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Moral discourse in General Practitioners' accounts of obesity communication

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Abstract

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

Keywords

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

Method

Study design

Theoretical framework

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

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

Participants and recruitment

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

Trigger film interviews

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

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

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

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

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

TABLE 1

Data collection

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

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

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

Analysis

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

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

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

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

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

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

Findings

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

TABLE 2

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

Communicating with caution

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patients think we're calling them fat

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

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

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

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

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

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

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

They think it's alright for you

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

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

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

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

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

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

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

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

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

Discussion and conclusions

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

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

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

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

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

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

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

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

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

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

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

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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

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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.