



# **Beliefs, attitudes and practices among GPs in relation to the promotion of physical activity in general practice – a qualitative study**

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## 1. Introduction

The significant contribution that physical inactivity makes to the burden of disease in the Australian population (Mathers et al, 2000) provides a strong impetus for the implementation of strategies across a range of sectors to address this risk factor. In Australia, the Strategic Intergovernmental Committee on Physical Activity and Health (SIGPAH), established to coordinate initiatives to increase physical activity participation, has recognised the engagement of general practitioners (GPs) and other health care providers in physical activity promotion as a priority. Other priority areas for action include supporting environment and transport initiatives that foster physical activity and facilitating the promotion of physical activity in settings such as schools and workplaces.

In order to maximise the effectiveness of physical activity promotion strategies in general practice and other settings it is necessary to undertake a regular examination of the growing body of evidence about the effect of different strategies to address this behaviour. From a public health perspective, it is also important to examine research about the feasibility and acceptability of physical activity promotion strategies in the settings where they could be potentially implemented. The purpose of this short report is to present the findings of qualitative research with GPs concerning their perceptions about the most practical methods for addressing physical activity in general practice. This is a complementary document to a systematic review of the published evidence about the effectiveness of physical activity interventions in primary health care settings commissioned by the National Institute of Clinical Studies (Smith et al, 2003).

The issues that this qualitative research aimed to investigate are:

- whether GPs perceive physical activity promotion to be part of their role and the reasons for their views;
- the variety of current approaches used by GPs to promote physical activity;
- the views that GPs have about systems that could be practical in general practice for promoting physical activity, and;
- the types of support that GPs believe would assist them in physical activity promotion.

Quantitative studies undertaken with GPs in Australia have provided useful data about major barriers that are faced in attempting to undertake health promotion (Bauman et al, 1989; Ruth et al., 1992) and , more specifically, the promotion of physical activity (Bull et al, 1995) in general practice. This area of investigation does lend itself to qualitative methods also, which have the potential to provide more in-depth information about the range of factors that affect the potential for physical activity promotion in this setting. This report presents the results of qualitative research about physical activity promotion in this setting, which is useful for designing practical approaches that GPs could use to address this risk factor.

## 2. Methods

Three focus groups were conducted with GPs; two in urban regions and one in a rural location. Each group consisted of a convenience sample of GPs who were identified through the Division of General Practice in each region. In total 26 GPs took part in

the discussions, with two groups including eight members and the third including 10. There were 7 female and 19 male GPs who participated. All were established in their practices with many engaged in postgraduate training and/or undergraduate teaching in general practice or who were active in their local Divisions of General Practice. There were no General Practice Registrars in the groups.

The group discussions were semi-structured and each was moderated by one person. The proceedings of each group were tape recorded and then the content of the transcripts of these discussions were analysed to identify the major themes that were discussed.

### **3. Results**

#### **3.1 Perceived role of GPs in promoting physical activity**

Exercise promotion is something that GPs saw as part of their role. They thought that GPs have a wide brief and are concerned about their level of skills and the effectiveness of interventions. The idea of promoting exercise was seen as “a good thing” and part of encouraging healthy behaviours in patients. This included patients at “high-risk”.

*“Who else will do it? We should encourage it?”*

*“Our role is in everything! “*

*“but we don’t know how”*

*“Yes, at present what do we tell patients to do? ‘Walk!’ We do not have the specific exercise prescriptions.”*

The GPs were clear that they had a significant role in the health and wellbeing of their patients. They saw this role as being quite broad. It included dealing with illness and clinical presentations as well as disease preventing activities. In addition, there was a clear expression of the GP as a link into the community as a part of the community. Often the needs of the patient could be met by the patient interacting with a variety of persons and agencies or by altering their social or behavioural activities. This contextualisation recurred as a theme. The idea of promoting exercise was seen as a “good idea” but usually would be enacted as part of a broader plan of management for that patient. The primary goals of that plan may shift from increasing aerobic fitness to social contact to weight reduction depending on the needs of the patient and the evaluation by the GP. Here the nature of general practice and its links with families and social groups became important.

*“We do have a role in using exercise as a bonding and social activity between children and parents, grandparents. If you get two people motivated they are more likely to continue. Social groups are more likely to succeed.”*

*“If you have a neighbour or friend walking with you, you are less likely to let them down. Also, I don’t tell somebody to walk, I ask what they enjoy and encourage a social activity. Do something that you enjoy and that includes social support.”*

#### **3.2 Current approaches to physical activity promotion**

When asked about components of their advice all groups identified specific information about types of exercises for different age groups and different medical situations.

*“if I have an elderly lady who falls, I can refer her to the clinic and we get a specific prescription for her. I don’t have that for most patients”*

*“Depends on the priority. If a crisis consultation you might only mention exercise. At others you might discuss time management and reviewing life goals”*

*“Depends on individual person, what is their problem; weight loss vs arthritis”.*

The types of interventions varied according to the specific needs of the patients. As a promoting event rather than a therapeutic event, interventions tended to be very brief, maximum of 3 minutes. This reflected the amount of interaction already in the GP consultation, the likely receptiveness of the patient and the GPs expectations of success.

*“Gauge readiness in the patient then try brief intervention. 60 sec to about 3 mins”*

*“One statement...mention exercise and see their response.”*

There were significant barriers to the exercise promotion message in the community across a spectrum of ages. Many of these related to the impact of being overweight on the psyche of the patient. Barriers existed for both patient and GP. Some of these barriers stem from time pressures, but some related to the GP’s focus on dealing with the serious conditions with which the patient presents and that is effecting their life sufficiently for them to attend their doctor.

*“Many women think it means getting into a leotard – that is what scares most off exercise”.*

*“I find myself continually prescribing exercise after the horse has bolted. Someone presents with diabetes, hypertension etc then the penny drops “I should do something about this” I would prefer to prescribe exercise for people to maintain their health, but I don’t do that.”*

*“(today) We in a focus group on exercise, but next week we will be in a focus group on osteoporosis, there are many calls on our consultations”.*

*“How much I promote exercise depends on how well I am doing myself. People see their GP exercising.”*

Despite the interventions by the GPs being opportunistic in nature, the GPs felt that these interventions were not random, nor unplanned. The GPs had some plans to put to their patients when the opportunity arose and/or when the patient seemed receptive. As discussed earlier, they and felt the need for more specific advice that could be tailored to the actual needs of that patient at that time. Nevertheless they were armed with some strategies for increasing physical activity and they tended to use these same strategies again and again. All of the GPs were happy that they understood the rationale for increased physical activity, and that they had translated the evidence into terms suitable for their patients. Few of the GPs had explored the outcome of their presentations to their patients. Indeed, the recurring themes were the need for the patient to be ready to hear the message and for the GP to have a variety of options to offer. All GPs tried to individualise physical activity options for their patients.

*“I don’t use exercise preventively much, but I do use it therapeutically eg for hypertension.”*

*“For many patients any movement is an increase in activity levels, others already have high levels of activity.”*

*“it is a treatment option – focus on exercise as the main option and leave weight and smoking alone for the time being, then it will have a greater impact”.*

### **3.3 Beliefs about practical strategies for addressing physical activity**

Whilst the GPs felt initially that everyone was suitable for promotion of exercise, they soon came to similar conclusions that certain groups were likely to respond more to such advice from a GP. However, they were not uniform about exactly which groups would benefit from exercise and how they might initiate change for those patients. A number of individual anecdotes about patients who had benefited from commencing exercise were exchanged. These anecdotes supported opportunistic interventions, but did not provide guidance toward effective opportunism.

Unless the patient was receptive, and this usually meant having a relevant medical problem, GPs believed that their interventions had little chance of being effective. This was in contrast to the GPs feeling that the optimal approach would be to encourage exercise habits in younger people, especially in younger females who would face earlier bone mineral loss and potentially influence their children about exercise. There was some frustration at this conflict in roles.

The GPs did not believe that they had the information to assist them in defining the “best bet” interventions. Consequently, although they expressed a desire to have a broad based influence, they defined their roles in advocating exercise programs for their patients relatively narrowly.

*“(Our role)*

- a. is rehabilitation after injury, achieving function.*
- b. reducing obesity to prevent medical complications.*
- c. rehabilitation after chronic illness, especially in the older patients*
- d. medical problems requiring lifestyle adjustment eg hypertension,”*

Role conflict for the GPs also emerged when they identified the groups that presented with the conditions for which they usually recommend exercise.

*“We are mostly talking about the elderly and those with disorders. My impression is that the message has got through to the older population. Most people out walking are elderly. People go to the doctor when things start going wrong and the elderly have the time.”*

*“We do not get a lot of contact with the 20 – 40 year olds. They are busy establishing themselves, raising children etc”*

This led all groups to promote opportunistic interventions. Each group agreed that the timing of the intervention was crucial to the outcome. There was general agreement that overweight people knew of their risks and did not wish to be reminded of their weight at each visit.

*“Usually the time we start talking about exercise and they listen is when they strike a problem, that is the best time to intervene.”*

*“They will listen when they have a crisis.”*

*“If patient is overweight, depressed etc it is not always appropriate to bring up exercise on every occasion”*

Some of these broader issues related to the barriers previously reported and explained some of the demography of the practices.

*“Somehow we need to recognise that everyone is time poor and we need to get the message across about exercise in small doses. That almost has to be a community attitude change, not just a single doctor change – it is a macrolevel change”.*

This idea of wider involvement in the process of activity level change stimulated ideas about younger patients.

*“One suggestion is that we force employers to encourage exercise at work. 9 o’clock to 10 past 9 you all do your exercises. OHS regulations should include exercise – this is where people are most of the time.”*

Even younger people were not seen to recognise physical activity as a health issue. There may be other inducements and encouragement, but these will probably not come from the GP.

*“Younger people do not link exercise with living longer, reducing diabetes risk, decreasing heart disease”.*

*“Younger people are interested in socialising – they will go where the other young people are – if all the girls were at the leisure centre doing 400 metres in the pool, that is where the boys would be as well”.*

Frequent reference was made to the need to engage others in this process and to make exercise a social activity tailored for different ages.

*“If you have a neighbour or friend walking with you, you are less likely to let them down . Also, I don’t tell somebody to walk, I ask what they enjoy and encourage a social activity. Do something that you enjoy and that includes social support.”*

*“Encourage them to walk to get the paper, or walk along the beach 3 times a week. Few people enjoy exercise – it is more the social contact. It is about meeting some people, not the exercise they engage in.”*

There was little support for planned recalls to discuss exercise promotion. Similar programs in other areas (eg asthma three-visit plan) were reported as successful if the patient were motivated. Other recall programs had variable success. They felt that only motivated patients did follow up with additional visits.

Most GPs felt that effective advice was best given face-to-face in the consultation room. Again, the importance of timing and relevance was emphasised.

*“There are pamphlets in the waiting room on exercise, but patients don’t read them when they turn up with something else eg injury.”*

*“written advice must be in discussion with the patient, negotiate with patient.”*

*“A person attending for a cold might answer an exercise questionnaire, but will not follow-up, unless it is relevant to them.”*

Follow-up, like initial interventions was described in therapeutic terms. This seemed something that both GPs and patients understood.

*“I will not send someone for cholesterol test until I assess what they are going to do about it. Then I can ask what about exercise?”*

*“When I recommend an exercise program I view that as any other treatment and so I schedule another appointment to review this treatment.”*

### **3.4 Types of support that GPs considered useful for physical activity promotion**

GPs sought specific supports in the forms of:

- data about which patients were most likely to benefit from physical activity;
- information about exercise programs available in their local district, including community and social groups with exercise and activity programs;
- sorts of exercises available and impact of these for different sorts of patients eg arthritis, hypertension (perhaps in leaflet type booklets);
- who to refer to for assessment (if this is required);
- handouts for specific exercises eg back strengthening
- instruction in effective brief intervention for GPs eg brief alcohol intervention but not a 20 minute spiel
- better understanding of the diabetes Enhanced Primary Care items

The rural GPs, especially, identified as part of a local community and saw local councils taking a more active role in physical activity promotion and support. They were vocal about general and community supports including:

- easy access to information about sporting clubs from local councils;
- free advertisements for sporting clubs in local papers;
- more cycle ways;
- public education about existing programs of local councils and Area Health Services;
- greater access to affordable hydrotherapy pools for non-weight bearing exercises, and;
- local government employed dietitians and/or exercise physiologists.

This last point was supported by the argument that:

*“One CABG costs \$100,000. That would employ two exercise physiologists for a year”.*

All GPs felt that they had sufficient evidence of the benefit of exercise to try and promote it to their patients. They did not need convincing of this and did not seek epidemiological support eg number needed to treat. Rather, they were concerned with individualising this to their patients, while at the same time encouraging a social structure that would support the exercise pattern and sustain their patient.

They strongly identified as members of a community and as such looked to the community to provide social standards about exercise that would support their beliefs of the benefit for their patients.

A number of examples of Divisional or local area initiatives were provided where groups of people engaged with physical activity in a social setting. These ranged from Tai Chi in retirement villages to bicycle groups of middle aged men or women's netball clubs that persisted for years.

#### **4. Discussion**

The GPs in the groups interviewed were supportive of encouraging physical activity in their patients. They rapidly identified that this message needed to be part of a community wide message for it to be effective. Suggestions about broad community "advertising" and targeting of specific groups were made, including introducing exercise at the workplace and suitable strategies to reach adolescents and younger adults.

Most interventions were opportunistic and where possible included social supports for the patient. Greater knowledge of the locally available social supports would assist in this task.

Although most interventions were opportunistic and were reported as between half a minute and three minutes, the success stories demonstrated a considerable investment of GP time in recruiting of additional supports. This approach will work for sporadic and individual cases but is not sustainable across the broad range of patients in a single General Practice.

There was no strong agreement on who would benefit most from the application of the limited GP time. Data on who would benefit most from physical activity and advice on suitable strategies to suit the identified target groups are required. There was strong agreement that readiness to change was associated with perceived need (threat) and timing. General patient recall may be counterproductive.

Assistance with locally relevant information, referral sources and provision of specialised personnel such as dietitians were seen as roles for local government bodies or divisions of General Practice. They did not usually identify the Area Health Services as sources of assistance with these patients.

Practice visits with advice on effective brief interventions were considered useful. Materials that would assist in their discussions with patients would be helpful. Additional supports could include well designed exercise prescription pads.

In general, while these GPs see their current role as promoting physical activity in all patients. They express the belief that the most effective interventions in the longer term will be with younger people. However, younger people are often not ready to hear or act upon the message of exercise related to health. Other exercise inducing messages may be more effective with younger people. Although they desire to have an impact on younger patients, including healthy younger patients, they find themselves mostly intervening in older patients with established disease. Older

people are more likely to have heard the health message, often because of some personal illness event. Older people, as a group, seem to have more time to devote to regular moderate exercise. The combination of the immediacy of the health issue and apparent available time make older people more change ready and therefore more likely to respond to the messages of their GP. One result of this is that GPs intervene where change is more likely to occur; that is in older patients. Despite their desire to influence younger patients, there is more apparent impact with older patients. This impact reinforces the pattern and more interventions occur with older patients, where there is perceived benefit and appreciation.

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