



Title: Gender perceptions and their impact when referring obese patients for exercise

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Gender perceptions and their impact when referring obese patients for exercise

Abstract:

Obesity trends in the UK have shown a steady increase over the past 20 years, yet differences have been identified in the uptake and adherence data for obese men and women attending exercise referral schemes (ERS). Moreover, evidence suggests that health professionals (HPs) may hold preconceived gender specific views about their patients and this has been identified as a potential barrier to male patients seeking help from their GPs for chronic conditions. The aim of this paper is to examine the gender dynamics associated with health profession/patient interactions in relation to the uptake of an ERS for obese patients. The ERS in question was based in a Primary Care Health Centre in the South West of England. The respondent cohort comprised 12 patients (8 women, 4 men) aged 55-74 years and their 6 referring HPs (4 women, 2 men). Semi-structured interviews were conducted with patients and HPs over an eight month period and the data were analysed via a grounded theory approach. The study found that HP gender specific perceptions of their patients had an impact on the methods used to encourage patients to participate. HPs typically adopted a direct interactional approach with obese men and a more cautious approach with obese women. Irrespective of gender, male and female patients found being informed of their obesity difficult to accept. The paper concludes that there is a need for a degree of care to be taken when communicating such health concerns and that this kind of approach may lead to increased ERS attendance (and adherence) by men.

Key words: Health, gender, qualitative research, exercise referral schemes, obesity.

Introduction

Obesity trends in the UK have shown a steady increase over the past 20 years from 14.9% in [1993] to 24.9% in [2013], with similar rates of male and female obesity being evident (Health Survey for England [HSE], 2013). When combined with data concerning the number of those who are overweight, this increases to 62.1% of adults (67.1% of men and 57.2% of women), with men more likely to be overweight than women (41.1% compared to 33.3% respectively) (HSE, 2013). Obesity has been linked to an increased number of chronic conditions such as Type II diabetes, vascular and respiratory diseases (Guh *et al.* 2009). However, Bacon and Aphramor (2011) challenge the assumption that adiposity poses significant morbidity risks. Indeed, epidemiological studies have shown that overweight or obese people can live as long as - or even longer than - people considered to be of 'normal' weight (see Trojano *et al.* 1996; Durazo- Arvizu *et al.* 1998; Flegal *et al.* 2005; Flegal *et al.* 2008). Such contradictory evidence concerning the impact of obesity on health status calls into question the emergence of the 'obesity epidemic', a term that originated from the World Health Organisation report *Obesity: Preventing the Epidemic* (World Health Organisation, 1998). Challenging this stance, Cooper (2010) argues that such claims may have been constructed by particular interest groups and subsequently used as a tool to perpetuate wider social and political concerns. Despite these evidential contradictions recent estimates by the Health and Social Care Information Centre (2014) indicate that 25% of men and women in the UK are obese, with this trend predicted to affect 60% of adult men and 50% of adult women by 2050 (Foresight, 2007).

For the purposes of the present discussion, obesity is classified as having a Body Mass Index (BMI) (Kg/m^2) of between 30-34.99 (moderate obesity) and 35-39.9 (severe obesity) (WHO, 2000). A limitation of using BMI to determine obesity is that it does not consider body adiposity either at subcutaneous or deep levels. Consequently, a highly muscular individual

could be considered to be overweight, but for the majority of healthcare professionals BMI is considered a useful initial indicator of obesity. Since the 1970s the Health at Every Size (HAES) movement has emerged in response to the ineffectiveness of weight control models for overweight and obese people (Mansfield and Rich, 2013). Calling into question the efficacy of BMI as a measurement tool, proponents of HAES suggest that weight cannot be measured objectively by standard formulas, scales or charts (Robinson, 2007). That said, HAES does acknowledge that health is shaped by various factors including physical interactions (Bacon, 2008).

Of course, a substantial body of evidence exists on the benefits of physical activity on both physical and mental health (Macera and Powel 2001, Department of Health 2009, WHO 2010). For some time exercise referral schemes have been used in primary and secondary care as a means of helping patients manage their obesity (Dugdill *et al.* 2009). A longitudinal prospective cohort study found that a lack of cardiorespiratory fitness can be a greater predictor of ill health than obesity in isolation, with no differences being found between mortality rates of non-obese fit men and obese fit men (McAuley *et al.* 2012). In turn, Bacon and Aphramor (2011) have highlighted that in the few epidemiological studies where factors such as fitness are taken into account, the risk of disease disappears (see, for example, Campos *et al.* 2005).

Differences have been identified in uptake and adherence data for men and women attending exercise referral schemes. For example, studies have shown that the number of men participating in ERS can be disproportionately lower than that of women (see Dugdill *et al.* 2005 [1098 men, 1685 women], Gidlow *et al.* 2007 [1386 men, 2182 women], James *et al.* 2009 [455 men, 860 women]). Despite these differences, prior research has also identified

that women are less likely to complete schemes than men (Gidlow *et al.* 2007, James *et al.* 2008, Morton *et al.* 2008). Explanations for low completion rates amongst women include greater domestic and social responsibility (Mackey *et al.* 2002; Aitchison 2003). Conversely, high completion rates for men have been associated with higher levels of exercise self-efficacy (Biddle and Mutrie, 2001).

Previous research has also shown that initial uptake and adherence to exercise referral schemes can be higher when referral comes from practice nurses rather than from General Practitioners (GPs) (see Dugdill *et al.* 2005, Leijon *et al.* 2010). Furthermore, Michie (2007) found that practice nurses were more likely than GPs to raise the issue of weight during a consultation, but that GPs were more likely to be concerned about raising the issue of overweight in fear of the patient reacting emotionally to such information (Michie, 2007). Patient referral rates from health professionals for weight management schemes have been shown to be higher for female than male patients. For example, a recent Australian study has shown that 69% ($n= 351$) of referrals for a weight management scheme were for female patients (Brook *et al.*, 2014). In a study of over 1000 Danish GPs, it was found that irrespective of the gender of the GP concerned, GPs referred more female than male patients for weight management programmes (Rohde *et al.*, 2014). Rohde *et al.* (2014) also found that the gender of HPs had an impact on the gender of the patients they referred into weight management schemes with 64% ($n=300$) of female GPs referring more women to weight management schemes than the 49% ($n=326$) of male GPs in the study.

A lack of physical activity knowledge associated with a dearth of professional development courses in physical activity promotion for GPs has been previously identified as a barrier to patients taking up ERS (McKenna *et al.*, 1998; McKenna and Vernon, 2004; Ribera *et al.*,

2005). In attempting to suggest recommendations to address this, Michie (2007) concluded that training should be provided to improve health professionals' (especially GP's) confidence in communication skills when discussing weight. A further explanation as to why GPs might find it difficult to give patients advice on weight loss is that they either have (or previously have had) weight problems themselves, consequently making them feel that they are not best placed to advise on dietary issues (Cade and O'Connell, 1991; Sebianny, 2013). However, more recently the Young Men's Christian Association (YMCA)¹ and the American College of Sports Medicine (ACSM)² have developed a range of courses and programmes for physical activity promotion in public health settings. This increase in physical activity promotion appears to be directed primarily towards the leisure industry and other health professionals, which calls into question the impact that such programmes might have on the development GPs' knowledge in this area.

A recent study of 223 Danish GPs (male 49.3% and female 50.7%) found that when health professionals undertake training in the frequency, intensity and duration of exercise necessary for health gains they are more likely to promote physical activity (Jorgensen *et al.*, 2015). Of all responding GPs, 57% reported promoting physical activity on a daily basis, with 38.6% and 4.5% reporting similar interactions on a weekly and monthly (or less frequent) basis respectively (Jorgensen *et al.*, 2015). A similar study in Holland of 340 GPs (male 58% and female 42%) also found that half (170/340) of the GPs involved perceived that they had an important role in promoting physical activity with their patients (Leemrijse *et al.*, 2015). These GPs ($n=170$) combined physical activity advice with a specific referral to either a health care setting or to local exercise providers. The other half simply gave advice on taking more physical activity (Leemrijse *et al.*, 2015). Research in Sweden found that whilst GPs

¹ YMCA Wellness programmes (see: www.ymca.org.uk).

² ACSM Physical Activity in Public Health Specialist (see: www.acsm.org).

tended to provide advice to patients on the importance of physical activity, few pro-actively prescribed it (Persson *et al.*, 2013). In addition, Persson *et al.* (2013) found that GPs held reservations about prescribing physical activity, due to the fact that their medical education (i.e. GP training) had been directed primarily towards the prescription of pharmaceuticals. Therefore, whilst there is evidence to suggest that health professionals acknowledge the importance of physical activity during interaction with patients, there are variances in the extent to which physical activity promotion takes place.

Despite the higher prevalence of combined overweight and obesity in men compared to women (HSE, 2011) more women attend weight-loss interventions (Mayre-Chilton and Joyce, 2011; Tsai *et al.*, 2015). One explanation for the lack of uptake of such interventions by men is the perceived tension between ‘getting physically active to lose weight’ and the unachievable masculine physique that is necessary for participation in sport (see Monaghan, 2008; Calzo *et al.*, 2013). However, Hunt *et al.* (2013) found that men were more accepting of a physical activity weight loss intervention if it was presented to them within a masculine context and technology was incorporated into the programme. When the intervention was encapsulated within context of the Scottish Premier League football, men were more accepting of the weight loss intervention as it bolstered their masculine identities. That said, adherence to weight-loss programmes has been shown to be similar in men and women (Mayre-Chilton and Joyce, 2011). Evidence suggests that men are more likely to sustain weight loss, increase exercise, take diet medication, and follow diets (Tsai *et al.*, 2015). Aphramor (2012) has highlighted a number of factors that may negatively impact women’s chances of successfully engaging with weight-loss behaviours, including experiences of ridicule, blame, insensitivity and discrimination both inside and beyond primary and secondary health care contexts. Therefore, it has been suggested that increasing health

professionals' awareness of size stereotyping may elicit a more compassionate consultative climate with overweight and obese women (Aphramor 2012).

In terms of the nature of HP-patient interactions, Cade and O'Connell (1991) and Sebianny (2013) found that advice to patients on weight loss can be brief and somewhat cursory. Some health professionals have been identified as being reluctant to encourage obese patients to participate in physical activity due to the possibility of jeopardising the GP/patient relationship (Epstein and Ogden, 2005; Walker *et al.*, 2007). Sebianny (2013) and Epstein and Ogden (2005) have also identified that some health professionals demonstrate a negative attitude towards the concept of obesity which may be attributed to the low success rates that have been reported around related treatments (see also Ogden *et al.*, 2001; Sebianny, 2013).

There is a dearth of information surrounding the impact of health professionals' gender on the referral of obese patients for exercise (Hale *et al.*, 2010). Preconceived views about the gender-specific behaviours of patients have been identified as a potential barrier to male patients seeking help from their GPs for chronic conditions such as obesity and Type II diabetes. Hale *et al.* (2010) found that some GPs believed that male patients may be reluctant to seek help until late in the course of an illness on account of the fact that they might be perceived as being 'unmanly' if they attended a consultation too early on. Other explanations that have been put forward for men not seeking help include the lack of routine checks available compared to those available to women, along with complicated appointment systems (Coles *et al.*, 2010).

Connell (2005) suggests that the greatest difficulty to overcome in relation to effectively engaging men in preventive healthcare are the narrow or stereotypical (hegemonic masculine)

assumptions about what it means to be a man in advanced industrial societies (see, for example, Smith, 2013; de Visser & McDonnell, 2013). However, despite the prevalence of such assumptions, evidence for men demonstrating such fixed behaviours, characteristics or traits (i.e. strong, stoical and aggressive) that limit their potential to engage with healthcare is somewhat sparse. Indeed, both Moller (2007) and Demetriou (2001) have challenged Connells (2005) established views on masculine behaviours. Moller (2007) argues that by laying claim to the existence of predictable and/or assumed patterns of masculinity, Connell (2005) inadvertently dismisses some of the nuances of what actually men do, say and feel, and that such behaviours are often more complex than can be defined amidst the somewhat reductionist conceptual backdrop of hegemonic masculinity. Furthermore, Demetriou (2001) has identified weaknesses in Connells' (2000) perspective that masculinity is framed solely within the context of white heterosexual masculinity in terms of the reproduction of patriarchy. Instead Demetriou (2001) suggests that discussions of hegemonic masculinity should more readily consider subordinate male masculinities thereby engaging with what is described as a 'hybrid bloc' that encompasses straight and gay, along with black and white elements and practices in order to adequately explain the reproduction of patriarchy. More specifically, Williams and Roberts (2006) argue that recognising the uncertainty and changing nature of modern masculinities may allow health practitioners to identify and take opportunities for successful engagement. Given all of the above, the intention of the present study was to examine the gender dynamics associated with health profession/patient interactions in relation to the uptake of an exercise referral scheme for obese patients and it is to a consideration of methodological underpinnings that we now turn.

Context and Method

The Primary Health Care Centre (PHCC) featured in this research was located in a small village in an area of high social deprivation (Index of Multiple Deprivation factor of 1) in the South West of England. The PHCC had a community gymnasium on site which was the result of a partnership between the National Health Service and a local leisure provider, the YMCA. The gym was open to community-based patients three days per week between 9.00 am and 5.00 pm and comprised two small rooms. The larger room was also used as a community meeting room; the smaller room consisted of a gym with four pieces of cardiovascular equipment and four multi-station resistance machines. The ERS was on-going with no specific start or end point. After initial referral patients contacted the PHCC to make an appointment for an initial programme induction and having completed this new attendees would join existing patients/clients and follow their own individualised exercise programmes under the supervision of an exercise professional. Exercise classes consisted of differentiated, small-group-based activities, i.e. floor, chair, walking, and resistance exercise with dumbbells. Health outcome measurements, such as blood pressure and peak flow were taken before and after each session. As their health outcome measures improved, patients were encouraged to progress onto cardiovascular and resistance equipment in the gym. In turn, they were encouraged to apply the information disseminated during sessions to their wider lifestyles.

Patients and health professionals were recruited to the study using a convenience sample (Bryman, 2015). All six HPs who were in general practice at the PHCC completed appropriate informed consent. The HP group comprised five GPs (2 male, 3 female)³ and one

³ To preserve anonymity, pseudonyms have been used throughout.

Practice Nurse (female). Both the patient and HP groups were interviewed on two separate occasions (January 2009 and September 2009) with each interview lasting between 30-45 minutes. Patients were referred into the Scheme by their HPs and were considered to be 'high risk' as they had a range of multiple co-morbidities associated with chronic obesity including angina, Type II diabetes, hypercholesterolemia, hypertension and coronary heart disease. All of the patients ($n=17$) attending the ERS were invited to participate in the study of which 12 consented. The University of Plymouth Research Ethics Committee approved the study.

Given the primary aim of the research to explore health professional's gender perceptions and their impact when referring obese patients for exercise, semi-structured interviews were perceived as the most appropriate method of data collection. The initial semi-structured interview schedules (January 2009) were developed in line with the key themes evident in the related literature (e.g. Dugdill *et al.*, 2005; Graham *et al.*, 2005; Gidlow *et al.*, 2007; Michie, 2007; Leijon *et al.*, 2008). In turn, the schedules used in September 2009 were developed from the central themes which emerged from the January 2009 interview data. The interviews were recorded on a digital voice recorder and transcribed verbatim. The questions asked during the HP interviews emerged from themes identified in the first set of patient interviews and focused on the impact of a patients' gender and if tensions arose during consultation with obese patients. Similarly, the questions put to patients in September 2009 were developed from the initial round of interviews and focused on how the patients felt about being told that you were obese and needed to exercise.

The justification for using semi-structured interviews was the need to ensure cross comparability of data which was achieved via line by line comparison of the responses from the participants to each of the questions asked. The data were analysed manually in order to

prevent the narrowness of approach that can occur when using computer software to analyse qualitative data (Silverman, 2010). This process aided the initial open coding stages by facilitating the identification of abstract representations of the events arising within the interview process (concepts), and then naming these in order to group (categorise) similar events under a common heading. Having identified these concepts and categorised them, similar responses were grouped into themes (sub-categories) that related to the concepts that had developed.

Insert Table 1 here

Theoretical development advanced through axial coding and the application of the axial coding paradigm shown in Table 1. Memos were used to explore the different dimensions of the emergent themes from the axial coded data, to develop meaning from the text units, and to help formulate questions for the subsequent interview schedules. Memos were also used as a means of describing and explaining the interactions between HPs and patients during the consultation phase of the exercise referral. The final analytical characteristic used to ensure a robust approach to grounded theory analysis was the construction of the end product of the research (Hutchinson *et al.*, 2011). This involved selectively coding the data and developing a ‘core story’ from the axial coded memos, from which a core category developed. This, in turn, led to the development of the conceptual model shown in Figure 1. This was followed by a descriptive account of the findings supported by evidence from the lived experiences of the participants.

Insert Figure 1 here

Traditionally, the rigour and quality of qualitative research has been judged through the application of a parallel perspective to the criteria of internal validity, external validity, reliability and objectivity as identified by (Lincoln and Guba, 1985). Their parallel perspective considered applying a range of trustworthy principles that included credibility, transferability, dependability and confirmability. However, this approach has come into question in recent years. For example, Sparkes and Smith (2014) have directed a number of criticisms towards Lincoln and Guba's (1985) trustworthiness perspectives which include: the lack of rationale for the criteria used; different interpretations of some of the techniques such as member checking; a lack of appropriateness of some of the techniques to establish trustworthiness; and a sense of ambivalence and unpredictability around the originally devised criteria (Sparkes and Smith, 2014).

Therefore, to enhance the quality of the present study the following principles were adapted and applied throughout and included: (i) *worthiness of the topic and significant contribution of the work* via contribution to debates on masculine health behaviours and how health professionals traditional perspectives on masculinity might impact on obese men's uptake of exercise referral schemes; (ii) *rich rigour* through the application of grounded theory techniques; (iii) *resonance* through the transferability of the findings to similar ERS in similar situations; and (iv) *sincerity* through the use of the participant voice. To enhance transparency, the study included an audit-trail of the data collection and analysis process including: audio recordings; transcripts; coding; the development of a theoretical framework; and a conceptual model. *Credibility* was authenticated through participants' reflections on the accuracy of the transcripts, and further established through enabling the direction of the narrative to rest on what the participants directly said or did.

Findings

The majority of the health professionals (HPs) interviewed identified a range of difficulties when referring obese patients for exercise with weight related conditions. These difficulties were often grounded in pre-conceived views held by the HPs about gender differences and the willingness of patients to accept that they were obese and could benefit from exercise. Contrasting evidence emerged from patients themselves about their willingness to accept advice on such matters. Consequently, the health professionals' pre-conceived notions of gender specific behaviours were considered to be a barrier particularly to male patients during initial referral into the Scheme.

In Figure 1 we have presented a conceptual model which is configured around the core category of 'Need for easier referral'. As we have seen, the concept of patient referral into a practice-based exercise referral scheme was the phenomena investigated and 'Need for easier referral' emerged as the core category. This category was selected as it best represented how the referral process affected the number of patients being referred into the Scheme. The need for an easier referral was the main theme that emerged from the data obtained from the health professionals. The core category 'Need for easier referral' was central to all other categories; it was regularly identified in the data and explained variation as well as the main issue highlighted in the data, which are requirements of a core category (Strauss and Corbin 1998). Each aspect of the conceptual model is described below:

Causal condition – Health professionals' views

The causal condition 'health professionals views' was a characteristic of the core category 'Need for easier referral'. This characteristic had an influence on the effectiveness of the

referrals made by health professionals. The property of the 'health professionals views' causal condition, considered the views held by the health professionals about their patients 'receptiveness of their obesity' and the patients 'need for physical activity'. The notion that GPs can hold preconceived views about male behaviours has also been highlighted by Hale *et al.* (2010), who found that GPs thought that male stoical behaviour may prevent men seeking help with chronic medical conditions. However, such views have been challenged by Coles *et al.* (2010), who found that men generally wanted to access medical services but were inhibited due to a lack of experience at accessing those services.

Amie (HP) perceived that the issue of obesity was more difficult to discuss with women than men: 'It's a harder thing to say to a woman as most females are more sensitive about their weight than a male'. Amie's explanation for this was that women often externalised their weight problems by not fully taking responsibility for them and blaming other things for their weight gain: 'Overweight women are very happy to blame all sorts of things like pregnancy, babies and contraception. They are a tough group to deal with'. Amie's views concur with those of Wiggins (2009) who suggests that obese patients may resist the notion that they are responsible for weight gain by blaming external events outside of their control. Such views are also supported by Epstein and Ogden (2005) who argue that obese patients may attribute their condition to either medical or external causes.

All of the health professionals interviewed considered women to present a greater challenge than men when discussing obesity and exercise. Phillip (HP) also found it harder to discuss weight issues with women, as he thought that they were socialised to be more aware of their appearance than men: 'As a male GP I would say it is harder to tell women [about weight

issues], it feels harder to tell women. I think women are socialised to be far more aware of what they should appear like’.

In turn, some HPs explained that discussing weight issues with women could be difficult as women were socialised to be more sensitive about their weight. Externalising the problem and not taking responsibility for it also made it difficult for some HPs to refer overweight or obese women into the Scheme. The majority of the views presented by HPs related to the difficulties associated with discussing obesity and the need for exercise with women. HP perceptions of male patients tended to assume that they would be more accepting of a direct approach to discussing obesity. According to Hanson *et al.* (2011), HPs have been shown to exhibit gender specific views that encapsulate traditional masculine (stoical) behaviours and this may partly explain why men have come to be seen as a ‘hard to teach’ group within healthcare (Connell, 2005).

Contextual conditions – Gender perceptions

Contextual conditions are sets of conditions that intersect at a specific time and place creating a series of problems to which people respond through actions and interactions (Strauss and Corbin, 1998). ‘Gender perceptions’ was the theme that emerged from the contextual conditions category. The property of the ‘gender perceptions’ theme related to the ways that health professionals held ‘gender specific views’ about the obese patients with whom they consulted. Amanda (HP) noted that in her experience: ‘Female GPs tended to see more female patients with regard to weight issues, as they were more sensitive about weight and image’. This view is consistent with that of Rhode *et al.* (2014) in relation to female HPs consulting with female patients regarding weight loss. Euan (HP) was of a similar view with regard to the gender of patients he consulted with in relation to obesity. However, he was also

of the view that consultation with obese men could be driven by concerns from their spouse/partners and rarely came from men directly:

Tensions arise with both women and men but you tend to be a bit more aware and careful with a woman. Although I probably talk to more men about weight problems they will rarely just come to talk about losing weight. It tends to be when their wife is with them and says: "I think he needs to lose weight", or I will bring the issue up during an appointment.

This supports the view that different consultative approaches are required for obese men and women but is in contrast to the notion that Western culture has historically been more accepting of male, compared to female fatness (Monaghan, 2005). If male fatness was socially acceptable then men potentially would be more comfortable attending weight loss consultations independently. An explanation for low uptake of men to weight loss schemes has been put forward by Monaghan (2008) who suggests that men hold unrealistic assumptions about the relationship between weight loss and becoming physically active, thinking that to be successful they must acquire an unachievable masculine physique for sports participation. Consequently, such unrealistic expectations may prevent obese men from attending weight loss schemes. Conversely, Cara (HP) was of the view that health professionals advised obese men and women similarly in the context of diet and exercise: 'I would say it is fairly close to 50-50, maybe slightly more women, certainly on the diet side of it. The exercise I guess comes in more with the men who have high blood pressure'. These views on diet are in stark contrast to those of Brook *et al.* (2014) and Rohde *et al.* (2014) who found that GPs refer more female than male patients for weight management schemes. The problem with women being the focus of GP referral for weight-loss is that it makes men an

even harder-to-reach group, as they attend fewer GP consultations than women in England (ICHSC, 2009; Hale *et al.*, 2010). This issue is likely to be confounded further due to the fact that the number of female GPs in England appears to be growing faster than that of males (GMC, 2012). This may make it more difficult in future for men to see male GPs. Further explanations as to why male HPs are reluctant to discuss weight related issues with male patients could be concerns about jeopardising GP/patient relationships (Walker *et al.*, 2007) or the negative attitude that some GPs have about treating obesity (Epstien and Ogden *et al.*, 2005; Sebianny, 2013) due to high failure rates for weight loss and poor adherence to schemes (Sebianny, 2013).

Intervening Conditions – Direct and cautious approaches

Intervening conditions are conditions that alter the impact of the causal conditions on the phenomena (Strauss and Corbin 1998). The emergent themes here were ‘direct approaches’ and ‘cautious approaches’. These different approaches were used by the health professionals during consultation with obese patients as a means of persuading them to participate in the Scheme. The property of the direct approach was ‘men’ and included raising the issue of obesity in a straightforward, matter-of-fact way, as the HPs were under the impression that men would be able to accommodate such an approach. The property of the cautious approach was ‘women’ and included being more sensitive when approaching the subject of obesity with women, as the HPs assumed that women were more sensitive about their weight than men.

Health professionals identified that trying to engage obese patients to participate in the ERS could, at times, be difficult. The main reason for this was that some patients were in denial about being overweight or obese, and, therefore, the need to exercise. Directness with

patients, whilst often difficult for the health professionals, was an approach that was often used when encouraging male patients to take up the exercise referral. The need for a direct approach was highlighted by Cara (HP), who identified issues of denial specifically around diet: 'The commonest reaction is that: 'I do not eat anything'. My reaction to this is ... 'You obviously need to exercise more because what you are eating is obviously too much, you are not burning it off'.

Resisting the notion of personal responsibility for weight gain has been identified as a difficulty associated with treating obese patients (Wiggins, 2009). Indeed, it has been shown that the longer a weight management scheme progresses, the more concretised patients' denial about their weight gain becomes. Wiggins (2009) highlights the absence of blame in medical circles for weight-gain which further complicates the issue of patient responsibility. Consequently, a more direct approach to gaining patients' acceptance of their obesity may be needed in order to progress more effectively with weight loss interventions. That said, direct approaches when consulting with men over weight loss have been reported as being unfavourable (Michie, 2007).

Euen (HP) believed that it was necessary to adopt a variety of approaches when consulting with men and women over weight-related issues. He supported the notion of a direct approach when consulting with obese men, but in contrast to the views of Wiggins (2009) thought that a more cautious approach was necessary with obese women: 'You tread a bit more carefully if you have a woman patient, whereas with a bloke you tend to be a bit more direct'. Amie (HP) was also of the opinion that men were more likely to accept a direct approach when discussing weight, but agreed that a more cautious approach was needed when consulting with women:

I think it is easier to say to a man: “Going by my BMI chart on the wall you are overweight, this is how overweight you are”, and they will take it. Most of them will ignore it but they will actually take it. It’s a harder thing to say to a woman as most females are more sensitive about their weight than a male.

Monaghan (2007) has argued that higher rates of obesity in men can be explained by a misunderstanding of the concept of obesity, and a lack of knowledge of and inability to comply with BMI thresholds. Therefore, the direct approach to male patient’s obesity identified by the HPs, for example by providing men with a greater understanding of weight-related issues, i.e. visual evidence in the form of BMI charts, could be seen as one way to address their lack of knowledge in this area (see also Hatchell *et al.*, (2013).

Wiggins (2009) has identified the importance of patients accepting that they are obese as a key factor in managing their weight control, and consequently, how lack of acceptance can be a barrier to patients engaging with an exercise referral scheme. Claris (HP) was of the view that both men and women could be equally resistant to accepting that they were obese. She stated that in her experience men tended to externalise weight-related issues by not accepting that they had a problem, whereas women tended to be more vulnerable, as they had often tried to lose weight unsuccessfully:

Gender-wise they can be equally as difficult or resistant. Some men can be more entrenched in their behaviour and more an external problem; it is not theirs to deal with. Women tend to internalise it as a problem because they have a sense of learned helplessness because in their mind they have tried every diet under

the sun but they still have not managed to lose weight. I think that both can be vulnerable in the same way for different reasons. Maybe women are under more pressure as they are socialised to lose more weight and do more exercise?

A lack of acceptance of female fatness in Western society (Monaghan, 2005), could explain HP views that obese women patients are more vulnerable when it comes to issues of weight loss and therefore require a more cautious approach. These views are in contrast to the findings of Aphramor (2012) who has highlighted how obese women can often be the subject of ridicule, blame and dismissal when accessing primary and secondary care weight loss services.

Phillip (HP) emphasised that one consequence of the direct approach was that patients could initially feel upset or angry:

It is actually a really tough issue - the exact words I would use when somebody is obese, as a considerable number of people who are obese have considerable emotional and mental health issues which have driven them to become that way. To blandly say that you are obese and need to exercise is a difficult thing to bring into a conversation. Some of them take it extremely badly when you have told them that they are obese. It is like you have just sworn at them. I have people actually leave the room; stormed out because I have called them obese, but they are. So, trying to persuade them to exercise to get rid of it or see the value of exercise is difficult.

Actions and interactions

Actions and interactions are purposeful acts that are undertaken to solve a problem and in doing so shape the phenomena (Strauss and Corbin, 1998). The theme identified in the data was ‘willingness to accept responsibility’ for obesity. The properties of the ‘willingness’ theme related to ‘HPs perspectives’ and contrasting ‘patient perspectives’ in relation to patients accepting that they were obese and could benefit from exercise. The majority of male and female patients found it hard to accept that they were obese. Yvette highlighted how she disliked the way that the health professional who she had seen, had communicated such a message to her: ‘I felt like I was a child being told off for something; something I knew. I suppose over the years I have got a bit blasé and not bothered really’. Yvette’s experience is illustrative of the findings of Aphramor (2012) who identified that insensitive and inappropriate language can make it difficult for women to engage with weight management schemes within primary and secondary care. Len also found it hard to believe that he was obese and expressed being shocked when he was confronted with this: ‘I was amazed, because I didn’t think I was obese. I was shocked as the only thing I had noticed was my trouser size had gone up two inches’. These issues are illustrative of the findings of Epstein and Ogden (2005) and Wiggins (2009) surrounding obese patients who fail to recognise or take responsibility for their weight gain. A contrasting perspective was put forward by Paul who did not mind discussing weight issues with his health professional. Paul believed that because he had always been involved in manual work, he did not need to be concerned about his weight, despite having arthritis and having to have a knee replacement as a result of being obese for 20 years: ‘It never bothered me as such because I was always active. All the work I’d done was labouring type of work, using up a lot of energy’. Therefore, it appeared that, despite health professionals’ and patients’ differences in gender perspectives when discussing the need for weight control, patients generally found this subject difficult to discuss irrespective of their gender.

Patient disdain about the way that their health professional had discussed obesity with them contrasted markedly with the way that they perceived being consulted over the need to exercise. Cardiorespiratory fitness has been shown to be an effective means of reducing mortality rates in obese men (Bacon and Aphramor, 2011; McAuley *et al.*, 2012), and that patients appear to be receptive to advice from their health professionals in relation to participating in ERS. Indeed, the majority of patient respondents in the present study embraced the advice that they received on this matter. Mary who had been obese for 20 years prior to her uptake of the Scheme, identified that PE lessons at school had put her off exercising in the past, but she was grateful that the need for exercise had been highlighted by her health professional. In turn, Mary had come to realise the importance of exercise in preventing the development of wider health problems, but wished that she had been more active during her life:

It was something I always hated when I was at school and if I could get out of doing PE lessons I would. In hindsight, looking back then, if they had said to me ‘If you don’t do it now you will suffer as you get older’, I think I would have done more.

These transcript extracts provide evidence to suggest that, as a social variable, gender did not play a part in the acceptance of advice from health professionals. Both the male and female patients found advice on obesity difficult to manage. Likewise, male and female patients received advice on the need to take up exercise in similar ways. However, what these extracts also illustrate is that denial and a lack of responsibility were germane to both sexes.

Conclusion

Our intention within this paper has been to consider the experiences of both referring health professionals and patients taking part in an NHS exercise referral scheme. We have examined the impact of factors associated with patient uptake, from the point of view of health professional referral, and the patient's perspectives of referral and the resulting scheme. Our findings demonstrate that health professionals held preconceived views and opinions about the different ways that men and women received advice on obesity and the need to exercise. These views had an impact on the way that health professionals encouraged patients to participate in the Scheme. Findings also identify that health professionals typically used a direct approach when discussing obesity and exercise with men and a more cautious approach with women. The adoption of such an approach with men is contrary to the findings of Michie (2007) and Coles *et al.* (2010), who highlight how feelings of stress, embarrassment and fear, during consultation may result in low male attendance at health clinics. Both of the approaches (direct and cautious) used by the health professionals in this study were based on their gender-specific views of their patients. In contrast, the gender views held by the patients themselves were somewhat different. Findings suggest that, irrespective of gender, male and female patients alike, found accepting that they were obese difficult to manage. However, the majority were not averse to being informed of the need to exercise. Male patients found it difficult to accept that they were obese at all.

Previous research suggests that men do not access medical services with the same frequency as women (ICHSC 2009) and have higher morbidity (ONS 2014a) and mortality rates (ONS, 2014b). In combination with the findings of this study, such assertions indicate that there is a need for more strategic, evidenced-based approaches to referring male obese patients, and less reliance on health professionals' perceptions of gender-specific views. Such approaches

may lead to increased numbers of men being referred into exercise referral schemes. This is particularly important when considering the positive influence that GPs can have on motivating patients to attend such schemes (James *et al.* 2008; Horne *et al.*, 2010), and that twice as many men complete exercise referral schemes than women (Gidlow *et al.*, 2007; James *et al.*, 2008; Lee *et al.*, 2009). In turn, further training for health professionals should consider techniques to reduce ‘direct’ approaches during consultation which are founded on perceptions of male-specific behaviours.

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