

REVIEW

Clinical Management

Barriers to obesity health care from GP and client perspectives in New Zealand general practice: A meta-ethnography review

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Summary

Obesity is a complex international health concern affecting individual quality of life and contributing to an unsustainable strain on national health systems. General practice is positioned as best suited to deliver weight management health care, yet, obesity rates remain high suggesting barriers are experienced within this space. The aim of this review is to synthesize general practitioner and client perspectives of weight management to identify barriers experienced in New Zealand general practice. Six databases were searched resulting in eight articles being included in this review. This interpretive synthesis was guided by principles of meta-ethnography and grounded theory. Four overarching themes were identified from client and general practitioner perspectives: stigma, communication, inadequate health care (system limitations for general practitioners and lack of tailored advice for clients), and sociocultural influences. These four barriers were found to be interdependent, influencing each other outside the general practice context, highlighting the intersectionality of weight management health-care barriers and further complicating effective weight management within general practice. Clients reported wanting tailored, non-stigmatized, effective weight management health care, yet, general practitioners reported being ill-equipped to provide this due to barriers both within and outside the limits of their practice. General practice requires more systemic support to deliver effective weight management including public health campaigns and indigenous health information to reduce health inequities. An appraisal of general practice being “best suited” to deliver effective weight management health care that is culturally appropriate is urgently required to improve obesity related health outcomes in New Zealand.

KEYWORDS

general practice, obesity synthesis review, primary care, weight management

1 | INTRODUCTION

Obesity is a significant health issue with 650 million adults worldwide classed as obese,¹ and New Zealand (NZ) ranked the third most obese

Abbreviations: BMI, body mass index; GP, general practitioners; MOH, Ministry of Health; NZ, New Zealand.

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nation in the Organization for Economic Co-operation and Development.² Obesity is a risk factor for several other physiological and psychological health conditions^{2,3} which further impact an individual's health. Obesity and obesity comorbidity rates are linked to low quality of life,⁴ and many also draw links between escalating obesity rates and economic strain on national health systems, such as via health care demand and a loss of productivity.⁵⁻⁸ From a national health system perspective, obesity and obesity-related comorbidity costs in NZ are estimated at \$624 million.⁵ This is recognized as an unsustainable economic strain,² resulting in the national health system having a vested interest in providing effective weight management interventions for those living with obesity. Obesity in NZ is recognized as a significant equity issue with Indigenous Māori, as well as Pacific and rural populations experiencing higher obesity rates and poorer health outcomes.⁹

Over 34% of NZ adults are classified as obese, with Indigenous Māori and Pacific populations experiencing 51% and 71% obesity rates, respectively.⁹ Obesity is a significant health issue despite being considered a preventable and treatable health concern through weight management interventions within and outside of general practice.¹⁰ The Ministry of Health (MOH) positions general practice health-care professionals, including general practitioners (GPs) as best suited to deliver weight management health care due to the frequency with which they see their patients (hereafter referred to as clients)^{11,12} and their capacity to assess, measure, intervene, and monitor the weight of clients in their practice.¹⁰ There are some weight loss interventions available in NZ general practice;¹³ however, these are limited in their efficacy¹³ and effective weight management requires a combination of dietary changes, exercise engagement, and behavior changes actioned in culturally appropriate ways.¹³

Previous literature has highlighted that effectively delivering weight management interventions has been challenging for GPs.¹⁴ Barriers reported in overseas literature include ineffective communication strategies, differences in perspectives of the role and responsibility of a GP in the obesity management process, the stigmatization of obesity in society as well as within the health system and its associated workforce, the perceived lack of motivation of clients to lose weight, the normalization of obesity, social determinants of health, and health-care system limitations.¹⁵⁻¹⁸ Despite the availability of interventions in NZ general practice, obesity rates are continuing to rise across all ethnicities in NZ. With obesity regarded as a complex health concern, so too is obesity management, indicating that potentially there are unknown barriers to effective weight management in the NZ general practice space. There is no clear understanding of the barriers faced by GPs in delivering weight management health care to the unique and culturally diverse NZ population. In addition, effective health care for indigenous populations around the world include the vital component of being culturally appropriate, yet there is limited understanding of obesity management in general practice from a Māori worldview,¹⁹ or from that of other vulnerable populations including Pacific and rural, despite experiencing significant health inequities and barriers to health-care services.^{20,21}

While some literature exists in countries that have lower obesity rates and lower strain on national health systems or economies, there is minimal understanding of weight management health-care perspectives in NZ despite being the third most obese nation worldwide. While a limited cadre of qualitative literature exists on weight management health care in general practice from either the GP or client perspective in NZ, there are no NZ studies that bring these perspectives together. This novel study aims to fill this knowledge gap and synthesize GP and client perspectives in an effort to identify barriers to weight management health care in NZ general practice.

2 | METHODS

This review was executed in three stages: identification of studies through database searching; content extraction and critical appraisal; and synthesis of extracted content. Six major electronic databases were searched for peer-reviewed papers: Scopus, PubMed, Web of Science, APA Psych Net, Google Scholar, and AlterNative with no date restriction. Keywords used in the search strategy were variations of “obesity,” “overweight,” “obese,” “weight,” “general practice,” “primary care,” “GP,” “clinician,” “doctor,” “barrier,” “perspective,” “attitude,” “view,” “belief,” “experience,” “client,” “patient,” “opinion,” and “New Zealand” with no date restrictions.

Inclusion criteria comprised the following: original research that focused on the health-care barriers from health-care professionals or client perspectives; based on primary care or general practice; published in English language; have a NZ adult sample aged 25–64; and have a qualitative component. While the role of nurses in weight management is important and recognized, the focus was on general practice which includes a multidisciplinary workforce of nurses, doctors, health coaches, health improvement practitioners, and kaiawhena (Māori advocate) in some practices. Therefore, the search terms “general practice” and “primary care” were used as well as “GP” and “general practitioner.” While three papers were identified through this search that included a primary care nurse perspective, none of these papers met the other criteria for inclusion. Articles were included (and data extracted) if they had components that addressed barriers to weight management health care in general practice, even if the research was not solely focused on barriers.

This interpretive synthesis was guided by the principles of meta-ethnography²² and grounded theory²³ to identify emerging themes. First, each article was read to understand the first order constructs (participants' direct quotes and study designs) and re-read multiple times to permit familiarity with the reported barriers. Second order constructs (authors' interpretations and identification of barriers) were grouped into themes for reciprocal translation. Analysis was loosely guided by grounded theory, to enable novel themes from the data to emerge and identify the key barriers faced by GP and clients in the general practice context.

3 | RESULTS

Figure 1 highlights the literature search process for this study with a total of eight articles found that fit the criteria for this review. Four studies were found with a focus on the GP perspective of weight management health care in general practice.^{24–27} Four studies were found with a client perspective,^{28–31} although these were not solely focused on weight management in a general practice context. One of these four client articles was specific to the Indigenous Māori culture of NZ (Kaupapa Māori design) whereby Māori worldview governs the research.³¹ Table 1 shows the details of the included studies in this review.

This review found four overarching barriers to weight management health care existed from both client and GP perspectives. Table 2 shows the first and second order constructs that formed the themes used for reciprocal translation detailed below. The four barrier themes were stigma, communication, inadequate health care (system limitations for GPs and lack of tailored advice for clients), and sociocultural influences. While these barriers influenced the general practice context in isolation, they were also found to overlap with each other, highlighting the interconnected nature of these categorical barriers, creating an interdependent system of barriers to effective obesity management. The intersectionality of these four barriers on weight management health care is reported below.

3.1 | Stigma

Clients reported experiencing obesity stigma both within and outside of the general practice context. In some cases, stigma reported outside the general practice context²⁹ seeped into health-care interactions. The latter was perceived as a barrier to accessing further health care in general as well as weight management.²⁸ Being obese was associated with feelings of social embarrassment, shame, or being perceived as having additional character flaws such as being lazy or stupid.²⁸ Other stigma examples included use of inappropriate humor from physicians, verbal insults, negative body language, breaches of dignity, and unmet health care needs (due to their obesity status and active avoidance at stigma inducing situations).^{28,29}

GPs reported an awareness of obesity stigma and positioned the latter as a barrier to providing effective weight management in their practice.³¹ GPs actively attempted to avoid stigma in their consultations in an effort to not offend their client or create an imbalance in the doctor–client relationship.²⁵ While stigma avoidance was reported to be important, achieving this was difficult and specific conversational tactics were used. These included use of clinical relevance as safe or neutral conversational territory²⁴ to justify bringing up a client's weight during consultation²⁵ and framing obesity as a non-discriminatory health concern affecting blood pressure or risk of diabetes from sugar levels in the blood.²⁵ These stigma avoidance techniques reportedly helped create constructive

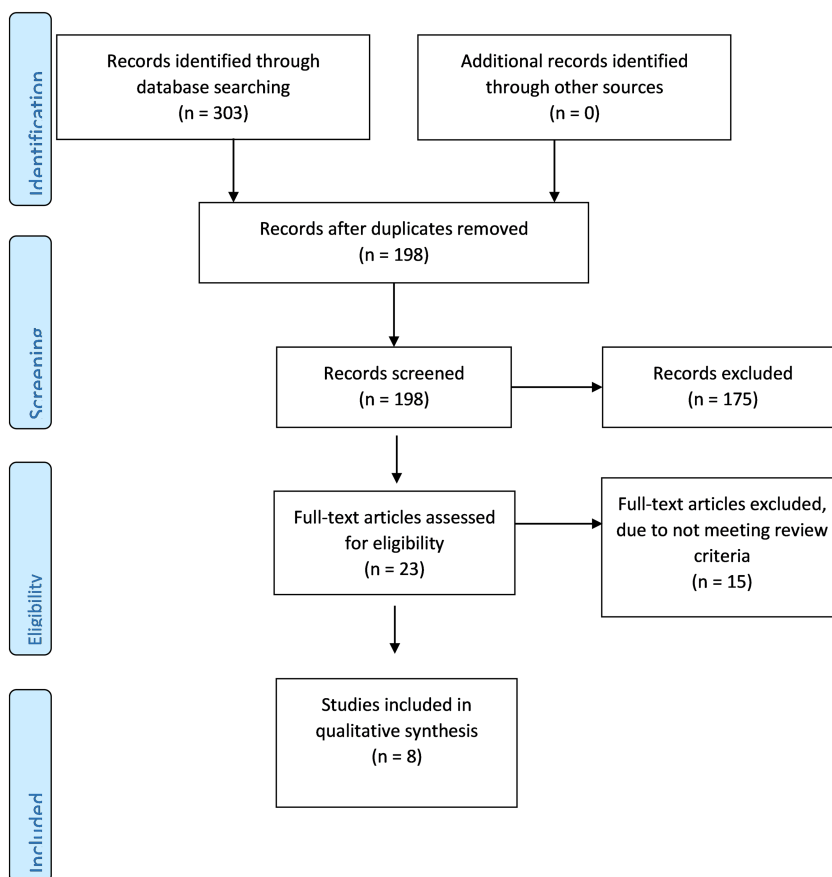


FIGURE 1 Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) 2009 flowchart diagram

TABLE 1 Studies included in this review

Paper	Aim	Methodology	Sample	Findings	Barriers
Gray et al. (2018)	To identify communication strategies used by GPs to open the topic of weight and weight management in routine consultation	Secondary analysis of video recorded consultations. Content and interactional analysis conducted in context of entire consultation	n = 36 Gender: 20 male, 16 female Age: 20–89 Ethnicity: NZ European, Maori Pasifika and Asian	Weight discussion was initiated by GPs more than clients GPs employed opportunistic strategies twice as often as they used structured strategies	Communication Stigma
Swinburn et al. (1997)	To assess the attitudes and perceptions of GPs towards the practice of writing green prescriptions (exercise intervention)	Qualitative design and analysis through structured focus groups	n = 25 Gender, age, ethnicity not specified	GPs felt comfortable discussing and prescribing exercise with and to patients. Time constraints, resource, and training required for successful implementation.	Time Resources
Claridge et al. (2014)	To identify GP opinion on weight management interventions	Qualitative study using inductive thematic analysis of semi-structured interviews	n = 12 Gender: 7 male, 5 female Age: 31–60 Ethnicity: Not collected	Five key themes found: What the GP can do; The roots of the obesity problem; Why the GP does not succeed; Primary care interventions; and Bariatric surgery	Normalization of obesity in society Client issues Lack of efficacious interventions Low resource availability Stigma
Patel et al. (2011)	To identify why GPs counsel for Green Prescription and examine GPs views and experiences of Green Prescription counseling for the management of depression	Qualitative design using an inductive thematic response from face-to-face interviews	n = 15 Gender: 10 female, 5 male Age: 36–64 Ethnicity: Not specified	GPs prescribed Green Prescription for primary preventive (e.g., weight control) and secondary management (e.g., diabetes management) purposes. Time constraints within the consultation was identified as a barrier. Green Prescription was viewed as beneficial for depression management	Time
Russell & Carryer (2013)	To explore "Large Bodied" women's experiences of accessing New Zealand-based general practice services	Descriptive, qualitative inquiry with post-structural feminist lens. Semi-structured interviews were analyzed thematically.	n = 8 Gender: All Female Age and ethnicity not specified	Negative stigmatizing experiences were reported, concerns about feeling "safe" to access care, participants were reported to be aware of their "inferior" positioning in society that values thinness.	Stigma Sociocultural influences Communication
Doolan-Noble et al. (2019)	To link the weight management experiences of these men in primary care, with their experiences of life in general as big men	Qualitative design using semi-structured interviews and coded against priori codes	n = 14 Gender: All male Age: Not specified Ethnicity: 12 NZ/European, 1 Samoan, 1 Tongan	Social consequences of obesity, stigma, and tailored communication were found to be relevant to primary care experiences. Gender-specific health care lacking	Sociocultural influences Stigma Communication

TABLE 1 (Continued)

Paper	Aim	Methodology	Sample	Findings	Barriers
Dean (2007)	To explore the attitudes and subjective experiences of those who received Green Prescription	Nested qualitative study within mixed methods approach using semi-structured interviews and an inductive approach to identify themes	n = 15 Gender: 6 male, 9 female Age: 43–78 Ethnicity: 11 NZ European, 4 Maori	Four themes emerged: tailoring of advice given; barriers to physical activity and psychological limitations; internal motivators including spiritual benefits; and role of significant others	Tailored advice Internal motivations Time Sociocultural influences Environment
Forrest et al. (2016)	To evaluate the effectiveness of a 9-week group exercise initiative that promotes physical activity and focuses on fat loss in order to reduce obesity in Maori.	Kaupapa Maori mixed methods. Qualitative part used for this review. Online focus group and interview with trainer analyzed	n = 13 participants and 1 Trainer Gender/Age not detailed for qualitative section of study	Maori practices (whakawhanaungatanga) is of the utmost importance for success of health initiatives	Psychological and physical motivations Time Sociocultural influences

conversations that potentially led to health improvement while avoiding negative reactions from the client.²⁵

3.2 | Communication

Clients reported a range of communication barriers between them and their health care provider. These included difficulties in raising the topic of weight with their GP, inappropriate²⁹ terminology used by their GP, unsatisfactory advice given about how to manage their weight²⁹ or not being advised about useful strategies or tools to manage their weight,²⁸ inappropriate style of communication from their GP, not feeling “heard” by their GP, or having their health concerns dismissed as related to their excess weight.²⁸ Some clients reported negative experiences and stigma with communication in general practice²⁹ as well as the need for sensitivity and culturally appropriate weight management advice, especially for Māori clients.³¹ These communication barriers led to some clients purposefully disclosing only selected health concerns²⁸ to their GP to avoid communication focused solely around their weight.

GPs also reported communication as a barrier to providing effective weight management health care in their practice. Raising the delicate topic of weight management,²⁵ discussing intervention options with the client, framing the clinical relevance of why weight is being raised, and avoiding stigmatization when asking questions were all factors that were found to be challenging.^{24,25} Opportunistic conversation tactics were used twice as often as structured tactics, and useful discourse was positioned as questions that were neutral, indirect, or open-ended.²⁵ Highlighting the clinical relevance of weight management was suggested as being an effective technique during discussions²⁵ and helped with GPs avoidance of offending their client.^{24,25}

3.3 | Inadequate health care (client: lack of tailored advice/GP: system limitations)

Clients reported a lack of appropriate tailored advice as a barrier to effective weight management. Some clients expressed that they wanted clear straightforward weight management help from their GPs.²⁹ Yet, the advice they received was inadequate, unsatisfactory, unhelpful,²⁹ not culturally appropriate³¹ or directly relevant to their individual needs,³⁰ which negatively impacted their experiences with weight management interventions. A failure to consider health “holistically” (with the inclusion of cultural and spiritual components)³¹ to attend to gender-specific weight management issues²⁹ and tailor advice to the challenges facing individual clients was reported to impact the likelihood of clients adhering to exercise in any lifestyle intervention.^{30,31}

GPs reported that system limitations acted as a barrier for providing effective weight management health care as the systems in place were inadequate for their clients' needs. GPs expressed a desire to want to provide help with weight management to their clients, but they lacked faith in the available general practice weight interventions

TABLE 2 First-order constructs, reciprocal translation of second-order constructs, and themes

First-order constructs	Second-order construct	Theme
Clients		
<i>[Assumption]it's that lazy thing, that you are greedy, gutsy, stupid. (Angela)²⁸</i>	Weight bias experiences (e.g., negative insults and humor, negative body language, dismissal, unmet needs) ²⁸	Stigma
<i>You're always sweating away when ... everyone else is sort of sitting around relatively comfortable ... and you think, oh god this is not good, ... so there's that sort of social embarrassment. (Participant 4)²⁹</i>		
<i>I choose not to go for certain things. I will avoid anything that will expose my imperfect body or go to the utmost extreme lengths ... smears and all that exposing type thing unless I really have to. Probably it's due to the fact of how many bad times I've had with people that I just do not feel comfortable ... you are constantly looking for responses. (Loreen)²⁸</i>	Avoidance of future health-care appointments due to previous humiliating experiences and negatively "labelled" in and out of general practice ^{28,29}	Stigma
<i>We know what needs to be done we just do not know how it's going to be done. (Participant 7)²⁹</i>	Lack of effective or clear communication within the GP-client relationship or not feeling "heard" by their health professional ^{28,29}	Communication
<i>If you aren't going to listen to me, then why should I listen to you? (Angela)²⁸</i>		
<i>They do not give you a lot to resolve the issue if you desire. I have asked several times for assistance with my weight issue and have not really been given the solution or tools that I need to help with that. I think they are too scared to approach it and do not know how to approach it without being negative or scaremongering. (Selina)²⁸</i>		
<i>It got to the point that everything about you was your weight. Whether you were sick, whether you went in for something like an infection on your leg - everything was about the weight. (Angela)²⁸</i>	Selectively disclosing health concerns to avoid their concerns being "dismissed" by GP as being "weight focused" ²⁸	Communication
<i>They do not come up with any b****y great ideas with what I can do about it, they, you know they have a bit of a moan and away you go. Mmm. (Participant 9)²⁹</i>	Unsatisfactory and unhelpful advice received from GPs ²⁹	Inadequate health care
<i>Just do not see the medical part of the person, of course that's what you are there for, but you have got to see the whole person first before you see what you are trying to "fix," because a lot of its combined I reckon, well it's all combined really. (Monica)²⁸</i>	Lack of tailored gender specific advice, "holistic," cultural/spiritual, or social support advice relevant to the individual ²⁹⁻³¹	Inadequate health care
<i>Being involved with you and the Green Prescription made me somewhere along the line pull myself together, mind body and soul, so I healed fast. Christine, 51 years, rural Māori³⁰</i>	Barriers to physical activity such as weather, physical environment, time, health, and psychological limitations ³⁰	Sociocultural influences
<i>[Barriers were] Put it off tomorrow, all the usual ones. It's too cold, it's too wet.' Kevin, 71 years, rural European³⁰</i>		
<i>'No barriers except my own mental state ... cannot be bothered today, I'm not going to.' Margaret³⁰</i>		
<i>"I think that personal responsibility ultimately, ... you are responsible for your body, that is the bottom line. However, the way that you think about what you put in your mouth is influenced by all sorts of messages that you get from the environment around you. (Participant 13)²⁹</i>	Difficult to make healthy food choices in an obesogenic environment that makes (unhealthy) food "quicker and easier" to access ³¹	Sociocultural influences
<i>Physically I was up to it; mentally I wasn't. I fell off about four weeks into the Hinu Wero mainly because I think grabbing stuff to eat was too easy and I suffered mentally as it got easier to eat all kinds of food. It was hard to get back into routine" (P1, male, 44)³¹</i>		
GPs		
<i>If we can control the, the sugar levels and your weight we, er, could actually control that blood pressure too. (DS-GP20-01)²⁵</i>	Avoiding stigma during consultation to avoid negative reactions from patient or damage GP-client relationship ²⁵	Stigma

TABLE 2 (Continued)

First-order constructs	Second-order construct	Theme
<i>Our practice is predominantly Māori and there's this issue of whakamā, or shame around being seen to be unhealthy and overweight. (GP 8)²⁴</i>		
<i>Being obese has a whole lot of medical implications. It's got tons of social implications but it's the medical ones that we tend to. We are on safe ground I suppose with medical implications. (GP 2)²⁴</i>	Utilizing the clinical relevance of obesity to not offend their client and avoid stigmatization ²⁵	Stigma
<i>[Opportunistic discussion] It's been a few years since we checked for glucose f- for diabetes and you know with you being overweight we ought to maybe review that again. (TS-GP03-12)²⁵</i>	Structured conversation tactics more difficult to use than opportunistic conversation tactics during GP-client discussions ²⁵	Communication
<i>Using indirect language: Now, s- some people manage to control the diabetes just by doing very good exercise and by eating a very healthy diet. (DS-GP24-03. GP)²⁵</i>	Challenging to have weight management conversations which are constructively progressed, no single "best way" for discussion ²⁵	Communication
<i>Open ended and neutral question used by GP: Weight wise where do you think you are at?²⁵</i>		
<i>Medication Intervention: I do use it a bit, but very uncommonly now. I find them all pretty useless ... we have all been through them all over the years. (GP 6)²⁴</i>	GPs general lack of faith in the efficacy of primary care interventions, no unanimous intervention identified as "successful" ²⁴	Inadequate health care
<i>I say to patients 'exercise has got many, many health benefits'. I think compared to the appropriate dietary changes, it's pretty lousy as a weight loss intervention. (GP 11)²⁴</i>		
<i>[Lack of] Time! Because patients generally have quite complex problems and multiple problems. (GP 7)²⁷</i>	Time constraints, system barriers (lack of resources for GPs) ^{24,26,27}	Inadequate health care
<i>It's either publicly you do not fit the very restrictive criteria, or privately you do not have the money to go [for bariatric surgery]. (GP 3)²⁴</i>		
<i>They [clients] had visitors from their family who told them to change their doctor because 'since you have been seeing that doctor you do not look well' and that their perception was that losing weight was equated with sickness. (GP 3)²⁴</i>	Overweight is seen as "normal" in society (therefore not needing "treatment") ²⁴	Sociocultural Influences
<i>Poorer areas do not have the same number of sports and recreation facilities as more affluent areas. And yet we know the obesity epidemic is worse in poorer areas. (GP 8)²⁴</i>	Obesity driven by both societal and individual factors (outside GP context) such as obesogenic environment and rooted in client's personal issues ²⁴	Sociocultural influences
<i>Physically they are doing well. It's these other areas like the mental and the social and I think that as a trainer if we can train ourselves within these areas then we can work with the whānau in areas that they are lacking³¹</i>		

with some options described as "useless" or "pretty lousy."²⁴ Barriers included low resource availability, lack of efficacious interventions, wide variations of interventions, lack of comprehensive training, and ranging opinions of the national weight management guidelines and bariatric surgery options.^{24,26} Time constraints were reported to be a significant barrier to referring their clients to the Green Prescription (exercise intervention)^{26,27} whereby GPs expressed that they see clients with a range of complex problems leaving minimal time for weight management to be addressed.²⁷

3.4 | Sociocultural influences

Those living with obesity reported that sociocultural factors acted as barriers to adhering to chosen weight management programs. Adhering to healthy lifestyle options was found to be psychologically challenging

and influenced by a range of environmental factors, cues, or triggers.²⁹ Specific barriers to physical activity engagement were reported to include individual factors (such as time, physical health, or psychological limitations) and external factors (weather and facilities).³⁰ Additionally, a lack of time management and routine also acted as a barrier to healthy decision making, whereby the ability to access unhealthy food quickly was "too" convenient.³¹ Cultural values were crucial for effective weight management, specifically for the Māori population³¹ as well as one Pacifica client reportedly wanting to avoid social contexts to avoid their family commenting about their excess weight.²⁹ Overall, the reasons for adherence and non-adherence were found to be individualized, complex, and outside of the general practice context that offered the weight management health "intervention."

GPs also reported that sociocultural factors outside the general practice context acted as barriers to providing effective weight management health care. These barriers included the links between

obesity and poverty, perception of clients cultural “norms” whereby weight loss was associated with illness,²⁴ or social pressures whereby some of their clients lived in sociocultural contexts that perceived obesity to be associated with concepts of “shame.”²⁴ GPs reported an overall sense of disempowerment with regards to their ability to carry out their role effectively when it came to obesity management in sociocultural contexts where “obesity” was viewed as “normal.”²⁴

3.5 | Intersectionality of barriers

These four barriers were found to act interdependently highlighting the intersectionality of these categorical barriers. This includes the interconnectedness of stigma and communication, stigma and sociocultural influences, communication, and inadequate health care, as well as sociocultural influences and inadequate health care. This intersection of barriers makes effective weight management more difficult for GPs to deliver. This synthesis explains how these barriers were found to interact and impact negatively on weight management health care in NZ general practice.

Communication was found to influence, and be influenced by, stigma and inadequate health-care barriers. While obesity stigma is experienced in a variety of ways throughout many facets of an individual's life,³² the subjective or constructed nature of the “obesity” definition³³ and the embodiment of an “obese identity”³⁴ can also vary in different sociocultural contexts, which further complicates the GPs role when consulting a variety of clients daily. Stigma avoidance behavior consequently causes communication breakdowns, whereby GPs are receiving limited health information from their clients, which increases the likelihood of unmet health care needs for clients. There is a need to remove stigma stemming from “obesity” in the general practice context that can then ensure open, honest communication between the client and their GP, which will contribute to making sure all health care needs are met.

Sociocultural factors outside the general practice were found to influence, and be influenced by, stigma and inadequate health-care barriers. GPs and clients reported that the efficacy of the weight management interventions available in general practice¹⁰ was influenced by other factors such as the obesogenic environment³⁵ and sociocultural norms, including Māori cultural worldview for participants who identified as Māori.^{31,36,37} Sociocultural norms and stigma dictate how “obesity” is constructed and “managed”^{33,36} within different populations. This intersection of barriers to obesity management is unique to each individual that further limits the efficacy of the minimal and non-tailored interventions available for GPs to refer their clients to. This intersectionality of obesity,³⁸ when combined with the western sociocultural norm of “political correctness”³⁹ makes, at this point in history, “best practice” for GPs complex with their need to provide weight management health care while simultaneously avoiding stigma or damaging their therapeutic relationships. While GPs are well versed in the biomedical knowledge of obesity, and clients are well aware of the social determinants of health impacting their weight management, improving health literacy for both GPs and clients would be beneficial for general practice. There is a need for clients to be informed that GPs addressing

weight in consultations is a regular part of a health check-up and GPs need to be systemically supported in avoiding stigma and cultural offence when addressing health care needs in general practice contexts.

4 | DISCUSSION

This study synthesized the barriers to weight management health care in general practice from GP and client perspectives in NZ. Four overarching barriers were identified: stigma, communication, inadequate health care (system limitations/lack of tailored advice), and sociocultural influences. It was surprising to find that both GPs and clients experienced similar barriers, indicating that there is some shared ground between these different groups. These barriers align with previous international literature that also identifies multi-levelled barriers to weight management in general practice, including stigma, communication, clinical and non-clinical factors, and sociocultural norms.^{16,37,40–43}

This review also shed light on the intersectionality of obesity management barriers, with four barriers also acting interdependently outside general practice further adding to the complicated web of barriers GPs are faced with. This intersectionality factor was a novel finding for this NZ review, although it is not surprising given the World Health Organization and MoH consensus that obesity and weight management care is complex and multifactorial.^{1,2} Overall, this review found that clients sought tailored, non-stigmatized, effective weight management health care, but GPs reported being ill-equipped to provide this due to barriers both within and outside the limits of their practice.

This review found that the perspective on “obesity” differed between GPs and clients. While attempting to find a unanimous definition of “obesity” that covers objective and subjective perspectives seems near impossible, there is potential to find some common ground within the general practice context. Similar to the previous smoking cessation health campaigns seen in NZ,⁴⁴ setting the expectation that weight management will be addressed in every consultation could assist desensitizing the weight discussion, creating an emotionally and culturally safe environment for the client, and minimize the risk of clients not disclosing a complete picture of their health to their GP, therefore avoiding further health issues.

Due to the multi-levelled nature of obesity, this campaign would benefit from including systemic support for GPs that incorporates education on appropriate conversational styles to use during weight management discussions. This would also assist with reclaiming the obesity discourse within the general practice context as a clinical health concern free from stigma or offence, which is also relevant for other countries experiencing the same barriers. Systemic support would also need to include culturally appropriate understandings so that both indigenous and non-indigenous populations will benefit. In addition, GPs could be supported to expand the weight discussions beyond the clinical definitions demarcated by the body mass index (BMI) to find common ground with their clients who do not subscribe to this arguably flawed BMI tool.^{45,46} This could include discussions around intersectionality of obesity and potential social determinants of health the client might be experiencing that are impacting effective weight management strategies.

With over 10 million adult GP consultations every year in NZ alone,⁴⁷ restructuring and normalizing weight discussions within this context could lead to less stigma experiences, more effective communication, increased health outcomes for clients, and increase the effectiveness of weight management health care in general practices worldwide.⁴⁷

This review found significant system and interactional barriers to weight management care. Time constraints, lack of effective interventions and resources, communication breakdowns, and obesity stigma made the role of the GP difficult, which aligned with previous literature^{14–16} and indicates the NZ population experience similar barriers to those faced overseas. The pervasiveness of the barriers found in this study was unexpected and suggests that the orientation of general practice as best positioned for weight management care be appraised. With similar barriers experienced from both GP and client perspectives, there is an ability to mitigate these in the future as there is already a level of shared difficulties.

This study highlights that further resources are needed to support GPs both within and outside their practice to provide effective weight management health care, otherwise any attempts to help their clients would be futile. Public health campaigns, culturally appropriate understandings of weight management, along with increased quality of intervention and referral options available within general practice would assist with mitigating some of these barriers. Culturally, specific barriers within and outside general practice would also need to be addressed for any future health improvements to be effective. There was no Pacific Island, and only one indigenous Māori study that was eligible for inclusion in this review, despite being reported as high-risk populations for obesity. This lack of literature further highlights the health inequities that need to be urgently addressed so general practice can provide appropriate and effective obesity related health care to those in most need.

Like any review, this study is subject to publication bias and time lag. Further limitations are the inclusion of English only, exclusion of gray literature, and secondary care. Surprisingly, there were only eight articles found to fit the criterion for this review (with one indigenous focused Kaupapa Māori article and no Pacific literature) despite NZ's significant obesity health issue.² The heterogeneous nature of the studies made this synthesis difficult. Although qualitative research cannot be generalized, the authors of these articles draw on empirical methodologies, and while the study size was small and samples varied, it enabled an examination of each study's contexts, which is a strength of meta-ethnography.⁴⁸

This review sought to identify and synthesize GP and client perspectives of barriers to obesity management in general practice. This review found four key barriers (stigma, communication, inadequate health care, and sociocultural influences) that interdependently impacted the efficacy of weight management in general practice. Clients reported wanting effective weight management advice, but GPs reported an inability to provide effective options. Mitigating these barriers is possible as both groups experienced similar barriers within the general practice context. More resources, support, and training are needed for both GP and clients with regards to weight management. Clients could be better informed about the health-related issue of obesity in the general practice context, and GPs could benefit from understanding the more sociocultural “lived” experience of obesity, as well as

reducing stigma through public health campaigns. An appraisal of general practice being “best suited” to deliver weight management health care is suggested, as this study found this concept questionable.

New Zealand is currently embarked on major health reforms which include an emphasis on reducing inequity for our high needs populations and a greater focus on health promotion and prevention. This review demonstrates the opportunities for general practice to develop further innovative programs including the involvement of the whole primary care team and with a focus on culturally appropriate programs for Māori and Pacific clients as well as tailored programs to suit the needs of rural clients.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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