

Healthy eating: the views of general practitioners and patients in Scotland¹⁻⁴

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ABSTRACT

Background: Scotland has one of the poorest health records of all Western countries, and this has been linked to poor diet. A key part of efforts to improve health has been an action plan to improve the Scottish diet. General practice has been identified as an important setting for health promotion and the provision of healthy eating advice.

Objective: The objective was to investigate the views of general practitioners (GPs) and their patients about healthy eating and the provision of healthy eating advice in general practice.

Design: This qualitative research study used semistructured in-depth interviews with 15 general practitioners (8 female and 7 male) and 30 patients (15 married couples in social class 3, 4, or 5 with young children).

Results: The study found that health was only one priority in patients' everyday lives and that these patients were also questioning the relevance of healthy eating advice. GPs were divided in their opinions, with greater enthusiasm being displayed by the younger and female doctors. However, despite their differing views, GPs felt that general practice was better suited to specific rather than general health advice.

Conclusions: If programs in general practice to address dietary inequalities are to succeed, both patients' views and GPs' views must be taken into account. *Am J Clin Nutr* 2003;77(suppl):1043S-7S.

KEY WORDS General practice, Scottish diet, qualitative methods, nutrition education, dietary advice, healthy eating

INTRODUCTION

Although life expectancy in Scotland is improving slowly (1), it still lags behind that of most comparable Western countries by some 2 to 3 y (2). During the 1990s, policymakers emphasized the need for health education initiatives to address the relationship between Scotland's poor diet and the country's poor health record. Many different approaches have therefore been proposed to tackle the problem of the "Scottish diet," with its high fat and sugar content and its low fruit and vegetable content (3).

Although general practice in Scotland may be positioned as a gateway to other health services, contractual obligations outlined by the UK and Scottish governments also require the provision of a range of primary health care services, including health promotion. General practitioners (GPs) are therefore considered a key resource in Scotland's diet action plan, reflecting the general view that GPs are well placed to tackle healthy living issues in the context of a routine consultation (1) and that general practice

represents a natural setting (4) with exceptional potential for preventive work (5).

There have been challenges—from both within and outside the profession—to the idea that GPs are effective providers of lifestyle advice. Not all health professionals share the same views about prevention and how prevention relates to actual practice (6). Sociology can play a key role in helping to understand what health promotion is and why it may be the subject of fierce disputes among professional practitioners and policy makers (7). A recent study on prevention in general practice found that there was a considerable gap between the rhetoric of prevention and the views of the rank and file GPs themselves (8). Research on the content of medical encounters suggests that miscommunications between doctors and their patients are most likely to occur with regard to patients' everyday lives and concerns, including healthy lifestyles (9).

In relation to GPs' potential role in providing healthy eating advice, studies from outside Scotland have noted that most primary health care professionals have limited training in diet and nutrition, and that many professionals are ill-informed and lack appropriate skills to convey such advice (9). Irrespective of how well motivated, informed, or trained primary care professionals are, there is also a need to acknowledge that patients are not homogeneous, passive recipients of information about diet and healthy eating. Fieldhouse (10) has argued, from studies of international evidence, that preventive health interventions are more likely to succeed if they are based on an understanding of social class, sex, and local customs and social structures. However, there is a lack of information on lay views on food and health, particularly in Scotland, and why preventive programs have not led to a greater improvement in dietary inequalities. Sociologists have therefore argued that their discipline can play a key role in informing health promotion policy and practice by considering the needs and the behavior of those who are being targeted (11).

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²Presented at the Third Heelsum International Workshop, held in Heelsum, the Netherlands, December 10–12, 2001.

³Supported by the Chief Scientist Office, Department of Health (Scotland), as part of a PhD scholarship. This article conveys the ideas of the authors only and not those of the host institution or funding body.

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METHODS

Semistructured in-depth interviews were carried out with 15 GPs and 15 low-social-class married couples with primary school-age children (30 patients).

As Britten et al (12) have argued, qualitative methods were deemed to be the most suitable because of their appropriateness to the exploration of a previously underresearched area. A semi-structured interview format, therefore, provides a high degree of interaction around a series of set questions yet allows for flexibility where needed (13). Thus, taken-for-granted assumptions can be put under scrutiny, or respondents can be asked probing questions to minimize misunderstandings (14).

The study had ethical approval from the local health board ethics committee.

Sampling and recruitment procedures

GPs

We reviewed routine data on the socioeconomic profile of 104 general practice populations in the Lothian area and produced a list of practices that fell into the bottom 50% of the Carstairs measure of relative social and economic affluence and deprivation classification (15). Patients were recruited from these practices from social classes 3, 4, or 5, described by the Registrar General classification as lower-income, manual-skilled, manual-nonskilled, and unemployed social groups (15). We asked colleagues working in primary care to suggest which of these practices might be likely to participate in the study (not necessarily because of a specific interest in health promotion or healthy eating) to facilitate the recruitment processes. Three practices were approached and agreed to take part in the study, and 8 of the 15 GPs working in these practices agreed to be interviewed. A further 7 GPs were recruited from the remaining eligible practices. Twenty-one GPs were approached before 7 agreed to take part. Overall, 8 female and 7 male GPs from 8 practices took part. Length of time in general practice ranged from 1 to 29 y.

Patients

Social class, sex, income, and family life are known to influence healthy eating, so we therefore decided to recruit patients with this purpose in mind and to allow us to explore views of healthy eating in the context of everyday life. We could explore the views of only a small number of people in-depth, and we decided against trying to capture and compare views across social class and household composition, as we would have had very few people in any one comparative group. We decided to include married couples with primary school-aged children in social classes 3, 4, and 5. We also decided to focus on patients who did not suffer from any chronic disease or illness to explore their views on general healthy eating advice. Couples were approached at random from lists provided by the 3 participating general practices. Thirty-three couples were approached, and 16 were interviewed (one completed interview was withdrawn from the sample because the couple separated).

Content of the interviews

Interview topic schedules were developed based on preliminary pilot study interviews. Patients' views of "healthy eating" were explored in relation to their everyday lives so that their views on advice provided in the general practice setting could be understood within this broader context. For the GPs, the focus

was on their professional views of "healthy eating" and how these related to their "personal" views on food, including any influence that the personal views were having on the professional advice that the GPs were providing.

Data analysis

Once the interviews were conducted, they were transcribed verbatim and then analyzed. Items were grouped into key themes through a process of constant comparison (16).

The interview extracts provided in this chapter use pseudonyms to protect patient confidentiality and anonymity.

RESULTS

Analysis of interviews with patients

Healthy eating in daily life

Analysis of the interviews with lay respondents revealed that health was only one factor that appeared to influence day-to-day decisions about food choice. In most families it was apparent that the women were responsible for the routine provision of family meals. They appeared to rely heavily on prepared/convenience foods to help them manage their obligation to routinely provide a family meal; these prepared foods typically consisted of cooking sauces, or frozen processed meats or fish marketed as children's food. Although discussions about food additives were rare and seemed to have been set aside in favor of the perceived benefits of these foods, the foods were nevertheless often viewed as a compromise. Like many female respondents, this mother had one main priority: ensuring that her children were eating a "substantial" meal—one that would prevent them from snacking soon afterward:

TRACEY: Because then you will find that they won't eat it, and then 10 min later they are down and they are raking for junk, and they are filling themselves up with biscuits or crisps or sandwiches or whatever.

For all respondents in this study, the idea that health was only one factor influencing foods eaten was also demonstrated in their discussions of a need to maintain a balanced diet. Although all the lay respondents recognized the importance of the relationship between food and health, many believed that you must watch what you are eating but not take healthy eating too seriously:

AMANDA: Well it's very important. You need food to survive. Too much of the wrong food's going to lead to all sorts of health problems. But you have also got to be relaxed and happy about what you are doing. I don't think it's healthy if you get too fanatical about how much of how many bits and pieces are in every bit of food. You've got to get a happy balance.

These lay respondents tended to stress that it was more important to eat a variety of different foods in moderation and balance the need to eat "healthy" foods with the need to satisfy other requirements, such as enjoyment of food. Respondents rarely talked in detail about different nutritional food groups or used scientific terminology. Instead, they tended to see a balanced diet as a balance between "good" or "bad," and "healthy" or "unhealthy" foods. On many occasions, for example, they often implied that just by avoiding certain foods (eg, chips) or cooking methods (eg, deep-fat frying), they were eating a balanced diet:

TF: You said you didn't have fried food?

TED: No. Very rarely do we fry food, occasionally if the kids want sausages we'll get them, but that's maybe once a month...



but we don't usually fry things. We wouldn't think of getting the frying pan out, or we don't have a chip pan. Just something we don't do.

However, it was apparent that although a basic knowledge of nutrition influenced their understandings of these dichotomous categories, their understanding of a balanced diet was complexly linked to other concepts of health, such as the idea that having a little bit of what you like is good for your mental health:

JENNIFER: Just trying to well, you try to eat a more balanced diet, I know we never get properly there, eh, I mean we don't eat as much vegetables an' things like that that we should, but eh, I think you try to eat as healthy as you can, without giving up too much of what you do like as well at the same time.

Attitudes toward healthy eating advice

Although respondents did talk about a range of different types of information on healthier eating and identified a range of commercial or official health promotion sources, they typically talked about how they felt they already knew they had a healthy diet and did not need any more advice. They often felt that they were constantly under attack from all directions about food and health, and as a result of being bombarded by all this information (especially from the media), they spoke about ignoring what else was being said. Furthermore, it was also felt that the experts were constantly changing their messages and contradicting themselves and there appeared to be a strong emphasis on trusting your own ideas instead. Perhaps the most influential idea, however, was that these lay respondents felt that a lot of the advice on Scottish television or in the newspapers was directed at the people who were eating a stereotypically unhealthy Scottish diet (of deep-fried foods and chips, for example). Therefore, they argued that healthier eating advice in general did not apply to them:

STUART: [The Scottish diet]—chips with everything, erm, yeah. As I say, we try and stay away from that sort of area. We try and make our diet varied. I can see when you read the paper or see the tele, and they do come up with this sort of Scottish diet and sort of heart disease, it is quite frightening. And hopefully we don't have a sort of Scottish diet in this house. I hope I'm right anyway!

When lay respondents were asked about the idea that a GP could talk to them about healthier eating, they typically felt that the GP's advice would probably be the same as that available elsewhere. However, respondents did acknowledge that GPs would have a legitimate role if respondents were actually sick and there was something wrong with them. This appeared to support their more general belief that healthy eating advice was not necessary when they were already eating healthily and would therefore be required only when they were ill:

SUE: I would feel like she was like all the other professionals, I would just go, "Oh yes, yes, uhuh, I agree, thank you very much, goodbye" because unless she was giving it to me for a reason, like you know, I'd gone to her to say "Oh, you know, like food's going straight through me" or "I'm sick all the time" or something like that, I wouldn't see the point, you know, in handing it out.

Analysis of interviews with GPs

Although there are both general government guidelines on what a healthy diet should be (2) and specific guidelines to steer the provision of healthy eating advice in general practice (17), the way in which GPs approached this type of work was expressed as a matter of personal preference. Although all of the

GPs recognized that they had a role to play in counseling patients with diet-related illnesses such as diabetes, high cholesterol, or high blood pressure, the older and male GPs in particular tended to have similar views as their patients. They felt that the general practice was a setting for treating illness rather than prevention and that preventive work was and should remain only a peripheral part of their own role. These GPs tended to feel, for example, that some preventive dietary advice was often ineffective, that patients were not interested in this area, and that it could also potentially damage their relationship because patients would feel the GPs were interfering. Although they might provide a basic level of advice on specific conditions such as diabetes, they spoke of how this work was normally delegated to nurses or dietitians; however, some GPs also appeared to doubt the benefits of providing dietary advice in primary care more generally. Alternatively, they felt that more generalized healthier eating advice was available in the public domain and as a result they had no specific skills to offer in this area:

GARETH: If someone wanted to go into specifics, then I'd have to say that's not my field of expertise, I'm giving general guidelines, and if they want more information I'd have to refer on. A good GP is probably one who knows their limits. When it comes to diet, sure I've got a general knowledge, but I am limited in that knowledge.

However, mainly the younger and female GPs had an opposing view and felt that healthier eating advice was a core part of their own and the primary care team's work more generally. In contrast, they believed that a GP's advice was more credible than advice from other sources, that it was worthwhile making a difference even when patients were not always initially receptive, and that patients welcomed their input. Perhaps reflecting their greater enthusiasm in this area, they presented a much more extensive range of diet-related conditions that they said they treated and relied heavily on their own personal dietary experiences to help them counsel their patients:

KAREN: I consider myself a reasonable expert in a range of diets because I've tried a few and there are certain ones that I would recommend; they are actually ones from the slimming magazine, which are either the greatest amount of calories which is very good if you want to count up to 1000, or fat units, which is where you count the fat units and you can do it very easily with pre-prepared food. And I usually say to them most of us have the same problem, myself included. I say that we take in too much food for our body and that's why we put on weight.

Despite these contrasting approaches toward healthier eating work and accounts of work involving dietary counseling, it was apparent that all of the GPs appeared to face many of the same practical barriers. All of the GPs talked about the need to delegate to some extent, the pressures on available consultation time, and the problems of finding a legitimate opportunity to intervene. Perhaps as a result of these barriers, they all seemed to talk about how most of their advice was in the form of secondary prevention, and therefore that more generalized and opportunistic advice on healthier eating was less common. However, their enthusiasm about dietary work did appear to be reflected in the extent to which they were willing to overcome these barriers and their willingness to be opportunistic:

TF: Would you make that distinction, people where there isn't something specific, and you have to wait for them to ask?

PAULINE: Yeah, I think again that it depends on what sort of mood I am in. If I am feeling bolshy, and I'm going to give them



the advice whether they like it or not, or whether I am looking for their leads.

DISCUSSION

A Scottish Health Survey press release (18) paints a more positive picture than previous research by providing some encouraging evidence that Scots are now beginning to heed the messages about the link between behavior and good health. However, the survey's authors also suggest that there is still a long way to go before Scots will achieve a lifestyle that will deliver better health to the population as a whole. Although it cannot be assumed that the lay or professional respondents in this study were representative of the Scottish population, what has this study contributed toward the idea that general practice is an appropriate setting to change Scotland's diet?

On a more generalized level, the results of this study suggest that the public may be prevented from making further changes to what they eat, particularly because they already regard their diets as being healthy. As Warde (19) argues, a nutritionally balanced diet should include a variety of items, with none to excess; however, people do not necessarily have the means to monitor their intake to ensure that there is this balance. The findings in this study, that a balanced diet did not contain chips or a balance was about eating everything in moderation, are perhaps good examples of Warde's arguments. So if health professionals are going to talk about balanced diets, they need to understand the complex processes on which these concepts are based and the multiple meanings attached to this term.


A second, more general implication for health promotion in Scotland appears to be that this study reflects Backett's (20) concerns about the divergence between health promotion advice and lay health behavior in the context of everyday life. Although it has been argued elsewhere that people rely on the media to translate medical advice (21), the Scottish media may play a key role in why the lay respondents in this study were distancing themselves from healthier eating advice. By perpetuating the stereotype of the unhealthy "Scottish diet" and by presenting scientific information as it does, the media may increase people's skepticism about expert advice.

Despite many years of health promotion policy focused on general practice, GPs and the lay respondents from this study still saw the setting as a site for treating illness and disease. However, this should not necessarily be taken as a reason not to provide more preventive advice. One problem with accepting this finding is that the lay respondents may have come to expect that their GPs will not have time for discussions of dietary topics because they think they are "too busy." Another reason is that although many of the respondents in this study had concerns about the GP's role in the area of food and eating, evidence from similar studies suggests that preventive advice is welcome (9, 22). On a practical level, therefore, this raises a further set of questions for policymakers and GPs. For example, how can general practice either broaden what types of advice will be accepted or improve the way that patients are counseled on dietary advice? Further still, does the culture of general practice need to change to encourage both GPs and other primary care professionals to implement their acknowledgment of the crucial relationship between food and health?

Finally, a key practical question that arises from this study is who within the primary care team is best suited to addressing

Scotland's poor diet-related health record. For Bruce and Burnett (23), GPs should not necessarily be the "main agent" of change for the general population; findings from this study reveal similar findings to other recent work that GPs may be better placed to focus on secondary prevention, rather than provide more opportunistic and general advice (24). A very few lay respondents did mention that they had received dietary advice as a result of a genetic family illness; therefore, patients may be more willing to accept advice when they do perceive they are at a higher risk.

CONCLUSION

This study has suggested that the implications for health promotion theory and the practical success of programs to improve dietary inequalities in Scotland, focus on a need to understand the views of all the parties involved. General practice does not appear to be considered by either the public or GPs as a site for providing generalized dietary advice. General practice resources may therefore be better focused on identifying and increasing the occasions when patients may be more willing to accept preventive advice. 

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