

Primary care support for tackling obesity: a qualitative study of the perceptions of obese patients

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ABSTRACT

Background

Obesity has become a major public health issue and there is concern about the response of health services to patients who are obese. The perceptions of obese patients using primary care services have not been studied in depth.

Aim

To explore obese patients' experiences and perceptions of support in primary care.

Design of study

Qualitative study with semi-structured interviews conducted in participants' homes.

Setting

Five general practices contrasting in socioeconomic populations in Sheffield.

Method

Purposive sampling and semi-structured interviewing of 28 patients with a diverse range of ages, backgrounds, levels of obesity and experiences of primary care services.

Results

Participants typically felt reluctance when presenting with concerns about weight and ambivalence about the services received. They also perceived there to be ambivalence and a lack of resources on the part of the health services. Participants showed a strong sense of personal responsibility about their condition and stigma-related cognitions were common. These contributed to their ambivalence about using services and their sensitivity to its features. Good relationships with primary care professionals and more intensive support partly ameliorated these effects.

Conclusion

The challenges of improving access to and quality of primary care support in tackling obesity are made more complex by patients' ambivalence and other effects of the stigma associated with obesity.

Keywords

obesity; primary health care; qualitative research; shame.

INTRODUCTION

Obesity is now seen as a major cause of disease and premature mortality in many parts of the world.^{1,2} The UK is typical of many countries in its mounting level of concern about obesity in the last few years.³ The prevalence of obesity has trebled over the last two decades in the UK⁴ and the annual costs for the health services in England alone have been estimated at around £1 billion.⁵ Evidence of the health and economic costs of obesity are reflected in significantly higher prescribing in primary care across a wide range of drugs.⁶ Among a range of responses to the public health problem of obesity there is an increasing focus on how health services respond to, and support, patients who are already obese.⁷

General practice is the main setting for NHS activity to help people who are obese, particularly those already diagnosed with related health problems.⁸ Public satisfaction with and use of primary care services in the NHS is very high. However, it is recognised that these services may not have been adequately resourced in specifically tackling obesity.⁹

Obesity is a condition associated with negative attitudes and discrimination in Western societies. Research suggests that health professionals may also have negative attitudes and that patients may be reluctant to access services.^{10,11} The evidence for

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the UK directly is limited, but there is some indication of dissatisfaction with primary care on the part of obese patients.^{12,13} However, the experiences and views of patients using primary care have not been studied in depth. The present study aimed, therefore, to explore the perceptions of these patients, focusing on first-line support actually experienced.

METHOD

Design and setting

We conducted a qualitative study drawing on grounded theory methodology.¹⁴ Sampling, data collection and analysis were interwoven and continued to the point of saturation. Semi-structured interviews were conducted with patients who had some experience of using primary care services after being diagnosed as obese. The range of the experiences varied widely, but all the study participants had experienced some intervention to address their weight.

Five general practices in Sheffield participated in recruiting patients using a purposive sampling strategy. The five were all group practices with established practice nurse resources but no additional projects or unusual services in relation to obesity. Apart from their typicality of services, the five practices were otherwise diverse in socioeconomic and ethnicity characteristics of their populations.

Sample

A purposive sampling strategy was employed to include a diverse range of experiences and social backgrounds of participants. Sampling was also undertaken in a number of stages concurrent with data analysis to enable emerging themes in the study to be investigated if necessary.

Participating general practices used their computerised records to identify adult patients (aged over 18 years) with BMI (body mass index) exceeding 30 kg/m², who were also fully aware of a diagnosis of obesity and well enough to comfortably participate in an interview. Each practice then prepared a purposive sample of 20 to give roughly equal proportions of male and female patients across a range of obesity levels. Potential study participants were contacted by the practice by post to see if they were interested in taking part in the study. Overall about 100 patients were contacted in this way to recruit sufficient volunteers for a purposive sample of 28 participants. A summary of the sample's characteristics is shown in Table 1.

Interviews

Twenty-eight patients were interviewed individually at home between November 2003 and March 2004. The interviews were audio-taped and lasted about 1 hour overall. The interviewer was guided by a

How this fits in

Obesity has become a major public health issue in England and there is concern about the response of health services to patients who are obese. The perceptions of obese patients using primary care services have not been studied in depth. A strong sense of personal responsibility and stigma related cognitions contribute to patients' ambivalence about accessing and using primary care services despite an otherwise positive view of general practice. A lack of resources rather than negative stereotyping or discrimination is perceived to have contributed to services that are not in tune with the needs of patients.

number of open questions (Box 1) with a view to exploring the type of experiences and perspectives of participants. Each section of the interview included checks with participants about the meaning and weighting to be given to their views.

The interviews were transcribed verbatim and entered onto QSR NVivo, a data management and analysis programme. The first five interview transcripts were initially coded into categories, themes and dimensions relevant to the study aims.¹⁴⁻¹⁶ These categories were expanded, developed and refined with further data collection and analysis after 13 interview transcripts and then again after 21 transcripts and finally all 28 transcripts. Data analysis was led by one member of the research team. Interpretation was verified using independent transcript analysis and research team meetings to scrutinise emerging categories and themes.

Table 1. Sample characteristics.

Age range (years) ^a	n (%)
18-35	3 (11)
36-55	9 (32)
56-75	14 (50)
>75	2 (7)
Sex	
Male	10 (36)
Female	18 (64)
BMI range (kg/m ²) ^b	
30.0-34.9	17 (61)
35.0-39.9	5 (18)
≥40	6 (21)
Occupation type	
Manual	10 (36)
Non-manual	18 (64)
Comorbidities present ^c	
0	4 (14)
1	12 (43)
≥2	12 (43)

^aMean age = 56 years (range 19-77 years). ^bMean BMI = 35.6 kg/m² (range = 29.4-61.5). BMIs calculated from self-reported height and weight. ^cMost frequent comorbidities: cardiovascular (50% of sample); musculoskeletal and joint (39%); endocrine (21%); others (21%).

Box 1. Questions used to initially guide interviews.

- ▶ Can I ask you about any illnesses or medical conditions your doctor has said you may have?
- ▶ We want a broad idea of which health services you have used in the last year especially any where you have been seen regularly. Who have you seen most regularly?
- ▶ Can you remember when a doctor or nurse first gave you advice about your weight? What happened?
- ▶ What sort of advice or help have you had more regularly about your weight?
- ▶ What do you think the doctor/nurse believes are the reasons for you being overweight? (Probe for perceptions of explanations about causes and consequences.)
- ▶ Immediately after you have seen the doctor/nurse to discuss your weight how do you generally feel?
- ▶ Do you ever feel the doctor/nurse judges you unfairly because of your size?
- ▶ I wonder what effects your experiences (of health services) had on the quality of your life. Do you think your experience helped you? Or do you think it made things worse in any way? What is your overall impression?
- ▶ What is the most helpful thing health services can do to help someone like yourself who is overweight?

The team included two patient representatives with personal experience of obesity who had been recruited via an advertisement circulated to community and patient support groups likely to have an interest in obesity. As well as contributing to the project steering group the two representatives joined discussions refining and testing data analysis.

RESULTS

First, a typology will be briefly outlined of the levels of support participants perceived themselves to have received and the key features they identified of a positive supportive experience. The results then mainly focus on themes that represent the typically ambivalent perceptions of the sample.

Levels of support

A typology of four levels of support in relation to obesity emerged from participants' accounts. At the first level a health professional had pointed out (and often continued to point out), that their weight was a 'problem': raising awareness but little more. There was dissatisfaction within our sample about this, particularly where it was not followed up by more practical advice and support:

'I suppose I feel a bit disappointed really because there I am trying to lose weight and just being told, "you need to lose weight", and ... that's it. There's no follow through with it.' (Interviewee 12)

A second level was where minimal support was

offered along with practical advice on steps to take, commonly in the form of a diet sheet. Again, participants sometimes perceived this as being 'brushed off' and did not see it as particularly helpful. Like the first level it was also frequently associated with ambiguity (see below).

The third level typically involved the practice nurse in providing weight monitoring and support over a period of time. There was a high level of satisfaction with this where it provided non-judgemental psychological support and practical advice. There was frustration, however, where practical content was lacking:

'So, practical advice, none. I'd go as far as — not apart from the sheet ... the diet sheet — but then I appreciate how busy they are. But very supportive every time, you know, encouraging and, you know, "Keep it up", type of thing.' (Interviewee 19)

The most intensive and long-term intervention levels involved group support initiatives. These fourth level experiences of positive support all had the following features: they were characterised by a longer term more intensive intervention; they were non-judgemental and sensitive but also direct and unambiguous; they provided personalised information, explanations and practical advice; they provided psychological support; and they provided referral to some kind of group support.

These findings are important but not unanticipated. However, only four of the sample had experienced this level of support; generally within initiatives provided by a community dietician rather than in general practice. For the majority of the sample their experience fell well short of this level of support. The rest of this section therefore explores the complex ambivalence of more typical perceptions within the sample.

Ambivalence and ambiguity

Most participants recalled their weight was first raised as a 'problem' by their GP or practice nurse in relation to the diagnosis or treatment of another condition:

'I went to the GP which I don't very often do and discovered my blood pressure was rather high ... and I was referred to the nurse to check my blood pressure every so often and then she began with the weight problem advising me over that.' (Interviewee 5)

Only four of the participants had presented with concerns about their size directly themselves. These few had actually found initial responses limited. More

typically participants reported reluctance and ambivalence about raising concerns about weight themselves even though concerns were present:

'I didn't like going and asking again because I thought, "Oh, he's going to think I'm a right ..." I don't know. "Oh, she's not bothered," and I were bothered.' (Interviewee 14)

'I mean, you know, you feel ... ashamed is perhaps the wrong word. I feel disappointed that I've ... that I have put some weight on or put some more weight on and I've not been successful in keeping it off.' (Interviewee 27)

Some participants also perceived ambivalence on the part of health professionals and ambiguity in the communication about their weight as a health issue:

'And maybe they were a bit embarrassed about bringing the subject up. I mean it didn't bother me, but you know, maybe they just felt a bit embarrassed about bringing the subject ... I don't know.' (Interviewee 10)

About a quarter of participants reported that they felt quite unsure about the reasons for weight being raised as an issue initially. They took it as a general admonition to lose weight rather than related to a specific health problem:

'They just said try and lose ... you know, try and lose some, but that's about it.' (Interviewee 4)

About two-thirds felt that nothing had ever been said in explanation of why weight had been gained. In this relative vacuum of explanations participants would fill in the gaps themselves with a strong tendency to imagine the worst must be thought of them:

'I think they must think I must be sat here eating sweets and putting ... lashing sugar on everything and eating loads of potatoes. Now, I've said those things because A, I don't like potatoes and I've never eaten them, B, we don't have any sugar on anything.' (Interviewee 15)

Personal responsibility and stigma

Almost all participants showed a strong sense of personal responsibility about their size which contributed to their ambivalence about accessing health services for support:

'You know, well that's ... it's your own fault, isn't it? I'm not blaming them. It's me.' (Interviewee 15)

'But only the fat person can do it for themselves and I think if the health service took ... were a bit more encouraging instead of so negative about obesity, then maybe we'd get somewhere.' (Interviewee 9)

The perceptions of a majority of participants also vividly illustrated the stigmatised nature of obesity and of a general expectation of negative stereotypes in social interactions:

'They must think, "Oh, there isn't any need. I wouldn't allow myself to get like that and I would lose weight".' (Interviewee 2)

'I'd be thinking everybody's thinking, "Oh, look at her. Look at her. Look at the size of her," and I couldn't cope with that.' (Interviewee 14)

'I think like I say, people think you're stupid. If you're fat you're stupid or you're a pig ... you're a glutton. You gorge yourself. I don't gorge myself.' (Interviewee 17)

This sense of an expectation of negative stereotypes was reduced but not absent in participants' discussion of their use of health services:

'I think occasionally I assume that they assume that I'm going to be idle ... that I'm an idle, lazy type because of the size, you know. But if it's one thing I'm not, I'm not idle. Just ask anybody, I never sit down. I'm always on the go, so ... but yeah, I think I tend to assume what they're thinking, if you see what I mean.' (Interviewee 19)

However, the source of these expectations appeared to be internal thought processes rather than actual experiences in primary care. Indeed, almost all the participants were keen to point out the good relationships they had with their GP and practice nurse. They were mostly very positive about other aspects of their care. Furthermore no one in this sample felt they had been directly treated unfairly by primary care services in relation to their size:

'No. No, not at all. I've got quite a good relationship with her. She's a very good doctor.' (Interviewee 3)

Against the general positive view of relationships with GPs and practice nurses there was a striking amount of dissatisfaction with services relating to obesity in the sample. Typically this was expressed as 'They're great, but ...':

'Our doctors are great. I wouldn't knock them except that I think they need to be more aware of this sort of thing. And I don't know ... I don't know if genuinely overweight people should have to be going to groups like WeightWatchers®. Why they can't get that sort of thing from the doctors.' (Interviewee 12)

Very typically these views related to perceptions of under developed and rushed services:

'I think they are very busy and they've only got a limited time, so, you know, is it their job? Are they right in just saying, "Go away and lose weight,"? I don't really know.' (Interviewee 7)

'I think they're very willing, but I don't think they've time. And I actually do think that obesity, overweight, being overweight in ... however much it might be, is a ... is a real health issue that needs to be addressed.' (Interviewee 9)

The perception of rushed services was seen to contribute to sometimes heavy-handed communication, to very limited levels of psychological support and to the perception that obesity is not taken seriously enough in primary care:

'It was more like, "You've got a big problem. Sort it," and not helpful.' (Interviewee 13)

'I'm more than a hundred weight over my weight that I should be. And nothing's ever taken seriously with the doctors about it. Mind you, they can't be looking after everybody all the time. And a lot of people think people are fat because they're not strict enough about themselves, but it's not always true.' (Interviewee 6)

Attributing all problems to weight

In contrast, another attitude perceived as troublesome by a few others was that every problem is attributed to weight:

'I think there are some doctors who are more obsessed [with] everything that happens to you, "Oh, it's your weight".' (Interviewee 24)

While this was an expectation of patients as part of their sensitivity to their size as a problem, there were also more direct experiences of it actually occurring in consultations:

'I couldn't see the reference to being overweight had any ... any relevance or helped in any way whatsoever and it just seemed totally unnecessary

to bring it up at all. But it annoyed me for a time and then I forgot about it.' (Interviewee 5)

In either case it was felt to be inhibiting and reinforced the individual's own ambivalence and shame in using services:

'If there's anything wrong with you, you see, she'll put it all down to your weight and that gets me annoyed because ... just because you're overweight and I ... you know, and you are overweight ... And so she used to really get my goat and I didn't like going ... at all, I never liked going to see her, but ... and then it gets you a bit paranoid then, you see because then you think, "Well, nobody's going to tell you what's wrong if you've got something wrong with you because they're putting everything down to your weight," and to me that's wrong.' (Interviewee 28)

Avenues for development

Participants believed that developing self help and group support should also be a main avenue for service development. This appeared to be a desire for a kind of hybrid of the best experiences of primary care and the best experiences of commercial sector groups in providing mutual support. Nurses were seen to be important in supporting such developments:

'To talk it with the nurse because, you know, you're not wasting the time of someone who's very very ... Well, they are busy, but you know, that's what they've decided to do for that a lot of time. Yes, I think that to recommend them to the nurse and just talk it through really.' (Interviewee 8)

'I think that if there was sort of a class where you could go and get weighed every week up at the clinic ... and possibly I feel perhaps a lot of people like myself would go ... say, just for the sake of argument, every Tuesday there's this class, ... for you to be able to just go and get weighed and discuss if you've got a problem with, not necessarily a doctor, but one of the nurses.' (Interviewee 24)

'I do know people that, you know, have gone to WeightWatchers ... well [!] would have liked to have gone to WeightWatchers, but couldn't afford them. Maybe, you know, put a free service of getting yourself weighed once a week and, you know, more help that way. You know, just a morning ... especially on an estate like this, I know plenty of people that just would like to go, but obviously can't afford it.' (Interviewee 22)

'If they ran classes. They gave us all a little ... like a health scheme like WeightWatchers sort of at the right time of the day, you know, I'd go to it.'
(Interviewee 11)

DISCUSSION

Summary of main findings

The study aimed to explore the experiences and perceptions of patients who have been diagnosed as obese. The findings show that, except where they have received intensive ongoing support, these patients are typically ambivalent for reasons that are complex. A perception of a lack of service resources and insensitive, rushed or ambiguous communication are all ingredients in the more complex picture. But these factors interact for the worse with patients' own thoughts and feelings about their personal responsibility, sense of stigma and expectation of negative stereotypes. Good relationships with primary care professionals only partly ameliorate the effects of stigma cognitions. Ambivalent communication and other characteristics of under developed services all exacerbate the effects of stigma, affecting access to and satisfaction with services for this group.

Strengths and limitations of the study

The study was successful in sampling patients of varied backgrounds and experiences across a range of levels of obesity. The findings were consistent across these backgrounds and different service providers in highlighting ambivalence and the other themes presented above.

It should be emphasised that as a qualitative design the study was oriented to theory development rather than statistical generalisation. A further strength of the study was the involvement of two patient representatives with direct experience of obesity. Like other research teams we too believe that this contributed to the relevance of insight provided by the study.¹⁷ Overall the findings give a fuller understanding of the needs of these patients and therefore appreciation of what is needed for development of accessible and sensitive services.

The strategy to recruit patients inevitably resulted in some bias of response, although the effects of this are difficult to assess. Wider surveys of primary care development suggest that the recruiting practices were typical in not having additional resources devoted to helping patients in relation to obesity.⁹ In agreeing to help with the study it is likely that they were more, rather than less, interested in the topic of obesity. A clearer limitation is that the sample did not include any participants from Black and Asian ethnic minority groups even though these groups were present within practice populations. Further research

is needed to explore the experiences and perceptions of these groups.

Other biases within the sample are difficult to assess. It is likely that those agreeing to participate in the study had stronger views and may have been generally more dissatisfied with their experiences. However, their perception of services generally was positive and this reflects wider surveys of primary care. It is possible that they were a particularly ambivalent group of patients. It should be noted that the majority (86%) had at least one of the common comorbidities associated with obesity and that their weight was first raised as a problem by a professional in this context. It may be that those without comorbidities, or those more actively seeking help specifically about their weight, may be less ambivalent. Finally, the sample did not include obese patients who, for whatever reason, are not using primary care services. A different sampling strategy would be needed to access these 384 patients who may hold quite different views.

Comparison with existing literature

There are few studies reporting obese patients' perceptions of primary care to directly compare with this study but there is some other evidence of general dissatisfaction with services from this group of patients.^{12,18}

The levels of support reported by patients closely match the interventions reported in other studies of general practice.^{8,19} These and other studies have also suggested that there is some uncertainty about what to do about obesity on the part of GPs and practice nurses.²⁰

It is particularly interesting to compare the perceptions of patients with the views of GPs about obesity treatments from a recent qualitative study in London.²¹ The GPs generally believed the patient is individually responsible for their obesity and felt resistant to treating it as a medical issue; particularly as they felt that they had no effective treatment options to offer. The GPs further believed that patients wanted to hand over responsibility for their obesity and they, the GPs, were aware of a need to manage these expectations and maintain good relationships. GP strategies included listening, providing support and empathy more generally.

The present study suggests that patients correctly sensed ambivalence on the part of health professionals and that not much specific support was available. They also correctly appreciated the general support and empathy on offer. However, the interpretation that patients want to give up responsibility may be a rather more complex issue.

Our sample clearly felt a strong sense of personal responsibility for their weight predicament and they

were often ambivalent about seeking help. Rather, the interaction should be understood as being complicated by the stigmatised nature of the condition and the ways that patients, in this context, manage the presentation of themselves.

The evidence otherwise about attitudes towards obesity of health professionals in the NHS is limited. If anything, previous research suggests professional attitudes may be more neutral and lacking enthusiasm rather than directly negative.^{20,22,23} The present study supports this in that it did not uncover direct experiences of negative stereotyping or discrimination from the patients' perspective but it did find perceptions of ambivalence about first-line support.

Implications for clinical practice

While the most intensive support may be appreciated and desired by patients who are obese it is not apparent this can be resourced or, indeed, is best provided from general practice. Complex group initiatives have evidence of being effective in the longer term for some patients but they, given the high drop out rates, only suit a minority.²⁴

More generally it is clear that unambiguous and non-judgemental communication is particularly important to work with patients with any stigmatised condition, including obesity.^{25,26} Initial constructive explanations are essential if the condition is to be made meaningful and tackled effectively. While this insight is present in some literature aimed at primary care it may not have received enough emphasis in clinical protocols.²⁷

It is important to recognise patients' strong sense of personal responsibility and how this interacts with the stigmatised nature of obesity. Obesity is particularly stigmatised because of its high visibility and because it is widely perceived to be readily controllable by the individual.²⁸ Stigma-related thoughts are detrimental to quality of life²⁹ and they also inhibit and negatively affect interactions with health services. These thoughts are likely to flourish in a vague consultation in which weight is not tackled in a direct and supportive way.

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Ethics Committee

Ethical approval from North Sheffield Research Ethics Committee (2003 6 1683)

Competing interests

The authors have stated that there are none

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