

EXPLORING GENERAL PRACTITIONERS'  
EXPERIENCES OF IDENTIFYING AND  
MANAGING CHILDHOOD OBESITY.

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## **ABBREVIATIONS.**

BMI: Body Mass Index.

CAMHS: Child and Adolescent Mental Health Services.

CMO: Chief Medical Officer.

CCG: Clinical Commissioning Groups.

DoH: Department of Health.

JSNA: Joint Strategic Needs assessments.

HWBB: Health and Wellbeing Boards.

NICE: National Institute of Clinical Evidence.

NCMP: The National Child Measurement Programme.

PCT: Primary Care Trust.

PSA: Public Sector Agreement.

QOF: Quality and Outcomes Framework

## **ABSTRACT.**

National policies (DoH, 2008; 2011) propose a clear role for GPs in responding to the increase in childhood obesity, despite a limited evidence base which would secure such an emphasis. Previous research has indicated multiple barriers to the engagement of GPs in this clinical activity due to the sensitivities of the subject, low levels of role competence and confidence and limited access to specialist services.

Using interpretive phenomenological analysis, this study explored how GPs made sense of their experiences of identifying and managing childhood obesity in order to provide a unique insight into these professional behaviours. Retrospective semi-structured interviews were carried out with ten GPs from Stockport, who had been in practice for over 25 years.

Four themes emerged. The first ‘understanding the family’ demonstrated how the GPs utilised their knowledge of the family’s health beliefs, motivations, skills, and wider socio economic factors to compile a unique understanding of the family which framed their responses to the obese child. The second ‘flexibility and responsiveness’ explored how this complex knowledge of the family was used to negotiate and address the different physical and emotional needs of the child. The third theme ‘professional and individual dilemmas’ explored areas of professional uncertainty, the identification of perceived legitimate role boundaries and the personal belief systems of the GPs regarding childhood obesity. The final theme ‘organisational challenges’ highlighted how time pressures, competing priorities, and structural constraints challenged their abilities to provide effective responses.

An extended explanatory insight is provided by exploring the GPs’ dominant epistemological framework which resulted in the identification of 4 role types, using Laws et al., (2009) theoretical framework. The role types are considered in relation to the GPs’ professional identities and their contextual responses to the child and family. The research concludes with practical recommendations for service improvement at the practitioner, commissioner and national policy level.

## **Chapter 1: Introduction.**

### **1.1. Research purpose and theme.**

This thesis presents an exploratory phenomenological study which aims to increase understanding of GPs' experiences of identifying and managing childhood obesity. It focuses on how GPs understand, make sense of and respond to children who are obese. This topic is a relatively unexplored area in the literature, yet warrants significant attention given concerns regarding the prevalence of childhood obesity in the UK, (DoH 2003; 2008; 2009; 2011; NICE 2006; 2013). The National Childhood Measurement Programme (NCMP) annual survey of children in England, 2012/13, indicates that one in five children aged 4-5 years are overweight or obese (boys 23.5%, girls 21.6%), and one in three children aged 10-11 years are overweight or obese (boys 35.4%, girls 32.4%), (NOO, 2013). Whilst there are some signs overall, of childhood obesity levelling off, (Mandalia, 2012) this has varied by population groups, and there is evidence that obesity levels among children of lower socio-economic groups have continued to rise (Stamatakis et al., 2010; Jebb et al., 2013). Child obesity is closely correlated with deprivation (Hancock et al., 2013), and obesity prevalence is significantly higher in urban areas than rural areas (NOO, 2013).

Although a role for greater GP involvement has been raised at a policy level (DoH, 2003; 2008; 2011), advocated in NICE guidelines (2006; 2013), and recommended by the Royal College of Physicians (2013), little is known and understood about what happens in routine clinical practice with children who are obese, and even less is known about GPs' own views and experiences. GPs are pivotal to the delivery of any initiative in primary care and their attitudes and practices are likely to determine the impact achieved in any clinical intervention, (Howie, 1996; Blakeman et al., 2006, Gabbay and le May, 2011). This thesis argues that it is critical to explore and understand GPs' attitudes and practices regarding interventions to indicate why this key strategy for tackling childhood obesity may not be achieving its full potential.

The methodological approach of this study, detailed in Chapter 3, is Interpretative Phenomenological Analysis, (IPA) (Smith et al., 2009). This thesis is the first known attempt to use IPA to provide a detailed examination of the GPs' experience of childhood obesity. The approach is phenomenological and exploratory in that it involves a detailed examination of the clinical experience and is concerned with the individual GP's personal perception and accounts of the event, and the meanings that the GP attributes to such experiences (Smith,

1996). A distinctive feature of IPA is its commitment to an idiographic perspective, (Eatough and Smith, 2006) and as such the research consists of an in-depth analysis of semi- structured interviews carried out with ten experienced GPs in Stockport, Greater Manchester. As IPA places emphasis on “sense making” (Smith et al., 2009, p.37), it is expected to be particularly salient in the exploration of a debated and complex concept such as childhood obesity (Lupton, 2013).

This remainder of this chapter provides the relevant policy context and background for the research in Section 1.2. It highlights relevant policies in England related to childhood obesity, and refers to the structural and organisational policy changes in primary care and child health services which are critical in order to situate the research context. Section 1.3 outlines the professional and personal motivations that led to this research topic and the decision to pursue a Professional Doctorate in this area. The three research aims are presented in Section 1.4, together with definitions and details of the research site. Section 1.5 outlines the key contributions that this research makes. Section 1.6 describes the content of the remaining chapters of this thesis.

## **1.2. The research context – childhood obesity and primary care.**

The following section identifies both national policy on childhood obesity in England, and the major changes to the organisation of primary care health services, as part of the wider reform of the NHS, in order to locate the research context for this study. It will argue that the policy context of childhood obesity has undergone considerable change in emphasis over the years, particularly in relation to recent politically driven discourses which relocate responsibility away from the wider social and environmental determinants of childhood obesity, to the level of the individual. It will illuminate the magnitude of the challenge of childhood obesity to the whole of society and confirm why a “*whole systems approach*” (Jebb et al., 2013, p.56) is advocated.

### **1.2.1. Childhood obesity: policy and context considerations.**

This section will detail and discuss the range of obesity policies that have emerged in the England over the last 20 years, (DoH, 1992; 1999; 2003; 2008; 2011). Throughout the 1990’s a small number of Public Health strategies were produced which recognised the challenge of increasing rates of obesity. These included the Conservative Government’s “*Health of the Nation*” (DoH, 1992) and the Labour Government strategy, “*Saving Lives: Our Healthier*

*Nation*” (DoH, 1999). However despite the articulation of high level ambitions to halt the rise in adult obesity, these reports seemed to have little impact in reducing obesity levels, which continued to rise throughout this time, (NAO, 2001). The focus on childhood obesity in the policy discourse emerged in 2002, and was vividly articulated in the Chief Medical Officer Annual Report (DoH, 2002).

*“The growth of overweight and obesity in the population of our country, particularly amongst children, is a major concern. It is a health time bomb with the potential to explode over the next decades. Unless this time bomb is defused the consequences for the population health and the cost to the NHS will be disastrous.”* (2002, p.44).

In 2004 an Inquiry by the Parliamentary Health Committee (2004) received further evidence of the health impacts of childhood obesity, and starkly concluded that as a consequence of the increase in childhood obesity *“today's generation of children will be the first for over a century for whom life-expectancy falls”*, (Jebb et al., 2013, p. 42). Such warnings led to the announcement of the first Public Service Agreement (PSA) for childhood obesity in 2003 designed;

*“To halt, by 2010, the year-on-year increase in obesity among children under 11 years’*, (DoH, 2003 p.6).

Whilst a range of public health strategies followed including *“Choosing Health: Making Healthier Choices Easier”* (DoH, 2003), and *“Choosing a Better Diet: A Food and Health Action Plan”* (DoH, 2005), the focus was primarily on addressing dietary issues and promoting physical activity, with a strong emphasis on personal choice and individual responsibility for changing lifestyles behaviours. The National Audit Office (2006) was again critical of the Department of Health’s approach, challenging the fact that;

*“There is little evidence as yet to determine whether the Department’s range of programmes and initiatives to improve children’s health and nutrition generally is sufficient to achieve any targets of reducing childhood obesity rates.”* (2006, p.12).

In October 2007, the highly respected, Foresight Report *“Tackling Obesity: Future Choices”* (Butland et al., 2007) was published, which confirmed that obesity is a complex problem with multiple drivers, including the advertisement of fast food products to children, the inclusion of high levels of sucrose in processed foods, and the increasing use of technology leading to sedentary behaviours among children. The report presented an extensive modelling and

forecasting analysis (McPherson et al., 2007; Finegood et al., 2010), which confirmed that obesity had significant cost implications for government and the wider economy, concluding that a comprehensive, co-ordinated approach was needed to address such challenges, (Jebb et al., 2013). Critically it called for action to be initiated and sustained at different levels: individual, local, national, and global (Kopelman et al., 2007). A number of the key recommendations highlighted in the Foresight Report (Butland et al., 2007) were accepted and included in the Labour Government's Public Health strategy "*Healthy Weight, Healthy Lives*" (DoH, 2008). Crucially, it was positioned as a cross-government strategy and contained commitments across a range of departments including transport and local government, with an emphasis on changes in the environment intended to make it more likely that families and children would adopt a healthy diet and increase their physical activity. In April 2008 a revised Public Service Agreement (PSA) on Child Health and Wellbeing was issued with the statement;

*"Our ambition is to be the first major nation to reverse the rising tide of obesity and overweight in the population. Our initial focus will be on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels."* (DoH, 2008, p.3)

Jebb et al., (2013) noted that such wording reflected a subtle but important change, adding overweight children alongside the obese child as a focus for action and effectively creating a target to increase the proportion of children with a healthy weight. In doing so, it shifted the emphasis from a narrow focus on treating established childhood obesity to a "*broader societal obesity prevention agenda*," (2013, p.8).

However the election of a new Coalition Government in May 2010 reflected a considerable change in emphasis. In the forward to the White Paper "*Healthy Lives, Healthy People: Call for Action on Obesity*" (DoH, 2011) the Secretary of State revealed the long standing criticisms by Conservative politicians of Labour's previous public health policies many of which were dismissed as "*nannying*" (Rayner and Lang, 2011, p.3). The Secretary of State announced;

*"The dilemma for Government is this: it is simply not possible to promote healthier lifestyles through Whitehall diktat and nannyism about the way people should live."* (2011, p.2).

In the evolution of childhood obesity policies, this White Paper marked a significant move away from policies led by Central Government towards locally delivery, albeit these continued to be heavily based on the Government's predominant discourse that achieving and maintaining calorie balance was an individual responsibility, which needed to be addressed by individuals making healthy decisions about their diet and levels of physical activity. Although a "*life course approach*" (Marmot, 2010) was advocated to effectively tackle obesity, from pre-conception, through pregnancy and infancy, to adulthood and older age, the main components focussed on the provision of guidance, advice, and information. This was delivered, for example, through national social marketing campaigns such as the Change4Life programme (DoH, 2009) launched with an annual budget of around £25 million. The particular emphasis in "*Healthy Lives, Healthy People*" (DoH, 2011) on policies that encouraged personal autonomy also leaned towards a voluntary, rather than mandated approach, to changing behaviour, which as Jebb et al., (2013) confirmed is consistent with "*a model of liberal paternalism*" (2013 p.44). In addition the earlier emphasis on centralist interventions, such as restrictions on advertising certain foods to children and mandatory school food standards, were replaced by an approach favouring greater co-production with food manufacturers and retailers, advanced in the "*Responsibility Deal*" (DoH, 2011) with industry positioned as benign helpers unconnected with the causes of the childhood obesity problem.

Mayor (2011) reported the clear disappointment amongst scientific advisers, public health leaders and obesity specialists, whose analysis and consensus regarding the complex multifactorial interplay of obesity (Butland et al., 2007), had been significantly relegated in "*Healthy Lives, Healthy People*" (DoH, 2011). There was particular criticism of the emphasis on individual choice and responsibility and on the over reliance on parents as being the sole "*agents of change*" (Mayor, 2011). The Faculty of Public Health (2011) also expressed disappointment over the Government's reluctance to protect the public's health by measures such as banning trans fats (Stender et al., 2006), utilising legislative changes to influence people's food buying through taxation (Swinburn and Egger, 2002; Freebairn, 2010; Swinburn et al., 2011), and banning all junk food advertising aimed at children, (Morley et al., 2008; Swinburn et al., 2008). Rayner and Lang (2011) added to the debate by criticising how the "*Responsibility Deal*" focussed on how companies influenced their consumers rather than on reforming their own business practices, and was highly doubtful that industry would voluntarily make the significant changes that were needed. Likewise, a number of key



organisations, such as Diabetes UK and the British Heart Foundation refused to sign up to the “*Responsibility Deal*”, arguing that the approach was fundamentally flawed in its expectation that industry would take voluntary actions that prioritise public health interests above its own commercial ones. Professor James, a leading nutritionist, reported that “*Healthy Lives, Healthy People*” (DoH, 2011) constituted an abrogation of responsibility around the vital role that the state must still play in creating healthy environments, concluding;

*“The plan is a completely inadequate response to the problem of obesity. It is not simply a question of personal responsibility. There is an environmental problem in terms of the food system we have.”* (Mayor, 2011, p.343).

Barry et al., (2012) however, have argued that policies consistent with the neo-liberal desire to avoid state regulation and intervention will inevitably focus on individually mediated approaches, such as encouraging families to swap unhealthy products for healthy ones. Such approaches are relatively inexpensive in financial and political terms, are perceived to be non-intrusive and are specifically designed to avoid “*accusations of the self-defeating, heavy handedness of the state*” (2012, p. 390).

The final, most recent published report, which considered childhood obesity was the Chief Medical Officer (CMO) “*Our Children Deserve Better: Prevention Pays*” (DoH, 2013). Although childhood obesity has previously been portrayed in national policies as an economic problem (Harrison, 2012), it is perhaps not surprising in a period of financial austerity, that the focus for prevention in this report was overt, stressing that;

*“Reducing obesity by just one percentage point among children and young people could lead to savings of £1 billion each year as children would be less likely to end up with long-term health problems needing NHS treatment.”* (2013, p.14).

Whilst the majority of the CMO’s report focussed on community initiatives to address childhood obesity there are a number of actions identified for General Practice. In particular the CMO called for the extension of GP training to include a core component on paediatrics and child health, and recommended that for certain groups of children with long-term conditions, they should have a named GP who co-ordinates their disease management care. However it is disappointing that the CMO did not advocate a lead named GP for childhood obesity in each practice, rather the report focussed on the key role that other health, early years and education professionals can make in addressing childhood obesity.

In summary, this section has demonstrated that respective Governments have recognised that childhood obesity has been a sufficient challenge to the health of the nation to warrant specific action. However, despite high quality evidence, (Butland et al., 2007) which demonstrated that childhood obesity could only be addressed via a system-wide approach, with clear leadership, accountability, and engagement of all Government agencies and departments, there has been an absence of long term, sustained interventions, in favour of a continued focus on individual responsibility and lifestyle change. Childhood obesity has been described as an “*issue-attention cycle*” (Barry et al., 2012, p.390) in which societal problems leap into public prominence, captivate public attention for some time, then gradually recede from the public's view, often before the problem has been resolved. This pattern, Barry et al., (2012) suggested occurs when initial public alarm over the discovery of a problem, and optimism about its quick resolution, are replaced by the realisation that solving the problem will require some public sacrifice and will displace powerful societal interests.

There is little doubt that the evolution of strategies to address childhood obesity have resulted in a mix of policy actions that have been shaped over time. Jebb et al's. (2013) review of childhood obesity policies between 2003 and 2013 identified 14 policies which ranged from regulatory interventions to improve nutritional standards in schools and physical activity and sport programmes, through to policies that focus on individual responsibility such as breast breastfeeding and healthy weaning practices. These policies, summarised in a synthesis table in Appendix One, demonstrate that despite some promising outcomes, primarily related to behavioural changes, overall the childhood obesity rates have not declined, which clearly reinforces the magnitude of the challenge of addressing childhood obesity.

### **1.2.2. Primary care systems: policy and context considerations.**

This section will consider how the current delivery of primary care services have also been formed by a wide range of policy drivers, NHS reforms and changing contractual arrangements. It will examine the current contractual context of General Practice in England, the emergence of policies to enhance the role of GPs in the promotion of health for individual patients, and wider system change in child health services. It will argue that some of these changes dilute the impact that individual GPs are likely to achieve in relation to supporting children who are obese.

Whilst it is beyond the scope of this study to provide a detailed history of general practice there are a number of key system reforms that have particular resonance for this thesis. The

1970s have often been considered as the “*golden era*” for the NHS where patient care was “*more effective, more humane and less authoritarian,*” (Tudor Hart, 2006, p.17). From the 1980s onwards, however there was a move towards increasing fragmentation of the NHS and the introduction of more managerial and accountability controls. Within primary care the development of “*Fund holding and GP Purchasing*” in 1995 formalised and rewarded the concept of internal competition, encouraging GPs to hold budgets to purchase health care services for their patients, (Kay, 2002). The 2004 new General Medical Services (nGMS) contract (DoH, 2004b) was probably the most significant contemporary reshaping of policy in General Practice, consistent with changes across the public services of increased definition, measurement and regulation of professional work. In this contract a range of clinical and organisational indicators known collectively as the “*Quality and Outcomes Framework*” (QOF) (DoH 2004b) were introduced in primary care, designed to improve quality by linking up to 25% of the income of GP practices to the achievement of quality targets for a range of chronic conditions. Although linking performance to payment is not in itself a new phenomenon, the format of the QOF, with 147 targets, was unprecedented in provoking a shift of clinical activity in response to financial rewards.

There was a very mixed response from GPs, academics and the Royal College of General Practitioners (RCGP) to the Quality and Outcomes Framework, (QOF). Those in favour credited the QOF for supporting an improvement in diabetic, asthma and coronary heart disease care, (Campbell et al. 2008). Others, however, reported that the management of non-incentivised conditions has been compromised, (Grant et al., 2009). Doran and Roland (2010) suggest that the adoption of the QOF has put into question the core values at the heart of general practice, arguing that the framework accorded greater status to what is written or coded rather than the interaction between the doctor and patient.

Whilst adult obesity was included in the GP QOF contract for 2006–7 and practices were rewarded if they produced a register of obese patients aged 16 years and over, the number of QOF points assigned to this indicator was less than 1% of the total, perhaps undermining the importance of obesity related care. In addition there have never been any QOF targets for childhood obesity related indicators. It is questionable whether childhood obesity targets will be included in future QOF contracts, or whether these would relate to health outcomes, rather than processes such as establishing childhood obesity registers. However, as Walker et al., (2007) have argued the current omission of childhood obesity QOF targets impacts on the time, priority and resources that GPs are likely to direct to this area.

A further policy change which is pertinent to this thesis relates to the delivery of the child health programme by GPs in primary care, which historically included certain screening procedures, routine childhood vaccinations and the provision of health promotion advice delivered within a routine Child Health Surveillance (CHS) review. However, the introduction in 2004 of *“Healthy Child Programme”* (DoH, 2004a) which provided families with an extensive programme of screening, immunisation, health and development reviews, and advice around parenting, significantly extended the range of health professionals and children’s workforce practitioners involved in such programmes. Whilst some GPs led on these programmes, a range of other health professionals such as Health Visitors and School Nurses and early childcare professionals increasingly became more involved in child health routine screening, and many of these services were delivered outside of the GP surgery in new settings such as Children Centres and schools. For example the annual National Child Measurement Programme established by the Department of Health (DoH, 2006) was carried out by School Nurses in the school setting.

One of the consequences of this diverse range of providers of child health was fragmentation, and as Wood and Wilson, (2012) demonstrated, resulted in designated preventive care, and universal health promotion programmes forming only a very small minority of GPs contacts with children, leaving the majority of GP consultations with children to focus only on more acute presentations. Walker et al., (2007) argues that the plethora of other professionals who have, quite rightly, taken on greater activity in the preventative area, may mean that GPs are less minded to consider the wider health of children as they might have been when this was considered core business.

A further, more recent health care policy which provides a background context to this thesis is *“Making Every Contact Count”* (NHS Future Forum, 2012) which, whilst not aimed specifically at children, and not exclusively to General Practice, aimed to locate the prevention of health problems and disease at the heart of every NHS contact. As the title of this policy suggests, the underlying intention of this policy was for professionals to use each contact with a patient to offer appropriate brief opportunistic advice on staying healthy and making positive changes to their lifestyles, (Elwell et al., 2012). Whilst the focus on encouraging health care practitioners to include health promotion interventions has been well received by public health professionals, Butler et al., (2013) have indicated that providing access to effective, theoretically sound, clinical interventions for the whole population raises challenges, often because it is unclear what constitutes effective interventions. Not

surprisingly the responses by GPs to such ministerial injunctions have been varied. Mooney, (2012), for example, challenged health promotion strategies which collectively over emphasise individualistic approaches, and ignore the economic influences on health and the role of social, educational and economic policies to promote health. Kaner and McGovern (2013) have also argued that policymakers and politicians have oversimplified the challenge, given that recipients of lifestyle intervention in primary care do not form a homogenous group and the varying ability, willingness and competence of GPs to motivate patients. It has also been suggested that the fact that “*Making Every Contact Count*” (NHS Future Forum, 2012) is conceptually and financially distinct from the QOF, dilutes its focus, credibility and priority in primary care, (Mooney, 2012).

Finally, the very recent NHS reforms defined in the Health and Social Care Act 2012 (DoH, 2012) has added considerable turbulence and complexity to the ambition of a system wide response to childhood obesity. Primary Care Trusts (PCTs) have been replaced by GP Clinical Commissioning Groups (CCGs), made up of local GP practices that are now responsible for commissioning the majority of local health services though control of substantial budgets. However, the accountability for delivery of the General Medical Service Contract is no longer held locally, but rests with Area Teams in NHS England. In addition, from April 2013 the local planning and delivery infrastructure for all public health programmes transferred from PCTs to Local Authorities, and Public Health England was also established to support local areas by providing public health evidence and sharing good practice. The Health and Social Care Act 2012 (DoH, 2012) also gave statutory responsibilities to Local Authorities to establish Health and Wellbeing Boards, bringing together key commissioners from the local NHS and local government, including Directors of Public Health, to strategically plan local health and social care services. Health and Wellbeing Boards were also held responsible for identifying the needs of the local population through the Joint Strategic Needs Assessment and developing priorities for action through Joint Health and Wellbeing Strategies.

It is important to consider the impact of such significant changes on the prevention and management of childhood obesity. Firstly in relation to commissioning, CCGs have new budgets and new commissioning responsibilities that will impact on childhood obesity, for example, they are responsible for commissioning Child and Adolescent Mental Health Services, Maternity and Paediatric services. However, it is Local Authorities (LAs) who commission School Nurses and NHS England who commission Health Visitors, until October 2015 when this will be transferred to Local Authorities. In relation to commissioning

childhood obesity services, Local Authorities through their Health and Wellbeing Board are responsible for commissioning prevention services, and commissioning childhood weight management services, (Tier 2), CCGs are responsible for commissioning specialist obesity services, (Tier 3) and NHS England commissions bariatric services (Tier 4). This diversity of commissioners has significant implications in terms of trying to achieve integrated planning and commissioning for childhood obesity. In addition the commissioning of GP primary care services rests with NHS England although both LAs and CCGs are able to established locally enhanced services with GPs for some prevention and lifestyle services.

For Local Authorities the picture is equally complex. The Health and Social Care Act 2013 has defined mandated activities in relation to obesity such as the National Child Measurement Programme and the NHS Health Check assessment, whereas other services such as School Nursing and weight management services for children are not considered mandatory. Whilst there are now unique opportunities for the Director for Public Health (DPH), to champion and coordinate the delivery of wider services that impact on childhood obesity across the Local Authority such as those in planning and environment, transport, leisure, parks and green spaces, education and early years, workplaces and housing, this has been given at a time of financial austerity and significant reductions in LA budgets. There have recently been strong assertions by the BMA, that Public Health budgets in Local Authorities have been used to fill the financial gaps caused by local Government cuts. Iacobucci (2014) reports a survey of Local Authority budgets and found that over half of the authorities had used the Public Health grant to fund local services that were at risk of being cut such as leisure facilities or parks and green spaces. Whilst the Local Authorities have indicated that these are a legitimate spend of the public health grant, the BMA warn that this will weaken the future commissioning of key public health services. Clearly the Directors of Public Health will have to assert a strong leadership role in prioritising childhood obesity in the constant competition for reducing resources. It is however encouraging that a recent North West Employers review of Health and Wellbeing Boards priorities (NW Employers, 2013) indicated that tackling obesity remains an important public health area with all Local Authorities in the North West of England including childhood obesity as a priority in their Health and Well Being Strategies.

In summary, Section 1.2 has provided an extensive discussion of the national and local policy drivers and changes that relate to the research topic. It has highlighted that addressing childhood obesity is complex and requires action at every level, from the individual to society, and across all sectors. However, to date the actions of all Governments have been

fragmented, short term, and failed to address the significant wider determinants of childhood obesity. Whilst individual programmes may have some short term effect (Appendix One) and the issue of childhood obesity still remains a government focus, it must be concluded that the continued emphasis on individual responsibility will only have limited impact in what is clearly a very multifaceted public health issue. A critical understanding of the complexity of the obesity debate, the varying policy responses and the structural and organisational changes identified in Section 1.2.1 provides a meaningful context for this research topic.

### **1.3. Personal and professional motivations for the research.**

The following section in this chapter addresses the motivation for this research topic and the professional and academic experiences of the researcher that have led to the decision to focus on GPs and childhood obesity, using a qualitative phenomenological approach.

#### **1.3.1. The research topic.**

My initial interest in the topic of childhood obesity and General Practice arose from a very practical, service evaluation perspective. In 2009 I commissioned a childhood obesity intervention programme, All Together Active (A2A) in Stockport. A2A is a community based, family intervention programme for children aged 7-11 who are obese (98<sup>th</sup> BMI centile and above). It is a structured, targeted intervention for children who are obese and their families, with a focus on behaviour modification, healthy eating, and physical activity. It also offers an opportunity for families to be supported and motivated to lead healthier lifestyles through a series of individual family appointments and group activity sessions, giving families the knowledge and tools to sustain healthy behaviour modifications in the long term.

The evaluation at the end of the first year of A2A showed promising outcomes for the children in terms of reduced BMI rates, with a mean BMI (SD) overall average reduction of 2.1% and a mean % BMI (SD) reduction of 3.2% (Sager and Turncliffe, 2009, unpublished report). However, it was clear from the evaluation that recruitment to the scheme was challenging, and despite extensive publicity we received no referrals from GPs. Initially the service providers believed we needed to write to GPs and provide further information about the A2A scheme. However, I have worked extensively with GPs in managerial roles for over 20 years and was very aware of the complexities, challenges and daily demands on General Practitioners. I was also aware that previous attempts at providing GPs with information about other schemes such as drug services or domestic abuse services yielded little success in terms

of securing their engagement in these areas, and therefore I knew that merely providing more information literature was not the answer. As the ethnographer Fetterman (2010) noted the researcher enters the field “*with an open mind but not an empty head*” (2010, p.13).

At this point I was greatly assisted in my thinking by Gabbay and le May (2011) ethnographic study of General Practice as described in their publication “Practice Based Evidence for Health Care”(Gabbay and le May, 2011). Through observation and analysis they documented the “*messy world of General Practice*” (2011, p.5) and highlighted the need to “*get below the surface and interpret the subtleties and meanings*” (2011, p.7) that GPs attribute to their clinical behaviours. This prompted a significant rethinking of my initial research question, and with my supervisors’ encouragement, I came to the conclusion that I needed to focus not solely on recruitment issues to weight management schemes, but take a much wider, more explanatory analysis of the actual day to day experiences of GPs in identifying and managing childhood obesity, in order to consider how they understood and made sense of these experiences in a primary care setting.

As the revised area of research interest was concerned with experiences and meanings, and the contexts in which meaning making takes place, (Willig, 2001), a methodology was required which enables a focus on the individual experiences of the GPs as participants and the meanings they attach to their experiences of identifying and managing childhood obesity. Chapter 3 explores the other research methodologies considered including Grounded Theory, (Charmaz, 1990), Conversational Analysis, (Drew et al., 2001), and Discourse Analysis (Willig, 2008) before deciding to utilise Interpretive Phenomenological Analysis (Smith et al., 2009). This methodology was chosen as it combined flexibility to deal with the complexities of the experience of GPs managing childhood obesity, with a rigorous framework to assist both the researcher and the reader in making sense of the material. IPA’s acknowledgment and corresponding use of reflexivity by the researcher was also considered essential, and its structured method, with clear stages of data collection, analysis and writing, offered firm support to the research process.

Further, one of the conclusion from the literature review presented in Chapter 2 is that some of the previous qualitative literature on childhood obesity and General Practice in the UK (Walker et al., 2007; Turner et al., 2009; Redsell et al., 2011) whilst critically important in starting to frame some of the key issues, demonstrated relatively superficial levels of interpretation, focussing more on the description of the GPs’ statements outlined in the



research findings, rather than a deeper exploratory analysis. As a consequence some of the research is somewhat flat or lacking in depth. The intention of the research in this thesis, and the unique contribution it will provide, is to explore through the IPA methodology, a more robust level of deeper interpretative analysis, exploring and exposing the underlying reflective assumptions that the GPs' descriptions point towards, in order to provide a further contribution to the literature.

### **1.3.2. Epistemological position.**

In this section I will identify and reflect on the influences on myself as a researcher - practitioner (Lee, 2009) and clarify my emerging epistemological position in order to explain how this aligns with the purpose and methodological approach of the study. Chapter 3 will describe how the IPA methodology requires a significant level of interpretation by the researcher; as such it is important to provide a clear statement of the perspective from which this specific research was made. This allows the reader to situate both the researcher and the research more transparently.

My first degree was in social anthropology and as an undergraduate I was introduced to qualitative methodologies and in the main Interpretivist epistemologies. I completed my first ethnographic study in East Africa as part of a local programme which looked at why families were ignoring locally available sugar and salt solutions to counteract oral rehydration for children with gastro intestinal disease, and choosing instead to purchase expensive, and often less effective oral rehydration sachets. My study found that mothers saw their purchasing decisions as indicators of their quest for upward social mobility, for example they pinned the empty boxes of these Western medicine on their walls as a visible manifestation of how they used their family income to enhance the health of their children. Returning to England I enrolled on a Masters in Community Medicine Health where the focus at that time (the early 1980s) was on epidemiology, infection control and health protection. The epistemology was strictly positivist and reductionist, with a biomedical framework underpinning most of the teaching. The concept of culture was only referred to when needing to explain unexpected or atypical epidemiological findings.

Whilst this new area of learning was an important one in terms of developing my research skill base, I was reluctant to lose my interest in qualitative research. My Masters dissertation included a substantive qualitative component evaluating why a programme to increase condom use in a deprived community was having little impact on teenage pregnancy rates. In

this dissertation I argued that our focus should be on challenging the prevailing normative socio-cultural identities of males where prestige, maturity, and masculine identity were associated with a young man's ability to "fill a pram". Providing these young men with condoms was of little use in such situations, rather the broader socio-cultural and economic dimensions of the community needed to be addressed, if any progress was going to be made in reducing teenage pregnancy rates. Interestingly one of the commentators on my dissertation, a community physician, described my work as excessively anecdotal, inappropriately based on too small a sample size, and too subjective. Fortunately the Professor of Public Health who led the Masters strongly supported my work and agreed the insights I have provided on this community were very powerful. The debates about the value of qualitative research are not new, and have been regularly articulated (Bryman and Burgess 1994; Silverman 2013), as have attempts to accurately define qualitative research (Mason, 2002; Blaikie 2007), and the range of philosophical traditions and methodological techniques and practices that underpin such research. As Mason (2002) argues, criticisms that qualitative methodologies are merely anecdotal or illustrative, practiced in casual and unsystematic ways, totally ignore the strengths of methodologies that can capture "*richness, depth, nuance, context, multidimensionality and complexity,*" (2002, p.1).

Since completing my Masters, Public Health has moved on significantly from a restricted consideration of biological phenomenon, to exploring wider societal patterns and contexts, and focussing specifically on the need to reduce health inequalities as evidenced in the Marmot Review "*Fair Society, Healthy Lives*" (2010). There is now a clear understanding, which I acknowledge in my professional practice, that causal pathways to secure population health improvement are likely to be longer, more complex and more diverse. Moreover the insistence on exploring the wider socio-economic determinants of health, and consider whole systems approaches to the promotion of health, are now mainstream in my public health professional activities.

Section 1.3.1 has identified my professional interest in the research topic of GPs and childhood obesity. In my career I have worked in the NHS in a primary care managerial role working directly with GPs, and in a Local Authority both as a Service Director in Children Services and more recently in a Public Health strategic role which includes professional leadership on childhood obesity. The experiences of working in the latter two roles have resulted in my personal motivations to seek continuous service improvement for a vulnerable group of children who are often marginalised and face considerable challenges and

discrimination. I see examples on a frequent basis of Puhl and Latner (2007) conclusion that *“the stigmatization directed at obese children, by their peers, educators, and others, is pervasive and often unrelenting.”* (2007, p. 574).

My decision to pursue a Professional Doctorate enabled me to continue in full time employment whilst studying and remain immersed within my field of professional work (Gregory, 1995). It was also in line with my ambition to acquire further professional research competencies, develop specific fields of expertise and to contribute to my professional body of knowledge, (Neumann, 2005; Wellington and Sikes, 2006). However, the determination to further advance and enhance professional practice (Lee, 2009) in the area of childhood obesity and produce new and original knowledge that would inform and underpin professional practice, was my ultimate consideration for both the choice of the Professional Doctorate and in the research topic.

Participating in the Professional Doctorate has provided me with an extremely valuable opportunity to revisit and further explore my epistemological position in order to embark on my thesis. My emerging epistemological position is critical realism, (Bhaskar, 2010) positing that knowledge is more than what can be measured directly, but includes that which exists underneath the surface of observable phenomena, and to some extent can be ascertained by theoretical reasoning (Archer, et al., 1998). Bhaskar (2010) distinguished between meanings of actions, which are social and inter subjective in character, and beliefs about, or reasons and motives given, for actions which are personal. He considered it important to distinguish the knowledge and meanings used in action from the belief and motives that prompt or rationalize it (Bhaskar, 1983, p.298). In relation to this thesis I was interested both in the decision making process which GPs used to decide how, and when, they would intervene and support children who are obese, and also how this related to their beliefs about childhood obesity and motivations around such interventions. It was felt that this was crucial to seek further understanding of the diversity and range of actions that GPs would or would not initiate with families and children who are obese.

Moreover, I hold the position that there is no unmediated access to a reality beyond us, and it is not possible to access an individual's world directly because there is no clear and unmediated window into that life. Investigating how events are experienced and given meaning, requires interpretative activity on the part of the participant and the researcher, and in the dynamic interaction between the two (Eatough and Smith 2006). Any findings from the

research are not the unmediated voice of the participants, but an interpretation from my professional and personal perspectives, experiences, values and pre-understandings (Smith et al., 2009). It is this emphasis on interpretation in IPA that I find appealing in my intentions to move away from simply describing the experiences of the participants in this study towards an understanding of the phenomenon that is context specific and inclusive of both the individual and the researcher.

#### **1.4. Overview of research aims.**

In December 2010 Research Ethics approval was secured from the University of Salford Research Ethics Committee to proceed with the research study, “*Exploring General Practitioners’ (GPs) experiences of identifying and managing childhood obesity*” (Appendix Four). The context and motivations for the study outlined in section 1.3.1 and the determination of the research methodology, described in section 1.3.2, led to the development of the following research aims.

The aims of the research were:

- To explore the experience of identifying and managing children who are obese from the GP’s perspective.
- To identify variations in these accounts which impact upon the type of responses that GPs provide.
- To relate the GPs’ perspectives on childhood obesity to current policy, in order to produce practical suggestions for improving service provision.

##### **1.4.1. Definitions**

In introducing this study it is necessary to provide a number of definitions which underpin the research.

##### **1.4.1.1. Childhood obesity.**

Childhood obesity is a complex and, at times, contested issue (Harrison 2012; Lupton, 2013). This complexity starts at definition. Obesity refers to an excess level of body fat (adiposity) and the measure of adiposity in children is a customised version of the weight measurement used with adults, known as the Body Mass Index (BMI), (Cole et al., 2000). The adjusted measure for childhood obesity is created using data from several international growth surveys

to develop a statistical definition of childhood obesity, (Cole et al. 1995). In sum this extrapolates the adult BMI definition (weight in kilograms/height in metres squared), where adults are classified as obese if their BMI exceeds 30kg/m<sup>2</sup>, or overweight if their BMI is greater than 25kg/m<sup>2</sup>, and uses variable thresholds that take into account the child's age and sex, (Cole et al., 2000). It is also important to note that the population monitoring thresholds used for most published obesity and overweight prevalence figures, including those using the National Child Measurement Programme (DoH, 2006) data differ from the clinical cut-offs recommended by NICE (2006) for use in clinical settings with individual children. A clinical diagnosis of childhood obesity is based on a BMI above the 99<sup>th</sup> percentile (NOO, 2013) but on the 95<sup>th</sup> centile for population monitoring.

The adoption of this BMI classification has had some benefits in research, enabling comparisons across data. However, NICE Guidelines (2006) issue caution in relation to BMI measurements as they cannot provide an accurate assessment of adiposity, primarily because they do not take into account body composition (lean and fat mass; muscle and bone ratios), and distribution of adipose tissue (Saxena et al., 2004). BMI can also underestimate the levels of overweight and obesity in young people (McCarthy et al., 2003). The recent NICE Guideline 47 (2013) also cautions that assessing the body mass index (BMI) of children is more complicated than for adults, because it changes as they grow and mature, and growth patterns differ between boys and girls. Although the choice of BMI as a measure of obesity in children is well established (Reilly et al., 2002), there is also emerging evidence to suggest that central adiposity in children is more relevant to health outcomes than overall adiposity estimated by BMI (Rodríguez-Rodríguez et al., 2011). Waist circumference has been advocated as a good indicator of central adiposity (Savva et al., 2000) and waist-to-height ratio (WHtR) has also been proposed as an additional indicator of childhood abdominal obesity (Griffiths et al., 2012). A further tool for monitoring and comparing the weight of groups of children and young people, is BMI z scores. These are a measure of how many standard deviations a child or young person's BMI is above or below the average BMI for their age and gender (NICE, 2013).

The use of the BMI data for children is widespread in the research base which will be addressed in Chapter 2 and therefore the data in the chapter should be read with an acknowledgement of these complexities. During the research interviews both the clinical diagnosis of childhood obesity based on a BMI above the 99<sup>th</sup> percentile (NOO, 2013) and the 95<sup>th</sup> centile for population monitoring were discussed with the participants.

#### **1.4.1.2. Children.**

In the context of this study “children” is the collective term used by the UN Convention on the Right of the Child (Southall et al., 2000) to describe those aged between 4 and 11 years. This age range is also consistent with the National Child Measurement Programme (DoH, 2006) surveillance data used to analyse trends in patterns of childhood obesity. It is acknowledged that defining discrete age ranges can sometimes be artificial. During the research interview process a definition of the age range pertaining to this study was identified and discussed with the participants.

#### **1.4.1.3. General Practice.**

This study is located in the contemporary setting of NHS General Practice in the UK, in which General Practitioners (GPs) contractually deliver General Medical Services to a defined registered population. In the UK, over 80% of the population consult General Practice annually with an average of 5.4 consultations per person per year (NHSIC, 2009). More than a quarter of the workload of general practitioners arises from consultations with children (NHSIC, 2009). Research based on a survey of 503 practices, found a mean annual consultation rate of 6.72 for children less than 5 years, and 2.5 consultations per year for children aged 5 - 9 per year (NHSIC, 2009).

#### **1.4.2. The research site.**

The research in this thesis was carried out with GPs who practiced in Stockport, an area located in the South East of the Greater Manchester conurbation. Stockport has a population of 283,900, which is a slightly older age profile than the national average, and is less ethnically diverse than the national average (ONS, 2012). The 2007 Index of Multiple Deprivation, ranked Stockport as having average levels of deprivation on a national scale, however within Stockport there is a considerable spectrum, ranging from very affluent areas to the south and east of the borough to significantly deprived areas in the north and centre of Stockport. There are 50 GP practices located within the borough and 184 GPs.

Appendix Thirteen provides data on Stockport childhood obesity prevalence. In reception aged children, Stockport had significantly lower rates than both the national and regional average for overweight and obese prevalence throughout the period 2006-07 to 2011-12. However in 2012-13 Stockport saw a significant rise in the number of overweight reception children, whereas nationally there had been a slight fall. More favourably the status quo has

remained in obesity prevalence and Stockport still has significantly lower rates than the national and regional average. Obesity rates in Stockport year 6 children have been significantly lower than the national and regional average since 2006-07 up to 2010-11. In 2011-12 the Stockport prevalence was similar to that of both the regional and national rate. In 2012-13 Stockport has returned to having significantly lower rates of obesity in year 6 children than the national and regional average. In Stockport there is a clear deprivation profile, with the most deprived children presenting significantly higher rates of overweight and obesity combined than the Stockport average in all years in both reception and year 6. Conversely the 40% least deprived reception children and 20% least deprived year 6 children show significantly lower rates than the Stockport average over the same time period.

### **1.5. Contribution to knowledge.**

This study will provide an important opportunity to advance our knowledge of GPs' experiences of childhood obesity in a primary care setting. It will add considerably to the limited research in the UK on GPs and childhood obesity, which to date, has focused mainly on the barriers, which inhibit the engagement of GPs in the identification and management of childhood obesity (Walker et al., 2007; Turner et al., 2009; Redsell et al., 2011; Banks et al., 2012). The literature review in Chapter 2 will highlight that the majority of published studies have been primarily descriptive in nature, and there have been relatively low levels of in-depth analysis conducted within this complex area of clinical practice. As the research presented in this thesis will be the first known attempt to utilise Interpretative Phenomenological Analysis (Smith et al., 2009), it will illuminate the value of this intense, interpretive methodological approach in providing additional explanatory insight in to the GPs' perspectives and experiences of responding to childhood obesity in a primary care setting.

In addition the literature review will reveal limitations in terms of the unique focus on GPs in many of the studies. Previous research on the experiences of GPs and childhood obesity in the UK setting, tend to discuss GPs within a community of health professionals. For example the findings, discussions and conclusions in Walker et al., (2007) and Redsell et al., (2011) refer to both GPs and Practice Nurses, and the unique focus on GPs, as a distinct group of professionals is diluted. In other research (Turner et al., 2009; Banks et al., 2012) the overall findings over simplify the GP community presenting them as a single entity, and the research offers little exploration of any diversity and variations within their sample. The research in

this thesis will focus solely on a group of GPs who have been in practice for over 25 years and will focus specifically on their skills, motivations and experiences. This sub group of GPs have not previously been purposefully sampled in the literature on childhood obesity, and therefore the research in this thesis will provide a new and additional contribution to the existing literature.

The considerable variance and differences in the ways GPs address and respond to the issue of childhood obesity will be also be highlighted, explored and discussed in this thesis, adding significantly to the existing literature, (Walker et al., 2007; Turner et al., 2009; Banks et al., 2012; Redsell et al., 2011). These divergent views will be closely examined to challenge current generalisations and offer a new extended insight into the behaviours, views and attitudes of GPs in relation to childhood obesity. The themes that will emerge following the methodological approach prescribed in IPA, will provide a deep understanding and coordinated explanatory analysis through exploring the phenomena with the GP as the “*experiential expert*” (Smith 2008 p.16).

Addressing the second aim, this thesis will contrast the thematic findings that emerge from the interpretive analysis with other research in order to identify new areas of understanding and extended insight. The identification of the likely epistemological frameworks which frame the GPs’ responses and the presentation of GP role typologies in Chapter 5, will extend the analysis beyond those revealed in the initial emergent themes, and add a unique, novel and a significant contribution to the existing literature. Collectively the findings and discussions will provide further directions for professional practice in commissioning, designing and developing interventions that will support GPs to provide a more effective response to children and their families. By exploring what is current mainstream practice, as opposed to what policies and guidelines have determined, there will be a stronger evidence base to construct programmes to support GPs in this growing and important area of clinical practice.

## **1.6. Structure of the thesis.**

The thesis is presented over six chapters. Chapter One has provided an overview of the emergent policy context for both childhood obesity and General Practice in order to position the research topic. It has outlined the professional and personal motivations for the research and the researcher’s epistemological framework. It details the research questions, related definitions which frame the study and the chosen methodology of IPA (Smith et al., 2009). It has highlighted the ambitions of providing practical recommendations that can drive



professional and policy advancement in the area of GP identification and management of childhood obesity.

Chapter Two provides a comprehensive overview of the current literature relating to the research questions of GPs' experience of the identification and management of childhood obesity. It critically examines the contribution of the literature to the debate around the research topic and identifies gaps in the literature which this thesis will seek to address.

Chapter Three focuses on the methodological choice of IPA (Smith et al., 2009) and details the research methods. The chapter provides an overview of the research setting and offers justification for the sampling strategy, the recruitment techniques and the use of semi-structured interviews for data collection. The theoretical foundation of the methodology is presented, and a discussion of the detailed data analysis procedures and the emergence of themes are provided. The chapter demonstrates how quality criteria were secured and includes a summative section on reflexivity.

Chapter Four starts with a summary of the findings of the qualitative interviews based on the 4 superordinate themes that are identified by the analytical methodological approach. The detailed sub themes within the super-ordinate themes are presented alongside direct illustrative quotes from the participants to add interest and clarity for the reader. The chapter ensures that the variances within the findings are highlighted and explored.

Chapter Five presents a coherent synthesis and discussion of the original findings that are contextualised in relation to the policy context offered in Chapter One, and in comparison with the existing literature review in Chapter Two. New literature to extend the thematic discussion is also considered. This chapter also provides an additional explanatory structure by considering the GP typologies identified in Laws et al., (2009) and the underlying epistemological frameworks of the GPs, to add robustness to the completed final discussion. The limitations of the study are presented.

Chapter Six concludes by summarising the complete thesis and the original contribution made by the research, and also identifies areas for further research. The chapter examines the implications of the study findings in order to improve the care of children who are obese, and offers recommendations at both a national policy and local commissioner level, and for individual GP practices.

## **Chapter 2: Literature Review.**

### **2.1. Introduction.**

This chapter will explore the literature on GPs' experiences of identification and management of childhood obesity through an evaluation of the relevant publications. Section 2.1 outlines the literature search strategy. Sections 2.2 to Sections 2.6 provide a contextual overview of the literature relating to the health, social and economic consequences of childhood obesity. These sections also explore the relevant literature relating to the prevention of childhood obesity, where settings outside of general practice seem to be the most effective; and the management of childhood obesity, concluding that the evidence of effective management interventions is extremely limited. Section 2.6.1 to Section 2.6.6 provides a critical summary of the literature pertinent to the research question of GPs' experiences of childhood obesity. It includes the views of GPs about their perceived roles, their perspectives about the causes of childhood obesity, and their reported experiences in the identification and management of childhood obesity in a primary care setting. Wider pertinent issues such as training and competence and how the infrastructure and organisation of primary care impact on their responses are also considered. Section 2.6.7 focuses specifically on the perspectives of GPs working with parents of children who are obese, and incorporates additional literature on parental needs, expectations and behaviours, and the views of parents regarding primary care interventions. The summary in section 2.7 draws together the discussion of GPs' experiences of the identification and management of childhood obesity and highlights the gaps in existing knowledge which this study aims to address, thus confirming the relevance of the key research questions in this thesis.

A review of evidence to address the research question of the experiences of GPs in identification and management of childhood obesity was undertaken using relevant databases and websites. Searches were carried out from the commencement of the Doctorate in September 2009 and systematically since that date until March 2014. The key words in the search strategy, "childhood obesity", "beliefs", "attitudes", "experiences", "knowledge", "views", "primary care professionals", "general practitioners", "practices", "parents", "prevention", "identification", "treatment" and "management" were entered into the following databases; PUBMED, MEDLINE OvidSP, SCORPUS, EMBASE, PSYCHINFO, CINAHL. The literature review was enhanced by access to the regular National Obesity Observatory research updates. Studies published in the English language between 1980 and 2014 were

included and studies were in the main limited to those countries with a high degree of applicability to the UK; including the USA, Canada, Western Europe, Australia and New Zealand.

## **2.2. The health, psychological and social consequences of childhood obesity.**

Childhood obesity is a complex, multifactorial condition that results from an interaction between genetic, environmental and behavioural factors, (Maffeis, 2000; Murray and Battista, 2009). Emerging research has attributed the growth in childhood obesity to a vast and often diverse range of factors including excessive food portions (McCrory et al., 2000), fast food consumption by young people (Ebbelling et al., 2002; Thompson et al., 2004), skipping breakfast (Niemeier et al., 2006), consumption of sweetened beverages (James et al., 2004), irresponsible food marketing (Lobstein and Dobb, 2005), sedentary lifestyles (Eisenmann et al., 2004), insufficient sleep (Chaput et al., 2007), increased television viewing (Crespo et al., 2001) and reduced breastfeeding (Arenz et al., 2004; Bovbjerg et al., 2013).

Whilst the causal factors of childhood obesity are complex, the serious health risks, both physical and psychological of childhood obesity are well recognised, (Reilly et al., 2003, Oude Luttikhuis et al., 2009; Reilly and Kelly, 2011), and are likely to have major implications for both population health and costs to health services (Butland et al., 2007). Children who are obese are at increased risk of chronic health diseases, such as cardiovascular disease, hyperlipidaemia, hypertension, insulin resistance and abnormal glucose tolerance (Reilly et al., 2003; Weiss and Caprio, 2005; Verbeeten et al., 2011; Lakshman et al., 2012). In addition asthma, non-alcoholic fatty liver disease, and obstructive sleep apnoea occur with increased frequency in obese children, (Dietz, 2004; Ebbelling et al., 2002; Lobstein et al., 2004). Research has indicated that when childhood obesity persists into adulthood it is associated with the development of several risk factors in heart disease, including hyperinsulaemia and hypertension (Janssen et al., 2005; Logue and Sattar, 2011) and carries an increased risk of premature morbidity and mortality (Franks et al., 2010; Juonala et al., 2011; Reilly and Kelly, 2011.) A recent analysis of hospital admissions for obesity-related diagnoses among 5–19 year olds in England found these to have more than quadrupled since 2000 (Jones Nielsen et al., 2013), with the majority of admissions for conditions where obesity was mentioned as co-morbidity, including sleep apnoea and asthma, (Jones Nielsen et al., 2013).

Obesity in childhood is known to have a significant impact on psychosocial health, and lead to an increased risk of developing behavioural and persistent psychosocial problems (Sjoberg et al., 2005; Griffiths et al., 2010). In addition, children who are obese are likely to experience bullying (Griffiths et al., 2006) which can affect their performance at school (Caird et al., 2011) and social functioning (Griffiths and Page, 2008). Children who are obese are known to become targets of significant discrimination and stigmatisation, (Dietz, 2004; Tang-Peronard, 2008).

### **2.3. Costs associated with childhood obesity.**

Rudolf et al., (2006) argues that if obesity could be reversed in childhood the benefits to individuals and the savings to the health service would be significant. Whilst research to quantify the economic costs associated with child obesity is still emerging, a review of nine recent studies of the economic burden of child obesity in different countries, reported that most found increased healthcare costs for obese children (Pelone et al., 2012). Analyses presented in the Chief Medical Officer Annual Report, *“Our Children Deserve Better: Prevention Pays”* (2013) suggest that the total current cost of treatment of child obesity and its associated consequences in England is £51 million per year. The report also identified that the long-term healthcare costs which can be attributed to child obesity in England are estimated to range between £172 million and £206 million. These figures draw on the healthcare costs of treating adult obesity and include the direct costs of treating obesity, including GP consultations, hospital attendances and prescription drugs, and the direct costs of treating the health consequences of obesity, for example type 2 diabetes, hypertension, myocardial infarction, stroke, selected cancers and osteoarthritis. The figures also include indirect costs as a result of loss of earnings attributable to premature mortality, incapacity and sickness. The estimates are based on the assumption that 68% of the obese child population aged 2–15 in 2012 will grow into obese adults (Park et al., 2012), and that treatment costs remain constant.

### **2.4. The prevention of childhood obesity.**

Waters et al. (2011) systematic review of the effectiveness of interventions for preventing childhood obesity considered interventions targeting diet and nutrition, and physical activity, and found that programmes were effective at reducing adiposity levels, although not all individual interventions were effective and studies varied greatly. This review of 55 studies, targeted at children aged 6-12 years, included a further meta-analysis of 37 studies of 27,946

children. Of the interventions considered, those combining dietary and physical exercise components were found to be more effective than isolated programmes. The authors identified a range of more promising strategies, typically based in a school setting, including school curriculums that promoted healthy eating and physical activity, increased sessions for physical activity and improvements in nutritional quality of the food supply in schools. In addition, they concluded that environments, cultural practices, parent support and home activities that support children eating healthier foods and being active contributed most to the beneficial effects observed (2011. p. 35).

The conclusions by Waters et al., (2011) were confirmed in a more recent review of child obesity prevention programmes (Wang et al., 2013). In this review, 124 intervention studies were considered, of which 84% were school based, although frequently with components implemented in other settings such as the community. The review found strong evidence that school-based combined diet and physical activity interventions and home (e.g. involving parents) or community programmes have some success in preventing childhood obesity.

However outside of the school and parental environment, there is a lack of high-quality studies that test environment or policy-based interventions to prevent childhood obesity, such as regulations on food retailing and distribution (Ding and Gebel, 2012). In addition, Bambra et al., (2013) have highlighted the lack of accessible evidence on interventions to reduce inequalities in childhood obesity, and their paper (Bambra et al., 2013) previewed a future systematic review, yet unpublished, which will examine the effects of individual, community and societal level public health interventions on addressing socioeconomic inequalities in childhood obesity (2013, p.16).

## **2.5. The management of childhood obesity.**

While population-based primary prevention strategies are undoubtedly essential to prevent any further increase in childhood obesity, and the resultant health, psychological and social consequences, it is recognised that the management of childhood obesity is also critical (Summerbell et al., 2003, Wake and McCallum, 2004). Oude Luttikhuis et al., (2009) identified that treatment for childhood obesity shares the same fundamental principles as treatment in adults, which is to decrease calorie intake and increase energy expenditure. However, Oude Luttikhuis et al., (2009) highlight the challenges of evaluating childhood obesity interventions given the fact that the primary goal of treatment (weight reduction or deceleration of weight gain), and the recommended mode of intervention is variable,

dependent on the child's age and BMI level. The lack of equivocal evidence to successfully address these complexities, particularly in the long-term, has made it difficult to draw firm conclusions regarding sustainable treatment options (Oude Luttikhuis et al., 2009; Whitlock et al., 2010).

The most current systematic review of childhood obesity treatments (Oude Luttikhuis et al., 2009) included 54 RCTs (5,230 participants), of which 12 were published studies of lifestyle interventions focussing on physical activity and sedentary behaviour, 6 studies of diet modification and 36 studies of behaviourally orientated treatment programmes. It concluded;

*“ While there is limited quality data to recommend one treatment programme to be favoured over another, this review shows that combined behavioural lifestyle interventions compared to standard care or self-help can produce a significant and clinically meaningful reduction in overweight in children and adolescents.”* (2009, p.2).

However, in relation to interventions to reduce childhood obesity in a primary care setting in the UK the evidence is very weak. This is confirmed in the NICE guideline 43 (2006) which, whilst offering a comprehensive summary of the international literature, provides no evidence of studies carried out in primary care in the UK, (Mercer, 2009). Section 5a of the NICE guideline, *“Management of obesity in clinical settings (children): evidence statements and reviews,”* (2006) concluded that;

*“Insufficient evidence is available on the effectiveness of interventions for overweight children and adolescents that can be conducted in primary care settings or to which primary care clinicians can make referrals.”*(2006, p. 465)

Outside of the UK, two trials, one randomised trial in Australia (McCallum et al., 2007), and one non-randomised in the US (Schwartz et al., 2007) evaluated brief, individualised primary care interventions targeting overweight or mildly obese children identified by screening. Neither of the studies was effective in reducing participant's BMI relative to controls. Wake et al., (2009) completed a RCT, including 45 family practices (66 General Practitioners) and 258 children in order to evaluate the LEAP 2 programme, a structured secondary prevention programme in primary care. The authors concluded that,

*“Primary care screening followed by brief counselling did not improve BMI, physical activity, or nutrition in overweight or mildly obese 5-10 year olds, and it would be*

*very costly if universally implemented. These findings are at odds with national policies in countries including the US, UK, and Australia.” (2009, p.339).*

Since the NICE guideline (2006) and the systematic review of childhood obesity treatments by Oude Luttikhuis et al., (2009), Banks et al., (2012) presented initial findings that offer a contribution to the literature on a UK based primary care childhood obesity intervention. The findings in their paper (2012) relate to the “*Primary Care – Care Of Childhood Obesity Study*”. Children and adolescents between the ages of 5 and 16 years with a BMI categorised as obese were identified from General Practice databases in Bristol UK, and invited for a primary care consultation. It is unfortunate that Banks et al., (2012) paper does not provide any outcome data on children’s BMI following the intervention outlined in the study, but its process findings are useful to consider in relation to the research question of this thesis.

Banks et al., (2012) reported that 285 letters were sent and almost half of the patients (134) consulted their GP in the follow-up period (minimum 3 months). However, only 42 of these consultations involved the GPs and the parents actually discussing the child's weight. Of these, 19 patients received a secondary care referral to a specialist clinic comprising medical, dietary, and exercise intervention, and 6 received an alternative weight-management referral. The researchers concluded (2012 p. 494), that the low take-up indicates the limitations of postal invites, but also highlights the inherent difficulties of engaging families and their children who are obese in care pathways that facilitate long-term weight management. The findings are consistent with previous studies (Grimmett et al., 2008) which indicate that negotiating a discussion regarding children’s weight can be a very sensitive difficult area for children, parents, GPs, and other healthcare workers. Banks et al., (2012) research also highlighted the reservations that parents may have in discussing and managing their child’s weight issue, even though the letters offered the potential for specialist medical, dietary, and exercise interventions. In addition Banks et al., (2012) highlighted the “*striking disjuncture*” (2012, p. 495), between those parents who consulted (n = 134) and those where a discussion about weight was recorded (n = 42). Thus, it appeared that even though the parental invitation was recorded in the clinical record, the GPs did not always use the opportunity to raise the issue. It was acknowledged by the researchers that this may relate to the nature of the condition with which the patient presented, as severe acute illness may limit the opportunity to introduce the issue of weight. However, these findings challenge previous reports that GPs were reluctant to engage with child obesity because of limited referral options (King et al.,

2007), as Banks et al., (2012) indicate that even with an available referral pathway there was a reluctance by GPs to engage in weight related discussions with children and their families.

In summary this section has confirmed there is very little published data that reviews quality primary care interventions in both the UK and in the international literature. Despite this being acknowledged by the Department of Health in 2005, it is concerning that there has been little progress in research. The NICE guideline (47) on Childhood Obesity Weight Management Programmes (2013) reiterates again the need for further research on the effectiveness of treatment in the primary care setting.

## **2.6. Childhood obesity and General Practice.**

Both the UK and the international literature have identified a range of consistent factors that impact on the experiences of GPs in the identification and management of childhood obesity. In order to explore previous research relating to the research question of this thesis, the literature will primarily consider GPs' knowledge, attitudes, beliefs and practices. It is acknowledged that the organisation of General Practice in England, in terms of the contractual arrangement, reimbursements mechanisms, accountability and political drivers varies from those in other countries, and therefore this literature review will define the countries in which the research took place in order to provide a wider contextualisation to the findings.

### **2.6.1 GPs' views about their role in identifying and managing childhood obesity.**

There is a relatively small, but emerging body of evidence in the international literature in the USA (Drohan, 2001; Story et al., 2002; Murray and Battista, 2009), Australia, (King et al., 2007, Pagnini et al., 2009) and Canada, (He et al., 2010) that highlights the views of GPs regarding their role in the identification and management of childhood obesity within the primary care setting. Van Gerwen et al's., (2009) systematic review of primary care physicians' knowledge, attitudes, beliefs and practices included 11 articles; eight from the USA, one in Israel and two in France. The review found evidence of primary care physicians reporting on the importance of primary care systems addressing childhood obesity. The prime reasons given were the significance of this issue for children's health (Price et al., 1989) the effect of being overweight on chronic disease risk, and the effects on the quality of the child's life in the future, (Story et al., 2002).

Research in Australia (McCallum et al., 2007) concluded it was logical that any package of interventions aimed at childhood obesity should include an intervention based within primary



care and working with GPs particularly given the importance of clinician acceptability, family involvement and sustainability. Whilst the Australian Weight of Opinion research (King et al., 2007) demonstrated that GPs felt confident and comfortable in dealing with assessment and managing the health consequences of obesity, their responses were mixed regarding their contributions to supporting families with behavioural interventions such as changing dietary behaviours. However, in contrast, Jelalian et al's., (2003) research suggested that some American primary care physicians considered childhood obesity counselling frustrating and not professionally gratifying.

A further view was expressed by He et al., (2010) who reported the responses of a representative random sample of 464 Canadian family practitioners to a self-administered 39-item survey, where the majority of GPs viewed childhood obesity as an *“important”* or *“very important”* issue. Although the majority reported providing dietary (more than 85%) and exercise (98%) advice, their perceived success rate in treating childhood obesity was limited (less than 22%). The authors concluded that the Canadian primary care system was *“not sufficiently equipped to combat this extremely complex issue”* (2010, p.426) highlighting too few government funded dieticians, time constraints and limited training for practitioners. In order to support efforts to identify or manage childhood obesity, they identified the need for office tools, patient educational materials and wider system-level changes addressing social and economic factors that may lead to increased rates of childhood obesity.

Campbell et al., (2000) also assessed, through a postal questionnaire, 840 Australian GPs' attitudes to their involvement in childhood obesity activities, and identified a range of predictive factors for the involvement of GPs. They found that involvement in childhood obesity increased by being female, receiving basic medical qualifications outside of Australia, attending continuing education and postgraduate training, and having confidence in dealing with babies, infants and preschool children. The most common barriers to involvement, according to Campbell et al., (2000) were insufficient time, inadequate financial reimbursement for long consultations, inappropriateness of raising the issues of childhood obesity in children presenting with acute illness, and lack of community resources.

To date, there have been three qualitative studies of the GP views and perspectives and experiences of the identification and management of childhood obesity in primary care in the UK, (Walker et al., 2007, Turner et al., 2009, and Redsell et al., 2011. A synthesis table of these UK studies is presented in Appendix Two. Turner et al., (2009) reported on 12 GPs

from 7 practices in Bristol, and found that most GP participants stated that they thought primary care was an appropriate treatment setting, as it was based in the community and offered scope for opportunistic interventions. The GPs put forward the view that they were known to families and could refer patients on for further support; they also felt that childhood obesity needed to be addressed before associated clinical complications developed (2009, p. 858). Walker et al's., (2007) study of 12 GPs in 11 practices in Rotherham however, found that the GPs in their study offered a more restricted view of their role which primarily was confined to raising the issue of a child's weight with parents, and managing only the associated medical problems. According to these GPs in this study the responsibility for "*solving the problem of obesity*", (2007, p.2) rested either with the family, or with a public health agency. Redsell et al's study (2011) in the East Midlands focussed on 12 GPs' views regarding identification of infants (those in the first 6 months of life) at risk of developing childhood obesity, and confirmed a strong rationale and acceptance by the GPs of the need to intervene in early childhood. However, the GPs were less likely to be consulted about infant feeding than Health Visitors, and were less confident about the advice they gave to parents, despite being more knowledgeable about the health risks of obesity. The GPs attributed their lower levels of confidence to the fact that infant feeding was not their primary role and that training was not readily available. Consequently their advice around infant feeding tended to be responsive, based on anecdotal or experiential knowledge. The GPs in this study reported adopting a parent-centred approach and were wary of adversely affecting the doctor-parent relationship. This research added to the literature by identifying that "*GPs value strategies that maintain relationships with vulnerable families*", (2011, p.58). However there is no indication in the paper how the term vulnerability is defined by the GPs or attempts to explore why the GPs felt this to be the case.

### **2.6.2. GPs' views on the causes of childhood obesity.**

The beliefs held by GPs about the causes of childhood obesity have been highlighted in only a small number of papers, but in the main, they confirm the complexity in determining causes and acknowledge the wide range of factors that can lead to childhood obesity. Lachal et al.'s (2013) systematic review of 45 qualitative studies, which included both international and UK studies, focussed on a comparison of the perspectives of children, parents and health professionals. The review found that the aetiological theories put forward by doctors and other healthcare professionals overlapped on multifactorial medical theories which included a combination of heredity and environmental factors (King et al., 2007; Pagnini et al., 2009).

However, Turner et al., (2009) suggested that the GPs in their study felt that obesity was a social and behavioural matter, rather than merely a medical problem, with the participants describing the main causes of childhood obesity as an unhealthy diet and lack of physical activity. These in turn were related to factors that the GPs felt were considerably beyond their scope of influence, such as the availability of junk food, unsafe streets, and a lack of family cohesion. Turner et al., (2009) found that the GPs used this complexity of the causes of childhood obesity to confirm their view that certain environmental and familial areas were outside of their clinical control (2009, p.859). Likewise Gerner et al., (2006) noted the Melbourne GP respondents' beliefs that the causes of childhood obesity were felt to be outside of the scope of their sphere of influence, and that as primary care practitioners they could only be one part of a broader approach to addressing childhood obesity, given the predominance of social causes. King et al.'s, (2007) study of Australian GPs found that they also included structural and social issues such as increasingly sedentary leisure pursuits, neighbourhood safety concerns, costs of sport, the availability of and exposure to energy-dense food, and advertising as causative factors in childhood obesity.

In addition Walker et al., (2007) reported that GPs believed that the causes of childhood obesity focussed primarily on individual family behaviours such as *“an unhealthy diet, lack of physical activity, and a lack of family cohesion”* (2007, p.69), referring to wider social and cultural norms about family behaviours and lifestyle practices. Edmunds (2005) suggested GPs were more likely to believe that parents bear sole responsibility for their child's weight, without acknowledging the environmental causes that can encourage weight gain. Interestingly Greener (2010) found significant conflicting perspectives of obesity causation and intervention among health professionals in the UK. Practitioners with a public health background, such as Health Visitors, offered ecological and political causation factors for childhood obesity, whereas the GPs were very focussed on individual behavioural traits such as lack of physical activities and poor diet as the major causes of childhood obesity. The recent Royal College of Physicians Report (2010) on training for health professionals in the prevention and treatment of childhood obesity reports that health professionals have a poor understanding and lack of recognition of the social and environmental determinants of obesity yet provides no references to research which would validate such an assertion.

### **2.6.3. Identification of children who are obese in a primary care consultation.**

If GPs are to actively become engaged in supporting children who are obese it is critical that such children are identified in a clear and systematic way. However, this can be problematic and published research identifies a clear diversity of practices amongst GPs. This literature review found very few studies that showed consistent and systematic use of BMI and height and weight measurements by GPs in assessing a child's weight, despite the fact that it has been shown that GPs fail to identify overweight or obese children on visual inspection only (Gerner et al., 2006). Smith et al., (2008) evaluated the ability of health care professionals to assess whether a child is overweight or obese study by providing photographs of 33 children aged 10–17 year. 80 health care professionals in the Yorkshire region were recruited for the study, (30 paediatricians, 20 GPs and 30 paediatric nurses). Whilst the study does not provide details of the outcomes specifically to GP, the authors conclude *“that health professionals in general are poor at assessing weight status and in particular tended to underestimate overweight and obesity in children.”* (2008, p.1066).

Detorri et al.'s. (2009) survey of 49 Australian GPs indicated that only a minority of GPs reported both measuring height and weight and using BMI for age percentiles as diagnostic criteria. Similarly, Wake and McCallum (2004) also recognised that diagnosis of overweight child in a primary care setting can be problematic. Their research of Australian GPs found few routinely weigh and measure children attending their practices in order to determine BMI status, and even fewer had equipment accurate enough to track changes over time. Gerner et al., (2006) completed practice audits of 34 GPs in Melbourne, Australia to assess the accuracy and accessibility of anthropometric equipment. They found that 44% of GPs reported regularly weighing children; 38% regularly measured children's height however, only 1% regularly calculated children's BMI, primarily due to the time commitments in terms of completing such processes. The authors also concluded, with concern, that *“the variability of anthropometric equipment audited could result in widely discrepant BMI values, leading to serious misclassification of many children's weight status.”* (Gerner et al., 2006. p.210).

Van Gerwen et al., (2009) found that between 50% and 80% of physicians in the papers identified in their review, relied on clinical impressions of the child's weight, (Barlow and Dietz, 2002; Goldman et al., 2004). Whilst Smith et al., (2008) suggest that it is not appropriate to rely on informal assessment to identify obesity, Redsell et al., (2011) indicated that for some GPs this was still the norm, and confirmed some of the difficulties the GPs

reported in the identification of obesity with very young children. For example one GP in this study declared, *“they don’t come in with their red books, so quite often I don’t know what centile they’re on, you just see a baby sitting on mum’s lap, and he just looks very chubby,”* (Redsell et al., 2011, p.6).

Whilst the NICE guideline 47 (2013) recommends that GPs weigh, measure and determine the BMI status this recommendation only relates to where there are concerns about a child or young person's weight, and currently there is no formal requirement or inducement for GP practices to record children's BMI. It is interesting therefore that Banks et al., (2012) in Bristol found that the overall number of children aged 5–16 years with a BMI recorded in the GP clinical record system of 12 practices, in the previous 2 years, whilst low (11.6%) was relatively close to the percentage prevalence of obesity in year 6 children in Bristol at 17.9%, (Banks et al., 2012). Whilst the authors acknowledged that they were unsure why such children did have their BMIs recorded by the practices, they suggest that this may be because the children had identified co-morbidities. It appears therefore that if routine screening is not likely to be achieved in primary care, there remains a potential for BMI data, which may be recorded for other purposes, to act as a trigger for GPs to consider raising the issue of weight and offering advice and referrals.

#### **2.6.4. Treatment and management of children who are obese in a primary care consultation.**

Van Gerwen et al., (2009) systematic review identified low levels of knowledge of primary care physicians about appropriate treatment and management regimes and a particularly low reported use of guidelines (Kolagotla and Adams, 2004). The review also found low levels of self-perceived competency to treat childhood obesity, (Price et al., 1989; Jelalian et al., 2003) and lack of clinical consensus around treatment. However, Sivertsen et al., (2008) study of GPs in South West Sydney challenged the view that reported use of guidelines equated to a lack of GP interest and found that although clinical practice guidelines adherence was far from universal, the GPs in this study were motivated and aware of the importance of managing childhood obesity.

Mazur et al., (2013) compared the attitudes, skills, and practices in childhood obesity management of primary health care providers from France, Italy, Poland, and Ukraine. Postal questionnaire was returned by 1119 participants, which had a limited response rate of 32.4%. The study revealed that most of the primary health care practitioners were aware of their

critical role in obesity management but did not feel sufficiently competent to perform this effectively. The adherence to recommended practices such as routine weight and height measurements, BMI calculation, and plotting growth parameters on recommended growth charts was also poor. Most primary health care practitioners in this review recognised the need for continuing professional education in obesity management, stressing the importance of appropriate dietary counselling. The authors concluded that the critical problem is not elaboration of guidelines, but rather creating support systems for implementation of the medical standards among primary health care practitioners.

Lachal et al., (2013) highlighted that most GPs, when managing a child who is obese in a primary care setting, tend to focus on nutritional and dietary advice (Holt et al., 2011) and the need for more exercise and less sedentary activities. Walker et al., (2007) extended this conclusion by reporting that whilst the GPs framed their interventions in terms of providing dietary and exercise advice, these were often felt to be ineffective, with a feeling of doubt that the advice would have limited impact upon the child's weight given the families' current eating patterns. This pessimism was reflected in one of the quotes from a respondent,

*“We talked about ‘five a day’ but this kid didn't eat five a week. Sunday lunch was the only time they ate vegetables. I have no great expectations that this kid will come back walking to school, eating ‘five a day’, and have lost any weight. I have very little faith.”* (Walker et al., 2007, p.5).

Turner et al., (2009) added a further perspective on the reluctance of the GPs in their study to sometimes offer little more than basic dietary advice, based on a view that parents may be unable to prepare healthy meals due to a lack of knowledge, money, or time. Again a quote from one of the participants reinforces the challenge that some of the parents felt, *“around here, to eat good food is expensive, finding the money to pay the rent is more immediate than whether they are getting the best fresh fruit and vegetables that they and their children need,”* (Turner et al., 2009, p. 860).

In addition, Turner et al., (2009) also found that some GPs in their study did not have the expertise or time to manage childhood obesity, and indicated that their concern that they had no effective treatment to offer, often affected their motivation to become further engaged in this area. When children did lose weight, they tended to think that they played little role in it, often attributing this to physiological changes such as growth spurts.

A further role presented in the literature related to the role of GPs in recruiting families to join weight management programmes. The recently publicised NICE guideline 47 (2013) on weight management interventions for obese and overweight children, highlights the key role of health professionals in referring children and families to community or clinic based weight management interventions. However the literature suggests that whilst both programme users and providers felt GPs should raise awareness, or refer children to lifestyle weight management programmes, there was an acknowledgment that this recommendation was rarely being sufficiently implemented, (Stewart et al., 2008; Watson et al., 2011). Other studies have also described circumstances in which children were not referred by GPs, or inappropriate referrals were made to such services, (Wolman et al., 2008; Woolford et al., 2010; Jinks et al., 2013).

Finally, the research literature has also identified that the perceptions of health professionals regarding childhood obesity treatment appear to be different than that of parents. Research by Staniford et al., (2011) of both parents and health care professionals, (which included GPs) found an agreement that treatment should be family based, incorporating physical activity, nutrition and psychological components, and should be delivered in local environments that are familiar to the recipients. However, there was incongruence between stakeholders towards the sustainability of obesity treatment interventions. For example, parents and children reported needing on-going support to sustain behavioural changes made during treatment, while health professionals suggested interventions should aim to create autonomous individuals who exit treatment and independently sustain behaviour change. Staniford et al., (2011) concluded that interventions need to incorporate strategies that promote autonomous and self-regulated motivation, to enhance families' confidence in sustaining behaviour change independent of health professional support.

Stewart et al., (2008) also highlighted the differences in opinions regarding treatment outcomes between parents and their doctors. For GPs the outcomes such as weight loss and improvement in BMI scores were of fundamental importance in the treatment of childhood obesity. However, for the parents interviewed in this study, weight and BMI were not a priority at the end of treatment; rather their prime desired outcomes were improvements regarding their child's self-esteem and quality of life. Further research has indicated that when families accept their child's weight status and are motivated to engage their children on a treatment programme, they have a number of outcomes they wish to achieve. For example, both the UK and international literature indicate that psychological wellbeing and improving

children's confidence and self-esteem appears to be highly valued among both children, (Holt et al., 2005; Murtagh et al., 2006; Morinder et al., 2011) and their families (Dixey et al., 2006; Stewart et al., 2008; Pescud et al., 2010; Twiddy et al., 2012). Stewart et al., (2008) suggested that the perceived benefits to children's self-esteem or quality of life were consistently more important than weight outcomes for parents. In addition the ambition to improve children's social integration, to make friends, or reduce bullying has been reported as key incentives to joining weight management programmes (Murtagh et al., 2006; Alm et al., 2008; Twiddy et al., 2012). Finally, improving the current health of the child and preventing future health problems were also described by parents and children as incentives to joining weight management programmes (Dixey et al., 2006; Alm et al., 2008; Watson et al., 2011; Jinks et al., 2013). It is perhaps inevitable that this lack of concordance on outcome measures between the priorities of the family and those of the GPs would lead to some frustrations from both parties, and provides challenges for commissioners and providers of weight management programmes.

#### **2.6.5. GPs' training and competence in relation to childhood obesity.**

One of the barriers for GPs engaging in childhood obesity work is often attributed to lack of competence and training (Jelalian et al., 2003), and the majority of papers recommend the need for training in order to improve their skills and interventions. Van Gerwen et al., (2009) highlighted a strong consistency among primary care physicians in relation to their perceived competence to manage obesity in children and adolescents with only 5% to 33% declaring them competent in treating childhood obesity. The review concluded that "*there is a need for education of primary care physicians to increase the uniformity of the assessment and to improve physicians' self-efficacy in managing childhood obesity*" (2009, p.235).

GPs participating in the Australian LEAP trial for overweight or mildly obese 5-10 year old children (McCallum et al., 2007), reported feeling unsure how to conduct consultations and found it difficult to put knowledge into practice. The authors concluded that there was a clear need for GPs to master specific techniques for complex behaviour change, such as motivational interviewing or brief, solution-focused therapy, in order to be confident in both broaching potentially sensitive issues with parents, and developing programmes and interventions to support parents. Story et al., (2002) reported that US primary care physicians also identified the need for training that focused on behavioural management strategies for parents and children, including guidance on parenting techniques which addressed family



conflict. In a further study of Australian GPs carried out by Detorri et al., (2009), 93% of the 33 respondents agreed that GPs had a role in management of childhood obesity, and that the educational programme they had participated in had made them more aware of the need to identify obese children. However, only 57% of the GPs reported changing their practice following the completion of their training.

The issue of training GPs on the identification and management of childhood obesity is therefore a contested one in the literature. Some studies have shown that structured training for health professionals has been successful in improving self-efficacy, attitudes and knowledge around childhood overweight and obesity (Crawford et al., 2004). However, other research has shown that even with additional training GPs did not always use their newly acquired skills (Banks et al., 2012) when other more pressing priorities in their practice workload reduced their opportunities to use these skills. Finally, Turner et al., (2009) asserted that whilst additional training and funding might improve management within primary care, factors such as time and resources which are unrelated to practitioners' skills may continue to limit the effectiveness of any treatment provided. In addition, Turner et al., (2009) acknowledged that GPs limited and infrequent contact with primary school aged children meant that there was a risk that they were unlikely to develop or extend their competencies because of the low prevalence of contact with this age group.

#### **2.6.6. General Practice infrastructure.**

Interestingly, in relation to childhood obesity and GP interventions, Wake and McCallum (2004) identified similar barriers to that of adult obesity management in primary care, including lack of time and competing workload priorities. Walker et al.'s, (2007) study of GPs also identified lack of resources and time, and Findholt et al., (2013) found similar barriers when exploring the perceived barriers to childhood obesity interventions amongst rural GPs in Oregon, USA. This study also identified time constraints and competing priorities during acute visits which made it difficult to conduct a comprehensive assessment of obesity risk and effectively counsel patients on diet and physical activity. A number of practising GPs have argued in editorials, often following the release of national guidelines, that primary care is not a suitable setting for the treatment of obesity, citing such issues as time constraints, skill shortages and a perceived limited effectiveness of their contribution (McAuley, 2006; Jarvis, 2006).

### **2.6.7. Working with parents of children who are obese in a primary care setting.**

There is a rapidly growing literature which indicates the crucial role that parents play in influencing children's weight related behaviours, such as their control of food habits and physical activity, which in turn are influenced by broader social and cultural norms (Pagnini et al., 2009). Intervening with families is significant as parental support of health promoting behaviours can impact positively on a child's weight, (Edmunds et al., 2001; Campbell et al., 2006). The NICE guideline 43 (2006) recommends;

*“All actions aimed at preventing excess weight gain and improving diet intake and activity levels in children should actively involve parents and carers.”* (NICE, 2006 p.20).

Despite this acknowledgment, the literature identified in this review, indicates that relationship between the GP and the parent of a child who is obese is often complicated and complex. For example, Story et al., (2002) research of American family physicians found that the most frequent challenges identified were the lack of parental involvement and motivation to address the issue of their child's weight, and concern that parents were not aware of the issue. They also identified an absence of support services such as behavioural management strategies, and guidance in parenting techniques, and addressing family conflicts. There is growing evidence which links wider issues of family functioning and childhood obesity. Halliday et al's., (2013) systematic review of 21 international studies concluded that poor communication, poor parental control and management of the child's behaviour and high levels of family conflict were associated with increased risk of obesity and overweight in children and adolescents. In the UK, Twiddy et al., (2012) research of parents attending Watch-It, (a UK-based community child weight management programme) found that parents struggled to provide consistent messages and were often permissive in their parenting style, for example not being able to resist their children's demands for treats, or excusing their children's behaviour if they refused to do any physical activity (2012, p.1315). King et al., (2007) also found that the GPs in this Australian study, focussed on the impact of parental influences when trying to address childhood obesity, which included a lack of knowledge of some parents on issues such as portion sizes, parental attitudes that link nurturing and eating, and parental modelling of poor eating practices.

Turner et al., (2009) suggested that whilst the GPs acknowledged the pivotal role of parents in managing childhood obesity they expressed further challenges in working with parents. These

included parents becoming defensive when their child's weight was raised, and refusing to accept that their child was overweight. Similar findings were reported in the Weight of Opinions Survey (King et al., 2007) in Australia where it was noted that GPs were deterred from raising the matter of childhood obesity because of parents' denial, or defensiveness about their child's weight. These perspectives identified by the GPs appear to have some validity in the literature. Research has indicated that parents, do not always recognise or accept that their child is overweight (Jeffrey et al., 2005; Edmunds, 2005; Stewart et al., 2008), may not be concerned (Eckstein et al., 2006), may have limited motivation to address their children's weight (Dixey et al., 2006; Stewart et al., 2008; Wong et al., 2010) or do not wish to discuss the subject with a health professional (Edmunds, 2005).

It is interesting that in terms of parental recognition Lachal et al., (2013) found that parents of obese children often relied heavily on comparative social markers to diagnose their children's weight problem; these included a wide range of factors from clothes size, general appearance, well-being and physical activity, and social and emotional distress (Jackson et al., 2005). However, a medical criterion was rarely mentioned by parents, (Jain, 2001; Edmunds, 2005). Jones et al., (2011) found that parents did not understand, use, or trust clinical measures and relied on alternative approaches, primarily dependent on comparisons with extreme cases. Research in the USA and Canada also found that parents may not recognise the detrimental health consequences of their children being overweight (Etelson et al., 2003; Carnell et al., 2005; He et al., 2010), and even when they do, may feel confused by the plethora of messages about strategies for addressing the problem. Evaluation studies in the UK of childhood weight management programmes also confirm that programme uptake was inhibited when families' did not acknowledge their child was overweight or obese (Murtagh et al., 2006; Stewart et al., 2008; Farnesi et al., 2012). Conversely when parents accepted and were motivated they were more likely to successfully engage with weight management programmes (Barlow and Ohlemeyer, 2006; Watson et al., 2011; Twiddy et al., 2012; Jinks et al., 2013).

The issue of GPs' concern about breaking or compromising their therapeutic ties with the family by tackling the subject of the child's obesity was highlighted as a key consideration in the literature review, (Lachal et al., 2013). Both Walker et al., (2007) and Turner et al., (2009) discussed the position of GPs who did not want to adversely upset parents and children by discussing what was often seen as a sensitive topic. Walker et al., (2007) highlighted one GP's concern *"I think, being honest, there is an element of not wanting to upset the child or the parent, despite the fact that I have no problem if an adult comes in, I'm quite blunt with*

*them, but it seems harder with children,”* (2007, p 54). King et al., (2007) found that the Australian GPs reported that children's weight was a sensitive topic which touched many of the emotions of the parents, and some of the GPs revealed that they felt that there were real risks of alienating families or losing them altogether by simply raising the issue of weight (2007, p.126).

Lachal et al. (2013) also highlighted a reticence amongst health care professionals to raise the topic of childhood obesity which is considered to be sensitive and often even taboo. They concluded that

*“Talking about obesity with parents means going beyond medical concerns, and facing the problem of family relationships. Talking to the child involves confronting social prejudices and stigma. In both cases, the risk that physicians want to avoid is the loss of therapeutic partnership by dealing with issues they do not quite consider as medical,”* (2013, p. 361).

The issue of sensitivity is also highlighted in the literature on parental concerns about the impact on the child of their excess weight. Pagnini et al., (2009) reported parents were concerned about upsetting or being too restrictive with their child, and thus disrupting the child and parent relationships (Shrewsbury et al., 2011). The consequential avoidance of emphasising their child's weight is consistent with research carried out by Jackson et al., (2005) who found that mothers' anxieties about their child's self-esteem meant that they were reluctant to discuss their child's weight. Curtis and Fisher (2007) captured the ambivalent and complex attitudes displayed by some parents who appear to be compromised by their desire to do something about their child's weight, primarily to reduce teasing and social isolation from their peers (Davis et al., 2007; Madowitz et al., 2012), but also are apprehensive about the potential consequences of initiating such action.

There is evidence in the literature to suggest that some parents of children who are obese adopt very protective attitudes. For example, Jackson et al., (2005) in Australia found that some mothers compensated for their child's weak self-esteem and poor social image using strategies to make the home a safe sanctuary. Some researchers have argued that childhood obesity actually creates a strong, protective, bond between parents and child (Dixey et al., 2006; Edmunds, 2005; Haugvedst et al., 2011). In addition, it has been identified that parents worry that discussing issues of weight may increase the risk of eating disorders (Eneli, 2007) despite the fact that there is no evidence to support this, (Shrewsbury et al., 2011).

Further research has found that clinicians are aware of the emotional links between nurturing, bonding and caregiving. King et al., (2007) reported that the use of food in the parent/child relationships was particularly significant, quoting one GP in their study who confirmed, *“It is very hard to tell a mother to stop feeding their child so much. It’s a deeply psychological thing,”* (2007, p.126). Turner et al., (2009) similarly showed that the GPs believed that parents used food as a symbol of affection and thus parents often felt uncomfortable denying their children food.

Finally, Gage et al. (2012) research on GPs and parents compared the views of GPs and parents about the causes, consequences and management of childhood obesity, and highlighted the varying positions, views and standpoints of the two stakeholders. The research surveyed all GPs on a PCT list in Southern England, and all parents in one primary school in southern England. 184 questionnaires (31.6% response rate) were returned by the GPs and 135 (35.5%) of parents. They reported that almost all GPs and parents (>95% in both groups) recognised that inadequate physical activity was a cause of overweight or obesity in children, and 90% of the participants identified poor diet. Both GPs and parents agreed unanimously that parents should be involved in the management of childhood obesity, but parents were significantly more likely than GPs to think that the GP should be involved, and GPs were significantly more likely than parents to agree that school nurses and children should be active participants. Less than one quarter of parents stated that GPs should take ‘no action’ when an overweight child presents with an unrelated minor illness, compared to 43% of GPs. High proportions of parents thought that GPs definitely should, or should, become involved in management through height and weight assessments, calculation of BMI, and referral to other services to support the child. In contrast, much lower proportions of GPs said it was very likely or likely they would perform these tasks.

#### **2.6.8. Parents’ view of GPs and primary care consultations.**

The final section of this literature review will explore the issues related to child obesity from the perspectives of parents and children, and examine factors that facilitate, impede or impact on interventions and treatments in primary care. A key area for consideration related to the research question of this thesis is how parents view, manage, and negotiate their interaction with GPs and how this impacts on the diversity of responses by GPs to obese children. Edmunds (2005) qualitative study of 40 parents in Central and South West England indicated a range of parental responses to GPs. In some cases the parents felt that the GPs had been

helpful when they attended a consultation with their child, particularly when the GP had responded with clinical actions such as conducting blood tests where the child's weight was unusual in the family, or there was a family history of thyroid abnormalities, heart disease or diabetes. These parents considered they had been listened to and their concerns taken seriously. Generally such GPs were seen positively but interestingly Edmunds (2005) suggested that parents went for help more with hope than expectation; *"Now I knew there wasn't gonna be a cure, but you always expect it don't you?"* (Edmunds, 2005 p.289). Whilst Edmunds (2005) also reported that some parents described the decision to see their GP in positive terms actively seeking support to address their child's weight, these parents had often previously initiated measures to address their child's weight gain and were disappointed and frustrated they were only given advice to eat healthily and to do more exercise. Such parents felt they required support to address the psychological distress that they believed their children were experiencing.

Turner et al., (2011) reported on in-depth interviews with 15 parents of children aged 5–10 years in Bristol which considered both their views of primary care as a health care setting in which to manage childhood obesity, and their experiences of consulting practitioners about their child's weight. Parents viewed primary care as both geographically accessible, as well as enabling relatively easy access to appointments, and not restricted by waiting lists. It is recognised in other research that accessibility is an important variable in encouraging both initial contact and continued treatment compliance. Barlow and Ohlemeyer (2006) for example, have shown distance from home to be a reason for non-return to a paediatric weight management programme.

However, Edmunds (2005), Stewart et al., (2008) and Turner et al., (2011), found that parents were worried that taking an obese child to the GP was likely to cause further embarrassment to the child, and they were fearful that the GPs would blame them for their child's weight. Parents also reported that GPs could often be dismissive telling the parent that the child would grow out of it or conveying an attitude that the parents were over anxious, or in some cases blamed for their child being overweight (Turner et al., 2011). The issue of the directness and insensitivity of some GPs to both parents and the child was also reported by Edmunds (2005) and Turner et al., (2011). For example Turner et al., (2011) suggested that this, on occasions, could totally disrupt the relationship between parents and the GP.

*“He said in front of my daughter, ‘God she’s obese, how on earth can you let her get that size? You’ve just simply got to cut down, you’re giving her the wrong foods, you know, she shouldn’t be that size,’ I took the kids out, went back in and said it was absolutely disgraceful, no way would I take the children back there again.”* (Turner et al., 2011, p.5).

Turner et al., (2011) also found that parents questioned the extent to which GPs had the knowledge, time and resources to effectively manage childhood obesity.

Stewart et al.’s, (2008) qualitative study of the families of children who are obese in Edinburgh and Glasgow has particular relevance in terms of GPs. This study presented three categories of parents; those unaware of their child’s weight, those in denial and those parents actively seeking treatment. Seekers approached their GP asking for help, while avoiders and deniers were typically attending for another reason when the GP raised the child’s weight. A number of avoiders and deniers became seekers once the weight concerns had been pointed out to them by the GP, and interestingly Stewart et al., (2008) found the discussing of weight by GPs was acceptable to these parents. The authors conclude that it is important GPs do not avoid the issue of excess weight but to raise it in a sensitive manner with the offer of non-judgemental help to parents.

Whilst there is no literature that identifies the child’s view of GPs in the UK, Jones et al., (2013) reported on a small qualitative study of eight families in Australia where children aged 4-10 were interviewed with their families in order to explore their perceptions and experiences of childhood obesity. The children in this study reported that the health risks of their weight were mainly addressed in the school environment where there was a focus on healthy food, healthy lifestyles and physical activity. One child however noted *“the GP could, like, try to help more than just telling me what to do, if they know of any places or things that could help me and show me and how to get in contact with them that kind of stuff”*, (2013 p.5). A further child, whilst noting that it was the responsibility of GPs to raise the issues as *“they know all about it”* concluded *“but they don’t really help.”* (2013, p.6)

In addition there have been a small number of qualitative studies that have explored children perspectives on wider issues related to their weight. Lachal et al., (2013) review indicated that children and adolescents’ definitions and awareness of obesity are based on social-related situations, rather than individual characteristics, and that their definition is never related to BMI or other medical-related signs. Rather visual judgements on appearance, such as

evidence of “*sagging skin*” or “*flabby body*” are seen as key indicators of weight problems, (Lachal et al., 2013, p.365). A number of key studies have also focused on the overall experiences of children who are obese which identifies that they are likely to be characterised in negative ways or victimised (Reilly et al., 2003; Puhl and Heuer, 2009). There is further evidence that children who are obese, particularly females, are more dissatisfied with their bodies than other children (Wardle and Cooke, 2005). Murtagh et al., (2006) surveyed the opinions of 20 obese children aged 7 to 15 years. These children identified humiliation, social torment, and exclusion as their primary reasons for wanting to lose weight. All 20 children acknowledged that they had been bullied because of their weight, as one child in the study stated, “*You're fat, you're slow, you're ignorant, you're useless*” (Murtagh et al., 2006, p. 921). In those situations, the predominant consequences were isolation, peer anxiety, low self-confidence and body dissatisfaction. Murtagh et al., (2006) confirmed that whilst a large number of these reported that children had received health advice directly from health professionals, there was no evidence in the paper to identify the children’s views or response to the health professionals. However, the authors conclude that these children seemed to attach little importance to the long-term implications of their own obesity, “*it was the social issues confronting them in the school playground, and not the promise of future morbidity that was fuelling their desire to lose weight,*” (2006, p.922).

## **2.7. Summary and gaps in knowledge.**

The literature review has provided valuable insights in order to progress the key research question of this thesis and explore the experience of identifying and managing children who are obese from the GP’s perspective. It has confirmed some of the challenges GPs face when they tried to address this complex phenomenon with a wide range of potential causes. The existing literature has confirmed that GPs in the UK and primary care practitioners in the US, Canada, Australia and other European countries express concern about the growing increase in childhood obesity (Murray and Batista, 2009; He et al., 2010), and view primary care as an appropriate treatment setting for the identification and management of childhood obesity, (King et al., 2007). However there are significant questions about the extent to which they can effectively manage this condition (Walker et al., 2007; Turner et al., 2009). The literature also suggests that despite the policy positioning of GPs as playing a key role in reducing childhood obesity (DoH, 2011) there is no credible research that shows they can be influential (Oude Luttikhuis et al., 2009; Wake et al., 2009). Moreover, there are a range of factors that impact on any interventions, including the GPs’ competence, skills, motivation and expertise, limited



time and resources and a lack of effective treatments, support and referral options, (Walker et al., 2007; Turner et al., 2009; Redsell et al., 2011) The need to work with parents and children who the GPs perceive may be unwilling or unable to address the matters appears to evoke both frustration and a resignation of limited achievable impact, (Edmunds, 2005; Stewart et al., 2008; Turner et al., 2009).

It is clear that the diversity of perspectives of children, parents and GPs relating to childhood obesity reflects the complexities inherent in tackling childhood obesity. It is also apparent from the literature that parenting a child who is obese is a very complex (Lachal et al., 2013); often emotionally charged area (Stewart et al., 2008; Turner et al., 2011) and the motivations and needs of parents vary considerably (Edmunds, 2005). Moreover, family circumstances and the broader social and environmental contexts which underlie family behaviours in relation to weight management are areas that GPs feel least confident and professionally capable to address (Walker et al., 2007). The literature review has also confirmed that there is a growing recognition that childhood obesity is not a stable condition, rather it represents a dynamic process; in which behaviour, cognition and emotional regulation mutually interact,(Murtagh et al., 2006; Pagnini et al 2009; Staniford et al., 2011). Family structure and context, parental and familial attitudes, activity, nutritional patterns as well as familial stress (Barlow and Ohlemeyer, 2006; Stewart et al., 2008; Lachal et al., 2013) all have a critical role with respect to the identification and management of childhood obesity.

It is encouraging that despite the challenges GPs face, many GPs still feel that they have a role to play in addressing childhood obesity (King et al., 2007, He et al., 2010) and in the main are keen to maintain positive and productive relationships between parents and the child (Walker et al., 2007, Turner et al., 2009). They are aware that childhood obesity is likely to be a growing presentation in their clinical practice (Lachal et al., 2013) and the need to identify the most successful way in which they can intervene remains an important priority. The fact that despite the clear challenges and reservations highlighted in the literature GPs often do raise the topic of obesity with children and families and therefore the focus of this thesis becomes even more important.

One of the critical conclusions of this literature review is that the previous consideration of the experiences of GPs and childhood obesity in the UK setting, tend to frame and discuss GPs alongside other primary health care professionals; Walker et al., (2007) and Redsell et al., (2011) findings, discussions and conclusions refer to both GPs and Practice Nurses, and

the unique focus on GPs is absent. Turner et al., (2009) extends the recruitment sample further including GPs, practice nurses, school nurses, and health visitors, and whilst this facilitates preliminary comparisons between the professionals it provides little in depth focus on the GPs. In other research (Staniford et al., 2011; Banks et al., 2012) the overall findings over simplify the GP community presenting them as a single entity, with similar perspectives. Moreover these papers offer little recognition of the multiple and diverse approaches, the varying perceptions of role congruence, motivations and views and the range of practice found in the complex world of General Practice (Gabbay and le May, 2011). The literature review has therefore highlighted the need for the research in this thesis to avoid any reductionist generalisations (Hertz, 1997; Stanley, 2004) about one professional group. It has also confirmed that there have been no studies that have explored the different perspectives and experiences of sub groups of GPs, such as more experienced GPs, newly qualified GPs or salaried GPs to add more detailed insight. The intention of this thesis to focus solely on GPs who have been in practice for over 25 years, is detailed in Chapter 3, Section 3.8.1 and is expected to add a new and valuable contribution to the existing literature.

A further limitation highlighted in each of the 3 key qualitative studies in the UK, is the acknowledgement that the participants in each of these studies volunteered to participate and therefore it may be assumed that they hold particular views about obesity management, (Turner et al., 2009) or reflect the views of local clinicians with an interest in obesity research, (Walker et al., 2007). Redsell et al., 2011 concluded that in addition to a poor response rate of 34% to their postal survey, the interview participants may have been biased towards health care professionals with an interest in the subject, (2011, p. 61). Whilst most of the authors state this point in relation to the fact that this may affect the generalisability of the study, it does questions whether these self-selecting participants represented a partial picture of GPs who had a greater interest in management of childhood obesity than GPs in general, (Detorri et al., 2009), or who were keener to discuss the issue of childhood obesity than others, (He et al., 2010). Chapter 3 of this thesis will explore how this challenge was addressed in the current study.

A final conclusion from the literature review conducted in this chapter, is that exploratory studies similar to this thesis, are relatively sparse, and there are currently no explicitly formulated theoretical frameworks which assist, or give additional insight in exploring the diversity and variations of responses to childhood obesity by GPs. It is intended that this identified gap in the literature will be addressed in Chapter 5 of this thesis where an

exploration and possible explanation focussing on the epistemological frameworks of the GPs will be presented to add further insight into the diversity of the responses of GPs to childhood obesity. It is expected that by presenting an appropriate ways of conceptualising the findings in a framework that has relevance to general practice, this will lead to the identification of more detailed and relevant recommendations for GPs to enhance the future delivery of effective primary care service interventions for childhood obesity.

The following chapter will detail how the findings of the literature review, and importantly some of the key limitations were addressed through the methodological approach, analytical procedures and methods used in this thesis.

## **Chapter 3: Research methodology and methods.**

### **3.1. Introduction.**

To address the research aim of exploring GPs' experiences of identifying and managing childhood obesity in a primary care setting, a number of methodological, epistemological and practical choices had to be made in relation to the research design. This chapter confirms that this thesis aligns itself with the phenomenological and hermeneutic traditions of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009). Sections 3.2 to 3.5 discuss the chosen research approach, the rationale behind this choice, the limitations of this approach, and alternative methods considered to address the research question. Section 3.6 makes a case for the quality of this research, using Yardley (2000) quality principles. Section 3.8 focuses on the methods used within this study, including the sampling strategy, recruitment of participants, the development of a retrospective, semi-structured interview guide, and ethical considerations. Section 3.9 describes the detailed method of qualitative analysis, the chronology of the data collection stage, and the emergence of themes which are presented in full in Chapter 4. Finally, the chapter concludes with an exploration of the reflection and reflexivity practice (Lee, 2009, p.42) adopted by the researcher.

### **3.2. Interpretive Phenomenological Analysis (IPA).**

The key theoretical strands of IPA phenomenology, hermeneutics, and ideography, (Willig 2001; Smith et al., 2009; Larkin et al., 2011) are now considered.

#### **3.2.1. IPA and phenomenology.**

IPA is phenomenological in that it is concerned with individuals' subjective reports rather than the formulation of objective accounts, (Langdridge, 2007; Smith et al., 2009). The phenomenological element of IPA is concerned with the study of human understanding and experience, and its intellectual origins derive from Edmund Husserl's transcendental phenomenological philosophy (Pivčević, 2013), first presented in 1937 (Husserl, 1937, 1970). Husserl attempted to construct a philosophical science of consciousness and rejected the view that empirical science is the basis for achieving an understanding of the world, stressing instead the importance of the "*life world*" or lived experience as the fundamental source of knowledge (Langdridge, 2007, p.39). Husserl argued this required, "*epoché*" (Husserl 1937, 1970), the process by which the researcher abstains from presuppositions around the areas of investigation, and suspends preconceived ideas, a term known as "*bracketing*" (Langdridge

2007, p.17), so that things are perceived only as they are experienced, (Ashworth, 2003; Langdridge, 2007). Based on a Husserlian view it could be argued that analysis cannot be both interpretative and phenomenological. However, it is important to understand that phenomenological thought has been developed in a variety of different ways. For example, Heidegger hermeneutic phenomenology (1927, 1962) extended this thinking by stressing the importance of “*being*” (Dasein) in the world and placing significant emphasis on understanding (Verstehen) rather than description (Finlay, 2009), and, hence, the inevitability of the world being understood through the lens of historical context and socio-cultural background. In contrast to Husserl’s search for objectivity, Heidegger’s belief (1927, 1962) was that each individual has a subjective viewpoint and interpretation of their experience depended on past experiences, culture, social status and their knowledge base (Krell, 1993). Van Manen (1997) expanded the challenge that phenomenology in its pure transcendental form may be unattainable since experience is always recounted retrospectively, , and a genuine experience of an individual’s life world can only be investigated after it has happened, (1997 p.346). He also discussed how the researcher’s perceptions get tainted by their previous interpretations of the world, and the resulting experience influences their interpretations. However, there are times when the researcher can be more aware of their assumptions and influences, using formal reflexive techniques, (Finlay, 2002).

Smith (2004) argues that IPA is both phenomenological in that it seeks an insider additional perspective, perception or account of the lived experiences, and also interpretative in that it acknowledges the researcher’s personal beliefs and standpoint and embraces the view that understanding requires interpretation. IPA considers that while trying to get close to the participant's personal world, the researcher cannot do this directly or completely. Access is dependent on the researcher’s own conceptions which are required to make sense of the participants’ personal world through a process of interpretative activity, (Smith and Osborn, 2007). IPA also recognises that meaning arises out of social interaction and is modified by interpretation of the encounter (Blumer, 1986). The researcher’s beliefs are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals. Reflexivity, (Parker 2004; Hunter, 2010) is viewed in this way as a tool to enable the researcher to formally acknowledge their interpretative role, rather than as an essential technique for removing bias.

### 3.2.2. IPA and hermeneutics.

Hermeneutics refers to the study of interpretation. It involves engaging in the “*hermeneutic circle*” (Smith et al., 2009, p.29) which requires a two-way engagement between the researcher and the participant (Finlay, 2002; 2009). The position of the researcher constantly shifts, as the researcher’s preconceptions are revealed by on-going engagement with the participant’s accounts (Gadamer, 1975; Smith, 2004; Smith et al., 2009). Knowledge becomes inherently relational, formed through such interaction (Finlay, 2002). Gadamer (1975) identifies an essential part of this using the concept of “*horizon*” which he defines as “*the range of vision that includes everything that can be seen from a particular vantage point,*” (1975, p.269), and describes a “*fusion of horizons, where consensus between the researcher and the participant’s world view is acknowledged,*” in the hermeneutic process, (Langdrige 2007 p .43). In IPA, the researchers are seen to employ a “*double hermeneutic*”, (Smith, 2004, p. 40), in that the participant is trying to make sense of their personal and social world and the researcher is trying to make sense of the participant trying to make sense of their personal and social world.

The social aspect of understanding is demonstrated further by IPA’s employment of symbolic interactionism (Smith, 1996). Symbolic interactionism (Blumer, 1986) focusses on the way people act towards objects and the meaning they ascribe to those objects which arise out of social interaction, (Smith, 1996). This forms the basis of IPA’s knowledge claims about people’s behaviours; if people act towards objects on the basis of their ascribed meaning, and that meaning can be accessed through interviews, then inferences can be made about behaviour on the basis of accounts created in interviews, (Hunter, 2010). IPA also acknowledges that meaning arises out of social interaction, and that by investigating meaning making, understandings emerge about social processes and discourse, (Smith, 1996). Finally, IPA places cognition, emotion, language and action as interconnected features of lived experience. Inspired by Bruner (1990), Smith et al., (2009) move beyond a traditional understanding of cognition as a separate and distinct information processing function to a broader use of cognition as “*dynamic, emotional and embodied*” (Smith et al., 2009, p.194). In IPA, participants are “*meaning-making beings*” (Smith et al., 2009 p.196) who use language to reveal “*the world and their relationship to it*” (Langdrige, 2007, p.161) and it is therefore important for researchers to consider how participants employ language to construct and understand their lives, (Smith et al., 2009).

### 3.2.3. IPA and the ideographic focus.

A central feature of IPA is its focus on the idiographic, the individual case, which allows a greater understanding of the general features of a phenomenon to be developed (Smith, 1996, 2004; Smith et al., 2009). It is through the combined focus on phenomenology and hermeneutics that the experiences and meaning making in each of the particular cases can shed light on the general phenomena. Phenomenologically rich, “*thick descriptions*” of experience (Geertz, 1994, p.213), developed through the IPA analysis, as outlined in Section 3.9, provide the nuanced detail required to relate aspects of individual experience to different circumstances and others experiencing the same phenomenon. This richness of data has been presented in many published IPA studies, for example Hunt and Smith (2004) study of 4 carers of stroke survivors, Knudson and Coyle’s (2002) exploration of 2 young men’s experiences of hearing voices and Smith’s (1996) study of perceptions of renal dialysis which was completed following interviews with one woman treated for end-stage renal disease with haemodialysis. The ideographic emphasis also has implication for the actual research methods, including the recruitment strategy, the focus on homogeneity and recommendations of sample size, (Langdrige 2007; Smith et al., 2009) which will be detailed in Section 3.8. As studies are primarily ideographic, IPA cautions against attempts to generalise beyond the sample, (Smith et al., 2009) and there is no assumption that the findings are representative, or reveal a universal feature of an experience for a broader population. The IPA methodology is more concerned with examining divergence and convergence in smaller samples (Smith et al., 2009) and, according to Langdrige (2007) its strength lies in illuminating “*a detailed description of the shared experiences of the particular cases studied,*” (2007, p.58).

To summarise, the phenomenological theory underpinning this thesis closely aligns with the hermeneutic/interpretative epistemology of Heidegger (1927, 1962) and Gadamer (1975). The methodological approach of IPA will be used to explore the phenomenon of GPs’ experiences of identifying and managing children who are obese within the setting of a primary care consultation. It recognises that GPs may have different experiences and that these experiences are likely to be shaped by individual “*thoughts, beliefs, expectations and judgements*” (Willig, 2008, p.66) as such it does not attempt to converge on a single truth (Sale et al., 2002). It also recognises that contextual factors influence how meaning is constructed by GPs, and that this will result not only in unique experiences being uncovered, but also will identify some of the shared aspects of an experience across the participants that result from the

*“external forces within a culture,”* (Shaw, 2001, p.49). Finally it is also interpretative in that it acknowledges the researcher’s personal beliefs and standpoint and embraces the view that understanding requires interpretation. Whilst trying to get close to the GP’s experience, the researcher cannot do this directly or completely; access is dependent on the researcher’s own conceptions through a process of interpretative activity, (Smith and Osborn, 2007).

### **3.3. The use of IPA in health care research.**

IPA is increasingly being adopted in health care research, in which the focus is on exploring patients’ *“lived experiences”* of the phenomenon being studied (Smith et al., 2009, p.33) and there have been a number of recent IPA studies which have focussed on the perspectives of GPs. A synthesis table of these IPA research findings, including the recruitment strategy and sample size is presented in Appendix Three. Fox et al., (2009) for example, used IPA to identify GPs’ experiences of illness and the influence that this has had on their practice. Taubert and Nelson’s (2010) IPA study of out-of-hours GPs and palliative care, identified the GPs overall strong perspectives and feelings of *“being alone out there”* (2010, p.10), which resulted in recommendations of different strategies on how palliative care could be better communicated between services. Nelson and Ogden (2008) used IPA to explore the phenomenon of food intolerance in primary care from the GP’s perspective. Through this approach they showed how, the GPs despite their scepticism about food intolerance chose to negotiate mutually acceptable ground with patients’ behaviours and beliefs in order to preserve the doctor–patient relationship. Epstein and Ogden (2005) were the first researchers to use IPA in their qualitative review of GPs’ attitudes to obesity in adult patients. Their findings indicated that GPs conceptualise and frame adult obesity in terms of personal responsibility of the patient, whereas the latter see obesity as a medical problem that should be managed by the doctor. The GPs reported how they responded to the conflict by sometimes offering treatments that they believed were inappropriate or offered support for patients’ other associated problems, in order to maintain the doctor - patient relationship.

### **3.4. Limitations of IPA.**

As IPA is a relatively new approach, it is still being developed and reviewed as a research tool (Larkin et al., 2011). In addition there are variations in the way this methodology has been used, which as Brocki and Wearden (2006) confirm, has made the IPA literature difficult to evaluate at times in order to fully justify claims for its significance, effectiveness and value.



As with all qualitative research methodologies, there are challenges and shortcomings in IPA which are both practical and theoretical. IPA has recently been criticised by Giorgi (2011) for being both methodologically unclear and having too much flexibility in its methods. However, it is difficult to agree with Giorgi's concerns as the approach identified in Smith et al.'s, (2009) IPA text book is very detailed, comprehensive and accessible, guiding the research process at every stage. As Brocki and Wearden confirm, IPA theorists have tended to use "*easily comprehensible language and straightforward guidelines, rather than using language to obscure meaning in the way that other qualitative methodologies might be criticised for*" (2006, p.101-2). However, as Smith (2010) points out, as with all research methodologies, following the guidelines does not in itself guarantee a quality outcome, rather it depends on the development of complex skills such as interviewing, analysis, interpretation, writing, and "*researchers at different stages will have different degrees of fluency and adeptness at these skills*" (Smith, 2010, p.188).

One of the main challenges highlighted in the IPA literature, (Brocki and Wearden, 2006; Eatough and Smith, 2006), is the length of time it takes to analyse the data in the depth required, for example, Smith et al., 2009, advise that new researchers will need several weeks to intensively analyse each individual transcript, (2009, p.55), which may limit its use in certain research settings where a rapid service evaluation may need to be completed. Secondly it is acknowledged that interpretations are bounded by participants' abilities to articulate their thoughts and experiences adequately (Baillie, et al., 2000) and, it would follow, by the researcher's ability to reflect and analyse. It therefore requires a high level of active engagement from its practitioners and a great deal of intellectual, practical and emotional effort from the researcher.

Collins and Nicolson (2002) argue that there is a risk of the participant's responses becoming diluted by the "*disaggregation and unitisation of the data*" (2002, p. 627) necessitated in following the analytic procedure detailed by Smith et al. (2009). They also question whether IPA in its search for connections, similarities or divergences across cases "*misses a potentially richer seam of data, that of a contextualised, unfolding and sequential account within a single interview*" (Collins and Nicolson, 2002, p. 627). However there are a number of examples in the IPA literature which would challenge such criticisms. Smith et al., (1999) present a series of single case studies, and there is a further detailed sequential analysis of impact on identity change of women during the transition to motherhood, (Smith, 1999).

There are wider questions as to whether IPA analysis is different from a rigorous thematic analysis, (Brocki and Wearden, 2006). Willig (2001) notes that IPA has been frequently contrasted with grounded theory, however, she argues that, in addition to IPA's theoretical grounding, IPA differs from grounded theory in its particular suitability for understanding personal experiences as opposed to social processes. It is also suggested that IPA's status as a new and developing approach allows researchers "*more room for creativity and freedom*" (Willig, 2001 p. 69), avoiding the debates and controversies associated with grounded theory.

### **3.5. Alternative methods considered.**

Different approaches to data collection, analysis and dissemination create different types of knowledge about "*humans, their experiences and their actions*" (Martin and Thompson, 1997, p.629). A number of alternative approaches to the use of IPA to address the research question were also initially considered.

#### **3.5.1. Conversational Analysis and Discourse Analysis.**

Initially consideration was given to discourse analysis and conversation analysis which focus on language and its use in social interactions and constructing the social world, (Drew et al., 2001), particularly because the aim of the research was to explore the experience of the consultation process between GPs and children who are obese. Whilst this approach would have been beneficial in exploring word choice, concepts and phrasing, it was felt that there would be significant ethical and practical challenges to the researcher accessing an actual consultation where children and families would be present.

Consideration was also given to discourse analysis and the way versions of the world, of society, and inner psychological worlds are produced in discourse (Willig, 2008) and the different role language plays in social interaction (Willig, 2001). Given the contested nature of obesity, (Lupton, 2013), the sensitivities of the topic (Puhl and Latner, 2007), and the power relations involved in primary care consultations (Fairclough, 2001), it was acknowledged that this approach could create useful insights. However, it was felt important to present a much broader picture of the experience of GPs, and there were concerns that an explicit focus on discourse may not enable a sufficient focus on experience to inform service recommendations. In addition, as Smith et al., (2009) encourage analysis of the participant's narrative in relation to semantic cues and other discourse structures, it was felt that this would enable such consideration to be included and highlighted in the research findings.

### **3.5.2. Grounded theory.**

Grounded theory (Charmaz, 1990) was also considered as it has been used within some qualitative childhood obesity research, for example Edmunds (2005) used this approach to explore parents' perceptions of help-seeking experiences with health professionals. Dapi et al. (2007) also used grounded theory to investigate social and cultural factors influencing rural and urban adolescents' food perceptions in Africa, and Wong (2010) examined how cultural influences play a role in family eating habits that contribute to the problem of childhood obesity in Chinese society.

In this thesis, a phenomenological approach was preferred over a grounded theory approach for several reasons. The first was that grounded theory focuses on explicating social processes, rather than on understanding the meaning of individual experiences (Starks and Trinidad, 2007). Secondly, phenomenology allows for the use of pre-existing theory in analysis, whereas grounded theory historically does not (Willig, 2001; Larkin et al., 2011). Finally, IPA explicitly acknowledges the influence of the researcher and their theoretical position, whereas traditional grounded theory typically assumes that themes are discovered during analysis, and the influence of the researcher is minimised, (Braun and Clarke, 2006).

### **3.6. Assessing for quality.**

The following section will address the issue of quality criteria in general, and establish the standards adopted in this thesis. There is considerable debate around the extent to which standards for quality in qualitative research are required, desired and possible. Some researchers have argued that quality criteria can restrict the aspects of qualitative research which are most valuable (Barbour, 2001; Hammersley 2008), and over-simplify qualitative research by the application of general criteria, (Silverman, 2011). However, it is also argued that a pragmatic agreement on standards is required in order to strengthen the case for qualitative research's position within the current evidence-based approach to healthcare delivery, (Yardley, 2000).

Different criteria have been proposed for assessing quality and validity in qualitative studies, and an extensive range of checklists, frameworks and criteria have been developed, (Patton, 2005; Flick, 2008; Silverman, 2013). Smith et al., (2009) and Langdrige (2007) offer Yardley's (2000) four principles as one way of performing this assessment. The decision therefore to adopt Yardley's criteria in this thesis was made with a conscious awareness of

other approaches, however it was also felt pragmatically that to use Yardley's criteria would ensure consistency with the IPA methodology chosen and the epistemological goals of the research (Yardley, 2000).

### **3.6.1. Sensitivity to context.**

Yardley's (2000) first principle expects the researcher to be well grounded in the method of analysis, the philosophy, the methodology and the underlying epistemology. This includes the need to be sensitive to the theoretical and academic context of the research, as the researcher positions the research in the context of current literature and relates the findings to relevant theory, and the socio-cultural setting of the study (Finlay, 2002; Smith et al., 2009).

Adherence to this principle is achieved in this thesis through the in-depth methodology, detailed in Section 3.2 to 3.5, and the adoption of the research methods recommended in IPA, identified in Section 3.9. Descriptions of the participant's characteristics, (gender, ethnicity, length of practice, and the Practice profile) and study context (childhood obesity prevalence for each Practice area) are presented in Appendix Eight of this thesis. Chapter 1 also highlights the current socio-cultural context of General Practice and childhood obesity in order that the research findings are considered in the current political and ideological context. In addition, the process of reflexivity has been used as a valuable tool for contextualising and reflecting upon the interpersonal and social context of interviews, as detailed in Section 3.10 and sustained throughout the in-depth analysis process.

### **3.6.2. Commitment and rigour.**

Yardley (2000) argues that demonstrating rigour in data collection and analysis will depend on the choice of method and the researcher's commitment to particular methodological and ethical principles. Within IPA, the relevant concepts include the adequacy of the sample size, the sampling technique used to offer insight into the phenomenon, the data collection and analysis, and the coherence of the narrative presented in the research findings, described within this thesis in Section 3.8 and 3.9. Rigour also includes a consideration of the epistemological and theoretical basis, and any limitations of the methodology, these areas are detailed in Section 3.2 to 3.5 and in Chapter 5.

The concept of commitment, according to Yardley (2000), also involves the researcher's in-depth engagement with the topic through developing competence and skill in the method used. The author of this thesis has acquired these skills through attendance at national IPA

training sessions, lectures and practical IPA group work activities, which have explored interview skills for semi-structured interviews, data analysis and ensuring quality. In addition, the author was a founding member of the Manchester IPA forum group, which met monthly and enabled postgraduate IPA students to meet, discuss their work and share learning. Four members of this IPA group provided peer review and critical interrogation of the data in this study. Peer review was also carried out in the form of audits of analysis carried out by the research supervisors of this thesis who have considerable professional and research expertise in childhood obesity. Throughout the supervision process both supervisors identified additional areas in the transcripts and narratives that they felt were interesting and important. Two of the participants in the study also agreed to read the findings, discussion, and recommendations chapter and provided comments. Finally the recommendations of the report were shared in the draft stages with GP Educators at the North West Deanery and Public Health Consultants to assess their relevance for future practice.

### **3.6.3. Transparency and coherence.**

Yardley's (2000) third principle of quality relates to transparency and coherence of the research process and the presentation of the research product. This should be demonstrated when developing the questions, collecting, analysing and reporting on the data, and accounting for the development of findings through reflexivity and explicit analytic methods (Yardley, 2000; Smith et al., 2009). The explicit and systematic process for IPA analysis and the development of themes is documented in Section 3.9 and evidenced in the accompanying Appendices Nine, Ten, and Eleven. Coherence also refers to the way the research is presented (Yardley, 2000). The findings in Chapter 5 include "*retrievable data*" (Stanley, 2004, p.10), such as extended quotes from the GPs to evidence the analysis. It was recognised at the onset that contradictions and ambiguities would be identified in this research given that the aim was to explore the perspectives of a professional group in relation to the complex area of childhood obesity. Chapter 5 specifically highlights this and provides a structural framework for providing an initial insight into such complexities.

### **3.6.4. Impact and importance.**

Finally Yardley's (2000) principle of impact and importance reflects that however well or sensitively a piece of research is conducted, the most decisive way it may be evaluated is in whether or not it tells the reader something interesting, new and novel. This commitment extends beyond the research setting to the ways in which the research is disseminated and

transferred to real world settings. There is an inherent commitment in this thesis to ensuring that the novel and original findings offer recommendations to support and improve clinical practice. Chapter Six of this thesis presents practical recommendations for consideration at a policy, practice and individual clinician level. Equally there is a clear commitment to the dissemination of findings in the most appropriate professional settings including journal publications and conference abstracts.

### **3.7. Ethical considerations.**

With qualitative interviewing, the researcher needs to remain constantly aware of ethical issues as ethical issues may change or emerge as the research progresses, (Cutcliffe and Ramcharan, 2002; Silverman, 2013). The main ethical issues identified were ensuring confidentiality and anonymity for the participants, securing fully informed consent and safeguarding the GPs from any emotional distress. The issues of privacy, anonymity and confidentiality were important considering the sensitive nature of the topic of childhood obesity and the description of professional behaviours and attitudes.

To protect the participants, the data was handled in accordance to the principles outlined in the Data Protection Act (1998). All recordings were kept in a locked filing cabinet in a Council office, and any information stored on computers was kept on a password-protected secure internal network. GPs' names and practice details were kept separately from transcripts and interview data, stored on a secure network, so that one set of information could not be mapped onto the other. Upon transcription, names, places, dates and any other potentially identifying markers were generalised to ensure that there was no loss of substantive meaning. The relatively small number of GPs was an issue given the potential for the participants to be identified from details in their accounts. Throughout the thesis, participants were referred to using markers, for example, 'GP No.1', to protect their identities.

To ensure informed consent, the information sheet was sent to the GPs prior to the interview, which enabled them to further consider whether they felt it was appropriate for them to participate the research and also given to the GPs to read prior to consent being taken, and the informed consent sheet (Appendix Six) was signed. Questions were encouraged prior to taking consent, and it was stressed that the GPs could withdraw at any time. There was a protocol in place to manage distress during the interview which included staying with the GP and listening to the issues being raised and offering support. This was not required in any of the interviews. All participants were given time at the end of the interview to reflect on what

the interview was like for them, and the A- Z of useful local contacts on childhood obesity were left with them for future reference. The researcher's contact details were also left with participants at the end of the interview.

Finally the researcher adopted Stockport Council's lone working policy whilst completing the interviews, ensuring that colleagues were aware of where the interviews were taking place, and the likely time of return.

### **3.8. Research methods used in the thesis.**

Consideration will now be given a description of the key research methods of this thesis that are coherent and consistent with IPA's conceptual and epistemological base.

#### **3.8.1. Sampling strategy.**

It is a general criterion of IPA that the sample is relatively homogeneous, (Willig, 2001; Smith et al., 2009), with the ambition that participants, in addition to sharing experience of a phenomenon, "*do not vary significantly across demographic characteristics*," (Langdrige 2007, p.58). This facilitates comparison across accounts and the development of a wider understanding of the phenomenon (Langdrige, 2007; Smith et al., 2009). In order to address the research aims of this thesis, it was important to be able to access GPs who could contribute their experiences of identifying and managing childhood obesity.

A decision was made to construct homogeneity on the basis of participants' length of experience working in a primary care setting, and for the purpose of this thesis, this was defined as having been a GP for 25 or more years, which was deemed a sufficiently pertinent period of time to evidence significant experience of primary care consultations. This time frame has been used in other studies of GPs which have purposefully sampled on the basis of experience. For example Elwyn et al., (2000) used this time frame when exploring how experienced GPs involve patients in healthcare choices, and in McKeown et al's., (2003) qualitative study of GPs' attitudes to drug misusers and drug misuse services in primary care. The decision was based on two key factors. Firstly this group of GPs have not previously been purposefully sampled in the literature on childhood obesity, and therefore the research in this thesis would provide a new and additional contribution to the existing literature. Secondly the decision to purposefully sample on experience was assisted by Elstad et al's., (2010) research on GPs and diabetes management, which focused on the skills practitioners acquire and develop throughout their clinical career. It concluded that GPs gain complex social,

behavioural and intuitive experiential knowledge as well as the ability to compare the present day patient against similar past patients. Highlighting and exploring these active cognitive reasoning processes was felt to be an important component of this research topic of GPs' experience and meaning making of childhood obesity. A practical decision was also made to restrict recruitment to this study from one PCT area, as defined in Chapter One, as it was felt that this would ease recruitment challenges and would secure sufficient numbers for a thesis which aimed to recruit ten participants.

The inclusion criteria therefore for eligible participants in this study were:

- GPs who had been registered practitioners in a NHS General Practice partnership for 25 years and over.
- GPs registered as partners on the Stockport PCT GP list (2009/10).

Whilst no further demographics were included in the inclusion criteria, descriptions of the GPs, their gender, patient populations, rates of childhood obesity, and the deprivation indicators of each practice are detailed in Appendix Eight. However, these are presented for contextual purposes rather than to highlight any claims of representativeness.

The exclusion criteria for the study were as follows:

- Trainee GPs, GP registrars, newly qualified or GPs who had been in practice for less than 25 years.
- Locum GPs.

The rationale for this exclusion criteria was again consistent with the IPA methodology, which does not support “*maximum variation sampling*” (Langdrige, 2007, p.58) but rather focuses on sampling which is purposive and homogenous. However, in identifying the above exclusions it was clearly recognised that further perspectives from trainee, newly qualified, younger GPs, or locum GPs would provide an equally valuable perspective. They may also provide a wider set of results that would enable a more comprehensive understanding of the population of GPs, and as such should be considered as a recommendation for future research.



### **3.8.2. Sample size.**

In IPA there is a consensus towards the use of smaller sample sizes (Smith, 2004, Reid et al., 2005). Whilst Smith and Osborn (2007) note that sample size depends on a number of factors and that there is no “*right*” sample size; as an idiographic method, they argue that small sample sizes facilitate greater analytical depth and an analysis of “*potentially subtle inflections of meaning*” (2007, p. 519). Smith et al.’s. (2009, p.52) later publications are more specific and recommend between four and ten interviews for a Professional Doctorate. However, sample sizes vary widely in IPA studies (Brocki and Wearden, 2006), who conclude that decisions about sample size and homogeneity should be made in the context of each individual study. For the purpose of this thesis, following considerations of time, resources, recruitment strategy and research question it was determined that the sample size would be 10 GPs, which would provide a sufficient perspective to explore the research question in depth. Guest et al. (2006) reviewed the concept of “*data saturation*,” (2006, p.59), that is the point at which no new information or themes are observed in the data. Using data from a study involving sixty in-depth interviews with women in two West African countries, they found that saturation occurred within the first twelve interviews, although basic elements for meta themes were present as early as six interviews.

### **3.8.3. Recruitment of participants.**

In determining the recruitment strategy for this study a number of issues were considered. The initial consideration was to write to all GPs in Stockport asking them to participate in the study. However it was acknowledged that recruiting GPs to take part in research in primary care can be challenging (Mason et al., 2007). Studies have indicated that GPs report to being overwhelmed by requests to collaborate in research (MacPherson and Bisset, 1995; Smith et al., 2003) and research falls low on GPs’ list of priorities due to high workload, lack of interest in the areas and lack of financial compensation (Salmon et al., 2007). The literature review in Chapter Two has identified that recruitment of GPs to research on childhood obesity by letters of invitation tend to have a poor response rate (Redsell et al., 2011), or the respondents who do volunteer tend have a particular interest in childhood obesity, (Walker et al., 2007; Turner et al., 2009), whereas those GPs who are the least interested in the areas of childhood obesity are less likely to respond to the invitation (Redsell et al., 2011).

It was therefore decided that a more direct approach would be adopted and telephone contacts would be made to the purposefully sampled individual GPs. In order to facilitate this, the

researcher obtained a list, from the PCT registered data base of all GPs who had been practising in Stockport for over 25 years, and the first ten on the list were approached directly via telephone and the research objectives were discussed. Eight GPs agreed to participate and two declined (one because he was about to start a secondment at a University and the second had very recently taken over a new practice), the next two GPs on the list were approached and they agreed to participate. Following the initial contact the respondents were sent the research information sheet and consent form, as presented to Salford University Ethics Committee in December 2010, (Appendix Four). The GPs were again given the opportunity to participate in the research and all agreed to do so.

There are both advantages and disadvantages in this approach. Firstly, the advantage was the researcher found it relatively easy to recruit participants to the study, possibly due to the fact that the researcher was previously known to the GPs and therefore was met with a favourable response at the initial telephone contact. Secondly, as Chapter 4 and Chapter 5 will indicate, there was clear evidence that some of the GPs perceived themselves to have a very limited role in supporting children who are obese, and probably would have been very unlikely to respond to a letter inviting them to participate in a study on childhood obesity. It could be argued that this approach was somewhat coercive. However this is unlikely as two of the contacted participants did not actually participate. Interestingly when the GPs were contacted many made it quite clear that they did not have any specialist interest or knowledge of childhood obesity, but agreed to proceed when it was confirmed that this was not a requirement of participation. The issue of the researcher's prior contact with the GP participants is also covered in section 3.10, and in the limitation section of Chapter 5.

Appendix Eight provides a description of the participant demographics and the practice childhood obesity prevalence rates. In summary four of the participants were female and six males. Three of the GPs were British Asian and seven British. The year of qualification ranged from 1979 – 1985, at the time of the interviews the number of years working as a GP ranged from 26 years to 32 years. The practice list size ranged from 2,150 – 11, 687, and the number of partners in the practice from one to eight partners.

#### **3.8.4. Method of data collection.**

Individual semi-structured interviews with the GPs were felt to be the most appropriate approach which would enable them to respond as "*experiential experts*" (Smith, 2008 p. 18), and is a method of data collection that is compatible with the data analysis techniques of

interpretive phenomenology (Willig, 2001; Langdridge, 2007). Whilst there are arguments for focus groups in IPA (Smith, 2004), in this instance the emphasis was on the individual experience of identification and management of childhood obesity and a focus group could have potentially clouded individual differences with the group dynamics. The practicalities of bringing 10 GPs from 10 different practices equally would have been challenging if not impossible. Similarly other methods of data collection, for example, reviewing case notes would have offered interesting insights, but this would not have enabled an exploration of how the GPs made sense of the clinical encounters with children who are obese. The benefits of using a semi-structured approach in qualitative research are well rehearsed (Mason 2002; Blaikie, 2007; Silverman, 2013), where it is acknowledged that this method enables the participant to articulate as much detail about the experience as possible (Langdridge, 2007).

### **3.8.5. Interview guide development.**

The interview guide detailed in full in Appendix Seven, emerged following the review of the UK literature on the identification and management of childhood obesity in primary care, (Walker et al., 2007; Turner et al., 2009; Redsell et al., 2011) and a consideration of the range of issues to be explored within the research aims. The interview schedule centred on the major themes of understanding of childhood obesity by GPs, their approach to the identification and management of childhood obesity and their particular experiences with families and obese children during the consultation process. Table 3.1 details the key areas in the interview schedule.

- Causes and implications of childhood obesity.
- Impact of childhood obesity on the child and the family.
- Experiences of identifying childhood obesity.
- Decision making and experiences of raising the topic in the consultation.
- Child and parental responses.
- Experiences of managing the child who is obese in the consultation.
- Support available to the child and family.
- Resources and support available to the GP.
- Experiences of working with obese children and their parents.

*Table 3.1. Summary of the key areas in the interview schedule.*

The interview questions were designed to be relatively general, and focussed on the interaction between the GP and the child and family. The first sets of questions were primarily descriptive, open and scene setting, and the focus was on their views, '*why do you think we are seeing an increase in childhood obesity?*', and '*what do you think is causing this?*' These were designed to enable the GPs to feel comfortable with the fact that the interview was focussed on their views and experiences, and it was not a test of their clinical expertise or knowledge of guidelines. Any leads opened up by the GPs were followed if it was perceived to be important to the GP or relevant to the experience of a primary care consultation. Later in the schedule the questions encouraged the GPs to be more evaluative and reflective about their own experiences, such as '*how did it go?*', and more analytical '*why do you think this is the case?*' Leading questions which previous research had focussed on such as '*the problem of childhood obesity*' (Walker et al., 2007), and those which asked the participants to identify the '*barriers*' to identification and management (Turner et al., 2009) were avoided. It was anticipated that this would reduce any presumptions about the GPs' experiences or concerns and would not limit them to only one of a range of possible responses, thoughts, or feelings. The key areas to be covered in the research interview were presented in the introductory invitation letter, (Appendix Five) and highlighted during the telephone conversation with the GPs when arranging the interview time. The interviews took place either at the GPs' surgeries or in an office at Stockport PCT and were carried out between January and March 2011. Each interview lasted between 30 and 40 minutes. With a participant's permission each interview was audio-recorded and transcribed verbatim by the researcher. All the GPs were provided with a copy of their interview transcripts and the opportunity to comment on the transcript in order to maintain rapport and trust between the GP and researcher. No amendments to the interview transcripts were provided by any of the GPs. In addition two of the GPs agreed to read sections of the thesis, including the findings, discussion and recommendations section and provide comments and check on the credibility and plausibility of the findings.

### **3.9. Data management and the process of thematic analysis.**

Whilst Smith et al., (2009) emphasise that the proposed method of analysis in IPA is not prescriptive, as a researcher new to the approach, the stages they suggest (p.79) were followed in detail, as they provided a constructive framework and methodological rigour to the research process. Evidence of adherence to the analytical focus is included in full in Appendices Nine, Ten, Eleven, and a relevant "snapshot" is also included in the following stages.

### Stage One: Engaging with the data and initial noting.

Each of the interview audio-recordings were transcribed verbatim by the researcher, ensuring a close familiarity with the narratives, and initial thoughts and ideas were recorded in the reflexive journal, (Table 3.6). This was followed with several detailed readings of each of the transcripts to obtain a holistic perspective of the text, and marginal marks were made on the transcripts, detailing ideas, and reactions to quotations, initial thoughts and observations. The next stage began with a single case and focussed on three discrete processes for each individual interview. Firstly the descriptive analysis in which key words, phrases or explanations which structured the GPs' thoughts and feelings about their experiences were highlighted. Secondly linguistic comments and language use was recorded, including areas such as fluency, repetitions, contradictions, metaphors, and tone of speech. Finally interrogative conceptual comments were made based on the researchers' own experiential and professional knowledge and awareness. A full coding of the transcript for one interview (GP No.7) is given in Appendix Nine. The following exert, (Table 3.2) gives a short worked example, with margins used for the coding in relation to the question

Descriptive Comments	Original Text: GP No. 7	Linguistic comments
<i>Time</i> <i>Competing pressures</i> <i>Skills</i> <i>Types of presentations</i>	<p><b>“When would you raise a child’s weight?”</b></p> <p><i>“Competing priorities is the bottom line here. When you are in the middle of a surgery, and you know, you are <u>running late</u>, and you have the ear infection in front of you – then dealing with the <u>thorny</u> and <u>very</u> sensitive subject of weight in that consultation is <u>very</u> difficult - particularly if they <i>didn’t present with it</i> and you’re trying to move from the reason why they came into a health promotion role and a <u>very</u> sensitive one as well, on the <i>back of that consultation</i> ...so it is <u>very</u> hard.”</i></p>	<p>Metaphor: Thorny = painful – to whom the child or the GP? High use of intensifying adverbs; <u>Very</u> sensitive x 2 <u>Very</u> difficult <u>Very</u> hard</p>
		<p><b>Conceptual comments</b></p> <p>Shifting the consultation from dealing with the immediate to a health promoting activity – requires skills and motivation especially hard given the sensitive nature</p>

Table 3.2. Extract of a coded transcript - GP.No.7

## **Stage Two: Developing emergent themes.**

After this stage, the researcher engaged more fully in the interpretive process, by refining and interrogating the initial impressions into themes. During this process a conscious decision was taken not to use a computer programme such as NVivo for searching, categorising and thematic analysis of the transcript as it was felt that this may have impeded the hermeneutic circle and lose some closeness to the data in a positivist preoccupation with programme specifications and the intricacies of software coding. Initial notes were made of areas that appeared significant, prevalent and important, and these preliminary ideas were translated into more concise themes. At the completion of this stage, the original transcript was reviewed to assess the interpretations against the participant's original account in order to ensure that during this data condensing process, the essential qualities of the interview were not lost.

Using again the example of GP No.7, the analysis identified 51 themes at this stage, (Appendix Ten). Some were organisational such as time constraints, busy practice; some related to the parents such as ridicule versus normalisation, difficult to engage, denial. Others were more specific to the consultation; responding to differences, skills and motivation, and some focussed on the language of difficulty. Further themes referred to professional challenges, for example, placating parents and providing professional reassurance, and the complexity of role span and legitimacy.

## **Stage Three: Searching for connections across emergent themes.**

All of the emerging themes were listed chronologically separately from the transcript and were then clustered into groups. Some emergent themes fell in importance, being either weak or indeed being subsumed under other stronger themes. A master list (Appendix Ten) was created for each GP, with comments from the analysis used to demonstrate the themes within the transcript. Table 3.3 highlights the master list of emergent themes for GP No.7.

Master list of emergent themes: GP No.7
<ul style="list-style-type: none"> <li>• Understanding the family.</li> <li>• Diversity of family responses.</li> <li>• Complexity of negotiation caused by difference.</li> <li>• Professional dilemmas and internal conflict.</li> <li>• Limits and span of legitimate role to challenge parents.</li> <li>• Language of difficulty.</li> <li>• Consultation skills / knowledge.</li> <li>• Competing priorities and demands.</li> <li>• Determining appropriate responses.</li> </ul>

Table 3.3. Abridged version of master list of emergent themes for GP. No. 7

#### **Stage Four: Looking for patterns across cases – developing subordinate themes.**

The analytical process of stage 1-3 was repeated for each of the remaining GP's transcripts until all ten interviews had been considered. The next stage of developing subordinate themes looked for patterns across the ten GPs, and utilised a more cyclical, analytical approach, making sense of connections between emergent themes, looking for recurrent patterns across cases that had a wider significance across participants, and completing a careful interpretative analysis of how the GPs manifested the same theme in particular and different ways. In collating the patterns of themes, which tended to be more descriptive and concrete, some groupings quickly became obvious, for example family dynamics, whilst other emergent themes stood alone, for example the role of advertising in promoting childhood obesity was presented by only two of the GPs. The criterion for whether an emergent theme remained was with reference to its importance for the "*participants' attempts to make sense of their experiences*" (Smith et al., 2009, p. 68) and that the theme was fully represented in the analysis. However, material that did not seem to fit the emerging picture, for example, where the individual's narrative or theme was markedly at odds with most of the other participants, was addressed by revisiting the earlier transcripts in case something vital has been missed or misunderstood. If this was not the case the contrasting theme was highlighted and explored in both Chapter 4 and 5. Table 3.4 provides an example of how two subordinate themes were defined, including the number of participants who presented such views, to give a measure of prevalence for a theme, and the accompanying quotes that relate to the theme, in order to provide some indication of convergence, representativeness, breadth and depth of the theme.

The full lists of all the subordinate themes are identified in Table 3.5.

<b>Example of a subordinate theme: Knowledge of the family and the child.</b>		
Emergent themes	No. of GPs	Illustrative Quotes
Included: medical history, lifestyles, weight history, family priorities, socio economic factors, cultural context.	10	<p>“I see them all the time. They are always in for one thing or another – mum is depressed, dad is on long term sick with his back” (GP No. 10).</p> <p>“A family budget pressure means they can’t always eat well.” (GP No.6)</p> <p>“I have been a GP there for 25 years and you see the patients grow up and their children grow - and you see where there is a pattern of obesity in the family.” (GP No. 2)</p> <p>“The mum has diabetes, the dad is overweight, and the child will no doubt be fat. It runs in the family. (GP No.4)</p> <p>“It’s about all those influences on the parents, influence of where you live, influence of social factors, poverty, affluence” (GP No. 7)</p> <p>“The majority of times the parents are also actually overweight as well, sometimes they don’t perceive their children also having problems.” (GP No. 3)</p> <p>“And his mother says he is in his bedroom on his X box and on Facebook” (GP No. 9)</p> <p>“You know the family risk factors and the conditions in the family that make the child obese”(GP No. 8)</p> <p>“One gets to know your patients and their health behaviours.” (GP No.5)</p> <p>“Some families are all overweight. It’s the norm in that family.” (GP No.1)</p>
<b>Example of a subordinate theme: Time and competing pressures.</b>		
Included :  Priorities, hectic practice life, time during consultation, follow up, time for a meaningful discussion, time to maintain long term commitment.	6	<p>“It’s never been seen as a huge priority in general practice when we have QOF and all the other things to compete against.”(GP No. 2)</p> <p>“You’ve got a pile of paper work in front of you because we are doing so many other things like fighting disease. You have to prioritise.” (GP No. 3)</p> <p>“Whether we have enough time – and you know, you are running late, 10 minutes really is not enough to deal properly with it in the consultation.”(GP No. 10)</p> <p>“It’s difficult to find the time to take on a long term management.” (GP. No 9)</p> <p>“I might sort out the presenting problem first and then if I have time come back to weight later (GP No. 6)</p> <p>“It’s very time consuming and it’s not something that you could do in a 5 minute consultation, unless you have a particular interest” (GP No. 8)</p>

*Table 3.4. Examples of two subordinate themes: Knowledge of the family and the child: Time and competing pressures.*



### Stage Five: Identification of the super-ordinate themes.

Super-ordinate themes were finally developed by evaluating and engaging with these subordinate themes, attempting to distil them into broader categories. Smith et al. (2009, p. 96) detail how super-ordinate themes can be identified through a range of processes including abstraction and bringing together related themes; contextualisation, where themes relate to particular structures or processes; and function which focusses on how the participants present concepts related to the self within the interview. Again the focus of this final stage was on in depth analysis as an iterative process, continuing to move between the text to interpretation, to elucidate the key super-ordinate themes which captured significant salience and resonance for all the participants' experiences. The four super-ordinate themes "understanding the family", "flexibility and responsiveness", "individual and professional dilemmas" and "organisational challenges" with the associated subordinate themes are presented below in Table 3.5.

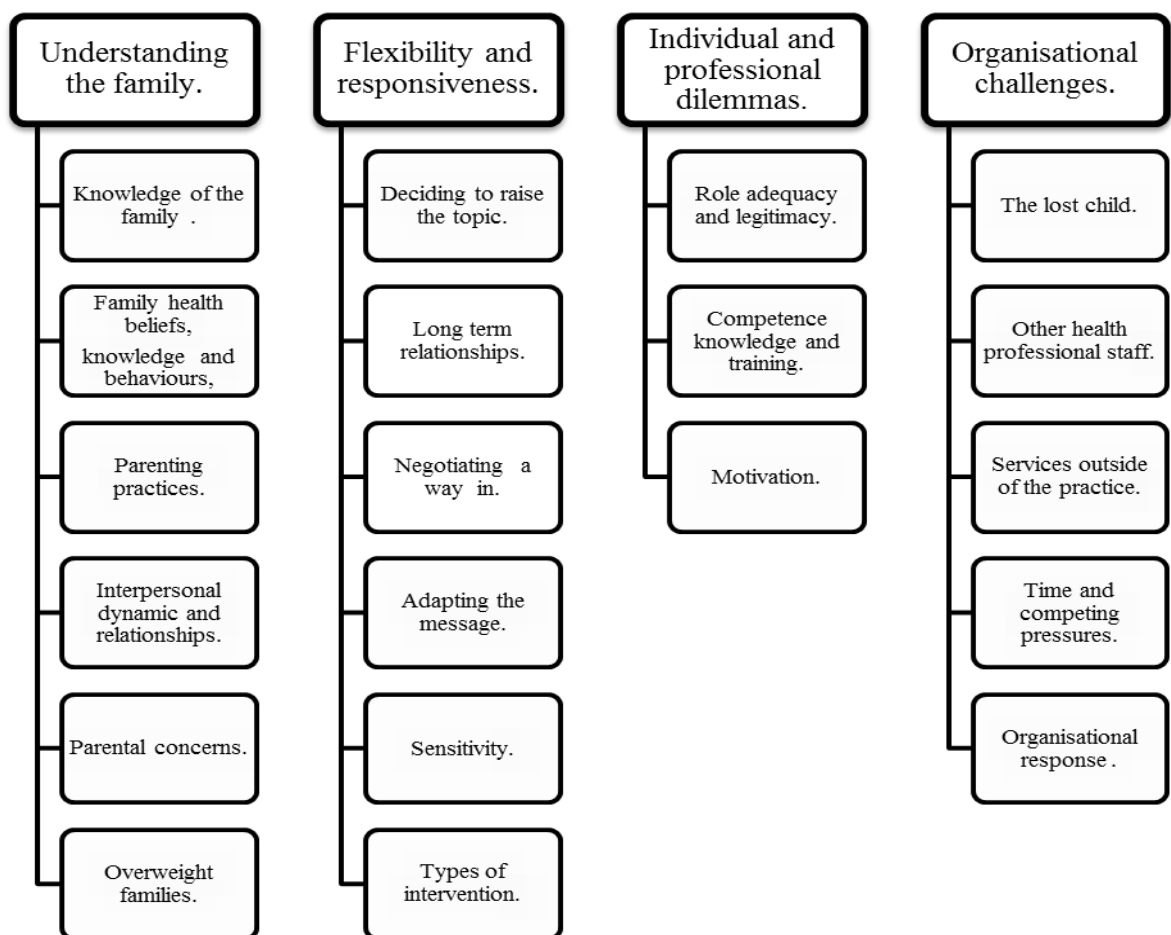


Table 3.5. Final super-ordinate and subordinate themes.

In summary, this section has defined the process of conducting the IPA analysis in this study in order to demonstrate transparency of the process (Yardley, 2000). Section 3.6.2 and 3.6.3 have detailed how the emergence of the themes, which were regularly discussed and assessed by both supervisors. In addition both GPs who commented on the analysis indicated that the findings were credible and informative account, and both recognised all the super-ordinate and subordinate themes, with one GP reiterating the importance and complexity of parental motivations as a critical factor in the consultation. The aim of the validity checks in this context was not to prescribe to “*the singular true account*” (Smith et al., 2009 p. 69), but to ensure the credibility of the final account (Osborn & Smith, 1998). However it is important to confirm that this is the heart of hermeneutics, whereby interpretation is always an interaction between the researcher and the participant to create dynamic, situated knowledge. As such the final section will return to the process of self-reflexivity in order to confirm the researchers’ engagement with the data and the nature of this interaction.

### **3.10. Reflexivity and qualitative research.**

The acknowledgement that the researcher always has an impact on research underpins most qualitative research, (Mason, 2002; Langdridge, 2007). Taylor and Hicks (2009) confirm that qualitative research with “*its focus on human subjects and their experiences*” (2009, p.62) requires reflective attention to be focussed on the important relationship between the researcher and the research subject. In this context reflexivity is seen as a process of engaging in critical self-reflection about the impact of the researcher, their background, their assumptions and their relationships with participants, on the research product (Finlay and Gough, 2008). As such it is “*a way of working with subjectivity*” in an explicit, accountable manner (Parker, 2004, p.25). Reflexivity can take many forms and various typologies exist in the literature (Taylor and Hicks, 2009). For example “*inter-subjective*” reflexivity which focusses on the way in which the relationship and interaction between the researcher and the participant creates data (Finlay, 2002), coheres with the central commitment of IPA to hermeneutics (Finlay, 2002, 2009; Smith et al., 2009).

Willig (2008) defines two types of reflexivity. Firstly, personal reflexivity which involves the researcher reflecting on how their personal and professional values, experiences, interests and beliefs have shaped the research process. Secondly epistemological reflexivity which encourages the researcher to explore how the assumptions about knowledge that have been made in the course of the research, including the design of the study, the methods of analysis,

and how the data is constructed, in order for the researcher to assess the implications of the relational way in which knowledge is constructed, (Langdridge, 2007).

In addition it is recognised that there is also an emotional aspect to this reflexive practice, as the researcher responds to participants on an individual level, (Finlay, 2002; Burns, 2003). Finlay (2002) argues that emotional work is an important source of insight and a powerful way in which researchers can challenge preconceptions and assumptions about a topic or a situation, (Hoffman, 1992; Finlay, 2002). Emotional responses and reactions to material are also informative of underlying prejudices, and offer insights to the social and political contexts of research (Hunter, 2010).

The boundaries between different types of reflexivity are clearly not strictly delineated. When reflexive practice is engaged with, it is unlikely that each type will be neatly bracketed and dealt with individually (Finlay and Gough, 2008). In addition, the limitations of what any individual researcher can reflect upon and critique must be acknowledged as total reflexive awareness is unlikely to be attainable (Rose, 1999). However in the context of this thesis research, given the importance of reflexivity for IPA, this final section of this chapter is a dedicated attempt at being explicit and reflecting on the issues that arose in the research process as an integral part of the methodology.

### **3.11. Reflexivity within the practitioner – researcher role.**

In relation to this thesis, the process of reflexivity, (Langdridge, 2007; Taylor and Hicks, 2009) was firmly established at the commencement of the Professional Doctorate and sustained throughout the research activity. Through attendance at seminars, workshops, assignments and extensive reading I became familiar with the challenges of the “practitioner - researcher” role (Lee, 2009, p.25), with myself as a researcher at the centre of the research process, and my professional drivers and motivations to conduct research which would make a significant contribution to improving services in my current area of professional practice. The Professional Doctorate also provided me with the opportunity to explore different epistemological perspectives, address my own epistemological stance, and actively consider a range of methodological approaches which provided a strong foundation for initiating the process of epistemological reflexivity. In the Doctoral Foundation course I completed an assignment critically appraising a process evaluation of Watch It (Rudolf et al., 2006) a community based intervention, for obese children from disadvantaged communities in Leeds. This enabled me to reflect on the challenges and complexities of service evaluation and

confirmed my determination that my research should make a meaningful contribution to policy and service development. A further module covered Professions and Practice and my reflective essay enabled me to explore the nature, role and changing function of professional practice and behaviours. As a consequence I have acknowledged the changing nature of governmental priorities, and emerging inter-professional work practices in relation to childhood obesity and General Practice in Chapter One. I am clear that this academic insight, formulated in the early stages of my Professional Doctorate, has been critical in the way that the conceptual analysis, referred to in Section 3.9 has been completed.

Reflecting on my current professional role, I am aware that that having worked with GPs for a significant number of years brought advantages and challenges, as has my current Public Health role in commissioning childhood obesity services. Firstly, in relation to primary care I am certain that recruitment challenges were eased by the fact that I had worked in primary care and the fact that the GPs were willing to be interviewed was a consequence of my long term relationship with them. Although not a clinician I have been perceived as an advocate of primary care and I recognise, and have dealt with, the complexities and multiple challenges that operating in this environment brings. This respectful familiarity also assisted in the actual interview process where I found it relatively easy to facilitate and develop a rapport which encouraged natural and open conversations. My prior knowledge, personal experiences and relationships I had with the GPs will have undoubtedly provided me certain insights and understandings. Similarly my professional drive to support children who are obese and their families, and the many narratives I have received from parents in this area must also be acknowledged, as my own feelings and opinions about this field will have influenced the interpretation. Supervision has been critical in enabling me to maintain a balance between avoiding too many assumptions, and still allowing my familiarity with the area to be of use.

Whilst I believe that my unique position as a practitioner - researcher has enabled a rich and comprehensive exploration of the research topic, this was not without challenge. For example, as a result of my long term professional relationship with the GPs I was able to empathise with many of the issues they raised such as time pressures, competing demands and lack of access to services. However I was also extremely aware that my overall ambition was to improve services for obese children and at times in the research process this seemed unlikely, especially when the GPs' narratives highlighted so many challenges and difficulties in implementing this role. At times I felt I had many demands on me; the need to produce a high quality rigorous academic study, the need to ensure my continuous professional development

and the need to ensure that the meanings and experiences that were offered by the participants were clearly presented, even when these conflicted with my personal drivers for the research. Maintaining an awareness of these, sometimes conflicting, but always interweaving multiple roles, and different perspectives was a critical part of my analysis, and one in which the support of my supervisors and IPA peer group was invaluable.

One of the reasons I chose IPA as the methodological approach was because it encouraged a consideration of the iterative engagement with the topic, the participants and myself at the centre of the knowledge creation, in order to situate and provide a contextual framework for the findings to be considered. To support me in the process of becoming a reflexive practitioner–researcher, a reflexive journal (Lee, 2009 p.42-43) was essential, and entries were made at every stage of the research process, whether this was during the literature review, following attendance at workshops or after meetings of the IPA forum. Each entry highlighted considerations for further exploration and documented challenges and extensions to initial thinking; for example the major conceptual theme of understanding the family stimulated further literature reviews on family dynamics, parenting styles and family structures. The reflexive journal (Table 3.6.) also included many reflexive accounts both to support my analysis and account for my positioning within the research. The act of writing down thoughts on an issue had the effect of shaping and transforming these thoughts, so that writing itself became an important aspect of the analytical process. The ability to look back through my reflexive journal on my thoughts and feelings during the project also encouraged a deeper reflection on the analysis to develop over time.

In terms of the analysis of the data the reflexive journal was particularly important. Thoughts and reflections were recorded after each interview in terms of the issues raised my initial perceptions of the actual interview process, and on occasions to record my emotional responses to some of the comments provided by the GPs. For example one of the GPs spoke in what could be perceived to be a very disparaging and crude tone about children who are obese and their families which resulted in a feeling of acute disconnection with the GP. I was determined that these comments such be acknowledged in the findings, especially as they had also been found in the literature, but I felt a significant responsibility, as part of my commitment to analytical reflexivity, to explore the reasons behind such statements and comment on both the ethical and professional consequences of such findings. Table 3.6 is an extract from my reflexive journal which highlighted some of my responses after the interviews of 2 GPs.

**GP No.7.**

The interview with GP No 7 was extremely informative. It started well as when I rang him he said great, I have been asked to give a talk at my daughter's school on childhood obesity can you bring some stats with you. I felt his responses whilst open were given with utmost integrity. In fact he said a couple of times in the interview 'to be honest Donna' and 'do you want to know the truth' etc. I felt privileged that he trusted me enough to be so honest.

His emphasis on science, evidence etc. was more acute than others and he appeared keen to be perceived as clinically competent. I was quite surprised how little reference there was to lifestyle change or any parenting issues. He proudly showed me a picture of his new bike but physical activity was rarely mentioned. I wonder why? I got the feeling that he found the whole process of supporting children who were obese quite dispiriting and he mentioned his feeling of powerlessness. After speaking with GP No 7 he seemed to summarise very well many of the issues raised by the other GPs. Time. Pressing priorities. Who else can help these families? I felt I had enough information from him to fill a whole thesis! Once again I was disappointed that despite our extensive publicity for A2A GP No 7 had never referred any of his families to the scheme.

**GP No. 3.**

I really struggled with some of the generalisations that this GP offered. The excessive use of the words "fat kids" and "lazy parents" caused me to shudder and it was hard to present a face in the interview which did not register my distaste. Moreover I felt guilty that I could not challenge the GPs assertions and even my attempts to encourage the GP to reflect on why he made such statements felt inadequate.

I tried to stay within the interview, and recognise that these insights would be powerful into the analysis but I still felt, and continues to feel during the analysis that I was in some way complicit and could have been more assertive in challenging such. I must accept that the GP's statements is how he interprets this experience but I need to speak to Lindsey and Orla about this and read more about responding and handling issues that cause such an emotional response.

*Table 3.6. Example of reflective journal post interview GP No.7 and GP No.3.*

The reflexive journal was also used repeatedly during the transcription and analysis stage as presented in Table 3.7.

#### **Analysis of Interview with GP No. 10**

After the long complex case study of one family GP no 10 concluded that ‘ it’s quite sad ‘ at first I thought that this was an indication of her response to the challenging family situation but I wonder now whether it related more to her feelings of professional insecurity? Or her distress that she couldn’t fulfil or achieve a satisfactory clinical or professional outcome. What does that mean in relation to her status as a GP?

What are the professional drivers that lead to her role satisfaction? How important is this to her needs?

I need to recheck how many other male respondents reflected in this way – Is it a gender issue? Is it more related to the fact that a mother she has shared many experiences with me where she had achieved her ambition to parent happy, healthy and active children.

*Table.3.7. Example of reflective journal analysis of interview with GP No.10*

As both these examples illustrate, the interpretive nature of the analysis highlights how my personal and professional experiences were embedded in the analysis, requiring active reflection to maintain an awareness of my position, in order to use this broader knowledge to inform the analysis but also to remain grounded in the data. In conclusion a dynamic reflexivity process helped me to identify and be aware of the inter-connectedness of my knowledge, experiences and the roles I hold. All have acted as a lens through which my interpretative analysis has focussed, and have been presented systematically to highlight the context of knowledge construction, at every step of the research process.

### **3.11. Summary.**

This chapter has defined the epistemology that forms the foundation of this IPA study, grounded in the theoretical commitments to phenomenology, hermeneutics and ideography, (Smith et al., 2009). It has outlined that the research strategy, design, analysis and interpretation are also coherent with its epistemological convictions, and have enabled the research questions of the study to be addressed. This chapter has also confirmed that the

research has been completed in an ethical manner and demonstrated the attempts to assure quality criterion have been addressed. The subjectivity of this research and my influence on the research process has been acknowledged through an exploration of my epistemological stance, the motivations for the research topic, the relationships with the participants, and the analysis and final presentation of the findings. It has demonstrated that on-going reflexivity has been a central feature of this thesis. The next chapter of this thesis will present a summary of the findings that have emerged through the analytical process based on the 4 super-ordinate themes and the accompanying subordinate themes.



## Chapter 4: The Findings.

### 4.1. Introduction.

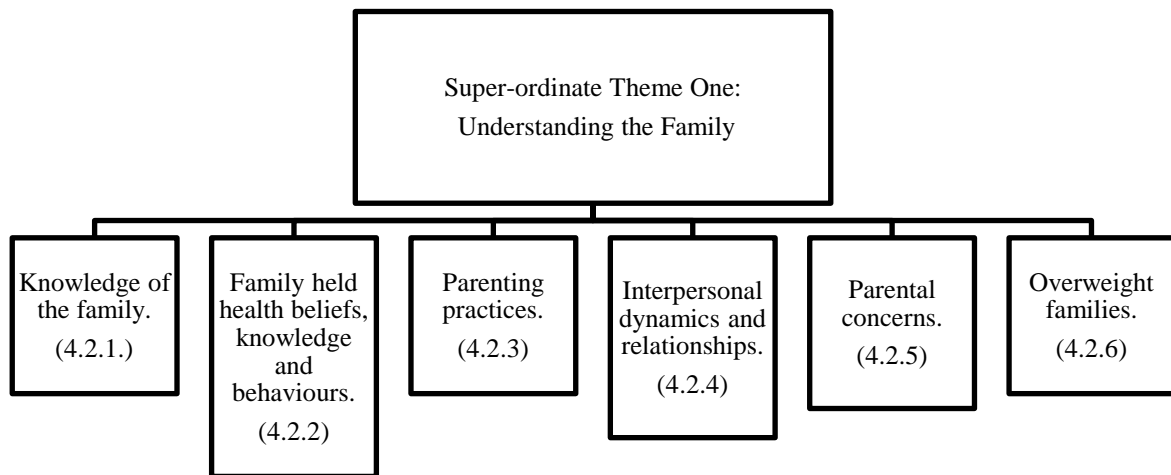
This chapter details the findings from the ten transcribed interviews, centred on the four super-ordinate themes (Table 3.4) which evolved following the analytical process detailed in Chapter 3. Section 4.2 presents the detailed findings analysis around the super-ordinate themes of Understanding the Family; Section 4.3 details Flexibility and Responsiveness, Section 4.4 covers Individual and Professional Dilemmas and Section 4.5 Organisational Challenges.

Each section explores the accompanying subordinate themes including direct quotations from the GPs referenced using the code numbers in Table 4.1. Section 4.6 presents a summary of the findings.

GP No.1.	Female. Qualified 1985. 5 partner practice in non-deprived area.
GP No. 2.	Female. Qualified 1984. 2 partner practice in a deprived area.
GP No. 3.	Male. Qualified 1980. 8 Partner Practice (11,687) in a semi-deprived area.
GP No. 4.	Male. Qualified 1982. 6 partner practice in a non-deprived area.
GP No. 5.	Male. Qualified 1979. Single handed GP in a semi-deprived area.
GP No. 6.	Female. Qualified 1981. 2 partner practice in a deprived area.
GP No.7.	Male. Qualified 1984. 4 partner practice, in a non-deprived area.
GP No. 8.	Male. Qualified 1985. 2 partner practice in a non-deprived area.
GP No. 9.	Male. Qualified 1982. 7 partner practice in a semi-deprived area.
GP No.10.	Female. Qualified 1984. 2 partner practice in a deprived area.

**Table 4.1.** Summary of GP participants.

## 4.2. Super- ordinate Theme One: Understanding the family of the obese child.



The first theme, understanding the family, was seen as a crucial driver for the GPs in their day-to-day experiences of identifying and managing children who were obese. In relation to the term “*family*” often there was specific reference to the mother as the key person who, in the GP’s experience, tended to have a more prominent role in both the care and the management of any matters relating to the child. However, there was also reference to parents in general and a small number of references to the wider extended family including grandparents. The GPs’ articulated, through a range of examples, a spectrum of parental lifestyle and parenting behaviours, attitudes, values, health beliefs, responsibilities, and social and financial circumstances which formed a framework for their subsequent interaction with the family. This framework was used iteratively, and dynamically, to determine and shape the nature of their individual interaction with the parents and children.

### 4.2.1. Knowledge of the family of the child who is obese.

In presenting their knowledge of the parents, the GPs often acknowledged the wider context of the socio - economic circumstances of the family. Sometimes this was offered as a generic over view, often with a particular contextual focus on levels of deprivation. GP No. 6 described how “*I work in an area where the families haven’t got much.*” In other cases, examples were given where the decision not to raise the child’s weight was directly related to a family’s current acute social circumstance. “*I knew this family were going to be made*

*homeless. There was no point in me raising the topic of losing weight. It was probably the last thing on their mind,”* (GP No. 10).

The GPs also described their clinical knowledge of the parents both as patients and carers of their children. GP No. 10 described her experiences of one family *“they are always in for one thing or another, mum is depressed, dad is on long term sick with his back.”* Through these long, sustained relationships the GPs were able to observe familial patterns of obesity, and the associated health and social challenges.

#### **4.2.2. Family health beliefs, knowledge and behaviours relating to childhood obesity.**

Knowledge of the family also included an awareness, understanding and familiarity with the prevalent family health beliefs and associated weight-related attitudes and behaviours. For example two of the GPs specifically discussed their patients’ health beliefs about the temporary nature of early infant obesity, and the parents’ belief that the young child would *“grow out”* (GP No. 6) of their current weight problem or that it would be resolved because *“it’s only puppy fat”* (GP No. 4). The knowledge of the families’ lifestyle patterns and weight related behaviours was also commented on. For example GP No. 9 presented a moralistic assumption about the lifestyle choices of families in his practice who *“live on a life of takeaways”* and *“you see them driving the kids to school when they could easily walk.”* This section of the interviews, included a number of value driven statements such as *“they eat cheap, crap food,”* (GP No. 3) and comments about the children’s lifestyles such as excessive recreational computer use, and habitual television viewing.

*“The mums will say that their kids are on their X boxes or Facebook. And yet when you suggest they go as a family for a bike ride they look at you as if you are mad.”*  
(GP No. 9).

In such circumstances these GPs highlighted their frustration that the very basic steps for a healthier lifestyle were not being followed, and the fact that they, as family doctors, had been unable to persuade the families to do otherwise. Often this had implications for their own feelings about how valuable or successful their interventions were likely to be both in the short and long term. Other GPs, however, were keen to explore the parent’s health related behaviour in the wider socio-economic context, and were very wary of being judgemental of the family citing, for example, the expense of healthy meals.

*“If it’s cheaper for parents to buy something from Iceland you know buy one and get one free, I can understand, but it’s not very healthy.” (GP No. 1).*

There was also an understanding that time restrictions and parental working patterns could determine food choices. GP No. 10, who was a working mother, could identify with this challenge and how it impacted on some families’ ability to comply with healthy eating messages. In some ways this may have been the reason why she wanted to defend or at least raise these wider influences on food choices.

*“They have ready-made meals, because mum and dad are working and they haven’t got any time to cook proper meals. We are the same; we always have a takeaway on a Friday when I have a late surgery.” (GP No. 10).*

Linked with the parental health behaviours was the issue of parental health related knowledge. In discussing this matter with the GPs it appeared that they constructed almost a generic script of certain family patterns and behaviours, which they used when exploring solutions with the families. GP No. 6 explained how she would start asking about *“How many take-aways they have, how many times the family cook, how much food they give the child, the child’s favourite meals etc.”* Within a short consultation however there was an acknowledgement from this GP that she was not able to ask detailed questions, nor respond in any depth. Often she felt that parents gave perfunctory response and she was concerned about the level of accuracy and truth of such responses. This doctor found it particularly hard to accept some of the answers, especially if the parents started to become defensive, but admitted she did not always have the time to challenge further.

*“They say we never have fried food, the kids never have sweets. Part of you wants to believe them, but part of you thinks that this just doesn’t add up.” (GP No. 6).*

Two GPs highlighted that, in their experience, some parents had a poor knowledge of what constitutes healthy eating, healthy food preparation and portion size.

*“They don’t seem to have an understanding of what is an appropriate portion size for a child. I remember one mum proudly saying that all her children have the same size plate as their dad at Sunday lunch.” (GP No. 2).*

In this example, the GP recounted that there was only one child who was overweight in the family whilst the other siblings were normal weight, and therefore any messages about portion control were extremely complex for the GP to deliver and for the parent to receive.

The wider determinants of food choice and availability were also highlighted in some of the accounts. GP No. 6 spoke with evangelical fervour of the challenges caused by the obesogenic environment *“I would ban crisps. They are everywhere.”* There were similar strong concerns expressed in relation to advertising and fast food retailers, who, both confused parents about what foods are healthy, and actively promoted supersized portions of unhealthy products. GP No. 9 spoke with an air of resigned defeat, *“You see some families all eating out in MacDonald’s - all heavy. The kids don’t have a chance.”*

#### **4.2.3. Parenting practices.**

There was a diversity of views amongst the GPs, regarding parenting practices. For example GP No. 3 described experiences of permissive, indulgent and lenient parenting behaviours which he believed were reflective of an absence of clear, consistent family rules, *“I think some of the parents just can’t say no, and the kids get to eat whatever they want.”* Some parenting behaviour however, for example was rationalised in relation to wider concerns regarding safeguarding of the child. *“I can remember days when I was little; we used to go out in the back street, but nowadays it’s not safe anymore.”* (GP No. 5). One GP, No. 8, tried to make further sense of parenting practices, offering the view that depression and anxiety often impacted on parents’ ability to manage their child’s weight. It is interesting that GP No.4 revealed that as a parent, he had sympathy trying to reconcile parental intentions with the complexity of children’s food preferences, *“I know some kids, my youngest son in particular, just doesn’t like healthy foods, so you can’t really win.”* (GP No. 4). As these examples show there were some occasions where the GP’s narratives moved outside of their clinical role and they displayed considerable empathy with many of the challenges that parents faced. This at times led one of the GPs to amend some of the lifestyle messages and adopt a less judgemental tone, *“I do acknowledge it can be difficult as a parent, sometimes it helps them to understand that you know that.”* (GP No. 10).

#### **4.2.4. Interpersonal dynamics and relationship with the family.**

In creating an understanding of the family there were also references to relationships within the family. At times this related to conflicting views from parents regarding how to manage

the child's weight. GP No. 9 commented on a specific family dynamic identified in one of the consultations where the child's needs were being subsumed by parental conflict. He mentioned how the mother was trying to manage the child's weight whereas the father was ignoring this. The GP despaired at what appeared to be the immature family dynamics where *"dad is being the good cop, treating kids at the weekend, whilst mum has to try and be strict."* For GP No. 8 the family dynamics could also be intergenerational, with contrasting generations offering different views, he noted *"Once Grandma told me she knew there was a problem with the little one's weight, but she was worried about interfering."*

The understanding of the family dynamics also included an acknowledgement of the power of children in some families. GP No. 4 reported that he had witnessed occasions where parents seem to have given up on addressing the child's weight as the child was particularly strong willed. When faced with such challenges, this GP admitted he was reluctant to take the matter further, and rationalised his reasoning as *"I can't change such behaviours."* A further feeling of limited personal power was articulated by one GP who focussed on the pervasive local social norms he witnessed in his practice area, *"I see all of them on the way to school, a can of Coke in one hand and crisps in the other. Not much you can do."* (GP No. 9).

Interestingly, there were occasions during the interviews when the GPs recalled varied experiences that took place outside of the surgery which highlighted and gave some insight into their wider attitudes and personal health beliefs regarding obesity. These appeared to be constructed not just within a medical framework, but also referenced related socio-cultural dominant perspectives about children's weight. One GP gave an example of a recent occasion where she had observed the behaviours of a family in a Chinese restaurant,

*"And it was one of those buffet style restaurants, and there was one family, really obese, sitting as close as possible to the buffet. You couldn't make it up could you?"*  
(GP No. 6).

A male GP who was also a sports coach spoke powerfully about his view of the importance of physical activity and the improvements in self-esteem he had witnessed through competitive sport. He expressed his concern about the potential isolation and marginalisation of children who were obese. *"It's interesting that we take the schools skiing every year, and in all my years I have never had a fat child come skiing. It's a shame."* (GP No. 4).

#### **4.2.5. Parental concerns regarding childhood obesity.**

The theme of understanding the family also focussed on the GPs' ascertaining and appraising what the parents' pressing concerns were about the child's weight, and trying to identify their belief system about the causative factors of their child being overweight or obese. Again there was a wide range of responses and motivations brought to the consultation. Some of the key areas reported by the GPs related specifically to mother's concerns about their child's emotional and psychological problems. Examples were given where children were brought in to the surgery primarily because they had been bullied at school, or there were significant behavioural problems, *"they may say he is being teased at school because of his weight and starting to get into fights and becomes quite aggressive,"* (GP No. 5).

In this area the GPs' classifications used a much more emotive register; parents were described as *"desperate"* and *"very anxious"* and this in turn affected some of the GP's feeling of needing to offer some support to the child and family. The GPs were particularly empathetic when describing the stigma and ridicule that some children and families had to face because of their weight. The complexity of dealing sensitively with this issue was compounded by the responses of some parents who tried to avoid direct conversations because of the potential negative impact on their child's self-esteem. Whilst GP No. 9 subtly responded to this by asking the parent to come back later when the child was not present, another GP expressed his conflicting views, *"I know sometimes mum doesn't want to upset the child, but sometimes you feel you have to be clear with the child or else the issue will never be tackled."* (GP No. 4).

#### **4.2.6. GPs' perceptions and values regarding overweight and obese parents.**

One of the strongest themes was the familial link when obesity was prevalent in other family members. Almost half of the GPs offered views which centred on a construction of parental determinism, and it was within this discourse that these GPs were more likely to express negative and sometimes dismissive attitudes towards the parents particularly around the likelihood of positive outcomes; *"I mean if the family is all overweight you wonder how much hope there is that the child will grow up differently,"* (GP No. 9). Some of the GPs explored how the parent's own weight often impacted on their ability to recognise, monitor or have the necessary insight into obesity as a problem for their children. GP No. 1 reported her amazement that some parents were *"totally oblivious"* to their child's weight. The apparent lack of motivation from overweight parents to tackle their child's weight challenged some of

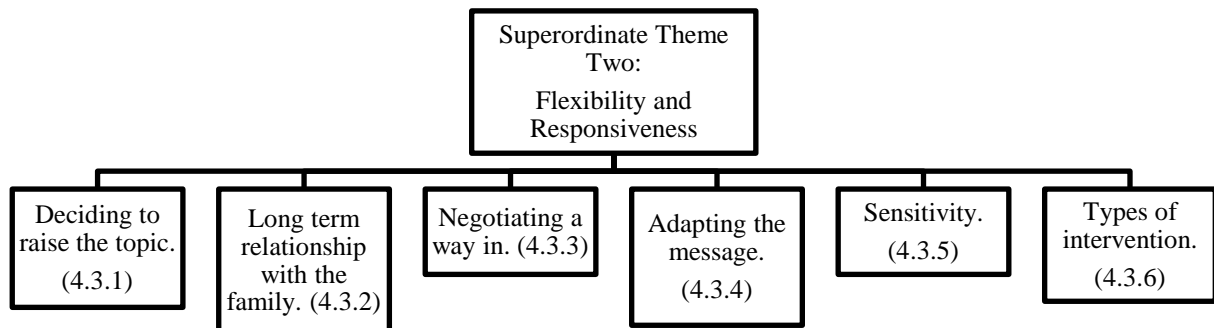
the GPs fundamental assumptions about parents taking responsibility for their child's health. Interestingly GP No. 10 described a set of parents who themselves were thin and who were concerned about their child's weight when they felt that they had set a good example. *"You don't want to stereotype but it didn't seem to fit, they seemed to be so well educated and seemed to understand everything about healthy eating."* This GP struggled to untangle this unusual contradiction and felt confused that her usual response of educating the parents about healthier lifestyles was not appropriate or sufficient for this complexity.

There was also reference to parental normative beliefs about obesity which the GPs indicated seemed to lead the parents to adopt a pragmatic view, or one of resignation. The GPs reported parents using phrases such as *"we're a big family,"* (GP No. 3), or *"it runs in the family, all my brothers were big too,"* (GP No. 2). In one case the GP highlighted what she believed to be a very extreme response of outright hostility and denial. *"In one case the parents went bananas, 'how dare you say my child is overweight'. They hadn't acknowledged the problem because the whole family was not exactly thin."* (GP No. 1).

One of the GPs offered a view that possibly overweight parents felt that the consequence of addressing their child's weight would mean that they would also need to lose weight themselves which previously they had failed to do. GP No. 3 was dismissive and critical, positioning such parents as weak willed and lacking motivation, *"they don't come to me with their children because they are too embarrassed that they haven't the discipline to lose weight themselves."* However, GP No. 2 described the emotional impact on a mother who felt she was going to be judged and in some ways blamed for her child's weight. In this GP's mind there was a fine balance between responding to these feelings of guilt and supporting the mother in addressing her child's weight. In a further case, outlined by GP No. 8 it was the parent's acknowledgement of their own weight issues that generated their decision to visit the GP, so that their child would not face future weight stigmatization or a lifetime of body dissatisfaction.



### 4.3. Super-ordinate Theme Two: Flexibility and Responsiveness.



The key themes of flexibility and responsiveness were apparent in the internalised decision making process that the GPs utilised in the consultation particularly around whether to intervene, negotiating a way in, adapting the message and presenting an intervention. Subordinate themes such as the long term relationship with the family, the sensitivities required, and the complex collection of current and historical issues that the family presented appeared to be important considerations. Moreover the fact that this information was not static and was continually refined as new information was presented and as organisational and operational contexts shifted required flexibility in constructing the forthcoming discussion with the family. The decision making process about whether to raise the topic of the child's weight sometimes appeared swift, *"at times it's just a quick calculation of what I see, what I know and what other things I have to get through that day."*(GP No. 2). At other times the sheer pace of general practice depleted some cognitive capacity as GP No. 9 confirmed.

*"Sometimes you are tired or stressed, or your mind is on your lunch time visits, and you might have just had a really difficult conversation with the previous patient, and perhaps you don't give the child in front of you the time and attention you really should do. I am sorry but that's how it is."* (GP No. 9).

#### 4.3.1. Deciding to raise the topic – the nature of the consultation.

The nature of the consultation, the presenting condition and the reasons why the parents had attended the surgery with their child were critical determinants for the GPs. GP No. 8 used the simile of being an actor with the requirement of flexibility and responsiveness in order to adopt multiple roles and take on the role that the parents requested. Some GPs explained that

if parents attended the surgery for their child's medical conditions and weight was considered a contributory factor, they were more likely to use the opportunity to raise the issue, albeit with the necessary conditions of sensitivity and appropriateness. It was almost as if such discussions were likely to be less challenging. *"Quite often it presents as knee problems or pain or getting out of breath. So you have an opportunity to talk sensitively about weight."* (GP No. 7). Likewise the decision to raise the topic for some of the GPs, became more of a clinical imperative with children whose weight was perceived to be at the severe end of the spectrum or if there were obesity-related co-morbidities. *"If there is a family history of diabetes you kind of have a way in which to raise it."* (GP No. 9).

However, the GPs described how there were clear boundaries, in their experience, when they felt it was evidently not appropriate or the right time to raise the topic of the child's weight. The most common of these explanations referred to clinical examples when the child was brought in for acute conditions such as gastrointestinal or respiratory conditions which overwhelmed any considerations of raising the topic. The term *"harp on"* in the quote from GP No. 1 clearly emphasises the GP's reluctance at this point. *"Yes I do see children for the usual coughs and colds, diarrhoea and vomiting, but we just want to get them better, it's not the right time to harp on about weight is it?"* Similarly the decision to raise the matter was contextual around the parent's immediate concerns. GP No. 5 noted that if a parent had been *"up all night with a poorly child with a chest infection"* he would not raise the matter of the child's weight, and appeared quite incredulous that any GP would do otherwise.

The GPs' experiences notably differed if the family brought the child specifically to discuss or seek help about their child's weight, often interpreting this as a clear sign that the parents were ready to make a change. As GP No.8 indicated, *"if they bring the child in asking for help, you're on stronger grounds and you know that you will be listened to, and the parents will work with you."* They also appeared to find the task easier if the parents just wanted reassurance and to have *"it checked out,"* (GP No. 2). Even in such cases, it was important to value and make sense of the narrative presented by the parents, which was likened to history taking before making a clinical diagnosis. GP No. 7 summarised a feeling portrayed in various ways by many of the GPs about responding to different consultations.

*"Dealing with a thorny and very sensitive subject like weight is very difficult, particularly if they didn't present with it and you're trying to move from the reason why they came, into a health promotion role. It is much easier if they come in and they*

*actually say my son is desperately overweight what can we do about it. To actually piggy back it in a 'by the way whilst you're here' is a very difficult skill."*(GP No.7)

#### **4.3.2. Long term relationship with the family.**

The permanence of the relationship with the family was also significant in terms of the decision process as to whether to raise the topic. GP No. 5 who was a single handed GP, , acknowledged that following his many years in practice, *"one gets to know your patients and their temperament, and generally that makes it much easier when you are discussing with the patients a very unpopular subject that might have a negative reflection on the parent."* This GP described how in his experience of doing locum sessions at other practices he would never raise the matter of a child's weight with families whom he had no previous knowledge. The long term relationship afforded in general practice also provided the GPs with the opportunity to defer a meaningful discussion with the families to a more appropriate time or future occasion, and there was an underlying assumption that initiating the conversation was sometimes just the starting point of a long journey of behavioural and attitudinal change. However the GPs did not reflect on how by ignoring the issues at certain times the child weight issues remained unaddressed and further problems may ensue for the child. It is unlikely that the GPs would ignore other chronic health needs which challenges how committed they really were to addressing a child's weight.

#### **4.3.3. Negotiating a way in.**

This theme was a popular one in the GPs' responses, with the majority of GPs keen to evidence the strategies and techniques they utilised. It was clear that there were qualitatively different ways of responding to the child's weight status. A range of complex family and context specific techniques and strategies were used, often described as the *"way in."* Interestingly this rarely started with independent clinical measures. Only one of the GPs indicated that they routinely measured and weighed the child. The remainder indicated that they were more likely to estimate the child's height and weight and their ability and perceived confidence to estimate and make subjective judgements was attributed to longevity of practice and having acquired the relevant knowledge and clinical experience of weight assessment in children. The GPs described approaches when identifying overweight children such as a rapid visual assessment, *"I eye ball them,"* (GP No. 10), or they used comparisons with other children as a reference point. *"It's not rocket science to see which kids are fat and which are OK."* (GP No. 9) GP No. 7 was far too pragmatic to describe what he did as having a

scientific foundation; and admitted *“It’s all terribly unscientific,”* in an attempt to distance himself from this one area of his clinical practice. Given that there is good evidence that GPs, and indeed the wider population are not able to accurately estimate children’s weight especially as societal norms about ideal weight have shifted, there was little recognition that this approach was likely to result in some children being missed. Again it is interesting to consider whether this was reflective of the GPs underlying attitudes to the childhood obesity, as it would be unlikely that GPs would have adopted such a casual approach to other common childhood conditions such as asthma or diabetes.

There were however attempts offered by two GPs to rationalise the non-measurement intervention. One was on the basis of not wanting to upset or embarrass the child by weighing them in the consultation room, although this GP did not evidence that they had previously done this and has been met with a negative response from the child. The other GP believed that the actual measurements were not the basis for a productive relationship with the family, *“they know that the child is overweight, putting them on the scales just doesn’t take us any further.”* (GP No. 2) with a resignation that knowing the weight did not necessarily lead to a motivation or commitment from the parent to change behaviours. Interestingly throughout the interviews the terms overweight and obese were used arbitrarily and were often interchangeable terms. The impression from the GPs was that this was solely based on their clinical judgement without any reference to defining BMI scoring mechanisms.

#### **4.3.4. Adapting the message.**

A key feature for the GPs was the requirement to be flexible, constantly adapting their communication, key messages and responses. This included both the nature and content of the message and the manner in which it would be delivered. The ability to modify the communication according to the needs of the family was both acknowledged as a skill they had acquired through their many years of practice, and was considered critical to ensuring that any communication related to weight loss was effective. In such consultations, GPs noted that they sometimes preferred euphemisms such as *“carrying too much weight,”* (GP No. 8) rather than clinical terms. Whilst the GPs reported their intention to avoid using terminology that could cause anxiety or upset the parents and the child, there was an acknowledgement of the need for balance in trying to give a clear message to the parents which would ensure that the parents recognised that the weight problem may have serious consequences. The following quote highlights these challenges.

*“And I last saw a fat kid on Friday. It was a 14 month old child with respiratory difficulties, and I remember saying to mum that her child was ‘well covered’. That was the expression that I used, she was quite significantly overweight actually but I think mum picked up on it.”* (GP No. 3).

One GP discussed how, following an initial assessment of the child and the family, he would ascertain if the parents were likely to be receptive and then address the issue directly, making an individual choice to either *“shock or remain friendly”* (GP No. 9). There was an awareness that for some families there was initially a need to *“plant a seed of recognition”* (GP No. 6) utilising metaphors that indicated the need for a longer term intervention. Some GPs offered more radical hard hitting approaches relating the presenting issue to future health consequences such as the risk of diabetes. One GP, who had displayed other pragmatic tendencies in his discussions about lifestyle advice, highlighted his preference to avoid being censorious, and adapting the message so that it was not too austere, *“I just say everything in moderation, I don’t preach.”* (GP No. 8). It was clear that there were challenges between educating, advising and even persuading the parent without alienating or *“switching them off,”* (GP No. 9). GP No.10 shared her use of seemingly innocuous comments, such as how the child was doing at school in order to provide an opportunity for the child to reveal any concerns they may be facing which could be weight related.

#### **4.3.5. Sensitivity of the topic of childhood obesity.**

The acknowledgement of the sensitivities around childhood obesity was clear in many of the narratives. GP No. 6 described it as a *“phenomenally sensitive area for children.”* The theme of sensitivity was more likely to be described with accompanying expressions of empathy. GP No. 2 specifically referred to her concern for the child who was obese, *“I do feel sorry for these children. Others can be so cruel to them.”* The issue of sensitivity however did appear to cause an added complication during some of the clinical encounters. The GPs recounted how the sensitivity of the topic required a specific skills set, as GP No. 2 further indicated, *“Whilst it is something we talk about, you have to be very careful and skilled as it’s such a sensitive area for children.”* GP No. 6 spoke how on one occasion she did not want to constantly raise this sensitive topic because of her fear of adding further to the child’s anxieties, and as a consequence she prioritised working with the parent on wider lifestyle matters rather than *“go heavy on day one about being overweight.”* There was also an acknowledgement that the issue of such sensitivities could at times deter an intervention. GP

No. 9 commented on the reality for him, *“I have to say because it’s so sensitive, your heart does sink and you think who else can help me here, or who else I can pass this on to.”*

#### **4.3.6. Types of childhood obesity interventions.**

The GPs also shared examples where they used knowledge of the parent to determine the type of intervention they would offer. The examples included determining the perceived likelihood that the family would both accept and act on the advice offered and the families’ general levels of motivation, confidence, and readiness to change lifestyle related behaviours. In addition, some GPs evaluated the chances of them being successful in terms of their previous knowledge of successful or sustained behaviour change in the parents. For some GPs this was tempered with a brief evaluation of how significant the wider influences, particularly social and financial factors were likely to impact upon such success.

*“You know A2A<sup>1</sup> is a great scheme but there is just no way that my families would travel across Stockport to attend. They haven’t the time or the bus fare. So if that was the case I would talk about going out for a walk at the weekend.”* (GP No. 10)

Again there was a pragmatic acknowledgement in recommending certain courses of action that many of the parents lead very challenging busy lives, and the health and fitness of their children often had to fit into this full and demanding family timetable.

The response offered to the parents took on many diverse forms including advising on healthy weight loss strategies. Some GPs were more prescriptive with advice aimed at preventing further weight gain instead of weight loss, as GP No. 1 noted *“I think kids’ going on strict diets is not a good idea.”* On some occasions parents and their children were offered a number of specific behavioural strategies and advice, such as considering portion control with their children, and encouraging the preparation of healthy meals. Three of the GPs also mentioned taking more exercise and trying to encourage more collaborative family efforts. However, none of the GPs referred to following any guidelines or national recommendations as they crafted their response, and the advice was generally summarised as *“basic brief interventions, often just general advice,”* (GP No. 2). Three of the female GPs all admitted that they used the knowledge they had secured when they had been trying to lose weight themselves. In relation to the advice there was the inference from two GPs that *“it’s just common sense, it’s not more than anyone would say,”* (GP No. 9) possibly challenging

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<sup>1</sup> A2A: Stockport Child Weight Management Scheme

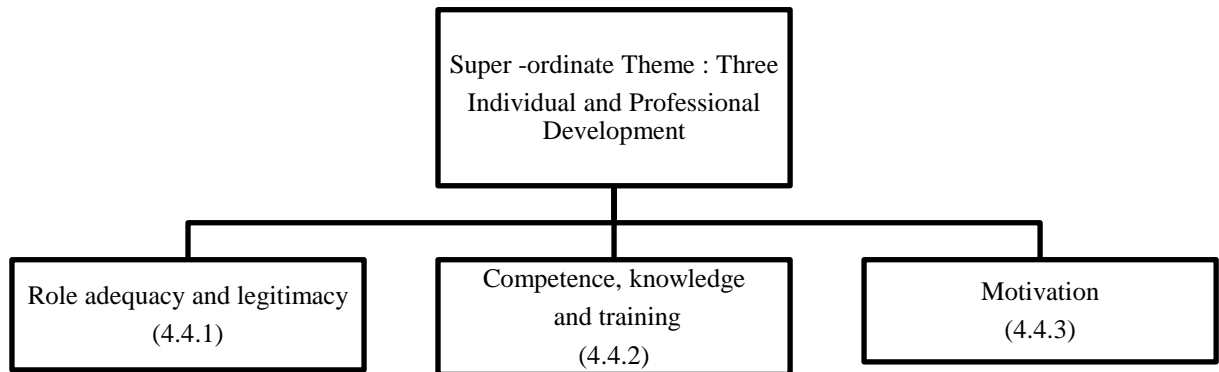
whether this was a good use of their time and skills. GP No. 7 was wary of unwanted paternalistic interventions and confirmed, in his opinion, *“most parents don’t want a 4 hour lecture on how to manage obesity plus referral to 12 agencies they just want to know some basics.”*

The GPs also noted that they sometimes signposted parents to other advice points where self-help literature and healthy lifestyle leaflets were available. However, there was clear variability in the underlying narrative, for example GP No. 6 described a much more proactive approach, describing leaflets and information in their waiting room, whereas GP No. 3’s approach was passive and ill-defined in terms of any outcomes, *“I send them to the libraries I am sure that they will have lots of books on this.”* The reference to web sites was also interesting. The Change4life website was identified by GP No. 7, who said that he had only found it because he had to do a talk on childhood obesity at his daughter’s primary school, which again is likely to be reflective of the GPs’ limited knowledge and awareness of sources of advice to parents of obese children.

The GPs also described the *“second opinion syndrome”* (GP No. 8) which was invariably used to placate or reassure the parents. Even when the GPs sent a child to the paediatrician *“just check it out to make sure they haven’t got any thyroid problems”* (GP No. 5), they often knew that the results would be negative or at best inconclusive and that there would be costs associated with such an activity. However, this pathway was followed as it was seen as a productive way to maintain relationships with the family knowing that there would be no harm in actually doing this, and that this would mean that the GP could then move on to address lifestyle factors.

It is interesting that some of the GPs indicated difficulty around offering weight related parenting advice. Some were clear that they had did not have the skills for such types of interventions, *“I can’t really give them advice about what to do if the child won’t try new foods. That’s the Health Visitors job”* (GP No. 3). Nor did they appear keen to acquire such skills which could be linked also the comment by a number of the GPs that they did not have the time to offer targeted support regarding parenting skills, or supporting more intensive family functioning. None of the GPs acknowledged the existence or the role of local Children Centres and staff that would be available to support parents in some of the more practical parenting issues or family based therapy programmes.

#### 4.4. Super-ordinate Theme Three: Individual and Professional Dilemmas.



The GPs' comments and narratives displayed many individual and professional dilemmas, tensions and conflicts which delineated and defined their experiences in the identification and management of childhood obesity. This theme evolved as a subtle but persistent, as opposed to an overt and structured one. It was one of the most interesting ones displayed at an idiographic level where incongruities, ambiguities and divergence were the most acute. These dilemmas and challenges will be explored through themes of role adequacy, legitimacy and credibility, competence, knowledge, training, and motivation.

##### 4.4.1. Role adequacy and legitimacy.

In terms of role legitimacy all the GPs recognised childhood obesity as an important area, and all the GPs articulated numerous physical, psychological and social consequence of obesity for their young patients. GP No. 5 said it was a doctor's "*duty*" to raise the topic and initiate early intervention because of the consequence of infant weight gain influencing later risk of obesity. He legitimised his right to intervene by pathologising the problem because "*you know that these children are not healthy.*" Whereas GP No. 9 held a more direct health promotion stance and reflected on the fact that during his GP training he was taught to ensure that the last few minutes of any consultations should cover health promotion issues. GP No. 1 confirmed "*it's definitely the right thing to do if we are ever to prevent the growing obesity epidemic in our society.*"

GP No. 3's view of legitimacy was on the other hand in stark contrast; he was clear that his efforts should be expanded on dealing with existing illness, and was adamant that the



management of childhood obesity was not part of his professional role or was an appropriate use of his clinical expertise or time.

*“I don’t think parents should be bothering a GP who has got so much to do dealing with chronic disease and acute illness than dealing with something that is really a lifestyle issue.” (GP No. 3).*

There was little doubt that a number of the GPs struggled with fulfilling this role which caused some additional conflict. GP No. 7 reflected that whilst the *“purist in me would say ‘yes’ to a proactive role in childhood obesity,”* he was conscious of the reality of an extremely busy daily practice which at times compromised this commitment. GP No. 1 was concerned that the increasing workload and demands on her time meant that preventative work often had to be shoehorned into a busy surgery, making the task, at times, seem overwhelming.

For other GPs their key concerns focussed on the extent and boundaries of their role legitimacy. Whilst some GPs felt that they had legitimacy in identification, this eroded as the options for management reached the edge of their preferred professional boundaries, for example a few GPs expressed their reluctance in trying to deal with the issues of a child’s self-esteem and other emotional complexities. GP No. 2 acknowledged her limits and avoided dealing with this issue by saying *‘If it’s bullying I usually just say you need to talk to the school.’* Comparisons were made to their practice work on adult obesity where, some felt that their professional credibility and legitimacy was much better established, secure and defined, often as a consequence of Government financial incentive schemes which were incorporated into practice priorities. GP No.6 described how *“we deal with an enormous amount of work with adult obesity, and we are fairly co-ordinated in that, and fairly practical about it, because of the QOF requirements, but unfortunately it’s not as well organised for children.”*

A further dilemma which impacted on role adequacy centred on GPs’ anxieties about raising expectations without access to appropriate pathways, or a defined evidence base that would secure a positive outcome. GP No. 9 spoke with unease about the challenges of addressing lifestyle changes, *“I know if someone has high blood pressure I can manage it, I just can’t say the same for obesity, whether its children or adults.”* Despite highlighting the absence of pathways and guidelines none of the GPs indicated that they were prepared to work collectively on developing pathways or that they had raised it with others in their teams or at any other professional settings. Finally, two of the GPs felt their role adequacy challenged in

the face of commercial vested interests, *“you know places like MacDonald’s and their so called happy meals that are pushed at kids all the time”* (GP No. 10), and the significant advertisement budgets for unhealthy fast food which, as single practitioners they felt quite powerless against.

#### **4.4.2. GP Motivation.**

Not surprisingly the GPs’ professional motivation varied. In one case the GP’s motivation to intervene took a considerable set back following a negative interaction where she had experienced significant hostility, and this poor outcome significantly impacted upon her future motivation. A further significant factor appeared to be a lack of feedback when they had previously supported a family. This linked with a more overriding pessimism about the likely impact of any advice that they had given, and a general despondency consequential on the fact that they rarely observed long-lasting results. The timeframe to achieve and maintain realistic weight loss was also a challenge for some GPs who expressed a view that they did not have the time to monitor continued compliance and offer long term support. This appeared to enhance their view that managing obesity was unrewarding, as GP No.9 indicated, *“it does annoy you when you have spent time with a family, you think they have listened and then absolutely nothing changes.”*

Many of the GPs articulated the need for intensive behavioural counselling if there were to be long and sustainable improvements in managing a child’s weight, but to achieve this would require skills that they were not confident that they could source either from themselves or other staff within the practice. Even with such skills and a significant redistribution of resources and time they were still uncertain that this would result in a successful health benefit. As GP No.7 summarised, *“I don’t think we are massively tooled up and skilled up and motivated necessarily.”* However, some of the GPs explained how they were prepared to accept relatively small markers of success, GP No. 8 noted, *“you can give out the same message time and time again, and then one day something clicks, and they will come in and tell you how the whole family goes for a swim every weekend.”* For this GP the willingness to accept small or incremental changes was sufficient to mitigate previous attempts that had yielded little impact.

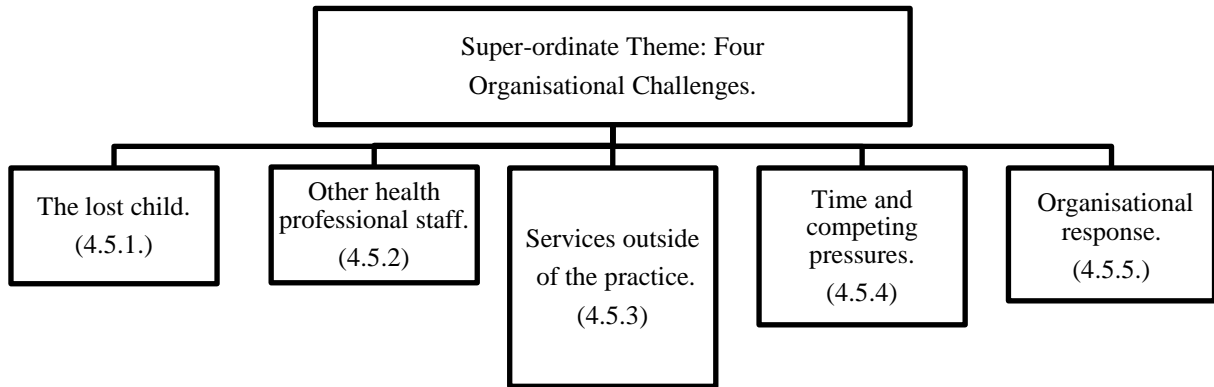
#### 4.4.3. GP competence, knowledge and training.

The remaining theme, closely linked with role adequacy, centred on issues of competence, knowledge and training. It appeared that some of the GPs were more likely to have a positive view of role adequacy as they generally felt confident in their communication skills and ability to build a rapport with certain parents. One GP spoke about varying degrees of confidence, *“my levels of confidence? Not in every child, but in a lot of children I would feel quite happy.”* (GP No. 1). Section 4.2 has explored how GPs relied on their experiential knowledge when responding to the different needs of the families. None of the GPs reported that they made great use of other more formal knowledge sources in reaching decisions. Whilst some mentioned that they might occasionally browse through journals that had articles on childhood obesity, they did not access or consult research articles or systematic reviews of evidence, even when seeking out answers to any specific or detailed questions about management. The futility of seeking additional training without accompanying referral pathways or any other effective strategies was also strongly felt by GP No. 4 who felt that the impact he could achieve was very limited, unless there was a service available to help the child lose weight, as he noted with a degree of resignation *“I can identify them but if there is nowhere to send them to then I am stuck”*. Others such as GP No. 10 however, felt less isolated and ineffectual. She felt that she had acquired sufficient knowledge during her years as a general practitioner that resulted in her feeling confident to both identify and manage children who were obese. GP No. 1 agreed that whilst she had acquired the necessary expertise, her perceived, but inaccurate view of the relatively small prevalence of childhood obesity presenting in her surgery led her to conclude that there was little need to access additional training on childhood obesity. Others discussed how demands on their professional development, meant that they limited their attendance to those areas of clinical interest, or those areas that were needed to update on Practice’ priorities, GP No 3 said *“there is so much training I have to attend just to keep ahead, you know prescribing , new services, that my time is very limited.”*

Finally, there was little evidence in the narratives to indicate that the GPs reflected deeply on their practise. Only GP No. 8 shared some initial thoughts he had considered in preparing for the research interview. He outlined how he had compared the challenges of adhering to weight management programmes, with the challenges he faced with his young diabetic patients and their struggles to comply with their therapeutic regimes and understand the reasons for their required behaviour change. He commented,

*“Take the diabetic teenager - despite lengthy consultations and advice with specialist staff, they still don’t eat well. If we can’t succeed with such patients who can have life threatening consequences, then there is little hope with others.”(GP No.8).*

#### **4.5. Super-ordinate Theme Four: Organisational Challenges.**



The final section of this analysis focuses on how individual family needs, and the concepts of professional legitimacy and role, also interacted with the multifarious operational, organisational and management challenges in General Practice. Even when the GPs’ motivation was to be responsive and deliver high standards of good practice in this area, there were often other practical constraints which impacted on this intention.

##### **4.5.1. The ‘lost child’ in primary care.**

An interesting feature highlighted by the GPs was that whilst there was an increase in childhood obesity in the community, it was rare for parents to bring their children who were obese into the practice for a consultation which was specifically focussed on their child’s weight. In the main such consultations were very low; for example GP No. 4 reported that *“it very rarely happens. I think the last one was several years ago.”* Others spoke of similar small numbers which is very surprising given the local prevalence data in each practice highlighted in Table 4.1. When the GPs were prompted as to why they felt that parents did not bring children with weight problems for an appointment, some believed that it was because the parents’ perceptions of the impact of obesity on their child were more in terms of social concerns rather than health issues and therefore the GP would not be the obvious source of advice. GP No. 1 wondered if her practice did enough to promote their services for children comparing this to the more proactive, better resourced services for overweight adults. Others

tended to be more cynical stating that some parents may have had little success with their own weight management support in general practice, and therefore probably could not see any added benefit that the GP might provide. It was also suggested that some of the parents protected themselves from any challenge or criticism from by the doctors by not bringing their child to the surgery, as GP No. 2 said *“they probably think we are going to have a go at them which of course we wouldn’t.”*

The experience of some of the GPs was also positioned in a wider concern about seeing fewer children overall in primary care. Legislative changes in the wider child health environments and the relocation of health visitors into Children’s Centres meant that fewer children were seen in the GPs practice and the GPs experienced losing key linkages with other relevant services. For some of the GPs the sense of loss came across very powerfully often because they felt that they now had a restricted role, which at best, resulted in short bursts of episodic care for children, and often based on acute need. GP No. 4 noted *“it’s sad that we never get to see them now that the Health Visitors do all the health promotion stuff.”* Even within the primary care setting, Practice Nurses were taking on an extended role in paediatric chronic disease management such as asthma or diabetes care, and as such the GPs did not see children routinely for health checks. In addition some of the practices’ delineation of responsibilities and special interests restricted their work with children; one GP described how in her practice, *“if we think the child is very heavy for their age, we refer to the in-house doctor who is our child doc, he is much better at making an official assessment if the child is overweight.”*(GP No.2). Another commented on the fact that in his practice cohorts of patients often chose a specific doctor, *“I have a lot of elderly patients. The parents with kids tend to see my younger partners,”* (GP No. 3).

#### **4.5.2. Other health professional staff.**

There was an acknowledgement that within the practice it was the Practice Nurses and Health Care Assistants who had received training and developed skills and experience to support adult patients in weight management. This was often as a consequence of QOF funding and the consequent apportionment of nursing time to secure the QOF targets. However there were concerns expressed by some GPs that the Practice Nurse did not have the clinical skills to manage or support children. GP No.2 admitted *“there is something a bit scary about children. It’s like with drugs you can’t just treat them as mini adults, you have to know what to do.”* It is interesting that the GPs failed to acknowledge their contradictory statements, that whilst

they saw little reason for training themselves, and whilst they believed that their advice to parents was often little more than basic common sense, they were reluctant to allow their staff to practice in such a way. GP No. 9 however, could see the logic in the *“argument for someone in the practice not necessarily the GP to be a useful point of contact,”* but, like the other GPs, he still believed that such staff would require additional training.

#### **4.5.3. Services for children who are obese outside of General Practice.**

Whilst the GPs recognised the limits of the staff in their practice, they also articulated their frustration and tension about the absence of services to refer children on to. In particular the GPs were very disparaging about the lack of dieticians both in the community and in the hospital, whom they felt had little interest or time to offer any support to overweight children. Similarly, the local CAMHS<sup>2</sup> seemed overwhelmed with dealing with complex children with acute mental health issues. *“There is nowhere to refer them onto, and you think do I refer them onto CAMHS or paediatrics. Neither is really appropriate. There are no dieticians. So you are very limited.”* (GP No. 4)

In terms of community based weight loss programme, few knew of the local A2A scheme, and when prompted about a local scheme one replied. *“I’ve seen the leaflets in the waiting room but it’s not quite in the GPs’ mind set when we think of referrals, we think of specialist treatment, referral pathways, and referral letters. Just telling someone to attend a scheme at a community centre feels a bit too loose.”*(GP No. 4). Another admitted that there probably were schemes and new initiatives, but found it difficult to co-ordinate and remember all the services that were available, especially as schemes seemed *“to come and go,”* (GP No. 9).

#### **4.5.4. Time and competing priorities.**

A theme of competing priorities was also included as contributing to some of the difficulties that the GPs felt they experienced in this area of work. For some, the daily time constraints of a busy general practice impacted on opportunistically raising the topic, *“every day is a rush you never seem to have enough time to really spend quality time,”* (GP No. 8). This theme was expanded by one GP who revealed the very real constraints between making the consultation as long as necessary to help the patient, but as short as possible to help those waiting outside and contribute to the smooth running of the daily surgery. This compromise inevitably meant that at times the GP had to make a difficult decision as to whether to initiate

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<sup>2</sup> Child and Adolescent Mental Health Service

any meaningful discussion about a child's weight. However, some highlighted that they would take extra time by encouraging the family to book a double appointment or alternative appointments so that they could provide follow up support. The issue of time was also related to their perception of responding to multiple and complex issues of childhood obesity that very rarely had an instant solution.

#### **4.5.5. Organisational response.**

Few of the GPs offered alternative practice arrangements which would facilitate a more concentrated focus on childhood obesity, although one GP had set up a daily lunch time clinic which covered all child health issues. It was noted by two of GPs that the infrastructure and organisation of general practice was not sufficiently flexible to offer group work for children, nor would the numbers of children in the practice support such investment. A small number of GPs finally talked about wider weight management programmes for children. In the main they regarded primary care intervention as just one part of a broader co-ordinated approach to tackling childhood obesity problems and were particularly keen to see better education about food and physical activity in schools and wider multi agency public health programmes in the community. They also indicated that they would strongly support interventions that were focused on encouraging children and families to make healthy lifestyle changes, rather than any acute interventions, *"we are highly unlikely to be looking at any bariatric surgery for children,"* (GP No. 1). Interestingly, the options that the GPs considered focussed on fun, social, safe and supporting group activities. One GP believed that programmes like MEND<sup>3</sup> should continue to be commissioned because of its focus on addressing family issues and supporting and empowering parental engagement. The need for a wide range of public health responses was also acknowledged given the previously expressed complexities of childhood obesity, *"there needs to be a big team, school nurses tackling school meals, PE teachers, parents, all these aspects are important."* (GP No. 8). GP No. 3 felt that public health commissioners should lead on more holistic approaches to childhood obesity prevention, and that the key way to secure wide scale improvements would be through a more co-ordinated, strategic approach. Whilst most of the GPs could see the value in having more local community based family intervention activities, they did not recognise that they had a role in advocating for such.

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<sup>3</sup> MEND: Mind Exercise Nutrition Do it! A national childhood weight management intervention

#### **4.6. Summary.**

The findings highlighted in each of the four super-ordinate themes, have revealed a rich and diverse range of factors which impact iteratively on the decision making processes that the GPs engage in, in order to identify and respond to the children who are obese. These processes are shaped by their understanding of the family and updated by the experiential evidence that the GPs encounter in their daily practice. The findings confirmed the breadth and variability of the diverse considerations, and the blend of knowledge and reasoning that the GPs took into account when deciding what to do and what to say to the family. The decision making process appeared to involve a rapid synthesis of known familial characteristics, behaviours, beliefs and motivations. However, alongside this complex but relatively stable, foundational knowledge of the family there were also more dynamic and fluid situational factors which influenced the final decision as to whether to raise the topic of the child's weight with the family and spend time on this issue. Sometimes the decision to raise the topic of the child's weight with the family were judiciously based on time available, or the staffing resources within the practice, or the priority they gave to this child's issues over the cascade of other extraneous pressures and demands they faced at that time. The decision making process seemed ambivalent to known guidelines issued by NICE (2006), the Department of Health (2011) and the Royal College of Physicians (2013). Similarly, the decisions about managing the child's weight tend to be pragmatic and iteratively negotiated between the family, the GP and sometimes the child. At the heart of this was an overwhelming need to sustain, wherever possible, the relationship between the GP and the family. The majority of the GPs explored how they experienced the most difficulties when the outcome the parents wanted was to address the child's personal psychological or social problems caused by obesity, such as bullying, lack of self - esteem or social isolation from their peers. The GPs were clear that such skills or knowledge were not necessarily in their repertoire, which caused conflicts for the GPs in terms of both role adequacy and legitimacy. It was also clear that there were mixed views about which services could support any psychological consequences of the child's obesity.

The findings also highlighted how the GPs' attitudes towards the parents, their own personally held health beliefs relating to preventative medicine and their role in this, and their overall understanding and perceptions of childhood obesity varied from GP to GP. For each GP it appeared that they accounted for their decision making as a resolution of their own particular set of motivators, competences, levels of confidence, values and beliefs. Moreover



it appeared that their attitudes to childhood obesity, whilst derived from their clinical training were also constantly modified by their experiences and interactions with parents in the consultation room, what they saw on television, what they read about in newspapers even what they saw in the supermarkets. It was clear from the ideographic analysis, that the GPs' attitudes were often framed outside of the medical discourse and referenced not only societal and cultural attitudes to childhood obesity, but also those relating more widely to norms and expectations regarding what constituted good parenting especially in relation to actively promoting the health of the child.

The GPs had varied views about their experiences of working with children and families. Some were concerned about the loss of active engagement with child health more generally which was completed in other settings by other professionals, and which led the GPs to acknowledge that some of their skills and experience in this area had been diluted. Whilst the GPs reflected that many of their experiences were complex, on the whole, the GPs felt that they could and should intervene, particularly with very obese children and their families. It appeared that the more the child moved along the spectrum towards being perceived as clinically obese, the more legitimate they felt in their decision to intervene. Overall they believed that intervening with children and their families was an important but challenging task. However the GPs articulated a range of practical limitations which included a lack of referral pathways and limited support from other staff and services.

## **Chapter 5: Discussion.**

### **5.1. Introduction.**

The findings outlined in Chapter 4 reveal complex and varied discourses in the GPs' description of their consultations and responses to the children who are obese. They also present the GPs' multiple and complex views regarding their roles, approaches, attitudes and motivations. This study has therefore added significantly to previous findings where GPs' responses tend to be presented and considered as one homogenous professional group (Walker et al., 2007; Turner et al., 2009). In this chapter, Section 5.2 will respond to the initial aim of the research which was to explore GPs' experience of identifying and managing children who are obese in a primary care setting, by providing a more detailed exploration and discussion of the complexities highlighted by the GPs in each of the super-ordinate themes. The intention is to consider the findings in relation to the existing literature presented in Chapter 2.

Section 5.3 will address the second aim of the research, namely to identify variations in the accounts which impact upon the type of responses that GPs provide. This will be achieved by presenting a continuum of GP role types linked to the aligned underlying epistemological frameworks of the GPs, as a new and innovative way of exploring and discussing this complex area of clinical practice. Section 5.4 will focus on the limitations of the research.

Chapter 3 highlighted that IPA involves an inductive, intense, interpretative analysis, (Smith et al., 2009). It is important to acknowledge that the analysis and discussion presented below will therefore be framed in the inevitable subjectivity inherent when there are multiple levels of interpretation. In presenting the evidence, categorising and organising the content, it is the researcher who has selected what counts as relevant material. Finally as this research is presented as a Professional Doctorate, with an ambition to "*further advance or enhance professional practice*" (Lee, 2009, p.7), this chapter will also focus on areas that can make a contribution to professional and policy recommendations regarding the potential opportunities and limitations of GPs' contribution to the identification and management of childhood obesity. Chapter 6 will address the third aim of this research to produce practical suggestions for improving service provision.

## **5.2. Discussion of the super-ordinate themes.**

This section will highlight and discuss areas in each of the super-ordinate themes that reflect, extend and expand on the existing literature on GP decision making regarding identification and management of childhood obesity. It will discuss the reality of clinical practice as presented by the GPs, and highlight both the potential opportunities and limitations of GPs' contribution to the identification and management of childhood obesity.

### **5.2.1. Understanding the family of the child who is obese.**

This research has uniquely identified that understanding the family and the child was a significant starting point for the GPs in their day-to-day decision making about how and when to intervene with a child who is obese. Indeed this understanding appeared more influential, at times, than the clinical risk or actual weight of the child. For example, in many of the narratives the GPs described how they chose not to discuss the child's weight because the child presented with more acute health problems, or because they had no prior relationship with the family, or because they had previously been unsuccessful in initiating lifestyle discussions with the family. A key issue for the GPs was their perception of whether the family and the child were willing or ready to address the matter of their child's weight. Whilst the GPs did not appear to formally assign stages of parental readiness to change, as defined in Prochaska and Di Clemente's (1982) stages of change model, there were stages where the GPs believed they were more likely to be effective. The majority of the GPs felt that unless parents were willing to accept that their child's weight was of concern they could achieve very little, and they felt they had limited skills in moving families from a "*pre-contemplation to a contemplation stage*" (1982, p.40). However, when parents were either contemplating or preparing for change, for example by bringing their child specifically to the GP for a weight management consultation, the GPs were likely to be more successful, and their perceived role legitimacy to work constructively with the family was confirmed.

This is a very important finding as it appears that there are a number of missed opportunities to raise the topic if the GPs limit their meaningful interactions to those where the parents initiate a discussion. However, it also questions whether GPs should prioritise their time and effort on particular families where they are more likely to be successful, rather than being encouraged to intervene with all families irrespective of parental preparedness to change. It is interesting that most childhood obesity pathways (NICE, 2006; 2013) start with a requirement that the GPs should firstly determine the weight status of the child. Whereas the findings from

this study suggest that understanding the family in its widest sense and particularly the parental responsiveness to change was the most important determinant in the decision making process for the GPs. It is recommended that understanding the family is recognised as a key starting point in any future pathways that are developed for primary care childhood obesity interventions.

#### **5.2.1.1. Knowledge of the family of the child who is obese.**

To add to this complexity, the findings in this research revealed that the GPs' construction of what is relevant knowledge about the family varied considerably. The factors ranged from family's health beliefs, their current state of motivation to address their child's weight, the prevailing health norms within the family, the parenting capacity of the family, even through to the weight of each of the parents. Such findings are significant, and highlight the difficulties in adopting professional guidelines on childhood obesity (NICE, 2006: 2013) which, consistent with most professional guidelines, are "*generally context free*" (Gabbay and le May 2011, p.101), and rarely take into account the very wide range of clinical and non-clinical factors that the GPs consider when constructing an understanding of the family.

Whilst locating the child in the wider context demonstrated the GPs' awareness of the complex causes of childhood obesity, it did at times have negative consequences. For example, some GPs expressed a reluctance to place a disproportionate weight of responsibility on the parents if the family's financial situation was challenging. This is a particularly important finding given the fact that such parents are more likely to require additional support from their GP. If GPs maintain such reservations, the well documented links between childhood obesity and inequalities (Stamatakis et al., 2010; Hancock et al., 2013) are unlikely to be constructively addressed. This finding has not been previously identified in the literature on GPs' management of childhood obesity, and requires further research in order to consider whether inconsistent delivery of preventive care extends health inequalities.

#### **5.2.1.2. Family health beliefs and behaviours relating to obesity.**

The issue of the GPs' perceptions of family health beliefs and behaviours was also significant. At times it was difficult to identify whether the issues the GPs identified as family behaviours, for example "*they live on takeaways*", or the kids are all "*couch potatoes*" were actual known health behaviours of the families, or were generalisations tainted with popular normative beliefs about childhood obesity. It therefore could be argued that such responses

were more reflective and indicative of the prevailing social, moral and cultural frameworks through which the individual GPs' considered childhood obesity and made sense of their encounters with children who are obese. Rich and Miah (2009) suggest that contemporary health discourses on childhood obesity are no longer confined to medical contexts, but are encountered through television programmes, such as "Generation XXL" and "Honey We're Killing the Children", where parents are shamed and humiliated. Puhl et al., (2013) analysis concluded that such programmes have a substantial influence on public perceptions of childhood obesity. It is important that GPs are encouraged to explore, as part of their reflective practice, how their beliefs and attitudes towards childhood obesity are constructed from their social and cultural life experiences, as well as their clinical experiences. If GPs passively absorb some of the negative stereotypes often depicted in the media, they may be less motivated to intervene and offer much needed support to children who are obese. Moreover, it is argued that GPs and their Royal Colleges should have a leadership role at a national level in constantly challenging, through media debates, the blunt, harmful stereotypes and stigmatisation of children who are obese, which can lead these children to suffer substantial psychological and social harm. At a local level GPs, because of their expert status in the community (Hearn et al, 2008); also have a potential role in influencing community attitudes about childhood obesity, and advocating for change in broader health and social policy.

Further the issue of GPs' perceptions of family health beliefs was also exemplified in the findings about the different explanatory models the GPs and the families held regarding the causes of childhood obesity. The findings in this study confirmed that whilst the GPs acknowledged the complex multifactorial aetiological theories for childhood obesity, including social, environmental and psychological influences, which is consistent with other research (Walker et al., 2007; Turner et al., 2009), they tended to be sceptical about solely hereditary causes of obesity, (King et al., 2007). Research on the parents' perspective however indicates that they attribute a range of causal medical explanations for their child's obesity, such as genetics or slow metabolism, (Jackson et al., 2005; Stewart et al., 2008). These different and dissonant explanatory concepts clearly had the potential to create tension between the GPs and the parents. However, one of the interesting findings of this study was that rather than risk damaging the relationship with the family, the GPs often suspended their scepticism and chose to negotiate mutually acceptable ground which accommodated some of the parent's beliefs. The GPs in this study described how they would often refer the child to a

paediatrician to allay their parents' concerns and confirm that there were no underlying medical reasons for the child's excess weight.

The findings in this study also highlight that the majority of the GPs located individual responsibility for the child's weight with that of the parents, which is consistent with other research, (King et al., 2007; Walker et al., 2007; Redsell et al., 2011). The GPs in this study often focussed on how parents controlled access to certain foods, and were influential in the physical activity choices of their children. This is also found in other research which acknowledges that parents control many aspects of their child's nutrition, (Dave et al., 2009; O'Connor et al., 2010; Vereecken et al., 2010), and physical activity, (Sonneville et al., 2009; Gubbels, et al., 2011). However, such research can be challenged as it often characterises a relatively hierarchical, uni-directional nature of the parent and child relationship, consistent with assumptions in policy discourses (DoH, 2009) that parents can successfully manage and control their children.

For the GPs in this study there was an acknowledgement that the position was often more complex. They discussed examples, which can also be found in the literature, of active resistance from children (Baughcum et al., 2000) who were able to demand different food (Wilson and Wood, 2004) and dismiss physical activity practices recommended by their parents (Jackson et al., 2005). Some of the GPs made sense of such dynamics by referencing their own familial circumstances, acknowledging that children can exert significant influence on parental decision-making about food choice (Dixey et al., 2006). This finding again challenges some of the national childhood obesity programmes such as Change4Life (DoH, 2009), which are based on the premise that parents have the agency, ability and resources to control and direct children's lifestyle behaviours. Whilst evaluation of the success of Change4Life is still awaited, it could be argued that for some families who the GPs worked with, such programmes assume an unreasonable expectation given wider structural factors, family constraints and parenting challenges.

#### **5.2.1.3. Parenting practices.**

Parenting styles, family dynamics, and relationships within the family environment have consistently been identified as crucial factors linked to childhood obesity, (Golan et al., 2004; Rudolf et al., 2010). However, the GPs in this study rarely explored in-depth typologies of parenting as a way of making sense of parental behaviours and attitudes; instead they tended to focus on negative or permissive parenting styles. Their view that permissive parenting or

“*giving in*” was more likely to be associated with weight gain in children, is consistent with other studies (Hesketh et al., 2005, Rhee et al., 2005, Stewart et al., 2008). However, few of the GPs explored how they could use this opportunity to work with parents on enhancing some of their parenting skills such as boundary setting, and positive discipline (Hughes et al., 2008). This is an important finding and is likely to impact on the responses that GPs could meaningfully offer in terms of managing childhood obesity. It also highlights the lack of knowledge GPs have about existing evidence based parenting services such as the Triple P-Positive Parenting programmes (Sanders et al., 2008) which are widely available at local Children Centres. This does appear to be a missed opportunity, and such services need to be widely promoted as many of the issues that GPs face in relation to child health could benefit from referrals or signposting to parenting courses.

#### **5.2.1.4. Parental concerns regarding childhood obesity.**

The findings in this study also indicated that there were significant differences in the underlying understandings, concerns and expectations of the parents and the GPs in relation to childhood obesity, which has clear implications for professional practice. The GPs in this study often expressed concern when parents disputed or refused to accept their medical opinion that their child was obese. However, the literature review in Chapter 2 highlighted a number of studies that have empirically demonstrated that parents have difficulty in recognising their child as being overweight (Carnell et al., 2005; Eckstein et al., 2006), and underestimate the weight status of their overweight or obese child (Jeffery et al., 2005; Jansen and Brug, 2006; Parry et al., 2008). Baur (2005) has argued that childhood obesity is different from other childhood chronic illnesses, such as asthma, where the child’s symptoms are usually clearly recognised as being abnormal by the family, with the result that medical treatment is then sought. However, in relation to childhood obesity there is the view that, as the prevalence of obesity is high, this problem may now have been normalised, (Kirk and Penney, 2013) and therefore parents struggle to assess if their child is overweight. This may particularly be the case if parents perceive obesity as temporary problem which will resolve as children grow older, (Stewart et al., 2008). In addition, Southwell and Fox (2011) report that parental misconception of weight may be a psychological process, which mothers particularly, use, to protect themselves from the perceived threat of stigma and blame. The fact that these issues were not considered or were poorly understood by the GPs in this research is likely to impact therefore on any meaningful support the GPs could offer.

#### **5.2.1.5. GPs' perceptions and values regarding overweight and obese families.**

The GPs in this study held a strong view that parental obesity was an important risk factor, for the child becoming obese (Burke et al., 2001; Danielzik et al., 2002; Whitaker et al., 2010). Wake et al., (2010) indicated that having an overweight parent quadruples the risk of child obesity. In addition to these risk factors however, the findings in this research also identified some attitudinal responses from the GPs in this study to obese parents. Research has documented the weight-based stereotypes and negative attitudes that GPs display towards obese adult patients (Foster et al., 2003; Epstein and Ogden, 2005). These include views that individuals who are obese are lazy, lack self-discipline, and rarely comply with weight loss treatment (Puhl and Brownell, 2001; Puhl and Heuer, 2009). It did appear that such stereotypes affected the GPs responses. Of particular concern was the fact that some of the GPs appeared to relate such stereotypes to low parental motivation to address their child's weight, a finding also identified in other research (Campbell et al., 2006; King et al, 2007). At times the GPs in this study doubted the value of providing weight advice to overweight parents and were less optimistic about a successful outcome, which is consistent with the conclusions of Gerner et al., (2006) and Hearn et al., (2008). The findings in this current study also indicate that some of the GPs expressed moral judgements (Monaghan 2005; Gard, 2007; Rich et al., 2010) that overweight parents were failing in their duty to promote the health of their child. However, Jackson et al's., (2007) research on overweight mothers described how, far from being uncaring or lazy, the mothers were extremely concerned about their child's weight problems and were motivated to ensure that their child did not suffer the stigma and embarrassment they had experienced. GPs should be prepared to reflect on whether the attitudes they hold are negatively impacting on the supportive relationship they need to establish with families of obese children if successful outcomes are to be achieved.

It is interesting to consider whether the GPs' own BMI impacted on their willingness to provide support to children who are obese. Whilst there is currently no literature specifically relating to GPs' BMI and management of childhood obesity, Bleich et al., (2012) found higher self-efficacy and confidence in addressing adult obesity among normal BMI physicians, as compared to overweight/obese physicians. There is further literature that would suggest that personal health promotion behaviours in doctors is a strong predictor of positive attitudes toward obesity care (Spencer et al., 2006). For example, Abramson et al., (2000) found that doctors who exercise more and maintain a healthy diet were more likely to discuss exercise and weight with their patients. Whilst none of the GPs in this study classified



themselves as obese, some acknowledged that they were overweight, but there was no indication that this was one of the reasons why they would not discuss a child's weight with parents. Rather they raised their own weight challenges as an example of their recognition that it was notoriously difficult to achieve and maintain significant weight loss. Interestingly the female GPs were prepared to use their own dieting experience to initiate further discussions with families.

### **5.2.2. Flexibility and responsiveness.**

The previous section has explored how the GPs develop and access their embedded knowledge of the families and use this as part of their decision making process. The theme of flexibility and responsiveness captured how the GPs adapted and changed their approaches according to individual family contexts and needs. Overall the current findings challenged any assumptions that at the heart of the GP's decision making about childhood obesity there was a rational, sequential clinical pathway, based only on clinical imperatives. Rather the decision making processes about raising the topic of a child's weight and offering a response appeared to be actively and consciously shaped by the GP, based on complex interactions between the objectives of the GPs and the family's needs. Their descriptions around this process included references to acting in different roles, taking cues from the parents, and modifying language in order to avoid embarrassment and stigmatisation of the child. At the heart of this was the need to sustain, wherever possible, the relationship between the GP and the family.

#### **5.2.2.1. Negotiating with the family to discuss the child's weight.**

One of the significant findings in this study was that the GPs rarely used objective height and weight charts, or measures of waist circumference, preferring to estimate the actual weight of the child. This finding again appears to contradict policy guidelines and pathways (NICE, 2006; 2013). However, it is a finding that has been confirmed in research with other GPs (King et al., 2007; Flower et al., 2007). Van Gerwen et al., (2009) suggest that multiple barriers might limit the assessment and monitoring of BMI in the primary care setting, including lack of familiarity with the use of BMI, lack of agreement about the utility of BMI as a screening and intervention tool, and lack of practice level resources. Smith et al., (2008) also found that health care professionals were generally poor at assessing the weight status of children through observation, and in particular tended to inaccurately underestimate overweight and obesity in children.

The GPs in this study offered additional comments particularly around the sensitivities of weight and being careful not to embarrass the child by weighing and measuring them. Such findings were also replicated in O'Shea et al., (2014) who found that GPs do not routinely check children's weight, partly due to concern regarding the parental and child response. However O' Shea et al., (2014) also found that almost all parents indicated checking weight was helpful, with only 4% of parents and just over 1 in 4 obese children responding negatively to weighing. Interestingly they found that children aged 5-6 years were most likely to respond positively. They concluded that whilst GPs are conflicted regarding the acceptability of weighing the child, almost all parents believed it to be helpful. It is therefore important that GPs are aware of such findings and open a dialogue with parents during any consultations regarding the value of weighing and measuring the child, rather than relying on subjective visual observations.

#### **5.2.2.2. Sensitivity of the topic of childhood obesity.**

The issue of sensitivity of the topic of childhood obesity has been consistently highlighted in the literature review (Walker et al., 2007; Stewart et al., 2008; Turner et al., 2009; Lachal et al., 2013), and the GPs in this study confirmed that they found the topic of a child's weight to be both a sensitive and difficult one. Gabbay and le May's (2011) research on decision making in primary care found that there was often a "*deeply embedded logic in GPs' thinking*" (2011, p.60). A clear example of such embedded logic, and one that is an important finding was that the family represented an important long term investment by GPs; one that they were keen to nurture and sustain. Raising the topic of a child's weight if not handled appropriately and sensitively could damage such a relationship. Sometimes the GPs reported tentatively raising the weight issue or dropping hints and then judging a parent's reaction before deciding to continue the discussion. This finding was consistent with Summerskill and Pope's (2002) research which considered consultations in which GPs had failed to implement conversations with patients regarding secondary prevention for cardiovascular disease. They concluded that the desire to avoid upsetting patients, and preserve a good relationship was sometimes more important than implementing secondary prevention.

Previously, the reluctance of GPs to raise the matter of a child's weight has been presented in the literature as indicative of their limited interest in the topic of childhood obesity (Turner et al., 2009). Whereas the findings of this current study indicated that they were an integral part of a more rational decision making process which was determined and contextualised by other

current extraneous considerations. Further, such findings challenge government policies such as “*Every Contact Counts*” (NHS Future Forum, 2012), which encourage all consultations to be health promotion ones. For the GPs in this study decisions to raise the topic of childhood obesity were often a compromise of multifarious considerations and different demands. It appeared that trying to juggle the competing imperatives of delivering individualised and responsive patient centred health care, whilst addressing Governmental determined public health concerns was often not feasible. It is suggested, therefore, that policy guidelines need to be aware that often GPs will exercise judgement about when to raise the topic. Whilst there is little doubt that every consultation provides a potential opportunity for this, it is clear that GPs are often likely to assess the family and child’s receptiveness before initiating any weight related discussions.

Linked with the topic of sensitivity was that of language choice. The current study highlighted tensions around language choice, with the GPs aware that the language used needed to be sensitive, but also had to be crafted in such a way that the concerns of the GPs were articulated. However, this is clearly a contentious area, for example Turner et al., (2011) found that many of the parents felt that GPs had been particularly insensitive when raising the topic of a child’s weight, either by using clumsy language or not acknowledging the distress that the topic was causing the child.

It is interesting that the findings in this study indicated a distinct gender difference in relation to language choice. None of the female GPs used derogatory or pejorative comments in any of the research interviews, preferring to choose terms such as “*overweight*” or “*obese*”. Perhaps, as women they were more sensitive to the societal constructions of the term “*fat*”, and more vigilant about the negative connotations and the inappropriateness of using such language in professional and personal discourses, (Lupton, 2013). This is in contrast to the male GPs, who on occasions, used the word “*fat kids*” when describing their experiences, albeit several noted that these were terms they would not use directly with patients. This selective use of context specific language was originally identified by Goffman (1959) who introduced the concept of front stage communication; that which is usually not controversial and appropriate to present to anyone, including patients (Goffman 1959; Ross and Hunter, 1991). Whereas, according to Goffman (1959), back stage communications included making controversial statements about patients, and displaying inappropriate attitudes and beliefs that are outside of the acceptable professional framework (Wear et al., 2006). Whilst the intention not to use derogatory or discriminatory expressions during the consultation could resonate with the

previous assertion that GPs were like actors using scripts at certain occasion to different audiences. It equally could be reflective of a more subtle alliance with social, cultural and moral constructions of obesity highlighting the potential stigmatising discourses on childhood obesity (Puhl and Latner, 2007). The issue of language choice in relation to childhood obesity is therefore one that GPs need support in addressing, and could benefit from guidance on how to discuss the topic in appropriate language that parents can respond to and accept.

#### **5.2.2.3. Lifestyle interventions for children who are obese.**

The previous section has highlighted the challenges, variations and complexities in raising the topic of a child's weight; the findings identified that such themes were also apparent in relation to the GP's determination about the nature and level of support they offered. This finding has key implications for future policy initiatives as there was a clear recognition in the current study that the approaches offered by all GP are likely to be different. A "*one size fits all policy*" which expects and directs all GPs to provide the same level of intervention may well be overly ambitious given the variance identified in this study.

Despite an acknowledgement of the complex phenomenon of childhood obesity, it is interesting that the majority of GPs saw their response, in the main, as restricted to providing information and advice about lifestyle factors such as diet and exercise. Such findings corroborate with other research, (Edmunds 2005; Walker et al., 2007, Pagnini et al., 2009). Whilst the focus of the GPs on the relevance of lifestyle issues to addressing childhood obesity, appeared to have been normalised and embedded in their clinical practice, there was however little evidence to suggest that the GPs based their advice on current guidelines. It is therefore critical that evidence based information which summarises national recommendations for diet and physical activity levels for children (NICE, 2006) is made available, in a simple, easily accessible format for GPs. This is particularly important as it appears that delivering lifestyle advice to children who are obese is one area of work that the majority of the GPs would consider it appropriate to engage in.

#### **5.2.3. Individual and professional dilemmas.**

The previous section has highlighted the variety of responses that GPs offered, which as detailed below, were highly related to their view of role adequacy, legitimacy, and competence.

#### **5.2.3.1. GPs' role adequacy and legitimacy in relation to childhood obesity.**

Unlike many other paediatric presenting conditions such as diabetes or asthma where the expectations of a GP's role are explicit, measurable and rewarded; the management of childhood obesity is limited primarily to NICE guidelines (2006; 2013). The research in this study identifies varying professional opinions on what constitutes role legitimacy, the boundaries of professional responsibility and role adequacy (Walker et al. 2007, Turner et al., 2009). As such any recommendations that attempt to influence or direct all GPs in their professional practice need to be aware of such variations.

The findings in this study showed that despite the many challenges the GPs identified in offering support to children who were obese, almost all of the GPs indicated a strong, moral responsibility to address the issue, almost more so than with obese adults, where there was a resignation that it was almost too late. This wider commitment to children's health is consistent with policy discourse around the child as a site of investment for the future (Baird, 2008), and is an important foundation for engaging GPs in further work.

However, for the GPs in this study, the role legitimacy appeared to have certain rigid boundaries; for example few GPs perceived that they had a constructive role in addressing issues that caused emotional distress for the child, such as bullying (Curtis and Fisher, 2007; Griffiths and Page, 2008) and social embarrassment (Alm et al., 2008), which they believed should be primarily carried out by staff in schools, (Pagnini et al., 2009.)

Previous research, (Jelalian et al., 2003) has also suggested that professional confidence is an important construct in relation to GPs and childhood obesity, with higher levels of confidence, or self-efficacy, increasing the likelihood that a GP would raise the matter and initiate behaviour change even when faced with obstacles, (Gerner et al., 2006). The findings in this current study indicated that the majority of the GPs often related their confidence to their seniority in the practice, and their long standing knowledge of the family. All the GPs in this study had been in practice for over 25 years, and many explored how, over time, they had acquired communication skills and knowledge which they constantly used in their consultations. These included skills about how to "*read*" social and behavioural cues, discern signs beyond the parents or the child's words, and adapt messages to suit the parental needs. However, specifically in relation to childhood obesity, there was an acknowledgment that this was often a much more involved and complex process than was usual in their consultations when treating an acute health problem.

The findings in this study identified how the confidence and commitment of the GPs was also affected by their perceptions about the effectiveness of their own interventions, and their lack of clear feedback about whether they had made a difference. This is consistent with the perceptions of GPs in other research (Walker et al., 2007; Staniford et al., 2011). For example other studies have indicated that GPs' motivation was impacted by low perceptions of effective treatments for obese children, and the limited evidence base of clinical effectiveness (Brontons et al., 2003 and Barlow et al., 2007). This finding is unsurprising as there is still debate and inconclusive evidence about the most effective way to manage childhood obesity and the most appropriate care setting (Summerbell et al., 2003; Oude Luttikhuis et al., 2009). It is important therefore that GPs, particularly when they refer children to other settings, receive regular feedback on the child's progress and success outcomes, which they can reinforce at future consultations.

#### **5.2.3.2. Competence, knowledge and training of the GPs.**

It is interesting that the majority of the literature on childhood obesity and GPs (Walker et al., 2007; Turner et al., 2009; Gage et al., 2012) inevitably concludes with the need for further training for GPs. The recent Royal College of Physicians report "*Action on Obesity*" (RCP, 2013) highlighted that training for GPs in this area has so far been minimal and often poorly coordinated, reflecting a lack of focus on obesity throughout medical training as a whole. However, the findings in this current research offered an additional view. All the GPs saw little need for extra training on childhood obesity, explaining that they did not believe that they had any specific knowledge deficit. The GPs made sense of their ambivalence to additional training in a number of ways. Firstly, given the small number of children who were obese that they actively supported, and secondly given their limited views of how personally effective they could be, they were satisfied that the range of knowledge, skills and confidence they has acquired, updated and reinforced through their clinical careers were all that they needed to "*get by*" in the consultation, without the need for any further organised learning. The majority of the GPs had little interest in acquiring any theory-informed or evidence based behaviour change techniques (Abraham and Michie, 2008), as they believed that such interventions were best delivered by other services which they could refer too. The findings of this research therefore highlight the discordance between recommendations by governing bodies to develop doctors who are proficient in supporting patients to make lifestyle changes and adopt more healthy behaviours (NICE, 2006; RCP, 2010), and these GPs' lack of interest and perceived need for training. If GPs are reluctant to attend specific training on childhood

obesity however there may be merit in including this topic in other training programmes on wider paediatric health which GPs are more likely to attend.

#### **5.2.4. Organisational Challenges.**

The findings in this study highlighted a range of organisational, operational and wider service challenges that could also impact on the decision making process of GPs regarding support to children who are obese.

##### **5.2.4.1. The 'lost child' in General Practice.**

As Chapter 4 has indicated most of the GP practices in this study had childhood obesity prevalence rates close or above the national average rate, (NOO, 2013). However, the GPs were unable to provide any reliable estimates of the number of children on their registered list who were obese. This is likely to be related to the fact that it is not routine practice for the GPs to record height, weight, and BMI for children, and not part of the General Practice QOF, (DoH, 2004b). In addition the NCMP data which records the BMI for children in reception and Year 6 children is currently not fed back, in the area of this study, to the child's GP, which again seems a missed opportunity for GPs to ask about weight, diet, and exercise when consultations are taking place for other reasons. It is recommended that GP practices develop more active recording on their clinical systems which would enable the production of individual registers of obese children. This would provide opportunities both to store and monitor such data and act as a trigger for GPs to consider raising the issue of weight and offering advice or referral.

##### **5.2.4.2. Other health professional staff.**

The findings in this study identified that GPs were reluctant to acknowledge or develop the support that Practice Nurses could provide to children who are obese. They indicated that Practice Nurses lacked key areas of knowledge, particularly around advice on food and portion size for childhood weight management and were generally unwilling to be involved in areas where there were few protocols or pathways. This is contrary to Walker et al., (2007) who found that Practice Nurses felt that their role centred upon raising the issue of a child's weight, and providing basic diet and exercise. However, other research (Hoppe and Ogden 1997; Nolan et al., 2012) found Practice Nurses had particular anxieties and fears about raising the topic of weight with children, young people and parents.

In light of the concerns of the GPs that there was no support available to them in the practice, it is interesting to consider why they did not encourage Practice Nurses to take a role in childhood obesity, particularly as they had acquired considerable expertise in health promotion programmes including those related to adult obesity. For example Ross et al's., (2008) evaluation of the Practice Nurse led Counterweight programme for obese adult patients, reported that this intervention successfully supported patients in achieving and maintaining "*clinically valuable weight loss within routine primary care,*" (2008 p.548). The reluctance of the GPs to use Practice Nurses may reflect the lower priority that the GPs afforded to childhood obesity as opposed to the other QOF targets, such as Coronary Heart Disease, that the Practice Nurses were heavily involved in. It does, however, seem that a valuable resource to the practice was not being utilised, and it is disappointing that the scope for a multidisciplinary team based approach in the practice was not considered. Furthermore, given the previous discussions about GPs staying within their preferred clinical domain there is the scope to consider whether GPs with a special interest (GPwSI) in childhood weight management should be developed. This could possibly be linked to those GPs in a practice who have specialist expertise in child health or to those GPs with an interest in obesity.

#### **5.2.4.3. Time and competing priorities.**

The current findings also identified a wide range of practical challenges that GPs experienced when raising childhood obesity in their consultations, often presented through concepts such as workload and conflicting and competing priorities. This is a consistent theme in the literature (Gerner et al., 2006; King et al., 2007; Turner et al., 2009). The GPs in this study were Senior Partners with time consuming responsibility for many managerial, organisational and financial decisions aligned to the General Practice contract (DoH, 2004b) and its associated QOF national targets (Doran et al., 2006; Roland, 2007). Some research (Walker et al., 2007) has suggested that because there were no childhood obesity QOF targets and therefore no financial gains to be secured from this work, GPs tended to give it a lower priority. The findings in this study also indicated that by excluding childhood obesity as a QOF target there was no access to all the other associated developments, such as staff training or the development of registers which were available for the adult obesity QOF targets.

The significant prominence given by the GPs to time factors is consistent with other research which documents that time restrictions could be a hindrance to engagement and deeper involvement with families during routine consultations (Walker et al., 2007; Lachal et al.,



2013). The fact that GP workload in primary care is often extensive (Lester et al., 2009) is rarely contested and it is acknowledged that many clinical decisions are taken in a context of pressure and time constraints, (Sayal et al., 2010; Illiffe et al., 2012). It is interesting that Turner et al., (2011) found that parents also picked up on the time constraints of some GPs questioning whether the GPs had the time and resources to effectively manage childhood obesity. Edmunds (2005) however found that parents spoke positively about their relationship with the GPs if they were given time to discuss the issues related to their children's weight. There is little doubt that GPs, by conveying the impression of having time for obese children and their families, would express a powerful message about their interest and legitimate parents' concerns. Moreover, having a series of short consultations over a period of time could benefit the family by promoting a trusting relationship where problems could be addressed gradually, and at a steady pace, in order to achieve long term behaviour change.

#### **5.2.4.4. Services for children who are obese outside of primary care.**

The lack of services outside of primary care for children who are obese was a key concern for the GPs in this study. At times this resulted in an unwillingness to raise the issue of a child's weight when they perceived the health care system was not currently structured to deal with this issue effectively. As a consequence they admitted that they were reluctant to uncover issues in the family that they themselves were powerless to help with. This view has also been expressed by other GPs, (Walker et al., 2007, Turner et al., 2009) and also in relation to where GPs felt there was no local support to access (Story et al., 2002). The GPs in this study expressed disappointment about the lack of clinical pathways, the paucity of available local specialist service or treatments to refer families to, which is consistent with Gerner et al., (2006) and Hearn et al., (2008). Locally the fact that provision of the children weight management service was only delivered at one site in the Borough was also of concern for some GPs, who felt this limited access for many families. Despite this the GPs displayed no intentions to address these gaps by campaigning for further sites or advocating on behalf of their parents for additional investment in such services. This finding has clearly supported the need for investment in extended weight management services for children (NICE, 2013) with accompanying seamless pathways for signposting families and children who are obese to such services and other community based exercise programmes. However, some of the GPs did acknowledge that environmental and social policy changes were needed if any substantial difference is to be made to current childhood obesity trends. This element of professional support for such changes is an important consideration for future policy makers.

### 5.3. Variations in the accounts of the GPs and the emergence of role types.

Throughout this chapter the multiple, complex experiences of the GPs regarding their roles, approaches, motivations and views of childhood obesity have been discussed. A second aim of this research was to identify variations in these accounts which impact upon the type of responses that GPs provide. The literature review in Chapter 2 has indicated that exploratory studies of childhood obesity and general practice are limited, and there are currently no explicitly formulated theoretical frameworks.

As a consequence attention was directed to theoretical models that looked at addressing wider lifestyle interventions in general practice. Laws et al., (2009) offers a theoretical model entitled “*The practice justification process*” (2009, p.66), which explores how clinicians' perceptions shape the implementation of lifestyle risk factor management in routine practice. This model was felt to be particularly relevant to the findings in this study as it discusses the value of identifying role types and their underpinning epistemological frameworks, and suggests how each of these role types determines and frames the nature of decision making and ensuing interventions. The next section of this chapter will discuss some of the variability in the clinical encounter with reference to Laws et al., (2009) role types and the likely underpinning epistemological positions the different GPs held. Discussions about the different systems of medical knowledge have a long history in the literature (Gabbay and le May, 2011). What clinicians know as individuals, where knowledge is developed, and how they come to select what counts as relevant material in the process of decision making are central concerns of medical epistemology, (Khushf, 2013).

Laws et al.'s (2009) taxonomy presented 4 prime roles; “*the Gatekeeper, Outside of Professional role, the Informer and Educator, and the Helper and Facilitator*” (2009, p.10). The GPs in this research occupied a range of positions within these roles, and although these positions are not fixed, the accounts of the GPs suggested that most practitioners tended to occupy a favoured position. It is acknowledged that the use of a general framework to situate the diverse perspectives highlighted in the findings could be seen as too positivist, forcing a classification that does not capture the rich distinctive views presented by each GP. Whilst such difficulties are acknowledged, it is felt that the broad analyses presented below offers a genuine and unique attempt to advance and develop knowledge and understanding of this area. Each role type will now be considered and discussed with supporting evidence from the

findings of the study in relation to individual clusters of GPs. Appendix Twelve provides a tabular summary of this data.

### **5.3.1. The Gatekeeper role.**

GPs No. 1, No. 4 and No. 7 could be classified according to Laws et al.'s (2009) taxonomy as Gatekeepers, where *“the overall intervention is considered outside of scope of professional expertise and job role, best addressed by qualified expert”* (2009, p.10). It is proposed that the Gatekeeper's role is predicated in the dominant, positivist biomedical framework, which prioritises biomedical knowledge as the defining ways of understanding and conceptualising illness and foregrounds the doctor as the principle actor, (Woods, 2007). The biomedical framework underpins the teaching of scientific principles, focuses on the biomedical component of illness, and has governed health care delivery for the past century (Gabbay and le May, 2011). This framework is clearly relevant for many disease based illnesses, has intuitive appeal, and is supported by a wealth of supporting biological findings (Khushf, 2013). Within the biomedical framework Schmidt et al., (2007) proposed an encapsulation theory whereby as clinicians develop their clinical competence, their biomedical knowledge and clinical skills become integrated and embedded in their professional practice.

Operating within the biomedical framework, the GPs who adopted a role similar to that of the Gatekeeper (Laws et al., 2009) described their experiences as raising the issue of childhood obesity, focussing on preventing future health problems, and prioritising the need for early identification of health issues. This is consistent with other research (Turner et al., 2009; Redsell et al, 2011). However, similar to the findings of Banks et al., (2012), the GPs in this role considered the management of childhood obesity as outside of their scope of professional expertise and one best addressed by qualified experts, such as paediatricians or specialist dietitians. Their need for biomedical certainty and diagnostic accuracy was fulfilled when parents initiated a consultation about their child's weight, where they could discharge their preferred role of responding to a presenting clinical condition. Similarly, they related their clinical duties as responding to symptoms with accompanying obesity co-morbidities, for example, managing joint pains. This is consistent with Walker et al., (2007) who found that GPs identified a role that primarily focussed on management of co-morbidities or high risk factors. The GPs operating in this role also felt it was their professional duty (Malterud and Ulriksen, 2011) to inform parents of the possible long term physical medical consequences of their child being obese, for example relating the child's weight to the increased risk of

diabetes, (Reilly et al., 2003). However the GPs who took the Gatekeeper role found it difficult to move from an acute presentation to one in which they would also raise the child's weight, and always felt that responding to the former was their legitimate role. They also explored the changes in child health policies (Wood and Wilson, 2012) which limited their legitimate involvement in child health screening, and as such they felt that they had restricted opportunities for constructive health promotion conversations with parents and children. This explanation was also offered to validate and make sense of their view that they did not need additional training or develop any enhanced expertise in the identification and management of childhood obesity.

Consistent with the biomedical model, these GPs had a good knowledge of the medical history and clinical risk factors of the child and the family. However, for these GPs their awareness of the families' wider social or financial context appeared to be less important in the construction of knowledge of the family. Dowrick (1997) and Armstrong and Earnshaw (2004) have also documented the reluctance of many GPs to acknowledge the social issues of patients and how they impact on the presenting condition. The GPs in this role appeared to adopt a professional detachment (Kaner et al., 2006) from the complexity of some of their families' lives, which were clearly framed as 'non-medical' and outside of the GP's identification of legitimate areas of medical concern. As scientific rationalists they were clear which areas of required interventions breached the boundaries they had constructed around their role. For example, offering parenting advice was considered outside of their professional domain (Curtis and Fisher 2007; Griffiths and Page, 2008) and was very unlikely to be discussed in the consultation. Similarly, they did not consider their legitimate role to extend to addressing issues that caused emotional distress for the child, such as bullying, (Griffiths and Page, 2008) or low self-esteem (Puhl and Latner, 2007). Whilst they used their knowledge of the family to ensure they were sensitive to previous health concerns, they were also aware of past responses from the family. They knew when they had reached a plateau and saw little value in further expanding their time in trying to move forward the family's cognitions and responses to their child's weight.

The GPs in this role made sense of their limited engagement by stressing that lifestyle behaviours, especially those for children are complex (Hearn et al., 2008) and require specialist input from qualified experts (Laws et al., 2009). They did not believe they could impact on childhood obesity in isolation from other allied health professionals, and therefore their role was to refer on in order to facilitate family behaviour change, (Chisholm et al.,

2012). Referring families onward to more specialist service was a one off task requiring minimal skill and investment of their perceived limited time to address complex issues in a busy surgery. Charles-Jones et al.'s, (2003) ethnographic study of general practice characterised GPs operating in a biomedical framework where patients are reduced to the condition or tasks of clinical-managerial surveillance that are required in order to "*dispose of them*" (2003 p.74). They concluded that those patients requiring the most technical medical expertise are the most valued and secure a higher priority in terms of the GP's time resources and professional attention. For the GPs in the Gatekeeper role it appeared that responding to obese children required little technical medical expertise (Ogden and Flanagan, 2008) other than referring them to other services.

However, for the GPs who operated within the Gatekeeper role, the inconsistent and limited access to other resources and services to support the child resulted in professional dilemmas. For example, whilst they were clinically aware of the psychological consequences of being obese, such as low self-esteem and poor body image (Puhl and Heuer, 2009), they questioned whether these were severe enough to merit a referral to a child psychologist. Equally they felt frustrated by the paucity of available specialist health services such as community dieticians to refer families to (Turner et al., 2009). As a consequence they admitted that they were reluctant to uncover issues in the family that they themselves were powerless to help with, or there was no local support to access (Story et al., 2002; Epstein and Ogden, 2005). Consistent with other studies, the GPs in the Gatekeeper role, made sense of their restricted role by indicating concerns that there were no clear scientific clinical pathways (Lachal et al., 2013) and the evidence base for childhood obesity management was too inconclusive to merit their intervention (Summerbell et al, 2003; Barlow et al., 2007). Overall they had low perceptions of their professional effectiveness, (Brontons et al., 2003) which again challenged their preference for medical certainty.

Geneau et al., (2008) suggested that GPs experience a sense of professional insecurity when they are uncertain about how to proceed in certain clinical territories, especially where the territory is unbounded and the clinical content unpredictable. Whilst the ability to handle the biomedical component of childhood obesity is evidently necessary for any GP, the above description of the Gatekeeper role has shown that delivering care and support within this epistemological framework, limits the scope and engagement that such GPs are realistically like to offer. Indeed the GPs in the Gatekeeper role were acutely aware that the biomedical core of their work offered few scientific answers to many of the problems that were associated

with childhood obesity such as addressing bullying, permissive parenting, and social isolation. Nor did it equip them to deal with the variations of particular families and their multifaceted wider circumstances.

### **5.3.2. Outside of professional role.**

A further category of Laws et al., (2009), is that of Outside of Professional Role “*where the expectation of the clinician is that that interventions are best addressed through population health approaches, and there is no discrete role to be to be adopted*” (2009 p.9). Only one of the doctors, GP No.3 was included within this role category.

The GP in this role offered extreme views within a biomedical framework which, whilst recognising obesity as a disease with significant biomedical consequences (Foster et al., 2003; Forman-Hoffman et al., 2006), also included a strong view that risk factors for childhood obesity were based on individual lifestyle choices. He made sense of his limited engagement in this area by locating lifestyle issues as an extremely peripheral component of his role, and one almost not worthy of his scarce time (Edmunds, 2005). He felt he had no legitimate role in motivating families to change behaviour, and he acknowledged that these would have required skills outside of his professional expertise, which was consistent with the findings of Banks et al. (2012). As this work was outside of his professional role, he felt that the topic of childhood obesity should be addressed through population health approaches by other agencies, which is consistent with other findings (Epstein and Ogden, 2005).

Geneau et al., (2008) indicated that GPs tended to stay within a particular professional “*niche*” (2008 p.140) in order to feel more secure or develop an expertise in a specific domain. The GP in this role indicated that as a consequence of his longevity in the practice it was usually elderly patients who specifically asked to see him and this patient initiated triage resulted in him having limited contact with young families. This may well have exacerbated or contributed to his lack of commitment and his perceived lack of capacity. As he reported having limited opportunities to intervene, he saw little need to acquire the relevant knowledge or skills around child weight management, or access support tools and resources.

The GP in this role appeared to adopt a paternalistic approach (Murray et al., 2006) to his patients where information transfer was one way and limited to providing bio-medical information, (Charles et al., 1997) whilst initiating some limited referrals to secondary care services. However, given the view that responses to childhood obesity should be found in the

wider community environment, he directed families to libraries where he assumed appropriate information would be available for the family to access. Whilst the GP in this role operated within the biomedical role he expressed the view that childhood obesity was the consequence of the deficient behaviour of the parent and the child (Ogden et al., 2001), and he firmly placed blame on the parents who he held responsibility for their child's weight. He held crude and negative assumptions about the health behaviours of the families and disparaging views of parents who were themselves overweight and where he felt obesity was the norm in particular households. Similar to GPs in other studies, (O'Dowd, 1988) he experienced feelings of frustration at the failure of parents who he conceptualised as being almost impervious to behavioural changes. This is consistent with Elstad et al., (2010) study of diabetes management who documented clinicians' frustration associated with behavioural noncompliance, and argued that this was enhanced by the fact that *"patients have the agency to undertake behavioural change, but physicians do not have the agency to make them do so"* (2011 p.13). The GP operating within this role held a very pessimistic view of his impact in addressing childhood obesity, (Epstein and Ogden, 2005), finding this work professionally unrewarding (King et al., 2007; Laws et al., 2009).

Whilst this GP clearly represented an extreme view there is some evidence that similar attitudes and behaviours were found amongst other GPs in other studies (Jarvis, 2006; Walker et al., 2007; Turner et al., 2009). This is concerning as research has indicated that many parents see their GPs as sources of advice and support on childhood obesity (Turner et al., 2011), and expect some help (Edmunds, 2005).

### **5.3.3. The Informer and Educator role.**

GPs No. 2, No. 5, No. 8 and No. 9 explored their practice consistently within Laws et al's., (2009) role of Informers and Educators, where they perceived their key focus was *"to ensure families has sufficient information to make an informed choice about lifestyle behaviour."* (2009, p.10). The most defining epistemological framework for these GPs appeared to be *"the biographical-biological"* (Armstrong, 1979; Heath, 2009; 2011). Heath (2009) argued that whilst the need to address the biomedical component of illness is necessary for any GP, the biomedical framework has limitation in primary care, where *"most patients have multiple, interacting, and compounding problems; physical, psychological and social."* (2009, p.911). The biographical-biological framework, in contrast to the positivist biomedical model, therefore provides a more comprehensive conceptual paradigm for integrating patients'

biological, psychological, and social presentation into a coherent clinical whole, (Armstrong, 1979), recognising that psychological and social factors influence a patient's perceptions and actions.

The GPs in this study who took the role similar to that of the Informer and Educator primarily identified their role in childhood obesity as addressing individual health related behaviours, for example, poor diet and physical inactivity. As they located childhood obesity within the domain of individual lifestyle behaviours, they expressed relatively strong role adequacy and role legitimacy (Fogelman et al., 2002) feeling knowledgeable about this area of their work and believing that they had the right to address these issues with the family (Cade and O'Connell, 1991), and were willing to invest some time in management and interventions. Walker et al., (2007) found similar views where GPs viewed childhood obesity, as primarily "*a family issue*" (2007, p.5), linked inextricably with family circumstances rather than a reductionist series of health risk factors.

The GPs operating within the biological-biographical framework were more likely to display an awareness of the impact of socio-economic disadvantage and its link with childhood obesity (Lobstein et al., 2004; Stamatakis et al., 2010), and they clearly recognised the importance of wider social contextual factors impacting on their decision making (Gabbay and le May, 2011). With their focus on the biographical and the need for a wider understanding of the presenting family's health beliefs and behaviours and attitudes, they rarely, if ever, raised the matter with a family they were not familiar with or did not have a previous relationship with. Therefore their commitment to addressing a child's weight was contingent on knowledge of the family. They were particularly sensitive to the parental anxieties, which Edmunds (2005) and Hughes et al., (2008) described, and the GPs in this role were concerned that negative responses from parents may impact on future relationships with the family. The lack of feedback on whether they have made a difference to the child's weight challenged their preference to have a complete biographical picture of the child and family.

However the GPs in the Informer and Educator role faced considerable professional dilemmas. Their underlying belief, consistent with the biological emphasis of the epistemology, that parents should address the health consequences of their child's weight, often proved to be an unreasonable expectation in the face of wider structural factors, social constraints and parenting challenges inherent in their biographical knowledge of the family.



Moreover, understanding the role of parenting and family dynamics in obese children did not necessarily offer an obvious solution or indicate the best response these GP could offer. For the GPs in this role, initiating a dialogue about parenting practices in a consultation could still be problematic, and they preferred to address issues such as having a healthy meal and portion control rather than behaviours at the table. Similarly Turner et al., (2009) identified that GPs expressed doubts about whether they had the resources and expertise to deal with a complex phenomenon with a wide range of potential familial causes. Whilst these GPs had a clear biographical understanding of the range of family situations that can impact on a child's weight, they remained reluctant to move beyond providing information and advice. Their role focussed primarily on the family and child in front of them, at the time of the consultation, (Lachal et al., 2013) and they acknowledged that they had limited opportunity, resources and expertise to make significant influences in the home. As a consequence they restricted their action to what could be achieved in a clinical setting. Indeed as Informers and Educators their interventions tended to be unidirectional, with an expectation that once the family had received information and advice they would then be able to independently sustain behaviour change, (Staniford et al., 2011).

Whilst their biological and biographical knowledge of the family provided them with a degree of confidence to be able to determine what messages would be most acceptable to the parents and the child (Chapman and Ogden 2009; Lindelof et al., 2010). However within this role there were variations in their approach. Two of the GPs pursued a "*doctor led*" agenda, consistent with the biomedical approach (Williams et al., 1998) telling the families which websites to visit in order to shape an intervention plan, which healthy eating plans to follow and what levels of exercise they should be taking; advice firmly based on their medical knowledge and perceived expertise. The remaining two were more "*patient centred*" (Mead and Bower, 2002), preferring to start with the families' agenda, asking the parents which exercise their child preferred, or what foods the child was more likely to try, before offering supporting information.

The GPs who operated within a biographical- biological framework demonstrated a much richer awareness of the complexity of many children and families' lives, yet they often experienced a sense of professional frustration at the limited support and facilities available to deal with family complexity. This finding appears regularly in the literature, (Gerner et al., 2006; Walker et al., 2007; Turner et al., 2009). They also highlighted, again consistent with the literature, (Pagnini et al., 2009; Banks et al., 2012 ), the fact that they only had 10 minutes

for each patient could be a disincentive to open up a conversation, particularly one which focussed on the sensitive area of childhood obesity. However as Marks (1977) observed, appeals to the finitude of time are culturally honourable excuses, and it may well have been that the GPs in this role used such explanations as a way of mitigating their responsibilities.

#### **5.3.4. The Helper and Facilitator role.**

Finally GPs No. 6, and No. 10, both female GPs, explored their interventions to support obese children consistently within the Laws et al's., (2009) role of Helper and Facilitator, "*helping move clients towards change over time by acting as a facilitator*" (2009, p.10). It is proposed that these GPs practiced with an interpretivist framework (Reeve, 2010, Reeve et al., 2011; 2013) using many of the epistemological positions of Narrative Based Medicine (Launer, 2002). Both positions have been proposed as a practical way to respond to the complex reality of patients' lives that are presented in a primary care setting (Greenhalgh and Hurwitz, 1999; Launer, 2002). Over the past two decades this framework has been increasingly acknowledged as a powerful alternative to the reductionist biomedical framework, in that it stresses the importance of a more empathic and holistic approach to patients, (Greenhalgh et al., 2005). Whereas the biomedical paradigm considers knowledge as a place of certainty and 'truths,' the Interpretivist offers an understanding of knowledge as being more "*contextual, contingent and fluid*" (Reeve, 2010, p.521). Narrative based medicine proposes the existence of multiple viewpoints, and that knowledge is constructed in the clinical interaction between the doctor and the patient, operating within a continuous interpretive and therapeutic framework that acknowledges the uniqueness and value of the patient's story (Launer, 2002).

The GPs in this study who took the role similar to that of the Helper and Facilitator continued to value the biographical accounts of the family experience as valid and epistemologically central to their everyday practice. They demonstrated extensive long term knowledge of many aspects of the families' lives, often extending this knowledge to include the health attitudes and behaviours of grandparents and members of the extended family. This is consistent with Berge et al., (2012) whose findings showed the impact of "*significant others*" (2012, p. 35) on children's weight status, dietary intake, and physical activity. Overall these GPs confirmed that establishing trust was critical to good practice and they prioritised relationship-centred care (Greenhalgh, 2002). They were more likely than any of the other GPs to focus on interventions that promoted a higher level of empowerment for the family, which they acknowledged may take time. Edmunds (2005) confirmed that this empathetic approach was

positively received by parents of children who are obese, especially when the liaison was built over time.

However, this wider understanding of complexity and intricacy of families' lives could lead to professional and individual dilemma for these GPs. Both of the GPs who displayed behaviours consistent with the Helper and Facilitator role, described how parents often adopted protective attitudes to their children who are obese, and the GPs appeared acutely aware of the important emotional role of food in family relationships (Lachal et al., 2013). For example they made sense of the strategies that parent's use, such as indulgent food treats, to compensate for their child's lack of self-esteem or difficulties with their peers. The GPs in this role were therefore often in a dilemma about whether maintaining healthy weight was more important than helping parents address the psychological issues of their child, (Dixey et al., 2006; Murtagh et al., 2006; Stewart et al., 2008). Often there were no easy solutions which impacted on the GPs feelings of self-adequacy (Nolan et al., 2012). Consistent with Narrative Based Medicine (Launer, 2002) the GPs in this role tried to make sense of the family situation through a shared exploration of the individual child and the families' experiences, the families' interpretation of childhood obesity, and the impact that the child's weight was having on them. These were addressed through continuous conversations, and moving towards a co-construction of responses which acknowledges the uniqueness and value of the families' story (Greenhalgh, 2002). For example, one GP after a long discussion with a mother about increasing physical activity and the expense of taking the whole family swimming was delighted to hear later from the parent that a neighbour had given her a bike for her child to use.

The GPs in this role were fully acquainted in their holistic approach to the wider social determinants which could lead to childhood obesity, (Bleich et al., 2012). Factors such as limited access to play and leisure facilities, the cost of healthy foods and parental working patterns were all considered as important in impacting on both the health choices of the families and the availability of parental skills and time needed to support their child who was obese. Many of these factors have also been identified in the literature on parent's perspectives about the challenges that parents of obese children face (Edmunds, 2005; 2008; Stewart et al., 2008). As both of the GPs in this role, practiced in areas of deprivation, they were aware of the association between socio-economic status and obesity (Perez-Pastor et al., 2009, Knai et al., 2012), and the link with deprivation and lifestyle choices and behaviours, (Kinra et al., 2000).

Both the GPs in the Helper and Facilitator role displayed a personal and practice commitment to addressing lifestyle management as an integral component of their role in providing holistic primary care (Gerner et al., 2006). They were keen to link discussion of risk factors to the presenting issue and displayed a high level of self-confidence and role legitimacy (Laws et al., 2009) in addressing the family's risk factors. These GPs provided tailored, individual advice, and were willing to suggest brief behavioural interventions (Munsch et al., 2008) such as working with families on food diaries and advising them on their shopping routines. They also used motivational approaches (Rollnick et al., 1992; Rubak et al., 2009) to facilitate behaviour change, (McCallum et al., 2007) and to help the families set relevant and feasible goals. In contrast to previous research (King et al., 2007; Walker et al., 2007; Turner et al., 2009), they did not consider a lack of motivation from either the child or the family as a deterrent, but rather part of a continuous longer term process, and one in which they were able to utilise their skills to facilitate behaviour change (McCallum et al., 2007). The holistic understanding of the family which enabled them "*to support the capacity of individuals in maintaining their daily lives*" (Heath, 2009, p. 62) often resulted in them working with the families to find more practical solutions. For example they would advise where to buy local cheap healthier food and encourage them to use local parks. This focus on wider practical support was an approach that the parents in Stewart et al., (2008) found very beneficial.

Whilst the GPs operating in this role, were more willing to invest time in addressing lifestyles issues in a more holistic way, they were conscious that their responses to children who are obese sometimes was diluted by excessive workload, conflicting and competing priorities and time (Lachal et al., 2013). The time required offering more intensive level of support and motivation to the families particularly challenged these GP and they tried to resolve these organisational constraints by offering additional consultations and arranging return visits for the families over a period of time.

Consistent with their holistic approach to childhood obesity the GPs in this role were sanguine in their beliefs that their support was one of many which may eventually have, a positive impact in addressing the cyclic relationship of obesity (Clocksin et al., 2002). As facilitators of change they judged the effectiveness of their intervention in terms of the process of change rather than solely achieving distinct weight reduction targets.

Finally, the GPs in this role held strong beliefs and values about their Practice having a positive health promotion focus; one had created a patient library with health promotion

leaflets and books, and the other held regular themed events around lifestyles issues at the surgery with displays and local specialist speakers. However, they also believed that their role to support the family was synergistic with a wider socio-ecological perspective approach (Bronfenbrenner, 1979) and were prepared to challenge at population level. As a consequence these GPs were prepared to take on advocacy roles (Schwartz et al., 2002) or health champion roles (Eakin et al., 2004). For example one GP had written to supermarkets about chocolate being available at tills and another had been an active campaigner at her local school to ban soft drinks.

#### **5.4. Summary.**

Geneau et al., (2008) identified “*many complex, causal loops of interrelated factors that shape the work of GPs*” (2008, p.12). The initial aim of this research to explore the experience of identifying and managing children who are obese from the GPs’ perspective has been discussed in depth. Chapter 2 has highlighted the many divergent perspectives of GPs on childhood obesity. However, this research has added a further dimension in terms of the primacy the GPs gave to understanding the family and responding to family’s needs, and in navigating interventions in order to preserve the relationship with the family. Such decision making has been considered in this chapter through varying frameworks of role legitimacy, professional confidence and personal values. In congruence with the theme of individual and professional dilemmas, there were significant variations in terms of personal characteristics, style, motivations and attitudes. The research has also highlighted that despite a commitment to addressing a child’s weight, overall organisational challenges of time, competing priorities and resources both within the practice and outside of it often impacted on their motivations.

The second aim of the research to identify variations in these accounts which impact upon the type of responses that GPs provide, has been given further focussed consideration by exploring the complexity and variances in relation to Laws et al., (2009) typologies of role types, and the underlying medical epistemologies, which add to the understanding of how GPs made sense of their experiences. It has also focused on how the results of this new analysis can be expounded upon through references to existing literature. The two GPs who have commented on the discussions chapter both noted their interest in the GP typologies and felt that they were helpful constructs. Interestingly one of the GPs observed that she recognised elements both of her own practice and had identified some of the role type behaviours in the other GP partners in her practice. Preliminary discussion of these role types

have also been held with GP Educators at the North West Deanery and Public Health Consultants have indicated that they are identifiable, relevant and are likely to prove valuable in understanding the complexity of this phenomena. Key issues in terms of attending to these areas have started to emerge in this discussion chapter, and the final chapter of this report will therefore utilise the analysis to propose recommendations for future professional practice and policy development.

### **5.5. Limitations of the research.**

A number of limitations to the study have been identified. Firstly, throughout this thesis it has been recognised that IPA is inevitably subjective, (Brocki and Wearden, 2006; Langdrige, 2007) and this may raise questions of validity and reliability (Goldsworthy and Coyle, 2001). Whilst the thematic analysis has been reviewed by the supervisors and anonymised transcripts have been considered by other IPA researchers in the regional IPA forum, only two of the GP participants have given feedback on the interpretations (Smith, 1999). Originally it had been intended to carry out a process of “*respondent validation*” (Kuper et al., 2008) with all the GPs in the study, to provide them with an opportunity to make judgements on the resonance of the analysis with their own experiences. Only two of the GP offered to do this and it could be argued that this made the process unsystematic, as the usefulness of member or respondent validation has been said to be at its most robust when it is carried with a wide number of respondents, (Bygstad and Munkvold, 2007).

The second limitation of the study refers to the familiarity of the researcher with the participating GPs who had been known to the researcher in other settings before the study. Within interpretive research this can be positioned as both strength and a limitation. It becomes strength if it is seen as facilitating the interview by putting the participant at their ease and thereby promoting a comfortable interview in which the participant feels able to speak openly and honestly. Chew-Graham et al., (2002) reported that there were differences where researchers were known to the GP, in that the interviews were broader in scope and provided richer and more personal account of attitudes and behaviour in clinical practice. However it can have limitations as all the GPs may have potentially shaped their narrative according to what they perceive the researcher expected to hear, presenting themselves in a favourable light, and offering a narrative or socially desirable answers which they imagine is consistent with the researchers’ position. Chapter 3 of this thesis outlines how the researcher relied on the use of reflexivity (Langdrige, 2007; Lee, 2009) during data collection,

transcription, analysis and writing in order to consider the inter-subjective and relational aspects of the research.

The final limitations relate to sample size and generisability. This study, in keeping with the interpretivist ideographic paradigm of IPA (Smith et al., 2009) is limited by a small sample size. This was a deliberate methodological choice mitigated by the purposive homogenous sampling strategy (Smith and Osborn, 2003) which has enabled the researcher to develop stronger claims about the experiences of a particular sub-group of GPs. However as with any small-scale study, the findings are limited in their generalisability (Mason, 2002, Silverman, 2013). The GPs in this thesis were all experienced practitioners and a further analysis of GPs who are younger or who have recently entered the profession may indicate generational effects or a stronger effect for age differences. Further, recruitment was restricted to geographical area rather than on a national basis, although the population of Stockport is socially and economically close to that of the national average, it has lower levels of ethnicity which may impact again on generalisability. However, despite such limitations this study has provided valuable information and insights that could be used to inform larger studies. As the following chapter will confirm it would be useful for further research to adopt similar methods at different sites, exploring the perspectives of different groups of GPs to produce a more comprehensive set of findings.

## **Chapter 6: Conclusion and Recommendations.**

The final chapter draws together the conclusions from the research by addressing the aims of the research, and outlines the implications for policy makers, local commissioners and individual GP practices.

### **6.1. Conclusion.**

The aims of the research were:

- To explore the experience of identifying and managing children who are obese from the GP's perspective.
- To identify variations in these accounts which impact upon the type of responses that GPs provide.
- To relate the GPs perspectives on childhood obesity to current policy, in order to produce practical suggestions for improving service provision.

The research aims were met by exploring ten GPs' experiences of identifying and managing childhood obesity, using an in-depth idiographic qualitative methodology. The research builds upon and extends existing accounts which have offered broad insights into childhood obesity and General Practice (Walker et al., 2007, Turner et al., 2009, Redsell et al., 2011). By utilising IPA (Smith et al., 2009) as a foundation for thematic analysis, the research has provided rich contextualised narratives of the experiences of these GPs. As such it has contributed to the research knowledge by providing insight into this complex area of clinical practice and offered a wider appreciation of the subtleties and variations of general practice. By focusing on a sub group of GPs with considerable experience of working in general practice, it has sought to provide further understanding into this important area of service delivery.

Chapter One initiated the exploration of these research aims by offering a wider policy context in which it was argued that national Government driven policies on childhood obesity, and local structural commissioning complexities, inevitably impacted on the scope, range and nature of the responses of GPs to children who are obese. In addition it was argued that the continued national discourses which rely heavily on individual responsibility rather than focus on the wider determinants of childhood obesity, frame the policy inference that GPs, alongside other health care professionals, have a role in addressing individual lifestyle change. The literature review in Chapter Two provided further context for the research aims,



highlighting the wide range of factors that impact on the experiences of GPs in identifying and managing childhood obesity, such as GPs' competence, skills, and expertise, limited time and resources, and lack of effective treatments, support and referral options (Walker et al., 2007; Turner et al., 2009; Redsell et al., 2011). The literature review also confirmed that factors such as family context, parental and familial attitudes, family lifestyle behaviours (Borra et al., 2003; Murtagh et al., 2006; Barlow, 2007; Hughes et al., 2008; Lachal et al., 2013) are important considerations in addressing childhood obesity. However, there were particular gaps in the literature relating to a deeper analysis and understanding of why there were variations in GP practice, and importantly how the GPs themselves rationalised and made sense of their individual approaches to childhood obesity.

A methodological approach was required to access such insight, and the research presented in this thesis is the first known attempt to utilise Interpretative Phenomenological Analysis (Smith et al., 2009) to explore the GPs' perceptions and experiences of responding to childhood obesity in a primary care setting. The intense interpretive analysis described in Chapter Three identified considerable variance in the ways that GPs address the issue of childhood obesity, and provided new and extended insight into GPs' behaviours, views and attitudes in relation to childhood obesity. The decision to use a purposive recruitment strategy ensured that the experiences of a particular sub group of GPs who had not previously been identified in the literature were explored. A particular strength of this thesis is that participants were not restricted to those GPs who were actively engaged and interested in childhood obesity. As such the findings provide a much broader understanding than has previously been reported in the literature in Chapter Two. Chapter Three also detailed the intense involvement with the methodology, the comprehensive and systematic thematisation of the interviews, the engagement of the research supervisors, other IPA researchers and two participants to assess the validity of the findings. It highlighted the reflective recognition of the researcher's interactive and dynamic role as a researcher-practitioner, which has resulted in a credible and informative account of the area of study.

The findings presented in Chapter Four and discussed in Chapter Five, significantly extend previous descriptive studies (Walker et al., 2007; Turner et al., 2009, Redsell et al., 2011) by providing new insights highlighted in the four super-ordinate themes and the range of subordinate themes. Whilst each theme was considered separately, they are clearly interdependent, and the on-going emphasis on variations showed that some themes featured

more prominently in some of the GPs narratives than others. This thesis has sought to integrate the findings to provide an extended understanding and explanatory analysis.

The first theme, understanding the family, highlighted how the GPs' understandings, perceptions and views which led to their decision about intervening with children who were obese, was heavily contextualised by the complex construction of knowledge of the family, and the nature of the relationships they had developed, as a consequence of their longevity in primary care. The key central emphasis that the GPs gave to understanding the family and responding to family's needs, has not been previously reported at this level of detail in other studies and may well be a consequence of the fact that these were experienced GPs who had spent many years in general practice. This research has also contributed to the literature by identifying the range of inter connected factors which GP access to complete their understanding of the family. These included family's health beliefs about the causation of childhood obesity, the normative lifestyle behaviours of the family, parental knowledge, understanding and acceptance of weight related behaviours and the parenting practices of the family. However, the findings also showed that understanding of parental concerns about the nature and consequences of the child's weight often resulted in tensions between the GPs and the families where there were different expectations, needs and anticipated outcomes. Some GPs tried to mitigate such tensions by negotiating common ground with the families about managing the child, others overruled the tensions by pursuing a dominant medically led intervention, and yet others presented the threat of tensions as a rationale for not raising the topic of the child's weight with the family. Moreover the findings in the study revealed wide variations in the extent of the GPs' knowledge of families; some were restricted to knowledge of health related issues whilst others embraced a much wider knowledge of the families including their social and financial circumstances. The diversity of range, scope and nature of family knowledge has not previously been identified in the literature.

The significant variation in the GPs' understanding of the family was clearly articulated in the second theme of flexibility and responsiveness. The decision making processes the GPs adopted, in terms of raising the issue of a child's weight, negotiating a way in and providing further support were formed, negotiated and consequential to a range of diverse factors. The GPs' drivers to maintain a relationship with the family, avoid embarrassment to the child and discuss an inherently sensitive and difficult issue resulted in the GPs evoking a range of strategies. Whilst at times some GPs confidently adapted their conversations to respond to the needs of the family and secure continued engagement, others concentrated primarily on health

related matters, and were unwilling to respond to the psychological support requirements of the child or to the presenting parenting challenges. In the main, the GPs offered basic lifestyle advice to the family focussing on diet and physical activity messages, with a presumption amongst many of the GPs that provision of information was sufficient to change behaviour. The majority of the GPs were cognisant of their limited ability to address, reach or influence matters relating to the family outside of their clinical setting and thus restricted their considerations of support to individual lifestyle change rather than address wider determinants of the family lifestyle behaviours. Two of the GPs however displayed a more holistic approach when supporting the family, offering practical advice that respected the family's social situation and focusing on motivational interventions and specific goal setting to manage the child's weight.

Even in this small sample of experienced GPs, there were significant variations in terms of personal characteristics, style, motivations and attitudes. There were also considerable variations in the GPs' definitions of role adequacy and legitimacy, professional confidence and personal values which collectively resulted in them experiencing individual and professional dilemmas in their consultations with children who are obese. Whilst almost all the GPs felt they had a role to play in preventing an increase in childhood obesity, and were motivated to do so, there were clear manifestations of role boundaries. This was aligned to their views about their level and scope of competence, their experiential beliefs about their limited impact given the complexity of the causes and presentations of childhood obesity, and the wider incomplete evidence base for successful interventions. However, despite this, they were generally unwilling to participate in additional training or skill acquisition to improve their practice.

The final theme of organisational challenges reflected on the reduced opportunities for health promoting or screening consultations with children as a consequence of policy drivers which have moved much of this work to other settings. In addition structural challenges such as time, workload pressures and competing priorities within general practice resulted in restricting some GPs full engagement in this area of work. The GPs in this study were reluctant to engage other staff in the practice in supporting childhood obesity interventions, and were concerned about the lack of pathways, guidelines and specialists expertise, which impacted on the scope and nature of support they could offer to the child and the family.

In Chapter Five the thesis contrasted the findings with other research in order to identify new areas revealed in the emergent themes alongside the existing literature. The discussion chapter offered an original insight into the considerable variations in practice by presenting Laws et al., (2009) typology and referencing the likely epistemological frameworks of the GP participants. Whilst the typologies are exploratory in nature, they provide further contextual understanding to this complex area of clinical practice, and a significant contribution to further exploration and analysis.

Section 6.2 will address the final research aim of producing practical suggestions at a national, commissioner and individual clinician level. Section 6.3 identifies areas of future research identified by this thesis.

## **6.2. Recommendations.**

This research has highlighted the varying multitude of experiences that GPs present in relation to the complex process of the identification and management of childhood obesity in a primary care setting. The multifaceted nature of this topic confirms that there is no single solution, however, a number of key recommendations are offered at the level of national policy makers, for local childhood obesity commissioners and individual GP practices.

### **6.2.1. National policy.**

The recommendations purposively start with those directed at national policy. Chapter One has evidenced how national policies set out a framework of key strategic drivers in which the role and expectations of individual practitioners are confirmed. For the last 10 years various Governments have determined that GPs have a pivotal role in the identifying children who are obese, and helping children and families manage weight (DoH, 2003; 2008; 2011). Yet there is no direct empirical evidence to support the positioning of GPs as such, and no data to suggest that this is a cost effective approach. Policy documents consistently present healthy lifestyle behaviours as a means to reduce population mortality and morbidity and the economic burden faced by the NHS (DoH, 2003; 2008; 2011). However, within such ambitions, policy makers seem to have given limited attention to understanding the relevant operational context of general practice and addressing the existence of significant variations in the attitudes, knowledge, skills and practices of GPs regarding childhood obesity. Policies such as “*Making Every Contact Count*” (NHS Future Forum, 2012) rightly attempt to focus GPs’ attention and engagement in preventative work and addressing lifestyle behaviours with

their patients. Yet the findings in this research indicated that these activities are often subsumed by other more pressing clinical needs of the child and the family which GPs tend to prioritise, and the time, resource and infrastructure constraints in the primary care setting. This seems likely to remain the case as general practice faces rising demand, workforce shortages and year on year reductions in funding (Gerada and Riley, 2012). However, GPs need to be allowed the time to listen to their patients and the freedom to use professional clinical judgment and medical evidence to provide the best personalised care possible according to the patient's individual needs. It is questionable whether this will be achieved without changes in organisational policy, infrastructure and investment in resources in primary care.

Recent national guidelines on childhood obesity (NICE, 2013; RCP, 2013) have started to focus on the importance of understanding the family, and their needs. However, in the main such guidelines and policy statements retain a strict clinical focus which emphasise health outcomes, and there are few references in the pathways to the complex social and economic family circumstances, and the challenges that many families face in supporting their obese child. It is recommended that such complexity is recognised, evidenced and addressed in the development of future guidelines. It is also recommended that new policies should be cognisant of the fact that GPs' behaviours in relation to childhood obesity are often adapted flexibly, according to contingent requirements which relate to the parents, their needs, circumstances and readiness to address their child's weight. This research found considerable examples of individual negotiations and individual practical decisions on each occasion in which the experiences, skills and attitudes of the GPs were matched against a range of relevant family factors and demands. It is recommended that policy makers recognise such findings and continue to engage and encourage discussion with GPs in order to ensure such policies assist and support GPs in this complex area of work.

Finally, as Chapter One has demonstrated, without an overall Government commitment to addressing the wider determinants of childhood obesity, the activities of individual practitioners will be extremely limited. Extending the involvement of GPs in this area is unlikely to have a significant impact without an accompanying focus on a more systematic approach to the wider economic and social causes of childhood obesity, and an accompanying investment in resources and political leadership to address this. The current prevalence of obesity among children and the multi-disciplinary complexity where policy, economics, socio-environment, biology, and psychology all play a role, indicates the need for new

strategies that encompass more than individual-level behaviour change initiated by sole practitioners.

### **6.2.2. Local commissioners of child obesity services and strategies.**

Since the “*Call to Action on Obesity*” (DoH, 2011) framework was published the responsibility for many of the actions to reduce childhood obesity have been devolved from Central Government to local commissioners. However, as noted in Chapter One, the commissioning landscape for childhood obesity has become increasingly fragmented and complex following the implementation of the Health and Social Care Act 2012 (DoH, 2012). It is critical therefore that local joint commissioning strategies are developed to prevent the rise in childhood obesity prevalence, and that local commissioners retain a commitment to continued investment in childhood obesity programmes. It is recommended that local commissioners work together to adopt and implement the NICE guideline 43 (2010) which outline sustainable community-wide actions to prevent obesity, and support the adoption of healthy lifestyles by parents and children in early years settings, children centres, schools and wider community facilities.

In relation to General Practice, the findings in this study indicate that local commissioners have a role in supporting GPs in their consultations with obese children and their families by providing accessible, comprehensive, local clinical guidelines and pathways, better tools for screening, more referral options and improved communication and co-ordination with other health and community providers. The provision of support services particularly those that meet the emotional and psychological support needs of obese children and their families also need to be prioritised. If local commissioners are committed to securing the involvement of GPs in the identification and management of childhood obesity it is important that there is a comprehensive provision of services for GPs to refer into, which inevitably calls for increased long term resources to be invested in this area. The nature, level and scope of this provision are clearly defined in the NICE guidelines (2006; 2010; 2013) which details system wide, evidence based interventions and activities for both the prevention and management of obese children. It is recommended that commissioners adopt and implement the NICE guidelines (2013) in their childhood weight management strategies and Health and Wellbeing Strategies and ensure family-based, lifestyle weight management services for children and young people are available as part of a community-wide, multi-agency approach to promoting healthy weight and preventing and managing obesity.

In addition, the research in this study supports the recommendation that commissioners should consider further support to GP practices, which may include the appointment of GPs with Special Interest in childhood obesity, or childhood obesity practice community coordinators. Such staff could facilitate interactions between practices, community programmes and families, developing and sharing good practice between GP practices, providing local practice based seminars, training and developing local resources.

Whilst the research found little evidence that payment incentives to individual GPs would enhance their involvement in this area, there are some opportunities for increased investment in Practice Nursing. Commissioners are also encouraged to support practices in setting up childhood obesity registers providing support around coding, record retrieval and register development. Finally, whilst there are challenges to the National Child Measurement Programme, (NCMP) providing child specific data to GPs, it is recommended that commissioners provide practice - based prevalence data derived from the NCMP data which GPs can use to assess the completeness of their own registers.

### **6.2.3. General Practitioners.**

This section of the final chapter will be presented as a series of practical recommendations that are applicable to individual GPs and GP practices. In addition, a summary chart, Table 6.1 of the recommendations is presented at the end of this section. This provides a subjective assessment of the likelihood of adoption of each of the recommendations according to the typologies advanced in Chapter 5, and is consistent with the on-going focus of variations in GPs' experiences in the identification and management of childhood obesity.

#### **6.2.3.1. Tools to assess parental readiness to change.**

This research has confirmed that understanding the variety of individual family perspectives seems to be critical in GPs' responses to a child who is obese. It is crucial that GPs continue to engage, explore, and assess how family lifestyle behaviours and parental needs, impact on parents and children's readiness to change. As such a focus should be on the GP inviting parent's views, perceptions and understandings. It is proposed that GPs can initiate such a dialogue by asking two, very simple, questions which will assess parent's readiness to change;

- Are you concerned about your child's weight?
- Do you want me, to help you, do something about this now?

Such short, non-judgemental questions are likely to be more acceptable to GPs who are uncomfortable or not confident about broaching the sensitive subject of a child's weight and require a minimal investment of GP time. By using open ended questions, the GPs give parents and children the opportunities to identify their individual concerns and views, and they highlight that the GP is prepared to work with the family and offer support. If parents are not willing or ready to address the issue at this time, GPs can repeat the question at future consultations as parents' views and readiness may change over time. It is recommended that these questions are used at the commencement of any clinical pathways provided to GPs regarding primary care interventions for childhood obesity.

#### **6.2.3.2. Family health and lifestyle assessment tools.**

If the families are ready to make changes it is recommended that GPs should complete an assessment of the child's BMI, any obesity associated co-morbidities, the child's nutritional intake, physical activity level, and family history of diabetes and cardiovascular disease. The GP should also discuss the family's history of attempts to manage their weight, and their existing knowledge of, and attitudes towards, food, physical activity and the amount of time spent being sedentary. A standard pre-defined template should be available to all GPs to complete such assessments in a systematic way. The fact that research has indicated that parents have a positive response to such assessments, if completed in a sensitive and supportive manner (Edmunds, 2005, Hughes et al., 2008; O'Shea et al., 2014) gives credence to this recommendation.

#### **6.2.3.3. Evidence based guidance and pathways for lifestyle advice and risk factor management.**

The findings in this study has indicated that most of the GPs were comfortable in providing advice to parents about healthy lifestyle behaviours, such as adherence to recommended dietary guidelines, increased participation in physical activity, and limiting sedentary behaviour. It is recommended that these should be integrated into routine practice and standard consultations for GPs working with children who are obese and their families in order to facilitate motivational conversations about lifestyle behaviour change. GPs however, need access to evidence based resources that will enable them to complete such tasks efficiently and effectively. It is recommended that these resources including templates for a structured diet and activity plan, and accompanying support leaflets for families are made



available to GPs. It is recommended that these are all easily accessible by being available for downloading on the practice electronic medical record system.

In addition, all GP Practices should be encouraged to be health promotion practices and increase the availability of family oriented educational resource materials that support healthy lifestyles, as well as information on other community resources and support services. There are significant resources available from local Public Health departments to promote healthy weight and exercise advice which should be distributed by practice staff and should be made available in the waiting room, on practice television screens and in practice newsletters.

Although the research in this study highlighted the ambivalence of GPs to specific training on childhood obesity it did indicate that GPs wanted more pathways and guidelines for working with children. Therefore, there is considerable scope to increase the knowledge of GPs, outside of formal training, by the systematic introduction of evidence-based guidelines which can be used within the consultation. It is recommended that new guidelines and pathways should be introduced through sources that are actively trusted by GPs, whether that is an expert paediatrician, practice based facilitators or respected opinion leaders. Dissemination could be achieved through discussions at the regular locality meetings and seminars which Clinical Commissioning Groups organise for practices.

#### **6.2.3.4. Information about local community services.**

Furthermore, GPs should also be encouraged to signpost obese children and families to local integrated healthy lifestyles websites which most Local Authorities have developed, where further information and details of local weight management and leisure activities can be accessed. For those parents who are ready to change, they should be encouraged to sign up to Change4Life (DoH, 2009) in order that they can access personalised family lifestyle advice and interventions. Given the fact that children who are obese face physical, psychological and social challenges, the scope and range of local facilities and services that parents could access is significant. However, as the findings in this study have shown it is unrealistic for GPs to have knowledge of all current locally available services for families. It is therefore recommended that there should be a single referral point, such as those that currently operate for integrated lifestyle services, which parents can ring or access via a website where they will be offered more individual support and given details of all the wider local community services that are available. It is recommended that GPs have such referral details on their practice electronic medical record system.

It is concerning that, at the time of this study, few of the GPs in this study had knowledge of the local family based community weight interventions for obese children (A2A), or the HENRY<sup>4</sup> (Rudolf et al., 2010) programmes which had been run at local Children Centres for two years. It is recommended that there should be on going extensive publicity of such programmes, through visiting practices, attending educational events that GPs may attend and producing information for locality meetings. It is also recommended that providers should work directly with those GPs who have referred children to these programmes, encouraging them assist in the dissemination of details of such schemes to their partners and other GPs and act as advocates of such schemes. Again referral to such services should be electronically available to all practices as part of their practice electronic medical record system.

#### **6.2.3.5. Evidence based guidance on the management of childhood obesity.**

Only a small number of GPs in this study indicated that they saw it as their role to be actively involved in the on-going management and treatment of children who are obese. For those GPs who were keen to offer such support, it is recommended that they follow proposals on the promotion of healthy lifestyle discussed in section 6.2.3.3, such as the promotion of improved nutrition and exercise habits and building self-esteem. Additional long term support should include motivational interviewing and setting goal-oriented targets with parents about specific behavioural and lifestyle changes. It is recommended that the GPs who feel confident to provide this role should have direct access to other professionals such as parenting advisers, behaviour-change experts, health or clinical psychologists, paediatric dieticians and physical activity specialists who can provide additional advice, information and support.

#### **6.2.3.6. The development of childhood obesity registers.**

GP practices should also be encouraged to record the assessment of weight status of all children through the use of BMI growth charts. The frequency of children attending general practice indicates that this is a feasible recommendation. A register of children, who are obese, would enable GP practices to target efforts to help families and also provide opportunities for further discussions when children and families attend the surgery.

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<sup>4</sup> Health, Exercise Nutrition for the Really Young programmes

#### **6.2.3.7. Evidence about successful weight management interventions.**

Many GPs were unclear about their personal efficacy in supporting children who are obese and their limited knowledge of effective outcomes in this area compounded this view. It is crucial that GPs are provided with successful case studies and evaluations of interventions which have worked. Equally when GPs refer children to services they should receive regular feedback on the child's progress as recommended in the NICE guidelines (2013) which GPs can then reinforce when they next see the child in the surgery.

#### **6.2.3.8. GP Training.**

Given the reluctance of the majority of the GPs to attend specific training on childhood obesity, it is recommended that training on childhood obesity is delivered within other areas of professional development which GPs may be more likely to attend, such as educational sessions on diabetes, cardiovascular health or paediatric care. It is recommended that all training is directly relevant to their role, and includes content that would stimulate and motivate the GPs, for example, by including real patient cases, and problem-based learning case scenarios. These could include topics such as raising the issue, evaluating weight status in children, focuses for behavioural assessments, parenting skills and maintaining follow up consultations with children who are obese. It is also important in such training, that GPs are encouraged to examine their own attitudes to obesity, and acknowledge the wider societal nature of the problem. Given the time commitments which GPs raised as barriers to access training; internet, webinars or podcasts learning on childhood obesity should be made available to GPs.

#### **6.2.3.9. Practice Nurse and other health care staff in the General Practice setting.**

The findings in this study have highlighted that whilst staff in General Practice have developed expertise in responding to adult obesity, the contribution of other members of the Practice team to addressing childhood obesity is very limited. It is recommended that GP Practices develop clear roles and responsibilities for team members. This could include providing training in child nutrition and motivational interviewing to Practice Nurses, to deliver individualised case management and behavioural counselling for children and their parents. If practices do not feel they have the resources for such investment, consideration could be given to sharing the position at the community level. Such a post could extend services to a greater number of families, integrate primary care and community-based

resources, and help distribute the cost of services across multiple practices and agencies. Group visits, where nurses engage in education and discussion with several individuals at one time, and families have an opportunity to interact with others who are facing similar challenges, could be a more efficient approach than having one central service which some families may not be able to access. In addition it is recommended that a designated GP obesity lead is identified in each practice for other partners to refer to. Support and training should be made available to these GPs who wish to extend their engagement with children and families.

#### **6.2.3.10. GPs' role in the wider community.**

Finally, whilst the research suggests that the GPs see themselves primarily as clinic-based practitioners; this was not the case for all. Outside of their clinical role and in the wider community, GPs should be encouraged to act as role models, educators, and promoters of healthy lifestyle practices and advocates of policy changes which address the wider obesogenic environment. It is recommended that all GPs have a role in challenging societal norms which discriminate and stigmatise children who are obese.

### **6.3. The likelihood of adopting the recommendations based on the GP typologies.**

There is a pragmatic recognition that, given the variations in responses demonstrated throughout this thesis, not all the recommendations detailed in the above section would be applicable or adopted by all the GPs. Table 6.1 attempts to summarise such likelihood in order to offer final insights.

	<b>Gatekeeper</b>	<b>Outside of Professional Domain</b>	<b>Informer and Educator</b>	<b>Helper and Facilitator</b>
<b>Tool to assess parental readiness to change (6.2.3.1)</b>	Possibly to assess suitability for onward referral.	No	Yes, but limited to readiness to accept information / advice.	Yes, especially if there is a motivational emphasis.
<b>Family health and lifestyle assessment tools (6.2.3.2)</b>	Possibly, particularly health assessment of co-morbidities.	No	Yes, but limited to readiness to accept information.	Yes, and could include wider family social/ economic circumstances.
<b>Evidence based guidance for lifestyle / risk factor advice (6.2.3.3)</b>	Possibly.	No	Yes, likely to be used when giving advice and information.	Yes.
<b>Information about local community services (6.2.3.4)</b>	Yes, for signposting	Possibly, would be limited use.	Yes	Yes, as part of a wider response of on-going support.
<b>Management Guidance (6.2.3.5)</b>	No	No	No	Yes
<b>Childhood Obesity Registers (6.2.3.6)</b>	Yes	No	Possibly, if resources available to the practice to support this.	Yes
<b>Evidence successful interventions (6.2.3.7)</b>	Yes	Possibly	Yes	Yes

	<b>Gatekeeper</b>	<b>Outside of Professional Domain</b>	<b>Informer and Educator</b>	<b>Helper and Facilitator</b>
<b>GP Training (6.2.3.8)</b>	Unlikely, but possible within wider training environment	No	Possibly, within wider training environment	Yes, especially advanced motivational behaviour change / positive parenting etc.
<b>Practice Nurse/ other staff (6.2.3.9a)</b>	No	No	Possibly, but would need additional resources	Yes
<b>Named GP (6.2.3.9b)</b>	Possibly	Yes, but more likely if resourced outside of practice.	Yes	No, see childhood obesity as every GP business - but may be interested in a wider role across multitude of practices
<b>Role in the wider community (6.2.3.10)</b>	Possibly, if focus was on health expert	No	Possibly some limited educational role	Yes, strong advocate role

*Table 6.1.* Likelihood of GP types adopting the recommendations

#### **6.4. Recommendations for future research.**

Chapter Two of this thesis has confirmed that there is currently no research that has evaluated the efficacy of GP interventions in the identification and management of childhood obesity in the primary care setting. The lack of progress in this important area of service delivery is a significant concern, and necessitates further attention and resources to be deployed if the ambition of enhancing the involvement of GPs in the identification and management of childhood obesity is to be secured.

Chapter Three has also indicated that there would be considerable merit in exploring the experiences of other sub groups of GPs such as trainee, newly qualified, or younger GPs to assess the impact of age and experience in this complex area of clinical practice. In addition further research on salaried and locum GPs would provide a valuable perspective, as would research in other geographic areas of the country.

Chapter Five has presented a new framework for exploring variability in individual GP responses by considering four different role types. It is recommended that further research should be carried out to both assess the applicability of these role types with other groups of GPs and evaluate the recommendations and the assumptions, presented in Table 6.1 about the likelihood of adoption.

Finally it is recommended that there is an on-going commitment to an exploration of parents and children's views of the identification and management of childhood obesity in a primary care consultation. The use of IPA (Smith et al., 2009) would equally be valuable in contributing to a richer exploration of these experiences and provide a further powerful contribution to the identification of service improvements.

## **6.5. Final Conclusion.**

Hudson and Viner in a recent BMJ editorial, (2012), state that

*“Childhood obesity, perhaps like climate change, is at times in danger of inciting an ennui borne out of a repetition of problems without answers, a long latency before problems become apparent, and a perception that solutions are out of reach”* (2012 p.2).

Whilst there are some early signs that the prevalence of childhood obesity is now stabilising, the figures still represent a considerable challenge. It is hoped that the findings, discussions and recommendations of this thesis will assist GPs, commissioners and policy makers in supporting GPs to continue to take a role in the identification and management of childhood obesity and thus improving the health and well-being of children who are obese.



<b>APPENDIX ONE. Synthesis Table of evaluation of childhood policy interventions, 2003-13 (adapted from Jebb et al., 2013)</b>			
Name	Year	Summary	Evaluation <sup>5</sup>
Travel to School Initiative (TTSI)	2003	A joint initiative between Dept. for Transport and Dept. of Children to tackle car dependency by supporting all schools to develop a School Travel Plan (STP) with additional funding for supportive measures such as cycle storage facilities, parent waiting shelters, traffic calming measures, cycle training initiatives and safety equipment, including high-visibility jackets and helmets. By March 2009, 81% of schools in England had a STP in place.	A report commissioned in 2010 found that STPs had only been modestly effective in reducing parental concerns about road safety issues. Data from the School Census show a small but significant decrease in car use, but no significant difference in the change observed in the proportion of pupils walking or cycling at STP and non-STP schools.
Healthy Child Programme	2004	The Healthy Child Programme provides families with a programme of screening, immunization, health and development reviews, supplemented by advice around health, well-being and authoritative parenting from 0 to 19 years. Specific goals is a commitment to healthy eating and increased activity, leading to a reduction in obesity and early recognition of growth disorders and risk factors for obesity as well as increased rates of initiation and continuation of breastfeeding. This was supported by a specific framework document for tackling obesity	None
School Fruit and Vegetable Scheme.	2004	Following pilot schemes in 2000/2001, the national roll-out entitles every child 4–6 years in state-maintained schools to receive a free piece of fruit or vegetable every school day. By November 2004, it included nearly 2 million children in 16,000 schools	The pilot schemes showed that 99% of staff regarded the scheme as a way of improving children's diets. The scheme promoted an increase in fruit intake after 3 months. At 7 months, the effect remained significant but reduced. Returned to baseline in year 2 when pupils were no longer part of the scheme.

<sup>5</sup> Evaluation report references in Jebb, S. A., Aveyard, P. N., & Hawkes, C. (2013). The evolution of policy and actions to tackle obesity in England. *Obesity Reviews*, 14(S2), 42-59.

Changing the Food Environment Television Advertising Restrictions	2007	A package of measures to restrict the scheduling of television advertising of food and drink products that are assessed as high in fat, salt or sugar (HFSS) as defined by the FSA's nutrient profiling scheme. As a result, advertisements for high in fat, salt or sugar (HFSS) products must not be shown in or around programmes specifically made for children (which includes pre-school children) or shown in or around programmes of particular appeal to children under 16 and these restrictions will apply equally to programme sponsorship by HFSS food and drink products. Key elements of the content rules include a prohibition on the use of licensed characters, celebrities, promotional offers and health claims in advertisements for HFSS products targeted at pre-school or primary school children.	Compared with 2005, in 2009 younger children (4- to 9-year-olds) saw 52% less and older children (10- to 15-year-olds) saw 22% less (1.4 bn impacts) of television adverts for HFSS foods. An evaluation using a repeat cross-sectional design 6 months before and 6 months after the legislation found that while adherence to the restrictions is good, limitations in the scope of legislation mean there was no reduction in children's exposure to HFSS foods and exposure of all viewers to HFSS foods increased.
Schools Nutritional Standards and Requirements for School Food	2007	Minimum nutrition standards initially based on food groups but later refined to include nutrient standards and applicable to schools maintained by a local education authority. In recent years, a growing number of schools have opted out of local authority control and a new review of School Food has been commissioned.	A number of studies have noted measurable improvements in the nutritional quality of food provided at school and there is evidence of improvements in nutritional quality of food consumed in primary and secondary schools, although there are still areas that need further improvement where intakes are not meeting nutritional standards. The impact on overall dietary intake is unknown.
Bikeability – on road cycle training	2007	A scheme designed to equip children with the skills and confidence for on-road cycling, leading to a National Standard for cycle training. Level 1 teaches trainees basic bicycle control skills in an off-road environment; level 2 is delivered on road, where trainees learn the basics of on-road cycling; and level 3 teaches trainees advanced on road cycling skills.	By 2012, almost 500,000 young people had received training, but no increase in the proportion of trips made by bicycle (<2%), An analysis in Hertfordshire secondary schools shows an increase in cycling in schools where Bikeability training is provided, compared with a decrease in schools with no training scheme operating.

Family Nurse Partnership	2007	An intensive, structured, home visiting programme, offered to first-time parents under the age of 20 years. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive relationship with the family.	By 2012, 600 places were available, with a commitment to increase to 13.000 by 2015. Mothers who receive support from family nurses show positive results, including: stopping smoking during pregnancy, high levels of breastfeeding, improved self-esteem, being much more likely to return to education or employment when their children are old enough.
National Helpline for Breastfeeding Mothers	2008	The Department of Health provides funding for The Breastfeeding Network to run the National Breastfeeding Helpline, working jointly with the Association of Breastfeeding Mothers.	Year to March 2012, 35,915 calls received with an average call time of 17 min
Physical Activity Children's Play Strategy	2008	In 2008, the Labour government launched a play strategy, to improve children's play opportunities through a dedicated play programme, this included a commitment to new community playgrounds, support for local authorities implementing 20 mph zones around places and spaces where children play, and higher level training for Play Workers.	None
Social marketing Change4Life	2009	A social marketing campaign based around the strapline 'Eat Well, Move More, Live Longer' to support individuals and families in making healthier decisions about food and activity. Established with a specific focus on families with children under 11 years to foster healthy behaviours intended to reduce the risk of obesity, it has since broadened to include adults whose current behaviours put them at imminent risk of developing long-term conditions. The Change4Life brand is now a vehicle for other health messages, including reduction in salt and alcohol.	In first year, 87% mothers of children under 11 years had seen the advertising campaign. The Change4Life brand has sustained strong awareness at over 85% among mothers and around 70% among adults. Over 1 million families registered on the Change4Life database. Over 40% of mothers and 30% of adults agreed that 'As a result of Change4Life I have made changes to make my life more healthy'.
Start 4 Life	2010	Start4Life was launched in February 2010 as a sub-brand to	Post-campaign tracking in July 2012 showed

		<p>Change4Life specifically devoted to pregnancy and early years. It was originally based on messages around breastfeeding, starting solid food and physical activity for infants. Most recently, Start4Life main campaign activity ran from May to early July 2012 and the focus was on maternal health, encouraging expectant mothers to adopt healthy behaviours during their pregnancies. The activity aimed to increase awareness of Start4Life among the target audiences and increase awareness of the importance of good maternal health relating to: a. Healthy eating b. Alcohol consumption c. Quitting smoking d. Physical activity e. Supplements</p> <p>Start4Life has now been expanded to campaign on maternal health and children up to the age of 5.</p>	<p>that a third (31%) of pregnant women recognized the Start4Life logo. A total of 68% of those aware of the advertising agreed the advertising made them realize how important being healthy in pregnancy was to the development of their babies. Overall, 64% claimed to have done something as a result of the campaign activity. The leaflet pickup rate (91%) was higher than the average pickup percentage (72%) across 34 other leaflet campaigns in the same period.</p>
Change4Life School Sports Clubs	2012	<p>Extracurricular sports club, designed to increase physical activity levels in less active children in primary and secondary schools, funded by the Department of Health and managed by the Youth Sport Trust</p>	<p>In 2010/2011, 61,000 young people participated in Change4Life School Sport Clubs in 2010/2011. A total of 90% of participants were choosing to play sport every week, an increase of 166% and those positive about sport increased by 89%.</p>
Olympic Legacy	2012	<p>A range of initiatives including Change4Life. Play schemes, School Games, the School Sport Funding and others, supported by government and partners in the private and voluntary sectors to fulfil the commitment to ‘harnessing the United Kingdom’s passion for sport to increase school-based and grass roots participation in competitive sport – and to encourage the whole population to be more physically active’.</p>	<p>An interim evaluation report on the impact of the games prior to the event itself showed that adult participation in sport and physical activity in England was increasing. Active sport participation in the last 4 weeks increased from 53.7% in 2005/2006 to 55.2% in 2011/2012, 1 × 30 min sessions of moderate intensity sport in the last week increased from 41.2% in 2005/2006 to 43.8% in 2011/2012 and 3 × 30 min sessions</p>

			of moderate intensity sport in the last week increased from 23.2% in 2005/2006 to 25.9% in 2011/2012.
School Sport Funding	2013	A new School Sport Funding worth £150 million per annum for the next 2 years (funded by the Department for Education [£80 million], the Department of Health [£60 million] and the Department for Culture, Media and Sport [£10 million]) provide funding directly to primary school head teachers for them to spend on improving the quality of sport and PE.	No evaluation yet

<b>APPENDIX TWO. Synthesis Table of UK qualitative studies of primary care and childhood obesity</b>			
<b>Authors, dates and title</b>	<b>Research approach.</b>	<b>Sample, data collection and data analysis.</b>	<b>Key Findings.</b>
<b>Walker et al., 2007</b>  A qualitative study of primary care clinicians' views of treating childhood obesity	Framework Analysis	<p>Opportunistic sampling from one PCT. Contacted 39 practices in Rotherham. 18 practitioners from 11 practices responded. These included 12 GPs (11 male and 1 female) and 6 (all female) practice nurses.</p> <p>The majority of the participants were aged 40–49 years.</p> <p>The practices varied in terms of their size, and the socioeconomic status of the registered patient population.</p> <p>Interviews were face to face and semi -structured.</p>	<p>GPs and practice nurses felt their role was primarily to raise the issue of a child's weight providing basic diet and exercise advice. Childhood obesity was a social and family problem. Barriers to intervention; time constraint, lack of training and lack of resources. lack of evidence for effective interventions, and sceptical that providing diet and exercise advice would have any impact upon a child's weight. Pessimism that dietary advice would be unsuccessful. Concern that the clinician-patient relationship could be adversely affected by discussing a sensitive topic. Fatalistic perception amongst health care professionals and parents that "nothing works".</p> <p>Concluded that Clinicians may find it difficult to make a significant impact on childhood obesity given the sensitivity of the issue, and poor evidence base for effective management.</p>
<b>Turner et al. 2009</b>  Practitioners' views on managing childhood obesity in primary care: a qualitative study	Framework Analysis	<p>Participants recruited from five purposefully sampled practices in Bristol. Thirty practitioners were interviewed: 12 GPs, 10 practice nurses, 4 school nurses, and 4 health visitors.</p> <p>Mainly women volunteered who may have had a wider interest in the topic. Interviews were face to face and semi structured.</p>	<p>Differences in their views about primary care as an appropriate treatment setting for childhood obesity. Causes of childhood obesity perceived on an individual level - unhealthy diet and lack of physical activity. Limited contact with obese children. Barriers to effective intervention; lack of expertise, resources, effective treatments, and referral options. Recognised need to work with parents but complexity of parental defensiveness or denial. Few participants had knowledge of the recent NICE guidance. primary care can only play a limited role in addressing the current obesity epidemic.</p>

Authors, dates and title	Research approach.	Sample, data collection and data analysis.	Key Findings.
<p><b>Redsell et al., 2011</b></p> <p>Preventing childhood obesity during infancy in UK primary care: a mixed-methods study of HCPs' knowledge, beliefs and practice</p>	<p>Mixed methods.</p> <p>1. Postal Survey</p> <p>Participants rated their confidence in relation to infant feeding advice and completed the Obesity Risk Knowledge Scale (ORK-10)</p> <p>2. Qualitative interviews using an Interpretivist analysis focusing on discourse and thematic analysis.</p>	<p>Recruited from two counties in the East Midlands region. Five sites were selected with different rates of childhood obesity in the practice population. Different study sites e.g. rural/urban, deprived/affluent areas included in the qualitative study.</p> <p>The sampling strategy was purposive to include HCPs from all groups involved in service delivery for infants, (GPs, practice nurses, health visitors, nursery, community and children's nurses).</p> <p>Survey; 118 postal survey returned (response rate of 34%)</p> <p>Telephone interviews were conducted with 12 GPs, 6 male, and 6 female and 6 practice nurses (all female.)</p>	<p>GPs were less confident about giving advice about infant feeding than health visitors and nursery nurses but more knowledgeable about the health risks of obesity than nurses</p> <p>Health care professionals (HCP) who were consulted more often about feeding were less knowledgeable about the risks associated with obesity. There was no relationship between HCPs' ratings of confidence in their advice and their knowledge of the obesity risk.</p> <p>Main themes emerged from the interviews.</p> <p>1) Attribution of childhood obesity to family environment,</p> <p>2) Infant feeding advice as the health visitor's role,</p> <p>3) Professional reliance on anecdotal or experiential knowledge about infant feeding,</p> <p>4) Difficulties with recognition of, or lack of concern for, infants "at risk" of becoming obese,</p> <p>5) Prioritising relationship with parent over best practice in infant feeding and</p> <p>6) Lack of shared understanding for dealing with early years' obesity.</p> <p>Further research is needed to determine optimal ways of intervening with infants at risk of obesity in primary care.</p>

**APPENDIX THREE. Synthesis Table of UK studies of IPA and General Practice**

<b>Authors, dates and title</b>	<b>Research approach. Recruitment strategy and sample size.</b>	<b>Data collection and data analysis.</b>	<b>Key Findings.</b>
<p><b>Epstein and Ogden (2005)</b></p> <p>A qualitative study of GPs' views of treating obesity in adult patients.</p>	<p>All 130 GPs on one inner London PCT list (excluding registrars and locums) invited to participate in the study. Thirty-five GPs responded.</p> <p>Twenty-one GPs from 15 different practices subsequently selected to create a heterogeneous sample varying in terms of size of practice, ethnicity, age and sex. 10 were male and 11 female.</p> <p>Age ranges 30–60 years, 15 participants were white, 5 were Asian and one was black African.</p>	<p>Semi-structured interviews with the 21 GPs and analysis followed IPA methodology</p> <p>The researchers were a GP and a Health Psychologist.</p>	<p>GPs believed that obesity was the responsibility of the patient, rather than a medical problem. Believed that obese patients wanted to hand responsibility over to their doctor. This contradiction created conflict for the GPs, which was exacerbated by a sense that existing treatment options were ineffective.</p> <p>This conflict was perceived as potentially detrimental to the doctor–patient relationship.</p> <p>Range of strategies used by GPs to maintain a good relationship; offering anti-obesity drugs, in which they had little faith, as a means of meeting patients' expectations; listening to the patients' problems, despite not having a solution to them; and offering an understanding of the problems associated with being overweight.</p>
<p><b>Nelson and Ogden (2008)</b></p> <p>An exploration of food intolerance in</p>	<p>Two separate recruitment strategies. Letters of invitation sent to all the GPs in the practices who were hosting the intervention branch of the wider study on food intolerance. 2 participants</p>	<p>Semi-structured interviews were carried out with 17 GPs</p> <p>Researchers were a Health Promotion Specialist and a Health Psychologist.</p>	<p>Three super - ordinate themes identified. 1. A spectrum of clinical importance was presented based on the certainty that the GP would have in making a diagnosis, the authenticity of</p>



the primary care setting: The GPs experience.	<p>recruited. 18 declined. The second recruitment strategy was snowballing. Four different initial contacts were used to gain an introduction to other GPs and practices. These were contacted by phone and e-mail and 15 of the 20 GPs approached agreed to an interview.</p> <p>17 GPs, 2 women and 15 men, interviewed. All working as GPs within NHS general practices. Qualified between 1973 and 2000 and all undertook their medical training in the UK. 8 participants held substantive academic roles. Practices' sizes ranged from 2600 to 15,000 patients, with 2 to 15 GPs working in the practices.</p>		<p>the patients' experience, and the threat posed to physical health.</p> <p>2. Perceptions of a proxy, with an assumption that food intolerance was a proxy for other non-medical problems.</p> <p>3. Mutual acceptable ground where by GPs chose, despite their scepticism, to negotiate mutually acceptable ground with patients and with patients' beliefs.</p> <p>The GPs acknowledged both personal and therapeutic benefit in working with the patients' belief in food intolerance and with behaviours associated with the beliefs.</p>
<p><b>Fox et al., (2009)</b></p> <p>Experiencing "The Other Side": A study of empathy and empowerment in GPs who have been patients.</p>	<p>Maximum-variation sampling strategy included GPs at any stage in their career, with a range of health problems. All GPs in 2 PCTs emailed inviting any who had experienced a significant illness to take part in an interview.</p> <p>17 participants; 10 male, 7 women. Aged 31 to 69 years. One GP was Asian British, and the remainder were all White British.</p> <p>All participants were qualified GPs, with experience of working either as locums, assistants, or practice partners.</p>	<p>Semi-structured interviews analysed using IPA. Interviewer was an experienced qualitative researcher from a non - medical background.</p> <p>NVivo computer software used to store and manage the data.</p> <p>Extended research team reached consensus about the organisation of the categories.</p>	<p>Three super-ordinate themes identified.</p> <p>1. Experiencing patient hood and sharing experiences, in which the GPs felt that their own illness offered them unique insight into the experiences of their patients.</p> <p>2. Developing empathy in which the GPs' subjective experiences of illness activated more empathic responses to their patients who had similar illnesses or conditions.</p> <p>3. Practicing empowerment which encompasses a range of experiences</p>

			including power imbalances, vulnerability, and changes in referral practices.
<p><b>Taubert and Nelson (2010)</b></p> <p>Out-of-hours GPs and palliative care -a qualitative study exploring information exchange and communication issues.</p>	<p>60 doctors who had worked in the out-of-hours setting for at least one year employed by out-of hour's service in Cardiff contacted.</p> <p>Nine participants' responded; 5 female and 4 male doctors. Ages ranged from 28 to 58 years of age.</p>	<p>Face-to-face semi-structured interviews.</p> <p>Research interview completed by a doctor and IPA methodology followed.</p> <p>Themes also analysed with a non-clinical researcher.</p>	<p>A predominant theme expressed by GPs related to constraints within the system provided by out-of-hours provider. A strong feeling of 'being alone out there' emerged, with some GPs more willing to call for help than others, and others expressing their concern at access to pharmacies and medication being very inconsistent. GPs felt left alone on occasion, unable to access daytime services and not knowing who to call for advice. Information hand-over systems from in-hours to out-of-hours with regard to palliative care were felt to being adequate.</p>

Academic Audit and Governance Committee

Research Ethics Panel  
(REP)



To Donna Sager  
cc: Orla Flannery, Lindsay Dugdill, Prof Tony Warne  
From Tim Clements, Contracts Administrator  
Date 25<sup>th</sup> November 2010

MEMORANDUM

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**Subject:** Approval of your Project by REP

**Project Title:** Exploring General Practitioners' (GPs) views and professional approaches in the identification and management of childhood obesity.

**RGEC Reference:** REP10/155

Following your responses to the Panel's queries, based on the information you provided, I can confirm that they have no objections on ethical grounds to your project titled project titled, "Exploring General Practitioners' (GPs) views and professional approaches in the identification and management of childhood obesity".

If there are any changes to the project and/or its methodology, please inform the Panel as soon as possible.

Regards,

Tim Clements  
Contracts Administrator  
TC/JH

For enquiries please contact  
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## Children & Young People's Directorate

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Ask for: Donna Sager

Our Ref:

Dear Dr

### **Study Title: GPs and Childhood Obesity**

Thank you for discussing the above research study with me today on the telephone. I informed you that I would be sending further information so that you could consider whether you are able to participate in the research.

This note will provide you with information about why the research is being done and what it will involve for you. Please take time to read the following information carefully and decide whether or not to take part. If anything you read is not clear or you would like more information please do not hesitate to contact me. My contact details are below.

The aim of my study is to identify GPs' views about the identification and management of childhood obesity, and in particular whether primary care is a good setting for such interventions. As you will be aware childhood obesity can cause significant health problems and there are a range of different views about what support GPs can offer, and the challenges and opportunities of delivering such services in primary care. I am also interested in your view as to how such services should be developed in the future. It is important that GPs have the benefit of giving their views on this important topic and to ensure that any new services that are developed locally are based on those needs and issues identified by general practice. The research will help to explore and identify the complexities of this area of work.

I have discussed this research with Dr Phil Allan, Medical Director Stockport PCT and he has accepted my research proposal.

If you kindly agree to participate in the research I will only need to interview you once and envisage that the interviews will take no longer than 30 minutes. I am very happy to come and interview you in the surgery at a time that is convenient to you. Alternatively if it suits you I can conduct the interview over the telephone at a pre- arranged time. I do not require you to submit or prepare

any information in advance. In order to capture the valuable information you will be providing I intend to audio-tape the interviews but only with your consent.

Participation in the research is entirely voluntary. Prior to the interview I will discuss again the content of this information sheet. I will ask you to sign a consent form to confirm you agreed to take part. You are free to withdraw at any time, without giving a reason. Any data you have provided will not be included in the final report and will be subsequently destroyed.

I would assure you that the confidentiality of your responses will be safeguarded during and after the study. The procedures I will adopt for the handling, processing, storage and destruction of data are consistent with the Caldecott principles and/or Data Protection Act 1998. The data you provide through the interviews will be anonymous and given a research code, known only to myself.

A master list identifying participants to the research codes data will be held on a password protected computer which only I will have access to. Any hard paper copies /taped data will be stored in a fireproof, locked cabinet, within locked office, which only I will have access to. Similarly all electronic data will be stored on my password protected computer. The data will be retained for a minimum of 3 years and then disposed securely. Some of the data may be used for future studies but if this is the case the above principles will be followed. If for any reason you decide to withdraw from the study all the information and data collected from you, to date, will be destroyed and your name removed from all the study files. The results of the study will be presented in my thesis with the expectation that they will be published at a later date. I will provide a summary of the findings and recommendations for each Practice, Stockport PCT and Stockport MCC. May I confirm that the final report / published work will not identify you or your responses in any way.

As the research is part of my Doctorate there is no organisation sponsoring or funding the research. However if at any stage you have a concern about any aspect of this study, please do speak with me direct. If you remain unhappy and wish to complain formally you can do this by contacting Dr Phillip Allan Medical Director Stockport PCT or the University Complaints Procedure, I am being supervised by Professor L Dugdill at Salford University. If you remain interested in participating in the research I would be most grateful if you could contact me on 07891 949407. I do look forward to meeting with you and thank you for your consideration of this request.

Kind regards

Yours sincerely

**Donna Sager**  
**Service Director, Children & Young People**

**APPENDIX SIX. Participant consent sheet.**

**Title of Project:** GPs' management and support of childhood obesity

**RGEC Ref No:**

**Name of Researcher:** Donna Sager - [donna.sager@stockport.gov.uk](mailto:donna.sager@stockport.gov.uk)

- I confirm that I have read and understood the information sheet for the above study and what my contribution will be.

Yes	No
-----	----

- I have been given the opportunity to ask questions (face to face, via telephone and e-mail)

Yes	No
-----	----

- I agree to take part in the interview

Yes	No
-----	----

- I agree to the interview being tape recorded

Yes	No
-----	----

- I understand that my participation is voluntary and that I can Withdraw from the research at any time without giving any reason

Yes	No
-----	----

- I agree to take part in the above study

Yes	No
-----	----

**Name of participant** .....

**Signature** .....

**Date** .....

## APPENDIX SEVEN. Interview schedule.

Can I start with some general questions re childhood obesity? There has been a lot in the news about the rise of childhood obesity.

- Why do you think we are seeing an increase in childhood obesity?
- What do you think are the causes of this?
- How do you think childhood obesity affects the child and the family?

Moving on to General Practice - let's start with identification

- In a routine consultation – if a child is brought to you for any reason but you think the child is obese – would you raise the matter with the child or the parents
- Can you think about what might affect your decision
- Are there any times when you don't raise the topic of a child's weight
- Would your response be any different if the child's weight was impacting on their presenting condition?
- In your experience how do the parents and the child react when you raise the matter
- When was the last time you saw a child who was obese - how many children who are obese do you have on your list
- How do you generally feel about raising child's weight

Can I ask you to try and think of a child who was obese who you may have seen recently?

- What was the trigger to make you decide to raise the child's weight
- If you didn't raise the issue – what stopped you doing this
- How confident did you feel in raising the matter?
- Did you feel that you had the right skills or training to do this
- How did it go?
- What things did you discuss?
- What happened next?

Moving to support.

- How about if a parent brought their child in and asked for your support in managing their child's weight – what would you do – what support could you offer?
- Can you remember any cases where this has happened – what did you do?
- How motivated and confident did you feel in this?
- Did you feel you had the necessary skills training knowledge to do this?
- How did it go?
- How often would you say this happens – why do you think this is the case?
- What about other staff or services supported you?
- What kind of support do you think is needed for the families and children who are obese?
- In your experience what do the child and parents usually want – why do you think this is the case?
- Thinking about the issues that we have discussed any further thoughts on your experiences.



<b>APPENDIX EIGHT. Participant demographics and childhood obesity prevalence rates.</b>	
GP No.1	Female. Qualified 1985. Senior Partner, 5 partner practice (8,844 patients) in non-deprived area <sup>6</sup> . Number of children estimated to be obese or overweight <sup>7</sup> in the practice, Reception Age: 68 (18%) Year 6: 85 (27%).
GP No. 2	Female. Qualified 1984. Senior Partner, 2 partner practice (3,530 patients) in a deprived area. Number of children estimated to be overweight or obese in the practice, Reception Age: 51 (25.9%) Year 6: 60 (36%)
GP No. 3	Male. Qualified 1980. Senior partner in an 8 Partner Practice (11,687) in a semi-deprived area. Number of children estimated to be overweight or obese in the practice Reception Age: 59 (21%) Year 6: 85 (31%)
GP No. 4	Male. Qualified 1982. Senior Partner in 6 partner practice (9,360 patients) in a non-deprived area. Number of children estimated to be overweight or obese in the practice. Reception Age: 66 (15%) Year 6: 91 (29%)
GP No. 5	Male. Qualified 1979. Single handed GP (2,150 patients) in a semi- deprived area. Number of children estimated to be overweight or obese in the practice. Reception Age: 26 (20%) Year 6: 33 (27%)
GP No. 6	Female. Qualified 1981. Senior Partner in 2 partner practice (4,456 patients) in a deprived area. Number of children estimated to be overweight or obese in the practice. Reception Age: 12 (21%) Year 6: 20 (31%)
GP No.7	Male. Qualified 1984. Senior Partner in a 4 partner practice, (8,724 patients) in a non-deprived area. Number of children estimated to be overweight or obese. Reception Age: 43 (18%) Year 6: 64 (29%)
GP No. 8	Male. Qualified 1985. Senior Partner and one salaried GP (3,734 patients), non-deprived area. Number of children estimated to be overweight or obese in the practice. Reception: 17 (15%) Year 6: 28 (27%)
GP No. 9	Male. Qualified 1982. Senior Partner in 7 partner practice (10,431) in a semi-deprived area. Number of children estimated to be overweight or obese in the practice Reception: 81 (18%) Year 6: 106 (27%)
GP No.10	Female. Qualified 1984. Senior Partner in 2 partner practice (3,876 patients) in a deprived area. Number of children estimated to be overweight or obese in the practice. Reception Year: 8 (16%) Year 6: 19 (38%)

<sup>6</sup> Deprivation data based on IMD (2007) patient population.

<sup>7</sup> Childhood Obesity Prevalence data estimates based on pupil's NHS Number at NCMP (2012/13) matched with the GP code held in Child Health record.

<b>APPENDIX NINE. Initial analysis, annotated transcript (GP No. 7).</b>		
<b>Emergent Themes</b>	<b>Original Transcript</b>	<b>Exploratory Comments</b>
Causes – Physical activity, diet , parenting, socio economic	<p><b>I: What do you think are the causes of childhood obesity</b></p> <p><b>GP No. 7:</b> Really multifactorial – really <u>eating too much</u> and <u>not exercising</u> is the simplest way of looking at it – but it’s obviously <b>more complex</b> than that ranging from family background, <u>influence of parents</u>, <u>influence of where you live</u>, <u>influence of social factors</u>, poverty, affluence all of those outside factors as well – that it in a nut shell but there are others well</p>	Moved from simple to complex – recognising the external societal influences
Obese Family  Ridicule v Normalisation	<p><b>I: How do you think it impacts on the family</b></p> <p><b>GP No. 7:</b> Comes in two directions – one is if the <u>whole family is obese</u>, which is not uncommon then I guess, there is almost a group effect, the whole families behaviour goes into line with each other, and the children may see it is nothing unusual or different because that is part of their whole family, that’s their life</p> <p>but on the other side of things the whole family might be being <u>pointed at and ridiculed and laughed</u> at because they are all huge people so it can affect them in different ways</p> <p>If we raise the diagnosis of obesity it <u>can affect the family in different ways</u> ... they can either say, yes, we realise this although we have no idea how to approach this – you know can you help us ..... or they can say it as well .. We don’t see this as an issue we are <u>big people</u>..</p> <p><u>Some people go into denial</u> some people go into a <u>yes thank you</u> very much for raising it - now how we deal with it and -anywhere in between the two</p>	<p>Obesity being the norm in some families which inhibits the desire to do anything about it – normalising effect – through to the family impact on emotional well being and confidence</p> <p>Concern about the impact on child and family</p> <p>Initial Binary response – acceptance and motivation to do something – or denial and reluctance to engage – the continuum of responses</p> <p>Non clinical language : big – huge</p>
Identification	<p><b>I: Do you think Primary care is the right place to identify Childhood Obesity</b></p> <p><b>GP No. 7:</b> That’s a really difficult one – <u>part of me says yes of course</u> – you know we are in the</p>	Identification of risk factors

Opportunistic	<p>business of <b>identifying risk factors for disease and for conditions</b> – so yes part of me feels that <b>we have a duty to</b> raise these issues with the families - particularly when you have a young person coming in with a parent and the child is clearly very obese ..</p> <p>Part of me also has a <b>slight reluctance</b> because there are all sorts of ... you know .. <u>What we do with it if</u> I raise it .. or are we <u>empowered</u> to actually do anything about it if we do raise it ...</p> <p>but yes the sort of the <b>purist</b> in me would say <u>yes we should have a role in actually managing</u> ... identifying and managing childhood obesity but it is very <b>difficult</b> from a primary care perspective.</p>	<p>is core GP business - Issue here of raising something but not wanting / knowing how to deal with the answer that follows.</p> <p>Following complexity outlined above .. recognised difficulties</p> <p>Individual Conflict for the GPs</p> <p>Terms of duty and reluctance</p>
<p>Competing Priorities</p> <p>Time</p> <p>Presentation of obese child</p>	<p><b>I: So what are the factors or the circumstances that would lead you to either identifying or raising a child's weight</b></p> <p><b>GP No. 7:</b> <u>Do you want the honest answer..</u></p> <p>Whether we have enough time – what the other pressing priorities are, how significant it looks, how severe it looks ..</p> <p>Competing priorities is the <u>bottom line here</u> . When you are in the middle of a surgery, and you know, you are running late, and you have the ear infection in front of you – then dealing with the <b>thorny and very sensitive</b> subject of weight in that consultation is very difficult - particularly if they didn't present with it and you're trying to <u>move from the reason why they came into a health promotion role</u> and a <b>very sensitive</b> one as well , on the back of that consultation ...so it is very hard..</p> <p>It is much actually easier if they come in and they actually say my son is desperately overweight what can we do about it .. <u>To actually piggy back it in a 'by the way whilst you're here' .. Is actually quite a skill and</u> it is quite difficult</p>	<p>Willingness to be up from even though knows this may impact on his professional esteem</p> <p>Language – reality back to duty</p> <p>Severe = sensitive – all additional challenges</p> <p>Prioritising – competing demands</p> <p>Metaphor: thorny</p> <p>Shifting the consultation from dealing with the immediate to a health promoting activity – requires skills and motivation esp hard given the sensitive nature</p>

		Recognise skill
Approach is age specific	<p><b>I: is the age of the child a factor</b></p> <p><b>GP No. 7:</b> I think the age impacts on how you approach it .. Where it moves from a <b>triadic consultation</b> where you are really addressing the parent ... to when you start moving through ..you know into the early teenage age and <u>the late teenage years then the consultation shifts ... so once they are at an age when they are able to <u>comprehend and be empowered to do something about it themselves you're tack will change</u>...</u> clearly if you have a consultation with a 5 year old clearly you can't start lecturing <u>the child</u> or addressing it with the child, you have <u>to start addressing it with the parents</u> as they get older and as they are more able to be involved in the decisions about how to deal with it themselves the conversation moves round</p>	<p>Challenges within the consultation – adapting the message</p> <p>Responding to individual needs</p>
Prevalence of obese children	<p><b>I: How many obese children do you think you have in your practice?</b></p> <p><b>GP No. 7: I dread to think ...</b> I can picture in my head in terms of the obese children who come in.... yes but the actual numbers are much higher than you would think.. I would imagine .....I dunno.. 14 -15% of our children are probably overweight and obese</p>	<p>Emotional response: dread to think. ? – is this because fears that his practice is underperforming</p> <p>Visual image of patients - clear knowledge of local families Recognition that the scale of the problem potentially is huge</p>
Diagnosis  H&W	<p><b>How do you make the diagnosis about the child's weight</b></p> <p><b>GP No. 7:</b> Now that's a good question ...<b>Its terribly unscientific</b> ... we can, you know, do BMI ... obviously check their weight and heights but we don't do it very often unless it clearly very obvious.</p> <p><b>I: Why not:</b></p> <p>Again it gets back to <u>competing things that</u> we have to do..... I suppose I know enough by</p>	<p>Continues to focus on the scientific response as being the key one</p> <p>Confident with history taking – defining and diagnosing the problem as with any clinical presentation -</p>

	looking at the child whether weight is an issue.. don't forget I have known these since children since they were babies.. and I know what the family looks like .. sometimes it's just a quick calculation of what I see and what I know and what other things I have to get through that day	acknowledges that it can be context specific
Support and management	<p><b>I: What kind of support would you offer the child</b></p> <p>Support to the child .. ur .. probably more support I <u>could offer just to the family</u> .. because that where it comes from doesn't it ..</p> <p><b>I: what would you do normally</b></p> <p><b>GP No. 7:</b> what do I do at present ... it's <u>the history bit isn't it</u>... its <u>finding out</u> what's behind it ... why the child has got to the weight they have so a lot .. the vast majority of it ... is just <u>exploring</u> quite how they have got to where they are .. Is it because they are <b>a couch potatoes on the settee all day long</b>... is it the family eating habits that they all have <b>4 takeaway meal a week</b>.. and <b>none of them take any exercise</b> ... so what is it in <u>the story</u> that really gives me the clues as to where you take it from there</p> <p>But in terms of where I take it from there it's about the <b>degree that I see in front of me</b>, <u>most people don't want a 4 hour lecture on how to manage obesity plus referral to 12 agencies</u> they just want to know some <b>basics</b> on you know the sort of eat less exercise more type of things.. and a few tips on calorie dense foods and ...and what is healthy eating so I tend to go for the <b>very basics</b> to start with ... just to <u>check their knowledge</u> about what constitutes solutions that would be useful for them and they could implement in terms of the eating / exercise / food side of things</p> <p>But beyond that ...its .. I then <b>hit into the problems</b> about where to next - <u>is it my role to be</u>, <u>you know ..a family</u> dietician and then all the rest of it and if its not me then - who would I then ask to be involved after that.</p>	<p>Focus on family as being the main contributors to the problem</p> <p>Exploring – seems more proactive than just clinical history taking</p> <p>Whilst previously recognised the wider societal influences in the consultation return to very individual issues of food and exercise Issue of takeaways</p> <p>Couch potato – lapsing into common vernacular – reflective of societal views re obesity??</p> <p>reluctant to be seen as lecturing.</p> <p>Basics – understand and are comfortable with that being their role – use history taking to develop management plan.</p> <p>Language: hit – sounds powerful / abrupt/ final</p> <p>Limits and span of legitimate role / challenge</p>

Hospital staff	<p><b>I; So who else would you involve</b></p> <p><b>GP No. 7:</b> That's really problem.. It's a mixture.. <u>Self-help using the websites</u> the fit for life type of thing .. to get some basic advice.. maybe <u>the paediatric dieticians'</u> .. There are not many .. There is one in every hospital but accessing them from general practice is quite difficult and yes there are them ..</p> <p>And yes <u>paediatrician</u> we do use <u>the paediatrics is this metabolic problem</u> is there something else going on .. So we do use the paediatricians sometimes particularly <b>when you hit an impasse with parents</b> who say ooh there must be something medical behind this, there has got to be a condition rather than it just be overeating ...so sometimes we <u>get a second opinion</u> just to say look .. <u>Just check it out</u> to make sure they have not got thyroid problems or something else and say Ok and then move it on</p>	<p>Second opinion syndrome – Range of other sources. Started with self help - And then other clinicians</p> <p>Sometimes used as a tool to placate the parent, maintain the positive relationship and for their own professional assurance that all bases have been covered</p>
Monitoring and review	<p><b>I: Would you keep in contact with the parents</b></p> <p><b>GP No. 7:</b> Do you know Donna I think that's <u>very sad</u> because I think a) we don't deal with the problem as <u>often</u> as we possibly could and</p> <p>b)when we do deal with it I am not convinced that we <u>deal with it terribly well</u></p> <p>c) when we do try and bring them back they don't see us as the person that <u>can help them terribly well</u> and ..... so I don't think we have terribly high success rate in terms of following up and managing the child with obesity</p>	<p>Language that indicates concern and missed opportunities but is able to rationalise why this happens</p> <p>Recognise the complexity of maintaining contact</p> <p>Phrasing of the answer a.b.c. as if each step in a pathway</p>
General Practice as a setting – Challenges	<p><b>I; Why don't the parents think you can't help</b></p> <p><b>GP No. 7:</b> Part of it is .. I think ...I don't think we are <u>massively tooled up and skilled up and motivated</u> necessarily and we have too many other competing things to do and it's not a its never be seen as a huge huge priority in general practice when we have QOF and all the other things to compete against</p> <p>So think that part of it is disinterest in GPs or perceived lack of interest in GPs because we are</p>	<p>Any issues that lifestyle advice does not need the clinical expertise that they have in this area</p> <p>Skills motivation and competition with other priorities - Priority is disease</p>

	<p>doing so many other things like managing <u>disease</u>. Sometimes maybe the parents realise that <u>doctors cant waive a magic wand and as all I do is tell them to do things .. then maybe .. they dont want to do it or b don't want to come back to me when they haven't done it.</u></p>	<p>Distinguish obesity as a lifestyle issue/ doesn't seem to be raised to the status of genuine disease?</p>
Training	<p><b>I: you mentioned not being particularly well trained to do this – would you attend more training</b></p> <p><b>GP No. 7:</b> That's an interesting one – would we take up training I suppose <u>something about brief interventions</u> ... I think there is an argument for someone in the practice not necessarily the GP to be a useful point of .. So if you <u>had a HCA</u> or an attached dietians or somebody attached practices who you could be used to sign post to deal with these – <u>its very time consuming and it's not something that you could do in a 5 minute</u> consultation and unless you have a particular interest ..... and its difficult to take on a long term interest for some of these families. So a lot of it – if you are asking what we should put in training we would <u>want brief interventions for GPs</u> and where to <u>sign post people</u> and families too</p>	<p>Practice structure to enable specialism – not a GP – other member of staff Acknowledges skill gap in brief interventions Would only be a GP if they had interests in this areas</p>
Community facilities	<p><b>I: What kind of facilities would you like to see out there to support the obese child and their family you could refer to.</b></p> <p><b>GP No. 7:</b> Definitely <b>group based</b> – definitely getting them more <u>active say with the school</u> – teaching about good <u>diet – motivating them</u> and their family in every way possible yes that's exactly what I am talking about All the things I suppose that I recognise that I can't do well enough in general practice and they need a more <b>holistic approach</b> and they need a bigger input from other people</p>	<p>Would support wider approach that can't be delivered in a practice setting</p> <p>Acknowledge limitation of primary care</p>

<b>APPENDIX TEN. Summary subordinate themes (GP No.7)</b>
<p><b>UNDERSTANDING THE FAMILY.</b></p> <ul style="list-style-type: none"> <li>• Ridicule v Normalisation</li> <li>• Denial and reluctance to engage with the problem / with the GP.</li> <li>• Family as a group</li> <li>• Acceptance</li> <li>• Gratitude for raising the topic</li> <li>• Requesting help – motivation</li> <li>• Impact on family – emotional well being</li> </ul>
<p><b>COMPLEXITY OF NEGOTIATION CAUSED BY DIFFERENCE</b></p> <ul style="list-style-type: none"> <li>• Different impacts on different people</li> <li>• Different presentations</li> <li>• Different influences</li> <li>• Different responses</li> <li>• Age specific</li> <li>• Different causes – complex multifactorial</li> </ul>
<p><b>PROFESSIONAL DILEMMAS AND INDIVIDUAL CONFLICT</b></p> <ul style="list-style-type: none"> <li>• Reluctance to raise – consequences of raising.</li> <li>• Duty to raise</li> <li>• Internal conflict – purist v pragmatic</li> <li>• Conscientious</li> <li>• Limits and span of legitimate role</li> <li>• Empowered</li> <li>• Ethics of raising matter but no credible response</li> <li>• Difficult to deploy rational linear scientific approach</li> <li>• Semantic field: triadic, medical , disease, accurate prevalence</li> <li>• Embarrassment of reality v evidence based practice.</li> </ul>
<p><b>CONSULTATION SKILLS / KNOWLEDGE</b></p> <ul style="list-style-type: none"> <li>• Consultation shift – from immediate to a health promoting activity</li> <li>• Skills and Motivation to deal with sensitive topics</li> <li>• Adapting the message – language change</li> <li>• Lifestyle advice not within legitimate clinical expertise</li> <li>• Value of piggy back consultations</li> </ul>



<ul style="list-style-type: none"> <li>• Communicating with children</li> <li>• Knowledge of patient v textbook knowledge</li> </ul>
<p><b>COMPETING PRIORITIES</b></p> <ul style="list-style-type: none"> <li>• Competing demands in presentation.</li> <li>• Competing priorities.</li> <li>• Time available in consultation</li> <li>• Time consuming – long term investment</li> <li>• Complexity of maintaining long term commitment</li> <li>• Significance / severity determines priorities</li> </ul>
<p><b>RESPONSES</b></p> <ul style="list-style-type: none"> <li>• History taking when presented</li> <li>• Defining and diagnosing – exploring – interpreting</li> <li>• Practice organisation framing behavioural responses</li> <li>• Getting stuck – referral to secondary care</li> <li>• Second opinion syndrome – placate parents / professional reassurance</li> <li>• Brief interventions – basic not lecturing</li> <li>• Community activities – holistic responses</li> </ul>

**APPENDIX ELEVEN. Example of subordinate theme – Individual and professional dilemmas – all GPs.**

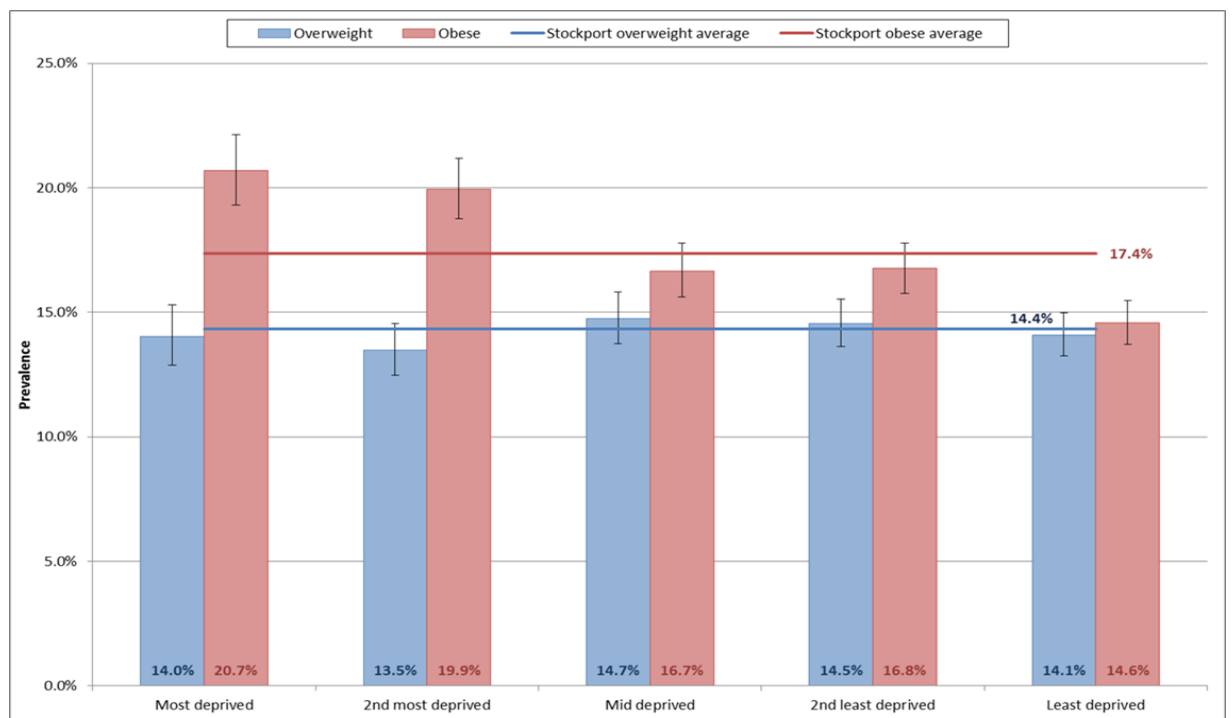
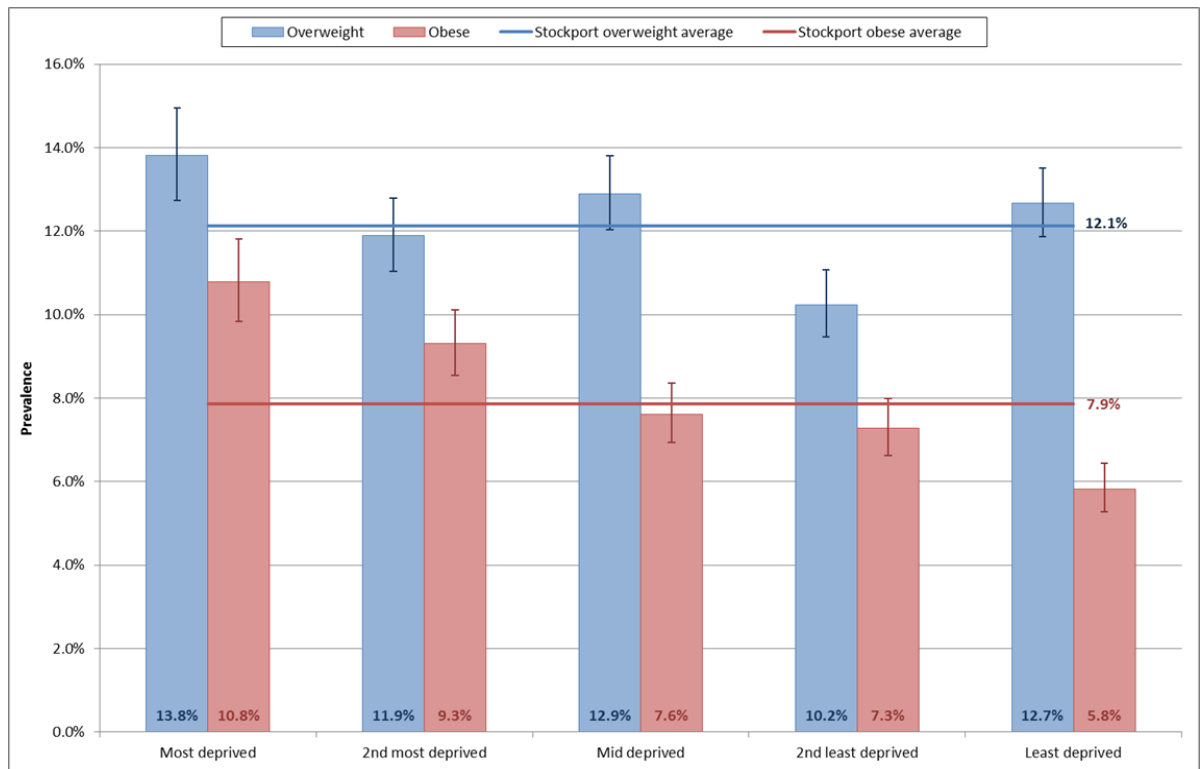
<b>Subordinate themes</b>	<b>Cluster themes</b>	<b>Illustrative Quote.</b>
Role legitimacy and adequacy	Lifestyle advice/ not within legitimate clinical expertise	There's lots of weight management stuff out there in the libraries and so hopefully people are accessing it as part of a lifestyle, rather than bothering a GP who has got so much to do dealing with chronic disease and acute illness than dealing with something that is really a lifestyle issue.(GP No. 3)
	parenting advice	I can't really give them advice about what to do if the child won't try new foods or kicks off at the dinner table – that's the Health Visitors job (GP No. 3).
	Limits and span of legitimate role	is it my role to be, you know ..a family dietician ( GP No. 7)
	Empowered	or are we empowered to actually do anything about it if we do raise it the issue (GP No. 9)
	Its Public health's job	It needs all the community coming together – schools – supermarkets, playing fields (GP No. 2)
	Reluctance to raise	Part of me also has a slight reluctance because there are all sorts of ... you know .. What we do with it if I raise it (GP No .7)
	Duty to raise	so yes part of me feels that we have a duty to raise these issues with the families - particularly when you have a young person coming in with a parent and the child is clearly very obese .. (GP No. 5)
	Conscientious /Concern if miss opportunity	you know we are in the business of identifying risk factors for disease and for conditions particularly when you have a young person coming in with a parent and the child is clearly very obese (GP No. 8)
	Internal conflict –	but yes the sort of the purist in me would say yes we should have a role in actually managing ...

	purist v pragmatic	identifying (GP No. 7)
	Raising unrealistic expectation	you know .. What we do with it if I raise it (GP No. 7)
	Poor service response	dietetics - there are very poor provisions of dieticians in this area – across the patch and I am not even sure if they look at such kids in fact so... you are very limited. (GP No. 4)
	Poor feedback	You don't know ... you never know ...because they don't come back 6 months later and say thank you very much I have got Jimmy with me and now he is a size 10 –you don't know whether you have done a good job ... it's a bit soulless really. (GP No. 3)
Competence, Knowledge and training	Hard and difficult	I suppose because they are children you feel you have to help even though it can be really hard. (GP No. 6)
	Hit into problems	So we do use the paediatricians sometimes particularly when you hit an impasse with parents who say “ooh there must be something medical behind this”, they seem to believe there has got to be a condition rather than it just being a matter of overeating.’ (GP No. 7)
	Emotionally draining	I think it's very sad because we don't deal with the problem as often as we possibly could and when we do deal with it I am not convinced that we deal with it terribly well.(GP No. 8)
	Getting stuck	It's all very well to have names and phone numbers and places, but knowing individuals is what helps with referrals, I can say with confidence “I know this person who is really good and will help you” but if I say “go to this place” it's not the same.’ (GP No. 2)
	Reality v evidence based practice	Starts laughing Do you want the honest answer.. laughing(GP No. 7)
	Knowledge of pathways and Protocols	‘If we did pick up a kid with obesity I would be a little lost as to know what to do with them – because there aren't the facilities ,, there is nowhere ,, where I know about – we haven't really got a treatment protocol for these kids’(GP No. 4)
	Guidance /	I know there is NICE guidance for adults but I haven't seen any for kids, it might be out there, but I

	guidelines	can't remember seeing it (GP No.2)
	Communication skills	clearly if you have a consultation with a 5 year old who is obese clearly you can't start lecturing the child (GP No. 8)
	Specialist Interest	I am not very good at it – I am not the child health doc in our practice – what we tend to do if we think the child is very heavy for their age, we tend to refer to the in-house doctor who is our child doc, he is much better at making an official assessment if the child is overweight.' (GP No. 2)
	Specific Paediatric Knowledge	But there is something a bit scary about children ... It's like with drugs you can't just treat them as mini adults... you have to know your stuff. (GP No. 2)
	Training	Training well - Lifestyle advice –I don't think I have had a specific training you would hope that you would pick that up as part of your general training. (GP No. 2)
	Service Knowledge	It's all very well to have names and phone numbers and places, but knowing individuals is what helps with referrals, I can say with confidence "I know this person who is really good and will help you" but if I say "go to this place" it's not the same. (GP No. 2)
	Behavioural Techniques	I'm a mum and I know how to get a child to act, but it's harder with parents. I suppose the whole thing of losing weight is just as hard with adults(GP No. 10)
	Poor practice	I think it's very sad because we don't deal with the problem as often as we possibly could and when we do deal with it I am not convinced that we deal with it terribly well.(GP No. 8)
	Experiential evidence	I can be trained ... I can know the dangers...and all that but what am I actually going to do for them there and then ...its about putting them on a programme that's going to make them lose weight .. Because just seeing me every week isn't going to work. (GP No. 4)
Motivation	Motivation to deal with sensitive topic	You can be motivated to work with people if you feel you can really help them, but if you are struggling to do anything worthwhile for them in the time that's available, then that's far more difficult really. I think our role will probably be best in terms of knowing who to refer to get the appropriate help rather than doing it ourselves. (GP No. 1)

APPENDIX TWELVE SUMMARY OF THE GP TYPOLOGIES				
	The Gatekeeper	Outside of the Professional Domain	Informer and Educator	Helper and Facilitator
Description	Lifestyle behaviours are complex and require specialist input from qualified experts such as paediatricians or specialist dietitians.	Intervention considered outside of the professional role, best addressed through population health approaches.  Risk factors for childhood obesity are individual lifestyle issues.	Ensure family has sufficient information on health risks/benefits of lifestyle risk factors to make an informed choice about lifestyle behaviour.  Provide additional assistance to motivated families.	Facilitate families to change their behaviour through providing tailored support strategies, moving towards change over time. Synergistic role with other providers and population health approaches
Epistemological Framework	Biomedical / Scientific rationalist with quest for medical certainty	Biomedical.	Biomedical – biographical.  Families have multiple, interacting, and compounding problems; physical, psychological and social.	Interpretivist - socio-ecological perspective. Narrative based medicine/ Integrating family's biological, psychological, and social presentation into a coherent clinical whole.
Understanding the Family	Focus on health problems of childhood obesity. Limited to medical history, presenting conditions Remains detached from wider social cultural and economic circumstances of	Focussed on deficient behaviours of parents and their unhealthy lifestyles. No awareness and of wider factors on parental behaviours. Crude and negative assumptions	Display an awareness of the impact of socio-economic disadvantage and its link with childhood obesity. Recognised wider social contextual factors on the family.	Demonstrated extensive long term knowledge of many aspects of families' lives; Fully acquainted with wider social determinants and impact of factors such

	the family	about the health behaviours of the families and disparaging views of parents.	Particularly sensitive to parental anxieties.	as limited access to play and leisure facilities, the cost of healthy foods and parental working patterns.
Professional Dilemmas	<p>Restricted opportunities to screen, absence of clinical pathways, guidelines and specialist secondary services</p> <p>No evidence base available for intervention.</p> <p>Found prevention role difficult and not their preferred clinical response.</p>	<p>Experienced feelings of frustration at the failure of parents who were conceptualised as being almost impervious to behavioural changes.</p> <p>Frustrated at limited response of the wider community to address childhood obesity.</p>	<p>The need to address the health consequences of their child's weight, often proved to be an unreasonable expectation in the face of wider structural factors, social constraints and parenting challenges. inherent in their biographical knowledge of the family.</p> <p>Professional frustration at the limited support and facilities available to deal with family complexity</p>	<p>Acutely aware of the emotional impact of childhood obesity on the child and concerned that their interventions may impact on their fragile self esteem</p> <p>Recognised complexity of parenting a child who was obese.</p> <p>Aware that wider social economic and financial consideration may impact on their resources and ability of the family to address childhood obesity.</p>
Organisational Challenges	<p>Identified no support within the practice to assist. Discouraged Practice nurses from being involved.</p> <p>Very little interest in training</p> <p>Focussed organisational priorities of the practice on acute delivery of primary care.</p>	<p>Had very limited access to children as this was managed by other partners in the practice.</p> <p>Felt that dealing with lifestyles issues was a drain on his scarce clinical time.</p>	<p>Struggled with time to address complexities which could be a disincentive to open up a conversation, particularly one which focussed on the sensitive area of childhood obesity</p>	<p>Excessive workload, conflicting and competing priorities and time impacted on ability to provide intensive support and motivation to the families.</p> <p>Fully committed to their Practice as a health promotion environment.</p>



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