

Australian GPs' perceptions about child and adolescent overweight and obesity

the Weight of Opinion study

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ABSTRACT

Background

GPs can potentially play a significant role in assessing weight status, providing advice, and making referrals to address overweight and obesity and its consequences among children and adolescents.

Aim

To investigate the perceptions of GPs about overweight and obesity in children and adolescents, including the extent to which they perceive it as a concern, the factors they see as causal, what actions they consider might be needed, and their sense of responsibility and self-efficacy.

Design of study

A cross-sectional qualitative study of GPs' perceptions.

Setting

General practice and primary health care services in the state of New South Wales, Australia.

Method

Focus groups using a structured protocol were conducted with samples of GPs. Groups comprised a mix of male and female GPs from a range of cultural backgrounds and working in practices in low, medium and high socioeconomic areas. Data were recorded and transcribed. Content analysis was used to identify key themes.

Results

Many GPs are concerned about the increasing prevalence of childhood overweight and obesity. They are committed to dealing with the medical consequences, but are aware of the broad range of social causes. GPs perceived that parents are sensitive about this topic, making it difficult for them to raise the issue directly in clinical practice, unless they use lateral strategies. GPs were confident about providing advice, with some managing the problem independently, while others preferred to refer to specialised services. GPs perceived that there were significant barriers to patient compliance with advice.

Conclusion

Whereas some GPs manage patients' lifestyle change directly, including children's weight management, others prefer to refer. Programmes, service delivery systems, and resources to support both approaches are required.

Key words

adolescents; child health; obesity; primary health care.

INTRODUCTION

The incidence and prevalence rates of overweight and obesity among young Australians are high and rising.^{1,2} This is part of a worldwide trend. The serious health risks of childhood overweight and obesity are well recognised and involve almost every system of the body.³

While there is universal endorsement of a comprehensive approach to the prevention of childhood overweight and obesity, it is recognised that primary healthcare professionals, and GPs in particular, can play a significant role.^{4,5}

To support this role, several countries, including Australia, have developed clinical practice guidelines for the assessment and management of overweight and obesity.^{4,6} However, very little is known about the perceptions and responses of GPs to the issue of childhood overweight and obesity. A deeper understanding about professional perceptions will influence many aspects of intervention planning, including communication and improved approaches to assessment, prevention, and management of overweight and obesity among children and adolescents.

This research was conducted to elucidate the extent to which GPs perceive overweight as a threat to the health of young people, causal factors that they identify, actions they consider might be most helpful,

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barriers to effective management they experience, and perceptions about their roles and responsibilities, sense of self-efficacy, and commitment to action.

METHOD

Qualitative research methods are valued for their ability to tap personal attitudes that are not readily expressed in response to survey questions.^{7,8} Therefore, they were considered to be most appropriate for investigating the range of GPs' perceptions on the issue of overweight and obesity in children and adolescents, and for exploring their views in depth.

Four focus groups, facilitated by the same two researchers, were conducted with a total of 26 GPs during 2005 in three metropolitan and one rural area of New South Wales (NSW), Australia. Study sites were selected to cover a mix of (patient) population characteristics, including socioeconomic differences.

Participants for the focus groups were recruited through the local division of general practice in each area. Information about the study was distributed by the divisional office to all GPs in the division. There was no further recruitment effort. Interested GPs registered directly with the researchers by telephone. GPs were accepted into groups in order of registration, up to a maximum of 12 per group. GPs were financially reimbursed for participating in the study.

Focus groups were conducted in accordance with a protocol of topic questions and prompts. The protocol was developed from an analysis of the published literature and consultations with GPs (Box 1). Adolescents and children (aged under 12 years) were discussed separately because of the more significant role of parents with children. Confidential group discussions of approximately 90 minutes were recorded and transcribed.

Researchers undertook conventional content analysis, with coding categories derived directly from the data. Coding and content analysis was conducted independently by two researchers, and checked by two other researchers.

RESULTS

The participating GPs comprised a mix of males and females, aged 30 to 70 years and from a variety of ethnic and language backgrounds. The comments from focus groups were spread across participants in groups rather than being attributed to individuals.

Awareness of child and adolescent overweight and obesity

Participating GPs were aware that child and adolescent overweight is a serious public health problem. All of the GPs were familiar with and concerned about the medical and social consequences of obesity:

How this fits in

The increasing prevalence of child and adolescent overweight and obesity is well-documented and there is universal endorsement that a comprehensive approach to prevention and management is required. However, little is known about the perceptions and responses of community members and professional groups, and the ways in which primary health care has responded. This research investigated and documented GPs' responses, as part of a larger investigation of community attitudes and perceptions. This is of direct relevance to clinicians in allowing them to compare their views and experiences, and to gain insight into approaches adopted by others in similar settings.

Box 1. Focus group questions.

► Broad Topic 1: To what extent do GPs recognise overweight and obesity as an important issue?

- Do you think overweight and obesity is an issue for children and adolescents in NSW? Why/why not?
- Do you see it as an issue for your practice?
- How do you know if a child or adolescent is overweight or obese? How do you make that distinction?
- When do you weigh children as part of a standard consultation? Up until what age?

► Broad Topic 2. Discussing overweight and obesity in (a) children under age 12 and (b) adolescents 12–18 years

- If a child presents who seems at risk of becoming overweight, do you talk to the parents/child about it?
- If a child presents who is overweight or obese, do you talk to the parents/child about it?
- Do parents ever come to you asking for help with their child's weight? What prompts them to ask for help?

► Broad Topic 3. Treatment/management of overweight and obesity in (a) children under 12 and (b) adolescents 12–18 years

- How do you currently manage the care of a child who is overweight or obese? How often do you refer to other services (for example, specialists, dietitians)?
- How easy/difficult do you find it to help overweight kids get to a healthy weight? Can you tell us any strategies that have worked well for you?
- How confident do you feel providing advice about healthy eating or physical activity?

► Broad Topic 4. Roles, responsibilities, and moving forward

- In an ideal world, what role do you think GPs should play in this issue?
- What kinds of resources, support, or training would make it easier for you to take an active role in preventing childhood overweight or obesity? What would make it easier for you to treat childhood overweight or obesity?
- What other things do you think would help reduce overweight and obesity in children?

'It's so profound — it's self-esteem, it's everything else — the correlation with obesity and just about every medical condition, heaps of cancer, it's asthma, it's injury, it's everything.' (Focus group 4)

All but one of the participating GPs reported that they dealt with childhood overweight and obesity in their clinical practice, including some children with type 2 diabetes.

Causes of child and adolescent overweight and obesity

While the GPs in this study were concerned about the medical consequences, they were also strongly aware that the development of overweight and obesity among young people had many social causes, and was more than just a medical issue. They cited structural and social issues such as increasingly sedentary leisure pursuits, neighbourhood safety concerns, costs of sport, the availability of and exposure to energy-dense food, and advertising. GPs also discussed parental influences, including parents' lack of knowledge on some issues (for example, portion sizes), parental attitudes that link nurturing and eating, and parental modelling of poor eating practices (for example, skipping breakfast).

Assessing weight status

While routinely incorporating weight assessment into standard medical consultations might be ideal, it was thought to be impractical. Some GPs reported weighing and measuring all children regularly, while the majority did so primarily when calculating dosages of medication or when they had a particular concern about a child's growth or development. Some of the factors that entered into GPs' decisions about whether or not to measure height and weight at a specific consultation included the reason for the visit, time factors, and whether the family members were established or new patients. GPs reported that children's weight was a sensitive topic and that there were real risks of alienating families or losing them altogether by simply raising the issue of weight.

Weighing and measuring a child because of a concern about overweight or obesity specifically was often prompted by a parent raising the issue or because the GP was concerned:

'I actually do the good old eyeball test and if I'm concerned what I do is I say, "Let's see how you are growing and how big you are going to be when you're 18", and I measure their height and then say, "Let's see how much you weigh", and we go "beep beep beep" on Medical Director [desk-top medical software], and then you have a chat.' (Focus group 4)

There was considerable discussion (and some disagreement) in the groups about the appropriateness of body mass index (BMI) categories for children, and in particular for population groups from different

cultural and ethnic backgrounds. Some GPs preferred using growth charts rather than BMI, because it seemed to make more intuitive sense to parents:

'If they are on the 50th percentile for their height but the 100th percentile for their weight, most parents realise there is a problem, so I tend to do that rather than give a number.' (Focus group 1)

Communicating with parents about children's weight

While it was fairly unusual, some parents did raise concerns with the GPs about their child's weight, often prompted by teasing at school, weight-related problems, or where the parents were specifically seeking the authority of the GP to motivate behavioural change in their child:

'I think they come after they fail and tell the child not to eat that, and come to us just for confirmation from a medical man, to tell him that what he eats is wrong. That is what it is — they want [us] to confirm. It's a scaring technique.' (Focus group 3)

More often it was the GP who had to decide whether to raise the issue. GPs recognised that children's weight is a sensitive issue because of its link to parenting behaviours, and that many mothers equate feeding with nurturing:

'It is very hard to tell a mother to stop feeding their child so much ... It's a deeply psychological thing ... Yes, it's sort of "love and food".' (Focus group 4)

Other barriers experienced by GPs included the parents' own weight issues, and parental denial or defensiveness about their children's weight. Others felt that it was difficult to raise an issue for which there was no service available for the family:

'How often do you get these people back? What infrastructure do you offer them? You send them out back into the wilderness really ... We really need a lot more resources.' (Focus group 4)

For these reasons, some GPs did not raise the issue independently:

'I would invariably not talk about it, unless patients come in and talk to me about it.' (Focus group 2)

However, the majority of the focus group participants did attempt to discuss the issue with parents, in spite of barriers, using a variety of approaches. One strategy

was to discuss weight in the context of a clearly associated health problem:

'Sometimes opportunities come, like the child is obese, and they come with some aches and pains in joints and ... asthma [and ask] how do we prevent that? ... Say "you do this" and she [the mother] is more likely to do it.' (Focus group 2)

Other strategies included using humour, using a staged approach over several visits, using family histories of metabolic disorders as a starting point, or talking about eating or physical activity rather than weight itself.

Communicating with adolescents about weight

GPs acknowledged that working with adolescents was different from dealing with children. There were specific circumstances where adolescents themselves may approach a GP, or where GPs have the opportunity to raise the issue (for example, when adolescent females seek prescriptions for the contraceptive pill). GPs were aware of the aesthetic and social incentives around weight that were important for adolescents, especially females. However, GPs were also aware that emotional eating issues or eating disorders may be involved. While it was felt that adolescents were often looking for a 'quick fix', some of the GPs were positive about dealing with adolescents, commenting that they can be motivated to make changes:

'It's easier with adolescents, they are a bit more aware of things and a bit more conscious of things around them and perhaps they understand better.' (Focus group 2)

Managing overweight and obesity among children and adolescents

It was common for GPs to conduct tests and health checks as part of an assessment process, to be sure that there were no (other) serious problems and to reassure patients. Generally, GPs were confident about handling health problems associated with overweight and obesity. They felt that they were well equipped to provide factual advice and explain the health consequences of overweight and obesity.

GPs also recognised that assisting children and adolescents to manage their weight was difficult because they were dealing with the family as a whole rather than an individual patient, and that many environmental influences supported weight gain:

'We are swimming against a huge tide ...' (Focus group 4)

Some GPs reported being actively involved in providing weight management advice to young people and their families, and felt that this was both part of their role and was expected by the families:

'I don't refer them. I try and handle the situation. I am the family doctor. I know their family setup.' (Focus group 2)

Some GPs reported that they provided advice on food, family food habits, and physical activity, including issues such as fats, carbohydrates, portion sizes, glycaemic index, calories, advising parents not to use food as a reward, and giving 'lifestyle prescriptions' to adolescents for a certain amount of physical activity. One GP asked his patients to compose a food diary and then went over it with them.

However, other GPs saw their role as more of a gatekeeper, and thought that it was not feasible for them to provide detailed dietary or physical activity advice for a variety of reasons, including limited consultation time, cost to families, and low expectations for patient compliance and success:

'It's difficult for GPs to charge GPs' fees and to sit down and talk about kids' diet and exercise.' (Focus group 4)

Instead, they expressed that:

'The GP is there to give more information to people coming in, wanting more information and details, and maybe orchestrate access to other appropriate resources.' (Focus group 4)

GPs wanted smooth processes for referring patients to dietitians, and physical activity facilitators and systems for reimbursement for weight management.

While many GPs often suggested that the families see a dietitian, they were aware of barriers, including cost to the families and limited availability of public and private dietitian services. While perceiving that patients may consider that much dietary advice is simply 'common sense', GPs thought there were specific benefits from frequent contact with dietitians that could not generally occur through GPs:

'Without the dietitians, we'd be overwhelmed, and I think it's pretty important — we can tell people what not to eat, and you need people to offer choices and offer parents, not tricks, but solutions, and a few things like that. I think it needs to be a joint process.' (Focus group 1)

Ideal role of the GP

In spite of the perceived difficulties that surround preventing and managing childhood overweight and obesity, these GPs genuinely felt they had an important role to play. They expressed the desire to provide direct, honest advice and for this to be perceived as acceptable and helpful:

'In an ideal world, perhaps being more proactive in helping parents identify their kid is at risk, because there is this whole like "my 3-year old, it's just puppy fat, they'll grow out of it," when do you finally say, "it's not puppy fat, they've got a problem", and so we maybe need to help parents identify that. So be more proactive in helping diagnose, but then also helping to steer treatment as well, and whether that is getting dietitians on board or whether it is getting schools to have a bit more focus on education and physical activity. So probably gatekeepers, helping to identify and give parents options, treatment strategies, and steering them in the right way.' (Focus group 1)

GPs cited a number of factors that would help them to play this role. Suggestions included strategies that would help break down the barriers about discussing weight with parents and young people, including community education campaigns to normalise GPs' involvement with weight, so that people would expect them to raise the issue and provide advice as part of medical care. The idea of screening programmes in schools that referred parents of at-risk children to their GP was raised on a number of occasions. A further suggestion was for the introduction of Well Child checks as part of primary health care:

'I think for us as GPs, a Well Child check looking beyond 5 years, where you weigh and measure kids once a year, and it's a way of getting kids in and checking for other things — like we do with our over 70s.' (Focus group 4)

GPs also suggested the value of more professional education, more appropriate patient education materials, and increased availability of subsidised and accessible dietary and physical activity programmes to which they could refer their patients.

Beyond the GP

GPs were aware that in the current social context it is difficult for people to change their behaviours and manage their weight. There was a strong perception that GPs can be only one part of a broad set of solutions, including community education, food labelling, limiting food advertising to children, improving access to sport and recreation programmes, and safe

playgrounds and open spaces. In particular, GPs saw that child care centres, preschools, schools, and school canteens provided important intervention points to reach children at an early stage, within a supportive context for healthy eating and physical activity.

DISCUSSION

Summary of main findings

This study demonstrated that most GPs who participated in the focus groups have a high level of awareness and concern about the problem of childhood overweight and obesity, and play a potentially important role in assessment, delivery of brief advice, and referral for weight management. It affirmed previous research on difficulties that GPs experience in raising the issue of children's weight, while presenting new information on the strategies they use to engage and communicate with patients in ways that are acceptable.

Most GPs indicated that they felt confident in dealing with the health consequences of overweight and obesity, but their responses were mixed regarding behavioural intervention. While comfortable with a role in assessment, some GPs preferred to refer for lifestyle and behaviour change management. Consequently, many GPs saw the value of service delivery arrangements that supported referrals to other health professionals.

Strengths and limitations of the study

The participating GPs were self-selected and may have had a particular interest in this issue. Consequently, it cannot be assumed that the findings presented here are representative of the views of all GPs in NSW.

While the number of groups and participants was small, the research achieved saturation in content, with a high degree of consistency of themes and with no new themes emerging. The use of the same facilitator for all groups, and four independent researchers for data analysis ensured quality control and minimal interpretive bias.

Comparison with existing literature

Most studies that have examined health professionals' attitudes related to overweight and obesity have referred to adults.⁹⁻¹³ There was no indication of negative attitudes towards obese patients in this study, such as have been described in relation to adults.^{8,10}

The findings that GPs take account of parents' sensitivities about children's weight and were concerned about offending (and thus possibly losing) patients is consistent with other findings that community expectations about the doctor-patient relationship influence providers' actual delivery of services.^{6,9,14} GPs' accounts of the circumstances in which they are most likely to assess weight correspond

to the findings of a recent quantitative survey of Australian GPs.⁴ Results from a series of parent focus groups in NSW, conducted as part of the Weight of Opinion study, demonstrated that although parents were sensitive about the issue of weight, they felt it was the role of the GP to raise the issue if the GP was concerned about their child (D Pagnini *et al*, unpublished data, 2006). GPs in this study demonstrated a strong commitment to dealing with parents who raised the issue and demonstrated a readiness to change, which is consistent with suggestions for how to overcome major barriers.¹⁵ GPs also showed a commitment to those who had not yet acknowledged that there was an issue. While preferring to focus on families, these GPs were aware of their limited capacity for change in many cases.

GPs' recognition that they could only be one part of a broader approach to addressing childhood overweight and obesity, given the predominance of social causes, is consistent with international and Australian policy, strategies, and commentary.¹⁶⁻¹⁸

Interestingly, the GPs in this study did not explicitly refer to relevant clinical guidelines, although they demonstrated familiarity with the intent of the first step, involving the measurement of BMI and comparison with appropriate norms. The finding that few GPs routinely assessed children is consistent with other research on Australian GPs.¹⁹ The results show that there is scope for ongoing development of GPs' skills in preventive medicine, such as skills in providing brief advice, motivating behaviour change, and goal setting for patients, which is consistent with other reports.^{4,18}

The potential benefits of collaboration between GPs and other allied health services, despite lack of good referral systems and reimbursement systems that were apparent in this study, have been widely documented.^{4,20,21} Other barriers described in this study, including competing demands and poor patient compliance, also confirm findings reported elsewhere.^{4,14,22}

Implications for clinical practice

The findings of this study have a range of implications. Programmes, service delivery systems, and resources should be developed to support GPs involved in lifestyle counseling, and those who prefer to refer. Strategies should be considered that would promote the regular monitoring of all children's weight and height as part of routine care, to normalise the discussion of weight. For interested GPs, professional education regarding the most effective forms of behavioural counselling for their patients and ways of applying practice guidelines is needed. All GPs require clear referral pathways to relevant allied health professionals so that multidisciplinary management approaches can be applied. Health funding and service

delivery arrangements that better support weight assessment and management by doctors, as well as allied health services, are needed.

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Ethics committee

The University of Sydney Human Research Ethics Committee gave ethics approval for the study (02-2005/1/7490)

Competing interests

The authors have stated that there are none

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