Opinions and Attitudes of a Sample of Swiss Physicians about Physical Activity Promotion in a Primary Care Setting

Abstract

Little is known about the opinions, beliefs and behavior of Swiss physicians regarding physical activity (PA) promotion in a primary care setting. A qualitative study was performed with semi-structured interviews. We purposively recruited and interviewed 16 physicians in the French speaking part of Switzerland. Their statements and ideas regarding the promotion of PA in a primary care setting were transcribed and synthesized from the tape recorded interviews. The main findings are presented in the following by thematic categories:

– Screening for sedentary lifestyle and counseling practices. History regarding PA was consequently taken with new cases, but not in a systematic manner. Counseling was more likely to be delivered if other cardiovascular risk factors were present.

– Counseling techniques and how to learn them. Practical education on motivational interviewing techniques and on the use of topic-specific tools was advocated. According to some interviewees, more emphasis should be put on well-being as a motivational tool, rather than on disease prevention.

– Barriers to counseling. Lack of time, lack of reimbursement, lack of clear guidelines.

– Interventions advocated by general practitioners for PA promotion in a primary care setting. Screening for sedentary lifestyle, booklets accompanying physician counseling, patient orientation to structured PA programs or to specially trained counselors.

– Effectiveness of counseling. Most physicians described themselves as rather pessimistic in their perception of counseling effectiveness.

We conclude that in order to find wider acceptance in primary care settings, the conception of PA promotion should take into account physicians’ barriers, and involve them in the development of a training curriculum.

Key words:
Primary care; health promotion; physical activity; counseling

Résumé


– Dépistage de la sédentarité et conseils en activité physique. L’anamnèse concernant l’activité physique est régulièrement pratiquée avec les nouveaux cas, mais pas d’une façon systématique. Les conseils en activité physique sont plutôt délivrés si d’autres facteurs de risque cardiovasculaires sont présents.


– Barrières au conseil. Manque de temps, manque de remboursement, manque de recommandations claires pour la pratique clinique.

– Interventions préconisées par les médecins de premier recours pour la promotion de l’activité physique au cabinet médical. Dépistage de la sédentarité, brochures d’information pour les patients, orientation des patients vers des programmes d’activité physique structurés ou vers des conseillers spécialisés.

– Efficacité de la consultation. La plupart des médecins se sont décrits comme plutôt pessimistes dans leur perception de l’efficacité du conseil en activité physique.

Nous concluons que pour trouver une acceptation plus large, le conseil en activité physique au cabinet médical devrait tenir compte des barrières décrites par les médecins, et intégrer ces derniers dans la conception du projet de formation.

Mots clés:
Médecine de premier recours; promotion de la santé; activité physique; entretiens de conseil
### Introduction

Sedentary lifestyle has become more and more prevalent in Switzerland during the last decade, as shown by the successive «Swiss Health Surveys» [1]. In 2002, up to two thirds of Swiss people report they practice less physical activity (PA) than is minimally recommended [2, 3].

Sedentary lifestyle increases the risk to develop many diseases [4, 5]. It has been estimated that sedentary lifestyle is annually responsible for at least 1.4 millions of disease cases, 2000 deaths and 1.6 billions of Swiss francs of treatment costs [6].

Efficacy of primary care physicians in changing unhealthy lifestyle habits has already been demonstrated, particularly when they have been adequately trained [7]. With respect to PA promotion in a primary care setting, as many as 20 original papers [8–27] can be identified through 10 reviews of the literature [28–37]. There is some evidence that multi-sessions interventions might be effective, at least in the short term. PA promotion has however not been taken up by general practitioners on a wide scale.

As demonstrated by Eakin et al. [38] in a recent review, this reveals a gap in the existing literature, regarding the determinants of physicians’ compliance toward PA counseling. This qualitative study aimed at better understanding the opinions, beliefs and behavior of Swiss physicians regarding physical activity promotion in a primary care setting.

### Methods

To favor the emergence of contrasted opinions, we used semi-structured interviews with an intentional sample of physicians from various age groups and training backgrounds, and with various individual PA behaviors. Additional physicians were recruited until saturation of data was reached.

Our final sample consisted of: 9 primary care physicians (GPs), 4 physicians primarily involved in activities related to preventive medicine (preventive physicians), and 3 physicians primarily involved in activities related to PA (PA physicians). For a more detailed description of the sample, see Table 1. Interviews were conducted between October 2003 and January 2004.

Questions were established on the basis of the existing literature [8–38], and content validity was cross-checked by an expert in the field (BM). Participants were free to interpret questions in their own way. The role of the interviewer was limited to ask for precisions through reformulations. Interviews were tape-recorded, and detailed notes were taken. All interviews were carried out by one of the authors (RB), who is specialist in internal and preventive medicine.

### Data analysis

Thematic categories were identified by listening to the recorded interviews. Statements, ideas, and illustrative quotes were transcribed and grouped in a contingency table with thematic categories divided in columns and responders distributed in rows. New columns were generated in an iterative process until every theme was included in the synoptic table. For each theme, concordant ideas were summarized, and divergent opinions outlined. Emblematic quotes served to illustrate and document the process of data analysis.

### Results

Opinions and attitudes of participating physicians are presented below by thematic categories. Diverging opinions are described at the end of each section.

**Screening for sedentary lifestyle and counseling practices** — History regarding PA was consequently taken with new cases, but not in a systematic manner. Structured PA (e.g. any type of sport, fitness sessions) was more likely to be recorded as compared with everyday life PA (e.g. walking or biking to work, gardening). One GP said: «...it is under (the heading) ‹lifestyle› that I write: swimming, skiing, judo...». When collected, information about the duration, the frequency, and the intensity of the PA was frequently incomplete. Counseling was more likely to be delivered if other cardiovascular risk factors were present. Preventive physicians and PA physicians advocated a systematic screening for sedentary lifestyle. They furthermore anticipated that health promotion might soon become a priority task of primary care physicians.

### Table 1: Description of responders

<table>
<thead>
<tr>
<th></th>
<th>Mean age (range)</th>
<th>M/F</th>
<th>FMH Title</th>
<th>Occupation</th>
<th>Individual PA behavior</th>
<th>Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs (n=9)</td>
<td>51 (41–64)</td>
<td>8/1</td>
<td>5 general medicine 4 internal medicine</td>
<td>5 private practitioners 4 private practitioners</td>
<td>5 2 2</td>
<td></td>
</tr>
<tr>
<td>Preventive physicians (n=4)</td>
<td>51 (41–76)</td>
<td>4/0</td>
<td>1 preventive medicine 3 internal medicine</td>
<td>1 retired director of a University Institute for Social and Preventive Medicine 1 director of an alcohol disorders clinic 1 director of a smoking cessation unit 1 senior researcher in a University Institute for Social and Preventive Medicine</td>
<td>0 4 0</td>
<td></td>
</tr>
<tr>
<td>Physical activity physicians (n=3)</td>
<td>45 (37–52)</td>
<td>2/1</td>
<td>1 internal medicine 1 cardiology 1 physiology</td>
<td>1 responsible for an obesity treatment program through physical activity 1 director of a cardiovascular rehabilitation center 1 director of a Sport and Movement Sciences Institute</td>
<td>0 3 0</td>
<td></td>
</tr>
</tbody>
</table>

M/F: Male/Female
FMH: Federation of the Swiss Physicians, responsible for specialization accreditation
PA: Physical activity
GPs: Primary care physicians

Preventive physicians: Physicians primarily involved in activities related to preventive medicine
Physical activity physicians: Physicians primarily involved in activities related to physical activity
Benefits of PA promotion – Sedentary physicians were rather
skeptical regarding the health benefits of PA except for well-being
improvement. One GP said: «…if I start to move 30 min a day, by
how much will I reduce my ten-year myocardial infarction risk? I
never saw this (information), I even don’t know if it does exist…». One
physician stated: «…note, everyone thought that health benefits of PA
were ignored by practitioners: «…GPs are not always aware that PA
promotion can be as effective as prescribing antidepressants…». The
strong psychosocial component of PA and its neutral connotation
was seen as an interesting way to build a good relationship
with patients. One preventive physician said: «…the clinician’s on
own behavior regarding PA is determinant for his counseling practice…».
Counseling techniques and how to learn them – Most physicians agreed
to target an increase in the amount of everyday life PA. GPs
however tended to describe the international recommendations
(30 min of moderate intensity activity per day) as discouraging.
More emphasis should be put on well-being as a motivational tool.
One GP said: «…it’s an enormous progress to have integrated
the notion of walking instead of running, because there are a lot of
people that could not run. They are encouraged by the idea of
walking…». Stages of change of the trans-theoretical model, as
well as motivational interviewing techniques were seen as rel-
vant in this context by all participants except 1 PA physician who
thought physicians should use a clearer language about sedentary
lifestyle risks to motivate their patients. Sedentary physicians ad-
vocated consecrating more time (20–30 min) to PA counseling
than their active counterparts (2–7 min).
Practical needs – Only a limited number of practical needs
were reported. Guidelines and algorithms for a tailored approach
to PA promotion, chart reminders and collections of all available
regional resources for PA practice were the main ones.
Barriers to counseling – About half of the physicians thought
there were few barriers. The other half mentioned as the most
important ones: lack of time, competition between the different
topics of health promotion and preventive medicine, lack of re-
imbursement, lack of clear guidelines, lack of knowledge about
downstream structures, lack of structural support to facilitate
behavioral changes in patients (architectural and in town planning),
or physician’s fear to be perceived as a «health moralist». One phy-
sician said: «…I think that having a sedentary lifestyle can make
people feel really guilty…». Another one claimed that: «…we know
there are people with whom it [PA promotion] won’t work…». Preventive
physicians and PA physicians were almost unanimous to incriminate as the
main barrier physicians’ lack of knowledge in PA (PA physicians)
or lack of skill in counseling and motivational interviewing (preventive physicians).
While he was discussing the issue of competing agendas, one GP said: «…according to what
patients bring me, I tend to become less systematic. I have to deal
with intermediate complaints…». A mainly curative rather than
salutogenic medical culture was also cited as a barrier. Many
physicians also stated that reimbursement should be more specifi-
cally linked to health promotion counseling rather than to the more
generic label of «consultation time» as it is now.
Other settings for PA promotion – Almost all physicians said
PA promotion should not be limited to primary care setting. More
visibility was advocated, for example through advertisements cam-
paigns or institutional promotion (at workplaces, in schools, in
communities…). One GP said: «…School is the right place to learn
how to become regularly active…».
Interventions advocated by GPs for PA promotion in a primary
care setting – Except 1 physician who advised against complexity,
A diversified approach was thought to be useful, with the follow-
ing proposed axes: systematic screening for sedentary lifestyle in
the waiting room, tailored motivational materials that accompany
physician’s counseling and patient’s orientation to structured of-
ers. Effectiveness of computer-based systems to promote PA was
thought to be limited to young people, especially with large diffu-
sion channels such as school or training workplaces.
Delegation of counseling to specifically educated counselors –
Many physicians felt patients often prefer not to receive care from
too many different professionals. One GP said: «…I have less than
10% of the people to whom I propose to go to a nutritionist that do
it, and I find it easier to recommend a nutritionist to them for their
cholesterol than a sport specialist for walking…».
Effectiveness of counseling – Most GPs described themselves as
rather pessimistic in their perception of counseling effectiveness.
Most of them thought that no more than 10% of the counseled
patients would initiate a regular scheme of PA. 2 preventive phy-
cicians mentioned however that these estimations compared well
with the «number needed to treat» of common diseases.

Discussion
The importance of PA for health was generally well accepted by
the interviewed physicians, even if benefits were better recognized
by those who were themselves more physically active. Assessing
PA seemed to be widely done with new patients, but not in a stand-
ardized manner. Many participants advocated for a wide definition
of health-enhancing PA, in order to avoid confronting patients with
too high expectations. They also called for a multi-dimensional
approach to health promotion, including other behaviors than PA.
Cited barriers to counseling included lack of time, lack of re-
imbursement, lack of skill and knowledge, and the fear to be
perceived by patients as having a moralistic attitude. According
to Booth et al. [39], this fear might be unsubstantiated. Similar
barriers were found in comparable studies [38, 40]. Interestingly,
contrasted opinions emerged on the perceived effectiveness of
counseling for PA. Preventive physicians qualified a 10% increase
in the number of physically active patients as a good result whereas
GPs tended to find similar rates discouraging. More definitive
evidence on the effectiveness of PA counseling in a primary care
setting is certainly needed in order to gain wider acceptance.
Our findings need to be interpreted in the light of some meth-
odological limitations. Training similarities between responders
and the interviewer may have limited the emergence of original
thoughts. We anticipated this disadvantage would be partially
compensated by the resulting trustful atmosphere. Data extraction
was conducted by 1 author. Results would have gained validity if 2
independent readings had led to the same conclusions.
This study confirms that time-efficient approaches, knowledge,
skills, and the feeling of being effective might be crucial com-
ponents for a wider acceptance of PA counseling by primary care
physicians. To address these points, further efforts in collaboration
between GPs and public health specialists will be necessary.

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References
1 Martin B.W., Mäder U., Calmonte R. (1999): Représentations, connais-
sances et attitudes de la population suisse concernant l’activité phy-
2 Martin B.W., Lamprecht M., Calmonte R., Raebet P.A., Marti B.
(2000): Taux d’activité physique de la population suisse: niveaux et
effets sur l’état de santé. Prise de position scientifique rédigée en com-
mun et publiée par les partenaires suivants: Office fédéral du sport
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