

the
WEIGHT
of
OPINION

General Practitioners' perceptions about child and adolescent overweight and obesity

Lesley King¹, Julika Loss³, Rachel Wilkenfeld¹,
Denna Pagnini¹, Michael Booth¹, Sue Booth³

¹ NSW Centre for Overweight and Obesity, University of Sydney

² Australian Centre for Health Promotion, University of Sydney

³ NSW Centre for Public Health Nutrition, University of Sydney

The Weight of Opinion Study: **General Practitioners' perceptions about child and adolescent overweight and obesity**

March 2007

Acknowledgements: This research was funded by NSW Department of Health and The Ross Family Trust. The NSW Centre for Overweight and Obesity and NSW Centre for Public Health Nutrition are funded by NSW Health and supported by The University of Sydney. Principal Investigators for the study were Dr Michael Booth and Lesley King. The authors would like to thank Louise Erickson for her valuable contribution to this project, as well as all the General Practitioners who participated in the study.

Suggested citation: King L, Loss J, Wilkenfeld R, Pagnini D, Booth M, Booth S. (2007)
The Weight of Opinion: General Practitioners' perceptions about child and adolescent overweight and obesity.
Sydney: NSW Centre for Overweight and Obesity.

Authors: Lesley King¹, Julika Loss², Rachel Wilkenfeld¹, Deanna Pagnini¹, Michael Booth¹, Sue Booth³

1. NSW Centre for Overweight and Obesity
2. Australian Centre for Health Promotion
3. NSW Centre for Public Health Nutrition

TABLE OF CONTENTS

Executive Summary	2
<hr/>	
Introduction	3
Methods	3
Results	6
Conclusion and discussion	10
Practice and policy implications	15
<hr/>	
References	17

Executive Summary

This report is one of a series from the Weight of Opinion Study (WOO), a qualitative study conducted by the NSW Centre for Overweight and Obesity (COO). This research was conducted to contribute to understanding the extent to which members of the community and professionals see overweight as a threat to the health of young Australians, the factors they see as causal, what actions they consider might be most helpful, and perceptions about their roles and responsibilities, sense of self-efficacy and commitment to action.

The research involved focus groups with General Practitioners (GPs) from four study sites in NSW. The sites were selected to reflect a range of socioeconomic and infrastructure differences, in order to obtain the views of participants from diverse backgrounds and circumstances. A core set of questions related to their perceptions about roles, responsibilities and potential solutions to addressing overweight and obesity amongst children and young people was discussed.

The results show that the GPs in this study were keenly aware that childhood overweight and obesity is a problem in the community and has potentially serious medical consequences. At the same time, they were aware that social factors were the main causes.

In terms of their role, some GPs reported that they weigh children regularly, but many do not. While most thought that it would be ideal to incorporate weight assessment into standard medical consultations, they were aware of significant barriers to doing this. The GPs reported that it was rare for a parent to raise concerns about their child's weight. Doctors were aware that parents can be sensitive about their child's weight, so they take account of the doctor-patient relationship when deciding how to approach this issue with a parent. The GPs in this study made specific suggestions about ways of raising the topic with parents and young people. The GPs felt confident about providing advice on weight management. Some GPs are directly involved in weight management with their patients and perceive that this is most acceptable to the patients. Others saw that their role was largely as a gatekeeper for other services, and thought it was not feasible for them to provide detailed dietary advice, in particular. The likelihood of referral was influenced by a variety of external factors including accessibility of referral services. In relation to adolescents, the GPs recognised the importance of talking with them privately and confidentially about weight issues, but would seek to involve parents, with the permission of the adolescent. There was a consistent view that weight management of both adults and children is complex and difficult, and not generally successful, particularly in the current social context.

The GPs in these groups were extremely positive and committed to working with parents, adolescents and children on preventing and managing weight problems, despite all the complexities. They seek to provide direct, honest advice for those who seek advice and assistance. The GPs wanted clear pathways for referrals to dietitians and physical activity providers, with simple systems for people to be reimbursed for weight management referrals. They would also like to see their role supported through community education campaigns, and perceived that they constitute only one part of a broader approach to addressing childhood overweight and obesity.

The findings have direct implications for professional education and development of GPs, as well as public policy and service delivery systems to support GPs.

Introduction

This paper is one in a series of reports on the findings from the Weight of Opinion Study (WOO), a qualitative study conducted by the NSW Centre for Overweight and Obesity (COO).

The incidence and prevalence of overweight and obesity among young Australians are high and rising (Booth et al, 2006; Magarey et al 2001). The consequences of overweight for the health of young people are extremely serious and involve almost every body system (Batch & Baur 2005). While information about childhood obesity has been widely discussed amongst specialist professional groups internationally, very little is known about the perceptions and responses of community members and broader professional groups to the issue of paediatric overweight and obesity.

This research was conducted to contribute to understanding the extent to which members of the community, professionals and government agencies see overweight as a threat to the health of young Australians, the factors they see as causal, what actions they consider might be most helpful, and perceptions about their roles and responsibilities, sense of self-efficacy and commitment to action. We aimed to describe and to compare responses from: parents, young people, members of school communities, childcare staff; and general practitioners (GPs).

While there is universal endorsement that a broad, comprehensive approach to the prevention of childhood overweight and obesity is fundamental, it is recognised that health professionals generally, and GPs in particular, can play a significant role in supporting children and families to understand the problem and make positive lifestyle changes (NHMRC 2003). This is consistent with the role of GPs as the key provider of primary health care services for children and young people in Australia, and expectations about their role in chronic disease assessment and management, either as a principal service provider or as part of a structured multidisciplinary team (Oldroyd et al 2003; Wake & McCallum 2004). To support this role, several countries have developed clinical practice guidelines for the assessment and management of overweight and obesity, including the USA,

Canada, Australia, Israel, Germany, Scotland and the Czech Republic (Loss & Wise, Submitted for publication).

A deeper understanding of community and professional perceptions will influence many aspects of intervention planning, including communication, methods of building community engagement and action, and improved approaches to assessment, prevention and management of overweight and obesity among children and families.

Methods

Selection of study sites

Four areas were selected as study sites¹ - three within metropolitan Sydney and one in rural NSW. The study sites were selected to reflect a wide range of socioeconomic and infrastructure in order to obtain the views of participants from diverse backgrounds and circumstances. Several criteria were used to select the metropolitan areas:

- socioeconomic status (a mixture required)
- location (spread across AHS required)
- enough schools, preschools, and childcare centres to support the study; and,
- number of schools, pre-schools and childcare centres in the area.

In addition, it was necessary for the NSW Department of Education and Training to have provided approval for access to schools in the area. Based on these criteria, three areas were selected within the AHS boundaries (as applicable in early 2005) of Northern Sydney, Western Sydney, and South Western Sydney. The areas selected also generally mirrored the boundaries of the NSW Divisions of General Practice. Within each of the areas, specific postcodes were chosen based on SEIFA² indices (Australian Bureau of Statistics, 2003), and adjoining postcodes were chosen in order to increase the number of preschools, child care centres, and schools available to the study.

¹ With the recognition that these are aggregate measures which represent a range of individual circumstances within each area. However, the areas did differ in terms of housing stock, population density and the availability of resources including public transport.

² SEIFA refers to the ABS socioeconomic index for areas.

The Weight of Opinion: General Practitioners' perceptions about child and adolescent overweight and obesity

The rural site was selected because it represented a rural area (rather than a large regional centre) yet still had enough preschools, child care centres, and public schools to support the study. The area, in South Western NSW, has a population of 25,000 and consists of a town surrounded by outlying villages, with one local hospital. The main industries of this area include agriculture/ horticulture, food processing, manufacturing, and wine production. Unlike many rural areas, however, it also has a large multicultural population.

Table 1 presents the average SEIFA scores in each of the areas. Although the SEIFA index for the Western Sydney area is below the state average, it was characterised as a medium SES area because it consisted of an older housing estate surrounded by much newer and higher cost housing.

Table 1. Average SEIFA Index for WOO Study Sites

Socioeconomic Status	Geographic Area	SEIFA Index
Low	South Western Sydney	937.3
Medium	Western Sydney	967.8
High	Northern Sydney	1130.4
Rural	South Western NSW	991.6
NSW State Average		992.0

With the selection of only four geographic areas, the results may not be representative of NSW. However, the purpose of this qualitative research was to provide an initial investigation into community perceptions about childhood overweight and obesity, and was not intended to be a representative population study. Remote areas, regional centres, metropolitan areas outside Sydney, and areas with large Indigenous populations could not be included in this study but deserve further attention in the future.

Development of the focus group questions

Questions to be discussed in the focus group were based upon a literature review identifying key issues faced by GPs in dealing with the issue of childhood overweight and obesity (Loss & Wise, Submitted for publication), including communication and treatment/prevention issues. Adolescents and younger children were discussed separately. As with all participant groups in the WOO study, a core set of questions related to perceptions about roles and responsibilities, policy options, whilst potential solutions

were also discussed. The topics were checked with a representative from the Alliance of NSW Divisions of General Practice and the actual questions were pre-tested with several GPs and modified to incorporate their feedback. The focus group questions are provided in Figure 1.

Recruitment of GPs

Recruitment of individual participants for the focus groups was done through the local Division of General Practice in each of the four areas. A multi-staged approach to recruitment was used:

- Based on information from the Alliance of NSW Divisions of GPs, a WOO researcher contacted the appropriate staff member within each Division, explaining the purpose of the study and asking whether the Division could provide assistance in recruitment and finding a suitable venue. All four divisions agreed to participate. Supporting materials were then faxed/emailed to the Division.
- WOO staff worked with the local Divisions to secure venues – a Division office, a local hospital, a medical school, and a local pub.
- The WOO team prepared individual, stamped envelopes containing a flyer advertising the focus group and information about the study. The Divisions then addressed and mailed the envelopes.³
- Interested GPs phoned COO to register for the focus group. Group size was restricted to 10. Additional interested GPs were placed on a waiting list.

Focus Groups

The same WOO researcher led all four of the focus groups, using a sociological methodology in which group discussion, rather than just the answering of one question after another, was emphasized. Before the groups commenced the purpose of the study was explained again and written consent was obtained from all participants. Confidentiality, the fact that there were no right or wrong answers, and that the purpose of the group was to hear about their experiences and ideas were all stressed to the participants. The group discussions generally took about 90 minutes.

³ For privacy reasons, the doctors' addresses had to remain with the Divisions.

The Weight of Opinion: General Practitioners' perceptions about child and adolescent overweight and obesity

The interviews were taped-recorded and later transcribed verbatim. Upon the recommendation of the Divisions, the GPs who attended were paid a sitting fee of \$150.

Figure 1: Focus Group Research Topics

Broad Topic 1: To what extent do GPs recognise overweight and obesity as an important issue?

1. Do you think overweight and obesity is an issue for children and adolescents in NSW?
Why/why not?
2. Do you see it as an issue for your practice?
3. How do you know if a child or adolescent is overweight or obese? How do you make that distinction?
4. When do you weigh children as part of a standard consultation? Up until what age?

Broad Topic 2: Discussing overweight and obesity among children (discussed separately for children under age 12 and adolescents)

1. If a child presents who seems at risk of becoming overweight, do you talk to the parents/child about it?
2. If a child presents who is overweight or obese, do you talk to the parents/child about it?
3. Do parents /adolescents ever come to you asking for help about their child's/own weight? What prompts them to ask for help?

Broad Topic 3: Treatment/management of overweight and obesity (discussed separately for children under 12 and adolescents)

1. How do you currently manage the care of a child who is overweight or obese? How often do you refer to other services (eg. specialists, dieticians, exercise programs, etc...)
2. How easy/difficult do you find it to help overweight kids adolescents get to a healthy weight?
Can you tell us any strategies that have worked well for you?
3. How confident do you feel providing advice about healthy eating or physical activity?

Broad Topic 4: Roles, Responsibilities

1. In an ideal world, what role do you think GPs should play in this issue?
2. What kinds of resources, support, or training would make it easier for you to take an active role in preventing childhood overweight or obesity? What would make it easier for you to treat childhood overweight or obesity?
3. What other things do you think would help reduce overweight and obesity among children?

Analysis

After the groups were completed and the tapes transcribed, the responses were collated under the appropriate questions to provide ease of coding. Two members of the research team independently coded the themes. Two other team members also read the collated responses and made general comments on them, which served as a further check on the consistency of the results. Agreement on the key findings was achieved quite easily, and the results are presented below.

Ethics

Ethics approval for the study was granted by The University of Sydney and the NSW Department of Education and Training (DET). All participants received information about the study and its purpose and signed consent forms. Participants were paid for their participation.

Results

The GPs' response rate to the focus group invitations was generally good. In two of the areas, the groups filled quickly and other interested GPs were placed on a waiting list. Only 10 GPs were in practice in the rural area, so recruitment was more difficult than in the larger metropolitan Divisions which had at least 80 GPs in each. In total, 31 GPs registered for the four groups, and 26 participated in the study.

Geographic Area	GPs registering	GPs participating
South Western Sydney	10	8
Western Sydney	9	8
Northern Sydney	10	9
South Western NSW (Rural)	2	1
Total	31	26

The participants were a diverse group, including both men and women, GPs from a variety of ethnic and language backgrounds, and GPs whose ages ranged from their thirties to sixties.

Results are reported below, with the key content from GPs organised in relation to the focus group questions. Overall, GPs' comments on responses to the questions and prompts were wide-ranging and inter-linked, so that comments on a topic arose at differing points throughout the group discussions.

This report presents the findings from the content analysis.

To what extent do GPs recognise overweight and obesity as an important issue?

The GPs were keenly aware that childhood overweight and obesity is a problem in the community. Some of the GPs noted that the patterns of childhood overweight and obesity seemed to be related to socio-economic status; others thought that the problem was widespread in society.

Most GPs reported that they dealt with this issue in their clinical practice, and some reported that they had seen children with type II diabetes. They were well aware of the potentially serious medical consequences of obesity, with some expressing a strong sense of urgency and concern: it's terrifying in its enormity and rapidity.

While the GPs were aware of the medical consequences, they thought that social factors were the main causes. They described a wide range of social changes that they saw were causing children's overweight and obesity, such as children's increasingly sedentary leisure pursuits, neighbourhood safety concerns, costs of sports, and the high level of availability and exposure to energy-dense foods. The GPs also discussed the influence of parents, including limitations in parents' knowledge, especially regarding portion sizes, parental attitudes that link nurturing and eating, parental modeling of practices that increase the likelihood of gaining weight, and family food practices, such as not eating meals together, skipping breakfast and purchasing energy-dense convenience foods.

Over the last few years we have definitely noticed the obesity problem, especially with children and I think it's an issue because their eating habits have changed and physical activity decreased.

Assessing weight status

In response to questions about how they assess weight status, some GPs reported that they weigh children regularly; but many don't. The circumstances where they were most likely to assess children's weight included: where they observe that a child is very overweight, when they need to calculate the right dose of medication for a child, or when parents state that they are worried about a child's weight, or a related problem.

I would invariably not talk about it, unless patients come in and talk to me about it.

There was considerable discussion and some disagreement between GPs about the applicability of BMI categories for children, and in particular for cross-cultural population groups. Many of the GPs referred to the use of growth charts, percentiles and age-adjusted BMI categories.

While most GPs thought it would be ideal to incorporate weight assessment into standard medical consultations, they were aware of significant barriers to doing this. One was that many children only attend irregularly, often when they have an acute illness. Another reason for not routinely weighing children was that it was not expected by parents, and parents were sensitive about their children's weight.

One suggestion was a system for monitoring weight among all school children, as part of routine school health assessments, thus making weight status assessment a less personally directed process.

Approaches to talking with parents about overweight and obesity where a child is at risk, or showing signs of overweight or obesity

GPs reported that, on the whole, it was rare for a parent to raise concerns about their child's weight. The main circumstances noted by GPs regarding when a parent might raise the issue included: teasing at school, the child experiencing a weight-related problem, or where the parents were specifically seeking the authority of the GP to motivate behaviour change in their child.

Sometimes you have an overweight child, and the mother always says 'listen to the doctor, listen to the doctor'.

Many GPs reported that they often choose to focus on the presenting problem, because consultation time is very limited and the topic of children's weight is not expected and sensitive. GPs felt that there is a high risk that patients may actually consider it offensive. Thus, most of the GPs said they would not act if a child is 'at risk' of being overweight, but only when they appeared or were assessed as overweight.

Doctors were clearly aware and sensitive about what parents do and don't want to hear; and take account of the doctor-patient relationship in deciding how to approach this issue. One GP noted that a child's weight status is a more sensitive issue than weight in adults. There was also awareness amongst GPs that parents' sensitivities can be associated with fears about anorexia.

I think it's a bit of a fear for parents to talk to their kids about being overweight – [they think] I can't bring it up, they will become anorexic.

A consultation that touched on children's weight was considered to be easier when there was a longer relationship with the family, or where there was a clearly associated health problem.

The GPs' perceived that this is a highly sensitive and potentially unacceptable issue to raise with parents: while they see it as a medical problem, they are aware that social factors were the main causes, and that parents and community members may consider it a social issue.

GPs' specific suggestions for ways of raising the issue included:

- Using percentiles to identify a weight problem
- Using family history of metabolic disorders as a starting point
- Humorous, tactful, slow approach; perhaps in stages

- Ask questions about a child's exercise and participation in sport.

Treatment and management of overweight and obesity in children by GPs

Some GPs reported that they conduct various tests and health checks as part of an assessment process, both to be sure that there are no (other) serious problems, and to allay patients' concerns.

Some GPs are directly involved in weight management with their patients. Direct management by GPs themselves was perceived by some as most acceptable to the patients.

I don't refer them, I try and handle the situation... I am the family doctor. I know their family setup.

As part of their management, some GPs reported that they provide advice on foods, and mentioned issues related to fats, carbohydrates, glycaemic index, portion size, calories. Some GPs referred to specific tools or approaches that they use – such as food diaries, telling parents not to use food as a reward, and giving 'lifestyle prescriptions' for physical activity.

One practical thing that worked for me, I ask the patient to compose a food diary.

Generally, the GPs reported being fairly confident about handling overweight and obesity issues with their patients. Overall, GPs felt that they are well equipped to provide factual advice and explain health consequences, but consider that it is up to families and people themselves to be motivated to make changes.

Some GPs saw that their role was mostly as a gatekeeper, to other services and that it is not feasible for them to provide detailed dietary advice. Lack of available consultation time, as well as the level of detail required for assessment and management advice, and the overall difficulty of achieving success in weight management, influenced this decision.

The GP is there to give more information to people coming in, wanting more information and details – and maybe orchestrate access to other appropriate resources.

The likelihood of referral was also influenced by a variety of other external factors including accessibility of referral services. For example, in discussing referral to dietitians, a number of GPs mentioned the costs to the patient, and that this may be a barrier, even though dietitian and other weight management services may ultimately be cheaper than GP services in terms of government expenditure. The extent to which public and private dietitian services were available was discussed by all groups.

A perceived advantage of referral was that the dietitian and GP can reinforce each other's advice. Having frequent and regular consultations, beyond that generally available through GPs, was also seen as an advantage.

Barriers associated with patient compliance

There was a consistent view that weight management of adults and children is complex and difficult, and not generally successful. It was considered hard to make advice feasible and practical, and difficult for parents and children to change complex behaviours. Childhood obesity is considered especially complex, as the whole family may need to make changes, not just one person. Many of the GPs indicated that there were significant limitations in what a GP alone could achieve; and that addressing the problem might require considerable back-up.

In fact it's almost impossible really – some parents will run with it, but a lot are defensive, and they are under-resourced with what they can do anyway, and you need a lot of back-up to get a message across, how to actually change lifestyle things...

The GPs also emphasized the difficulties of weight management in the context of the availability of energy-dense fast foods. Other barriers for compliance that were mentioned included the high costs of children's sports

The Weight of Opinion: General Practitioners' perceptions about child and adolescent overweight and obesity

and gym membership and the lack of time for parents to supervise their children's activities.

We are swimming against a huge tide....

One GP was quite explicit about the difficulty and lack of satisfaction related to preventive medicine generally.

This whole subject of obesity... is really time-consuming, and unless you are passionate enough you won't get anywhere. I have found despite my liking and preference to preach preventative medicine, that is the least effective dollar-wise and fulfillment-wise in my practice.

The groups frequently made suggestions for actions and solutions in other arenas, as noted below.

Approaches to adolescents by GPs

GPs acknowledged that working with adolescents on weight issues was different to dealing with younger children. Some commented that they rarely see older children, both because many adolescents don't realize they are eligible to get their own Medicare card, or because some adolescents may find GPs intimidating.

Other GPs thought that adolescents do perceive them as trustworthy, and noted the circumstances where adolescents approach them or where they can discuss the issue of weight. For example, one occasion is when girls seek prescriptions for the contraceptive pill. Other suggestions for bringing up the issues with young people included initiating a conversation about exercise or sports, or asking whether they were comfortable with their weight.

While adolescents were often looking for a 'quick fix', some of the GPs were very positive about dealing with adolescents and recognised that sometimes they can be very motivated to make changes.

It's easier with adolescents, they are a bit more aware of things and a bit more conscious of things around them and perhaps they understand better.

The GPs mentioned the aesthetic and social incentives for adolescents, especially girls, in being in the healthy weight range. They also noted that there may be emotional eating issues at play with adolescents; and sometimes potential eating disorders.

Often with teenage girls and boys they use food as a weapon to the parent.

While the GPs recognised the independence of adolescents, and the importance of talking with them privately and confidentially, they reported that they would generally seek to involve parents, with the permission of the adolescent. They saw that the family was responsible for many of the food choices available to the adolescent, as well as to younger children.

I tend to speak separately to the teenager and to the parents, and with the teenager's permission I would ask the parent to come in.

The GPs commented on similar factors influencing weight status in adolescents as in children, such as the over-availability of energy-dense fast foods, the lack of healthy family food habits, and lack of active transport. They considered that health promotion actions through schools and other sectors were important for adolescents, as well as for younger children.

Ideas on the ideal approach and role of GPs

The GPs in these groups were extremely positive and committed to working with parents, adolescents and children on preventing and managing weight problems, despite all the complexities. They wanted to provide direct, honest advice for those who seek advice and assistance.

I think GPs should be able to give credible accurate advice to people who want that advice.

The GPs would like to see their role supported through community education campaigns, so that people expect them to provide advice as part of routine medical care.

Awareness is the first thing, and brochures and so on in the waiting room, so people bring it up for a start.

The GPs also wanted clear pathways for referrals to dietitians and physical activity, including smooth, simple systems for people to be reimbursed for weight management referrals.

Overall, the GPs were highly aware of the difficulties of weight management in the current social context. They recognised that their role is only one part of an overall approach, and that while their role deals with the medical consequences, it does not address the basic causes of overweight and obesity. There was a prevailing and strong perception that GPs must be only one part of a broad set of solutions. Schools, in particular, were the focus of many suggestions:

I think it has to start at school, the education.

Other specific suggestions included:

- government policy generally
- community education campaigns
- school programs, including school weight assessments and school canteen foods
- community programs
- food labeling (e.g. exercise equivalents)
- limiting junk food advertisements to children
- improving access to sports and recreation programs, physical activity venues and facilities
- health system reimbursement arrangements
- food subsidies
- addressing community safety issues and indemnity insurance related to playgrounds and open spaces
- guidance on shopping for people, such as supermarket tours and fridge and trolley audits.

Conclusion and Discussion

The study shows that GPs have a high level of awareness and concern about the problems of overweight and obesity in children and adolescents. The GPs appreciated the wide range of social factors contributing to the problem of childhood obesity. At the same time, they were keenly aware of medical consequences and risks.

Interestingly, the GPs did not specifically mention the *Clinical Practice Guidelines for the management of overweight and obesity in children and adolescents* (NHMRC 2003), although they demonstrated familiarity with the intent of the first step of the Guidelines, involving the measurement of BMI. They were not always familiar with the appropriate reference points.

Information on the recommended percentile charts illustrating BMI-for-age is provided in Figure 2; and a summary of Evidence-based practice tips from the NHMRC Clinical Guidelines is presented in Figure 3.

This study supports findings from other studies that only a small proportion of GPs routinely assess children's weight (Gerner et al 2006), but adds new information on why this is the case, and strategies they use to raise the issue. GPs strive to engage with patients on this topic in ways that are acceptable and sensitive. GPs' comments describing the complexity of raising the issue of children's weight with parents powerfully illustrate previous research findings, that community norms and expectations, and perceptions about the doctor-patient relationship, directly influence providers' delivery of services (Zapka and Lemon 2004; Loss & Wise 2006).

The GPs' experiences and perceptions are in accordance with the findings from focus groups with parents, that show that parents are ambivalent about what they want from GPs, both respecting the professionalism and duty of GPs to address genuine health concerns, and at the same time feeling defensive and emotionally sensitive about their children's eating patterns and weight (Pagnini et al 2006).

The Weight of Opinion: General Practitioners' perceptions about child and adolescent overweight and obesity

The findings of this qualitative study emphasise the importance of GPs' role in initial assessment, brief advice and referral for weight management with children. Access to referral pathways, and collaboration between GPs and other allied health services (Oldroyd et al 2003) were identified as important components of an effective health system. As identified in Australian research in relation to other health problems, effective reimbursement systems were considered to be an essential ingredient in ensuring that GPs can play an effective role, and make appropriate referrals for assessment and management of weight (Kang et al 2003; Oldroyd et al 2003).

Many of the issues and proposed solutions apply to the assessment, management and referral of patients in regard to behavioural risk factors (Goldstein et al 2004). Both the GPs' perceptions about community sensitivities and their appreciation of the complexities and difficulties of behaviour change reinforce the observation that primary care practice is complex (Dietz & Nelson 1999; Loss and Wise 2006). While focused on adults, the practical checklist to guide GPs in dealing with overweight patients, presented as part of an article in a recent edition of the MJA (Stanton 2006), may provide a sound basis for approaching overweight adolescents, and parents with overweight children (see Figure 4).

The GPs clearly recognised that they could only be one part of a broader approach to addressing childhood overweight and obesity. This is consistent with both international and Australian policy, strategies and commentary (Koplan & Dietz 1999; National Obesity Taskforce 2003; Stanton 2006).

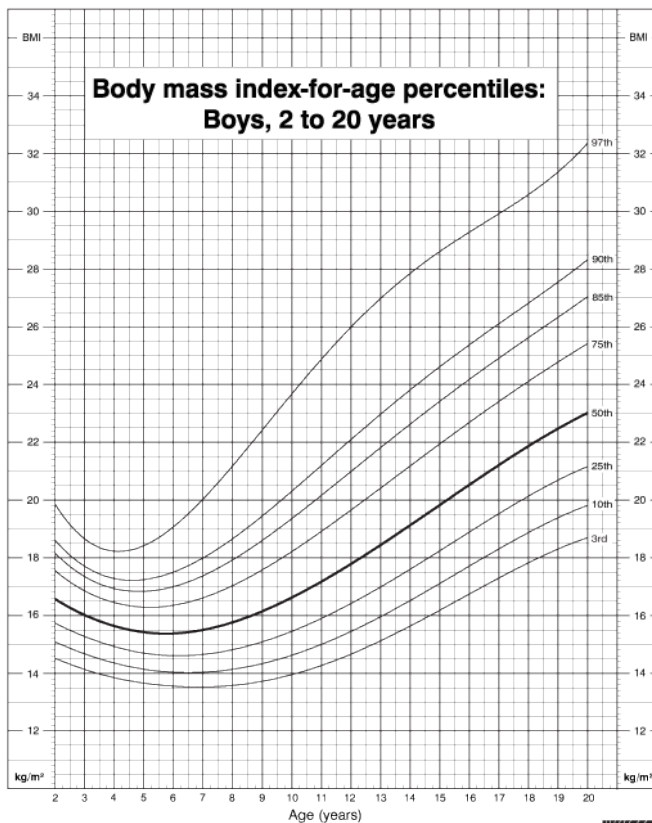
Figure 2: Definition of overweight and obesity

An Australian expert working group has identified body mass index (BMI) as the most appropriate measure of excessive weight in children. BMI is calculated by dividing the weight (kg) by the height squared (m^2).

Rapid changes in BMI occur in normal growth, and BMI varies with age and sex. It rises in the first year of life, then falls during preschool years, before rising again into adolescence. The point at which BMI starts to rise again (usually around 4–6 years of age) is termed “adiposity rebound”. Thus, calculated BMI values need to be compared with age and sex reference standards.

For clinical use, the expert working group has recommended the BMI-for-age percentile charts developed in the United States by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion. These can be downloaded from the Centers for Disease Control and Prevention website (for boys 2–20 years: <www.cdc.gov/nchs/data/nhanes/growthcharts/set3/chart%2015.pdf> for girls 2–20 years <www.cdc.gov/nchs/data/nhanes/growthcharts/set1/chart16.pdf>). BMI greater than the 85th percentile suggests overweight, while BMI greater than the 95th percentile suggests obesity. These charts can be used in clinical practice to monitor progress.

CDC Growth Charts: United States

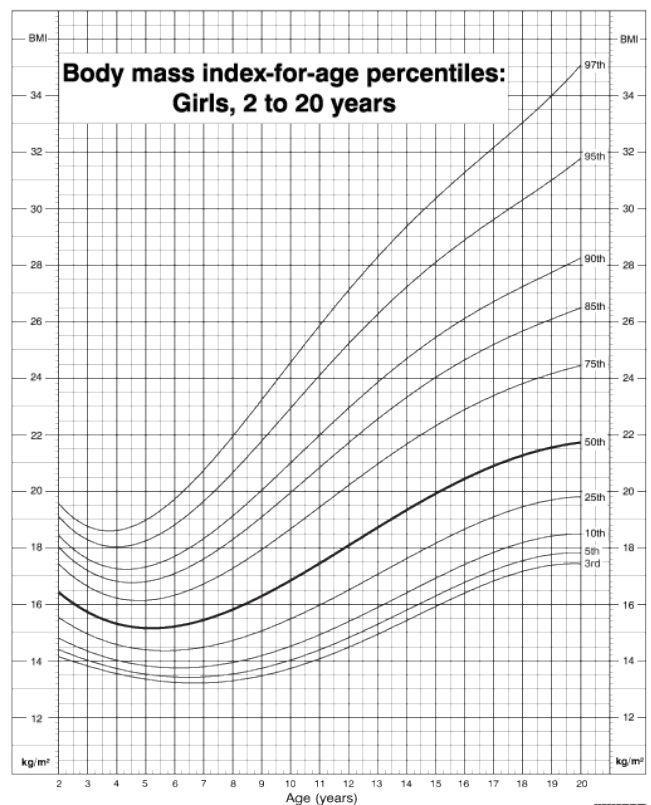


Published May 30, 2000.
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



SAFER · HEALTHIER · PEOPLE™

CDC Growth Charts: United States



Published May 30, 2000.
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



SAFER · HEALTHIER · PEOPLE™

Figure 3: Evidence-based practice tips

From Guidelines for the Management of Overweight and Obesity (NHMRC 2003)

- Parents influence food choices and other eating behaviours in their children. Disordered eating in a parent may be associated with excess body weight in the child (III-3).
- The prevalence of type 2 diabetes is increasing in children and adolescents, particularly in certain ethnic groups. This increase appears associated with high levels of obesity in these populations (III-2).
- There is short-term evidence that reducing sedentary behaviours in obese children is as effective for weight management as increased activity (III-3).
- There is some limited evidence that a weight management program for children and adolescents can be delivered in a variety of settings and achieve similar outcomes. The majority of such programs use a group format (III-3).

Levels of evidence (I–IV) are derived from the National Health and Medical Research Council's system for assessing evidence.

Figure 4: Checklist for use in clinical setting

From: Stanton, RA (2006) Nutrition problems in an obesogenic environment. *Medical Journal of Australia* 184 (2), 76-79.

Practical checklist for overweight patients

- Check that patients understand that weight problems are almost inevitable in an obesogenic environment that encourages more eating and less activity; and that the media does not always give the full picture. Explain that the best safeguard for an adequate and healthy diet is to follow well documented guidelines to eat plenty of vegetables, include fruit and wholegrain products and avoid foods high in fat, sugar and salt.
- For patients with body mass index > 25, explain:
 - > the importance of permanent changes to food, drinks and exercise for long-term weight loss;
 - > loss of body fat cannot occur quickly, and 1 kg fat is equivalent to a 32 000 kJ deficit (it may help to show patients 1 kg of lard or dripping);
 - > small manageable changes can create an energy-intake reduction of 2500 kJ/day;
 - > fast weight loss means an undesirable loss of fluids and lean muscle
 - > studies do not show long-term benefits from fad diets, and side effects are likely;
 - > omitting or consuming only token quantities of carbohydrate-containing foods such as wholegrain breads and cereals, fruit, many vegetables and low-fat dairy products will reduce intake of many nutrients and create a potentially serious lack of dietary fibre; and
 - > movement and exercise is essential for weight maintenance.
- Suggest smaller portion sizes for most foods (except vegetables), and especially for alcohol and foods containing fat or sugar. Suggest drinking water.
- If patient insists on a low-carbohydrate or other fad diet, monitor blood fats and ask about constipation, headaches and other symptoms.
- When faced with difficult or lengthy questions on nutrition and diet, a dietitian is ideal for an individual dietary assessment and continued counselling. The Dietitians Association of Australia website lists accredited dietitians at <<http://www.daa.asn.au>> and provides information and practical advice.
- Medical practitioners rarely smoke and this great personal example has enabled them to counsel patients about smoking. Many doctors currently ignore their own diet and health, and attending to this may be essential before helping patients make appropriate dietary changes.

Practice and Policy Implications

Professional education and development

- Include best practice guidelines for childhood obesity management, including accurate measurement of weight in undergraduate and postgraduate medical training.
- Include motivational interviewing in professional development for GPs.⁴
- Incorporate an additional module on the management of overweight and obesity in children and adolescents in the SNAPO on-line learning module that is currently under development.⁵
- Include all practice staff, especially practice nurses, in professional education initiatives.

Service delivery systems and practices for general practice

- Seek to ensure that BMI for age charts are incorporated into general practice software, such as Medical Director.
- Seek to incorporate brief advice messages appropriate for adolescents, children and families, similar to adult lifescrpts, into Medical Director.
- Make recommendations about the frequency of routine weight measures in children. For example, routine measurement of weight in children could be done at the same time as immunisations.
- Develop and pilot a brief intervention model for childhood obesity management/prevention in general practice. This could be consistent with the evidence-based 5A's model designed to guide implementation of multiple behavioural risk factor interventions.⁶

- Consider a “whole of family” approach as part of any model for childhood obesity intervention, given the clustering of behavioural risk factors in families and high rates of adult overweight/obesity and sedentary lifestyles. This should be in line with other initiatives such as the lifescrpts program.
- Develop and test service delivery arrangements that incorporate sustainable referral pathways. Referral points could include groups run by lay persons, community organisations, NGOs etc, as well as public allied health services (e.g. dietitians, exercise physiologists).
- Develop and test integrated models for management and prevention of childhood obesity involving other primary health care practitioners such as child and family nurses and community health services. These services often have good links with other community programs such as parenting classes, supported playgroups etc. This may also provide opportunities to develop more sustainable referral pathways.
- Investigate and develop partnerships between Divisions of General Practice and population and community health services, around referral pathways. Practical tasks could include collaboration on developing and maintaining referral directories (e.g. physical activity options locally) as well as developing sustainable referral services through community organisations and groups.
- Ensure that proposed interventions and service delivery arrangements are designed to be flexible and adaptable, to meet requirements of different practices.

⁴ This is consistent with recommendations of the 2004 RACP Cottrell Conference on Managing Chronic Conditions (Baur 2004).

⁵ Under development by the NSW Heart Foundation.

⁶ The 5 As comprise: Assess, Advise, Agree, Assist, Arrange, from Goldstein et al (2004).

Public Policy

- Seek to reform funding arrangements to ensure that there is MBS remuneration for General Practice consultations, and other service delivery systems and referrals related to the management of weight in children and families.
- Investigate the cost-effectiveness of introducing a system for children's wellness checks as a routine component of primary health care.

Advocacy

- Medical professionals should continue to support and advocate for a broad array of actions to address factors that contribute to children's risks for becoming overweight and obese, as has occurred as part of public health efforts towards tobacco control.

References

- Australian Bureau of Statistics (2003) Information Paper: Socio-economic Indexes for Areas. Australia 2001. ABS Cat. No. 2039.
- Batch JA & Baur L. (2005) A management and prevention of obesity and its complications in children and adolescents. *Med J Aust*, 182(3):130-135.
- Baur LC, Caterson I, Gill T, Metz G, Osborn M, Procopis P, Swinburn B, Wittert G. (2004) *Cottrell Report 2004: Managing chronic conditions*. Sydney: The Royal Australasian College of Physicians.
- Booth M, Okely T, Denney-Wilson E, Yang B, Hardy L, Dobbins T. (2006) *NSW Physical Activity and Nutrition Survey (SPANS) 2004: Full Report*. Sydney: NSW Department of Health.
- Dietz WH, Nelson A. (1999) Barriers to the treatment of childhood obesity: a call to action. *J Pediatr*, 134:535-536.
- Gerner B, McCallum Z, Sheehan J, Harria C, Wake M. (2006) Are general practitioners equipped to detect child overweight/obesity? Survey and audit. *J Paediatr Child Health*; 42:206-211.
- Goldstein M, Whitlock E, DePue J. (2004) Multiple behavioural risk factor interventions in primary care: summary of research evidence. *Am J Prev Med* 27(2S): 61-79.
- Kang M, Bernard D, Booth M, Quine S, Alperstein, G, Usherwood T, Bennett D. (2003) Access to primary health care for Australian young people: service provider perspectives. *Brit J General Practice* 53,947-952.
- Koplan JP, Dietz WH. (1999) Caloric imbalance and public health policy. *JAMA*, 282:1579-1581.
- Loss J, Wise M. (2006) Beyond behaviour: a systems to the implementation of clinical practice guidelines for the management of overweight and obesity. <http://www.coo.health.usyd.edu.au/pdf/loss_wise_report.pdf> Accessed: 1 June 2006.
- Magarey AM, Daniels LA & Boulton JC. (2001) Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions. *Med J Aust*, 174:561-4.
- National Health and Medical Research Council (2003) Clinical practice guidelines for the management of overweight and obesity in children and adolescents. Canberra: Commonwealth of Australia, Department of Health and Ageing.
- National Obesity Taskforce (2003) Healthy Weight 2008. Australia's Future. *The national action agenda for children and young people and their families*. Canberra: Commonwealth of Australia.
- Oldroyd JP, Infante FA, Powell Davies G, Bubner T, Holton C, Beilby JJ, Harris MF. (2003) Providing healthcare for people with chronic illness: The views of Australian GPs. *Med J Aust*, 179(1):30- 33.
- Pagnini D, Wilkenfeld R, King L, Booth M, Booth S. (2006) *The weight of opinion: perceptions of parents*. Sydney: NSW Centre for Overweight and Obesity. (Submitted for publications)
- Stanton R. (2006) Nutrition problems in an obesogenic environment. *Med J Aust*, 184(2):76-79.
- Wake MM, McCallum Z. (2004) Secondary prevention of overweight in primary school children: What place for general practice? *Med J Aust*, 181(2):82-4.
- Zapka JG, Lemon SC. (2004) Interventions for patients, providers, and health care organizations. *Cancer*, 101(5 Suppl):1165-87.

The Weight of Opinion:

General Practitioners' perceptions about child and adolescent overweight and obesity

March 2007



The University of Sydney