PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Raising the topic of weight in general practice: perspectives of GPs and primary care nurses
AUTHORS	Blackburn, Maxine; Stathi, Afroditi; Keogh, Edmund; Eccleston, Christopher

VERSION 1 - REVIEW

REVIEWER	Lisa Hanna Deakin University, Australia
REVIEW RETURNED	15-Jun-2015

GENERAL COMMENTS	p5, lines 6-7: What type of existing evidence on why GPs/ nurses find obesity difficult to discuss? Would be helpful to add more fully in introduction (and discussion) how this study differs from those already carried out and in discussion include a more specific implication for practice. Otherwise an excellently written paper; clear and methodologically congruent, and on an important topic for public health and primary care.

REVIEWER	Jane Wardle UCL, London UK
REVIEW RETURNED	20-Jun-2015

GENERAL COMMENTS	The issue of primary care staff not addressing weight is increasingly being identified as a barrier to initiating the process of making appropriate treatment recommendations. This study involved interviewing GPs and nurses about the barriers they experienced to raising the issue of weight. The study drew on a very comprehensive model of behaviour change (TDF) to frame the interviews, and ultimately concluded that three general areas of barrier were contributing to the problem. I have a few suggestions for revisions that I think could improve the manuscript: 1. The first paragraph of the introduction (reminding us of the problem of obesity) could be omitted. Starting with the second paragraph would give a more incisive start. 2. It could be helpful to mention that the same issues have been discussed over decades for smoking, and more recently for alcohol. There may be nothing special about obesity. 3. I personally found use of the TDF both overinclusive of behaviour change strategies and underinclusive of potential barriers to a conversation. The authors recognise this limitation in the discussion, but it made me wonder whether there were other important quotes (e.g. about raising the issue of a highly stigmatised condition) that

	were not listed in the results because of the imposition of a framework that was not a perfect fit for the problem. 4. It would be helpful to know what proportion of people approached for an interview agreed to do one, and what they were told the interview was about. 5. It would be helpful to know whether the interviewees usually raised the topic of weight with their patients or didn't. 6. I found the title of the first theme (uncertainty about raising the issue) a bit vague; it was almost a restatement of the problem they were studying. It also had two rather distinct sub-themes (knowing about medical issues of obesity and having the skills to raise the issue of weight). I did wonder if they should be separate themes. In contrast, the other two themes were quite distinct. 7. The authors recognise the limitations of TDF for the question they are addressing, but I wanted to know if other topics came up and should be given a bit more discussion. 8. It would be helpful to give a bit of information on are GPs were supported to raise the issue of smoking, and comment on whether this has any implications for weight.

VERSION 1 – AUTHOR RESPONSE

Reviewer Name Lisa Hanna
p5, lines 6-7: What type of existing evidence on why GPs/ nurses find obesity difficult to discuss? Would be helpful to add more fully in introduction (and discussion) how this study differs from those already carried out and in discussion include a more specific implication for practice.

We have added the following paragraphs to the introduction:

This research has largely focused on barriers to obesity management, particularly the provision of advice for obesity. Studies, mainly using survey and interview methods, indicate that lack of time, limited training, low expectations of success and worry of offending patients prevent health professionals from playing an active role in treating obesity[8-10].

In summary of the literature to date, there has been little exploration of the full range of barriers that may hinder clinicians from raising the topic of weight for the first time with a patient.

We have added the following paragraph to the discussion:
Training and education which provides health professionals with a comprehensive understanding of stigma and the psychological impacts of obesity, and which includes the views of individuals with obesity, is just one way that health professionals could be empowered in this area of practice.

Reviewer Name Jane Wardle
1. The first paragraph of the introduction (reminding us of the problem of obesity) could be omitted. Starting with the second paragraph would give a more incisive start.

Thank you. We agree so have removed the first paragraph.

2. It could be helpful to mention that the same issues have been discussed over decades for smoking, and more recently for alcohol. There may be nothing special about obesity.

We agree so have added the following paragraph to the introduction to address this point.

It is also useful to review the barriers that health professionals experience when addressing other

public health problems, such as smoking and alcohol use. Like obesity, smoking and alcohol consumption have been framed as 'lifestyle risk factors' and have been identified as sensitive matters to address in the consultation[11-13]. Whilst studies have reported some similarities in the barriers to raising these issues, for example all relate to individual lifestyle habits and are thus potentially 'face threatening'[11, 14], there are also differences in the challenges of addressing such topics. Smoking is an area of public health that has received support at both a primary care and national level, resulting in increased provision of services in general practice and greater acceptance of smoking as a health threat[15, 16]. In addition, beneficial effects for clinician-delivered brief interventions and referral to specialist services have been established for smoking and harmful and hazardous alcohol consumption[17-20], yet there remains a lack of evidence for weight loss interventions that can be delivered at a population level in primary care[21, 22]. It is therefore important to recognise that obesity presents unique challenges to the primary care team.

3. I personally found use of the TDF both overinclusive of behaviour change strategies and underinclusive of potential barriers to a conversation. The authors recognise this limitation in the discussion, but it made me wonder whether there were other important quotes (e.g. about raising the issue of a highly stigmatised condition) that were not listed in the results because of the imposition of a framework that was not a perfect fit for the problem.

That is a fair point. The second theme, beliefs about consequences, captured much of the worry and concern about raising the issue, particularly that related to obesity as a stigmatised condition. Although the quotations selected do not expand on the stigma attached to obesity, they do relate to stigma in their reference to judgment and trust. In addition the second quotation used in the paper also relates to the stigma around obesity. Although stigma related to many of the barriers in the paper, we were mindful not to focus over-exclusively on this barrier since the aim was to capture a broad range of barriers influencing clinician behaviour rather than conducting an in-depth investigation into a single barrier. However, we do agree that stigma is a salient barrier which is interrelated with many barriers and thus difficult to isolate. In response to this comment we have added a further comment in the discussion:

Future research may wish to explore insights from the study that the framework failed to adequately capture. For example, it was noted that clinicians held conflicting views, particularly regarding the framing of obesity as a medical condition, suggesting ambivalence and discomfort around this area of care. Furthermore, it was possible to detect implicit frustration regarding the perceived lack of responsibility and denial/defensiveness demonstrated by patients. Another interesting insight was the uncertainty around initiating discussions about weight with patients presenting with emotional and/or mental health problems including low self-esteem, depression and body image concerns, with many clinicians expressing reluctance to discuss weight in such situations. Given that obesity is associated with an increased risk of depression and reduced psychological well-being [62], a potential mechanism of this association being weight stigma [63,64], there may be a significant number of patients who are not offered support to lose weight or discuss weight-related concerns, suggesting compromised care for these patients.
The implications section now also includes:

Training and education which provides health professionals with a comprehensive understanding of stigma and the psychological impacts of obesity, and which includes the views of individuals with obesity, is just one way that health professionals could be empowered in this area of practice.

4. It would be helpful to know what proportion of people approached for an interview agreed to do one, and what they were told the interview was about.
The participant selection and recruitment paragraph has been changed to the following:
Study information was provided at a practice manager meeting and emails outlining the study were

sent to 58 GP surgeries and to a network of sessional GPs in the local authority. This resulted in thirteen GPs and fourteen nurses agreeing to be interviewed after receiving further details about the study. Snowball sampling was also used to recruit participants; four GPs and three nurses were approached, either in person or via email and all agreed to be interviewed. Prior to taking part in the study, participants were informed that interviews would involve discussion about views of obesity, role and efficacy beliefs, and the challenges involved in raising the topic of weight in general practice.

5. It would be helpful to know whether the interviewees usually raised the topic of weight with their patients or didn't.

Good point. That would have been interesting but unfortunately we did not ask. However, the data suggests that clinicians do not raise the issue as a routine part of practice and we have added the following comments in the discussion.

The majority of clinicians working in generalist roles do not discuss weight with patients as a routine part of clinical practice due to beliefs that it is inappropriate, unfeasible or unacceptable to patients. Whilst clinicians said they were more likely to discuss weight with patients in the context of a weight-related health problem, the multitude of barriers in any single consultation including factors that appear to be distinctive to obesity, such as stigma, may prevent clinicians from discussing weight despite recognising the need to.

6. I found the title of the first theme (uncertainty about raising the issue) a bit vague; it was almost a restatement of the problem they were studying. It also had two rather distinct sub-themes (knowing about medical issues of obesity and having the skills to raise the issue of weight). I did wonder if they should be separate themes. In contrast, the other two themes were quite distinct.

Thank you. That is helpful. This theme has been re-named to 'Limited understanding about obesity care'. This captures more adequately that clinicians do not have the required insight into obesity, including insight that obesity is a medical condition (as per NICE guidelines). The theme includes both skills about how to perform the behaviour and knowledge, including a health professional's schemata/mental model of obesity. The theme demonstrates the misunderstanding in this area of care and relates to training needs. Furthermore, knowledge and skills has been presented as one theme is to align with behaviour change theory which underpins this study. The TDF coding manual was used (attached as additional file 1) and demonstrates that a health professionals correct and incorrect knowledge and rationale for performing the behaviour sits under Knowledge in the TDF and ultimately Capability in the broader COM-B model.

7. The authors recognise the limitations of TDF for the question they are addressing, but I wanted to know if other topics came up and should be given a bit more discussion.
We have addressed this as per comment 3 above.

8. It would be helpful to give a bit of information on are GPs were supported to raise the issue of smoking, and comment on whether this has any implications for weight.
We have added the following paragraph to the discussion, implications:

Lessons from other areas of public health could be drawn on, particularly smoking where clinicians are equipped with smoking cessation services, pharmacological treatment, and are incentivised by the Quality and Outcomes Framework as part of a comprehensive strategy to lower rates of smoking in the population [65, 66]. Although such changes may encourage practitioners to raise the topic routinely, this study confirms that there are challenges which are unique to discussing obesity, particularly weight stigma, that need to be further explored and targeted in future research.