 43) and policy documents (DOH, 2010; NHS Future Forum, 2012). Lifestyle or behaviour change is the initial approach health professionals are expected to take when patients present with overweight or obesity (NICE, 2014, cg 189) and there is focused efforts to educate and train health professionals about behaviour change theory. However, there are limitations to applying behaviour

change theory (a body of research which draws on psychological models of behaviour) to obesity which seem to go largely unacknowledged amongst policy makers and researchers (Shove, 2010).   Whilst it is beyond the scope of this thesis to identify these limitations, the main criticism relates to the focus on individual level determinants of behaviour and the lack of consideration given to social factors which shape the extent to which people engage in self-management and behaviour change strategies.   It is well acknowledged that behaviour is extremely complex, embedded, and that theories which account for the complex interaction of genetic, material and socio-cultural influences influencing behaviours are needed to better understand how to change behaviour.   There is a risk therefore that the focus on behaviour change as a solution to obesity will shape views that obesity is controllable through individual level effort with little consideration for the "socio-cultural, physiological, biomedical, psychological and iatrogenic factors that determine energy input, metabolism and expenditure" (Sharma & Padwal, 2009, p. 363), thus leading to blame if patients do not lose weight.   In addition, the universal approach to applying behaviour change to overweight and obesity ignores the social determinants of behaviours which lead to obesity.   Although current behaviour change theory reflects the dominant and accepted ways of understanding behaviour, the status of which is reinforced through the rhetoric of being 'evidence-based', we should not allow this to prevent us looking critically at such models and thinking about other ways for health professionals to work with people to facilitate behaviour or social practice change.   An interesting research direction would be to look at behaviour change through the lens of stigma theory. The growing body of research demonstrating how the policy focus on behaviour change aligns with the neoliberal approach to government (Leggett, 2014; Marteau, 2008) could also inform future direction.

7.10   Final Conclusion

It is said that a society can be judged 'by the way it treats its most vulnerable citizens' (attributed to Aristotle, 384-22 BC). We might extend this idea by applying it to the way that medicine, highly governed and inseparable from societal forces, is treating individuals with obesity.

Despite more than half of our society having adiposity beyond what physiologists consider normal for their musculoskeletal frame, the response of

medicalised and individualised cultures has been to frame this phenomenon as a disease of epidemic proportions that requires major public health intervention. Dealing at the interface between society and the individual, are doctors and nurses who are under constant pressure to act, a formidable challenge given changing relations and power dynamics within the consultation, and over an issue that clinicians themselves are not immune to.

In this thesis I found that clinicians both reinforce and resist medicalising obesity which is constructed both as a lifestyle choice and as an individual problem in need of fixing. Simultaneously, clinicians take up a humanistic discourse. Regular encounters with patients provide clinicians with an appreciation of the complex and lived experience of obesity and a clear recognition of the harms of subjecting patients to the current reductionist understandings of obesity.

In a society which emphasises the pursuit of individual choice and competition with little tolerance for uncertainty, difference or social values which diverge from the neoliberal agenda, it is possible to understand how encounters about obesity are a moral and ethical endeavour, to be approached with trepidation, if at all. Yet obesity is not unique as a societal issue subjected to increased surveillance and intervention. As is the case within the areas of sexuality, mental health and unemployment, individuals who do not meet prescribed standards are blamed and cast as deviant with little interrogation of the conditions that people are embedded within, the functions that behaviour serves or ways to understand social problems other than as behaviourally driven.

However of great importance is that obesity is a marker of disease and for some a chronic and relapsing condition causing much social and emotional distress. The complex and multifaceted nature of obesity warrants recognition, in parallel with greater appraisal of the current medical model of treatment. To conclude, it seems that health professionals and their patients are entwined and uncomfortably positioned within an evolving epidemic of shame and stigma.

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Raising the topic of weight in general practice: perspectives of GPs and primary care nurses

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ABSTRACT

Objective To explore general practitioners' (GPs) and primary care nurses' perceived barriers to raising the topic of weight in general practice.

Design A qualitative study using the Theoretical Domains Framework (TDF). Thirty-four semi-structured interviews were conducted to explore views, opinions, and experiences of initiating a discussion about weight. Content and thematic analyses were used to analyse the interview transcripts.

Setting General practices located in one primary care trust in the South West of England.

Participants 17 GPs and 17 nurses aged between 32 and 66 years. The modal age range for GPs was 30 - 39 years and for nurses, 40 – 49 years.

Results Barriers were synthesised into three main themes: (1) limited understanding about obesity care, (2) concern about negative consequences, and (3) having time and resources to raise a sensitive topic. Most barriers were related to raising the topic in more routine settings, rather than when dealing with an associated medical condition. GPs were particularly worried about damaging their relationship with patients and emphasised the need to follow their patient's agenda.

Conclusions Uncertainty about obesity, concerns about alienating patients, and feeling unable to raise the topic within the constraints of a ten-minute consultation, is adding to the reluctance of GPs and nurses to broach the topic of weight. Addressing these concerns through training or by providing evidence of effective interventions that are feasible to deliver within consultations may lead to greater practitioner engagement and willingness to raise the topic.

ARTICLE SUMMARY

Strengths and limitations of this study:

- This article explores GP and nurse barriers to raising the topic of weight in general practice, and found that some encounter significant barriers. The identification of barriers was facilitated by drawing on a validated theoretical framework based on behaviour change theory.

- The inclusion of both GP and nurse barriers provides novel insight into the research problem.

- A strength of the study is the underpinning theoretical framework which facilitated a broad and comprehensive approach to the identification of barriers to raising the issue. However, this could also be considered a limitation since it precluded in-depth analysis into the nature of individual barriers and may have prevented the identification of barriers that deviated from the framework.

- A limitation of the study design is the focus on clinician beliefs and attitudes rather than the social and moral context of the consultation or the ways in which clinical encounters are mediated by broader social and cultural discourses surrounding obesity.

- A further limitation of the study design is the absence of theoretical concepts such as stigma and power in the analysis of our findings. Whilst we consider these important and relevant concepts to include in research concerning obesity, it was beyond the scope of this study to include this level of analysis.

INTRODUCTION

Primary care clinicians including General Practitioners (GPs) and primary care nurses have been assigned a key role in the prevention and treatment of excess weight and obesity.

Recent reports produced by the Academy of Medical Royal Colleges[1] and the Royal College of Physicians[2] emphasise the influence that clinicians can have on their patients' health behaviours[1, 2]. Evidence-based guidelines recommend that practitioners identify and classify overweight and obesity by using 'clinical judgment to decide when to measure a person's height and weight'[3], and offer clinical management[3, 4]. Despite these strong calls to action, evidence from patient surveys suggest that less than half of obese patients are advised by their physician to lose weight[5, 6]. Recently in Great Britain, a cross-sectional survey of 810 overweight or obese adults found that only 17% of overweight and 42% of obese respondents recalled ever receiving health professional advice to lose weight[7].

In order to engage GPs and nurses in supporting patients to lose weight, it is important to explore why discussions about weight loss in primary care are infrequent. Evidence to date suggests that GPs and nurses find obesity difficult to discuss and are concerned about raising the subject within the consultation[8]. This research has largely focused on barriers to obesity management, particularly the provision of advice for obesity. Studies, mainly using survey and interview methods, indicate that lack of time, limited training, low expectations of success and worry of offending patients prevent health professionals from playing an active role in treating obesity[8-10].

It is also useful to review the barriers that health professionals experience when addressing other public health problems, such as smoking and alcohol use. Like obesity, smoking and alcohol consumption have been framed as 'lifestyle risk factors' and have been identified as sensitive matters to address in the consultation[11-13]. Whilst studies have reported some similarities in the barriers to raising these issues, for example all relate to individual lifestyle habits and are thus potentially 'face threatening'[11, 14], there are also differences in the challenges of addressing such topics. Smoking is an area of public health that has received support at both a primary care and national level, resulting in increased provision

of services in general practice and greater acceptance of smoking as a health threat[15, 16]. In addition, beneficial effects for clinician-delivered brief interventions and referral to specialist services have been established for smoking and harmful and hazardous alcohol consumption[17-20], yet there remains a lack of evidence for weight loss interventions that can be delivered at a population level in primary care[21, 22]. It is therefore important to recognise that obesity presents unique challenges to the primary care team.

In summary of the literature to date, there has been little exploration of the full range of barriers that may hinder clinicians from raising the topic of weight for the first time with a patient. In addition, few studies have sought the views of both GPs and nurses who have a shared responsibility to promote weight loss and facilitate access to weight management support[2]. In light of this gap, the study sought to systematically identify and describe GPs' and primary care nurses' beliefs and attitudes regarding barriers to raising the topic of weight with overweight and obese patients presenting in general practice. Raising the topic was defined as initiating a discussion about weight loss.

METHOD

Design

This was a qualitative study using semi-structured interviews drawing on constructs and definitions from the Theoretical Domains Framework (TDF)[23, 24]. The framework was judged to be a suitable conceptual tool to guide the design and analysis of the study since it enables an exploration of the full range of potential influences on behaviour and has been validated to facilitate research into implementation problems[24].

The TDF is a framework based on theories of human behaviour and behaviour change and is in line with calls for complex interventions to improve health to be informed by theory[25, 26]. The TDF was developed to identify the causes of implementation difficulties and promote understanding about how to change health professional behaviour. The framework

derived from the integration of 33 theories and 128 constructs from behavioural theory, resulting in twelve theoretical domains useful for categorising barriers and enablers to specific behaviours. The TDF has been used in a number of empirical studies with healthcare professionals to explore implementation problems in clinical areas such as low back pain[27], mental health[28], smoking cessation[29] and dementia[30] supporting its validity as a theoretical framework[24]. Recently a coding manual has been developed by Heslehurst et al[31], adapted from Michie et al[23] and Cane et al[24], which lays out twelve theoretical domains used to inform the topic guide of qualitative studies and the analysis of interview transcripts (additional file 1).

Participant selection and recruitment

This study received approval from the University of Bath ethics committee and permission was granted by the local National Health Services Research and Development unit. All participants gave informed consent before taking part in the interviews.

Purposive sampling was used to recruit a heterogeneous sample of GPs and nurses working within one primary care trust in the South West of England. Study information was provided at a practice manager meeting and emails outlining the study were sent to 58 GP surgeries and to a network of sessional GPs in the local authority. This resulted in thirteen GPs and fourteen nurses agreeing to be interviewed after receiving further details about the study. Snowball sampling was also used to recruit participants; four GPs and three nurses were approached, either in person or via email and all agreed to be interviewed. Prior to taking part in the study, participants were informed that interviews would involve discussion about views of obesity, role and efficacy beliefs, and the challenges involved in raising the topic of weight in general practice. Participants were recruited until no new information and understanding from the interviews occurred[32, 33]. As a token of appreciation, participants were offered the opportunity to claim practice level reimbursement for their time.

Data collection

A flexible interview schedule was developed based on the TDF domains and a review of empirical research literature concerning barriers to health professional prevention and management of obesity in primary care (additional file 2). The topic guide for the interviews began by asking participants about the factors that triggered them to broach discussions about weight loss. The remainder of the questions focused on the theoretical domains to gain insight into factors hindering discussion about weight loss. Prior to interviews the questions were piloted with three GPs and two primary care nurses to assess clarity and focus of the interview schedule and refined as appropriate.

Face-to-face individual interviews were conducted by the lead researcher (MB), at a time and place to suit the participant. Interview locations included general practice offices, the University of Bath, and participants' homes.

Interviews lasted between 30 - 90 minutes. Participants were encouraged to express the barriers most salient to them and prompted to expand on views when deemed appropriate by the researcher. Interviews were digitally audio-recorded and then transcribed verbatim by the lead researcher and an external agency with transcription expertise.

All data collection took place over January and February 2013.

Data management and analysis

Audio recordings were transcribed verbatim in Microsoft Word and then uploaded to NVivo (Version 10) for coding and data organisation. A period of familiarisation with the dataset by the lead researcher was followed by a process of coding whereby a-priori themes directed by the interview topic guide, unexpected emergent themes, and recurring viewpoints were identified. A deductive approach to content analysis[34] was used to code the data to the TDF framework whereby data were reviewed for content and correspondence to identified categories of the TDF[31]. Both the manifest and latent content were examined[35, 36].

The TDF coding framework developed by Hesslehurst et al[31] was used to ensure code names were matched to the appropriate domains. The accuracy of this initial coding, derived from a subset of the data, was checked by other members of the research team, and then used to guide the indexing of the remaining transcripts. Following the mapping of codes to the domains of the TDF, the lower-order themes were charted and organised into three salient higher order themes that manifest within the whole dataset. This process was facilitated by drawing on principles of thematic analysis[37] and additional behaviour change theory designed to guide the grouping of domains in the TDF into broader components[38]. At the final stage of data analysis, the derived themes for GPs and nurses were compared and similarities and differences were identified. Analysis was a recursive process which developed over time, with the lead researcher continually revisiting the data set and theoretical literature before arriving at the final themes.

RESULTS

Characteristics of GPs and nurses

Of the 17 GPs interviewed, five were partners, six were salaried (one of whom was a GP assistant), and six were locums. Of the 17 nurses interviewed, three were nurse practitioners. Nursing roles varied widely: six nurses specialised in diabetes care (three of whom also carried out general practice nurse duties), three nurses specialised in COPD and asthma (two of whom also carried out general practice nurse duties), and four nurses worked in emergency and minor illness roles (one of whom also carried out general practice nurse duties) and four nurses identified as having a generalist practice nurse role. Respondents came from rural, semi-rural and urban practices. Additional demographic data are presented in table 1.

Table 1 Demographic details reported by participants

	GPs	Nurses
Sex:		
Male	6	
Female	11	17
Age:		
30-39	7	1
40-49	3	7
50-59	6	5
60-69	1	4
Experience as GP/nurse in General Practice:		
0-9 years	7	7
10-19 years	3	6
20-29 years	7	4
Weight status:		
Normal (BMI 18.5-24.9 kg/m²)	9	9
Overweight (BMI 25-29.9 kg/m²)	7	4
Obese (BMI 30 kg/m² and above)		4
Not specified	1	

Content analysis[34] resulted in 25 individual barriers to raising the issue, which were then mapped to ten behavioural domains of the TDF (table 2). Barriers identified do not apply to all clinicians but were identified as barriers for at least two clinicians. Barriers were synthesised into three higher-order themes (figure 1) that manifest within the entire dataset. Each theme is described and illustrated by selective quotations from respondents to aid understanding.

Table 2: Barriers coded to the TDF framework

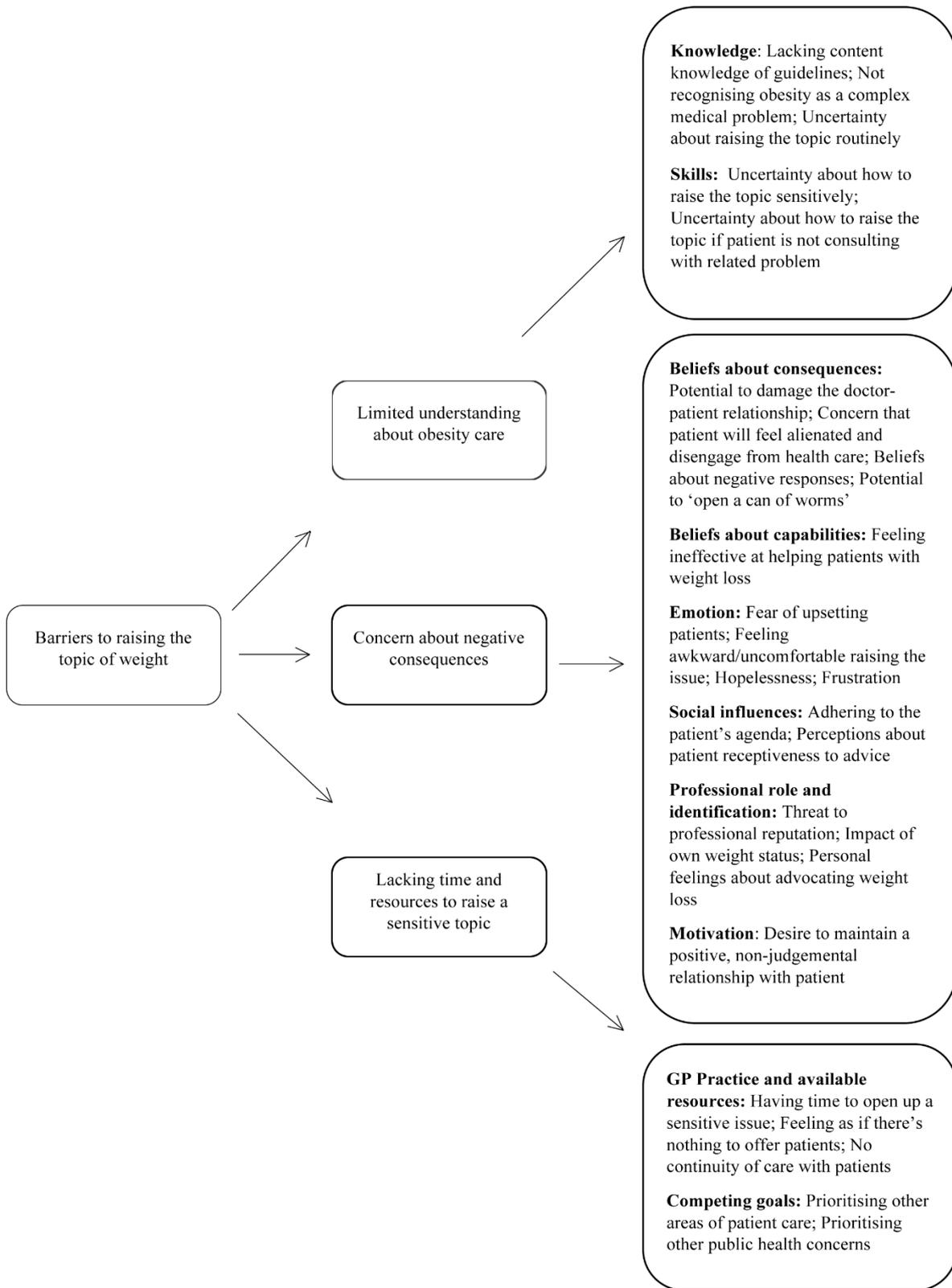| Behavioural domain	Barrier
Knowledge	Lacking content knowledge of guidelines Not recognising obesity as a complex medical problem Uncertainty about raising the topic routinely
Skills	Uncertainty about how to raise the topic sensitively Uncertainty about how to raise the topic when patient is not consulting with related problem
Beliefs about consequences	Potential to damage the doctor-patient relationship Concern that patient will feel alienated and disengage from healthcare Beliefs about negative responses Potential to open a can of worms
Beliefs about capabilities	Feeling ineffective at helping patients with weight loss
Motivation	Desire to maintain a positive, non-judgmental relationship with patient
Competing goals	Prioritising other areas of patient care Prioritising other public health concerns
Emotion	Fear of upsetting patients Feeling awkward/uncomfortable raising the issue Hopelessness Frustration
Professional role and identification	Threat to professional reputation Impact of own weight status Personal feelings about advocating weight loss
GP Practice and available resources	Having time to open up a sensitive issue Feeling like there's nothing to offer patients No continuity of care with patients
Social influences	Adhering to the patients agenda Perceptions about patient receptiveness to advice

Knowledge: Lacking content knowledge of guidelines; Not recognising obesity as a complex medical problem; Uncertainty about raising the topic routinely

Skills: Uncertainty about how to raise the topic sensitively; Uncertainty about how to raise the topic if patient is not consulting with related problem

Beliefs about consequences: Potential to damage the doctor-patient relationship; Concern that patient will feel alienated and disengage from health care; Beliefs about negative responses; Potential to 'open a can of worms'

Beliefs about capabilities: Feeling ineffective at helping patients with weight loss

Emotion: Fear of upsetting patients; Feeling awkward/uncomfortable raising the issue; Hopelessness; Frustration

Social influences: Adhering to the patient's agenda; Perceptions about patient receptiveness to advice

Professional role and identification: Threat to professional reputation; Impact of own weight status; Personal feelings about advocating weight loss

Motivation: Desire to maintain a positive, non-judgemental relationship with patient

Limited understanding about obesity care

Barriers to raising the topic of weight

Concern about negative consequences

Lacking time and resources to raise a sensitive topic

GP Practice and available resources: Having time to open up a sensitive issue; Feeling as if there's nothing to offer patients; No continuity of care with patients

Competing goals: Prioritising other areas of patient care; Prioritising other public health concerns

Figure 1 Barriers to raising the topic synthesized into three analytic themes

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Main themes

Barriers were synthesised into three over-riding themes during the second-stage of the analysis: limited understanding about obesity care, concern about negative consequences, and lacking time and resources to deal with a sensitive issue. Each theme is described and quotations from interviewees provided to illustrate the barriers within the themes. If applicable, differences between GP and nurse barriers are highlighted in the description of each theme.

Limited understanding about obesity care

The first theme relates to two domains of the TDF: knowledge and skills. Within this theme, there was low awareness of the contents of any guidelines around raising the topic. Clinicians expressed beliefs that there is no standardised approach to raising the issue and acknowledged that they relied on a range of sources to provide weight loss advice including personal experience and media sources. Divergent opinions around when to raise the topic were apparent with some clinicians believing it inappropriate to raise the topic in routine consultations. Whilst some practitioners described obesity as a complex medical condition requiring medical support, a minority of interviewees explicitly questioned whether obesity was a medical problem. These clinicians expressed the opinion that although obesity had medical implications, it was largely a social problem which may be better tackled outside primary care. Other clinicians described concern about creating obesity into a medical problem.

"Is obesity a medical problem? It has medical implications, I don't think necessarily it's a medical problem, and I think sometimes it's better being dealt with outside the NHS, you know, because it has a lot of, there are a lot of other factors that cause people to be heavier than perhaps they need to come to a medical practice for." (Participant 25, Nurse)

Uncertainty about how to initiate weight loss discussions when patients were presenting with problems unrelated to excess weight were discussed. In these consultations, the identification of excess weight was considered to be particularly problematic, and there was

uncertainty about the appropriate language and terminology to use. Negative societal views about obesity contributed to the difficulty of framing a discussion about weight loss in a positive and constructive light.

"Just bringing it up….how do you bring it up, when they've come in about a cold? It's really difficult isn't it because you know we've all got to be very PC [politically correct] and people get very hurt even with medical terms like obesity or overweight, it can be really challenging." (Participant 13, GP)

Feeling unable to help patients with weight loss was identified as a barrier for a proportion of clinicians. In contrast, other respondents emphasised the value of being able to offer advice and support. Nurses who had been involved in training and research studies discussed their increased confidence and perceived effectiveness of supporting patients with weight loss, suggesting a lack of knowledge and skills around obesity management may have acted as a barrier to raising the topic previously.

"I don't find it that difficult any more. I think I may be used to but I think again because we took part in the research study and things, I think I find it a bit easier. I think I find it easier in the fact that before - it's okay to raise a patient's issue of weight, but if you've not got any advice to give them then what's the point? So yeah, so I don't mind so much now because at least I can sort of steer them, give them a bit of advice." (Participant 28, Nurse)

Concern about negative consequences

Negative consequences of raising the topic of weight relate to six domains of the TDF: beliefs about consequences; beliefs about capabilities; emotion; social influences; professional role and identification; and motivation. The potential for patients to feel blamed, persecuted and further stigmatised about their weight was widely discussed. Concerns were expressed that a narrow focus on weight at the expense of other health problems could be counterproductive and alienate patients from consulting in the future.

"The last thing you want to do is completely disenfranchise a patient such that they're very reluctant to see anybody, that'd be counterproductive. We are very time limited but I don't think it takes long to raise the issue of weight so I think the main thing would be losing the patient trust and the patient's engagement." (Participant 1, GP)

Several of the barriers within this theme were unique to GPs' who expressed concern that raising the topic of weight conflicted with their desire to maintain a non-judgmental relationship with patients. Raising the topic of weight was viewed as a threat to professional reputation with acknowledgement by some GPs that they did not want to become known as the 'nagging Doctor'. GPs also expressed concern about deviating from the patients' agenda, stressing the importance of treating a patients' presenting problem and meeting expectations.

*"I think patients having confidence that they can come and talk to their GP about anything and they won't be judged … if I have to not talk about something or talk about something very sort of gently in order to preserve my reputation as being non-judgmental then I will do that." (*Participant 15, GP*)*

In regards to a health professional's own weight status and personal health beliefs, no clear pattern emerged in relation to whether these factors acted as barriers to raising the topic. Having a BMI in the normal weight range was viewed as a barrier by some clinicians due to beliefs that patients would perceive them to lack empathy. Having a BMI in the obese range was viewed as a barrier by several nurses who acknowledged feeling uncomfortable raising the issue due to the personal nature of such discussions, the difficulties of weight loss and uncertainty about the credibility of their message.

"Being a rather larger person myself, I find it sometimes a little bit sensitive to say, 'You really ought to lose some weight', when, actually, the same person could be saying it back to me." (Participant 23, Nurse)

Lacking time and resources to deal with a sensitive issue

The lack of time available in a consultation was judged to hinder the opportunity for clinicians to engage in sensitive discussion about weight loss. This theme consisted of two domains of the TDF: GP practice and available resources, and competing goals within the consultation. Due to limited time and the need to run to schedule for other patients waiting in the surgery, clinicians perceived they lacked time to initiate a discussion about weight loss. This barrier was particularly salient for clinicians working to ten-minute consultations and when patients were attending for medical problems unrelated to excess weight. Nurses with longer appointment times and clinicians working in practices and/or roles which facilitated continuity of care with patients, emphasised their confidence in having adequate time to begin a dialogue about weight loss and emphasised that discussions could continue over a series of visits.

"I think often it is time because you have a patient that comes, you have ten minute appointments, there is not really much scope, patients are not happy to wait generally in general practice so even if you think you should really mention this, you know it's going to be time consuming, it's not a quick consultation about weight." (Participant 14, GP)

Views about services to offer overweight patients differed between clinicians. Some clinicians expressed optimism about signposting to groups like Slimming World or Exercise on Referral, comparing this with being able to offer a prescription. Others felt these schemes lacked evidence of long-term success and expressed ambivalence. Clinicians perceiving themselves unable to offer any assistance or constructive support to patients expressed hopelessness and frustration.

*"It's just not something I enjoy doing because people do get very offended and feel very judged and also I feel I haven't got, having brought it up, I haven't got huge amounts of resources then to offer people to help them with it." (*Participant 12, GP*)*

Competing goals within the consultation were perceived to hinder the opportunity to raise the issue. Clinicians asserted that their main concern was to deal with the patients presenting problem which often restricted the opportunity to raise weight as an additional issue.

Factors relating to individual patient needs and preferences, such as the patient's presenting illness and the broader social context of a patient's life, were also judged to inhibit the opportunity for clinicians to initiate a discussion about weight loss. Raising other public health issues, such as smoking, was identified as a barrier mainly discussed by nurses.

"That's the trouble isn't it, it's the conflict of time for all the other things that we're supposed to do in a ten minute consultation, of which probably smoking cessation comes quite high on the sort of health promotion thing... and alcohol, of course, that's another." (Participant 34, Nurse)

DISCUSSION

The purpose of this study was to systematically map the barriers of raising the topic of weight in general practice by capturing the perspectives of GPs and primary care nurses. Using behaviour change theory, barriers were mapped onto 10 domains on the TDF and synthesised into three higher-order analytic themes. Future interventions wishing to change the behaviour of GPs and nurses may wish to target the identified domains of the TDF that are proposed to be mediators of behaviour change[23, 24].

This study confirms that the majority of barriers relate to raising the topic of weight when patients are consulting with a medical problem that is not considered to be linked to obesity[8, 39]. The majority of clinicians working in generalist roles do not discuss weight with patients as a routine part of clinical practice due to beliefs that it is inappropriate, unfeasible or unacceptable to patients. Whilst clinicians said they were more likely to discuss weight with patients in the context of a weight-related health problem, the multitude of barriers in any single consultation including factors that appear to be distinctive to obesity, such as stigma, may prevent clinicians from discussing weight despite recognising the need to. An important finding is the uncertain knowledge demonstrated by GPs and nurses about obesity as a medical condition that should be prevented and treated in primary care. This suggests that despite increased attention toward the role of primary care in

treating obesity, there are still gaps in the implementation of this knowledge. A proportion of clinicians remain ambivalent about their role in helping patients with weight loss. It has been reported elsewhere that medical professionals view lifestyle change as a personal choice[40] and believe obesity may be better addressed by politicians at a societal level[9, 41, 42]. Although the findings of the current study suggest that the health and economic consequences of obesity are recognised, knowledge surrounding how obesity should be treated remains disputed and inconsistent amongst practitioners. These views may also reflect the limited evidence-base for effective primary-care led weight loss interventions[43] as well as the controversy and uncertainty surrounding obesity on a national level[44, 45].

A novel insight to emerge is the personal dimension of discussing weight loss which appears to influence clinician views. The majority of GPs and nurses expressed the view that their own body weight and personal beliefs about weight loss could act as barriers to raising the issue. Research has highlighted that clinicians with a BMI classified in the overweight or obese weight range experience more barriers to offering weight loss advice than clinicians with a BMI categorised in the normal weight range[46, 47]. However, this study suggested a more complex and nuanced picture between clinician weight status and attitudes, with both normal weight and overweight clinicians expressing the view that their own weight status was a potential barrier to raising the issue. At a time when negative views and attitudes towards people with excess weight are evident in society[48, 49], it is important to explore how clinicians perceive the increased pressure to deliver weight loss advice and understand the influence their personal values and experiences of weight loss have on this task.

Key differences between GPs and nurses

In comparison to nurses, GPs expressed greater concern about the potential to damage their relationship with a patient and divert the consultation away from the patient's agenda. GPs

were particularly cautious about raising the topic in routine consultations due to the risk of losing patient trust and damaging their professional reputation. Other research has emphasised the centrality GPs place on abiding by their patients agenda[40, 50] as well as highlighting that doctors may fail to take account of unvoiced agendas[51] or recognise elements of the patient's agenda, particularly those of a social and emotional nature[52, 53].

Strengths and limitations of the study

A key strength of the research is the underpinning theoretical framework guiding the design and analysis of the study. Using constructs drawn from theories of behaviour change facilitated the identification of the factors influencing health professional behaviour. The qualitative design of the study revealed the nuances and tensions inherent in managing obesity in primary care. The recruitment of a diverse sample of GPs and primary care nurses with a wide range of experience and specialities is a further strength of this study. The inclusion of locum GPs and the diversity of nursing roles ensured the identification of a wide variety of barriers.

Limitations include the nature of recruitment, with the majority of GPs and nurses actively volunteering to this study. This may have resulted in recruiting clinicians with more interest in identifying and discussing the issue of raising the topic of weight and obesity than is typical. The sample of health professionals are also drawn from one location. Although, we ensured that the interviewees operate in diverse socio-economic environments, recruitment from other sites might have revealed new dimensions. In this study we explored barriers to raising the topic of weight in consultations focussing on related as well as unrelated problems. Since findings of our study highlight the particular difficulties of broaching the topic in consultations about unrelated problems, future research could focus mainly on exploring this in more detail. The study did not recruit any GPs who self-reported a BMI in the obese range which may have excluded gaining more insight into barriers related to a

GPs own weight status. For this reason the study does not claim that having a BMI in the obese range is a barrier for nurses only, as it is possible that it is also a barrier for GPs. Since both GPs and nurses with a BMI in the normal range considered their weight status a potential barrier to raising the topic, the study identified 'impact of own weight status' as a barrier on a broader level. Finally, variation in interview length occurred due to constraints and demands on clinician time.

Strengths and limitations of this study in relation to other studies

Whilst a strength of this study is the comprehensive coverage it has given to a multitude of barriers, it precluded the in-depth investigation into each barrier or behavioural domain. Other studies investigating interactions concerning obesity have incorporated theoretical concepts such as stigma[54, 55] and shame[14],whilst taking a critical stance to the use of language. These methods give rich and contextualised findings, provide insight into meanings and power dynamics, and go beyond the individual clinician to incorporate broader socio-political influences[56, 57]. Since the purpose of the TDF is to identify behavioural domains which warrant further investigation[24], findings of this study can facilitate future research as they can be used to indicate the selection of relevant theory to generate more detailed understanding.

A further limitation of this study in comparison to other qualitative research conducted in general practice is the deductive nature of enquiry taken and the implications this has for how the research was conducted and the resultant findings. The TDF is based on behaviour change theories that carry assumptions about the relationship between cognitions and behaviour, and that focus on individual-level beliefs and attitudes in relation to a discrete behaviour. It can be argued that this method is inadequate to capture the dynamic and interactional aspects of practice[58, 59]. Other research exploring how topics such as smoking and alcohol are introduced into the consultation have emphasised the process of

negotiation inherent in these consultations and highlighted the importance of the context in which advice is given, including the interactional and practical constraints on practice[60, 61]. Although the targeting of specific barriers by eliciting clinician beliefs can be considered a strength of the current study, a method better able to incorporate the socially-situated and interactive nature of barriers in the context of general practice is needed in future enquiry.

Future research may wish to explore insights from the study that the framework failed to adequately capture. For example, it was noted that clinicians held conflicting views, particularly regarding the framing of obesity as a medical condition, suggesting ambivalence and discomfort around this area of care. Furthermore, it was possible to detect implicit frustration regarding the perceived lack of responsibility and denial/defensiveness demonstrated by patients. Another interesting insight was the uncertainty around initiating discussions about weight with patients presenting with emotional and/or mental health problems including low self-esteem, depression and body image concerns, with many clinicians expressing reluctance to discuss weight in such situations. Given that obesity is associated with an increased risk of depression and reduced psychological well-being [62], a potential mechanism of this association being weight stigma [63,64], there may be a significant number of patients who are not offered support to lose weight or discuss weight-related concerns, suggesting compromised care for these patients.

Implications

The findings of this study provide a detailed insight into how practitioners can be supported to discuss weight loss with patients. Most apparent is the need to address the uncertain knowledge about obesity as a complex medical condition and to clarify the role of primary care professionals in the management, and potentially prevention, of obesity. Concern about negative consequences of raising the topic suggests that clinicians need support to engage

with patients about weight in a non-stigmatising or harmful way. Training and education which provides health professionals with a comprehensive understanding of stigma and the psychological impacts of obesity, and which includes the views of individuals with obesity, is just one way that health professionals could be empowered in this area of practice. In addition, evidence of brief interventions feasible to be implemented in primary care settings which target multilevel barriers is required. Finally, lessons from other areas of public health could be drawn on, particularly smoking where clinicians are equipped with smoking cessation services, pharmacological treatment, and are incentivised by the Quality and Outcomes Framework as part of a comprehensive strategy to lower rates of smoking in the population [65, 66]. Although such changes may encourage practitioners to raise the topic routinely, this study confirms that there are challenges which are unique to discussing obesity, particularly weight stigma, that need to be further explored and targeted in future research.

CONCLUSION

Raising the topic of weight within a general practice consultation is a complex endeavour for GPs and practice nurses to negotiate with their patients. Uncertainty about how and when to raise the topic of weight and the threat of alienating and/or upsetting patients are contributing to an unease and a lack of motivation by healthcare professionals to identify weight as an issue. Furthermore, competing demands and limited time available in brief consultations limit the opportunity for intervention.

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Data sharing: No additional data available for sharing.

Manuscript Figure Legend:

Additional file 1: Theoretical Domains Framework Coding manual developed by Heslehurst et al, 2014

Additional file 2: Interview topic guide

Figure 1: Barriers to raising the topic synthesized into three analytic themes

Appendix B: Email circulated to practice managers study 1 and 2

RAISING THE ISSUE OF WEIGHT IN GENERAL PRACTICE

Dear Practice manager,

I am now recruiting GPs and practice nurses to participate in interviews on **raising the issue of weight in general practice**. Currently there is very little evidence on the best way to do this or the challenges that GPs and practice nurses face.

If any GPs or nurses in your practice are able to take part in the study, I would like to listen to their views and experiences of addressing weight in a consultation, during an interview which will last between **30-60 minutes**. The interview can be carried out at a time and location convenient to them- for example during lunch time or before or after work.

Reimbursement will be offered based on service support level. For GPs this will be **£80** and for nurses this will be **£21.96**.

This research is exclusive to practices in Wiltshire and aims to produce findings that will help overcome the barriers faced by practice staff throughout Wiltshire. Findings will be disseminated to all those interested including Wiltshire public health team and will inform the design of my next study focused on patient's views of receiving initial weight loss advice from their GP and/or nurse.

If you would like more detailed information about the study and/or to express your interest in participating, please email: m.blackburn@bath.ac.uk or call 01225 385168 or 07411 058176. Interviews can be carried out from January.

Your help with this project is very much appreciated. Please do not hesitate to contact me with any queries.

Kind regards,

Maxine Blackburn
PhD student, University of Bath

Appendix C: Semi-structured interview guide study 1 and 2

How important do you think it is to raise the topic of weight in a general practice consultation? (Please expand)

How easy or difficult do you find raising the topic of weight in a general practice consultation? (Please expand)

How confident do you feel about raising the topic of weight in a general practice consultation? (Please expand)

How comfortable do you feel raising the topic of weight in a general practice consultation? (Please expand)

What do you consider to be the benefits or advantages of raising the topic of weight in a general practice consultation? (Please expand)

What do you consider to be the costs or disadvantages of raising the topic of weight in a general practice consultation? (Please expand)

How much impact do you think you can have then when you raise the issue of weight in a general practice consultation? (Please expand)

Whose role in general practice do you think it should be to raise the issue of weight in a general practice consultation? (Please expand)

How, if at all, does raising the issue of weight conflict with your other goals as a GP/nurse in a general practice consultation? (Please expand)

How well equipped do you feel to raise the issue of weight in a general practice consultation? Do you require any further support?

To what extent do patient emotions influence your decision to raise the topic of weight in a general practice consultation?

Are there any emotional reactions that you feel concerned about evoking by raising the topic of weight in a general practice consultation?

What kind of emotions have you yourself felt in relation to raising the topic of weight in a general practice consultation?

Do you feel your own weight status or health habits have made it easier or more difficult to raise the topic of weight in a general practice consultation?

Are you aware of any pathways or protocols or guidelines on raising the topic of weight in general practice consultation?

Is there anything else you want to add about your views on raising the topic of weight in a general practice consultation?

Appendix D: Study information sheet study 1 and 2

Participant information sheet for GPs and Nurses:

Study Title:

What are the barriers and enablers of raising the issue of weight in general practice?

Invitation paragraph:

We would like to invite you to take part in a research study. Before you decide whether you would like to participate, you need to understand why the research is being conducted and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish to and please do not hesitate to ask if there is anything that is not clear or if you would like more information. If you would like to participate, please email a signed consent sheet to Maxine Blackburn (m.blackburn@bath.ac.uk) or a consent form will be available to sign on the day of the interview.

Purpose of the study:

The purpose of this study is to understand your views on initially identifying and raising the issue of weight with overweight and obese patients in general practice. I am specifically interested in how you do it, the challenges you face, if you believe it is your role and the impact you believe you can have on a patient in this situation. Due to the frequent visits many obese and overweight patients have to general practice, primary care clinicians have been identified as key players to help overweight and obese patients change their behaviour. Your views on fulfilling this role and the challenges you face are essential if we are to improve patient outcomes and reduce demand on general practice. It is hoped that this research will be published and findings will be considered by the Public Health team at Wiltshire PCT and perhaps other policy makers in the UK. A further purpose of this study is to inform the design of a second study which will seek to elicit the views of overweight and obese patients in relation to raising the issue of weight in general practice.

Why have I been invited?

You have been invited to take part in this study because you are a GP or practice nurse whose job entails interaction and communication with overweight and obese patients.

Do I have to take part?

It is up to you to decide. The information sheet describes the study and what your participation would involve. If you are willing to participate, please sign two copies of the consent form, to confirm that you understand what participating in the study involves and that you have voluntarily agreed to take part. You are free to decline entry to the study or to withdraw at any time, without giving a reason. You can also request that any data gathered is withdrawn once the interview is over. There will be no negative implications if you do decide to withdraw from the study and it will not affect the standard of any healthcare you receive in anyway.

What will happen to me if I take part?

We will ask you to attend an interview with the study co-ordinator, Maxine Blackburn. This can be conducted in your own surgery or another convenient location. The interview will last for up to one hour, and will take place at an agreed time that is convenient to you, such as at the end of a staff meeting, before or after your working day.

Expenses and payments:

Reimbursement is available for you based on the current service support rate- this will be £80 if you are a GP and £21.96 if you are a nurse. If you do incur travel expenses, these will also be covered. Details on reimbursement is provided at the bottom of this sheet.

Are there any advantages or disadvantages to taking part?

You will receive no immediate benefit from taking part. However, when this research is completed, it should give a greater insight into the factors that can facilitate lifestyle change. Therefore, in future consultations with overweight and obese patients you may benefit from a greater understanding of weight management such as how to engage and motivate patients. In addition, the findings will be disseminated to your local PCT so this could be viewed as an opportunity to communicate your views on the challenges you face in regards to this area of practice.

Will my taking part in the study be kept confidential?

If you consent to take part in this study, all data will be handled and stored following strict ethical and legal guidelines. Soon after the interviews, the audio material will be transcribed and an appropriate coding system for the interview transcripts will be used so that all participants are only identifiable by the lead researcher. Only researchers involved in the study who work in the Department for Health at the University of Bath will have access to the transcripts. In any publications or reports disseminated, quotations from the transcribed recordings may be used, but names and any details that would allow you to be identified will be removed. All personal data will be destroyed after 5 years – anything on paper will be shredded and anything digital will be erased.

What will happen if I don't want to carry on with the study?

If at any point during the interview you wish to withdraw or modify your consent and to ask for the destruction of all or part of the data that you have contributed to during any time in the study, you are completely free to do so and we will act in regards to these wishes.

What if there is a problem?

We do not anticipate any problems with this study. However, if you have concerns about any part of your participation in it, you can contact the study coordinator, Maxine Blackburn, at the address below. Alternatively, you can contact Darrell Gale, Public Health Consultant at Wiltshire PCT: Darrell.Gale@wiltshire.nhs.uk, tel: 01380 733942 or Professor Christopher Eccleston, one of the study supervisors at

the University of Bath: c.eccleston@bath.ac.uk. If you would rather raise your concern with someone not directly involved in the study, you can contact Irene Blair, Research Governance Facilitator: I.Blair@bath.ac.uk, tel: 01225 384197.

What will happen to the results of the research study?

The data collected will be analysed and a report will be written. It is hoped that the findings will help to inform the knowledge we have about clinician-patient interactions and assist policy makers when they are considering how to improve guidelines and recommendations for NHS staff working in general practice. The data will also be used for a doctorate, and may be published in a peer reviewed journal. If you would like to receive a summary of the research findings when they are written up, please indicate this on the informed consent sheets below and one will be posted or emailed to you.

Who is organising and funding the research?

The research is being organised and funded by the Public Health department of Wiltshire Primary Care Trust (PCT) in collaboration with the University of Bath.

Who has reviewed the study?

In line with The Department of Health's Research Governance Framework, this research has gained permission from the Research and Development committee representing Wiltshire PCT. This study has also been reviewed and given favourable opinion by the University of Bath's Psychology and Department for Health Ethics Committees.

Further information and contact details?

We hope that this information sheet has answered any concerns that you may have had. If you require any further information please do not hesitate to contact the study co-ordinator, Maxine Blackburn, Department for Health, 1 West 3.36, The University of Bath, Claverton Down, Bath, BA2 7AY; email: m.blackburn@bath.ac.uk or call 01225 385186 or 07411 058176. If you wish to seek general advice about participating in research studies, you may contact Lisa Austin, Research Manager, Bath Research and Development, Research Design Service, University of Bath or email L.Austin@bath.ac.uk.

Thank you very much for your time and co-operation

Appendix E: Consent form study 1 and 2

Informed consent sheet for GPs and GP surgery staff- for participant to keep

Researcher: Maxine Blackburn

Please read and sign both consent sheets. Once you are sure you understand what participation involves and have had any queries answered please return one to the study co-ordinator, Maxine Blackburn either in person or by email to m.blackburn@bath.ac.uk, or, by using the enclosed stamped, addressed envelope. If you have mislaid the envelope, the address is: Miss Maxine Blackburn, The Bath Centre for Pain Research, Department for Health, 1 West 3.36, The University of Bath, Claverton Down, Bath, BA2 7AY.

Title (Ms, Miss, Mrs, Mr, Dr, Other (please specify):

Name (please print your full name in block capitals):

Address (please print in block capitals):

Daytime telephone number:

Mobile telephone number:

Email address:

Please tick the following boxes, if the statements are true for you. Please note, you can only participate in the study if all the boxes are ticked.

- ☐ I am 18 or over.
- ☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- ☐ I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.
- ☐ I agree for the interview to be audio recorded and for the recording to be retained in a secure location at the University of Bath for up to 5 years after the end of this study, after which time it will be destroyed.
- ☐ I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- ☐ I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).

Name of participant   Date   Signature

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Name of person taking consent   Date   Signature

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Appendix F: The TDF coding framework developed by Heslehurst and colleagues (Heslehurst et al, 2014)

Additional file 1: Theoretical Domains Framework, Domains and Constructs Coding manual (Adapted from Michie et al 2005 and Cane et al 2012)

Domains and Constructs	Examples of relevant data

<u>**1: Knowledge**</u> *(An awareness of the existence of something)*
• Knowledge *(including knowledge of condition /scientific rationale)*
• Procedural knowledge *(Knowing how to do something)*
• Schemas + mindsets + illness representations
	• Statements about having/not having/wanting factual or procedural knowledge of when and how to do the behaviour
	• Statements about having/not having/wanting an understanding of the rationale behind performing the behaviour
	  o I know/do not know/want to know how/when to do the behaviour
	  o I know/do not know/want to know why I should do the behaviour
	In the context of this study, knowledge of the condition/scientific rationale could relate to knowledge of obesity determinants, risks in pregnancy, weight management theory etc. Knowledge of these factors may be both correct and incorrect knowledge.

<u>**2: Skills**</u> *(An ability or proficiency acquired through practice)*
• Skills development *(The gradual acquisition or advancement through progressive stages of an ability or proficiency acquired through training and practice)*
• Competence *(One's repertoire of skills, and ability especially as it is applied to a task or set of tasks)*
• Ability *(Competence or capacity to perform a physical or mental act. Ability may be either unlearned or acquired by education and practice*
• Interpersonal skills *(An aptitude enabling a person to carry on effective relationships with others, such as an ability to cooperate, to assume appropriate social responsibilities or to exhibit adequate flexibility)*
• Practice *(Repetition of an act, behaviour, or series of activities, often to improve performance or acquire a skill)*
• Skill assessment *(A judgment of the quality, worth, importance, level, or value of an ability or proficiency acquired through training and practice)*
• Coping strategies
	• Statements describing techniques/capability/skills used/how they do the behaviour in practice
	• Statements about wanting to develop/improve skills in doing the behaviour
	  o In practice, I do x,y,z to help me perform the behaviour
	  o I would like training in how best to do the behaviour/we haven't had any training in how to do the behaviour
	In the context of this study, skills may be interpersonal skills (e.g. using empathy, practice, encouragement, sensitivity, practical advice, promote benefits, non-judgemental approach, terminology, normalisation, communication skills etc). May also involve skills adopted to cope in the absence of specific skills training related to behaviours (e.g. 'We've never been told how to broach categorising women as obese so I try to normalise it by x, y and z')

<u>**3: Social or Professional Role and Identity (Self-standards)**</u> *(A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting)*
• Professional identity *(The characteristics by which an individual is recognised relating to, connected with or befitting a particular profession)*
• Professional role *(The behaviour considered appropriate for a particular kind of work or social position)*
• Social identity *(The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a social group)*
• Identity *(An individual's sense of self defined by a) a set of physical and psychological characteristics that is not wholly shared with any other person and b) a range of social and interpersonal affiliations (e.g., ethnicity) and social roles)*
• Professional boundaries *(The bounds or limits relating to, or connected with a particular profession or calling)*
• Group identity *(The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a group)*
	• Statements relating to how healthcare profesionals see themselves
	• Statements relating to the extent they view the behaviour as a characteristic/ feature/ meaningful aspect/ representative of their professional role
	• Statements relating to the extent their personal identity influences doing the behaviour
	  o It is/isn't part of our role/job/profession/responsibility to do the behaviour
	  o My [personal identity] impacts on how/whether I perform the behaviour

• Organisational commitment *(An employee's dedication to an organisation and wish to remain part of it. Organisational commitment is often described as having both an emotional or moral element and a more prudent element)* • Social and group norms • Alienation *(Estrangement from one's social group; a deep seated sense of dissatisfaction with one's personal experiences that can be a source of lack of trust in one's social or physical environment or in oneself; the experience of separation between thoughts and feelings)*	In the context of this study, professional role may relate to the extent that healthcare professionals feel that providing obesity and weight management support is part of their professional role, and the roles of other healthcare professional groups. Personal identity may relate to healthcare professionals gender or own weight status and the impact this has on providing obesity and weight management support.

4: Beliefs about Capabilities (Self-efficacy) *(Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use)*
• Self-confidence *(Self-assurance or trust in one's own abilities, capabilities and judgment)*
• Perceived competence *(An individual's belief in his or her ability to learn and execute skills)*
• Self-efficacy *(An individual's capacity to act effectively to bring about desired results, as perceived by the individual)*
• Perceived behavioural control *(An individual's perception of the ease or difficulty of performing the behaviour of interest)*
• Self-esteem *(The degree to which the qualities and characteristics contained in one's self- concept are perceived to be positive)*
• Empowerment *(The promotion of the skills, knowledge and confidence necessary to take great control of one's life as in certain educational or social schemes; the delegation of increased decision-making powers to individuals or groups in a society or organisation)*
• Professional confidence *(An individual's belief in his or her repertoire of skills, and ability especially as it is applied to a task or set of tasks)*
• Control of behaviour and material and social environment
• Optimism *(The confidence that things will happen for the best or that desired goals will be attained)*
• Pessimism *(The attitude that things will go wrong and that people's wishes or aims are unlikely to be fulfilled)*
	• Evaluative statements of healthcare professionals confidence, judgements about their competence and control in their ability (or inability) to perform the behaviour
	  o I do/don't feel confident/able/capable/compet ent to do the behaviour
	  o I find it difficult/easy etc to do the behaviour
	  o I feel that I have/don't have control in doing the behaviour
	• Statements relating to expectations of carrying out a behaviour due to beliefs of competency in performing the behaviour
	  o I know [behaviour] will be/won't be successful because I am/am not very efficient at that task
	In the context of this study, beliefs about capabilities relates to healthcare professionals making evaluative judgments on their ability to do the behaviour, for example their confidence in being able to sensitively discuss women's weight and subsequent risks in pregnancy etc. This would also include expressing optimism/pessimism of effectively discussing obesity, weight management, nutrition etc. based directly upon their believed competence in these behaviours.

5: Beliefs about Consequences (Anticipated outcomes/attitude) *(Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation)*
• Beliefs *(The thing believed; the proposition or set of propositions held true)*
• Outcome expectancies *(Cognitive, emotional, behavioural, and affective outcomes that are assumed to be associated with future or intended behaviours. These assumed outcomes can either promote or inhibit future behaviours)*
• Characteristics of outcome expectancies *(Characteristics of the cognitive, emotional and behavioural outcomes that individuals believe are associated with future or intended behaviours and that are believed to either promote or inhibit these behaviours. These include whether they are sanctions/rewards, proximal/distal, valued/not valued, probable/improbable, salient/not salient, perceived risks or threats)*
• Anticipated regret *(A sense of the potential negative consequences of a decision that influences the choice made: for example an individual may decide not to make an investment because of the feelings associated with an imagined loss)*
• Consequents *(An outcome of behaviour in a given situation)*
• Unrealistic optimism *(The inert tendency for humans to over-rate their own abilities and chances of positive outcomes compared to those of other people)*
• Salient events / sensitisation / critical Incidents *(Occurrences that one judges to be distinctive, prominent or otherwise significant)*
• Attitudes
• Contingencies *(A conditional probabilistic relation between two events. Contingencies may be arranged via dependencies or they may emerge by accident)*
• Reinforcement *(Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus. A process in*
	• Statements relating to healthcare professionals beliefs/views etc on the outcome/consequences of doing/not doing the behaviour
	• Statements can include positive or negative consequences of doing/not doing the behaviour
	• Statements can include consequences of doing/not doing the behaviour on themselves or their patients
	  • If I do/don't do the behaviour, x,y,z will happen
	  • Doing the behaviour will have a beneficial/adverse impact on me/my patient
	• Statements relating to doing the behaviour being directly contingent on receiving rewards or punishments
	  • I do/don't do x, y, z because otherwise x, y, z will/will not happen
	  • Getting praise/thanked etc for doing the behaviour encourages me to do it

which the frequency of a response is increased by a dependent relationship or contingency with a stimulus) • Punishment *(The process in which the relationship between a response and some stimulus or circumstance results in the response becoming less probable; a painful, unwanted or undesired event or circumstance imposed as a penalty on a wrongdoer)* • Consequences *(An outcome of behaviour in a given situation)* • Rewards *(proximal / distal, valued / not valued, probable /improbable) (Return or recompense made to, or received by a person contingent on some performance)* • Incentives *(An external stimulus, such as condition or object, that enhances or serves as a motive for behaviour)* • Sanctions *(A punishment or other coercive measure, usually administered by a recognised authority, that is used to penalise and deter inappropriate or unauthorised actions)*	• I do the behaviour because I will be in trouble/get told off/be reported/get reprimanded etc if I don't In the context of this study, beliefs about consequences could relate to healthcare professionals beliefs that doing the behaviour will result in negative reactions from women being categorised as obese/damage the midwife-woman relationship etc. Also willingness to perform the behaviour based on expectations of outcomes (e.g. weight management in pregnancy is pointless/too late to reduce risks etc). Reinforcement could relate to doing behaviours such as categorising a woman as obese because she needs to have a risk assessment by another department, or if the behaviour is linked with punishments such as litigation/ complaints, or rewards such as continued professional development/personal satisfaction/patient satisfaction rewards etc

6: Motivation and Goals (Intention) *(Mental representations of outcomes or end states that an individual wants to achieve)*
• Goals: distal / proximal *(Desired state of affairs of a person or system, these may be closer (proximal) or further away (distal))*
• Goal priority *(Order of importance or urgency of end states toward which one is striving)*
• Goal / target setting *(A process that establishes specific time based behaviour targets that are measurable, achievable and realistic)*
• Goals: autonomous /controlled *(The end state toward which one is striving: the purpose of an activity or endeavour. It can be identified by observing that a person ceases or changes its behaviour upon attaining this state; proficiency in a task to be achieved within a set period of time)*
• Intention *(A conscious decision to perform a behaviour or a resolve to act in a certain way)*
• Stability of intention/certainty of intention *(Ability of one's resolve to remain in spite of disturbing influences)*
• Transtheoretical model and stages of change *(A five-stage theory to explain changes in people's health behaviour. It suggests that change takes time, that different interventions are effective at different stages, and that there are multiple outcomes occurring across the stages)*
• Intrinsic motivation
• Committment
	• Statements relating to the healthcare professionals goals/aims/desired end result of doing the behaviour
	• Statements relating to other goals which may interfere with doing the behaviour
	• Statements relating to how prioritising goals influences whether or not to do the behaviour
	  ○ Competing priorities mean I do/don't do the behaviour
	  ○ I do/don't do the behaviour as it will/won't meet my main goals
	  ○ I prioritise other behaviours which are more important
	• Statements relating to healthcare professionals resolve to/the extent they plan to perform the behaviour
	  ○ I plan to/set out to/aim to /am determined to/want to/don't want to do the behaviour
	In the context of this study, intentions may be a midwife stating how she aims to always discuss diet and nutrition when she sees a pregnant woman or conversely weak intentions may be a lack of intention to discuss diet and nutrition (e.g. I don't always make a point to discuss it) In the context of this study, healthcare professional's goals may relate to wanting to support obese pregnant women with their weight-related behaviours to improve their health, their family's health, pregnancy outcomes, to reduce risks, to make their job easier etc. Goal priorities may relate to the competing topics to cover during antenatal appointments, and how important obesity and weight management is perceived in comparison with other priorities such as smoking cessation etc.
	(Intentions – things I want to do; Goals – things I want to achieve)

7: Memory Attention and Decision Processes *(The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives)*	• Statements relating to time/situations etc when the

• Memory *(The ability to retain information or a representation of a past experience, based on the mental processes of learning or encoding retention across some interval of time, and retrieval or reactivation of the memory; specific information of a specific past)*
• Attention *(A state of awareness in which the senses are focussed selectively on aspects of the environment and the central nervous system is in a state of readiness to respond to stimuli)*
• Attention control *(The extent to which a person can concentrate on relevant cues and ignore all irrelevant cues in a given situation)*
• Decision making *(The cognitive process of choosing between two or more alternatives, ranging from the relatively clear cut to the complex)*
	healthcare professionals would remember or forget to do the behaviour
	• Statements relating to relying on cognitive approaches to perform the behaviour/make a quick decision
	• Statements relating to cognitive limitations such as forgetting/overseeing/not being able to make the decision
	   • We have to discuss so many issues that I forget to do the behaviour
	   • There are so many problems with doing the behaviour that I can't decide/feel overwhelmed/don't know where to start
	   • I don't do the behaviour because I can't make the decision in the pressure of the situation and competing demands/feel too tired at the end of the day to concentrate to make the right decision
	In the context of this study memory, attention and decision processes may relate to the healthcare profesionals ability to remember to discuss weight/weight management at specific appointments, or due to the complexity of obesity not knowing where to start, or due to having to discuss too many different public health issues they feel overwhelmed and find it difficult to make the decision on how much information or the priority of information to give.

8: Environmental Context and Resources *(Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour)*
• Environmental stressors *(External factors in the environment that cause stress)*
• Resources / material resources (availability and management) *(Commodities and human resources used in enacting a behaviour)*
• Organisational culture/climate *(A distinctive pattern of thought and behaviour shared by members of the same organisation and reflected in their language, values, attitudes, beliefs and customs)*
• Salient events / critical Incidents *(Occurrences that one judges to be distinctive, prominent or otherwise significant)*
• Person x environment interaction *(Interplay between the individual and their surroundings)*
• Knowledge of task environment *(Knowledge of the social and material context in which a task is undertaken)*
	• Describing the presence or absence of tools/resources/ equipment/ services/ organisational structures which facilitate/impede performing the behaviour
	• Describing how the organisational practice/culture/maternity population facilitates/impedes performing the behaviour
	• Wanting tools/resources/equipment/services/ changes in the organisational structure to facilitate performing the behaviour
	   • We have/don't have/need services/resources etc to do the behaviour
	   • The services/resources etc that we have to do the behaviour are good/sufficient/poor/insufficient etc
	   • The environment/organisational culture etc has an impact on doing the behaviour
	Examples of the environmental context and resources in this study could be the availability of support services, patient or healthcare professional information, equipment, service-level pathways of care for obesity, time, staffing levels, whether organisation culture prioritises/provides resource for obesity or not etc (note: in relation to having to prioritise behaviours due to time

	restrictions then time would be coded as goals)
9: Social Influences *(Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours)* • Social pressure *(The exertion of influence on a person or group by another person or group)* • Social norms *(Socially determined consensual standards that indicate a) what behaviours are considered typical in a given context and b) what behaviours are considered proper in the context)* • Group conformity *(The act of consciously maintaining a certain degree of similarity to those in your general social circles)* • Social comparisons *(The process by which people evaluate their attitudes, abilities, or performance relative to others)* • Group norms *(Any behaviour, belief, attitude or emotional reaction held to be correct or acceptable by a given group in society)* • Social support *(The apperception or provision of assistance or comfort to others, typically in order to help them cope with a variety of biological, psychological and social stressors. Support may arise from any interpersonal relationship in an individual's social network, involving friends, neighbours, religious institutions, colleagues, caregivers or support groups)* • Power/hierarchy *(The capacity to influence others, even when they try to resist this influence)* • Intergroup conflict *(Disagreement or confrontation between two or more groups and their members. This may involve physical violence, interpersonal discord, or psychological tension)* • Group identity *(The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a group)* • Learning and modelling *(In developmental psychology the process in which one or more individuals or other entities serve as examples (models) that a child will copy)* • Organisational culture/climate *(A distinctive pattern of thought and behaviour shared by members of the same organisation and reflected in their language, values, attitudes, beliefs and customs)* • Organisational development • Leadership *(The processes involved in leading others, including organising, directing, coordinating and motivating their efforts toward achievement of certain group or organisation goals)* • Team working • Professional boundaries/roles • Management commitment • Supervision • Champions • Social comparisons • Identity *(An individual's sense of self defined by a) a set of physical and psychological characteristics that is not wholly shared with any other person and b) a range of social and interpersonal affiliations (e.g., ethnicity) and social roles)* • Group identity *(The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a group)* • Social identity *(The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a social group)* • Organisational commitment/alienation • Feedback • Conflict—competing demands, conflicting roles • Change management • Crew resource management • Negotiation	• Statements expressing the influence of others on doing the behaviour (social support, group norms etc) ○ I do/don't do the behaviour this because 'others' condone/ support/ advocate/ disapprove/ dictate/ demand it In the context of this study, others may include individuals or groups of peers, other healthcare professional groups, colleagues, management/authoritative organisations etc. Additionally, when healthcare professionals want patient perspectives, feedback, and experiences to influence their behaviour this would be a social influence (e.g. healthcare professionals want feedback on patient experiences of obesity communication to help develop their communications skills etc). However when referring to the interpersonal nature of conducting the behaviour with the patient (e.g. discussing weight management strategies, informing of obesity status) this would be classed as Skills.

10: Emotion *(A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event)*
• Fear *(An intense emotion aroused by the detection of imminent threat, involving an immediate alarm reaction that mobilises the organism by triggering a set of physiological changes)*
• Anxiety *(A mood state characterised by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe or misfortune)*
• Affect *(An experience or feeling of emotion, ranging from suffering to elation, from the simplest to the most complex sensations of feelings, and from the most normal to the most pathological emotional reactions)*
• Stress *(A state of physiological or psychological response to internal or external stressors)*
• Depression *(A mental state that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration)*
	• An expression of their own personal emotional reaction/state to performing the behaviour
	• Expressing how their emotional reaction/state positively or negatively impacts on them doing the behaviour
	  • I get embarrassed/ upset/ scared/ anxious/ stressed/ depressed/ uncomfortable/ happy/ elated/ relaxed/ pleased etc when doing the behaviour
	  • I do/don't want to do the behaviour because it is embarrassing/ upsetting/ elating etc

• Positive / negative affect *(The internal feeling/state that occurs when a goal has/has not been attained, a source of threat has/has not been avoided, or the individual is/is not satisfied with the present state of affairs)* • Burn-out *(Physical, emotional or mental exhaustion, especially in one's job or career, accompanied by decreased motivation, lowered performance and negative attitudes towards oneself and others)* • Cognitive overload / tiredness *(The situation in which the demands placed on a person by mental work are greater than a person's mental abilities)* • Anticipated regret • Threat	• I feel sympathy / empathy / sorry for the patient which makes me want to do the beahviour In the context of this study, emotion relates to the emotional response of the healthcare professional in relation to performing the behaviour, and not the emotional response of the patients to the behaviour (e.g. healthcare professionals being anxious about telling women obesity-related risks rather than women getting upset by risks etc). Would include emotive response to performing a behaviour irrespective of competence of competence in performing behaviour (e.g. apprehensive of informing a woman she is obese regardless of whether good or bad at broaching the subject)
11: Behavioural Regulation *(Anything aimed at managing or changing objectively observed or measured actions)* • Self-monitoring *(A method used in behavioural management in which individuals keep a record of their behaviour, especially in connection with efforts to change or regulate the self; a personality trait reflecting an ability to modify one's behaviour in response to situation)* • Action planning *(The action or process of forming a plan regarding a thing to be done or a deed)* • Barriers and facilitators *(In psychological contexts barriers/facilitators are mental, emotional or behavioural limitations/strengths in individuals or groups)* • Goal / target setting *(A process that establishes specific time based behaviour targets that are measurable, achievable and realistic)* • Implementation intention *(The plan that one creates in advance of when, where and how one will enact a behaviour)* • Goal priority *(Order of importance or urgency of end states toward which one is striving)* • Generating alternatives • Feedback • Moderators of intention-behaviour gap • Project management	• Statements where healthcare professionals want audit/evaluation/feedback on their behaviour • Statements about processes in place/needed to monitor doing the behaviour • Statements about prompts/processes etc used or required to make the behaviour sustainable/routine/habit • Statements about using conscious effort to ensure the behaviour is carried out • I plan in advance/make notes/use prompts so I don't forget to do the behaviour In the context of the this study behavioural regulation may relate primarily to the need for/use of prompts relating to the behaviour such as having specific sections of womens notes that relate to the behaviours, pathways of care etc.
12: Nature of the Behaviours • Routine/automatic/habit • Breaking habit *(To discontinue a behaviour or sequence of behaviours that is automatically activated by relevant situational cues)* • Direct experience/past behaviour • Representation of tasks • Stages of change model *(A model that proposes that behaviour change is accomplished through five specific stages: Pre-contemplation, Contemplation, Preparation, Action, and Maintenance)*	Statements referring to – • The nature of the behaviour including type, frequency, (including routines/habits), duration and intensity of past or current behaviour (statements about the future type, frequency, duration and intensity of a behaviour coded in *motivation & goals*). In In the context of this study, this may include the time spent discussing weight management strategies, nutrition, physical activity recommendations in an appointment, reporting the procedure of conducting the behaviour (e.g. we calculate BMI by measuring their weight and height and then use a chart for their BMI status)

Department for
Health

UNIVERSITY OF
BATH

Bath BA2 7AY · United Kingdom

OBESITY RESEARCH: RAISING THE TOPIC OF WEIGHT IN GENERAL PRACTICE

GPs, PLEASE SHARE YOUR VIEWS!

I am looking for GPs to take part in a one-to-one interview, lasting between **30-45 minutes.** The interview will include reflecting on and discussing some short video clips of doctor-patient encounters (via the researchers iPad) for the final study of a PhD Thesis.

Interviewees will receive £50 Amazon vouchers.

The interview can be carried out at a time and location convenient to you- including at lunch time and before/after working hours.

If you would like further information about the study please get in touch:

Email: m.blackburn@bath.ac.uk

Telephone: 01225 385168
Mobile: 07411 058176

Study Title

Exploring the challenges of raising the issue of weight in general practice using trigger films to aid reflection

Invitation Paragraph

We would like to invite you to take part in a research study. Before you decide whether you would like to participate, you need to understand why the research is being conducted and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish to and please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of this study is to develop understanding into the challenges GPs experience when raising the issue of weight with patients in the context of a general practice consultation. More specifically, the study aims to enhance understanding of clinical decision-making around broaching the topic of weight and to explore views on the consequences of raising the issue of weight. To achieve these aims, the study invites GPs to reflect on and discuss doctor-patient interactions involving weight loss depicted within short video vignettes.

Why have I been invited?

You have been invited to take part in this study because you are a GP whose role entails interaction and communication with overweight and obese patients. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time, without giving a reason, and without penalty.

Who can take part in the study?

GPs and trainee GPs working in primary care.

What will happen to me if I take part?

After reading this information sheet and giving your written consent you will be asked to view some film clips (each approximately 2 minutes long) of doctor-patient interactions. These interactions are fictional and the characters are played by actors. After watching the film clips, you will be asked some interview questions about the videos. Interview questions will focus on the factors that influence your clinical decision making in each situation and your views on patient reactions to the issue being broached.

What do I have to do?

We will ask you to share your views in an interview with the study co-ordinator, Maxine Blackburn. During the interview the film clips will be played via a lap top computer provided by the researcher. This can be conducted in your own surgery or another convenient location. The interview will last for up to one hour, and will take place at an agreed time that is convenient to you, such as at the end of a staff meeting, before or after your working day.

What are the side effects of taking part?

There are no known negative side effects of taking part.

What are the possible benefits of taking part?

You will receive no immediate benefits from taking part. However, reflecting on videos of mock consultations about weight loss may be helpful for reflecting on your own practice in this area. When this research is completed, it should give a greater understanding into weight loss communication in general practice and how this can be improved. In addition, the findings will be disseminated to your local public health team so this could be viewed as an opportunity to communicate your views on the challenges you face in regards to this area of practice.

Expenses and Payments:

To thank you for your time in the study, you will receive £50 of Amazon vouchers. In addition, if you incur travel expenses, these will be covered.

Will my taking part in the study be confidential?

If you consent to take part in this study, all data will be handled and stored following strict ethical and legal guidelines. Soon after the interviews, the audio material will be transcribed and an appropriate coding system for the interview transcripts will be used so that all participants are only identifiable by the lead researcher. Only researchers involved in the study who work in the Department for Health at the University of Bath will have access to the transcripts. In any publications or reports disseminated, quotations from the transcribed recordings may be used, but names and any details that would allow you to be identified will be removed.

What will happen to the information/data provided after the study?

All data collected during the study will be given a unique code number. This means that information collected will not have your name or any other means of identifying you personally. A computer file with all data will be kept, but this will not identify you in any way i.e. it will be anonymous. The consent form will, of course, have your name on it, and is stored in a locked filing cabinet. In any publications or reports disseminated, quotations from the transcribed recordings may be used, but names

and any details that would allow you to be identified will be removed. All personal data will be destroyed after 5 years – anything on paper will be shredded and anything digital will be erased.

What will happen to the findings of the research study?

The data collected will be analysed and a report will be written. It is hoped that the findings will help to inform the knowledge we have about clinician-patient interactions and assist policy makers when they are considering how to improve guidelines and recommendations for NHS staff working in general practice. The data will also be used for a doctorate, and may be published in a peer reviewed journal. If you would like to receive a summary of the research findings when they are written up, please indicate this on the informed consent sheets below and one will be posted or emailed to you.

Who is organising the research?

The Centre for Pain Research, University of Bath, is organising and conducting the research.

Who has reviewed this study?

This research has been reviewed and approved by the Health and Department of Psychology Ethics Committees at the University of Bath.

What if there is a problem?

If you have concerns about any part of your participation in this study you can contact the study coordinator, Maxine Blackburn, at the address below. Alternatively, you can contact Professor Christopher Eccleston, one of the study supervisors at the University of Bath: tel 01225 386439, email c.eccleston@bath.ac.uk. If you would rather raise your concern with someone not directly involved in the study, you can contact Irene Blair, Research Governance Facilitator: I.Blair@bath.ac.uk, tel: 01225 384197.

Contact details

Your contact for further information is: Maxine Blackburn, Centre for Pain Research, University of Bath, Bath, BA2 7AY, Tel: 01225 385168, email: m.blackburn@bath.ac.uk. Alternatively you can contact the study supervisor, Professor Christopher Eccleston at the University of Bath: Tel: , email c.eccleston@bath.ac.uk or .

Please note that you will be given a copy of the information sheet and a signed consent form to keep.

Appendix I: Consent form study 3

Participant Consent Form

Study Title

Exploring the challenges of raising the issue of weight in general practice using trigger films to aid reflection

Researcher

Maxine Blackburn, Centre for Pain Research, University of Bath, Bath, BA2 7AY email: m.blackburn@bath.ac.uk

Please read and complete the following:

I consent to participate in the research study as outlined in the information form. I understand that my involvement is voluntary and that I can withdraw from the study at any time without negative implications.	☐ Please tick
I am aware that the study will involve viewing and commenting on short film clips of mock consultations between a fictional doctor and patient	☐ Please tick
I understand that my personal data will be kept securely and that anything published will be kept confidential as described in the study information leaflet.	☐ Please tick
I agree for the interview to be audio recorded and for the recording to be retained in a secure location at the University of Bath for up to 5 years after the end of this study, after which time it will be destroyed.	☐ Please tick
I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐ Please tick
I would/would not (please delete) like to receive a report on the study findings. I would like to receive this by email/by post (please delete as appropriate).	☐ Please tick

Name of
participant:……………………………………………………………………………
…………….

Date:……………………………………………………………………………………
……………………....

Signature:………………………………………………………………………………
……………………..

Appendix J: Interview schedule study 3

VIDEO 1: PAUL CONSULTING WITH KNEE PAIN

- How likely would you be to raise the topic in this consultation? (prompts: how would you approach it, why/why not)
- What role do you think the GP can play in this situation (what would the intervention involve)?
- What would make it easier for GPs to raise the topic in this situation?
- How much influence do you think you can have by raising the topic in this situation?
- If you did decide to raise the topic, what difficulties might arise as a result of raising it?
- If the same patient came in with ear ache, how likely would you be to raise the topic? (why? Would it be easier or harder? Why?)
- What makes you feel effective in this area?

If not likely to raise:

- When is it relevant to raise the topic?

VIDEO 2: ELEANOR CONSULTING WITH HEEL PAIN

- How likely would you be to raise the topic in this consultation? (prompts: how would you approach it, why/why not)
- How would you feel about the patients response?
- What would your main concerns be if a patient responded like this?
- Are there any other reactions you can talk about from your experience of raising the topic?
- Do you worry about offending patients?
- How does gender affect how you feel about raising the topic of weight?

VIDEO 3: PAULINE

- What are your views on the GPs approach to raising the topic?
- What are your views on raising the topic if a patient comes in with an unrelated problem?
- Thinking about the wider context of general practice, can you talk about how things like QOF and guidelines impact on how you respond to patients with obesity?

Relationship with patient:

- How does your relationship with your patient influence whether or not you raise the topic?
- Do you have any concerns about damaging the doctor-patient relationship by raising the topic?

Future:

- Thinking about your experience of raising the topic, what has worked for you in the past?

- Do you think GPs need more support around raising the topic?
- Are there any opportunities to improve this area of practice? (not just targeted at the individual GP)
- What advice would you give to a GP trainee about raising the topic?