Attitudes towards obesity treatment in GP training practices: a focus group study

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Background. Both patients and government expect the GP to treat obesity. Previous studies reported a negative attitude of GPs towards this task. Little is known about the attitude of GP trainees.

Objectives. To assess the attitude and other factors that influence the willingness and ability of GP trainees to provide lifestyle interventions for overweight patients.

Methods. A qualitative study was performed using focus groups, consisting of first- and third-year trainees, GP trainers and teachers. Two researchers analysed the data independently.

Results. First-year trainees lack knowledge and a positive attitude. Third-year trainees, although trained in motivational interviewing techniques, lack specific knowledge and feel cheated when discussing eating habits. Trainers are despondent as they rarely observe long-lasting results. Teachers warn the trainees not to have high hopes. The trainers and trainees fear ruining the relationship with their patient, and all make a request for evidence-based multidisciplinary treatment programmes, joint responsibility and an image change in society to stop the epidemic.

Conclusions. Trainees do not feel more competent in treating overweight patients successfully over the course of their GP specialty training and GP trainers are not convinced of the success of the treatment of overweight patients. Therefore, it could be equally important to reflect on the GP trainer as a role model as to concentrate on the education of the trainee. Both need a revived attitude and evidence-based treatment programmes, help from policy makers and an attitude change in society are desired.

Keywords. Attitude, family practice, obesity, qualitative research, treatment.

Introduction

In the Netherlands, as in many other countries, overweight [body mass index (BMI) 25–30 kg/m²] and obesity (BMI > 30 kg/m²) are becoming an epidemic.¹,² This epidemic is a challenge to public health and requires medical interventions, individual behaviour modifications and environmental changes.²

The multiple guidelines on the management of overweight and obese patients that are available in the international literature [NHLBI,³ NICE⁴ and CMA⁵] merely state that ‘there is limited evidence on the effectiveness of interventions based in non-clinical settings to manage obesity in adults’ [NICE⁴] and rarely contain evidence-based practical tools to reach the stated goals in the Dutch GP setting. No practical guideline regarding the treatment of obesity for GPs is available in the Netherlands. Treatment options depend on local circumstances and initiatives from insurance companies. The guidelines on cardiovascular risk management and diabetes⁶ of the Dutch Society of General Practitioners advise GPs to promote a healthy lifestyle and weight loss for their patients when necessary but do not provide a programme to help implement these recommendations. A multidisciplinary guideline of the Dutch Institute for Health Care Improvement (CBO)⁷ for treating obesity provides an evidence-based recommendations but does not explain how to incorporate these recommendations into the daily practice of GPs. There is as yet no translation of this multidisciplinary guideline into a specific guideline for GPs⁸ in the Netherlands as there is in Australia⁹ and Belgium.¹⁰ For a successful implementation, a guideline needs to be concrete, precise, easily accessible¹¹,¹² and specifically aimed at the Dutch GP.
Dutch patients who are overweight do however consider their GP to be the best source of information about healthy weight loss. The majority of GPs agrees that giving advice about healthy eating should be part of their daily routine, especially when the patient is overweight. Yet factors such as lack of knowledge and time, doubts about their patients’ motivation to change their eating habits and difficulties in talking to their patients about their weight keep them from executing this task.

If we want to combat the increasing obesity rates, we will have to develop strategies to break down the GP’s barriers to weight management and to stimulate changes in the GP’s attitude. Studies show that strategies to promote change in clinical practice are more likely to be successful if they are based on a content-specific analysis of barriers and facilitators. Another strategy would be to prevent these barriers and negative attitudes from coming into existence by focussing on GP trainees. The current practice of weight management and the attitudes and possible barriers of GP trainees towards the treatment of overweight and obesity is unknown. Such information could help educators in the further curriculum development.

Objectives
The aim of this study was to assess the attitude, barriers and other factors that influence the willingness and ability of GP trainees to provide lifestyle interventions for overweight and obese patients.

Methods
Context
The Dutch 3-year GP specialty training is based on the CanMEDS model. In the first and third year, the trainees work 4 days a week in the medical practice of a GP trainer who supervises them and assesses their skills at the end of the training period. One day a week trainees attend a central curriculum at one of the eight educational institutes throughout the country, where they are taught by GPs and behavioural scientists (both called ‘teachers’).

This study took place at the institute for GP specialty training of the Academic Medical Center, University of Amsterdam. The institute is located in a multicultural community outside the old city; training practices are located throughout the north-western part of the Netherlands. In the central curriculum, the only focus on advising weight loss is part of the treatment of chronic diseases. Furthermore, trainees learn motivational interviewing techniques and they can choose an optional elective on obesity.

Three researchers are assigned to this institute: a GP/head research department (MWW), a physician/research coach (NvD) and a GP trainer/teacher (HGAJL). None of them are involved in the training of the GP trainees who participated in this study. HGAJL has a special interest in the management of patients with overweight and obesity.

Sampling
Four focus groups consisting of first- and third-year GP trainees, GP trainers and teachers, facilitated by the same moderator (NvD) and observed by the same researcher (HGAJL), were conducted in 2008. By using these four groups, we hoped to obtain a comprehensive view of the barriers and attitude of GP trainees (triangulation). In order to obtain a secure environment for discussion, first- and third-year trainees, trainers and teachers participated in different groups. Participants were invited for each group, using purposive sampling. Nine subjects per group were invited, by selecting every third name on an alphabetic list of the four target groups, while making sure that the sample consisted of subjects with a different gender, age, clinical experience and ethnic background. If an invitation was refused, the next person on the list was invited.

All participants received written information on the study, including a clear statement that participation was voluntary and the results of the study would be used and analysed anonymously. This information was repeated at the start of the session. Verbal consent of each participant was recorded on tape. The study was approved by the head of the institute.

Data collection
The 45-minute focus group sessions were introduced with the following questions based on an analysis of the published literature: ‘because of their long-lasting contact with patients, GPs have the opportunity to screen for, recognize and treat patients with obesity. How do you feel about this?’ And ‘Do you think that this is the responsibility of the GP?’ These questions were followed, if necessary, by questions on the attitude of the GP towards obesity, interventions during consultations, barriers to discuss the diagnosis of obesity and the need for tools and education. Also, the difference between a protocol to help patients quit smoking using a minimal intervention strategy (MIS) and a protocol to help patients lose weight was discussed.

Data analysis
All sessions were audiotaped and verbatim transcribed. The descriptions of discussions and the notes of the observer were used for analysis.

Two researchers (NvD and HGAJL) analysed the text independently by placing the statements into categories based on the introductory questions. After comparison of the results, differences were discussed and a consensus was reached. Based on the discussion, three
categories were added: ethnicity, children and the GP trainer as role model. Categories were divided into positive and negative statements. During the second round of analysis, a check was performed to ensure that all statements fitted one of the categories and all positive and negative statements were recognized. The final formulation of the results and the selection of representative statements were decided upon after consensus between the two researchers.

Results

Focus group characteristics are shown in Table 1. All trainees were of Western European descent. The training practices were situated in Amsterdam (3), newly built cities (3), medium-sized old cities (4) and villages (3).

The analysis resulted in a comprehensive list of barriers and facilitators for overweight and obesity treatment (Table 2) and showed specific differences and similarities between the groups. This information is described below per identified category.

Responsibility

First-year trainees consider it their responsibility to offer weight treatment to patients suffering from weight-related diseases. Third-year trainees think it can already be effective to make every overweight person aware of their weight problem. Trainers want to identify the patients’ causes of being overweight, motivate them to lose weight and provide them with treatment options. All groups consider prevention and advice on how to live healthily a responsibility of the government, schools and youth health organizations. In addition, patients have a responsibility for their own health.

Is this our responsibility? I rather see it as a task for the entire community to pay more attention to this problem and to stop portraying slim people as role models. (Third-year trainee)

Attitude

The first-year trainees feel that patients think something other than themselves is causing their weight problem and that patients will not or cannot do anything about it. This gives the trainees a sense of defeat.

I experienced negative emotions. I thought: why are you doing this to yourself? (First-year trainee)

Third-year trainees especially feel pity for obese children.

How is it possible that parents allow this to happen to their children? Is it because they don’t pay attention or don’t they see that their children are overweight? (Third-year trainee)

The GP trainers are disappointed and despondent: patients always return to their old bad habits. The teachers consider it too easy to disapprove of people with overweight. GPs should not behave paternalistically.

Intervention

First-year trainees think that they can only give simple advice or refer the patient to a dietician. Third-year trainees, like the teachers advice, use motivational interviewing techniques.

You have to find a suitable approach for each patient. The patient has to set his own goals. (Third-year trainee)

GP trainers and teachers make a plea for a multidisciplinary treatment programme, covered by health insurance.

A good multidisciplinary programme close to my practice that renders positive results will make me enthusiastic. (GP trainer)

Only then or if they can refer a patient for surgery do GP trainers think that it is sensible to discuss their patients’ weight problem with them. Furthermore, they believe that the help of a nurse practitioner and addressing the patient’s family can be useful.

Barriers

First-year trainees feel unable to help their patients.

The fear of not knowing where to refer them. (First-year trainee)

Third-year trainees require more knowledge of risks and special problems in overweight children. They ask for evidence-based interventions.

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**Table 1. Characteristics of the participants of the four focus groups**

<table>
<thead>
<tr>
<th>Focus groups</th>
<th>Number of participants</th>
<th>Male</th>
<th>Female</th>
<th>Age (years)</th>
<th>Years in practice</th>
<th>Years as GP trainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-year trainees</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>29–35</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Third-years trainees</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>32–36</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>GP trainers</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>5–29</td>
<td></td>
<td>1–9</td>
</tr>
<tr>
<td>Teachers</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Responsibility of the GP**  
To make patients aware, look for causes and treat in case of complaints and high cardiovascular risk | Not to screen or to treat every patient |
| **Attitude towards patients being overweight**  
To see it as a disease, an addiction, a risk factor and a shortage of knowledge | To have feelings of incomprehension, disbelief, astonishment, helplessness, discouragement and disappointment by missing long-lasting treatment results  
To blame the patients that they don’t want to take responsibility or action and to blame society to let it come this far |
| **Intervention of GPs with overweight patients**  
To take action, always because of the long-lasting relationship, when there is an opening to speak about it, when there are tools developed, using motivational interviewing techniques, using humour  
To refer to dietician, popular diet, physiotherapist, nurse practitioner, psychologist, youth care organization, supervised sporting facility, special paid for multidisciplinary programme close to the patients own home, special clinic and surgical procedure | Not when there is no medical reason or patient is coming in for different reasons or they want everybody else to do something about it  
Not because of having fear of offending or losing the patient  
no knowledge of possibilities or nothing to offer the patient  
no evidence-based or long-lasting results of treatment  
no easy to follow (national) programme as a result of the money going to the wrong people for what is becoming a booming business |
| **Barriers** (motivating factors)  
To have access to  
change of image formation in society  
healthy food available for low prices  
more rules and information about risks by the government | Not every overweight patient visits the GP, has related complaints, has a cause to address, comes in on the right moment, has knowledge about the risks, wants to get out of the passive role of having an illness and will come back  
To have change of image formation in society  
healthy food available for low prices  
more rules and information about risks by the government |
| **Culture**  
To have more possibilities to refer patients to sponsored programmes | To have  
no acceptance in society to address people about their weight  
cheap junk food available everywhere all the time  
not enough government regulations  
no programmes for screening  
no access to a special programme or clinic at short notice  
no possibilities to establish permanent lifestyle changes |
| **Children**  
To address them, also because of the greater health risk, and to refer them to special programmes, is easier  
To notice that parents need support, it is more a problem of changing lifestyle of children as a group and the youth health organization can help | To notice that eating a lot of candy is frequent, being big is considered beautiful and healthy, women are often not allowed to go outside or do sports and confirming a child’s overweight being an illness is more appreciated by the parents  
To have  
no acceptance in society to address people about their weight  
cheap junk food available everywhere all the time  
not enough government regulations  
no programmes for screening  
no access to a special programme or clinic at short notice  
no possibilities to establish permanent lifestyle changes |
| **MIS**  
To have a tool, an instrument, an intervention strategy, a way of motivational interviewing, a valuable extension, also for the nurse practitioner, that is not dictating and still possible to use if everything else fails and not to feel desperate anymore | To have  
no acceptance in society to address people about their weight  
cheap junk food available everywhere all the time  
not enough government regulations  
no programmes for screening  
no access to a special programme or clinic at short notice  
no possibilities to establish permanent lifestyle changes |
| **Smoking**  
To see it as a risk factor, an addiction | To notice their is more evidence for smoking as a risk factor, that smoking is more a choice while becoming overweight just happens, that the use of a MIS makes it easier to stop smoking |
It is not clear to GPs which interventions have been proven to be effective and that is confusing towards patients, so they give up. (Third-year trainee)

Trainees mention being afraid to offend a patient when addressing his or her weight. That is why third-year trainees find it easier to address a patient anonymously, by letter or written protocol. Trainees also think a mental change in society is needed. They discuss whether medical treatments should be withheld from patients when overweight and whether healthy food should be made cheaper than fast food.

The GP trainers find that telling patients that they are overweight ruins the relationship. When patients regard their overweight as an illness they become passive. Trainers are demotivated because no long-lasting positive results followed.

Discouraged ... No effect in more than 20 years. (GP trainer)

The teachers find it important for the trainees not to expect too much; despite all the efforts until now, the epidemic is still growing.

**Tools (MIS)**

The trainees and GP trainers think that a tool like an MIS will help the GP to intervene.

A tool is good; it would be nice to have a tool that can be used for your patient. But whether or not it works does of course depend on the patient who decides to go along or not. (First-year trainee)

The first-year trainees and the trainers say that they also need a treatment protocol. The teachers expect an MIS to work as a screening method.

**Smoking cessation protocol**

Third-year trainees are not yet convinced that being overweight has the same negative effect on a patient’s health as smoking. They consider smoking to be more of a choice than overeating.

Smoking seems to be something you can stop yourself; it isn’t something that happens to you, but something that you started yourself some time ago. (Third-year trainee)

The trainees therefore find it easier to tell a patient, even jokingly, to quit smoking than to lose weight. Another reason for this is that patients know that smoking is bad for their health—as all four groups observed—and that smoking is no longer accepted by society. This is not yet the case with overweight.

When I started working here people were smoking in every room. Now you simply can’t imagine that anymore. It shows you how effective government regulations can be. I think that’s a good example. (Teacher)

**Ethnicity**

First-year trainees feel that having a different cultural background is an advantage for overweight patients because of the many specific health insurance-financed courses that have been developed for these patients. Third-year trainees and GP trainers think that overweight may be culturally determined.

In Turkish or Moroccan families, they feel that when a child is skinny, it isn’t treated well... (GP trainer)

GP trainers find that women in some cultures are not allowed to do sports or frequently leave the house.

**Children**

First-year trainees think that it is easier to talk to a child than to an adult about their weight problem. Third-year trainees think the opposite: they are afraid to stigmatize a child and to make it prone to teasing.

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>To use the smoking cessation protocol for people with overweight</td>
<td>To see that social regulations against smoking (not yet for obesity) are successful</td>
</tr>
<tr>
<td>To address smokers is easier than overweight patients</td>
<td>To stop smoking or to lose weight; for both a patient needs to be motivated</td>
</tr>
<tr>
<td>To get help from nurse practitioners for smoking cessation and losing weight</td>
<td>Not enough knowledge, especially about children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training and trainers</th>
<th>Not integrated in present education</th>
</tr>
</thead>
<tbody>
<tr>
<td>To have possibilities on demand</td>
<td></td>
</tr>
<tr>
<td>To fit in cardiovascular risk management programme, social discussions and quality improvement programme</td>
<td></td>
</tr>
<tr>
<td>To train motivational interviewing techniques in third year</td>
<td></td>
</tr>
<tr>
<td>To use examples from other GP practises</td>
<td></td>
</tr>
<tr>
<td>To know what the possibilities in the training practice are and what the expectation and competence of the GP trainer is</td>
<td></td>
</tr>
</tbody>
</table>
I want to figure out for myself how I should tell a child that it has a weight problem without making the child feel defenceless. (Third-year trainee)

Trainees and trainers feel that the parents may be to blame for their children’s overweight by having set a bad example or by not having spent enough time with their children; the parents need support.

When I see a child sitting in a stroller with a bag of crisps and a soft drink I think that they deserve better. (Third-year trainee)

Teachers and trainees find that there are more special GP referral programmes for overweight children than for adults. Teachers, on the other hand, worry that healthy overweight children will not visit the GP; screening should therefore be a task of the youth health organizations. In their opinion, the problem for overweight children more often lies within the family than within the individual. They expect schools to actively participate in education on healthy lifestyle and promotion of sports. In complicated cases, schools can work together with GPs.

Education/role model in GP training
Third-year trainees and teachers mention the need for education about overweight. Teachers would like to implement a programme on this subject in the first year of training.

What the trainee learns about treating obesity depends on which part of the specialty the GP is interested in. But I think that the GP specialty training institute and probably also the GP trainers should make the trainee more aware of the existing possibilities to help people lose weight and of the difference between being healthy and being ill. (Teacher)

The teachers think that it would stimulate the trainees’ interest if the GP trainer is convinced of the importance of treating overweight patients and if the trainee knows what the trainer’s expectations are of the treatment. The other groups did not mention the role of the GP trainer.

Discussion
Summary of main findings
First-year trainees lack a positive attitude towards and knowledge of the treatment of obese patients; they feel helpless. Third-year trainees complain about attitude problems, even after having been trained in motivational interviewing techniques. Both groups are afraid to offend a patient when addressing his/her weight and lack support of their despondent trainers.

Trainees do not feel more competent in treating overweight patients successfully over the course of their GP specialty training.

Strengths and limitations of the study
Thirty-six participants were recruited for the focus group session, 25 of whom attended. The reason for not attending the focus group session was not asked.

Participants show substantial differences in gender, age and clinical experience but not in ethnic background. The small sample size limits the generalizability of the results and may have resulted in an overrepresentation of participants with an interest in the management of overweight patients, which in turn may have led to an incomplete representation of barriers and a more positive attitude of the participants. The collected data however showed a high degree of consistency with the existing literature, and even new themes and a difference in barriers between the first-year trainees, third-year trainees, GP trainers and teachers emerged, indicating an adequate sampling strategy.

Although our study took place at only one training institute, the CanMEDS model and the health care organization are (inter)national, and the training practices cover all patient groups. The same attitude problems and barriers can therefore be expected with trainees from institutes in other regions.

It might be more difficult to extrapolate some of the results to countries with a different position of the GP in the health care system or where the insurance system is different. Yet because the attitude of the general population towards obesity and the (increasing) size of the problem are similar in many countries, we do expect most of the problems mentioned in our study to be comparable to those in other western societies.

Comparison with previous research
The finding that trainees do not become more competent during specialty training is similar to the results of a study among internal medicine residents. These third-year residents did not feel more competent in treating obesity than first-year residents, reported more negative reactions to the appearance of obese patients, and more often lost confidence in their patients’ ability to lose a significant amount of weight. Focus group studies with primary care clinicians and residents showed that barriers to discuss obesity with patients could be reduced by training physicians in weight loss counselling; an increase in knowledge on weight loss treatments has been shown to decrease negative attitudes in family physicians. In our groups, however, the third-year trainees had more knowledge and received more training in motivational interviewing than the first-year trainees, yet still had a negative attitude. This was also
seen in a study examining the correlation between knowledge and attitude among internal medicine residents.34

Primary care physicians in other studies were ‘blaming the patient’22,23 and found their overweight patients weak-willed, sloppy, lazy, awkward (as opposed to graceful), unattractive, ugly,26 unwilling to make time for diet or exercise24 and lacking compliance and motivation.21 The attitude problems found in our study differed among the groups and from those mentioned above. The first-year trainees in particular had very negative emotions; they felt incomprehension, disbelief and astonishment. The third-year trainees felt pity for the children and blamed the parents. Yet our GP trainers blamed cultural differences for the obesity of Dutch citizens from a non-Dutch origin. A recent study showed that especially Turkish children are more overweight and obese than other children.25 The trainers are despondent due to the lack of long-lasting results. This is consistent with other studies confirming that treatment is viewed by many physicians as ineffective and futile22,24–26 or that family practice physicians are cynical about the prospect of weight loss.19,26

Both trainees and trainers make a plea for evidence-based treatment: interventions that have proven to be effective and programmes with positive results, like The Counterweight Programme in the UK.36 But even studies on this evidence-based and effective approach for weight management in routine primary care identified wide ranging barriers to engaging practices: overambitious expectations of weight management outcome, doubt about the cost-effectiveness of the programme and weight management being too labour-intensive/resource-intensive. They conclude that a key factor for maintaining engagement with staff is experiencing success.

In contrast with the opinion of patients,13,28 the government1,17 and primary care physicians in other countries,27–29 the trainees and GP trainers in our focus groups feel that GPs do not have the leading role in the management of obesity. Our groups see only parts of this task, like making patients aware of their obesity, looking for causes and treatment in case of complaints and high cardiovascular risk, as their responsibility. GPs in an inner London Primary Care Trust even indicated not yet to be convinced that obesity treatment should be part of their professional domain.25

The increasing tolerance and acceptance of overweight and obesity31,32 may have been an important reason for avoiding the issue of weight by the participants in our groups because of the risk of offending the patient. This was also found in GPs in London and Australia25,30 However, as our groups had previously experienced that advice to stop smoking could be given without a problem, they conclude that an image change towards obesity, similar to the change in attitude towards smoking, is necessary in society. Furthermore, time is a generally recognized barrier.20,24,26,27,29 Easy-to-use tools37 and brief weight management interventions, similar to those available for smoking,37 are therefore being developed to fit within the time frame allotted to most primary care consultations.24,38

During their three years of GP training, the knowledge and skills of the trainees regarding overweight patients improved and their attitude changed, yet they did not feel more competent in treating their overweight and obese patients. This result could not be clearly explained. Trainees might be influenced by the attitude and negative experiences of the GP trainers with whom they work so closely, but this is not directly clear from our study. A study among primary care internal medicine residents showed that the actual practice behaviour of the trainer might exert a broad influence on the behaviour of his residents.39 This influence was confirmed by other studies.40,41 It is therefore important to understand the role model position of the GP trainer if we want to prevent negative attitudes and improve lifestyle interventions for obesity in the daily practice.

Implications for future research and clinical practise
To improve the GP trainees’—and future GPs’—performance in weight management interventions, a quantification of the problems and barriers, including the GP trainer as a role model, is necessary to identify those aspects that mostly require adjustment in specialty training.

There is a big gap between the reality of people becoming more and more obese and the theory on how this epidemic should be stopped. Our focus groups asked other parties to participate or even take the lead in solving this problem, acknowledging that the GP can only be part of a broader approach in addressing obesity.30 Our participants need tools and programmes with known long-term results, but most of all they need a revived attitude. To accomplish this, it may be equally important to reflect on the GP as a role model as to concentrate on the education of the trainee.

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Declaration
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Conflict of interest: none.