# Ask –
# getting a good conversation started

## Session 3

*Acknowledgements*
**Obesity Canada**

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# 5 As of Obesity Management framework

- **Ask** for permission to discuss weight.
- **Assess** obesity-related risk and potential “root causes” of weight gain.
- **Advise** on obesity risks, discuss benefits and options.
- **Agree** on realistic weight management expectations and on a SMART plan to achieve behavioural goals.
- **Assist** in addressing drivers and barriers, offer education and resources, refer to provider, and arrange follow-up.

# What we know from international experience: patient perspective

- Physicians routinely asked and advised patients to lose weight; they rarely assessed, assisted or arranged.
- Information from physicians is seldom helpful.
- Physicians lack sensitivity in addressing obesity.
- Patients want more support in self-management.
- Patients want specific tailored weight management strategies.
- Patients want reliable resources.

# Recall: primary care setting

- Primary care is an ideal setting for weight management.
  - Long-term patient care establishes the relationships needed for sensitive and complex issues to be addressed.
  - The embedded nature of weight issues can be harnessed as an advantage, providing multiple starting points for treatment.
  - Primary care has the space to work on prevention as a goal.
- Provider knowledge is only one aspect of weight management. Interventions should address team issues and the work environment, and build upon existing experiences and skills.

# Ask

- Weight is a sensitive issue.
- Many patients are embarrassed or fear blame and stigma.
- So it is important:
  - to be non-judgmental
  - to explore readiness for change
  - to use motivational interviewing
  - to create weight-friendly practice.

# Ask (adults/paediatrics)

- Do NOT blame, threaten or provoke guilt in your patient.
- Do NOT make assumptions about their lifestyles or motivation (your patient may already be on a diet or have already lost weight).
- Do acknowledge that weight management is difficult and hard to sustain.

# Ask (pregnancy)

- Do acknowledge that weight gain in pregnancy is expected.
- Do provide education about the recommended amount of weight gain to optimize health.
- Do not make assumptions about a woman's life, lifestyle or motivation. She may be living as healthy as she can, or she may be ready to take action, or in the action stage of making a change.

# Why are obesity discussions difficult?

- Obesity commonly triggers the judgemental view that the individual is responsible for their own misfortune and can thus be blamed for their condition; this results in dismissive and sometimes bullying attitudes.
- Many health workers struggle with the balance between personal responsibility ("why don’t they just eat less?") and difficulties of medicalization ("the treatments I can offer are either rationed or ineffective").

# Poppy's comments – a patient with obesity and co-morbidities

- "Just because I'm fat doesn't mean I'm stupid."
- "I've got a good brain and even greater is the size of my feelings."
- "I've felt degraded, dismissed, stupid and treated like a freak by some of the so-called 'caring profession'."
- "These phrases raise my hackles: 'Do you know you're overweight?' 'You need to consider losing weight.'"
- "If I come to see you with earache, please treat my earache and don't go on about my weight – ask me if I want further help."

# A doctor's comments may convey something quite different to the patient ...

| I think you ought to lose some weight. | The doctor thinks **I'm fat**, despite my diet attempts. |
|---|---|
| Your weight is making your joints worse. | **My pain is my fault.** |
| Do you realize your weight is causing your illness? | To rescue my dignity I shall have to become either defensive or aggressive – or simply **not come back** to this doctor. |
| You can't have your operation until you lose weight. | My actual **needs don't count**. They are rationing care for obese people. |
| You just need to eat less. | This doctor has **no idea what it is like** fighting obesity. |

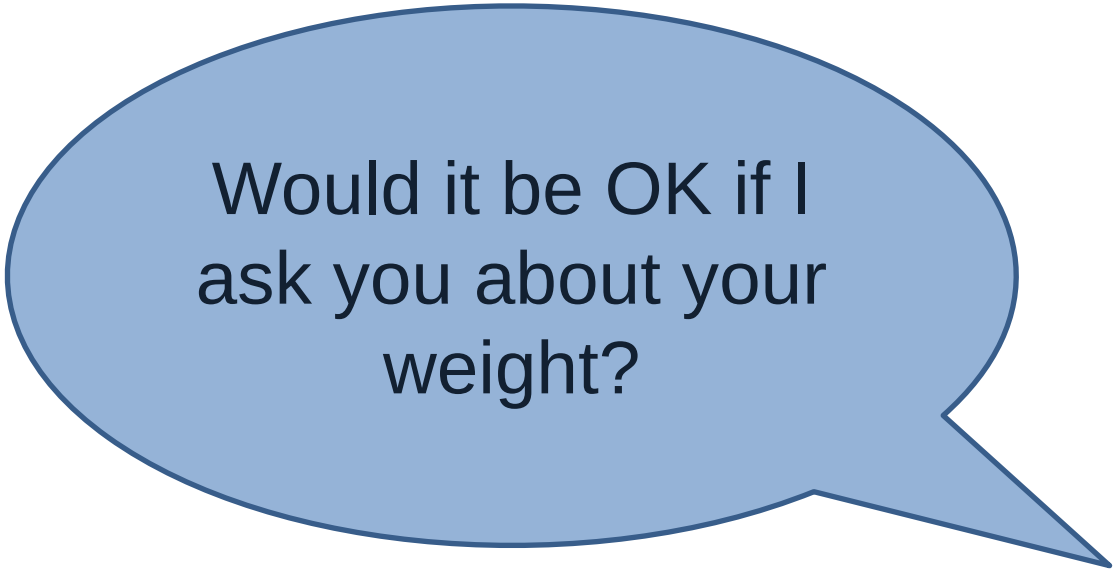
# Pitfalls to watch out for

- Being judgemental – people appreciate discussing their concerns, they dislike being judged by their appearance.
- Jumping to conclusions.
- Passing on blame.
- Being unkind.
- Being sensationalist.
- Being dismissive.
- Frightening patients – fear is a poor motivator but good at generating denial.
- Misinterpreting denial.

# Safe openers: let the patient set the agenda

| Question | GP's hidden agenda | Patient perception |
|---|---|---|
| How do you feel about your weight? | Is this a touchy subject? | Open invitation to talk about topic that may be of concern. |
| Do you keep an eye on your weight? / When did you last weigh yourself? | Where should I start? Is the patient actively engaged or in denial? | I can explain whether this is important to me or not. |
| What has happened to your weight over the last few years? | Where is the patient on their weight continuum? | I can explain some background to my successes/difficulties. |

# Or – simply ask permission …



Would it be helpful if we talked about your activity levels? Would today be OK, or would you prefer to have a think about it and come back another time?

Would you like to hear some healthy eating suggestions that other patients have found useful?

We know that weight can affect health/ arthritis/breathing. Is this something you would like to discuss?

Lifestyle can have quite an impact on people diagnosed with cancer. Is this something you would like to find out more about?

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# Ask

- Use motivational interviewing to move patients along the stages of change.
- Ask questions, listen to patients' comments, and respond in a way that validates their experience and acknowledges that they are in control of their decision to change.
- If patients are not ready to address their weight, be prepared to address their concerns and other health issues, and then ask if you can speak with them about their weight again in the future.

# Ask

Explore readiness for change.

- Determining your patient's readiness for behaviour change is essential for success. Recognize that different patients will be at different stages of readiness.
- Use a patient-centred collaborative approach (genuine collaboration that acknowledges that the patient is central).
- Initiating change when patients are not ready can result in frustration and may interfere with future attempts to support healthy change.

# Ask – Prochaska's stages-of-change model

| | |
|---|---|
| **Pre-contemplation** | Patient has no intention of changing behaviour in the foreseeable future (within next six months). |
| **Contemplation** | Patient is aware that a problem exists and is seriously thinking about overcoming it (within next six months). |
| **Preparation** | Patient is intending to take action in the next month. This phase combines intention and small behavioural changes. |
| **Action** | Patient modifies behaviour, experiences or environment to overcome the problem. It involves the most overt behavioural changes. |
| **Maintenance** | Patient works to prevent relapse and consolidate the gains attained during action. |

Source: **Prochaska, J. O. et al.** In Search of How People Change: Applications to Addictive Behaviors. *American Psychologist* 47(9): 1102-1114 (1992).

# Sample questions (adults)

- Would it be all right if we discussed your weight?
- Are you concerned about your weight?
- On a scale of 0 to 10, how important is it for you to lose weight at this time?
- On a scale of 0 to 10, how confident are you that you can lose weight at this time?

# Sample questions (paediatrics)

- Are you concerned about your (child's) health?
- Are you concerned about your (child's) weight?
- Would it be all right if we discussed your (child's) weight?

Depending on a child's age and developmental stage, it may be more appropriate to speak with parents alone.

# Sample questions (pregnancy)

- Could we discuss your thoughts and feelings regarding weight gain during your pregnancy?
- Are you concerned about weight gain during your pregnancy?
- Would you be interested in information about weight gain during your pregnancy?

# Ask

Create a weight-friendly practice.

- Facilities: handicapped accessibility, wide doors, large restrooms, floor-mounted toilets.
- Scales: over 160 kg (350 lb) capacity, wheel-on accessible, located in a private area and used with sensitive weighing procedures.
- Waiting room: sturdy, armless chairs, appropriate reading material – no glossy fashion magazines.
- Exam room: oversized gowns, scales, wide and sturdy exam tables, extra-large blood pressure cuffs, longer needles and tourniquets, long-handled shoe horns.

# *Exercise A1*
## Doctor, patient and optional observer (in groups of 2 or 3)

- How might you introduce the patient's weight into the conversation?
- What sentences work well?
- What element of a phrase causes upset or risks a defensive response?
- **Role play (patients)**
  *How does it feel to be challenged about a topic that is sensitive or difficult?*

# Recap

- Recognize the importance of discussing weight and physical activity.
- Get off to a good start and avoid upsetting the patient.
- Recognize the need to begin with the patient's perspective and understand a bit of the "back story".
- Do not get too hung up on specific dieting regimes or detailed description of a person's diet.

# Explore confidence in how to move forward

What does the patient want help with?

| **Understanding factual nutritional/physical activity information** | **Understanding eating behaviour – to achieve good nutrition in practice** | **Motivational approaches** |
|---|---|---|
| “What to do” | “How to do” | Swapping “I Can’t” for “I Will” |
| “I get confused with food labels and knowing what is good for me.” | “I know what to do but my family doesn’t like it …” | “I’d love to lose weight but nothing I try ever works” |

How confident are you about choosing or preparing healthy foods?

You mentioned difficulties with your family accepting healthy options. Would you like more help with this?

Are there particular aspects of doing physical activity that you struggle with?

You said you feel disheartened because previous weight loss was not maintained. Would this be a good area to explore more?

# Consider the resources you/your patient can access

- How much time/capacity do you have? “Quick fix” suggestions have no place in weight management.
- Ongoing engagement is more important than short-lived bursts of effort.
- Ensure any approaches you recommend are accessible, affordable and culturally acceptable to the patient, as well as evidence-based.
- Encourage a family-based life-course approach.

# Learning points

- The “back story” will typically highlight both emotional and organizational issues.
- Most people will have already tried something and have some nutritional knowledge.
- Struggling to lose pregnancy weight is a common factor for many overweight/obese women.
- Medical causes of obesity are comparatively rare – hypothyroidism, Cushing’s syndrome, medication, genetic conditions.
- Although stopping smoking can trigger weight gain, the health benefits of stopping outweigh the harm.

After you have asked for permission to talk about weight and assessed readiness to change, you may need to have some **critical conversations** with patients.

# Having critical conversations

- Health professional–patient relationship
- Talking about weight
- Potential barriers for patients

# Therapeutic relationships: what works

- empathy
- alliance
- goal consensus and collaboration
- unconditional positive regard
- genuineness
- feedback
- recognition and repair of alliance ruptures

# Therapeutic relationships: what does not work

- confrontation
- negative processes
- assumptions
- rigidity
- the ostrich
- one approach fits all

# What we can do

Be clear about expectations and minimize the risk of misunderstandings. This will:

- demonstrate respect for patients
- acknowledge patients' autonomy
- increase engagement in treatment.

# Critical conversations: talking about weight

Have you heard this?

- What is a healthy weight?
- How much should I weigh?
- My goal? Well, I was 65 kg in Year 10, so that would be nice.
- 10% weight loss? That's it? Maybe to start with, but I want to lose more.
- I am doing everything you said, but it isn't working – I only lost a kilo this week!
- I need to lose 45 kg to get my hip fixed.
- But that girl on TV lost 73 kg in four months, why can't I?

# Expectations

- Weight loss expectations are high.
- Evidence-based outcomes are lower than expectations.
- Patients want permanent weight loss when regain is normal.
- Effort and outcome are mismatched.

# Where do weight loss expectations come from?

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**Table 1: The International Classification of adult underweight, overweight and obesity according to BMI**

| Classification | BMI(kg/m$^2$) | |
|---|---|---|
| | Principal cut-off points | Additional cut-off points |
| **Underweight** | **<18.50** | **<18.50** |
| Severe thinness | <16.00 | <16.00 |
| Moderate thinness | 16.00 - 16.99 | 16.00 - 16.99 |
| Mild thinness | 17.00 - 18.49 | 17.00 - 18.49 |
| **Normal range** | **18.50 - 24.99** | **18.50 - 22.99** |
| | | **23.00 - 24.99** |
| **Overweight** | **≥25.00** | **≥25.00** |
| Pre-obese | 25.00 - 29.99 | 25.00 - 27.49 |
| | | 27.50 - 29.99 |
| **Obese** | **≥30.00** | **≥30.00** |
| Obese class I | 30.00 - 34.99 | 30.00 - 32.49 |
| | | 32.50 - 34.99 |
| Obese class II | 35.00 - 39.99 | 35.00 - 37.49 |
| | | 37.50 - 39.99 |
| Obese class III | ≥40.00 | ≥40.00 |

*Source: Adapted from WHO, 1995, WHO, 2000 and WHO 2004.*

# Where do weight loss expectations come from?

| Classification | BMI (kg/m$^2$) |
|---|---|
| Healthy weight | 18.5–24.9 |
| Overweight | 25–29.9 |
| Obesity I | 30–34.9 |
| Obesity II | 35–39.9 |
| Obesity III | 40 or more |

CMAJ RESEARCH

# Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity

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## Abstract

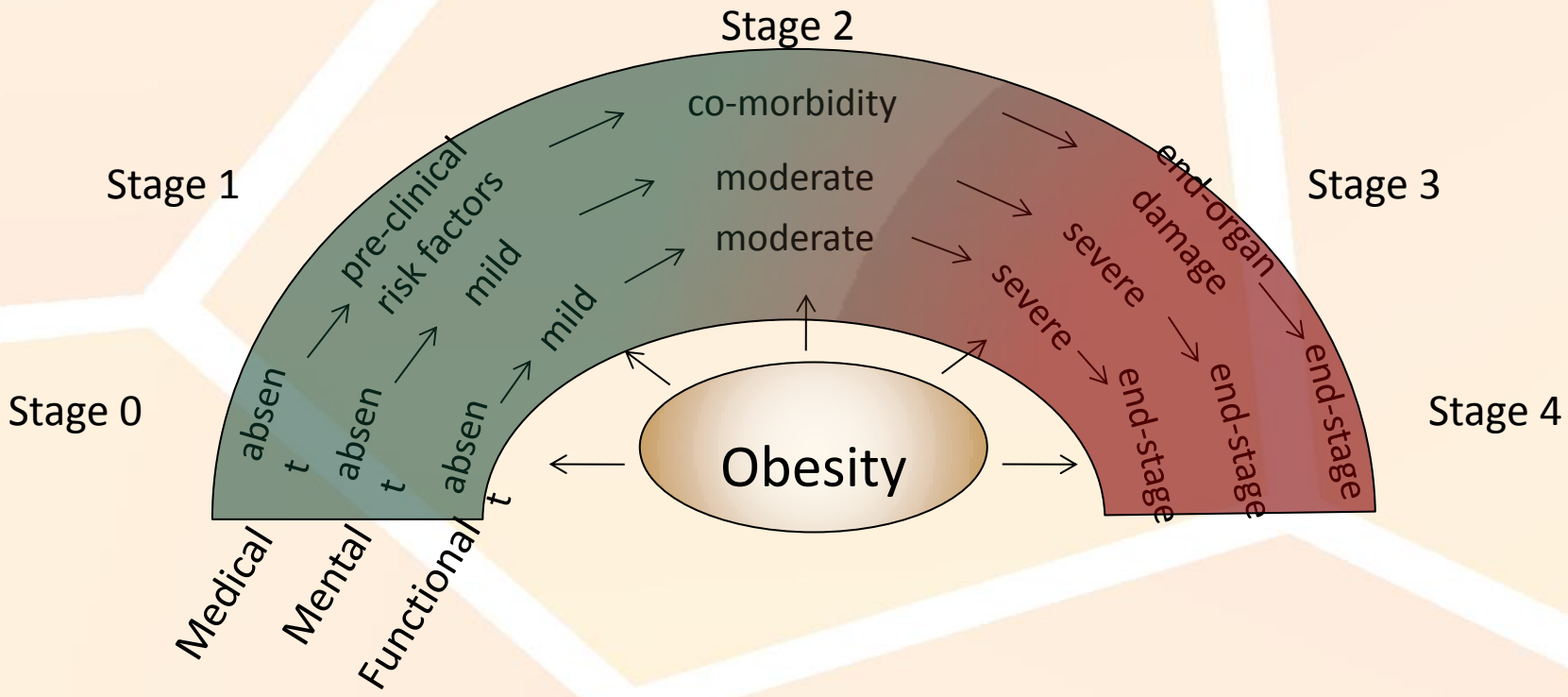
**Background:** Anthropometric-based classification schemes for excess adiposity do not include direct assessment of obesity-related comorbidity and functional status and thus have limited clinical utility. We examined the ability of the Edmonton obesity staging system, a 5-point ordinal classification system that considers comorbidity and functional sta-

Scores of 4 could not be reliably assigned because specific data elements were lacking. Survival curves clearly diverged when stratified by scores of 0–3, but not when stratified by obesity class alone. Within the data from the NHANES 1988–1994, scores of 2 (hazard ratio [HR] 1.57; 95% confidence interval [CI] 1.16 to 2.13) and 3 (HR 2.69; 95% CI 1.98 to

**Competing interests:** Raj Padwal and Arya Sharma are supported by an alternative funding plan from the Government of Alberta and the University of Alberta. David Allison has received grants, honoraria, donations, and consulting fees from numerous other commercial

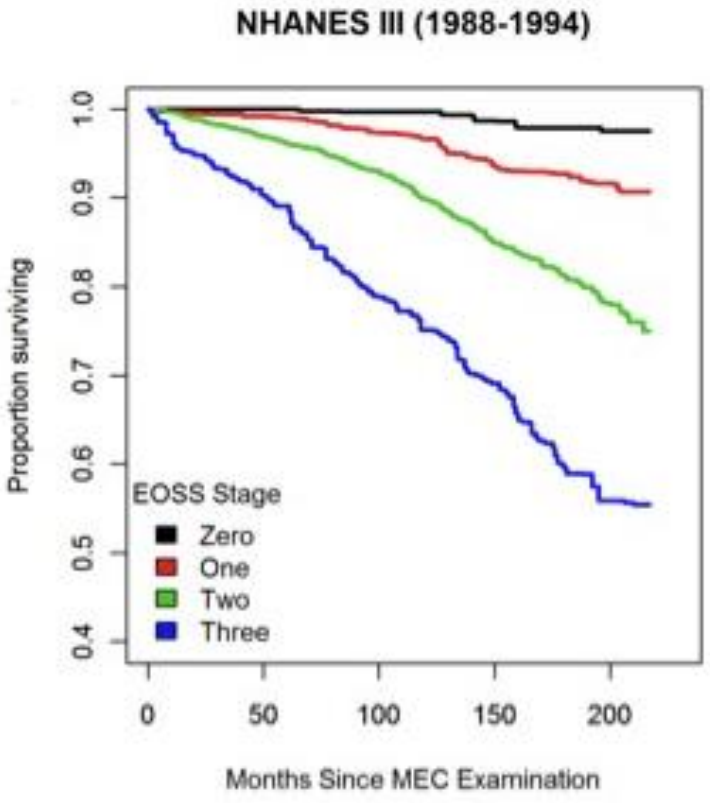
ASSESS

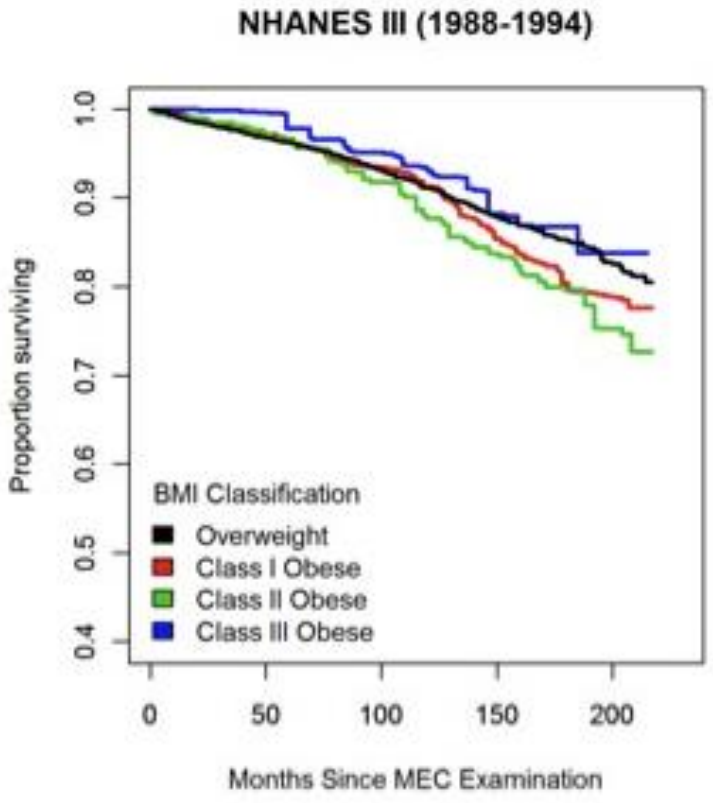
# Edmonton Obesity Staging System (EOSS)




Sharma AM, Kushner RF. A proposed clinical staging system for obesity. Int J Obes (Lond). 2009;33(3):289–95.

# EOSS predicts mortality in NHANES III



# Setting a weight goal

- First step is not weight loss
  - Stop the gain and maintain
  - Assess: is weight loss indicated? Wanted?
- Yes?
  - Target up to 10% of current weight in 6 months, maintain loss at 1 year
- Rate?
  - Up to 1 kg (2.2 lb) on average per week
- Outcomes
  - Improve health, prevent or delay the onset of obesity-related conditions

# How do you talk to your patients about weight loss expectations?

1. Listen to patients' expectations.
2. Acknowledge that weight management is difficult and requires long-term strategies.
3. Present evidence on weight outcomes.
4. Discuss phases of weight management.
5. Focus on health outcomes.

# Evidence on weight outcomes

| Intervention | Short-term – 6 months | Long-term |
|---|---|---|
| Commercial programmes | 4.6% | 3% at year 2 |
| Calorie restriction (-400 calories per day) | 5% | 3% at 3 years |
| Diet and exercise | 8.5% | 4% at 4 years, back to baseline by 5.5 years |
| Low calorie diet | 9.7% | 5% at 1–2 years |
| Medications + lifestyle | 8% | 7–11% up to 3 years |
| Behaviour therapy | 10% | 8% at 18 months |
| VLCD (<800 Kcal) | 16% | Rapid weight regain |

# Weight expectations and goals

| % weight loss (n+658 adults) | All | Women | Men | BMI 25–25.9 | BMI >30 |
|---|---|---|---|---|---|
| Expectation (realistically) | 8.0 ± 6.4 | 9.1 ± 6.6 | 6.7 ± 5.8 | 6.8 ± 4.5 | 9.2 ± 7.8 |
| Goal (ideally) | 16.8 ± 9.5 | 19.7 ± 8.5 | 13.7 ± 8.5 | 12.1 ± 9.7 | 21.2 ± 10.5 |
| This attempt | 8.9 ± 7.2 | 62% achieved “less than expected” | | | |

- Predictors for higher expectations/goals: higher BMI, younger age, female.
- Higher attrition rates for patients who expect the highest reductions.
- Challenging to alter patient perceptions of “realistic” weight loss.

# Weight loss expectations from bariatric surgery

- Different procedures have different outcomes.
- Realistically, 20–30% weight loss.
  - 20–30% of patients do not achieve “successful” weight outcomes.
  - Average regain of 21% of total weight lost.
  - 10–20% of patients regain a significant portion (2–3 years post surgery).

# Weight loss expectations from lifestyle interventions

- 20% are successful in keeping 5% weight off with long-term support (McGuire 1999).
- Most regain 30% of weight lost within 1 year and 95% within 5 years (Barte 2010).
- 6% weight loss (2 BMI points) at 12 months; weight returned to baseline in 5.5 year (Dansinger 2007).

# Discuss the phases of weight management with your patient

- Patients want to focus discussion on weight loss outcomes.
- Weight loss is only one phase of weight management.
- Develop a strategy and plan for all phases:
  - prevention of further weight gain
  - weight loss
  - weight stability/plateau
  - weight regain.

# It’s not just about the weight

Discuss with the patient what the true goals are (health, quality of life, etc.).

- What is important for the patient?
- What is the goal?
- How will you define/assess success?
- What is the plan?

# Summary: critical conversations

- Use evidence about weight outcomes to structure the conversation.
- New evidence is becoming available constantly.
- Recognize individual variation and responses to treatment.
- Discuss the phases of weight management and develop strategies for each phase.
- Keep focus on health, not numbers on the scale or BMI ranges.

# Summary: critical conversations

- Building therapeutic relationships.
- Critical conversations: what to do?
  - patient-centred goals
  - support self-management
  - expectation management
  - focus on quality of life
  - address barriers
  - set up supports

# Reflection

Please take a moment to consider your own practices in the past.

- What worked well in conversations you have had in the past? What did not work well?
- When you had a situation where the conversation did not work out, were you able to retrieve the therapeutic relationship? If so, how?

# Future practices

Please consider your future practices.

- How will you balance active listening and empathy with the time constraints of a busy practice?
- Do you have personal examples of utilizing the various styles of motivational interviewing (following, guiding, directing)? If so, please discuss.