

CHAPTER 1: INTRODUCTION

1.1 Background

Worldwide, the prevalence of obesity varies but the disease is rising at an alarming rate^{1,2,3,4}. It is estimated that globally about 250-300 million people are obese (BMI \geq 30) and 1-1.5 billion people are overweight (BMI 25-29,9)^{1,5}. In America 25-33% of the adult population is obese^{2,6,7}. The prevalence of obesity in the United States has risen by 10% in the last decade alone^{4,8,9}. Some studies have found that 64.5% of American men and women were overweight, 30.5% of these being obese^{7,10}. Obesity in Canada affects more than 20% of the adult population¹¹. Elsewhere, obesity ranges between 30% in other Western countries, 2% in some developing countries, and 89% in the remote Pacific Islands². In Malaysia for instance, a survey revealed that 20.7% of adults were overweight and 5.8% of them were obese¹². In Europe the prevalence of obesity increased by 14% in the last 10 years⁵. In England, about 45% of men and 34% of women are overweight and an additional 21% of men and 21.4% of women are obese¹³. Overweight and obesity levels have also risen to epidemic proportions over the past two decades in Australia¹⁴.

Countries in economic transition from undeveloped to developed, such as China, Brazil and South Africa, are particularly affected and have an increased rate of obesity across all economic levels and age groups¹⁵. South Africa is currently experiencing an epidemic of obesity¹⁵. In 1998, it was found that 31.2% of men and 56.8% of women between the ages of 15 and 64 years were overweight or obese⁵. In the same year a separate survey in South Africa found that 29.2% of the males and 56.6% of the females were overweight or obese¹⁶. One study, conducted in a private practice in Bloemfontein and published in 2006, found that 64.3% of the males and 77% of the females were overweight¹.

South Africa is suffering from a triple burden of disease - a combination of poverty-related infectious diseases (including HIV/AIDS), lifestyle-related non-communicable disease and violence-related trauma¹⁷. Obesity as a risk factor for non-communicable diseases is a major global public health concern^{4,18,19}. Over the

past decade, the main focus of public health programmes in Sub-Saharan Africa has been on eradication of under-nutrition and infectious diseases¹⁵. However, in urban areas of our country obesity co-exists with malnutrition¹⁵. It is thus clear that overweight and obesity are becoming a major health problem worldwide, and in South Africa, and require much attention.

Obesity has been implicated in various long-term chronic diseases, including: diabetes mellitus, hypertension, coronary artery disease, stroke, hyperlipidaemia, osteoarthritis, cancer, depression and other psychological illnesses, impaired quality of life, sleep apnoea, disability and increased mortality^{3,4,20,21}. Overweight is listed by the World Health Organization (WHO) as one of the ten leading risk factors for high mortality in developing and developed countries, contributing to the burden of disease^{15,16} and significantly increasing healthcare costs^{2,5,22}. Economic costs include treatment of obesity and associated conditions, sick leave and early retirement¹. Obese people are, furthermore, socially disadvantaged and also experience discrimination and prejudice related to employment opportunities^{5,15}.

Obesity is a complex chronic disease that develops through the interaction of genetic, metabolic, social and behavioural factors⁵. The increase in obesity can be attributed to a range of factors like changes in eating behaviour and exercise patterns, genetics and an increasingly obesogenic environment designed to encourage overeating and a sedentary lifestyle²³. Obesity prevention and treatment is problematic and should be based on many interventions. These should include public education, behaviour change, public participation and support from the healthcare and food industries, media, government and politicians¹⁵. However, most management of obesity still happens in primary care^{18,23,24}. Primary care doctors play a very important role in identifying and treating obese and overweight patients^{2,9,25}, yet the primary care approach to treatment is uncoordinated and inconsistent²³. Furthermore, some medical experts and professional bodies in the clinical field of obesity feel that doctors are not taking the issue of obesity as seriously as they should¹⁹. Doctors should remember that even a 10% decrease in weight produces medically important decreases in blood pressure, blood lipids and blood glucose^{13,24}, thus reducing factors related to

chronic diseases as well²⁶. A sustained weight loss of 5-10% over one year is nowadays often considered acceptable by expert panels²⁷.

Simple office-based measures, like assessing patients' BMI at each visit, offering appropriate advice and using educational materials, have been proven to be effective in everyday practice where there are time and resource constraints^{4,9,24}. Interventions may include addressing patients' concerns; giving advice on reasonable weight-loss goals, healthy eating and physical activity; development of a practice formulary for anti-obesity drugs; continued support; appropriate follow-up; appropriate referral and auditing of patient outcomes^{4,9,13,24}. Even simply maintaining a good doctor-patient relationship and offering anti-obesity drugs (in which doctors may have little faith) as a means of meeting patients' expectations; listening to their problems (despite not having a solution for them) and offering an understanding of the problems associated with being overweight can help some patients²³. It is also important for clinicians to realise that changing eating habits and exercise takes time and even small changes can be meaningful; in fact the distribution of small changes amongst many people benefits a population significantly²⁸. Above all, overweight patients deserve to be treated with the same degree of care and compassion as those of normal weight. For some patients being treated in this way could be their first positive experience with a doctor in many years. Rarely do doctors have an opportunity to have as much of an effect on the patient's mental and physical health as they do in managing and interacting with overweight patients²⁹. Yanovski²⁹ quotes a pioneer in obesity treatment, Albert Stunkard, who stated "the experience [of being treated by a physician with respect] may be the greatest gift a doctor can give an obese patient".

Potter et al³⁰ suggest that doctors are struggling to incorporate weight-loss management issues into their daily practice. Doctors are missing many counselling opportunities²⁵. In fact, obese patients are often not advised or counselled by their primary care doctors to lose weight^{8,9,10,21,24,25,31} and these patients are also not being referred to weight management services²¹, even though primary care doctors are the most important source of information for patients³¹. It has also been proven that overweight and obese patients do not

receive adequate healthcare²⁹. There is also evidence that primary care doctors are negative about their own role in obesity management, which reflects the problematic nature of managing obesity²³. In addition, research indicates that doctors' and patients' perceptions of obesity differ, which can be detrimental to successful management of the condition³².

Barriers to effective weight-loss management interventions identified by primary care doctors include perceptions that: most obese and overweight patients are not ready to make the lifestyle changes needed for sustained weight loss (Some doctors feel that they are lazy, sad and lacking in self-control); patients are uncomfortable with a more proactive approach; office visits are too short; patients lack the ability to change behaviour; attitudes towards obese patients are negative and the safety and efficacy of obesity management drugs are questionable^{21,24}. Primary care doctors felt that obesity was mainly the responsibility of the patient but obese patients wanted to hand the responsibility over to them and treatment of obesity was not within their domain^{21,23}. Physicians indicated that unrealistic patient weight-loss expectations, lack of continuity of care, lack of teaching materials, lack of staff support, time constraints and inadequate payment or reimbursement were other common reasons why they failed to tackle these issues in clinical practice^{4,18,21, 25,27,33}. Despite these well-researched findings regarding potential barriers in weight-loss management, poor physician understanding of patients' experiences and expectations still remains an essential element in sub-optimal management³⁰

As obesity has been implicated in poor control and potentially worse outcomes in chronic illnesses^{4,13,20,26} and since diabetes mellitus is the most expensive health complication of obesity¹, this research concentrates on a specific category of patient: the obese patient with Non Insulin Dependent Diabetes Mellitus (NIDDM).

Although research on primary care doctors' attitudes to managing overweight and obese patients has been done^{3,10,18,21,24,34,35,36,37,38}, little is known about what patients experience and expect from their primary care doctors regarding weight-loss³⁰, and no research on this aspect has been conducted previously in South Africa. The research was motivated by experience of a large burden of obesity in

a practice. Analysis of the data of this qualitative study was undertaken with a focus on in-depth exploration of what patients experience and expect from their primary care doctors concerning weight-loss management.

1.2 Aim

To explore what obese patients with Non Insulin Dependent Diabetes Mellitus (NIDDM) experience and expect from their primary care doctors concerning weight-loss management

1.3 Objectives

- a. To explore weight-loss management experiences of patients consulting their primary care doctors.

- b. To explore patients' expectations of their primary care doctors concerning weight-loss management

CHAPTER 2: LITERATURE REVIEW

In recent years obesity experts have developed guidelines to assist doctors in helping their patients to lose weight^{8,9,24}. As primary care doctors look for ways to use these guidelines with good results, an understanding of patients' experiences and expectations in the physician-patient setting will be useful. Some primary care studies have attempted to address these issues^{6,14,20,25,30,39,40,41}.

In a study done by Wadden et al⁶ at the University of Pennsylvania, women's perceptions of their physicians' weight management attitudes and practices were studied. A questionnaire was used as a measuring tool. The authors concluded that participants were generally satisfied with the care that they received for their general health and also with their doctors' medical expertise. However, they were significantly less satisfied with care shown regarding their obesity and with their doctors' expertise in this area. Almost half of the participants reported that their doctors had not recommended any of the ten common weight loss methods. Two thirds of the participants did not appear to rely on their primary care doctors for weight management issues. This was found to be a reflection of poor clinical practice. Nevertheless, patients generally had positive experiences with their physicians, for the majority of women did not report that they had been treated disrespectfully or insensitively by their physicians when weight management was discussed. A small minority however did believe that they were treated disrespectfully by their doctors. In addition, there are physicians who have negative attitudes when treating obese patients^{3,10,21,25}. These contrasting findings are a cause of concern. Although, the authors did state that the prevalence of doctors treating obese or over-weight patients disrespectfully is far lower than the anecdotal reports.

Potter et al³⁰ conducted a quantitative study to determine what patients want from their primary care physicians concerning weight management. The population comprised 410 consecutive adult patients attending two primary care practices at the University of California. Of these patients, 61% reported that doctors had not raised weight issues with them previously. It was concluded that although most patients believed that they should lose weight, this was not often discussed

during their office visits with their doctors. Most of the patients in the study wanted more help with weight-loss management than they were getting from their primary care doctors. Most said that in future they would like their doctors to assist them with dietary advice, exercise recommendations and help in setting realistic goals. The authors concluded that most patients are open to greater doctor involvement in weight management. A limitation of the study may be that all the data was obtained from self-reporting of patients (although self-reporting by patients may be the most relevant measure of what communication is remembered by the patient).

Davis et al²⁵, did a quantitative study of physicians' practice patterns and patients' preferences regarding obesity management of 110 consecutive patients, in New York. They concluded that although most of the patients believed that they were overweight, wanted to lose weight, believed that their doctors could help them do so and wanted their doctors' encouragement, only 17% of obese patients were referred to a dietician and only 36% of patients received weight-loss advice from their doctor. The authors also found that 64% of patients felt that they wanted a referral to the dietician, and concluded that further studies should focus on examining the barriers that doctors experience in managing obesity. A Limitations in the study may be that the sample was small.

In a rural New South Wales practice in Australia, Tan et al¹⁴ did another quantitative study of what patients want regarding weight management in a general practice. Seventy-eight percent felt that their general practitioners had a role to play in weight management, fifty percent said that they would see their doctor for weight-loss advice and sixty-eight percent felt their general practitioner had the necessary knowledge and skills. However, only 46% thought that their general practitioners would be able to spend enough time to provide effective weight-loss advice. Thirty-three percent said that they needed to lose weight but their doctors had not advised them to lose weight. Perceived useful weight-loss strategies perceived by the patients included: advice on healthy eating and increased physical activity, information on obesity, information on conditions related to obesity and regular medical reviews. Although some were in favour of dietician referrals, few were likely to take weight-loss medication. A limitation of

this study may be that it involved only a small number of practices and may not have reflected the views of all the patients. A contrasting view reported in the study is that twenty-five percent of patients felt that they would not see their general practitioner for weight-loss advice. The reasons for this included: they could lose weight on their own, they would seek help from somewhere else first, they did not feel the doctor would provide adequate advice nor would they have the time and the cost of seeing the doctor.

Levy and Williamson³⁹ attempted a telephonic survey in Iowa City, America, about patient perceptions and weight loss in obese adults. The authors found that respondents felt that attention from their doctors regarding their obesity was more likely to lead to weight loss than not. Other factors that participants felt were important were exercise and self-motivation. The authors also noted that the doctor is in a key position to assess, and have an impact on, the patient's exercise programmes and self-motivation. There may be the possibility of recall bias in this study due to the retrospective design and this could be cited as a limitation for the study.

Murphree²⁰ conducted a qualitative study covering patients' attitudes toward physician treatment of obesity. A focus group of obese patients was formed to discuss weight-loss therapy from the patients' viewpoints. Three sessions were held; one each for patients' feelings and life experiences, exercise and eating habits. All the patients reported that their doctors' attempts to help them lose weight had failed, but most patients desired to lose weight and most appreciated their doctors' interest in their attempting to do so. Most patients in this study were not supportive of doctors' traditional approach to helping patients lose weight. This can be significant because it calls into doubt the doctors' standard practice related to weight-loss management. The conventional approach by doctors mentioned in the study consists of weight checks and doctor encouragement, referral to a dietician for nutritional education, and occasional referral to a counsellor or behavioural therapist for assistance in losing weight. But within a qualitative framework, this is meaningful information, not a standard.

Brown et al⁴⁰ explored obese patients' perceptions and experiences of support offered by primary care services in five general practices in Sheffield, England. Their qualitative study used purposive sampling and semi-structured interviewing of patients in the patients' homes. Patients, who showed a strong sense of personal responsibility about their condition, reported difficulty in presenting weight-loss concerns to doctors. They also perceived the health services to lack the resources required in dealing with patients' weight-loss issues but felt that a good relationship with their doctors and more intensive support partly helped. A clear limitation in this study is that the sample did not include any participants from the Black and Asian ethnic minority even though these groups were present within the practice population.

Another qualitative study, conducted in Bristol, England, explored parents' perceptions of help-seeking experiences with health professionals, including their responses when seeking help for their overweight children. Semi-structured interviews and body shapes were used as prompts⁴¹. Responses from the doctors ranged from 'positive, but not very helpful' to 'negative and dismissive'. According to the findings, many doctors had shown a lack of interest and offered general advice and referrals that parents had known and/or tried before, which did not work. On the positive side, some of the parents felt that some doctors had tried to help and were very empathetic about their plight.

The metabolic syndrome which includes obesity and hypertension has a significant impact on the health of individuals. The syndrome is associated with an increase in cardiovascular events, hyperglycaemia and diabetes mellitus, elevated blood pressure and hypertension as well all-cause mortality^{42,43,44}. Weight-loss is an important intervention in managing the metabolic syndrome. Cameron et al⁴⁵ commented that measures to decrease television time and increasing physical activity can be effective in controlling obesity. Other programmes other than the standard practice identified to reduce weight include: commercially available over-the-counter mixtures of essential nutrients (very low energy drinks) supplied as powders to be mixed with water, commercially available meal replacements and commercial weight-loss centres and slimming groups and self help methods^{46,47}. Although some patients can appear happy

with these programmes, there is no published evidence of their long-term efficacy, and it may only reflect short-term weight loss. The least useful sources reported to help with weight-loss were newspapers and magazines⁴⁷. Other useful tips interventionists can use in weight-loss programs include: the need to find flexible and creative ways to maintain contact with participants, better methods of self monitoring and collaboration between health services and patients, obtaining skills to recognise frustration and provide timely support, frequent reminders and helping participants develop their problem solving skills^{47,48}.

In summary: while patients were generally happy with the general medical care received from their primary care doctors⁶, they were less satisfied with their doctors' care regarding their obesity⁶ and, especially, the traditional methods used by doctors in trying to help them lose weight²⁰. In the Browne et al⁴⁰ study, patients found it difficult to present with weight-loss issues to their doctors and felt that health services lacked the resources to deal with the issues. In some studies many patients reported that their doctors had not recommended weight-loss methods^{6,14,25}. In fact, weight-loss issues were not even raised by doctors in the Potter et al study³⁰. When doctors did intervene to help patients lose weight, successful weight-loss did not occur^{20,41}. Patients showed a strong sense of responsibility about their weight⁴⁰. Most patients wanted to lose weight and they certainly wanted more help from their doctors regarding their weight-loss management^{14,20,25,30}. In the Wadden et al⁶ study, patients did not report being treated disrespectfully by their doctors because of their obesity but in the Edmunds study⁴¹, patients felt that doctors did show a lack of interest when treating weight-loss issues. In many studies patients felt that their doctors were in the best position to help them lose weight^{14,25,39,40}. Patients expected the following from a primary care doctor regarding weight-loss management: a good doctor-patient relationship, adequate empathy and attention, sufficient time spent with them, dietary advice, exercise prescriptions, information on obesity, information on obesity related conditions, setting of realistic goals, referral to a dietician, regular follow-up and help with self-motivation^{14, 25,30,39,40}.

The current qualitative study aimed to elicit and clarify what South African patients experience and expect from their primary care doctors regarding weight-loss management in a specific group of patients: obese adults with NIDDM.

CHAPTER 3: METHODS

3.1 Design

Research that attempts to uncover the nature of people's experiences naturally lends itself to qualitative analysis⁴⁹. Thus a qualitative study exploring, through free attitude interviews, the experiences and expectations of obese and NIDDM patients regarding their primary care doctors and weight-loss management was undertaken. In free attitude interviews, the interview takes the form of a discussion between the interviewer and the patient about the area of research, where the trigger for the discussion comprises one or two standard questions⁵⁰. The interviewer directs the discussion to some extent, so that the required information is obtained, but the patients are encouraged to talk and cover the area on their own terms and from their own perspectives.

A list of points which needed to be covered in the interview helped to give direction in the interviews. The list of points and prompts included: patients' expectations from their doctors concerning diet, exercise, medication, referral; checking of weight; doctors telling patients if they are over-weight or not; cost of medical intervention and who's responsibility it is to lose the weight.

Two open ended questions and skills like empathy, congruency, respect and attentive listening, together with frequent summarization and clarification, were used to facilitate the flow of information from the patient and to draw out the meaning and sense of reality that the participant expressed about the pertinent issues.

This form of interview was chosen in an effort to understand the patients' behaviour and thinking because, in contrast to a written questionnaire, it allows individuals to express themselves about their experiences and expectations without being forced to choose responses, thus not limiting study findings. The aim was to develop new themes or theories not previously discovered, through analysis of the data.

3.2 Site of the study (setting)

General practitioners from the East Rand, in Gauteng, South Africa, were asked to provide participants. The interviews were done at a site convenient to the patients: at home or at the general practice rooms.

3.3. Study population

All obese and NIDDM adult (> 18 years old) patients attending general practices on the East Rand.

3.4 Sampling

Purposive sampling was done of patients from the various practices. Purposive sampling is a sampling method in which the researcher deliberately chooses patients in order to ensure that the sample covers the full range of possible characteristics⁵⁰. The criteria chosen for inclusion (i.e. obese NIDDM, > 18 years old and fluent and conversant in English), was how the researcher interpreted his purposive sampling. The practitioners were randomly selected from a doctors' list provided by the East Rand Medical Group of Doctors.

The practitioners were asked to give the patients a brief explanation of the research to be carried out and they were then given the researcher's cell phone number so that they could contact the researcher if they were interested in participating in the research. This prevented the patients from being forced to participate.

Apart from the eight participants interviewed in the study. Three people telephoned and enquired about the study but refused to be interviewed. One person with NIDDM telephoned and enquired, but he was a thin individual (not obese). Another three people telephoned and enquired, showed an interest but said they would call when they ready. All three did not call again. One person telephoned and enquired after saturation was reached.

All those who telephoned and agreed to participate in the study were given an explanation of what the study was about. The researcher checked whether the patients were > 18 years old, NIDDM, obese and fluent in English before interviewing the participants.

Permission to record the interviews was sought and informed consent was obtained in writing from the participants.

Saturation of information determined the sample size. Saturation is the point reached where no or very little more new information is being gained from successive interviews. Saturation was reached after eight interviews.

Exclusions:

- People 18 years and younger
- Non-obese, non-NIDDM patients
- Patients not fluent in and conversant with the English language

Inclusions:

- Obese, NIDDM patients
- Ages > 18 years old
- Patients fluent in and conversant with the English language

3.5 Data collection

The two main exploratory questions asked in all interviews were:

- What are your experiences of your family doctors concerning weight-loss management?
- What do you want from your family doctors concerning weight-loss management?

All the interviews were conducted by the researcher in English and were recorded on audiotape.

The researcher was interviewed by his supervisor before data collection began, to ensure that the researcher would be aware of his own perceptions and bias i.e. bracketing.

3.6. Ethics.

Ethical approval was obtained from The University of the Witwatersrand Human Research Ethics Committee (Medicine).

Permission to do the research on their patients was sought from the general practitioners servicing the patients involved. The general practitioners signed a consent form.

Informed consent for the research was obtained from the participants.

The participants' information sheet clearly explained that no patient or practice's name would be used, ensuring anonymity and the use of this study solely for academic purposes. Efforts were made to keep personal information confidential. It was also made clear that the patients' care would in no way be affected by their responses.

Participants were informed of the audiotape recording, and they signed informed consent forms regarding the use of the audiotapes.

All participants had the right to refuse to participate and were assured that this would not jeopardize their future management by their own doctors. Their doctor would not know whether they had called the researcher and the researcher would not divulge the information to their doctors.

A third person did the transcribing.

3.7 Sources of bias

The researcher's own subjective perceptions, pre-conceived ideas and bias having been elicited during interview with his supervisor, the researcher then "bracketed" them.

The interviews were dependent upon the counselling and communication skills of the researcher.

The research was also dependent upon good language capabilities of patients. It seemed as if the participants at times only said what the researcher wanted to hear.

The researcher had no control over which participants the general practitioners selected to call the researcher; for example, they might have asked only their favourite and most co-operative patients to respond.

Language limitations meant that only a selected group of patients was chosen.

3.8 Data analysis

The interviews were audio-taped after permission had been given by the patients. All the interviews were transcribed verbatim, using Microsoft Word. The interview transcripts were then printed on different colour pages for each patient. This helped the interviewer to identify which patients had raised which topic or theme.

The researcher conducted an analysis after each interview. The transcripts were read carefully so as not to lose the sense of wholeness of the patient's experience in the context of the study.

The transcripts were then read independently again. The lines of information were cut and pasted onto separate sheets of paper. The different coloured pages helped in identifying which participant had made which statement and how many

of them had made the same statement on a particular issue. This is commonly referred to as the “cut and paste” method.

Next, the information was reviewed and ordered, to form clusters of similar meanings or themes that summarized the content of the narratives. The predominant and common themes were then identified. The list of themes was then reorganized to create a coherent picture.

Themes were sent to the respondents to indicate that, after transcription and initial coding, the documents were sent to participants who were asked to verify the accuracy of the transcriptions. All the participants were happy with the accuracy of the transcriptions.

The findings regarding the common themes were then written up.

3.9 Strengths and limitations

The present study used a qualitative design with open-ended questions, to encourage patients to express their own views on what they had experienced and expected from their primary care doctors concerning weight-loss management. Such a design emphasizes the participants’ own perspectives and minimizes the impact of the researcher’s own agenda.

A clear limitation in the study is that certain steps were not taken to enhance rigour, validity and authenticity of the study. Apart from member checking, there were no attempts to triangulate the data nor the methods nor the analysis. There were no field notes taken nor researcher’s journal entries nor peer group checking in the accounts of analytical procedures to justify the coding, categorisation and identification of themes.

It is possible that the views and perspectives of the researcher influenced either how the participants responded to the questions in the interviews, or how the data was interpreted.

Also, the researcher had no control over which participants the general practitioners selected to contact the researcher.

Even though the study was of a small scale, valuable information and understanding about managing obesity in clinical practice was obtained.

In terms of further research, findings obtained in this study can be transferred (not generalised) by using the same qualitative method to address the same phenomenon with similar participants in a similar context. Findings in this study can also help guide further large quantitative studies.

CHAPTER 4: FINDINGS

4.1 Demographics

The demographic details of the participants are given in Table 4.1.1.

Table 4.1.1: Demographic details of the patients

<u>Patient (Pseudonym)</u>	<u>Body / mass index (BMI) in kg/m²</u>	<u>Age in years</u>	<u>Gender</u>	<u>Race</u>
Fati (FT)	38	61	Female	Indian
KK	37	53	Male	Black
Billy (BL)	34	35	Female	Indian
Boss (BS)	36	52	Male	Black
Ismail (IM)	31	46	Male	Indian
May (MY)	39	59	Female	White
Thuli (TH)	36	45	Female	Black
Feefee (FF)	33	47	Female	Coloured

There are three over-arching themes for both questions i.e. advice, weight issues and doctor-patient relationships and within this, sub-themes are highlighted with its pertinent verbatim excerpts.

4.2. Themes that emerged from what patients experienced with their primary care doctors concerning weight-loss management

Advice

Doctors had been **encouraging and counselling** patients to lose weight:

- *Billy: "They have always told me that weight loss was very important..."*
- *KK: "Well the doctor actually encourages me to lose weight..."*
- *Ismail: "And, in fact he has placed a big thing onto weight-loss now."*

- *May: "Well, he would like to see me come down..."*
- *Thuli: "My family doctor is so concerned about my weight... So I have to try and reduce my weight"*
- *Feefee: "Especially with weight-loss, they tell me to lose weight..."*

Although patient Boss remarked that he was not encouraged by his doctor to lose weight, he stated:

- *"And he didn't tell me what I must do to lose weight".*

Patients said that doctors had been **advising** them about weight loss.

Advice had been mainly **dietary**:

- *Fati: "The doctor put me on a diet ..."*
- *Billy: "They have always instructed me to eat healthily and like eat the correct foods ..."*
- *Boss: "Ja, and also he said I must take little food to lose weight."*
- *Ismail: "So he is saying, eat correctly and eating less and ..."*

But, patients had reservations about the dietary advice:

- *Fati: "It never helped me ..."*
- *Billy: "But the difficulty you have had is that because you have to prepare for your family"*
- *KK: "People cannot afford to buy or to cook two pots in the house ..."*
- *May: "It's impossible to cook two separate meals a day."*
- *Thuli: "I can't cook two separate meals."*

Preparing two separate meals daily is clearly a problem for patients.

The weight loss advice given by doctors did not include **exercise** though. Apart from patient Ismail (*"He said listen, you have to go to the gym now"*), most patients did not recall having been encouraged to exercise.

Two patients remembered being **referred by their doctors to a dietician** to help with the weight loss:

- *Ismail: "He sent me to a dietician."*
- *May: "They sent me to a dietician ..."*

Patient May did comment that the doctor did not follow up with her regarding her visit to the dietician: *"And I was never asked again, did I follow up or anything like that."*

Weight issues.

Three patients recalled that their doctors did **check their weight** during consultations:

- *Fati: "He is checking my weight, he calls me once a month, takes weight..."*
- *Billy: "The first thing they will come out and check your weight..."*
- *KK: "Ja, lets say each time you go to the doctor he wants to check your weight first ..."*

Patient Boss commented that his weight was not taken: *"But he didn't check my weight"*.

Patients seemed to take responsibility for losing the weight and did not shift responsibility onto the doctor:

- *Fati: "I take full responsibility for my weight ... I am not losing much so I don't expect much from the doctors. If I can't do it myself, the doctors can't do it for me."*
- *Boss: "The doctor must lose weight for me! No, it don't work like that ... Ja, the doctor must help me to lose the weight."*
- *Ismail: "No, but that's not possible. We all look for the easy way out, but not the doctor to lose the weight for me."*
- *May: "No, it is my responsibility, not the doctor's."*
- *Thuli: "No, I want the doctors to help me to lose the weight."*

Doctors had been **encouraging and counselling** patients to lose weight:

- *Billy: "They have always told me that weight loss was very important..."*
- *KK: "Well the doctor actually encourages me to lose weight..."*

Doctor- patient relationships.

Patients found that **pleasant (good) doctor qualities** helped them:

- *Fati: "My doctors are very friendly ..." and "You see I know the doctor for so many years, and I trust the doctor."*

- *May: “I am confident he knows how to manage me” and “He has a much better patient-doctor communication” and “My current doctor is very conscientious ...He encourages a person.”*
- *Thuli: “I think my family doctor is helpful so much.”*

Patient Boss had a **nasty (bad)** experience with one of his doctors:

- *“The doctor he didn’t speak nicely to me.” and “I was thinking this man is fighting with me.” and “He is always in a hurry.”*

Patients appreciated doctors’ being patient and friendly with them. The adverse effect of aggression and impatience from the doctor leads to what patient Boss remarked later in the interview:

- *“That’s why I don’t like to go to him, because now he is shouting at me”.*

This type of bad behaviour can make patients feel that the doctor is incompetent as well, as patient Boss hints:

- *“If he talked with me very nicely, then I can hear him what he is saying ... But then he fights with me. I don’t think he is going to give me the right thing” .*

4.3. Themes that emerged regarding what patients expect from their primary care doctors concerning weight-loss management

Advice.

Patients expect their doctors to **advise** them in general about weight loss:

- *Fati: “The doctor should give me advice and I will follow it ... It will be very nice for the doctor to advise ...”*
- *KK: “Information should come from doctors ...”*
- *Ismail: “Maybe more advice, more monitoring, you know”*

Patient Ismail made the point about the **impact of doctors’ advice**:

- *“But something from a layman in the street does not carry as much weight as from a doctor”*

Being **patient-centred** also seemed to be important:

- *KK: “That is why I say find out from the patient”*
- *Ismail: “Ja, so the doctor must know how you feel in order to advise you”.*

Patient KK added that the advice should be given in a way that does **not alarm the patient**:

- *“You must tell me you should not worry about this, this should not be something to crack your head ...”*

Patients expect **advice on exercise** from their doctors, to assist them in losing weight:

- *KK: “Let them encourage patients to exercise.”*
- *Boss: “He must tell me what I must do about gyming ...”*
- *Ismail: “Where you got the professional advising you on the type of exercise that you need to do ...”*
- *Thuli: “I think he can give me a schedule.”*
- *Feefee: “Ja, a walking program or exercise program or whatever”*

Patient May did admit that it was not the doctor’s responsibility to advise her on exercise:

- *“No, I don’t think it’s his concern if I can exercise”*

Patient KK wanted the doctor to give **practical advice on exercise**:

- *“Lets give them ideas as to how you can do your normal exercise. Ten minutes tapping the ball at home is very important.”*

Two patients expected the doctor to **detect possible barriers to exercise** when advising them:

- *Ismail: “We haven’t got the time to go to a gym...” and “If you coming in your house and you doing the damn thing in your house at ten or eleven at night, you can still do it ...”*
- *Fati: “The day I am in a lot of pain I don’t do a lot of exercise.”*

Patients also expect **dietary advice** from their doctors to help them lose weight:

- *Billy: “The doctor could give me a special diet to follow.”*
- *Boss: “I want my doctor to tell me what I must eat and drink ...”*
- *May: “Maybe if he had an eating plan to give me ...”*
- *Feefee: “It’s just you must control your eating habits and he could perhaps put me on an eating plan.”*

Patient Feefee expected the doctor to look at her grocery list:

- *“List of groceries, what I should buy ...”*

Patient KK expected the doctor to give advice on a **variety of foods** and to consider **costs of foods**:

- *“Let us have a variety of foods ... , and lets look at affordability as well.”*

Affordability of foods was also emphasised by patient Thuli:

- *“I feel the doctors must have something or maybe a solution to prescribe some cheap foods because we can’t afford so much money to be able to buy other healthy foods.”*

Patient Ismail said that doctors should **set small and realistic goals for weight-loss** when advising them:

- *“In fact, you set small goals for him ... But you know that the doctor must also be realistic.”*

Weight issues.

Most patients expected their doctors to **check their weight** during consultations:

- *Billy: “Yes, he can check my weight, he is free to check my weight ...”*
- *Ismail: “Yes, absolutely. Like I told you I lost one kilo from the last two checking’s ...”*
- *Researcher “And you also mentioned that the doctor must at least check your weight ?” Boss: “Yes.”*
- *May: “Ja, perhaps every six months when I have my check up”*
- *Thuli: “If he scales me, then I will be able to reach my goal.”*
- *Feefee: “But I rather prefer the doctor to do it. Even if I have to go once a month for a check up”*

Certain patients expected the doctor to **tell them whether they were overweight or not**:

- *Billy: “Ja, he must tell me so. He is free to tell me if I have put on weight or lost weight.”*
- *Boss: “Ja. He must, if it is going down or up.”*

- *May: "I think people should be reminded that they are over-weight."*
- *Thuli: "But if he continues to tell me that you are not losing or you are losing, that will encourage me."*
- *Feefee: "Ja, if I'm over-weight."*

Patient Fati felt it was **not necessary for the doctors to tell her whether she was over-weight:**

- *"Why should I let the doctor tell me that I am over-weight when I know that I am over-weight ..."*

Patient KK said :

- *"Let them not prescribe as to how much weight one should lose."*

Most patients **did not expect the doctor to prescribe medication** to help them lose weight or they were sceptical about the benefits of the medication:

- *Fati: "So far as I can see, you lose one kilogram and pick up ten kilograms later, so those tablets are not worth it."*
- *Billy: "Ok, I've experienced it using tablets to lose weight. You can lose weight for a while, and lose the weight but at the end of the day when you stop you gain that weight again."*
- *KK: "Yes, I can have some tablets to help me to lose weight ... But they should not be my way of losing weight."*
- *May: "Ja, no. I don't want medication ... You know what, when the medication is finished, it all comes back on."*
- *Feefee: "No man, tablets is not good...You get addicted to them."*

Other patients **expected the doctor to prescribe medication for weight loss:**

- *Boss: "But I favour tablets..."*
- *Thuli: "Maybe, if my doctor got the cheapest medicines that he recommends that will help me"*
- *Ismail: "I mean, if there is a safe tablet, with no side effects and proven to be a good drug and be effective, the doctor should advise you about it."*

Patients **trusted their doctors** and expected them to advise them on losing weight **instead of referring them to a dietician or a gymnasium:**

- *Fati: "Ja, I prefer my doctor's advice because I trust my doctor ... I am more comfortable with my doctor."*
- *KK: "But if you can't, give him the advice"*
- *Billy: "After I went for my operation, the specialist told me I must go to a dietician, but they were too far."*
- *Boss: "No, he can't refer me."*
- *Ismail: "Absolutely, ja. The best person is the doctor..."*
- *Thuli: "No, I think the doctor must give the advice himself."*
- *Feefee: "No, I want the doctor to give the advice himself... You don't need outsiders to assist you. Your doctor is there, your doctor is your friend ..."*

Patients were **ambivalent when it came to the cost of medical intervention** in helping them losing weight. Patients KK and Thuli were worried about the cost of foods. Others were not so sure:

- *Thuli: "I am on the medical aid. The only problem is the high medicines and cost of food... Maybe if my doctor got the cheapest medicines that he recommends that will help me"*
- *KK: "Affordability is the key ..."*
- *Ismail: "No, we got medical aid. But at the same time, I got a family, and a need to be careful how I monitor my funds ..."*
- *May: "I have a medical aid ... But I do feel sorry for people who can't afford medical care."*

Cost was not a problem for patient Feefee:

- *"No it doesn't affect me at all. I know some people can't afford it, but not me."*

Doctor-patient relationships.

Patients expected their doctors to **communicate effectively** with them:

- *KK: "You see another thing is, communication between doctor and patient is very very important ..." and "Because maybe he don't know the importance of losing weight ..." and "You tell him to lose weight, but you tell him why he has to lose weight ..."*
- *Boss: "I want my doctor must tell me everything he wants to tell me and I must understand what he is saying ..." and "Ja, the doctor must speak nicely to me."*
- *Ismail: "The doctor's got to know how to interact with you ..."*
- *Feefee: "Communication is a very good foundation ... The doctor is the only one who can listen to you."*

Following and listening to the patient seemed to be important for patient KK:

- *"And let the patient tell you ..." and "Find out from the patient how are you going to try and lose weight"*

Patient Ismail commented that doctors needed to be **more proactive**:

- *"So, I think the doctors need to be more proactive with the patient" and "You know what, I think every person is an individual ... What might make you lose weight, might not be the same for me."*

Communication has to be **bilateral**, as patient Feefee emphasised:

- *"I must communicate with my doctor... Because if you don't talk to him, how will he know how you feeling? ... But communication from both sides is important."*

Patient KK believed that weight-loss management should be an **empowering process not a disciplined process**:

- *"Well, weight-loss management as well, it shouldn't be implied as if it is a watchdog. It should be something that you encourage a person to do. Not from the doctor's point to say that this is what you must do".*

Later in the interview patient KK said:

- *"But let it be a process that I do ... But you can lose weight, but in your own way ... And let him do it in his own pace."*

4.4. Summary

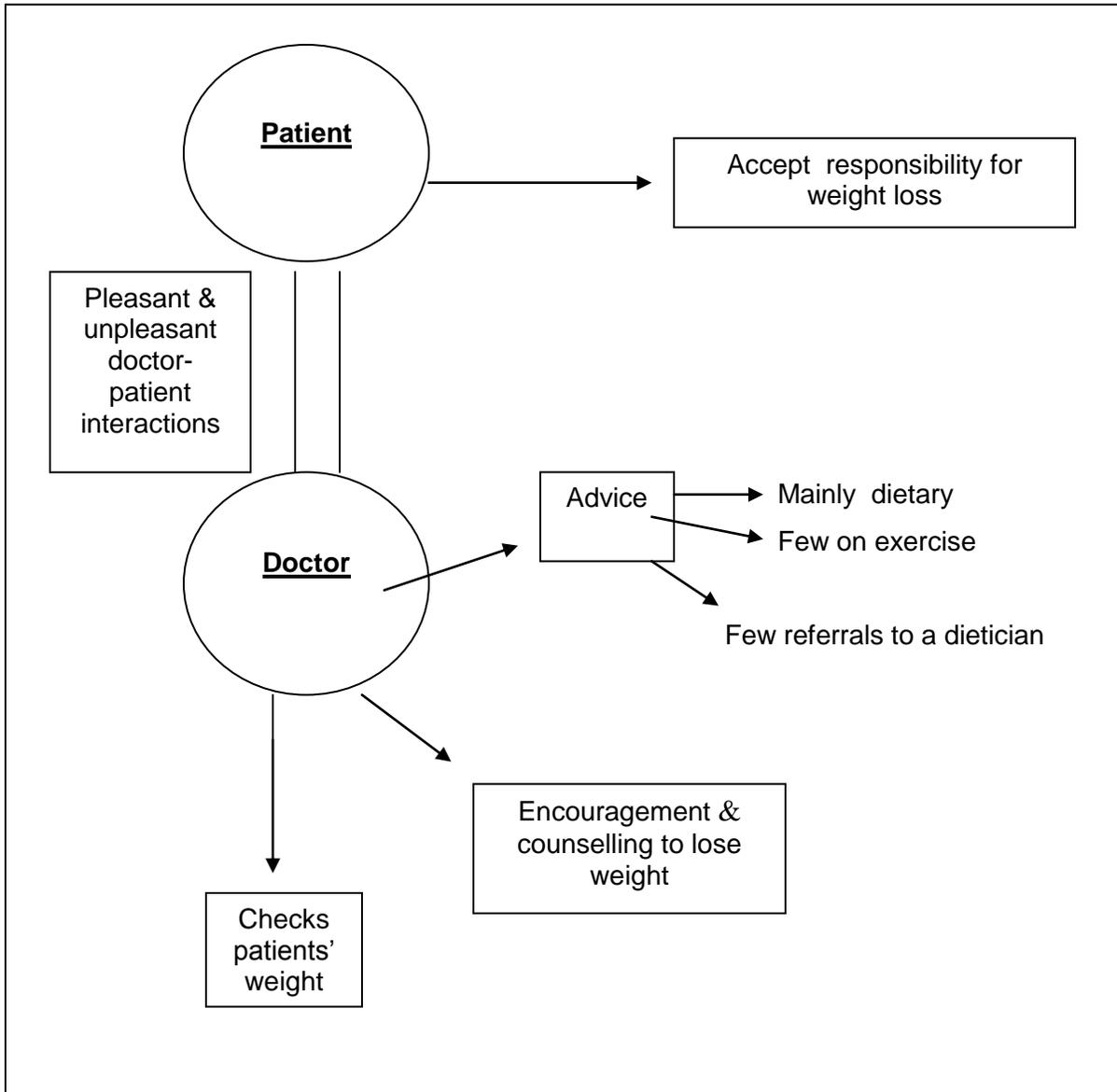


Figure 4.4.1 Experiences of patients

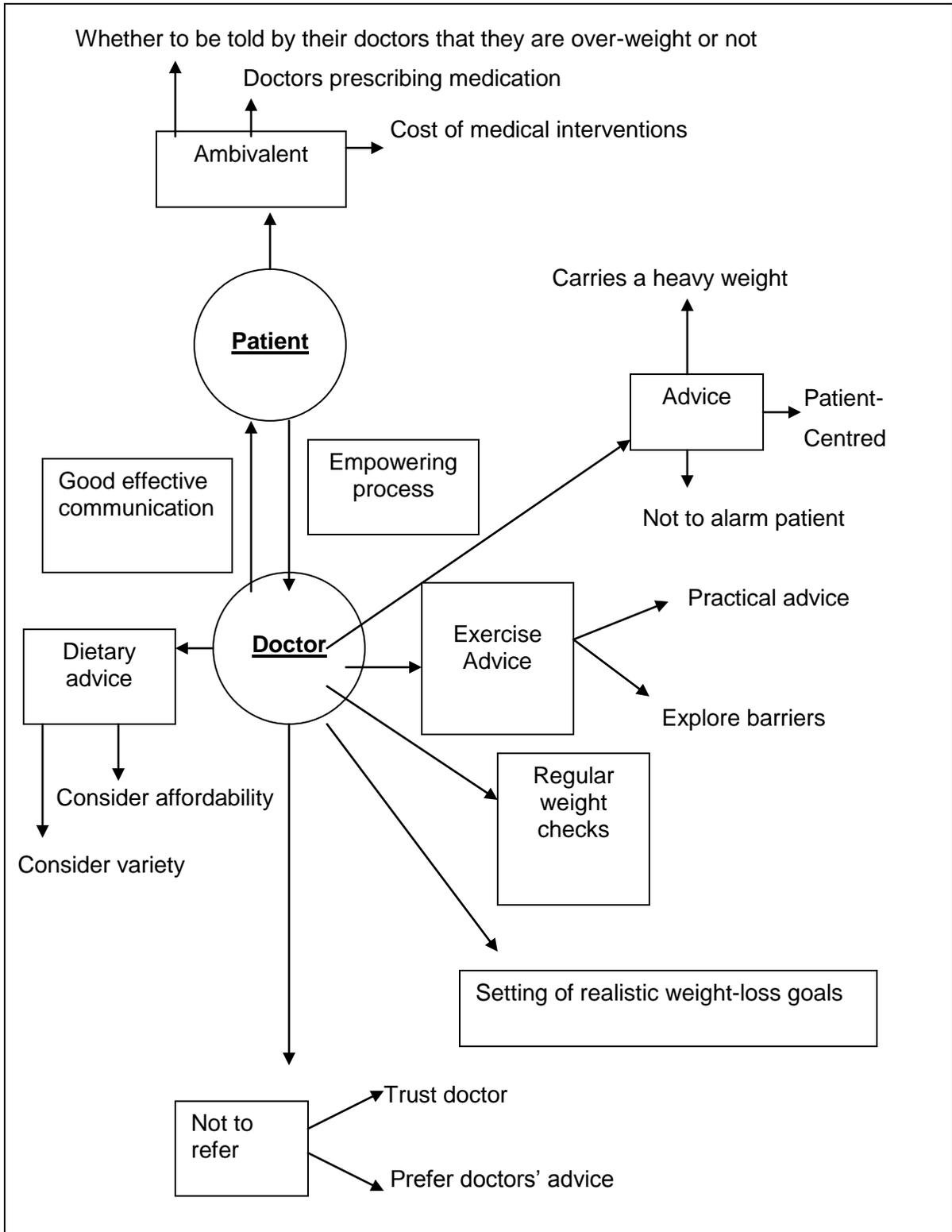


Figure 4.4.2. Patients' expectations

CHAPTER 5: DISCUSSION

5.1. Summary of findings.

The study aimed to explore experiences and expectations of obese non-insulin-dependent diabetic (NIDDM) patients concerning their primary care doctors and weight-loss management. In terms of patients' experiences, the findings show that doctors had been encouraging and counselling patients to lose weight, doctor-patient relationship and interaction was important in the management of weight loss, doctors did not routinely weigh patients during visits, doctors had mainly been giving patients dietary advice about losing weight (exercise advice and referrals to dieticians had been less common) and patients seemed to take full responsibility for losing weight and did not shift the responsibility onto the doctor.

In terms of patients expectations, the findings indicate that patients expected doctors to advise them on weight loss because doctors' advice carries power and authority, but the advice should be patient-centred and must not alarm the patient. Patients mainly expected advice on exercise and diet. The advice related to exercise should be practical and the doctor should discuss barriers to exercise with the patient. The important factor regarding dietary advice is that doctors should recommend a variety of foods that the whole family can eat (cooking two separate meals is a major problem) and should consider the affordability of the foods. Patients did not expect their doctors to refer them to dieticians or gymnasiums. They trusted their doctors and felt that they were in an ideal position to advise them. Advice on medication to help patients lose weight should be tailored to the individual patient as some patients expected medication, while others did not. Patients expected their doctors to communicate effectively with them. They felt that doctors should communicate proactively with them and allow them to express their concerns, views and feelings. Most patients expected their doctors at least to check their weight during consultations. Whether to tell patients that they are over-weight or not also needs to be considered on an individualised basis, from patient to patient, as some expect to be told, while others do not. Patients also expected the doctor to help them set goals for weight-loss if the goals set would be realistic. The participants felt that this whole

process should be an empowering, and not a disciplined one. The cost of medical intervention did not seem to be problematic for this group of patients.

5.2. Comparison with existing literature.

Whereas in certain studies patients expressed dissatisfaction with the care received from their doctors in relation to their obesity, especially regarding the traditional methods that doctors used to help them lose weight^{6,20}, the researcher found patients to be generally positive about their experiences. In the previously mentioned literature, patients found it difficult to talk to doctors about their weight-loss issues⁴⁰ and in some studies weight-loss methods were not even recommended to many patients by their doctors^{6, 8,9,10,14,21,24,25,31} or, as in the Potter et al study, not mentioned at all³⁰. However, this group of patients said that their doctors had been supportive in encouraging patients to lose weight. The advice given dealt mainly with diet. Few patients were offered advice about exercise or referral to a dietician. In fact, patients in this group did not expect to be referred to a dietician.

Doctors conceptualise obesity in terms of responsibility and, in general, they believe its management is primarily the responsibility of the patient²³. In this study and in the Brown study⁴⁰, patients seemed to take on the responsibility for losing weight and did not shift the responsibility onto the doctor. This is contrary to what doctors believe: that obese patients want to hand the responsibility of weight loss over to them²³.

Doctor-patient relationship and interaction (good and bad) seemed to be a key issue for this group of patients, as also shown in the literature, where some patients felt disrespected^{6,29,40,41}. In one study, doctors were shown to have a desire to maintain a good relationship with obese patients²³. That this is an factor agreed upon by doctors and patients, emphasises the point that the doctor-patient relationship is important for a successful consultation, from both the doctors' and the patients' perspectives.

In many studies, as in this one, patients felt that their doctors were in the best position to help them to lose weight^{14,25,31,39,40}. Cost of medical intervention for weight loss was not a problem for this group of patients but it is a problem for the doctors, in terms of re-imburement²¹. Although cost of seeing a doctor was indicated as a reason for a few patients not seeing their general practitioner for weight-loss advice in the Tan et al study¹⁴.

Some of the barriers to effective weight-loss management identified by doctors included a perception that most obese patients are not ready to make lifestyle adjustments to lose weight²⁴. That patients are uncomfortable with a more proactive approach^{21,24} is discounted in this study, as patients indicated that they were responsible for the weight-loss but would appreciate more proactive support from their doctors. In fact in the Potter et al study³⁰, the authors commented that doctor encouragement can increase a patient's readiness to make important lifestyle changes over time. Thus doctors should try and correct this misperception, for the benefit of their patients and to improve their job satisfaction in treating them.

According to the literature, most patients want to lose weight and they want more help from their doctors in doing so^{14,20,25,30}. Regarding weight-loss management, they expect the following from their doctors: a good doctor-patient relationship, adequate empathy and attention, sufficient time spent with them, dietary advice, exercise prescriptions, information on obesity, information on obesity related conditions, setting of realistic goals, follow-up visits and help with self-motivation^{14,25,30,39,40}. In this study patients expected the same. They also wanted effective communication with their doctors; checking of their weight by doctors; advice about practical exercise and discussion about possible barriers to exercise; dieting advice covering a variety of foods and consideration of the cost of foods.

Patients in the study were ambivalent about whether they wished to be told that they were over-weight and about whether they wanted their doctors to prescribe medication that would help them lose weight. This ambivalence about the usefulness of medication as perceived by patients has been documented in the

literature as well ¹⁴. In fact studies of general practitioners have also shown reluctance to prescribe medications for weight-loss to obese patients ^{10,14}, and that only a few general practitioners thought that medication alone for weight-loss was useful ¹⁸.

5.1. Implications for practice

Guidelines have been published for the assessment and management of overweight and obese adults in primary care ^{8,9,24} have been established and are necessary. However, research indicates that doctors and patients hold different ideas about obesity, which can result in unsuccessful weight-loss management ³². Thus knowing and understanding what patients experience and expect from their primary care doctors regarding weight loss management, as indicated in this study, can help doctors meet these expectations in a reasonable manner and engender positive experiences for themselves and their patients, resulting in improved weight-loss outcomes.

Some doctors believe treatment of obesity is not their domain ^{21,23}. Nevertheless, in this study, and in others studies as well ^{14,25,31,39,40}, patients indicated that their doctors were in the best position to help them to lose weight. This should encourage doctors and give them confidence about being more positive in treating obese patients for weight loss.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATION

Obesity is a complex, global problem, with significant morbidity and mortality rates. Needed interventions range from policy-making to lifestyle changes embarked upon by individuals. Primary care doctors, at the individual patient level, remain an important cogwheel in the management of this intractable problem. Barriers to successful weight-loss outcomes in primary care are many and have been well researched. This study concentrated on patients' experiences and expectations regarding their primary care doctors and weight-loss management.

The results of this study indicate that doctors have been encouraging and counselling patients to lose weight, doctor-patient relationships play an important role in weight-loss management and patients seem to take full responsibility for the weight loss.

Patients expected doctors to advise them, mainly about exercise and diet, and expressed high regard for their doctors' advice. Regular weight check-ups by doctors were also expected by the patients, who wanted their doctors to communicate effectively with them. Patients trusted their doctors and did not want referrals to gymnasiums or dieticians. Patients also felt that the whole process of losing weight should be an empowering one.

One concern is that even if the doctors were to accept obesity management as a legitimate part of their responsibility to patients, and implement the findings of the study regarding patients' experiences and expectations, they might remain sceptical about these findings. Future research with a larger sample size is thus needed, as better understanding will contribute to improved management and patient care and to improved efficacy of interventions for obesity management.

APPENDIX 1

INFORMATION SHEET FOR THE GENERAL PRACTITIONER

What obese Non-Insulin Dependant Diabetes Mellitus patients experience and expect from their primary care doctors concerning weight-loss management.

Hello, thanks for taking the time to read this form

I, Dr. Zuneid Bham, am doing research on what obese, Non-Insulin Dependant Diabetic patients experience and expect from their primary care doctors concerning weight-loss management. Research is just a process to learn the answer to a question. In this study I want to learn the experiences and expectations of obese, Non-Insulin Dependant Diabetic patients of their primary care doctors, so that doctors can understand patients better and thus treat them better.

We would please like to ask permission from you to do the research on the patients selected from your practice.

The research involves a number of processes. These include: information gathering from free-attitude interviews with the participants, field notes will be collected and the interviews will be audio taped to be analysed at a later stage. Depending on how much data the patients provide, I may require you to identify more patients at a later stage.

There may be no direct physical benefit for the patient to be involved in the study. But, perhaps once they are given an opportunity to speak about their perceptions and expectations of their doctors concerning weight-loss management, they may be motivated to start losing weight. They may also start interacting with their doctor in a more positive way. They may also benefit indirectly, as doctors will know what patients experience and expect from them. In this way doctors can manage their patients better and improve the quality of care.

No direct risks for the patient being in the study. But, perhaps once they start talking about the issues involved, unwanted feelings, attitudes and experience may surface
Efforts will be made to keep personal and practice information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Research Ethics Committee, Post-graduate Committee and examiners.

If results are published, it may lead to individual identification.

If you agree to have your patients participate in the study, you can ask your obese, NIDDM patients to please give me a call at the numbers provided. They will be re-imbursed for the phone call and the transport costs if they choose to be interviewed at the your rooms.

If you agree, you will also need to sign a consent form allowing your patients to participate in the study.

Permission and support for this research has been granted by the University of the Witwatersrand Human Research Ethics Committee. Should there be any enquiries please contact Ms. Anisa Keshav on 011-717-1234

Yours sincerely

Dr. Z. A. Bham (MBBCh Wits)
083-444-6586/011-423-1000

APPENDIX 2

PARTICIPANT INFORMATION SHEET FOR INFORMED CONSENT.

What obese Non-Insulin Dependant Diabetes Mellitus patients experience and expect from their primary care doctors concerning weight-loss management.

Hello, thanks for taking the time to read this form

I, Dr. Zuneid Bham, am doing research on what obese, Non-Insulin Dependant Diabetic patients experience and expect from their primary care doctors concerning weight-loss management. Research is just a process to learn the answer to a question. In this study I want to learn the experiences and expectations of obese, Non-Insulin Dependant Diabetic patients of their primary care doctors, so that doctors can understand patients better and thus treat them better.

I am asking you to participate in this research study.

If you decide to participate, I will conduct an interview with you at a time and place convenient to you. I will ask you a couple of questions that you can talk about. There are no correct or incorrect answers. Any response will be valid. The interview will be as long as you have something to say, but I will try and limit it to less than an hour. I will audio-tape the interview so that I can use the tape to type the different responses onto paper at a later stage. If you don't give me permission to audio-tape the interview, it will not be possible for you to participate in the study

There may be no direct physical benefit for you to be involved in the study. But, perhaps once you are given an opportunity to speak about your perceptions and expectations of your doctor concerning weight-loss management, you may be motivated to start losing weight. You may also start interacting with your doctor in a more positive way. you may also benefit indirectly, as doctors will know what patients experience and expect from them. This way doctors can treat their patients better and improve the quality of care.

No direct risks for you being in the study. But, perhaps once you start talking about the issues involved, unwanted feelings, attitudes and experience may surface

You will be given relevant information on the study while involved in the study and after the results are available.

You have the right to refuse to take part in the research at any time. If you refuse to participate or withdraw, there will be no prejudice for your future medical treatment. Your refusal or withdrawal will not have any negative effect on the relationship with your doctor, as your doctor will not be aware of your refusal or withdrawal.

You will be re-imbursed for the phone call made to me for your interest in the study and those of you that wish to be interviewed at your doctor's rooms will be re-imbursed for transport costs

Efforts will be made to keep personal information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Research Ethics Committee, Post-graduate Committee and examiners. If results are published, it may lead to individual identification.

If you agree to participate, you will be asked to sign a consent form.

At the end of the interview or in the month thereafter, you can speak to your doctor if you need to about some issues raised.

The research is approved by the University of the Witwatersrand Human Research Ethics Committee. Should there be any enquiries please contact Ms. Anisa Keshav on 011-717-1234

For further information please contact me:
Dr. Z. A. Bham (MBBCh-Wits)
083-444-6586/011-423-1000.

APPENDIX 3

PARTICIPANT INFORMATION SHEET FOR AUDIO-TAPING.

The researcher will audio-tape the interview so that he can use the tape to type the different responses onto paper at a later stage. You will not be identified at any stage and efforts will be made to keep the information confidential. The tapes will be used for research purposes only and will be destroyed when the transcript is completed.

You cannot participate in the study if you do not give the researcher permission to audio-tape the interview.

The research is approved by the University of the Witwatersrand Human Research Ethics Committee. Should there be any enquiries please contact Ms. Anisa Keshav on 011-717-1234

For further information please contact me:
Dr. Z. A. Bham (MBBCh-Wits)
083-444-6586/011-423-1000

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