



Original Article

“90% of the time, it’s not just weight”: General practitioner and practice staff perspectives regarding the barriers and enablers to obesity guideline implementation

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ABSTRACT

Objective: To identify the views of GPs and general practice staff regarding barriers and enablers to implementation of obesity guideline recommendations in general practice.

Methods: Twenty general practitioners (GPs) and 18 practice staff from inner-eastern Melbourne, Australia, participated in semi-structured telephone interviews. The interview schedule was informed by the Theoretical Domains Framework (TDF). Interviews were audio-recorded, transcribed verbatim and underwent thematic analysis.

Results: Participants lacked familiarity with and knowledge of the NHMRC obesity guidelines. Barriers and enablers were predominantly related to five theoretical domains: (1) environmental context and resources, (2) knowledge, (3) emotion, (4) beliefs about consequences, and (5) motivation and goals. Time pressures in consultations, costs for the patient, reluctance to add to patient burden particularly in those with comorbidities such as mental health issues, lack of awareness about services to refer patients to and GPs' fear of embarrassing patients and losing them were significant barriers. Enablers included having a strong doctor–patient relationship and a sense of responsibility to the patient to address weight.

Conclusions: Obesity guidelines and policy makers need to better engage with issues of multimorbidity, socioeconomic disadvantage and workforce issues if recommendations are to be widely adopted in general practice. Tasksharing, teamwork and technology are potential solutions to some of the barriers. Patient perspectives and approaches to being able to overcome stigma and legitimise obesity management in primary care consultations could also assist.

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Introduction

Rates of overweight and obesity have doubled over the past two decades [1], with two thirds (67%) of adults affected [1]. By 2025, approximately 80% of adults will be overweight or obese [2] with associated increased risk of cardiovascular disease, type 2 diabetes, musculoskeletal conditions, reduced quality of life and depression [3,4].

In 2013, the National Health and Medical Research Council (NHMRC) released updated clinical practice guidelines for the management of overweight and obesity in Australia [5]. The guidelines

provide evidence-based recommendations for the management of individuals who have a body mass index (BMI) greater than 25 kg/m² and are at risk or currently have an obesity-related comorbidity and are intended for use by general practitioners (GPs), primary health care nurses, primary health care professionals and allied health professionals (see Table 1).

General practice is an ideal setting for the identification and management of overweight and obesity, given that over 60% of primary care patients are overweight or obese [6]. Nearly 85% of Australians attend a GP at least annually [7] and importantly, most Australian adults attend a regular general practice [8]. Affiliation with a GP or practice promotes continuity of care which has been linked with better health outcomes [9]. Patients also identify GPs as their preferred source for weight management advice [10].

There are many challenges to obesity management in primary care. Barriers to the provision of best practice include GPs' low confidence in their skills [11] and in the success of available treatments

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Table 1
Key recommendations (for adults) of the NHMRC obesity guidelines [7].

1. Calculate BMI, measure waist circumference
2. Discuss readiness to change lifestyle behaviours
3. Convey the message that even small amounts of weight loss improve health and wellbeing
4. Use multicomponent approaches
5. Refer appropriately
6. Support a self-management approach, provide ongoing monitoring

[12], and time constraints [11]. Referral to other health professionals, specialists and community-based programs can also be impractical for some patients due to associated costs [13,14].

Little attention has been given to understanding the reasons why implementation of specific obesity-related guidelines has been poor. In Australia, under 25% of health professional encounters for obesity deliver evidence-based care [15] and in general practice, key measures for the routine assessment of obesity are poorly recorded with BMI documented in only 22.2% of patients, and for waist circumference in only 4.3% [16]. Under-recording of BMI and waist circumference was also identified among patients with obesity-related comorbidities.

We therefore aimed to determine the views of GPs and practice staff regarding the barriers and enablers to the implementation of the NHMRC guideline recommendations for the management of overweight and obesity.

Methods

A qualitative approach was used to identify and explore the attitudes of GPs and practice staff towards the implementation of obesity guidelines in general practice. This study was approved by the Monash University Human Research Ethics Committee.

Invitation letters were sent to 272 GPs and 126 practice staff (nurses and managers) from 50 GP clinics in inner-eastern Melbourne involved in our previous study on obesity, a retrospective analysis of routine general practice data [16]. Reminder letters were mailed to non-responders two weeks later. GPs were eligible to participate if they worked at least four sessions per week. Twenty GPs (14 female, 6 male) and 18 practice staff (all female; 14 practice nurses, 2 practice nurse/managers and 2 practice managers) participated. Five GPs declined to participate due to conflicting schedules. Informed consent was obtained from all participants and GPs and practice staff received a gift card of \$200 and \$80 respectively as compensation for their time.

Interviews were based on questions derived from the Theoretical Domains Framework (TDF) [17] which outlines domains related to behaviour change that can be used to inform the development of interventions by addressing domains most likely to explain the underlying behaviour (Table 2). The interview guide was pilot tested with 3 GPs and subsequently refined to ensure appropriateness of the questions for the intended time frame. Semi-structured telephone interviews were conducted, each approximately 30–60 min in duration. Interviews were audio-recorded and transcribed verbatim. Interviews were conducted until data saturation was achieved. Transcripts were de-identified, checked for accuracy and imported into NVivo 11 software (QSR International 2012, Melbourne). Data were analysed via thematic coding that used deductive techniques to classify responses within themes. This was done using the TDF as the coding framework to map thematic data to each domain. To increase rigour, two researchers (EM and NS) coded each transcript independently. Codes were then cross-checked and any interpretive differences were resolved by consensus. The research team discussed and verified the final interpretation.

Results

Most GPs (n = 13) had no knowledge of the guidelines and six were unsure if they had read the guidelines. One GP had read the guidelines, but had limited recollection of its content, “If I remember correctly, it was all about waist measurements and BMIs. That’s all I can remember.” (GP24). Almost all practice staff (n = 17) were unfamiliar with the guidelines.

Interviews revealed that key barriers and enablers to implementation of the obesity guidelines were predominantly related to five theoretical domains: (1) Environmental context and resources, (2) Knowledge, (3) Emotion, (4) Beliefs about consequences, and (5) Motivation and goals.

Environmental context and resources

This domain highlighted the barrier of time constraints in general practice and GPs’ concerns about the accessibility of services to support weight management.

Time constraints

GPs found it challenging to follow guideline recommendations due to competing health concerns/priorities within time-pressured consultations, particularly when weight management was often not the presenting problem.

“Time is the biggest obstacle... People usually haven’t come just about their weight.” (GP08)

“90% of the time, it’s not just weight.” (GP10)

Cost of other health services

Most GPs identified cost as a major barrier when considering whether to refer patients to other health professionals (e.g. dietitians, exercise physiologists and other sources of support) for assistance in making lifestyle changes.

“There aren’t any obesity places I can send patients to at a reasonable cost.” (GP17)

“I have referred a few people to the dietitian, obviously that is a bit limited for those who can’t really pay for it... They can’t really afford to do that even if they want to do it.” (GP19)

Knowledge

This domain identified gaps in GPs’ knowledge of available obesity-related support services and the efficacy of those approaches to obesity management.

Lack of awareness of services to refer to

While many GPs had referred their patients to allied health services, most were unfamiliar with local community-based programs that could further assist their patients to achieve their health goals.

“I never send anyone, I used to years ago, to the obesity clinics at the hospitals. I don’t even know whether they exist anymore.” (GP24)

They also expressed concern as to whether obesity-related support services were effective.

“If I don’t know the quality of the service, I’d hesitate to refer them.” (GP02)

Emotion

This domain captured the reluctance of GPs and practice staff to discuss weight. The risk of embarrassing the patient by raising the often sensitive topic of weight was identified as a major barrier. GPs were concerned they would damage relationships with

Table 2
Theoretical domains and corresponding interview questions.

Domain	Interview questions
Knowledge	<ul style="list-style-type: none"> - What do you know about the 2013 National Health and Medical Research Council guidelines for the management of overweight and obesity? - What do you think these guidelines recommend?
Skills	<ul style="list-style-type: none"> - How easy or difficult do you find discussing the weight management in consultations? - Can you describe what is involved with carrying out the recommendations?
Social/professional role and identity	<ul style="list-style-type: none"> - Are carrying out the recommendations compatible with your role?
Beliefs about capabilities	<ul style="list-style-type: none"> - How difficult or easy is it to carry out the recommendations? - What would help you? - What problems have you encountered? - How confident/well-equipped/comfortable do you feel carrying out the recommendations?
Beliefs about consequences	<ul style="list-style-type: none"> - What will happen if you follow the recommendations? - What will happen if you do not follow the recommendations? - What are the incentives to carry out the recommendations?
Motivations and goals	<ul style="list-style-type: none"> - What kinds of incentives would encourage you to carry out the recommendations? - How much do you want to follow the recommendations? - How much do you feel you need to follow the recommendations?
Memory, attention and decision processes	<ul style="list-style-type: none"> - What is involved and which are done routinely at your practice? - What would make you decide not to carry out the recommendations?
Environmental context and resources	<ul style="list-style-type: none"> - To what extent do physical or resource factors facilitate or hinder you following the recommendations?
Social influences	<ul style="list-style-type: none"> - Do you know if your peers follow the recommendations? - What professionals (besides GPs) at your practice are involved with carrying out the recommendations?
Emotion	<ul style="list-style-type: none"> - Are there any emotions that come with carrying out the recommendations?
Behavioural regulation	<ul style="list-style-type: none"> - Are there procedures or ways of working that encourage carrying out the recommendations?
Nature of behaviours	<ul style="list-style-type: none"> - What contextual factors could prompt you to do what the recommendations suggest? - What would need to be done differently?

their patients if they did not follow the agenda set by them. However, some GPs believed that having a strong rapport with patients enabled them to comfortably discuss weight.

Fear of embarrassing patients

Most GPs and practice staff were apprehensive about discussing weight with their patients due to the stigma and sensitivity of the topic.

“The end game is that I want this person to lose weight, not feel humiliated.” (GP03)

“No one wants to hurt or embarrass or insult their patients. For a lot of them [GPs and practice staff] broaching that topic sensitively is not easy.” (PS15)

Meeting the patient's expectations

GPs were particularly hesitant to discuss weight if their patient had not broached the topic themselves. Meeting their patients' expectations of their consultations was important to them, and they were often unwilling to stray from their patient's agenda.

“If they've come in for something else and we've had difficulty getting to the issue of weight and I can see they're awkward, I will probably not push it.” (GP08)

Strong doctor–patient relationship

A strong doctor–patient relationship gave GPs confidence in discussing weight and readiness to change lifestyle behaviours as recommended by the guidelines.

“Readiness to change can be very threatening to patients... You need to know them fairly well to bring that discussion up.” (GP06)

Beliefs about consequences

This domain highlighted the expected outcomes and realities relating to the discussion of weight in general practice. GPs were often reluctant to discuss weight in multimorbid patients, particularly those with mental health concerns. However, some GPs and practice staff also believed that discussing the benefits of exercise for both weight and mental health could be well received.

Patients with comorbidities

Concerns were raised about burdening patients with the discussion of obesity, especially those with mental health issues:

“It’s all about what’s appropriate to the consultation. If they’ve come in with major depression, I’m not going to give them a hard time about their obesity.” (GP01)

“GPs tell me they’re more often than not dealing with multiple issues. There are a lot of mental health issues in this area, and they’re very conscious of not reducing the patient’s engagement with them by raising and dealing with their BMI.” (PS16)

In contrast, some GPs reported that raising the topic of weight was appropriate during discussions about managing other health conditions.

“I did say as an adjuvant to treating her depression that I’d like to see her do half an hour of walking every day. She found it really beneficial.” (GP20)

“If someone comes in and they have asthma, then part of that is we’re talking about exercise. If there’s something that I can slip in there to show that I’m open to having a conversation about diet and lifestyle related behaviours then definitely.” (GP03)

Concern about losing patients

Health professionals valued having a continuing professional relationship with their patients and some feared they would lose their patients if they raised weight issues.

“If you go too hard you will put the patient off and they won’t come back to see you. They will just go to an easier GP who will do what they want them to do.” (GP06)

“I have lost a few patients by weighing them and telling them their weight. I am very conscious of that.” (GP23)

Motivation and goals

This domain identified enablers to the discussion of weight such as GPs’ sense of responsibility to patients, and according to some practice staff, financial incentives to motivate GPs. However, a lack of personal experience of GPs and practice staff with weight issues was perceived to be a barrier in terms of their ability to relate to their patients’ personal experience.

Professional sense of responsibility to patients

Most GPs and practice staff cited a professional sense of responsibility and a desire to bring about good outcomes for their patients as a strong incentive.

“It’s not fun to see someone who’s a walking risk factor. . . . You can help a person change their life.” (GP03)

Financial incentives

While most GPs did not believe that financial incentives would encourage them to carry out the recommendations, some practice staff provided examples of how financial incentives could motivate GPs and successfully change their professional behaviours.

“For example, the new shingles vaccination. The doctors encourage patients to have that, they will get money from Medicare. That will definitely, definitely be the best incentive.” (PS04)

“Money always works. When they were doing the immunisation uptake, trying to get GPs to register through the immunisation register, they made it a monetary incentive.” (PS10)

Continuing Professional Development (CPD) points were also raised as a “sweetener” (GP05) that would likely encourage GPs to take up learning opportunities.

Ability of health professionals to relate to their patients

GPs and practice staff described how their personal experience with weight issues and their own weight status influenced whether they could relate to their patients on a personal level. For example, those who were not overweight doubted whether their advice would be well-received if they were perceived to have no weight issues by their patient.

“It’s hard for me to convey these messages when they look at you and say, ‘You don’t know what it’s like.’ And it’s true, I don’t know what it’s like to be overweight, or to lose weight.” (GP16)

“I’m a thin person. . . . I just know what it’s like from what I’ve read and from what I understand, from a nursing perspective. . . . I didn’t know what they were going through.” (PS05)

However, some GPs and practice staff believed that their own overweight or obesity and their own proactivity towards lifestyle changes enabled their preparedness to offer advice about weight.

“I give my own example. I say that I’m a bit overweight and I’m also taking every precaution for my health. . . . I exercise. . . . I cut down on certain foods.” (GP17)

“We weigh ourselves weekly as well. . . . Because we’ve got to set an example. I can’t go and tell a patient ‘you need to lose weight’ and I’m obese.” (PS02)

Discussion

Despite the high prevalence of obesity in our community, our study revealed a disturbing lack of familiarity with and knowledge of the NHMRC guidelines in general practice by both GPs and practice staff. Our findings also highlight significant barriers to implementation: time pressures for GPs, costs for the patient, reluctance to add to patient burden, particularly in those with comorbidities such as mental health issues, lack of awareness about services to refer patients to and GPs’ fear of embarrassing patients and losing them. Other barriers included reluctance to deviate from the agenda set by the patient and the inability of health professionals to relate to their patients’ experience of weight issues. Enablers included having a strong doctor–patient relationship and a sense of responsibility to the patient to address weight.

A major barrier to the implementation of the obesity guidelines was time pressures faced by GPs which hindered their ability to discuss weight management in detail, especially in this group of patients with comorbidities. This issue has also been identified among GPs and also by practice nurses who are reluctant to discuss weight with patients presenting with minor health concerns [11,18]. However, nurse-led interventions are as effective in bringing about changes in diet, physical activity and readiness for lifestyle changes as those delivered by other health professionals [19]. Extending the involvement of practice nurses through programs such as the UK-developed Counterweight Program allows practices to provide structured, evidence-based weight management support to patients without adding to the workload of GPs [20]. Studies have also shown that GPs prefer practice nurses to be involved with weight management and that practice nurses have identified weight management as part of their health promotion and chronic disease management role [21,22]. Alternatively, telephone coaching and mobile apps (developed with input from health experts) can provide convenient, interactive and effective evidence-based weight management support [23,24].

Another major barrier was GPs’ concerns about patient costs for referral to allied health professionals. Referring appropriately to enable lifestyle changes is one of the key recommendations of the guidelines. In Australian general practice, these referral rates are low [25]. GPs in our study were unaware of both affordable and available services. In Australia, the use of chronic disease manage-

ment items in the Medicare Benefits Schedule (MBS) (Australia's universal health insurance scheme) enables patients to access multidisciplinary care at a reduced cost. However, obesity is not listed as a chronic medical condition under the MBS [26]. According to the Canadian Medical Association, recognising obesity as a chronic disease rather than a lifestyle risk factor encourages treatment and ongoing management [27]. Formal recognition of obesity as a chronic medical condition in Australia would enable those patients to qualify for a General Practice Management Plan and therefore access subsidised consultations with allied health professionals such as dietitians, psychologists and exercise physiologists. Furthermore, using reliable, freely available government-endorsed health websites (e.g. "Get Healthy" Information and Coaching Service in New South Wales, Australia) [28], peak industry bodies (e.g. Australian Medical Association) [29] and peak condition-specific organisations (e.g. Diabetes Victoria Life! Program) [30] can help support GPs and practice staff's ability to promote healthy living.

GPs and practice nurses lacked knowledge about local services that can assist patients to achieve their health goals. Furthermore, GPs and practice nurses lacked confidence in referring patients particularly if they are ambivalent about the efficacy of these services [12,14]. Providing GPs and practice nurses with accessible, up-to-date information about local allied health services, specialists and community-based programs would support their ability to refer appropriately and build partnerships across services to support weight management.

Another barrier to the implementation of the obesity guidelines was a fear of embarrassing patients if this sensitive topic was broached. This echoes the findings of Michie et al. [31] who reported that GPs and practice nurses were reluctant to initiate discussions about weight if they thought patients would react negatively. GPs feared losing their patients to other GPs who may not raise this difficult topic [32]. Further training and education for GPs and practice nurses about how to sensitively raise the topic of weight would provide them confidence to broach this topic. Practice nurses from our study spoke positively about the LiveLighter public health education campaign (initiated by the West Australian Department of Health in 2012) and resources provided to health professionals to facilitate discussions surrounding weight [33]. Supporting GPs and practice nurses with accessible tools (online BMI calculators, meal plans, online training) may encourage them to discuss weight more routinely.

Similar to other studies, GPs were reluctant to address weight in consultations where it was not the presenting problem [18,32]. Few patients present to their GP with a single health issue [6] and the likelihood of multimorbidity in obese patients brings further complexity to weight management in general practice. Carey et al. [4] reported a high prevalence of depression among patients with obesity (23%) and our study identified GPs' reluctance to discuss weight for fear of exacerbating existing mental health concerns. Obesity may therefore be more appropriately addressed as part of an ongoing chronic disease management plan in conjunction with other health issues.

Some GPs and practice nurses feared their lack of personal experience with weight issues hindered their ability to understand their patients' situation and confidence in addressing it. A previous study also showed that GPs were concerned their patients would believe they were unable to empathise if they had a BMI in the normal range themselves [32]. While it has been reported that there is no significant relationship between the personal weight status of doctors and nurses and their assessment of overweight and obese patients [34], practice nurses have reported that their personal weight loss experiences enabled them to better understand and empathise with patients who had weight concerns [11,18]. In our study, some GPs and practice nurses believed that using their own overweight status and sharing their own proactivity towards making lifestyle changes

Table 3
Practice and policy suggestions.

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- Practice nurse-led interventions to support patients to make changes to their diet, physical activity and readiness for lifestyle changes.
 - Greater use of telephone coaching, online resources and mobile apps developed with input from health experts.
 - Formal recognition of obesity as a chronic medical condition in Australia, which would enable those with a diagnosis of obesity to qualify for a General Practice Management Plan and therefore access subsidised consultations with allied health professionals such as dietitians, psychologists and exercise physiologists.
 - Providing GPs and practice nurses with accessible, up-to-date information about local allied health services, specialists and community-based programs to support their ability to refer appropriately and build partnerships across services to support weight management.
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for weight management enhanced their ability to offer advice to their patients.

Key enablers to the implementation of the guidelines were also identified in this study. The discussion of weight was often facilitated by the discussion of comorbidities, particularly where weight loss, diet and physical activity were important considerations for managing other health conditions. Similar to previous studies, an established doctor–patient relationship and sense of professional responsibility for best patient outcomes allowed GPs to follow the recommendations [14,32]. GPs, however, had conflicting views about whether financial incentives would motivate them to follow the guidelines.

The generalisability of our findings is limited by the self-selecting GPs and practice nurses in our sample who likely had an existing interest in obesity, or an interest in improving their knowledge of the guidelines. We did not collect data on their years of professional experience, or the extent of their experience managing patients with obesity. Furthermore, our sample from a limited metropolitan region within Melbourne, Australia, includes areas among the most advantaged [35]. Further analysis of the barriers to obesity guideline implementation should explore the views of health professionals with patients from populations identified as high risk groups, including those working in low income areas, rural and remote locations and in high Indigenous Australian populations.

Our findings demonstrate a disturbing lack of familiarity with national obesity guideline recommendations and profound barriers that unless addressed will continue to render the guidelines unimplementable. The need for obesity management in the context of multimorbidity which often co-exists with mental health and socioeconomic pressures, was a strong feature of our findings. This needs to be acknowledged by guideline developers and addressed by policy makers disseminating guidelines. Task shifting and improved teamwork with nurses and telephone coaches, and supportive eHealth technologies can help address time issues (see Table 3). Improved community awareness of the ability of primary care to assist with obesity is required to help destigmatise and legitimise the management of obesity in general practice. Equipping health professionals with the training and tools to facilitate consultations about weight and help them build and maintain strong doctor–patient relationships will optimise patient outcomes. GPs need greater awareness of the availability and value of services available, and potential costs to their patient. Further exploration of the barriers and enablers faced by practice nurses who are actively involved with weight management services would be worthwhile. Patient perspectives on these issues are also required.

Ethical statement

I have read and have abided by the statement of ethical standards for manuscripts submitted to the Obesity Research and Clinical Practice journal.

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Declaration of interest

The authors declare that they have no competing interests.

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