

Contributors to patient engagement in primary health care: perceptions of patients with obesity

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Background: Patients with obesity are at risk for treatment avoidance and nonadherence. Factors that contribute to engagement in primary health care for patients with obesity are not fully understood. **Aim:** The purpose of this pilot study was to identify issues associated with engagement in primary health care for patients with obesity. **Method:** Using qualitative methodology, 11 patients with a mean body mass index of 40.8 kg/m² registered with a primary health care practice were interviewed. Conventional content analysis was used to identify factors that contribute to engagement in primary health care. **Results:** Barriers and facilitators to engagement in primary health care were categorized into the following themes: availability of resources, importance of the relationship, meaningful communication, feeling judged, lack of privacy, poor communication and limited provider knowledge about obesity. **Conclusion:** Obesity was identified as a health condition that requires additional considerations for patient engagement in their health care.

Key words: obesity; patient engagement; primary health care

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Introduction

A recent study of primary healthcare services utilization found that patients with obesity had almost one and a half times more visits with their primary care physician than patients without obesity (Twells *et al.*, 2012). Utilization rates provide information about the amount of contact a patient has with their physician; however, these do not provide information about the quality of these visits. Such information is needed to better

understand factors that facilitate engagement in primary health care. Patient engagement, grounded by the principles of patient-centered care, is characterized by promoting patient involvement in decision making, providing sufficient time to discuss issues related to promoting health or treating a health condition and providing opportunities to ask questions about treatment recommendations (Health Council of Canada, 2012). Patient outcomes associated with engagement in primary health care include increased participation in health-promoting behaviors, such as disease prevention and screening, improved self-efficacy for self-management of health conditions (Hibbard *et al.*, 2004; Coulter and Ellins, 2007) and improved satisfaction with care (Osborn and Squires, 2012).

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The physician–patient relationship can impact a patient's engagement in primary health care. Research in the area of bias, discrimination and obesity found that healthcare providers, even those who work in the area of obesity, reported negative attitudes toward patients with obesity (Puhl and Brownell, 2001; Schwartz *et al.*, 2003; Brown *et al.*, 2006; Forhan and Law, 2009). A recent study of physicians providing primary care to patients with obesity reported an inverse relationship between a patient's body mass and the respect of physicians toward their patients (Huizinga *et al.*, 2009). Another study of over 620 primary care physicians found that over 50% of participants viewed patients with obesity as awkward and non-compliant with one-third of the sample further characterizing these patients as lazy and weak with respect to will power (Foster *et al.*, 2003).

In addition to, and perhaps enhanced by weight bias, patients with obesity report barriers in the physical environment that limit access to health care. These include seating in the waiting areas, poorly fitting gowns and blood pressure cuffs (Forhan *et al.*, 2010). Such barriers are cited by patients with obesity as reasons for delaying or forgoing preventative services including screenings for breast, cervical and colorectal cancers (Drury and Lois, 2002; Reidpath *et al.*, 2002; Mitchell *et al.*, 2008).

Inadequate knowledge about obesity care and management has been identified as another barrier that caused patients to be reluctant to seek care or to follow through with recommendations made by practitioners (Brown *et al.*, 2006). A report published by the Health Council of Canada (2012) provided tips for physicians on how to redesign their service around patient needs and for patients on how to be more involved in their care. These universal strategies may benefit patients who resemble the general patient population but it is not known whether such strategies will meet the needs of patients with obesity.

No studies to date have explored factors that contribute to engagement in primary health care for patients with obesity from the patient perspective. A better understanding of the primary healthcare experience for these patients is needed particularly with the increase in prevalence of obesity and the demand for primary healthcare services.

The purpose of this qualitative study was to understand patients' perceptions of the barriers

and facilitators of engagement in their health care in a primary care setting.

Methods

The Hamilton Health Sciences and McMaster University Research Ethics Board approved this study. Adult patients with a minimum body mass index (BMI) of 30 kg/m², who were registered with an academic family health team, were invited to participate in an interview through posters located in waiting and patient treatment areas of the clinic. The family health team is located in a large city in Ontario, Canada and is associated with two large teaching hospitals. The core healthcare team consists of a family physician, family medicine residents and a nurse practitioner. A registered dietitian and occupational therapist are also available for consultations. Of the twenty patients who volunteered to participate in the study, 15 patients agreed to be contacted for an interview. One of these patients cancelled the interview due to an illness in the family and three people did not return calls from the researcher to schedule an interview leaving a final sample of 11 participants. Participants completed a semi-structured interview focusing on their perceptions of the barriers and facilitators to patient engagement. The main questions asked of participants were: (1) Please describe what it is like to be a patient with obesity at this clinic. (2) What is it about this clinic that keeps you coming back? (3) What, if any, factors at this clinic interfere with you getting the care you want or think you need? A study investigator (MF) who was not affiliated with the family health team conducted the interviews. Parking expenses or cost associated with public transit was provided.

Interviews were audiotaped and transcribed verbatim. The experiences of being a patient with obesity in primary health care were analyzed using conventional content analysis (Hsieh and Shannon, 2005). The analysis began with the independent review and coding of three transcripts by each of the investigators. Then the investigators met to develop an initial coding scheme. The investigators used the coding scheme to independently code two more transcripts. Following review of these transcripts, the investigators developed a

final coding scheme and the six remaining transcripts were analyzed independently. The investigators met on two occasions to reconcile any differences in coding. An iterative analysis occurred and recruitment continued until saturation of the data had been reached. A final step in the analysis was a review of the codes for the purpose of identifying themes related to patients' perceptions of factors that contributed to their engagement in primary health care.

Results

Eight women and two men participated in face-to-face interviews and one man participated in a telephone interview. Interviews averaged 33 min (range 21–49 min). Participants had a mean age of 44 years (range 19–64-year old) and a mean BMI of 40.8 kg/m² (range 30–45 kg/m²).

The overarching theme of engagement in primary health care included sub-themes with content labeled as facilitators or barriers to engagement in primary health care. Themes and illustrative participant quotes are summarized in Table 1.

Facilitators to engagement

Availability of resources

The availability of resources for the management of obesity was identified as important for engagement of patients in their primary health care. These included resources specific to the management of obesity-related health concerns and resources aimed at helping individuals to lose weight.

Importance of the relationship

Participants described several factors that promoted the sharing of information with a provider including trust and respect. Participants stated they were more likely to follow through with treatment recommendations when they had developed trust with their healthcare provider. As in many large family health teams, patients do not always see the same provider at each visit. Having repeated contact and interaction with the same provider was identified as important. The length of time available from the provider was identified as central to establishing a relationship and thought to demonstrate concern for the participant.

Meaningful communication

Participants described helpful ways in which the provider communicated with them about their overall health and obesity. Providers who explained the connection between specific health concerns and body weight in a way that was meaningful to patients provided motivation for participants to engage in health behavior change.

Barriers to engagement

Feeling judged

Participants described carrying pre-conceived thoughts about health providers' beliefs and attitudes toward persons with obesity with them to their visits. Although these thoughts were not always directly triggered by an experience with the family health team, the thoughts accompanied the participants to every clinical visit. A number of participants described believing that they knew what the provider was thinking even though these thoughts were not validated by what the provider said to them. These feelings had a negative impact on engagement in primary health care by limiting the information they would share with the healthcare provider. This included reluctance to stating the purpose of their visit or having their body weight measured or recorded. Participants also described a belief that their physician would attribute all of their health concerns solely to their obesity. This was identified as a barrier to exploring any factors beyond obesity that may be the cause of their health concern.

Lack of privacy

Privacy was perceived as an important component of care particularly when providers were gathering information about a patient's weight. Participants described feeling self-conscious and embarrassed when the scale was in an open area. Another privacy-related concern was the requirement to identify the purpose of the visit when phoning to make an appointment. Although participants understood the importance of such information in order to book adequate time for the visit and to enter a billing code, they described being reluctant to disclose to the booking agent that they wanted to discuss their obesity with their provider.

Poor communication

Aspects of communication identified as barriers to engagement in primary health care included

Table 1 Summary of themes and corresponding participant quotes

Contributor types and sub-themes	Key elements	Participant quotes
Facilitators		
Availability of resources	Patient access to resources for weight management. Care provider knowledge of resources for weight management.	'Losing weight, doing it on my own is kind of hard so it was nice to have (the health providers) say well, here are some doctors, here are some books. That was helpful' (participant 1)
Importance of the relationship	Trust, respect, seeing the same provider, having enough time allocated for the clinical visit.	'It's all about finding that trusting doctor. If you don't trust whom you are talking to or you don't feel like they are listening to you then you don't want to come. I don't feel different or awkward here' (participant 4) 'I try to call ahead and try to see when that person is in again so I will wait if I can see the same persons' (participant 6) 'I genuinely feel that she does care. Usually her appointments last longer than they should so it makes me feel like I'm not getting the bum rush out of there' (participant 4)
Meaningful communication	Provider makes the connection between body weight and the patient's specific health concerns.	'...just say, we are concerned for your health and as your weight gets higher these are some of the complications. Say, I am your doctor and I am concerned about you and I want to make sure we don't have to deal with these complications. If I was a car going to my mechanic, the mechanic would not have a problem saying this is what is wrong with your car and this is what you need to do to fix it and why' (participant 7)
Barriers		
Feeling judged	Care provider assumptions about the patient based on body size	'I guess I wonder if they may think why I don't make the extra effort. That might be on the back of their head but they never actually say so. But, you get good at reading people when you are obese. You see it and you kind of know what they are thinking' (participant 4)
	Patient perceptions about what care providers think about their level of motivation, intelligence, effort	'...the doctor should look at my life a bit more and not just tell me, you know you should not be eating so much' (participant 8)
Lack of privacy	Body weight measurements taken in a public place	'The first few times (I had my weight taken) it took be back a bit because the scale was in the hall. There use to be scales in the exam rooms. It would be better to have it in a more private area' (participant 9).
	Expectation by booking clerk for patient to state reason for the visit	'They (booking agent) ask you what the purpose of your visit is. I know that is required of them but sometimes you know you don't want to or feel like telling them because it is personal...I am thinking as an overweight person, what if it is related to your weight, how do you explain that?' (participant 7)
Poor communication	Care providers implying they understand what it is like to live with obesity	'Hearing from my doctor that they understand what it is like to have obesity is useless. Saying you understand when you don't is a lie. You don't understand, you can't understand because you never went through it...it's strange how words can have such a large effect' (participant 3)
	Obesity not raised by the care provider as a health concern	'I am looking at myself and thinking, this can't be right. Why are the red flags not going up in their head? I guess if he or she is not worried about it (obesity) why should I be worried about it' (participant 3)
	Comments made while searching for equipment to assess the patients' health status	'No one likes to hear, well, oh, we have a larger cuff that we will use to take your blood pressure today. That can be awkward particularly if they say, oh, just a minute, I need to get the larger cuff' (participant 9)

Table 1 *Continued*

Contributor types and sub-themes	Key elements	Participant quotes
Limited care provider knowledge about obesity	Lack of knowledge about obesity and how to support and treat patients with obesity	'There seems to be a lack of knowledge and ability of health providers in general about all of the possible factors that cause weight gain' (participant 5) 'I don't think the medical profession knows what to do or have done enough to help people with weight' (participant 10)

use of language that implied a level of understanding by providers about living with obesity. Participants described feeling as though providers assumed what it was like living with obesity and this led to a reluctance to share information. Participants described feeling as if their obesity was ignored as a health concern and that this was an indication that it was not an important issue to be addressed. The way in which a care provider reacted in situations where medical equipment such as blood pressure cuffs did not fit a patient also created a barrier to patient engagement.

Limited care provider knowledge about obesity

Participants described an overall sense that most physicians did not have the training or knowledge to work with patients who have obesity despite the fact that it may be raised as a health concern.

Discussion

This is the first study in which patients with obesity in a primary care setting were asked directly about their experiences with general care and not focused on weight loss treatment. Participants identified trust, respect, contact with the same provider and knowledge about their health status in the context of their daily lives as key elements to feeling engaged in their care. Such expectations are essential factors for patient-centered care and are not unique to patients with obesity (Belle Brown *et al.*, 2003).

Disparity in primary healthcare experiences occurred when participants perceived that providers had pre-conceived notions about patients with obesity and attributed all health concerns to their body weight. Participants wanted to avoid being weighed or sharing their weight with the provider in an effort to shift the focus away from

body weight and onto the exploration of specific health concerns for which the visit was scheduled. Participants who wanted to focus on obesity-related concerns perceived a lack of knowledge on behalf of the provider about obesity and its treatment. This finding is consistent with studies that found physicians acknowledged their limited competence and/or interest in addressing obesity in primary healthcare settings (Leverence *et al.*, 2007; Tham and Young, 2008) and by patients with obesity who reported being unsatisfied with obesity specific care provided by their primary care physician (Wadden *et al.*, 2000). Sensitivity with respect to gathering information about a patient's body weight or having equipment that fits an obese body was identified in this study as a unique issue. Recommendations to address such issues have been made in a guide for bariatric practitioners but could also be considered for use by primary healthcare practitioners (Freedhoff and Sharma, 2010).

Limitations

Some of the positive findings in this study may result from a volunteer bias. Those patients who have had negative primary care experiences may not access their primary care providers or volunteer to participate in the study. This study took place in a family practice center in which medical residents may have provided direct patient care under the supervision of a primary care physician. We did not collect data on the role of the care provider and duration of the appointment. It is possible that contact with the medical resident resulted in longer appointment times due to consultations with physician supervisors and could have influenced patient perceptions of care. As in all qualitative studies, the intent is not to generalize results from this to all patients with obesity seeking primary health care.

Conclusion

This study provides information about the conditions necessary for patients with obesity to engage in primary health care. Although expectations for patient-centered care are not unique to this population, sensitivity and privacy is required when gathering information about a person's body weight. Having medical equipment designed for obese bodies is recommended for patients to feel comfortable and valued in the primary care environment. Future research is needed to explore the extent to which interventions aimed to promote patient-centered care meet the needs of patients with obesity. Knowledge about and uptake of effective strategies to enable engagement in primary health care for patients with obesity has the potential to contribute to health promotion and chronic disease prevention for this high-risk population.

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