Journal of Health, Medicine and Nursing
ISSN 2422-8419 An International Peer-reviewed Journal
Vol.46, 2018

A Qualitative Survey Study in Managing Patient Obesity for Exploring Self Efficacy among Saudi General Practitioners

Dr. RADHI NASSER S ALKUBAIDAN
Dr. ABDULMAJEED AHMED D ALSAIDAN
Dr. Sulaiman Zayed Alamri
Dr. Mohammed Mons Alruwaili

Abstract
This study aimed at investigate the management of obesity patients for exploring the self-efficacy among Saudi general practitioners in a qualitative survey methodology, by conducting interviews that were recorded digitally and transcribed verbatim by a professional transcription service. DE identified data were transferred into NVivo 10 for data organisation and coding. Data were analysed independently by the researchers and coded using social cognitive theory as a guiding framework. Twenty GPs recruited via a snowball sampling strategy to deliver a pilot of an obesity management program ("The Change Program") participated in semi structured interviews before commencing the pilot. Of the 20 participating GPs (twelve males and eight female), ages ranged between 33 and 55, and years working in general practice ranged between 5 and 25. The Interviews were face-to-face and were conducted in June and July of 2017. The study concluded that shifting the frame away from weight loss per se and towards these other goals might therefore allow for a more authentic GP-patient interaction and increase the self-efficacy of both GP and patient for healthy lifestyle changes.

1.1 Introduction

The prevalence of people who are overweight and obese is rapidly increasing in the Kingdom of Saudi Arabia. There are many health risks and associated comorbidities including hypertension, diabetes, ischemic heart disease, gallstones, osteoarthritis and malignancy (Fogelman, Vinker, Lachter, Biderman, Itzhak & Kitai, 2002). Globally, the prevalence of overweight and obese children and adolescents has reached epidemic proportions (World Health Organization [WHO], 2015).

The latest statistics on the incidence of overweight and obesity in developed and developing countries indicate the seriousness of this issue. For instance, in developed countries, within the European region, a study conducted in 15 European countries (Spain, Italy, Belgium, Greece, Czech Republic, Hungary, Ireland, Latvia, Lithuania, Malta, Norway, Cyprus, Portugal, Slovenia and the Republic of Macedonia) presents alarming statistics showing that the rate of overweight ranged between 18% and 50% among girls and between 18% and 57% among boys (Wijnhoven et al., 2014).

In developing countries, the prevalence of obesity among children and adolescents was found to be 22.1 % in Brazil, 41.8 % in Mexico, 19.3 % in Argentina and 22.0% in India (Gupta, Shah, Nayyar & Misra, 2013).

A recent review in the Eastern Mediterranean Region (EMR) showed that between 7% and 45% of school children were overweight or obese (Musaiger, 2011).

Several studies conducted in Kuwait show that overweight and obesity are indeed prevalent in this country, with estimates suggesting that one third of children and adolescents are overweight or obese (Zaghloul, 2013).

Research studies have shown that individuals who were overweight or obese in childhood are more likely to have adverse health consequences during adulthood (Reilly & Kelly, 2011).

Several studies have also identified that obese children are more likely than healthy-weight children to become obese adults (Biro & Wien, 2010).

Overweight and obesity are preventable conditions that have been identified as primary contributing factors in chronic disease. In fact, weight gain has been identified as contributing to more than 34% of mortality in people younger than 60 years of age in most Arab-speaking countries (Rahim et al., 2014).

The Global Burden of Disease study in 2010 estimated overweight and obesity as secondary only to dietary factors (such as diets high in fat and salt and low in vegetables) in terms of risk for burden of disease in Australasia, placing it above even cigarette smoking. The proportion of Australian adults classified as overweight or obese by body mass index (BMI: *see figure 1*) is increasing and currently includes nearly two-thirds of the population.

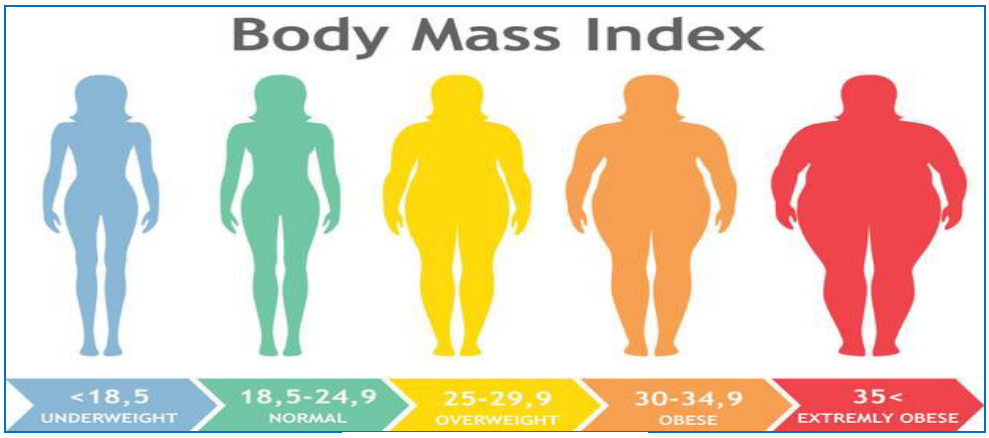

Figure (1): Body mass index

Similar rates of overweight and obesity to the national prevalence have been seen in patients attending general practitioners (GPs), with Saudi data suggesting that over 3 million obese adults attended GPs (for any reason) over the period of 2006–2008 (Valenti, 2009).

Patients do believe that the GP has a role to play in weight management. Various guidelines exist to inform GP management of overweight and obesity [4, 5], though there is a lack of evidence in the literature for any lifestyle intervention achieving significant, sustained weight loss [6–8]. This has contributed to an increasing amount of discussion in the literature of newer obesity paradigms such as the Health at Every Size movement, which aims to reduce stigma and dehumanization of overweight and obese people and to move from a weight-focused approach to a broader health-focused one (Penney & Kirk, 2015).

A large amount of literature exists around GP attitudes to management of overweight and obesity in adult patients. Barriers to effective care in this area commonly identified by GPs include time constraints, lack of adequate training, frustration at previous outcomes, and poor patient compliance or motivation (Thuan & Avignon, 2005).

A study of rural Australian GPs identified the relative lack of health resources available in rural areas as a barrier. In addition, an interview study of GPs in the UK identified as barriers the conflict between GP and patient opinions about who had the primary responsibility for managing the patient's obesity and the potential strain the GP's efforts placed on the GP-patient relationship.

Self-efficacy refers to the perception that people have of their ability to perform the actions necessary to achieve a desired outcome. Multiple mechanisms by which self-efficacy beliefs can be influenced have been identified. These include direct mastery experiences (performing the action oneself), vicarious experiences (observing other people performing it), imagined experiences (e.g., visualization exercises), and verbal or social persuasion (being told that the action is possible) (Ashman, Sturgiss & Haesler, 2016).

1.2 Problem Statement

Studies have consistently agreed that GPs have low self-efficacy and low expectation of effective treatment in the area of weight management. Insufficient confidence has been quoted as a barrier both to delivering weight loss counselling and to raising the issue of weight with patients initially. Studies have shown associations between both high self-efficacy and high outcome expectation in this area and the amount of counselling performed by the doctor. Therefore this study will investigate the management of obesity patients for exploring the self-efficacy among Saudi general practitioners in a qualitative survey methodology.

1.3 Methods and Producers

The methodology of a qualitative survey study using semi structured interviews, drawing on the theoretical framework of social cognitive theory (SCT). This is a theoretical framework, which has since been commonly employed in the field of health promotion (Bandura, 2004).

The theory outlines a number of determinants of behavior that include self-efficacy, outcome expectation, and perceived barriers and facilitators.

Twenty GPs recruited via a snowball sampling strategy to deliver a pilot of an obesity management program ("The Change Program") participated in semi structured interviews before commencing the pilot. Of the 20 participating GPs (twelve males and eight female), ages ranged between 33 and 55, and years working in general practice ranged between 5 and 25. The Interviews were face-to-face and were conducted in June and July of 2017. All interviews were conducted by the lead researchers. A self-efficacy questionnaire adapted from previously validated tools was administered at the start of the interviews.

It comprised a 4-point Likert scale with items loosely arranged under the framework of the "5As" (assess,

advise, agree, assist, and arrange), in line with the current guidelines for obesity management in general practice. The GPs were asked about their current management of obesity and read two short clinical vignettes to prompt reflection on their own practice and then were asked to discuss those items on the questionnaire where they had indicated they were "less confident" or "not at all confident."

Interviews were recorded digitally and transcribed verbatim by a professional transcription service. DE identified data were transferred into NVivo 10 for data organisation and coding. Data were analysed independently by the researchers and coded using social cognitive theory as a guiding framework.

1.4 Results and discussion

Five main themes emerged from the data in regard to factors influencing GP self-efficacy in the management of obesity.

1.4.1 Skills and Knowledge

Several of the GPs felt that there were specific gaps in their knowledge or skillset which lowered their confidence.

"I think for people…who are considerably overweight I don't understand enough about the effect of physical exercise on their bodies to be confident of giving them a good exercise program."

Other examples included lack of awareness of the specific caloric value of foods, inexperience in providing advice on diet in obesity in combination with other diet-specific management problems (e.g., high cholesterol or iron deficiency), and not knowing target heart rates for exercise.

The majority of the GPs stated that they often referred patients to allied health specialists such as dieticians or exercise physiologists or recommended commercial weight loss programs.

"I don't feel confident to really get into the nitty gritty of… patients' questions about this diet, this food and that food, and I think, oh, I'll leave that to somebody else to do."

1.4.2 Structure to Approach and Follow-Up

Many GPs felt that their approach to managing obesity was disjointed or opportunistic. The GPs stated that this lack of structure made them less confident in their obesity management, and they expressed an interest in The Change Program as something that might address this particular issue.

"It comes down to follow up, I think, and feeling confident that I have a system in place that I'm going to see them and act on. I feel like a lot of my obesity management has been very opportunistic with not a lot of protocol or system around it."

They spoke confidently about initiating the conversation about weight and giving counselling to the patient at that time but admitted they often did not make concrete plans to follow up the patient's progress.

"I'd say it's just really ad-hoc. So, we'll talk about it here or there, but not 'we said we'd do this, did we?' kind of thing. Sometimes they won't come back for six months."

1.4.3 The GP-Patient Relationship

The unique therapeutic and often long-term relationship between a GP and their patient was mentioned as impacting GP behavior and confidence. GPs can have comprehensive knowledge of the patient's personal situation, medical comorbidities, and possible barriers to lifestyle change. This was seen by most of GPs in this study both as a time saver (with less history taking and teasing out of individual challenges required) and as facilitating the GP's ability to counsel and empower patients to change. Some GPs described a good-quality and trust-based therapeutic relationship between themselves and the patient as improving their personal confidence in their counselling ability by acting as a facilitator of open disclosure and honesty from the patient, allowing for a more accurate gauge of a patient's state of change and current lifestyle and perceived by the GP as providing "permission to engage."

"[Having an established relationship] makes it easier because you know what works and…what makes this patient tick…With a patient that you've seen over many years you know where they stand…You can be more frank with them I suppose, and you know their life situation."

Conversely, some GPs spoke about what could happen when their relationship with the patient actually hindered their management attempts.

"You then stop doing it with certain people if you're finding that…they put up the barriers and that you've done the same discussion over and over again. It might be hard to readdress that with the same person cause you feel like you're battering them a bit."

A few of the GPs reflected that the possibility of patients feeling guilty or reprimanded if they failed to lose weight might contribute to patient failure to attend follow-up or negatively affect the GP-patient relationship.

"I think if patients haven't been successful they generally don't turn up on those follow up appointments as well. And I know of some patients who… actually put on weight instead of losing weight…that patient will now come and see me cause they don't want to see [their usual GP] cause they feel like they're going to be in trouble."

1.4.4 Acknowledging Barriers to Weight Loss

Most GPs expressed a strong awareness of multiple barriers to weight loss that their patients might experience, which tended to negatively affect the GPs' confidence.

"I look at the social difficulties for them to lose weight, whether they're the person who does the cooking or the shopping in the family, who else is at home, who else are they having to cater for…what sort of work she's doing, whether it's sedentary work or not… Whether she actually has any free time for herself or whether her whole life revolves around work and shopping and rushing the children around."

They showed awareness of background factors contributing to obesity, such as the "obesogenic environment" and an increasingly sedentary society but also discussed many different social and lifestyle factors that might obstruct change for their patients. Commonly quoted examples were the impact of a patient's family context, the distribution of roles such as shopping and cooking, the easy availability of high-calorie food, and time pressure around work and home duties.

Another acknowledged barrier, which some GPs reported as negatively affecting their confidence and decreasing their expectation of weight loss outcomes, was their awareness of the lack of evidence for any lifestyle intervention to cause significant sustained weight loss. Several GPs also mentioned "biological set points" and the tendency of the body to regain weight in the long term even if some weight loss was achieved, and they also showed awareness of this lack of evidence in the literature.

"I don't want to be falsely saying…'I really believe if you do this this would be effective'… I just think if people have put on weight often their body's fighting to get back up to that weight… and I know some people lose weight and they do keep it off with a lot of effort, but I think the majority of people put it back on… So I don't feel confident empowering people."

Some of the GPs in this study discussed making attempts to readjust patient expectations if, for example, a patient expressed a desire to lose an amount of weight that the GP considered particularly unrealistic.

1.4.5 Prior Experience and Outcome Expectation

Almost all GPs reported that their confidence was negatively affected by their failure to successfully achieve weight loss in most of their patients with obesity and their subsequent low expectation of being able to achieve this in the future.

"I've been treating patients who are overweight or obese for years, and I wouldn't say that my success rate is particularly high…in seeing my patients lose weight, so that's why I don't feel particularly confident that I'm good at it…I've made suggestions that I think would be effective, but in so many times… we don't actually get very far."

In some cases, the GPs had experienced success in assisting their patients to achieve weight loss, which was accompanied by increased confidence. However, these instances were heavily outweighed in the data by GPs speaking negatively about failure of their patients to achieve weight loss outcomes and expressing feelings of frustration and low confidence in managing their patients' obesity as a result.

Some GPs mentioned using their own personal experiences in behavior change and weight loss in order to motivate patients.

"I've heard of the 5:2 diet, and I sort of practice a little bit of it. I share my own experience as well … invite them to try what I'm trying."

In addition, a few GPs brought up alternative (i.e., not weight loss per se) outcomes and endpoints, such as considering patients' blood pressure or fasting blood results, aiming for a lack of weight gain, or simply having raised the issue and provided patient education as a "good result."

Based on the results from this study, GPs' self-efficacy for obesity management is affected by their previous experiences and practice, their perception of the low level of evidence for interventions achieving successful long-term weight loss, and their perceived level of knowledge and skills.

The perceived efficacy of the GPs' counselling skills was affected by a series of barriers and facilitators. These included the presence or absence of a structured approach to weight management in practice and awareness of the larger context such as the obesogenic society but also the therapeutic relationship that exists between GP and patient. General practitioners perceived this relationship as being important for the level of trust the patient placed in them, the doctors, to act in the patient's best interest. They also identified that relationship as influencing how much they know about the patient's own self-efficacy and personal life circumstances (which could influence the patient's lifestyle change attempts).

The GPs were pragmatic and sometimes pessimistic about the limits of their own influence in the context of everyday practice. They showed awareness that their own knowledge base and their skills, for example, in motivational interviewing, were the factors over which they had the most control. This has highlighted an issue in considering GP management of obesity from a social cognitive theory perspective: in essence, it is a single-body psychological framework being applied to a two-body problem. The therapeutic relationship between those two bodies further muddies the waters by potentially acting as a barrier or facilitator (or both) in its own right.

In a sense, too, patient self-efficacy appeared to influence GP self-efficacy. In many cases the GP was less

confident as a result of barriers to behavior change their patient faced. The interviewed GPs actually reported strategies in keeping with social cognitive theory, which they employed in order to increase patient self-efficacy, for example, modelling the advised behaviors ("this worked for me!"), motivational interviewing as a form of delivering imagined experience, and discussing with the patients the recognised barriers to mastery experiences.

1.5 Conclusions

When it comes to improving GP confidence around management of obesity, this study suggests a small role for addressing areas of knowledge that GPs might want to improve in order to feel more confident helping patients themselves instead of referring directly to allied health practitioners. In addition, given that the participants involved were a presumably motivated and interested subgroup of GPs, these perceived knowledge gaps may be even more of an issue in the wider GP population.

The findings also suggest that GPs are likely to welcome any tools or support when it comes to having a structured approach to the management of overweight and obesity in practice. To this end, the same GPs will be interviewed after the six-month pilot study of "The Change Program" and will be directly asked about whether the structure inherent in the program had an effect on their confidence in this area.

Shifting the frame away from weight loss per se and towards these other goals might therefore allow for a more authentic GP-patient interaction and increase the self-efficacy of both GP and patient for healthy lifestyle changes.

References

Ashman, F., Sturgiss, E., & Haesler, E. (2016). Exploring self-efficacy in Australian general practitioners managing patient obesity: a qualitative survey study. *International journal of family medicine*, *2016*.

Bandura, A. "Health promotion by social cognitive means," Health Education and Behavior, vol. 31, no. 2, pp. 143–164, 2004.

Biro, F. M., & Wien, M. (2010). Childhood obesity and adult morbidities. American Journal of Clinical Nutrition, 91(5), 1499S–1505S.

Fogelman, Y., Vinker, S., Lachter, J., Biderman, A., Itzhak, B., & Kitai, E. (2002). Managing obesity: a survey of attitudes and practices among Israeli primary care physicians. *International journal of obesity*, *26*(10), 1393.

Gupta, N., Shah, P., Nayyar, S., & Misra, A. (2013). Childhood obesity and the metabolic syndrome in developing countries. The Indian Journal of Pediatrics, 80(1), 28–37.

Musaiger, A. O. (2011). Overweight and obesity in eastern Mediterranean region: Prevalence and possible causes. Journal of Obesity, 2011.

Penney and S. F. L. Kirk, (2015), "The Health at Every Size paradigm and obesity: missing empirical evidence may help push the reframing obesity debate forward," American Journal of Public Health, vol. 105, no. 5, pp. e38–e42, 2015.

Rahim, H. F. A., Sibai, A., Khader, Y., Hwalla, N., Fadhil, I., Alsiyabi, H., . . . Husseini, A. (2014). Non-communicable diseases in the Arab world. Lancet, 383(9914), 356–367.

Reilly J. J., & Kelly, J. (2011). Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: Systematic review. International Journal of Obesity, 35(7), 891–898.

Reilly J. J., & Kelly, J. (2011). Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: Systematic review. International Journal of Obesity, 35(7), 891–898.

Thuan and A. Avignon, (2005), "Obesity management: attitudes and practices of French general practitioners in a region of France," International Journal of Obesity and Related Metabolic Disorders, vol. 29, no. 9, pp. 1100–1106, 2005.

Valenti, 2009, "Overweight and obesity," in General Practice in Australia, Health Priorities and Policies 1998 to 2008, H. Britt and G. Miller, Eds., AIHW, Canberra, Australia.

Wijnhoven, T. M., van Raaij, J. M., Spinelli, A., Starc, G., Hassapidou, M., Spiroski, I., . . . Pérez-Farinós, N. (2014). WHO European childhood obesity surveillance initiative: Body mass index and level of overweight among 6–9- year-old children from school year 2007/2008 to school year 2009/2010. BMC Public Health, 14(1), 806.

World Health Organization. (2015). Obesity and overweight. Fact sheet. Retrieved 10 October 2015 from http://www. who.int/mediacentre/factsheets/fs311/en/.

Zaghloul, S., Al-Hooti, S. N., Al-Hamad, N., Al-Zenki, S., Alomirah, H., Alayan, I., ... & Jackson, R. T. (2013). Evidence for nutrition transition in Kuwait: overconsumption of macronutrients and obesity. Public Health Nutrition, 16(04), 596–607.