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Moral discourse in General Practitioners' accounts of obesity communication

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1 **Moral discourse in General Practitioners' accounts of obesity communication**

2 **Abstract**

3 Obesity is not addressed with a large proportion of patients presenting in general practice. An
4 increasing body of evidence suggests that health professionals view body weight as a
5 sensitive topic to include in routine consultations and face barriers in initiating weight loss
6 discussions. This study examined the discursive power relations that shape how general
7 practitioners (GPs) understand and talk about obesity using a novel methodology to elicit
8 responses from GPs about raising the topic of weight. Twenty GPs from the South West of
9 England reflected upon novel trigger films simulating doctor-patient interactions, in which a
10 doctor either acknowledged or ignored their patient's body weight. Underpinned by a
11 discourse analytic approach, our findings suggest that GPs both reproduce and resist moral
12 discourse surrounding body weight. They construct obesity as an individual behavioural
13 problem whilst simultaneously drawing on socio-cultural discourse which positions body
14 weight as central to social identity, situating obesity within a context of stigma and
15 positioning patients as powerless to lose weight. Our findings highlight a need for increased
16 reflexivity about competing discursive frameworks at play during medical consultations
17 about obesity, which we suggest, contribute to increased tension and powerlessness for GPs.
18 Trigger films are an innovative method to elicit information and discuss competing
19 discourses.

20 **Keywords**

21 Obesity, discourse analysis, general practitioners, stigma, critical public health

22 **Introduction**

23 There is pressure within UK General Practice to contribute to the public health drive to lower
24 rates of obesity (Academy of Medical Royal Colleges, 2013; Royal College of Physicians,

25 2013). General practitioners (GPs) are expected to routinely talk to patients about their
26 weight, both when presenting with obesity related problems and for other purposes (NHS
27 Future Forum, 2012; NICE, 2014). However, evidence suggests that many patients are not
28 approached about their weight (Aveyard et al, 2016). Alongside a perceived lack of time and
29 competing demands, GPs indicate that the reluctance to talk to patients about weight loss
30 stem from concerns around damaging their therapeutic relationship and professional
31 reputation, as well as feeling ill-equipped to help patients (Blackburn et al, 2015; Michie,
32 2007).

33 While studies give insight into factors that prevent GPs from approaching their patients about
34 weight loss, most have focused on individual-level determinants of behaviour. For example,
35 studies have emphasised that clinician beliefs are a salient barrier to raising the issue of
36 weight, demonstrating that GPs have concerns about upsetting patients and perceive
37 themselves as lacking the knowledge and skills to help patients lose weight in a ten minute
38 consultation (Blackburn et al, 2015; Michie, 2007). As a result, limited attention has been
39 paid to the sociological, political and cultural influences that shape, and are in turn shaped by,
40 GPs' beliefs and behaviour. Such a stance also ignores the ongoing debate within academic
41 circles about what obesity actually is, which, importantly, has led to diverse ways of viewing,
42 understanding and researching obesity. Indeed, a growing evidence base demonstrates
43 contested knowledge surrounding obesity and diverse views around the framing of fatness
44 (Bombak et al, 2016; Trainer et al, 2015; Warin, 2015).

45 In addition to a medical model of obesity which broadly views obesity as a biomedical risk
46 requiring change at an individual level, either through behavioural, pharmaceutical or
47 surgical intervention (Webb, 2009), several other models of obesity have been identified in
48 the literature. Discourses of obesity promulgated by the news media (Frederick et al, 2016),
49 health policy (Ulijaszek & McLennan, 2016) and those campaigning for political and social

50 change (Bombak, 2014; Cooper, 2010) are important to consider. News and television
51 media, for example, regularly portray individuals as lazy and gluttonous and assert that
52 weight loss is controllable through will power and better choices (Saguy & Alemling, 2008)
53 thus highlighting personal responsibility. Empirical research also demonstrates that media
54 reporting promotes a public health framework of obesity whereby obesity is framed as an
55 'epidemic' or 'crisis' warranting governmental action (Frederick et al, 2016; Saguy & Gruys,
56 2010). In this portrayal of obesity, fatness is constructed as a normal response to an
57 obesogenic environment and government regulation of food and marketing activities are
58 advocated. In a policy context it has been argued that despite some recognition of the
59 complex array of causes of and thus proposed solutions to obesity, the dominant framing of
60 obesity as an individual problem requiring behaviour change continues (Ulijaszek &
61 McLennan, 2016). In contrast, 'health at every size' and 'fat rights' frameworks draw on
62 political discourse. A political model of obesity presents fatness as a form of natural
63 diversity, promotes greater social tolerance rather than individual behaviour change and
64 opposes weight-based discrimination and stigma (Cooper, 2010; Rothblum & Solovay,
65 2009).

66 Competing frameworks surrounding obesity appear to be particularly salient in relation to the
67 medical management of obesity where dichotomous thinking and heated debate over how to
68 understand and treat obesity continues (Bombak et al, 2016; Trainer et al, 2015). Although
69 there is heterogeneity in the critique they provide, researchers taking up a feminist or social
70 constructivist orientation argue that public health and medical authorities provide the
71 dominant perspective on obesity, drawing attention to its biophysical attributes and labelling
72 obesity as a pathology, disease or social problem (Patterson & Johnston, 2012; Warin, 2015).
73 Inherent within this medical framing of obesity is the notion that excess fat is unhealthy and
74 that behaviour change is the most effective strategy for intervention. Scholars who are

75 sceptical of obesity as a medical problem argue such a framing contributes to a reductionist
76 and individualistic conceptualisation of obesity and could lead to victim blaming (Gard &
77 Wright, 2005; Lupton, 2013). A contrasting perspective put forward by critical theorists and
78 activists is that body weight is an embodied, personal and social issue (Medvedyuk et al,
79 2018; Tischner & Malson, 2012). Here, researchers argue that constructing obesity as a
80 medical problem, and doing so unreflexively, has consequences for social identities,
81 potentially contributing to stigmatisation (Bombak et al, 2014; Monaghan et al, 2013).

82 As these debates serve to illustrate, competing discourse surrounding obesity contribute to
83 fatness being viewed and understood in a variety of ways. Somewhat surprisingly, little
84 research has looked at how health professionals discursively construct obesity and their role
85 in talking to patients about weight loss, or how their understanding of obesity is situated
86 within a wider socio-cultural and political context. It remains unclear how GPs, who are
87 involved in supporting patients who are overweight or obese (Aveyard et al, 2016), are
88 influenced by, and in turn shape, these discourses.

89 In sum, despite a need to understand why obesity is infrequently addressed in general
90 practice, few studies have reflected on the meanings that health professionals ascribe to body
91 weight in relation to the wider discursive resources available to talk about weight, which limit
92 and constrain meanings. Most saliently, given the ubiquitous and damaging nature of moral
93 constructions of obesity frequently alluded to by scholars, particularly those who seek to
94 politicise obesity (Bombak, 2014; Lupton, 2013), it remains unclear whether GPs are
95 influenced by, and indeed contribute to, moral discourse surrounding obesity. For the
96 purposes of this study, we define a moral discourse of obesity by drawing on descriptions
97 provided by scholars such as Jutel (2005) and Throsby (2007) whereby obesity is viewed as a
98 problem to be fixed, weight is judged to be a direct indicator of health, and individuals are
99 obliged to take personal responsibility for weight loss through initiating behaviour change.

100 Given that previous studies in this area have been limited to surveys and interviews, we
101 decided that an innovative method tailored to the needs of this specific area of empirical
102 investigation would make a useful contribution to understanding the management of obesity
103 in general practice. Trigger film interviews (Ber & Alroy, 2001; Johnston & Chan, 2012),
104 were used to explore the discursive power relations at play when body weight is negotiated in
105 the clinic. The rationale for using, and the process of designing trigger films is described
106 further in the methods section of this paper.

107 Given the diverse and contested discourse surrounding obesity, this study sought to explore
108 the discursive power relations that shape how GPs understand and talk about obesity by (a)
109 identifying the ways in which obesity and the challenges of raising the topic of weight are
110 presented within GPs' accounts and (b) situating these accounts within wider socio-cultural
111 and political discourse surrounding obesity in order to explicate the extent to which moral
112 discourse is both reinforced and resisted.

113 **Method**

114 **Study design**

115 **Theoretical framework**

116 This study was underpinned by a Foucauldian approach to discourse analysis (Willig, 2001)
117 and it was this epistemological framework which influenced data collection and analysis.
118 Discourse can broadly be defined as 'a group of ideas or patterned ways of thinking which
119 can both be identified in textual and verbal communications and located in wider social
120 structures' (Lupton, 1992, p. 145). Foucauldian discourse analysis addresses how language
121 constructs particular realities (Cheek, 1999; Parker, 1992), thereby reproducing normative
122 constructions that in part reflect social relations of power in a specific social, economic,
123 political and historical milieu (Sims-Schouten et al, 2007).

124 Discourse analysis, a methodological approach used in health and medical research to
125 understand how contested issues are constructed (Paulson & Willig, 2008;Ussher et al, 2013),
126 was used to identify discursive constructions of obesity and obesity communication, in the
127 context of broader cultural discourse. Arguably, a key strength of undertaking a discourse
128 analysis is the capability of the method to question dominant understandings, focus on power
129 relations and knowledge construction and ultimately to produce new insights into areas of
130 health and illness which are overlooked when using conventional qualitative methodologies.

131 **Participants and recruitment**

132 Ethical approval was gained by the Research Ethics Committee for Health and the
133 Psychology Ethics Committee, University of [Bath]. Participants included GPs working in
134 three Clinical Commissioning Groups (CCGs) in the South West of England who responded
135 to an invitation circulated through professional networks. Snowballing sampling procedures
136 were used: GPs who had stated interest in participating in another study conducted by the
137 lead author (MB) as part of her PhD research were contacted directly. Twenty two GPs
138 expressed interest in the study and were sent further details about the study. Subsequently,
139 twenty GPs agreed to participate. Participants received an online retail voucher for
140 participating. Interviews took place between February and April 2014.

141 **Trigger film interviews**

142 Trigger films are typically 2 to 4 minute video clips simulating real-life clinical scenarios,
143 (Ber & Alroy, 2001; Johnston & Chan, 2012). They are a type of video vignette used to elicit
144 discussion about beliefs, values and norms and can be used as a tool to encourage
145 respondents to reflect on their own experiences (Hughes & Huby, 2012; Mah et al, 2014). In
146 line with the discourse analytic approach taken in this study, the capacity of vignettes to
147 situate clinical scenarios within a specific social and cultural context (Jackson et al, 2015;

148 Mah et al, 2014) was considered an optimal way to prompt respondents to draw on the
149 discursive resources available to them. Furthermore, vignettes facilitate the exploration of
150 topics which are often considered sensitive due to moral and ethical dimensions and are
151 increasingly used to explore topics that attract diverse and entrenched views (Hughes &
152 Huby, 2012; Mah et al, 2014). Thus, the trigger film interviews were used in this study to
153 stimulate discussion about obesity and the challenges of addressing weight loss, and, to
154 encourage GPs to draw on their own experiences.

155 Three trigger films were designed for use in the interviews taking into consideration: the aims
156 and research questions of the study, a review of the research literature, our findings from a
157 previous study in which we identified barriers to raising the topic of weight in general
158 practice (Blackburn et al, 2015), and pragmatic considerations such as cost and time. We
159 were particularly mindful of balancing the number of trigger films with the time available for
160 respondents to talk about the scenarios and their practice in adequate depth whilst allowing
161 time for the discussion of supplementary matters emerging from the films. Following
162 considerable discussion in team meetings and drawing on guidance from Hillen et al (2013),
163 three clinical scenarios were arrived upon which incorporated trigger points that generated
164 divergent views (as identified in our previous research) and thus were likely to elicit
165 discussion within interviews. The trigger films varied in relation to whether the GP raised the
166 issue or not, the patient's reaction to their GPs' intervention (when the issue is raised), and
167 the reason for the patient consulting, which prior research indicated were important
168 dimensions in clinical decision making and/or were likely to produce a diversity of
169 reflections from GPs. The content and purpose of each trigger film is shown in Table 1.
170 Initial scripts were written by MB based on prior empirical data and discussed with primary
171 care and public health practitioners to ensure the scenarios were reflective of real life clinical
172 practice.

173 A professional film company was commissioned to produce the films and four actors were
174 recruited to enact the doctor and patient roles. Filming took part in a GP surgery and a retired
175 GP attended brief periods of the filming to ensure clinical realism. An image from one of the
176 final set of trigger films is provided in Figure 1.

177 FIGURE 1 (in colour online only, 1.5 column fitting image)

178 TABLE 1

179

180 **Data collection**

181 Prior to interviewing participants, the trigger films were piloted with five GPs, providing the
182 opportunity to trial the interview questions and ensure the films were effective at generating a
183 discussion about obesity and raising the topic of weight. During interviews, participants were
184 invited to watch each trigger film before being asked to discuss their thoughts and feelings
185 about raising the topic of weight; their views about the challenges of talking to patients about
186 weight; and, beliefs about efficacy. The interviewer remained open to and followed up on
187 elements of the scenarios raised by participants to allow GPs to discuss aspects of the trigger
188 films that were most relevant to them and their broader practice. The opening screen of each
189 film clip informed participants that the video was a simplified representation of a medical
190 consultation and was designed to trigger discussion.

191 GPs were interviewed in their surgery, in a study room at the University of [Bath] or at their
192 home. Interviews were audio recorded. The duration of interviews ranged between 30 and 95
193 minutes. Interviews were transcribed by MB for word and punctuation only, in line with the
194 discourse analysis procedure followed by Parker (2002) whereby interviews are viewed as a
195 constructive practice with the aim being to read representations of the world rather than being

196 concerned with 'truth'. Thus the approach was concerned with a macro-analysis of language
197 use and text.

198 **Analysis**

199 A discourse analytic approach, guided by the method described by Parker (1992) and Willig
200 (2001), was employed to analyse the interview transcripts. In line with a Foucauldian
201 analytic approach, the discourse analysis was performed at a macro level with the emphasis
202 being on the way that language available to GPs 'sets limits upon, or at least strongly
203 channels' what can be thought, spoken about and done (Burr, 2003, p. 63) and reproduces
204 power relations (Parker, 1992). Thus, prior to and in conjunction with the analysis, the lead
205 author read widely, paying attention to the way that obesity is constructed in current and
206 previous research and policy documents. This exercise demonstrated that a number of
207 discourses including biomedical, moral, public health and political discourse are drawn on to
208 construct obesity. Given that previous literature emphasised a moral discourse of obesity and
209 the negative implications of this discourse for doctor-patient interactions and patients health
210 (Throsby, 2007), the primary aim of the analysis was on the ways in which GPs engage with
211 or resist moral constructions of obesity, in addition to shaping and reproducing moral
212 discourse.

213 Analysis focused on the entirety of each GP's account rather than responses to individual
214 trigger films in order to identify patterned ways of thinking and talking about obesity and
215 barriers to raising the issue of weight. Initially, the whole of each participant's transcript was
216 read and re-read to gain familiarity with the data. Analysis followed a four-stage process
217 adapted from the method outlined by Parker (1992) and Willig (2001): (1) Sections of the
218 text which alluded to obesity and the challenges of talking about weight were extracted and
219 subjected to a closer analysis; attention was paid to the ways in which GPs' talk cohered

220 around specific understandings of obesity and meanings related to raising the topic of weight.
221 (2) Each of the extracted sections were coded for wider socio-cultural discourses which were
222 consistent with a moral discourse of obesity (Jutel, 2005; Throsby, 2007). (3) The subject
223 positions (the rights and obligations, and what a person can and cannot say, based on what
224 discourse makes possible) were identified (Davies & Harrè, 1999). (4) The implications for
225 subjects and social practice were outlined.

226 The coding of the data was carried out by the lead author (MB). The extracted text was
227 subjected to line by line coding and then grouped into discursive themes focusing on the way
228 that obesity and the challenges of discussing weight were constructed in the context of
229 broader cultural discourse. The analytic process drew on principles of thematic analysis
230 (Braun & Clarke, 2006) using a deductive approach to generate themes which exemplified
231 the ways in which GPs' constructions of obesity and barriers to communicating about weight
232 were reflective of dominant discourse about obesity. The sectional division of the themes
233 arrived at represent a structural division imposed on the data by the lead researcher and the
234 categories are not mutually exclusive (Throsby, 2007). Rather each theme demonstrates how
235 GPs' talk reinforces and resists moral discourse and when read in conjunction with one
236 another demonstrate the dominance of moral discourse in structuring talk about obesity. A
237 second member of the research team with qualitative research expertise (CE) reviewed the
238 coding of the text to ensure rigour of analysis (Shaw & Bailey, 2009). Regular team
239 meetings allowed dialogue about, and comparison of perspectives, in regards to the reading
240 of the text.

241 Reflexivity was central to the analytic process. In line with a discourse analytic approach, the
242 interview data was viewed as being collaboratively produced. We view GPs' talk as being
243 produced in response to the interview questions and in negotiation with the interviewer, thus

244 their talk speaks to and emerges from the discursive frameworks and macro-discourses
245 available in the context of this particular interview (Paulson & Willig, 2008; Rapley, 2001).

246 **Findings**

247 In total, 20 GPs participated in the study. Three of the GPs were partners, seven were
248 salaried, six were locums, two were both salaried and locums, and two were trainees. Other
249 participant demographics are presented in table 2 below.

250 TABLE 2

251 Analysis demonstrated that a moral discourse was evident within the accounts of all
252 respondents. This discourse constructs obesity as a health risk, draws on assumptions that
253 individuals can and should lose weight through behaviour change and demonstrates the way
254 that ‘weight’ or ‘fatness’ is assumed to indicated poor health and thus a ‘spoiled identity’
255 (Goffman, 1963; Monaghan, 2017). Here we discuss three themes, demonstrating the ways in
256 which GPs both reinforce and resist moral discourse surrounding obesity: *communicating with*
257 *caution, patients think we are calling them fat, and they think it is alright for you.*

258 **Communicating with caution**

259 When reflecting on the challenges of talking to patients about weight loss, GPs positioned
260 themselves as stuck in a precarious space, expressing concern that interventions around
261 weight loss would subject patients to judgment yet simultaneously expressing a desire for
262 patients to take responsibility. Weight loss was described as something that patients often
263 “struggled with”, “a long and difficult journey”, and something that patients had to “battle”
264 with. Broaching the topic of weight loss without appearing insensitive was considered a
265 delicate task. GPs described concern that talking to patients about weight loss might deter
266 individuals from returning to seek medical advice for other health problems. Raising the topic
267 of weight was thus constructed as a risk to a patient’s broader medical care.

268 Patients were mainly positioned as aware of the need to lose weight and assumed to be under
269 pressure to do so from others, such as family members. In addition, GPs perceived that
270 patients had been trying, often without success, to lose weight over a long period of time.
271 Thus, by distancing themselves from being “yet another person” (GP 9) pressurising their
272 patient to lose weight and by arguing that their intervention would marginalise patients, GPs
273 were able to justify not raising the issue.

274 *“I have to be very careful ... not to sound as if I’m making assumptions that they just haven’t*
275 *thought about this or tried it before me mentioning it, they’re not just waiting there to be*
276 *given my opinion and go off and act on it, they’ve got their whole complex story before that*
277 *point which would involve all sorts of things around them having tried to lose weight and not*
278 *being able to”*. (GP 9).

279 GPs therefore described taking a cautious approach to raising the issue to avoid patients
280 feeling blamed. Opening up discussions about weight loss were limited to instances when
281 GPs were confident that a patient’s excess weight related to an already established medical
282 problem, giving them “good medical grounds to do so”. Thus, when obesity could be framed
283 as a risk factor for a(nother) medical problem, GPs positioned themselves as feeling safe to
284 bring the issue up. In the following excerpt GP 16 discusses “treading carefully” to ensure
285 she doesn’t “get patients’ backs up”; raising weight in this scenario might lead to patients
286 feeling unfairly “picked on” and indicate subjective judgment rather than an evidence-based
287 need to raise the topic.

288 *“You have to be careful about unnecessarily attributing something to weight if it isn’t*
289 *because patients are very, very sensitive about it so when you’re sure of your ground then it’s*
290 *absolutely correct so if someone develops diabetes or something like that erm and you’ve*
291 *looked at all the lifestyle things and they still haven’t lost weight then that’s absolutely*
292 *appropriate, when someone’s got bad arthritis in their knees and you know that, that is*

293 *entirely correct to sort of bring it up because that is a direct cause and effect, it's attributing*
294 *something."* (GP 16).

295 When reflecting on the vignette portraying a patient's body weight being raised in the context
296 of a consultation about plantar fasciitis (trigger film 2), GP 10 similarly expresses discomfort
297 and cautiousness about focusing predominantly on body weight. The following quote
298 demonstrates the way that raising the issue of weight is constructed as a GP's obligation (or
299 'agenda') which is in tension with the expectations and needs of the patient.

300 *"so she clearly didn't think her foot problem was related to weight and so bringing it in just*
301 *felt like I came to you about my foot and now you're pushing your agenda on me (GP10)*

302 Throughout accounts, GPs expressed concern that patients and members of the public
303 perceived medical professionals as authoritative figures who were unduly focused on weight
304 loss, attributing excess weight to the cause of all medical problems. Patients were positioned
305 as sceptical of the support or advice that GPs could offer, with the broader patient population
306 described as dissatisfied and frustrated about being given simplistic advice for a complex
307 issue.

308 *"They think well they're just going to tell me to lose weight and I know that and I can't do*
309 *anything about that and a feeling of being kind of disempowered and out of control and*
310 *feeling useless and judged ...they might think well the doctors going to tell me it's all about*
311 *my weight and you hear people, people on buses and in public say things like that, people say*
312 *'they're just going to tell me to lose weight', and you want to avoid that."*(GP 17).

313 Despite this concern, GPs expressed their desire for patients to take responsibility for being
314 overweight and for changing this through lifestyle change. Assumptions that patients had
315 caused their excess weight and needed to change their eating and physical activity behaviour
316 were evident throughout accounts. Several GPs described patients who "blamed" their excess

317 weight on external factors and wanting medical professionals to give them the solution to
318 weight loss. It was thus considered an important role of the GP to help patients become
319 accountable and motivated to lose weight, albeit, without upsetting patients in the process

320 *“You don’t want to seem as if you’re blaming them so if they feel like you are, or they’re*
321 *trying to shift the blame onto something else that can be quite difficult cause really it’s the*
322 *patient’s responsibility we feel and they don’t want to take responsibility sometimes and that*
323 *can be hard to try and shift that around yeah, don’t want to get into a fight about it.” (GP*
324 *18).*

325 Through demonstrating that a discussion of body weight is not interpreted as a value-free and
326 benevolent topic but one that takes them off “safe ground” and which might result in a
327 ‘fight’, GPs appear to be drawing on, and reinforcing, a moral discourse of obesity. Whilst
328 GPs express concern about patients feeling judged, responsibility for weight loss remains
329 with the patient, echoing cultural views that weight loss is an individual, behavioural
330 problem.

331 **Patients think we’re calling them fat**

332 Throughout their accounts, GPs expressed concern that patients would feel labelled as ‘fat’.
333 As one GP described, “I worry about offending people and kind of going “you’re fat” erm
334 you know and I can call you obese and that is medical but it just sounds offensive” (GP 8).
335 GPs positioned patients as interpreting their interventions about obesity as a personal insult
336 and non-medical rather than a legitimate medical topic. The following GP describes
337 exercising caution around broaching the topic of weight which she attributes to the negative
338 experiences of other health professionals. These constructions point to the personal nature of
339 talking about obesity and the relationship between body weight and a patient’s identity.

340 *“I know kind of there’ll be situations where kind of nurse colleagues have had a relationship*
341 *that completely broke down with a patient for trying to address the issue of weight and them*
342 *going ‘well you said I was fat’ and that’s really rude kind of thing. ” (GP 8).*

343 Inadequate medical solutions available for GPs to support patients with weight loss were
344 described as contributing to the difficulty of raising the issue, with GPs positioning
345 themselves as reductionist in the way they could only offer dietary and physical activity
346 advice despite recognising the complexity of obesity. Thus, as well as perceiving themselves
347 as personally insulting patients by labelling them as overweight, GPs were reluctant to further
348 compound this by offering simple solutions.

349 *“It’s just the stigma and not wanting to offend people as well as not, not necessarily being*
350 *confident that you can provide them with a solution so it’s kind of a, you know, it’s a horrible*
351 *thing to say well you know this is a big problem but you know run along and eat some salad,*
352 *it’s not easy.” (GP 3).*

353 Another GP discusses a past experience of raising the issue of weight which resulted in a
354 patient feeling blamed. To demonstrate the difficulty of engaging patients and promoting
355 shared understandings about weight loss, the GP emphasises her “well-developed
356 relationship” and “gentle approach” with the patient.

357 *“I eventually said you know and I’ve been seeing her for about two years, this is not a new*
358 *relationship, this is a very well-developed relationship, very established and I felt at that*
359 *stage, you know to say you know ‘one of the things I think that’s contributing to this that we*
360 *haven’t talked about is your weight’ and she went absolutely off the deep end you know, well*
361 *you’re calling me fat and you’re calling me greed, you’re just saying I’m greedy aren’t you’*
362 *and you know I approached it in the gentlest way possible.” (GP 16).*

363 As discussed widely in the research literature, the association between ‘fatness’ and moral
364 deviance is deeply pervasive (Lupton, 2013; Throsby, 2007), thus by referring to excess
365 weight as ‘fat’, obesity is taken out of a medical domain and situated in a personal and moral
366 domain. Whilst GPs accounts suggest that patients are resistant to being labelled in this
367 simplistic way, their continued use of the term suggests they have limited alternative (and
368 constructive) language in which to discuss weight with patients. Their accounts work to
369 demonstrate that fatness is a ‘spoiled identity’ (Goffman, 1990) which supersedes taking a
370 “gentle approach” to talking about weight or a “developed” doctor-patient relationship. In
371 constructing obesity as ‘fatness’ GPs’ appear to be drawing on, and reinforcing, a moral
372 discourse of obesity which is amplified through the inadequate medical solutions available
373 for GPs to support patients with obesity.

374 **They think it’s alright for you**

375 In addition to positioning obese patients as subject to judgment and blame, some GPs
376 described their own bodies as being evaluated and criticised during consultations. Several
377 GPs described feeling scrutinised by patients due to being perceived as either ‘overweight’ or
378 ‘too slim’. In the following extract, judgment about body weight is construed as being
379 equivalent to judgment about one’s life. While the GP positions the judgment she receives
380 from patients as simplistic and unfair, she then goes on to suggest that maintaining a normal
381 body weight is important since she has a ‘duty’ to act as a role model.

382 *“Patients ... won’t say ‘doctor so and so’s fat’ but they will give you the look, and the other*
383 *thing, the other way round you get it is ‘it’s alright for you’ which is the reverse on it’s head,*
384 *‘it’s alright for you to talk about my weight because you’re really nice and slim’...and so it’s*
385 *like, you don’t know, you don’t know my life sort of thing, you don’t know my issues type*

386 *reply so it's, it's both ways. They do, do see you as a role model so I think one should,*
387 *doctors should reflect what they're telling patients.”(GP 16).*

388 As is evident in the excerpt below, GPs construe judgment about body weight as equivalent
389 to judgment about the way a person lives their life. Implicit within this excerpt and
390 throughout accounts is the assumption that obesity is inextricably linked to deviant behaviour
391 and a lack of self-control whereas a slim body is linked to effort and hard work. By
392 positioning themselves as subject to their patient's gaze, GPs challenge the idea that patients
393 are the only 'victims' in regards to being morally evaluated based on their body size.

394 *“I think patients probably think horrible and personal things about their doctors as well and I*
395 *think they make assumptions ... I think they make personal assumptions about you and they'll*
396 *probably be like 'bloody doctor you know it's easy for them to say, their life is perfect'*
397 *because what they'll see is somebody sat next, you know, sat, talking, their job erm not all*
398 *doctors are, got a BMI in range but I think they probably think it's easy for them to say but*
399 *they don't live my life and if they lived my life they might struggle.” (GP 7).*

400 In contrast to those GPs who positioned their “slim body” as an obstacle for patients to feel
401 understood, the following GP positions her own “slightly overweight body” as an aid to
402 talking about weight loss, helping her to feel less judgmental and paternalistic. Being
403 'overweight' is thus constructed as a body size which facilitates shared understanding and
404 empathy, rather than contempt and distance.

405 *“I find it easier to raise the subject with people because I'm slightly overweight myself*
406 *whereas in the past when I was younger and skinnier I probably would havefound it harder*
407 *because I could almost like join people on the same side of the fence... if you're kind of*
408 *sitting there as some super-fit skinny person saying 'well frankly Mr So and so, you know*
409 *you're frightfully obese and you've only got yourself to blame for your knee pain because if*

410 *you weren't so overweight then'... I think that is what you potentially feel as a doctor*
411 *broaching it with people."* (GP 14).

412 As the extracts demonstrate, GPs position the way their body either conforms or deviates
413 from 'normal' weight as central to the way that patients respond to their attempts to broach
414 the topic of weight. In categorising their own bodies as either an aid or a hindrance in talking
415 to patients about weight loss, GPs reinforce the dichotomy between fat and thin. Further, by
416 positioning themselves as subject to judgment from patients, GPs' accounts demonstrate the
417 way that obesity is a personal and indeed political issue for all involved and highlights that
418 the normalising and regulatory power of obesity discourse is diffuse rather than operating in a
419 unilateral way (Foucault, 1991).

420 **Discussion and conclusions**

421 This is one of the first studies using trigger films to look at how socio-cultural and political
422 discourses influence and shape, and is in turn shaped by, GPs' understandings of obesity. A
423 key finding is the ambivalence evident within GPs' accounts, demonstrating the conflicting
424 and multiple discourses surrounding obesity. GPs draw on discourse which constructs obesity
425 as primarily caused by individual behaviour whilst simultaneously drawing on discourse
426 which positions patients as powerless to lose weight, and, as subject to judgment and blame
427 by wider society. Furthermore, whilst framing obesity as an important health problem that
428 should be addressed rather than ignored, GPs simultaneously describe body weight as central
429 to one's sense of self and a personal attribute, which they feel reluctant to criticise. Thus GPs
430 appear to be trapped in an ambiguous space, occupying a professional role which requires the
431 promulgation of biomedical risk discourse yet cognizant of reductionist and moral discourse
432 pervasive within society. Significantly, our findings demonstrate the difficulties of

433 communicating about body weight and weight loss practices in ways that avoid the
434 reproduction of dominant constructions of obesity.

435 Aligning with other studies, our findings highlight the pervasive nature of moral discourse
436 surrounding obesity (Bombak et al, 2016; Owen-smith et al, 2018). Whilst we suggest that
437 GPs' constructions of obesity are broader and more complex than being a simple
438 reproduction of moral discourse, it is important to emphasise that the majority of their
439 discursive constructions were based on assumptions that individuals should and could lose
440 weight through changing their eating practices and/or through physical activity. Focusing on
441 behaviour change and/or individual responsibility in isolation to wider societal and economic
442 solutions, aligns with beliefs that obesity is under individual control, which could contribute
443 to stigma being enacted and enforced in subtle ways within medical consultations (Brown &
444 Flint, 2013; Malterud & Ulriksen, 2011).

445 Our findings also suggest that GPs may internalise and come to regulate themselves with the
446 same moral discourse, reinforcing individualised and reductionist constructions of obesity in
447 relation to their own bodies. Despite a growing evidence base challenging the
448 conceptualisation of obesity as a simplistic behavioural problem, including the publication of
449 the Foresight report 10 years ago (Butland et al, 2007; Ulijaszek & McLennan, 2016), our
450 findings suggest that in clinical practice, obesity continues to evoke blame and moral
451 judgement. We therefore highlight the need for all those involved in the medical management
452 of obesity to recognise and reflect on the complexity, and multiplicity of meanings
453 surrounding body weight. It is notable that despite guidelines advocating that health
454 professionals routinely prevent and manage obesity in general practice, there is little advice
455 or evidence around ways that clinicians can challenge, rather than reinforce, simplistic and
456 oppressive understandings of obesity deeply embedded in the powerful discourses
457 surrounding body weight (Aranda & McGreevy, 2014).

458 In addition to identifying the reproduction of moral discourse within GPs' accounts, our
459 findings also demonstrate that GPs resist moral constructions of obesity by drawing on socio-
460 cultural discourses of body weight and stigma. Whilst obesity was described as an important
461 health risk, many GPs claimed they did not prioritise this risk over the social and personal
462 experience of *being* overweight and construed efforts to lose weight as a 'struggle' for
463 patients. The recognition of obesity as a complex problem was positioned in stark contrast to
464 over-simplified solutions such as 'eat less, move more'. Being equipped with such a
465 reductionist approach appeared to be adding to the discomfort and reluctance of GPs who
466 demonstrated concern that patients feel blame rather than support when weight loss is
467 broached in general practice. In framing obesity as a complex and multi-faceted problem,
468 GPs presented a sense of powerlessness, positioning themselves as working within a medical
469 system unable to provide patients with comprehensive support. As others have contended,
470 health care systems are not yet designed to deal with the clinical complexity of obesity, being
471 more aligned to treat acute conditions (Kirk et al, 2014). Significantly, GP ambivalence
472 resulting from these competing discourses may manifest as discomfort and awkwardness
473 when interacting with patients about weight management (Mold & Forbes, 2013).

474 Building on research that demonstrates diverse views and tensions around the
475 conceptualisation of obesity (Trainer et al, 2015; Warin, 2015), we have demonstrated the
476 complexity of meanings attached to body weight and the centrality of power relations
477 involved in categorising body weight and communicating about obesity. The ambiguity of
478 obesity as a legitimate medical condition reflects the ongoing debate between researchers and
479 throughout society more broadly as to whether obesity is a lifestyle, a disease and/or a social
480 identity (Patterson & Johnston, 2012). Indeed, given the contestation around the
481 medicalization of fatness demonstrated by researchers and activists, as well as the attention
482 obesity has gained from the media and public health institutions, it can be concluded that

483 obesity has become a political issue (Monaghan et al, 2013; Ulijaszek & McLennan, 2016).
484 Thus the uncertainty and ambivalence demonstrated by GPs towards discussing weight loss
485 with patients seems to echo the social and political landscape they are working within.

486 In describing their patients' experiences, GPs in this study were drawing on metaphors that
487 are widely used within healthcare (Fullager & O'Brien, 2012; Skelton et al, 2002) and which
488 have been documented in relation to experiences of obesity and by health professionals
489 caring for people with obesity (Kirk et al, 2014; Schmied et al, 2011). In the context of
490 obesity, scholars have repeatedly noted the use of military metaphors within dominant
491 discourse surrounding body weight (Saguy & Almeling, 2008; Tischner & Malson, 2011),
492 which to some extent (i.e. in describing obesity as a 'battle'), have been reproduced here.
493 The varied ways in which GPs respond to their patients' use of metaphors about the
494 embodied experience of obesity and weight loss, and the extent to which GPs' responses and
495 use of metaphors provide hope rather than futility, is worthy of further investigation.

496 A key strength of this study is the creation and operationalisation of trigger films which were
497 designed to prompt reflection into an area of clinical practice that is difficult to research in an
498 abstract way. As demonstrated, trigger films proved to be an innovative methodological tool
499 to explore the ways in which GPs discursively construct barriers to raising the topic of weight
500 with patients. In line with other studies which report that vignettes can stimulate health
501 professionals to discuss personal experiences, trigger discussion of supplementary matters
502 and generate multi-layered accounts (Llanwarne et al, 2017; Mah et al, 2014), the films in
503 this study were well received by respondents who, after watching the trigger films, discussed
504 examples of their own clinical encounters and appeared comfortable to express their
505 ambivalence around this area of practice. One way to extend the use of such trigger films
506 would be to increase the variety of actors used to depict the role of the Doctor. This could
507 enable further insight into discursive constructions, including the role of a GP's own body

508 weight, and whether and how GPs feel judged by patients. In this study only one actor
509 (female, 'normal' BMI) was used to play the role of the doctor yet several GPs commented
510 that if the Doctor was overweight, raising the topic of weight would be uniquely challenging.
511 Similarly, if actors with a BMI in the 'severely obese' rather than 'obese' range had played
512 the patient, alternative constructions about obesity and additional examples of clinical
513 encounters may have emerged during the interviews.

514 In line with other qualitative studies, the data generated is a co-creation of the encounter
515 between researcher and participants. The accounts of GPs were based on reactions to three
516 trigger films which were constructed by the research team. If another set of vignettes had
517 been shared, GPs' accounts and the discourses identified may have differed, particularly as
518 the vignettes were based on the current individualised approach to obesity management in
519 general practice. However, one of the criteria for designing trigger films is that they
520 represent clinical realism and resonate with participants' experiences, which our findings
521 suggests they did, thus we argue that they align with the current medical approach to obesity.
522 In addition, as with all discourse analytic studies, the discourses identified as being
523 operationalised by GPs in this study are specific to the design of this research project.

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674

675 **Tables and figures:**

676 Table 1

677 Content and purpose of trigger films used within qualitative interviews

	Trigger film 1	Trigger film 2	Trigger film 3
Plot	Paul consults with knee pain	Eleanor consults with heel pain (Plantar Fasiitis)	Pauline consults with ear ache
Objective	To explore GP 'avoidance'	To explore patient reaction	To explore a 'health promotion' approach to raising the topic
Trigger point	GP avoids raising the topic of weight	Patient does not want to talk about weight	GP asks patient if she wants to talk about smoking, alcohol consumption, diet or fitness

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682 Table 2

683 Demographic details reported by participants

	Number of participants
Sex:	
Male	8
Female	12
Age:	
21-30	3
31-40	12
41-50	4
51-60	1
Experience as GP in General Practice:	
0-5 years	11
6-10 years	5
11-15 years	2
16-20 years	1
21-25 years	1

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688 Fig. 1. Still of Trigger film 1

689 Paul consulting with knee pain



690

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ACCEPTED MANUSCRIPT

Research highlights

- Trigger films were produced to facilitate discussion about obesity communication.
- GPs simultaneously resist and reproduce moral discourse surrounding obesity.
- Competing discourse surrounding obesity contributes to GP ambivalence.
- Blame and moral judgment are central to GPs reluctance to discuss weight loss.