# Patient responses to opportunistic weight loss advice

Jarvis, K., Tremblett, M., Luick, M. & Aveyard, P.

2023

## Abstract

GPs are told to opportunistically provide weight loss interventions to patients living with obesity but rarely do so. This is partly due to concerns that such discussions could be offensive or ineffective, but little is known about how patients respond to interventions. To understand what patients say in response to weight loss advice, we categorised the content of their responses during brief interventions with GPs.

Qualitative content analysis was applied to 98 audio recordings of consultations from the BWeL trial. Using data on patient weight loss at 12 months, the association between the categories identified and effective weight loss action was analysed.

Four key categories in patient responses were identified: (1) perceived barriers to weight loss, (2) intended weight loss action, (3) frustration and hopelessness, and (4) acknowledgement and accountability. A key finding was that those who repeatedly mentioned an intention to lose weight went on to do so (p=0.008, 95% CI 1.24-8.41).

GPs should focus on providing further support to patients who do not repeatedly state their intention to lose weight. Improved guidelines for GPs should also consider the moral and emotional aspects of weight management as these may contribute to patients feeling judged during interventions.

## Background

The National Institute of Health and Care Excellence (NICE) recommends that GPs opportunistically provide weight loss interventions to patients living with obesity, but the evidence indicates that this advice is rarely followed. Doctors report a lack of time, training and resources, vague guidelines, a fear of alienating or offending patients, the stigma surrounding the topic, a lack of confidence in treatment options, and a belief that patients would not successfully lose weight as barriers to providing weight-related interventions.

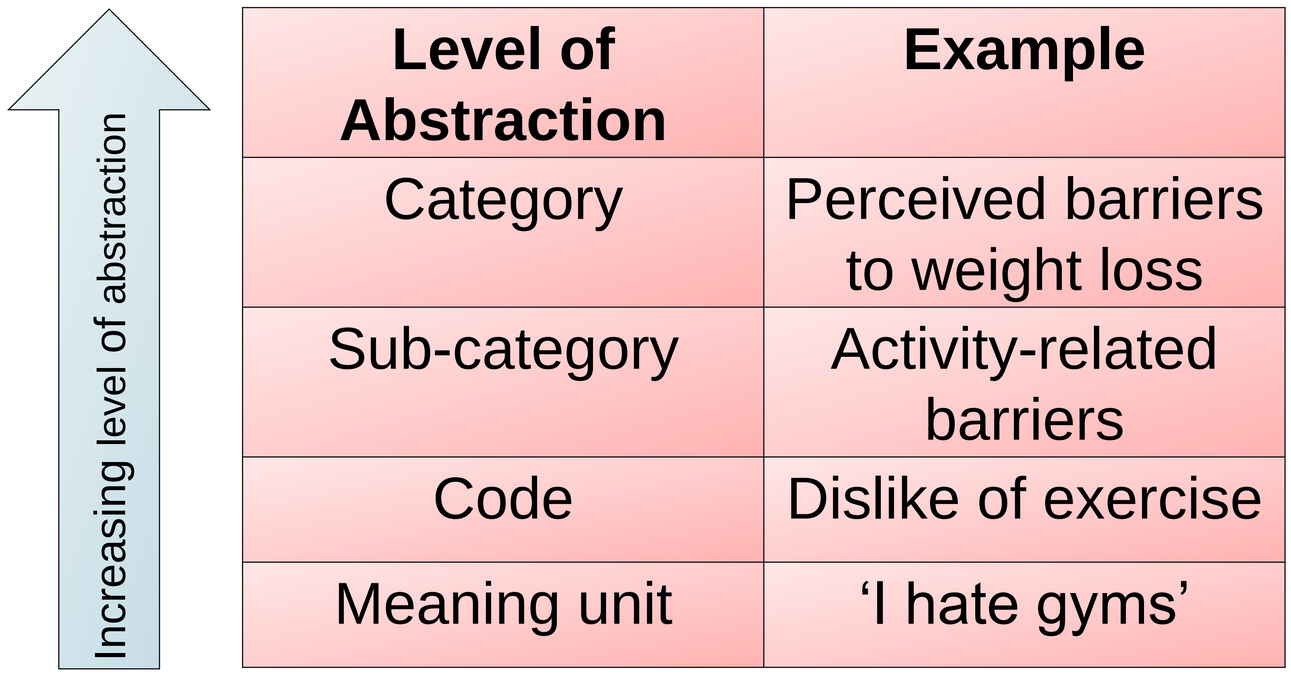
However, there is still little known about how patients respond to weight loss advice from their GPs, and whether the concerns of GPs are actualised in these responses, as our evidence is based on post-hoc accounts of weight management consultations. In this research, we therefore analysed the content of patient responses during consultations as well as their weight loss at 12 months – investigating what patients actually say and do in response to weight loss advice.

University of Oxford

## Qualitative Content Analysis

Data were collected as part of the Brief Interventions for Weight Loss (BWeL) trial, which investigated the effectiveness of screening and brief opportunistic intervention in obesity. In this study, we used recorded interventions from the advice arm, in which physicians were instructed to advise patients that their health would benefit from behaviour changes.

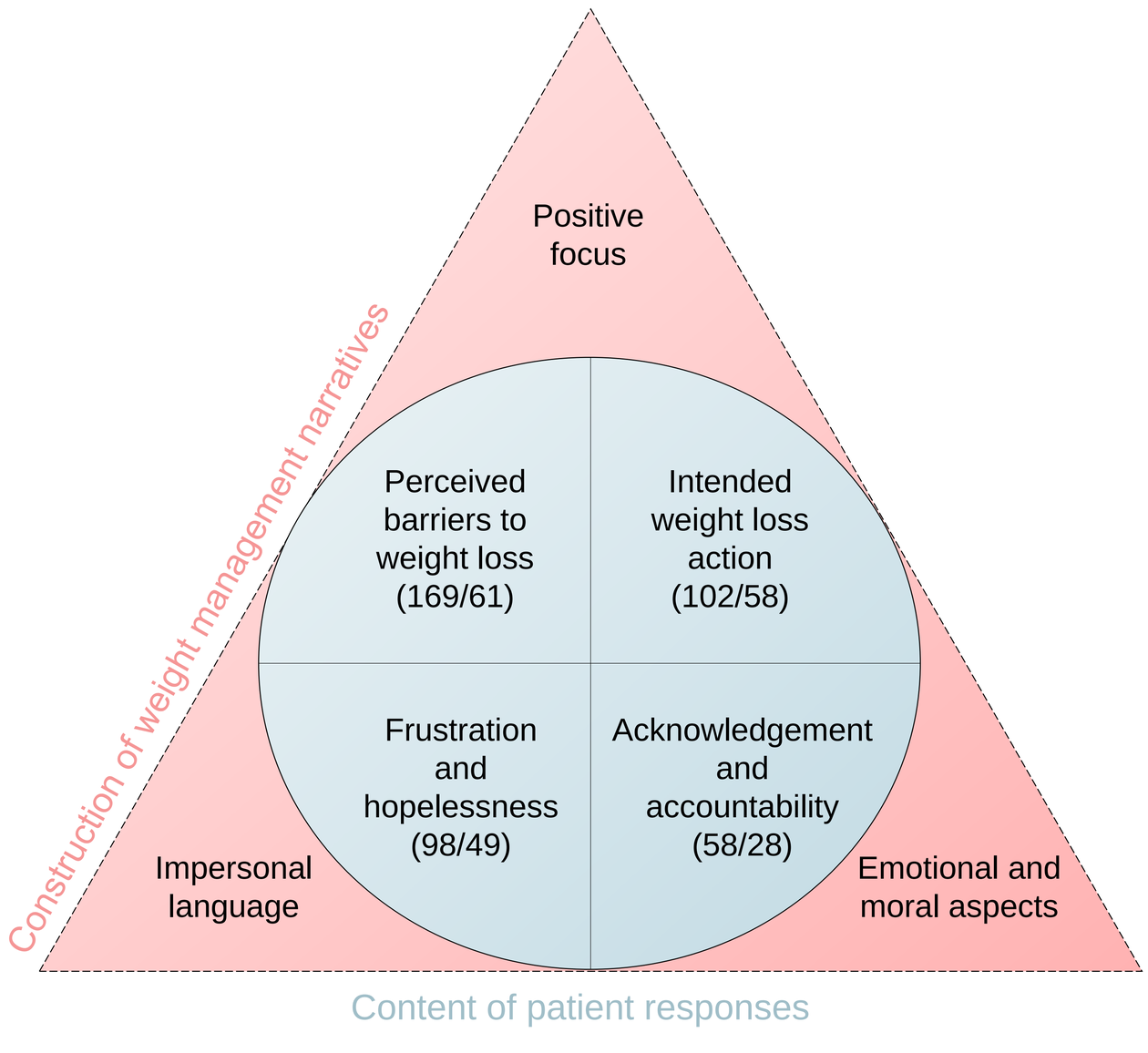
98 transcripts of doctor-patient consultations were selected for qualitative conventional content analysis (QCCA). QCCA involves coding, categorising, and describing the data in order to better understand the phenomenon that produced the data. The transcripts were inductively coded line-by-line to descriptively capture the content of patient responses: they were divided into meaning units, which were then given codes to reflect the basic meaning of a patient's comment on weight management. Codes were then grouped into sub-categories and ultimately categories to reflect the higher-level meaning in the text. This process is shown in the figure below.




## Results

The results of QCCA comprised four major categories: 'perceived barriers to weight loss', 'intended weight loss action', 'frustration and hopelessness', and 'acknowledgement and accountability'.

We were also interested in how patients construct narratives of weight management; the key themes that we coded were a positive focus, use of impersonal language, and framing of weight management as an emotional or moral issue. Patients often structured their responses such that they focused initially, or even exclusively, on positive aspects of their lifestyle. These were typically discussed in the first person, whereas the discussion of barriers to weight loss and weaknesses in the patient's lifestyle were frequently relayed in impersonal language. Finally, many patients discussed weight management in emotional or moral terms, using words like 'good', 'wrong', 'failure', or 'cheating'.




## Results

'Intended weight loss action' was found to have a significant effect on percentage weight change at 12 months: mention of 'intended weight loss action' was associated with 1.65% greater weight loss at 12 months (95% CI 0.48-2.82), p=0.006).

Further analysis revealed that, compared to those who did not mention it at all, mentioning 'intended weight loss action' just once was not associated with significant weight loss (p=0.428), but mentioning it twice or more *was* associated with significant weight loss – an average of 4.83 greater percentage weight loss than those who did not mention 'intended weight loss action' (95% CI 1.24-8.41, p=0.008).

## Discussion

Our content analysis showed that patients commonly discussed barriers to and frustration with weight loss; they often spoke about these difficulties with weight management in impersonal language, creating a sense of separation from perceived failures. However, many patients took accountability for weight management and stated an intention to lose weight. The key finding of this study was that patients who repeatedly mentioned an intention to lose weight went on to do so.

Contrary to both doctors' concerns and former research that suggested that opportunistic interventions may not lead to effective weight loss, the patients in this study did go on to lose weight. Furthermore, the finding that patients who repeatedly stated an intention to lose weight went on to do so could be used to inform the more detailed guidelines sought by GPs: doctors could focus on providing further support to those patients who do not mention their intention to lose weight, as these patients appear to achieve less successful weight loss.

We also found that many patients constructed weight management as an emotional or moral issue, and many either neglected discussion of weaknesses or discussed them in impersonal language. This corroborates former research in the field which describes 'defensive detailing', whereby patients explain problems in a way that frames them as outside of their control. This appears to be because the perceived link between morality and weight management behaviour makes patients feel judged during interventions.

We conclude that patients who repeatedly state an intention to lose weight go on to do so. Improved guidelines sought by GPs should take this, as well as the perceived moral aspects of weight management, into account.