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Discussing Weight in Real World GP Consultations: A Video Recording Analysis Study

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ABSTRACT

Objective: GPs have a complex role in obesity management due to patients' individualized experience of living with obesity, coupled with the challenge to deliver healthcare messages in non-stigmatizing ways. This study aimed to explore who initiates the topic of weight and how weight was discussed in real-world GP-patient consultations.

Method: A multi-disciplinary team, including obesity lived experience experts, undertook a secondary data analysis of 43 Australian video recorded consultations and patient surveys from The Digital Library using descriptive content analysis.

Results: 17/43 consultations included the topic of weight in the discussion. 15 were initiated by the GP and 2 by the patient. 14/17 used a structured approach. All GPs asked for consent to discuss weight or gave patients space to decline the discussion. No overt stigmatizing language was identified. A post-consultation survey found 15/17 patients (2 unanswered) felt listened to and respected during consultations.

Conclusion: This study identified the intricate ways GPs approach weight discussions in consultations. GPs navigated weight discussions in ways that made patients feel respected and listened to and related weight to health concerns relevant to each patient.

Practice Implications: The findings in this study can serve as a foundation for establishing education and training resources for GPs and can be utilized as a way of continuing professional development. Any future communication technique resources for GPs should be co-designed with obesity lived experience experts to ensure appropriateness and avoid potential stigma and harm.

1 | Introduction

Similar to other countries including the UK, New Zealand, Canada and the US [1–4] Australian GPs in primary care are well positioned to support patients with obesity management due to their community reach and the frequency with which they see their patients [4, 5], with approximately 85% of Australian adults visiting a GP every year [6]. However, obesity is a highly complex, individualized and stigmatized health issue [7–10]. Communicating obesity related health messages to patients can be a challenging, difficult and delicate endeavor for GPs [11–14].

GPs have reported many barriers to effective obesity management in their practice, with no "one" strategy suiting all patients. These barriers included a lack of time during 15-min

consultations, insufficient training for GPs on the topic of obesity, lack of financial reimbursement for GPs, lack of confidence in raising, discussing, preventing or treating obesity, contested views of whose responsibility a patient's obesity was, limited funding or suitable referral options available in primary care, barriers faced by disadvantaged patients, obesogenic environments, the normalization of obesity, obesity and weight related stigma, and patients' readiness to change [11, 12, 15–22]. Obesity management discussions frequently occur in GP-patient consultations. Reports have indicated that a range of framing techniques are used by GPs, including pointing out the health benefits of weight management, the risks of not managing weight over time, and taking a neutral approach by focusing on the overall health of a patient [14, 23, 24]. High-quality communication in healthcare settings is crucial to ensure safe practice and optimize patient health, especially for stigmatized issues such as obesity.

Communicating obesity health messages is notably complex. GPs reported the necessity to raise the obesity health risk in relation to patient health concerns. However, they feared raising the topic of obesity might cause offense, thereby jeopardizing the therapeutic relationship and inadvertently leading to poorer health outcomes [15, 22]. Previous literature highlighted that people living with obesity experienced negative obesity stigma in all contexts of life, including healthcare settings [7, 25]. Some patients had experienced obesity stigma and discrimination from healthcare staff, which led to further psychological harm such as depression, anxiety, low sense of self-worth, and isolation [12, 26, 27]. Consequently, many people living with obesity reported sometimes avoiding healthcare settings in order to avoid potential stigma and discrimination experiences [10, 27–29]. However, not attending healthcare settings could further perpetuate health complications [20, 27, 30] and made a GP's ability to provide obesity related healthcare near impossible. One review highlighted the range of patient experiences and indicated that some patients wanted to discuss their weight and positively received offers for support and monitoring of weight [31]. The highly individualized patient experience of obesity coupled with the difficult nature of communicating obesity healthcare messages in non-stigmatizing ways made the role of a GP increasingly complicated even before discussing obesity treatment options.

Limitations to methodological processes are not new in research contexts. Previous research had primarily explored the experiences and perspectives of GPs and patients using surveys, in-depth qualitative interviews and observation strategies; however, these methods were potentially affected by issues such as recall or social desirability bias. International studies had used video recordings of GP-patient consultations to reduce this margin of error or influence in the data collected and had significant success [12, 32, 33]. However, real world video analysis has not been explored in the Australian general practice context yet, despite over 32% of Australian adults living with obesity and at risk of further health complications [34]. This research aimed to explore the way that weight management is discussed in general practice consultations. Specifically, (a) who initiated the discussion (GP or patient), (b) how the discussion is initiated (structured or opportunistic), and (c) how weight was discussed during consultations, with a focus on positive versus stigmatizing language.

2 | Materials and Methods

2.1 | Design and Setting

This was a qualitative research project that utilized descriptive content analysis of secondary data of recorded real-world primary care GP-patient consultations.

2.2 | Data Collection: Video Recordings

The Digital Library, held with the National Center for Healthy Aging at Monash University in Australia, is a digitized repository containing real world video-recordings of health and social care consultations from community, outpatient, and residential care settings. The Digital Library includes data from all parts of the healthcare system, including community health and primary care, hospitals and other acute settings, aged care facilities, telehealth and outreach services. The Digital Library repository provides an infrastructure for research and education purposes to improve healthcare interactions, communication strategies to improve patient safety, support clinicians, increase patient health outcomes and consumer satisfaction. Our study focused on the general practice context. We used a video collection containing real-world GP-patient consultations and related data, including transcripts, patient survey logs and participant demographic data [35]. At the time of this study, the Digital Library held 43 GP-patient consultations which were used as data for this project that had been collected between August 2021 and February 2022. We used this data repository for our analysis [35].

GPs with teaching and/or training responsibilities were recruited from GP practices across Melbourne, Australia. They were identified from public profiles, existing databases of GPs interested in research or previous GP participants (snowballing). GPs were sent information about the project, and followed up twice as per the Dillman method of recruitment [36]. Informed consent was obtained from volunteer GPs prior to the first recording day. Only GPs were offered an honorarium of $120 per day in recognition of their time to contribute to research.

A research assistant attended each clinic recording day. They explained the study to all patients seeing the participating GP that day and sought informed consent. Patients who did not consent did not have their consultation recorded. Video recordings were transferred to a secure hard drive at Monash University with restricted access. These videos were transcribed verbatim using transcription software [37] for analysis. All identifiers were removed from the video and survey data prior to analysis. Ethical approval was granted for recording consultations (#37638) and secondary analysis (#39605) on August 8, 2023 with the Monash University Human Ethics Committee.

2.3 | Data Collection: Weight Related Consultations

Two researchers (K.N. and N.G.) viewed all 43 naturally occurring video consultations to locate instances of discussion

around the concepts of "weight" or "obesity." Two consultations were excluded as the topic of weight was linked to pregnancy and another had pharmacological issues that greatly influenced the communication pattern. Seventeen consultations were identified to include the topic of "weight" or "obesity" which formed the data set for this project (Figure 1).

2.4 | Analysis

Two researchers (K.N. and N.G.) analyzed all 17 consultations that included the topic of weight looking for (a) who initiated the topic (GP or patient), (b) how was this topic initiated (structured or opportunistic), and (c) how was weight or obesity discussed in the consultation (specifically guided by appreciative inquiry [38] and stigmatizing language relevance). Researchers analyzed the consultations using descriptive content analysis [39, 40] and also drew upon the two consultation discussion strategies for initiating health topic discussions identified by Flocke, Kelly, and Highland [41]: structured and opportunistic. Structured strategies were defined as health professionals utilizing a routine or planned pattern of questioning to introduce a topic (such as obesity) and can include a written form or mental "checklist" of topics to cover during a consultation. Opportunistic strategies were used when a topic was raised in relation to a specific acute symptom, chronic issue, or a topic in the patients' medical records. Given that obesity was a nuanced, stigmatized, and complex health issue to discuss or manage, we were open to, and looked for, any novel or organic strategies used that are not pre-formed conceptualizations from our research aim.

Each consultation video was watched and initial notes were recorded in an excel spreadsheet. The researchers read and reread the transcripts of each consultation to familiarize themselves with the data. Using analysis software [37], passages of text were manually highlighted and labeled (by K.N. and N.G.) into codes that were related to the research aims. These preliminary concepts of how weight was discussed in the videos were discussed with the wider research team (K.N., E.S., N.G., K.W., N.G., and D.R.) comprising early to mid-career researchers, obesity lived experience experts, lived experience researchers, and practicing urban and rural GPs. From this meeting, the consultations were all revisited (K.N.) for concepts or perspectives of the wider team. The updated list of descriptions about how weight was discussed was brought to the wider team for further debate and discussion. From this meeting, the ways in which weight was discussed in consultations were identified, which form the findings of this project. While data saturation is positioned as subjective and situated [42], this analysis continued until the two researchers (K.N. and N.G.) agreed that no new codes were identifiable in the data post-wider team meeting analysis.

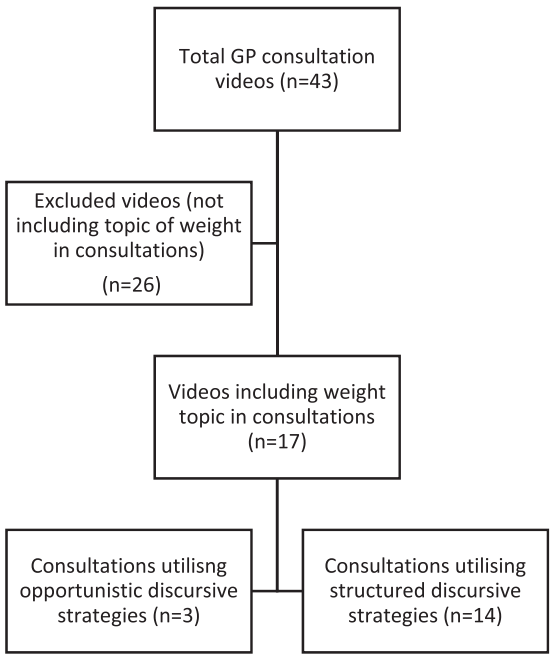

FIGURE 1 | Flow diagram outlining the total number of GP consultations and included videos for analysis.

3 | Results

3.1 | Topic Frequency

GPs initiated the topic of weight in consultations (15/17) more than patients (2/17).

3.2 | Structured or Opportunistic

Weight was raised mostly in a structured way and was linked to the patients presenting health problem. Tables 1 and 2 give some examples of structured and opportunistic ways that the topic of weight was raised within consultations. 14/17 consultations included the topic of weight in a structured manner, and all of these were initiated by GPs. 3/17 were opportunistic discussions, two of these were initiated by patients and one by the GP. Patient post-consultation surveys demonstrated that 15/17 (2 unanswered) patients felt listened to and respected in their consultation.

In many consultations, weight was raised in relation to a GP Management Plan, which was an organized plan for patient healthcare with chronic conditions. This plan includes an assessment of current lifestyle factors and referral to specialists that can help improve patient quality of life, such as dietitians, physiotherapists, and psychologists.

3.3 | Weight Was Raised in Relation to a Presenting or Relevant Health Issue

When weight was raised by the GP, it was always in relation to the presenting health issue or reason for consultation, often as part of a GP Management Plan. Primarily, GPs responded to the patient needs. Some examples included diabetes, blood pressure, and blood sugar test results.

TABLE 1 | Selection of structured examples of GPs raising the topic of weight in consultations.

Structured	
P 06	Consultation context: GP going over GP management plan (overall health check) with patient: *GP 01: How's your weight? I think overall your weight's been coming down.*
P 12	Consultation context: Patient getting blood test results and cholesterol checked: *GP 02: I would like to check your blood pressure [and] I would like to check your weight.* *P 19: Sure*
P 34	Consultation context: Patient presented feeling unwell and the GP is exploring symptoms: *P 34: I finished my last t- tip- get it right. Trulicity on Friday. My injection I finished that on Friday. So I've had four doses.* *GP 04: [Any] weight loss?* *P 34: I think so. According to my pants, yes.*

TABLE 2 | Opportunistic discussion examples.

Opportunistic	
P 14 (GP initiated)	Consultation context: Patient self-reports increase in exercise engagement: *P 14: Yeah, yeah, definitely. Cardio wise. I'm sure I'm getting healthier from that.* *GP 02: Are you losing a little weight too?* *P 14: I have Yeah.*
P 21 (patient initiated)	Consultation for check-up about previous spinal injury surgery: *GP 03: Are there any other questions you want to ask me today?* *P 21: I don't you think so, um...* *GP 03: We covered a lot last time, obviously.* *P 21: Yeah. I might get you to weigh me. I'm curious to see if I'm up or down GP 03: Happy to.*
P 41 (patient initiated)	Consultation for diagnosis of symptoms patient is presenting with: *P 41: And I've also put on a lot of weight in the last couple of months without changing my diet or my exercise and that, just the aging, and then* *GP 03: So without any direct change that you can attribute this to?* *P 41: No I'm really very careful with stuff.*

3.4 | GPs Raised the Topic of Weight in Ways That Ensured the Patient had Autonomy Over the Discussion

GPs predominantly asked for their patients consent to talk about weight in the consultation and created space for the patient to accept or decline talking about weight. This positioning helped demonstrate that the patient was in control of their health consultation:

> GP 03: So you know, I'm just checking that the medical side of [things] and just make sure, can I do your blood pressure today?
> P 43: Yep.
> GP 03: Do you know how your height and weight, do you know what it is?
> P 43: Ah, I haven't weighed myself for a while.
> GP 03: Shall we pop you on and see? Is that alright?
> Patient: Yeah.

GPs demonstrated respect when patients declined referral options for weight management during the consultation. One GP was completing an update on a patient's GP management plan, which included checking in to determine if the patient was to be referred to a dietitian. The patient declined the referral, which was respected by the GP and care plan continued:

> GP 01: Good, that's great. Where did we get to with [dietitian name redacted]? Did we organise for you to see [them]?
> P 05: Yeah, but no.
> GP 01: You don't need it?
> P 05: No.
> GP 01: You know what you're doing don't you.
> P 05: I'm cutting down. My weights coming down. I eat fine.
> GP 01: Exactly.
> P 05: But nah, nah, I don't need that.
> GP 01: And it's the pool that works for you isn't it?

> [patient nods] Yeah. I like that, and your weight is coming down. So- yep! It's beautiful. Love it.

In some cases, patients were happy to include the topic of weight in the consultation; however, the act of being weighed was rejected. The GPs respected these decisions and continued to provide routine care.

When GPs generated space for patient autonomy during consultations, some patients indicated they were open to discussions about their weight; however, they had more urgent health concerns that needed addressing in their consultation. One GP had a patient presenting with menstrual health concerns, where weight gain was included in self-observation of symptoms. While weight was a concern for the patient, the pain and period irregularity issues were more urgent to treat during this consultation and so weight was not discussed any further:

> P 41: So it's [period side effects and weight] something that I monitor daily. And I know that it fluctuates. And um, water retention and all of that, but we're talking about like eight kilos in a couple of months. For me that's just a lot. But obviously, I'm more concerned about the bleeding [and] of the pain.

3.5 | Weight was discussed in positive ways and tailored to the patient's health circumstances and goals

When weight gain had occurred since the previous consultation, GPs did not discuss this as a negative or a failure. Instead, GPs focused on the wider positive aspects of improvement in health risks. Weight was discussed in the context of strength-based, long-term, sustainable weight loss. One patient expressed feelings of not working hard enough to reach their health goals and used self-deprecating language during their consultation. The GP did not reinforce this framing the patient had used. Instead, the GP highlighted that the patient was making positive long-term sustainable progress over time and further supported them with their goals:

> GP 01: So you're 106 kilograms, you've gone down to 101, which might not sound like a lot, but that's the kind of- that's what we want that slow gradual, you know, just bit by bit. So that's great! Let's- I think next goal is to just get it under 100 kilograms? Is that fair?
> P 07: Yep, sure.
> GP 01: [types in GP Management Plan for next time] The goal under 100 kilograms.

Weight was not the sole focus of all obesity management in consultations as GPs worked with patients on lifestyle changes at a pace that was suitable for the patient. One patient identified that having food easily accessible in all rooms of their home was a hindering factor in improving their health and wanted to change this. For this patient, the GP focused positively on their patient's progress toward their behavioral/environmental health goal to remove food from all rooms in their home:

> GP 01: So now 145 kilograms, and that's fine. Now, so you've actually started—oh! and the other thing is we wanted to healthier relationship with food, didn't we?
> P 13: Yeah, so that's more or less.
> GP 01: Yes, starting to get there?
> P 13: So, yeah.
> GP 01: And we've got the food into one room?
> P 13: Almost. Getting there. I only eat in two rooms now.
> GP 01: That's good!
> P 13: Yep.

Another GP focused on the improvement of exercise in their patient's routine and the positive side effects exercise can have on overall health without focusing on weight loss itself:

> GP 02: And I'm very impressed you're keeping all this exercise going.
> P 19: Have to.
> GP 02: It's amazing for both your physical health but also your psychological well-being as we both know. So- I hear you're doing that regularly, that's fantastic.

3.6 | Stigma

Overt stigmatizing language was not found in these consultations; however, there is potential for some language to be perceived as stigmatizing by patients due to their individualistic experiences of stigma.

Language can be received in different ways by individuals. This following example demonstrated the individualized nature of communication in obesity whereby the implication of “fixing” something that was “wrong” could be perceived as stigmatizing language to one patient and not another.

> P 08: I'm not over, not over-eating.
> GP 01: You've fix some things up, haven't you? You got- I think there are some things you removed like coke and things haven't you?
> P 08: I still having my Pepsi Max.
> GP 01: It's the Pepsi Max but Pepsi Max is okay, isn't it?
> P 08: Yes.

In this example, the GP was referring to the patient's prior consult with a dietitian. However, this patient reported being satisfied, heard and respected by their GP in their consultation, which suggests that the language was well received.

4 | Discussion

This study found that when the topic of weight was discussed in GP consultations, it was predominantly initiated by GPs in a structured format that was relevant to the presenting health issue of the patient. These findings offer support for previous research from The Netherlands, New Zealand and Scotland [12, 32, 43] that also found that weight discussions were initiated by GPs more than by patients. Notably, when weight was raised by GPs, this was always in relation to a patient's presenting health issue or part of a routine health check (GP management plan). This study found that GPs were not referring to weight as a health concern unto itself, and instead the patients' health goals overall were the focus of the consultation. Patients reported high levels of consultation satisfaction overall, including feeling heard and respected by their GPs, supporting the varied ways that GPs discussed obesity in the consultations.

The GPs in these consultations seemed to operate in a patient-centered manner by reducing the power imbalance between the GP and patient. The three most significant components of patient centered care are sharing responsibility, the therapeutic relationship and the patient as a person [44], which are all important when addressing a stigmatized health risk such as obesity. One common and useful tactic GPs used for actioning patient centredness in this study was asking patients for consent to speak about weight, include the topic of weight in their consultation, or have their weight measured and recorded during their consultation. This enabled space and opportunity for the patient to accept, reject, or negotiate the extent to which the topic of weight was included as part of their health consultation.

Previous literature had indicated that discussing and delivering weight management healthcare is often a complicated and delicate act, with GPs reporting many barriers [12, 13, 15–18, 45] including patients often blocking attempts to have obesity discussions if raised by the GP [43]. This study found minimal blocking tactics by patients when their GP raised the topic. The post-consultation surveys indicated that these patients felt heard and respected with their GP in their consultations, suggesting that the power imbalance risk was minimized or that the sharing of power was achieved on some level. However, we acknowledge that obesity stigma has been reported to be experienced at public, provider and structural levels and can often go unreported [46] and the representation of patient voice in patient-centered literature is questionable [44]. Ensuring power imbalance is minimized and that patients have autonomy over their health remains a high priority task for future research and implementation efforts.

GPs discussed weight in a way that promoted patient autonomy and minimized the potential for stigmatizing experiences. Previous literature has stressed that some patients who experience stigmatizing experiences avoid future health appointments, further perpetuating the negative health outcomes (regardless if related to weight or not) [10, 26, 28, 47]. The consultations in this study demonstrated GPs promoting patient autonomy in their own health journey by asking patients what their health goals were, working with patients to facilitate their health goals, and working at a pace that suited each individual patient. The recent Health at Every Size approach of moving away from traditional weight-centered care to a more holistic weight-neutral form of healthcare has been indicated to improve obesity health outcomes long-term and reduce the potential for stigmatizing experiences [14, 48, 49]. GPs in this study consistently focused on positive factors, behaviors, or overall health improvements relevant to each patients' individual circumstances.

This study found no overt discourse or behavior from patients to indicate obesity stigma was present; however, stigma is reported to sometimes be covert, internalized, structural and perceived differently by individuals [10, 28, 46, 47]. Stigmatizing experiences are reported to have significant social (reduced interaction), behavioral (unhealthy coping mechanisms), emotional (feelings of shame, self-blame, depression, anxiety), and physiological (chronic stress) impacts on the overall health and well-being of someone living with obesity [46]. Post-consultation surveys did not include a stigma-specific question and therefore no stigma conclusion can be made in this study. However, post-consultation surveys found that 15/17 patients (2 did not answer) reported feeling heard and respected by their GP in their consultations, which supported and indicated a positive patient experience. Patient-centered care exhibited by GPs in this study was found to contribute to a positive therapeutic relationship, which is considered paramount for long-term patient health improvements and reducing stigma [50]. Future research should look to explore the intricate involvement of obesity related stigma in real world health consultations both within and beyond general practice, and include the patient voice more explicitly.

The consultations in this study were only a snapshot of multiple GP-interactions over time and can only be viewed in isolation. The longitudinal nature of general practice care means that these snapshots might not have captured weight related consultations with the same patients at different time points. These recordings occurred during the height of the COVID-19 lockdown restrictions in Melbourne and these restrictions could have impacted the types of consultation discussions that were priority at the time. In addition, concerns about the "Hawthorne Effect" [51] are often raised with recorded consultations with the potential for altered behavior by participants due to the awareness that they were being recorded. However, a previous US primary care study [52] found little Hawthorne effect from an in-person observer and another [53] audio-recorded study identified there to be no significant Hawthorne effect on doctor-patient communication, confirming the valuable contribution of real-life recordings for empirical research. This study specifically analyzed the verbal mention of the topic of patient weight and potentially, the topic of weight or obesity could be implied in other consultations but not explicitly discussed.

This research demonstrated that there were a myriad of ways for GPs to approach weight discussions with their patients in a personalized and tailored manner. This study highlighted that both structured and opportunistic strategies for discussing weight could be effective but should be tailored to each patient's health needs and personal obesity related health goals or circumstances. GPs could be better equipped and supported in their role with training in diverse communication techniques for the topic of obesity. The findings in this study serve as a foundation for establishing education and training resources for GPs to use in their practice when discussing weight with their

patients. The education and resource support for GPs could be utilized as a way of continuing professional development. Future development of any obesity conversation techniques should consider motivational interviewing, empathetic listening, obesity stigma, cultural background, social determinants of health, foster supportive strength-based dialog, and work in a collaborative goal-setting manner with patients. In addition, these resources should be co-designed with obesity lived experience experts [54] to ensure they will be appropriate and maximize healthy communication practices that avoid stigma or perpetuate further harm for patients living with obesity.

This study explored naturally occurring GP-patient consultations to identify how the delicate and stigmatized topic of weight is discussed. Most discussions were GP initiated, structured, patient-centered, respected the autonomy of the patient, used language that minimized the potential for patients experiencing stigma, and focused on overall positive health gains relative to each patient.

Author Contributions

Kimberley Norman: writing–review and editing, writing–original draft, visualization, validation, methodology, formal analysis, data curation, conceptualization. **Neha Giri:** data collection, preliminary analysis. **Nilakshi Gunatillaka:** writing–review and editing, analysis, project administration, methodology, funding acquisition, conceptualization. **Kellie West:** writing–review and editing, analysis. **Divya Ramachandran:** writing–review and editing, analysis. **Elizabeth Sturgiss:** conceptualization, methodology, analysis, writing–review and editing, supervision, funding acquisition.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data for this research is in a data repository (Digital Library, Monash University). This research data includes sensitive and confidential information including patient data and identity through video recordings. Participants have not consented their data to be accessible publicly. Access to this repository is available but restricted to ethical and institutional guidelines around research and usage.

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