What goes into discussing referral and treatment options? A qualitative study of primary care staff reflections on supporting adults living with obesity.

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Abstract

Background: Policy and National guidelines place healthcare professionals (HCPs), particularly those employed in Primary Care, in a key role to assist with weight management. Previous research has acknowledged a number of practice barriers present for HCP in this role. An understanding of HCPs practice during healthcare appointments with adults living with obesity is necessary for the development and delivery of effective weight management initiatives.

Aim: The primary aim of this qualitative study was to explore how primary care staff support adults living with obesity, from the initial discussion regarding weight to exploring treatment options. Secondary aims were to explore any factors that might influence staffs' ability to work effectively with this population.

Method: A qualitative study design using semi-structured interviews with a sample of 15 HCP including general practitioners (N=5), nurses (N=4), pharmacist prescribers (N=2), dietician (N=1) and Health and Wellbeing practitioners (N=3). Staff were recruited through the regional Clinical Research Networks. Reflexive Thematic Analysis was used to analyse how HCP work with adults living with obesity.

Results: Six themes and 15 subthemes were identified: It's not all about weight: Holding the discussion with the person in the room; Fostering a respectful and stigma-free environment; Weight is only one piece of the treatment puzzle; The struggle of navigating weight management systems; The problem with contemporary weight narratives; and the route to knowledge and expertise.

Conclusion: The results of this study highlighted HCPs' dedicated efforts to support adults living with obesity. Those interviewed recognised their role in weight management and

described ways they facilitated open, safe discussions about weight. Strategies included inviting individuals to discuss weight and health, listening to the patient's full story, and fostering engagement and motivation in weight management efforts. These discussions helped create tailored, holistic treatment plans focused on achievable, realistic, patient-centred health goals. HCPs also acknowledged the impact of weight stigma on these conversations, emphasising the importance of mindful language and rapport-building. However, they spoke of the challenges to preventative healthcare caused by societal narratives and organisational factors, including lack of training, limited specialist services, rigid referral criteria, and long waiting lists. As a result, there are a number of clinical implications and recommendations that could be made considering these findings.

Introduction

Overweight and obesity are classified as a medical condition where excess body fat is accumulated to an extent where it can potentially have negative effects of health (World Health Organisation, 2021). In the United Kingdom (UK), the National Institute for Health and Clinical Excellence (NICE, 2023, 2025) defines overweight with a Body Mass Index (BMI) greater or equal to 25 kg/m^2 and obesity refers to a BMI greater than or equal to 30 kg/m^2 in white adults and a BMI greater than or equal to 27.5 kg/m^2 in South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean adults. In 2022, the UK National Statistics estimated 41% of adults were classed as overweight and 26% were obese (Office for Health Improvement and Disparities, 2022). As the prevalence of obesity in the UK continues to rise, weight-related illness is considered to pose a concern for the NHS, with direct costs estimated at £6.1 billion in 2019 (Department of Health and Social Care, 2020). This concern is due to the association between obesity and increased risk of disease and mortality (Abdullah et al., 2010; Földi et al., 2020; Fruh, 2017). Currently obesity has been related to >50 comorbid conditions that include metabolic dysfunction (type 2 diabetes, hypertension, non-alcoholic fatty liver disease, polycystic ovary syndrome, and cardiovascular disease, mood disorders (depression and anxiety), dementia, joint problems (osteoarthritis), chronic kidney disease, obstructive sleep apnoea (Renehan et al., 2008), and at least thirteen types of cancer (Hruby & Hu, 2015). In 2018/19 there were 11,117 hospital admissions with a primary diagnosis of obesity, an increase of 4% on 2017/18 statistics (Office for Health Improvement and Disparities, 2022). There has been an upward trend since 2014/15, with an increase of 22% over that period (National Statistics, 2022). As such, obesity is often reported as the most important health challenge faced at a global level representing a rapidly growing problem to the health of populations (WHO, 2021).

This opening paragraph is often how many scientific journals researching obesity introduces the topic. Often referred to as the obesity epidemic (Gard & Wright, 2005), research cites increasing prevalence rates (Office for Health Improvement and Disparities, 2022), associated comorbid diseases and mortality (Hruby & Hu, 2015), and increased 'burden' on the NHS (Department of Health and Social Care; DHSC, 2020). This evidence has been used to increase research in and funding to treat obesity, with increased focus on finding effective weight-loss interventions. In 2021, the UK government announced £100 million of new funding to help support people in achieving a healthier weight. The NHS Long Term Plan (NHS, 2019) set out a preventive model of healthcare, where practitioners and patients share responsibility for health and aimed to make weight management services available to those living with obesity and most at risk (with type 2 diabetes and/or hypertension). In essence, such policies serve as a call to action, placing responsibility on both individuals and HCP to support the population in achieving a healthier weight.

Yet in 2022, the £100 million funding was cut, one year after it was announced (Mahase, 2020). The abrupt withdrawal of or inconsistent funding is shown to have negative impact on health outcomes, including increased weight status of individuals (Mason et al., 2021) and placing additional stress on already strained services (Metcalfe & Sasse, 2023). Furthermore, the impact of COVID-19 pandemic significantly reduced access to weight management services, with many Tier 2 and 3 provisions suspended as a result of the lockdown (Ells et al., 2020). While it is unsurprising that the NHS, Public Health England, and the wider healthcare system prioritise obesity prevention and treatment, obesity prevalence continues to rise (Office for Health Improvement and Disparities, 2022). The Department of Health and Social Care, (2020), Tackling Obesity strategy focused expanding weight management services through the NHS and local authorities. However, in light of such expansive policy, efforts

have not led to clear and effective pathways for prevention or treatment, and the provision of weight management services remains inconsistent (Hazlehurst et al., 2020).

Furthermore, such public health policies and guidelines have been criticised for placing too much emphasis on obesity as a result of individual-level decision-making and focussing too much on weight-loss to reduce obesity severity (Westbury et al., 2023). This view tends to oversimplify the causes of obesity and places responsibility on the individual. This neglects the complex interplay between genetic predisposition, environmental (Berthoud et al., 2017) and socioeconomic factors (Adams, 2020), that in turn receive inadequate attention and support (Westbury et al., 2023). Thus, the aim of such policies is to motivate people to make the 'right' choices towards health (Greener et al., 2010). This narrative is shown to lead to harmful assumptions and stigmatisation about the lifestyles and characters of individuals living with obesity(Puhl & Brownell, 2001). This also places emphasis on appearance and weight-loss as the only subjective measure for success which may demotivate and ostracise individuals living with obesity, thereby hampering their weight management efforts (Puhl & Suh, 2015). This suggests that the current approach taken by policymakers may be overly individualistic and weight-focused, overlooking the multifactorial causation factors contributing to obesity, and is therefore ineffective in reducing the population prevalence of overweight and obesity (Gard & Wright, 2005).

The Role of Primary Care in Obesity Management

In the UK, Primary Care (PC) staff are considered as the frontline for obesity management as they are the first point of contact for the community in the healthcare system (Starfield et al., 2005) and are thought to be best placed in understanding the community's unique health disparities, cultural and social circumstances (Jeffers et al., 2024). PC networks have evolved to incorporate several HCP from different medical backgrounds. These include general

practitioners (GP), nurses and, through the additional roles reimbursement scheme (ARRS), physiotherapists, physician associates, dietitians, nursing associates, social prescribers and health and wellbeing coaches. Weight management services in the UK are based on a four-tier system. HCP have an important role in the screening of obesity, delivery of Tier 1 and 2 weight management interventions and facilitating referrals to Tier 3 and 4 services. The role of PC within tier 1 is to reinforce the healthy eating and physical activity messages, complementing community advice and public health messaging. Tier 2 involves the implementation of behavioural interventions within PC or referral to external community-based lifestyle and weight management interventions. HCP can also refer to Tier 3 (specialist, clinician-led weight management) and 4 (bariatric surgery).

The first step for HCP is to identify those who are overweight in determining whether weight management is needed and the potential benefits. The Royal College of Physicians (2010) advises HCP to initiate discussions, using neutral, non-judgmental questions such as, “How do you feel about your weight?” and “Is it something you would like to discuss further?” HCP are tasked to obtain a weight-focussed history, exploring the patient’s life circumstances contributing to weight, physical and mental health issues, sleep, prior weight-loss attempts, drug-induced weight gain, current dietary and activity habits, and readiness to make lifestyle changes (Luig et al., 2018; Ogden et al., 2009a). This is because the potential underlying drivers are many, varied and individualised (Westbury et al., 2023), including biological, genetic, environmental, economic, social and psychological factors (Omer, 2020). Where many HCP report a lack of knowledge and supportive frameworks to hold discussions (Mercer & Tessier, 2001; Nolan et al., 2012), the use of standardised templates may be helpful in shaping the discussion (Luig et al., 2018). Within this exploration, goals and treatment options should be discussed in line with the individuals’ unique experiences (Spreckley et al., 2023).

There are a number of accessible and effective weight-related interventions HCP staff can offer their patients, although this is dependent on their training, knowledge and professional background. Brief, 30 second, opportunistic interventions delivered by a primary care staff is shown to be motivate individuals towards weight-loss goals and are generally well received by patients (Aveyard et al., 2016). Tools that HCP can use to help patients lose weight include, Motivational Interviewing (MI), behavioural modification, or tailoring medications that impact weight, and surgery (Turer, 2015).

MI is designed to help patients identify their own concerns regarding weight status, associated risks, and goals for a healthier life, focusses on enhancing their intrinsic motivation towards behaviour change (Turer, 2015). While there is some evidence suggesting MI does not improve the effectiveness of behavioural weight management programmes (Michalopoulou et al., 2022), other evidence contradicts this (Armstrong et al., 2011). Barnes & Ivezaj, (2015) systematic review of MI delivered in primary care for weight management found that over a third of studies participants lost significantly more weight than those in usual care, with half losing 5% or more of their initial weight. Despite modest weight-loss results, the study concluded that MI interventions in primary care are worth the investment (Barnes & Ivezaj, 2015).

Most behavioural interventions typically involve reducing caloric intake, limiting certain foods and increasing physical activity, and can result in weight-loss over the short-term (Franz et al., 2007; Wadden et al., 2014). Increased physical activity at higher intensities and when combined with dietary changes, supports weight-loss and improves cardiovascular risk (Shaw et al., 2006). There have been two systematic reviews of randomised control trials of behavioural interventions that were delivered in PC. Both LeBlanc et al., (2011) and Madigan et al., (2022) concluded that such approaches can result in modest weight-loss at 12-month

follow-ups. Recommended behavioural strategies include self-monitoring of weight, diet, and activity, advice and information, as well as identifying triggers for eating, such as lack of sleep, time constraints, and stress (Jensen et al., 2014).

The relationship between patients and their HCP is crucial when discussing weight and ensuring that care remains person-centred (Greenhalgh & Heath, 2010; Mold & Forbes, 2013a). Evidence consistently demonstrates the influence of effective patient relationships on a patient's weight-loss efforts (Lang, 2012), including the development of trust (Leslie & Lonneman, 2016), empathy (Pollak et al., 2007) and respect (Leach, 2005; Ross, 2013). Using patient-centred communication and person-first language, (person living with obesity) (Albury et al., 2020) is also shown to facilitate conversations about behaviour change, (Turer, 2015), increasing patient satisfaction with care and improved physical and social wellbeing (Crompvoets et al., 2024). Thus, the professional-patient relationship and language used are considered crucial in obesity care, and HCPs may be missing opportunities to support adults effectively if these factors are overlooked (Ananthakumar et al., 2020; Aveyard et al., 2016).

HCPs should also ensure weight-loss advice is realistic, healthy, and evidence based. While the abundance of diets and weight-loss options promoted in the media complicates this, HCP should promote small, realistic goals that are sustainable over time and that align with patient needs and circumstances (Spreckley et al., 2021, 2023). A realistic weight-loss goal of 5–10% has been suggested and is associated with improved quality of life, reduced pain, and better cardiovascular and blood sugar outcomes (Wing et al., 2011). SMART goals (specific, measurable, achievable, realistic, time-bound) help direct attention and action, sustain effort, and encourage strategy selection (Van Dillen et al., 2015). Goals should be agreed collaboratively, drawing on both intrinsic and extrinsic motivators (Rose et al., 2005; Silva et al., 2010). Although goals that foster intrinsic motivation are more likely to support long-term

change (Spreckley et al., 2023). Perceived setbacks can hinder behaviour maintenance and so incorporating problem-solving may help individuals achieve and sustain their weight-loss goals (Whitehead et al., 2020).

For those who are able to prescribe, HCP could consider medication that promotes weight-loss. While weight-loss medication on the NHS have specific prescribing criteria and cannot be prescribed for weight-loss alone, they have shown to aid weight-loss (Peri & Eisenberg, 2024), improve metabolic function (Courcoulas et al., 2014), diabetes, cardiovascular risk, and sleep apnoea (Chang et al., 2014). However, adverse events, particularly gastrointestinal issues, are common and lead to higher discontinuation rates (Liu et al., 2025). Despite effectiveness, patient access to such options are limited due to the prescribers' discomfort and beliefs regarding medication for weight-loss and strict prescribing criteria (Henderson Lewis et al., 2024).

Challenges of Weight Management Led by Primary Care

While there are a number of guidelines and policies present to support HCP in weight management, there is a considerable gap between policy and practice (Blane et al., 2015). HCP report guidelines to lack clarity, negatively impacting staff confidence and willingness to hold consultations (Dewhurst et al., 2017). Whilst there is an emphasis on HCP initiating conversations around weight, this is not shown to be common practice (Kaplan et al., 2018), with evidence suggesting it is the patients that routinely initiate discussions (Pollak et al., 2007). Few patients are referred to external sources of support (Nolan et al., 2012) and a minority are receiving evidence-based behavioural, pharmacological and/or surgical treatment (Rubino et al., 2021). Survey results suggest HCP discuss weight management treatment in less than one-third of clinical encounters (Oshman et al., 2023). While behavioural interventions can induce clinically meaningful weight-loss, HCP generally do not

provide such care (Wadden et al., 2014). A cross-sectional study found that only 40% of adults with obesity reported receiving counselling to lose weight (Greaney et al., 2020) and only a minority are receiving behavioural, pharmacological, or surgical treatment (Rubino et al., 2021). This is echoed in qualitative studies with HCPs, who reported they did not routinely refer patients to external sources of support (Nolan et al., 2012).

Qualitative research has identified a number of barriers for HCP to over weight management intervention to patients (Bornhoeft, 2018a). Barriers include a lack of consultation time, confidence in communication strategies (Dewhurst et al., 2017), perception of poor intervention outcomes (Ciao et al., 2012; Dansinger et al., 2007), a lack of culturally appropriate materials (Nolan et al., 2012) and fear of causing offence (Michie, 2007). A lack of obesity knowledge and training opportunities has continuous been reported as a barrier to the discussion and obesity care (Bleich et al., 2015; Jeffers et al., 2024). This has been shown to affect HCP confidence to engage in weight-related discussions (Kolasa & Rickett, 2010), with some avoiding the topic entirely (Gudzune et al., 2021), thereby limiting patients' access to appropriate treatment from obesity-trained clinicians (Washington et al., 2023).

While obesity-related comorbidities are frequently addressed, obesity itself is shown to be chronically undertreated (Fitzpatrick & Stevens, 2017). Similar findings have been reported, with obesity management in clinical practice described as 'extremely patchy' and 'inconsistent' (Flodgren et al., 2010) with current interventions failing to have a significant impact (Kaplan et al., 2018). Reflecting on the four-tiered system, progression through the tiers requires all other treatment options to have been attempted and found ineffective, indicating that the approach lacks a preventative focus (Hazlehurst et al., 2020). Thus, highlighting the need for innovative, research-based strategies to enhance prevention and treatment options available for the individual. This evidence supports Tucker et al. (2021),

who concluded that obesity is the most 'undertreated' chronic disease in primary care due to the significant challenges HCPs face in delivering weight management support.

Furthermore, HCP are shown to hold their own weight biases and negative attitudes (Puhl & Brownell, 2001; Puhl & Heuer, 2009). The clinic environment can also alienate individuals living with obesity, with waiting room chairs too small, and medical equipment designed for use with smaller patients (Albury et al., 2020). Weight stigma within healthcare interactions is well-documented as a barrier to the therapeutic relationship (Malterud & Ulriksen, 2011), with evidence suggesting that an HCP's conscious or unconscious biases can negatively impact care (Darling & Atav, 2019; Miller et al., 2013), and the patient's health motivation (Hayward et al., 2020). Such attitudes can lead HCP to inappropriately focus on weight during consultations (Phelan et al., 2015), with some HCPs perceiving weight management efforts as futile and unwilling to dedicate time to support (Bornhoeft, 2018a). For patients, such experiences can lead to negative self-evaluations, mental health difficulties and low self-esteem (Puhl & Brownell, 2001; Wu & Berry, 2018). Consequently, patients may delay seeking medical care due to concerns about receiving inadequate or disrespectful treatment based on their weight, increasing the likelihood of disengagement from services, ultimately leading to poorer health outcomes (Phelan et al., 2015). However, the HCP who hold positive attitudes towards those living with obesity and weight management are shown to be more likely to offer weight management interventions (Nolan et al., 2012), and can conduct supportive and empathetic discussions that are productive to weight management efforts (Hayward et al., 2020).

Public Discourses Surrounding Obesity

Dominant public health discourse frames obesity as a major health issue (Jia & Libetkin, 2010), often described as an epidemic due to its global rise in recent decades (Gard & Wright,

2005). The traditional view sees obesity as the result of a sustained positive energy balance, whereby calorie intake exceeds expenditure. Consequently, obesity is portrayed as a lifestyle issue under personal control (Lau et al., 2007), reinforcing the belief that individuals are solely responsible for their weight (Westbury et al., 2023). In Western society, bodily control is viewed as a sign of intellect, mind over matter, overlooking the deeper role of body image in our value systems (De Garine & Pollock, 1995). Thus, regulating diet is often seen as the mind exercising control over the body, where failure to do so labels a person as obese or 'out of control' (Turner, 2008). This framing evokes assumptions of weak willpower, self-indulgence, laziness, gluttony, and ill health for anyone with a higher body weight (Puhl & Heuer, 2009).

In light of this discourse, treatments are often focussed toward weight-focused interventions, promoting individual weight-loss through diet and exercise, and placing responsibility on the individual to 'eat less and move more' (Penney & Kirk, 2015). However, interventions focused solely on the individual and weight reduction show limited long-term success, with modest weight losses that often diminish over time (Dansinger et al., 2007; Franz et al., 2007), despite patient gains in knowledge and skill (Jain, 2005). Many individuals have often struggled with weight for years before seeking help from a healthcare professional (Caterson et al., 2019), are often taking action to try and lose weight (Piernas et al., 2016), or would have already attempted and failed to lose weight through traditional approaches (Miller, 2005; Santos et al., 2017). When people living with obesity do not lose a predetermined amount of weight, they may feel they are abnormal or unhealthy unless they conform to a narrow, socially constructed body ideal (Dixon et al., 2025). Unsurprisingly, patients often describe weight discussions as humiliating and shameful (Malterud & Ulriksen, 2011; Mold & Forbes, 2013b).

The term “obesity” now carries strong negative connotations. The body is shaped by cultural norms, and those who don’t conform risk stigma and discrimination. Such narratives are harmful to people living with obesity, who face societal judgement for failing to manage their weight (Kirk et al., 2014; R. Puhl & Brownell, 2001) and are more likely to be thought of as lazy, unintelligent, lacking self-discipline and unmotivated compared to those of normal weight (Puhl & Brownell, 2001; Puhl & Heuer, 2009). Weight stigma has been consistently linked to negative outcomes, including greater shame, blame, and stress (Salas et al., 2019), reducing overall quality of life (O’Hara & Taylor, 2018), poorer body image, lower self-esteem, higher levels of depression, anxiety and suicidal thoughts and predicted future overweight and disordered eating (Puhl & Brownell, 2001). Obesity stigma significantly impacts mental health, where people with obesity are 32% more likely to develop depression than those with a ‘normal’ weight (Pereira-Miranda et al., 2017). Internalised stigma is also associated with similar psychological effects as external stigma (Papadopoulos & Brennan, 2015). Furthermore, this has been shown to result in poorer healthcare provision and reinforcing health inequalities (Carr & Friedman, 2005). Despite this, media, policy, and health practices often focus on lifestyle changes, placing full responsibility on the individual and promoting ‘acceptable’ weight-loss behaviours (Couch et al., 2018; Henderson, 2015).

Another discourse presents obesity as a complex, chronic disease. In 2019, the Royal College of Physicians formally recognised obesity as a disease in the UK. However, this view remains controversial. Supporters argue that obesity involves pathological changes to tissues and organs, distinct clinical symptoms, increased risk of complications, and reduced quality of life (Bray et al., 2017). This recognition has led to increased funding (Luli et al., 2023), greater access to care (Rubino et al., 2023), and reductions in weight stigma and bias (Rathbone et al., 2023). The use of language can influence how patients feel about their condition. While patients have described a dislike the term ‘obesity’ (Ward et al., 2009),

medical terminology may reduce stigma, and highlight the seriousness of the condition, encouraging behaviour change (Tailor & Ogden, 2009). It may also improve public, professional, and policymaker education, and promote cross-sector engagement (Rathbone et al., 2023). Critics argue that labelling obesity as a disease risk unnecessarily medicalises the problem. Obesity related diseases can develop in the absence of obesity and conversely, many with excess weight may not develop comorbid risks (Padwal et al., 2011). Furthermore, many people with overweight or obesity remain metabolically healthy (Phillips, 2018). However, there is a concern that reducing personal responsibility through the labelling of obesity as a disease, may unintentionally encourage unhealthy behaviours, though this concern may itself reflect underlying societal weight bias (Rubino et al., 2023).

In contrast to weight-centric discourses, there is growing support for Health at Every Size (HAES), which challenge traditional views of obesity. This approach promotes body acceptance, intuitive eating, and reasonable physical activity without focusing on weight, shape, or size (Bombak, 2014). It rejects assumptions that weight-loss is necessary for health, that adiposity always poses health risks, or that sustained weight-loss is achievable for all (Bacon & Aphramor, 2011). Body positivity and weight-neutral discourses reject narrow beauty ideals and emphasise self-acceptance and respect for all body types (Lazuka et al., 2020). They have been linked to improved self-esteem and mood (Selensky & Carels, 2021), while exposure to average and plus-sized models can reduce body anxiety and improve body satisfaction (Clayton et al., 2017). However, criticisms include limited research validity, lack of diverse samples (often focused on white, Western women with histories of binge eating), and insufficient attention to social and structural causes of obesity (Penney & Kirk, 2015).

Westbury et al. (2023) call for a weight-inclusive approach, shifting public health messaging away from obesity towards holistic health, allowing greater focus on the environments in

which behaviours occur. This perspective acknowledges the multifactorial causes of obesity and recognises that no single intervention, such as lifestyle changes alone, is likely to achieve widespread success (Jain, 2005). There is growing support for moving from a weight-centric to a weight-inclusive model (Boswell, 2016; Gard & Wright, 2005). Two systematic reviews of non-diet interventions reported improvements in psychological health, no deterioration in physical health, and lower attrition rates compared to diet-based interventions (Clifford et al., 2015; Schaefer & Magnuson, 2014). By shifting attention away from body shape and size, this approach may empower individuals to adopt healthier behaviours and reduce societal weight stigma (R. Puhl et al., 2013). However, weight-centric models remain deeply embedded in society, making the adoption of evidence-based, weight-inclusive care challenging and requiring systemic change among professionals, stakeholders, and policymakers (Mauldin et al., 2022).

HCP are not immune to discourses about weight. Professionals hold their own social identity influenced by the social groups and culture that they are part of (Haslam, 2014). However, they also hold their own professional identity, which can be influenced by 'the world around them' (Cornett et al., 2023). Qualitative studies highlight HCP hold their own negative perceptions individuals living with obesity, including beliefs that they are evasive, untrustworthy about lifestyles, and expect professionals to fix the problem for them (Epstein & Ogden, 2005; Hansson et al., 2011). Mercer & Tessier, (2001) found that GPs and practice nurses often lacked enthusiasm for weight management, viewing it as an inefficient use of time and feeling frustrated by perceived patient apathy. Similarly, Dewhurst et al., (2017) reported feelings of pessimism, hopelessness, and frustration among HCP, who preferred to address weight only when linked to comorbidities. The HCP stigmatising attitude can negatively impact the patient's health motivation and compliance (Hayward et al., 2020), yet the failure to lose weight has often been attributed to patient-related factors rather than

professional ones (Epstein & Ogden, 2005). It is likely that HCP hold more complex views. HCP are shown to perceive weight as a sensitive issue to discuss with patients and therefore try to achieve a balance between factors involving personal responsibility and factors outside the individual's control (Brown & Thompson, 2007). Hansson et al., (2011) highlighted the value of active interest and enthusiasm from HCPs, where strong commitment was seen to enhance patient encounters and improve support for those living with overweight and obesity. Such challenges may contribute to uncertainty among HCPs regarding how to address obesity (Martin & Learmonth, 2012), potentially resulting in a perceived lack of 'authority' within consultations (Abildsnes et al., 2012). These findings suggest that societal tensions around obesity are mirrored in healthcare settings. The discourses HCPs are exposed to can directly influence the level and type of support offered to individuals seeking weight management (Hansson et al., 2011).

Systematic Literature Review

1.2 Introduction

As discussed, HCPs in primary care are responsible for the screening and delivery of weight management in the UK (NICE, 2025). While the evidence reviewed highlights several significant challenges HCPs face in providing this support, patients still seek support and guidance from primary care. This meta-ethnography aims to explore the experiences and perceptions of adults living with obesity during primary care consultations in which weight was or could have been discussed. The study aims to generate insights into these discussions, including factors that may facilitate or hinder them from the patient's perspective. This is particularly important for understanding how patients perceive current HCP approaches to obesity management and could help inform recommendations to improve HCP efforts, ensuring that interactions are both respectful and effective from the patient's perspective.

1.2 Method

1.2.1 Search Strategy

Literature searches were conducted to identify studies reporting qualitative research on adults living with obesity and their experience of consulting with professionals within the healthcare system. An electronic search of APA PsycINFO, MEDLINE Ultimate, CINAHL Ultimate, SPORTDiscus and APA PsycArticles was conducted on the 05th February 2024 and reran on 13th January 2025. Journal articles were filtered using the option 'title' and time limiters '2000-2024'. Studies written in English were included. The search terms used included Obes* OR overweight OR fat OR obese OR "unhealthy weight" OR "high bmi" OR "high body mass index" AND Experience* OR perception* OR attitudes OR views OR feelings OR qualitative or perspective AND "healthcare professionals" OR "healthcare workers" OR "healthcare provider*" OR physician OR nurse OR doctor. Reference lists of included studies were read to identify additional eligible research.

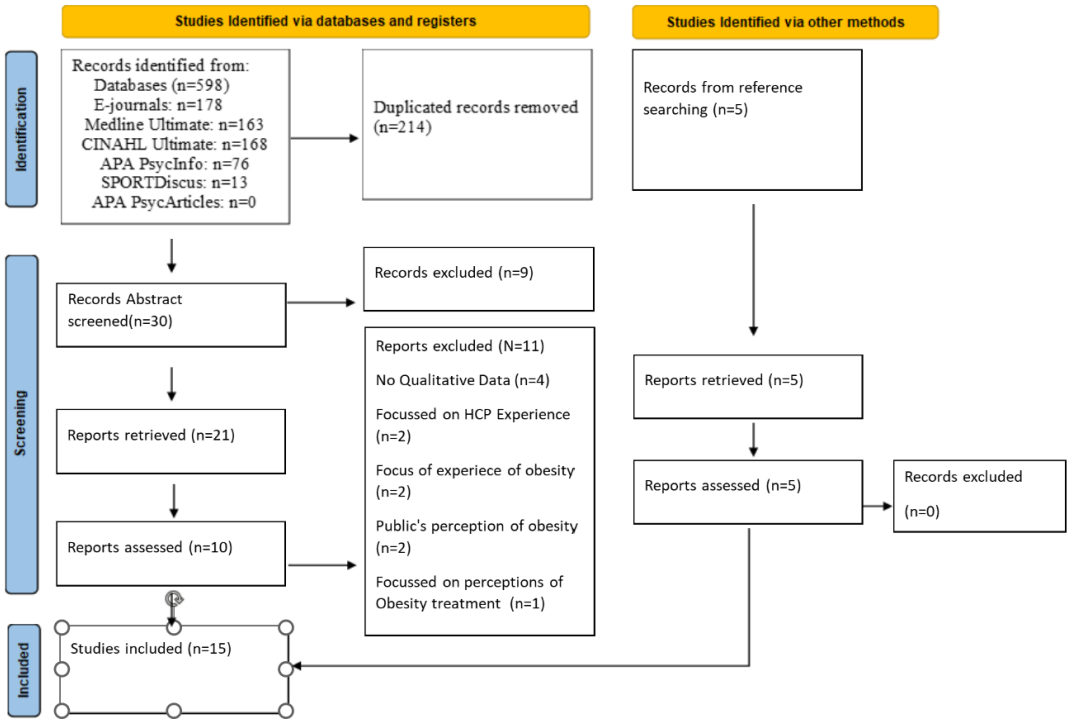
1.2.2 Screening Procedure

Qualitative studies were eligible for review if their titles and/or abstracts indicated a qualitative approach to explore the experiences of individuals living with obesity when consulting with healthcare professionals. Qualitative methods were defined as interviews or focus groups, followed by a form of in-depth qualitative data analysis. Eligible studies included adults who were 18 years or over and had consulted with health care professionals about their weight or where their perceived weight was relevant and could have been discussed. 14 studies reported an inclusion criteria of adults reporting to have a BMI of > 25kg/m² (following national classification, NICE, 2006). Only one study did not report their participants BMI or use this as inclusion criteria for their sample (Glenister et al., 2017).

This study focused on adults' experiences consulting healthcare professionals about overweight or obesity. Studies where the consultation focused on co-morbid conditions (e.g., diabetes) or pregnant women living with obesity were excluded, as were those exploring healthcare professionals' or the public's experiences. Figure 1 demonstrates the inclusion and exclusion process.

Figure 1

PRISMA flow chart for inclusion of studies



1.2.3 Search Results

The database search yielded 598 articles, with 214 duplicates. After screening titles and abstracts, 21 studies were assessed for eligibility. Four studies were excluded for not reporting qualitative data, two for focusing solely on healthcare professionals' experiences,

two for addressing obesity without discussing healthcare experiences, and two for focusing on public opinion rather than individuals living with obesity. One study was excluded for focusing on treatment options for obesity.

After the final review, 15 studies were identified for inclusion (Alarab & Antoun, 2022; Allen et al., 2015; Banerjee et al., 2018; Brown et al., 2006; Buxton & Snethen, 2013; Chugh et al., 2013; Ely et al., 2009; Glenister et al., 2017; Heintze et al., 2012; Leske et al., 2012; Ragsdale et al., 2017; Wangler & Jansky, 2023; Ward et al., 2009; Yunus et al., 2023; Zevin et al., 2019).

1.2.4 Data Analysis

This review used a meta-ethnographic synthesis approach to analyse the data. Meta-ethnography is an inductive, interpretive method (Sattar et al., 2021), commonly used in healthcare research (Hannes & Macaitis, 2012). Through the reinterpretation of the primary studies conceptual data (themes, concepts, or metaphors), it is considered well-suited for developing conceptual models due to its focus on analytical rather than descriptive findings (France et al., 2016), revealing reciprocal translations, oppositions, or new lines of argument (Britten et al., 2002), and create higher-order themes (Sattar et al., 2021). The approach offers the inclusion of multiple study designs (Atkins et al., 2008) and accommodates studies with unclear data analysis process (Sattar et al., 2021). This enabled the researcher to gather a larger body of qualitative research on the given phenomenon, identifying common or refuting themes to provide deeper insights into the experiences of adults living with obesity in primary healthcare consultations (Erwin et al., 2011). These interactions are multifaceted and relationship-based, making quantitative research less suited to understanding their efficacy, including facilitators and barriers (Erwin et al., 2011). While it doesn’t prove causal connections, qualitative meta-ethnography provides contextually valuable evidence,

illuminating how, when, or why an intervention could be effective (Erwin et al., 2011). This broader lens helps capture the subtleties of social, cultural, and environmental dynamics shaping the experience of adults living with obesity interacting with healthcare providers (Sattar et al., 2021). The findings can provide actionable insights to shape interventions, training programs for healthcare providers, and policies to improve care for adults living with obesity.

This synthesis followed Noblit and Hare's (2012) seven step model, with adaptions from Sattar et al.'s, (2021) for clarity. After completing steps one (getting started) and two (deciding what is relevant), the fifteen studies were read multiple times (step three: reading the studies). This involved familiarisation with key concepts and metaphors, followed by extracting 'raw data' by collecting a verbatim list into a Microsoft Word document (Atkins et al., 2008; Appendix A). Step four identified common and recurring concepts across the studies to generate themes that explained the data innovatively. These themes were written on post-it notes, arranged, and compared to explore relationships. Step five compared each concept across all papers to highlight similarities and differences. Step six (synthesising the translations) involved writing the report and how the studies are related. Step seven, expressing the synthesis, followed the eMERGe reporting guidance (France et al., 2019).

1.2.5 Quality Assessment

The Critical Appraisal Skills Programme (Critical Appraisal Skills Programme UK, 2018) was used to assess the quality of the selected qualitative studies. The studies were generally appropriately conducted (Table 1), although almost none commented on the context of the researcher or impact of the investigator on the study findings. This omission hinders judgements about how the investigators may have influenced the results presented.

Table 1

Quality assessment of fifteen papers using the Critical Appraisal Skills Programme

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?
Heintze et al., (2012).	N	Y	Unclear	Unclear	Y	Unclear	Y	Y	Y
Ward et al., (2009).	Y	Y	Y	Y	Y	Unclear	Unclear	Y	Y
Zevin et al., (2019)	Y	Y	Y	Y	Y	Y	Unclear	Y	Y
Ragsdale et al., (2017)	Y	Y	Y	Y	Y	Unclear	Y	Y	Unclear
Wangler & Jansky (2023)	Y	Y	Y	Y	Y	Unclear	Y	Y	Y

Buxton & Snethen (2013)	Y	Y	Y	Unclear	Y	Unclear	Unclear	Y	Y
Banerjee et al., (2018)	Y	Y	Y	Y	Unclear	Unclear	Unclear	Y	Y
Alarab & Antoun (2022)	Y	Y	Y	Y	Y	Unclear	Y	Y	Y
Yunus et al., (2022)	Y	Y	Y	Y	Y	Unclear	Y	Y	Y
Chugh et al., (2013)	Y	Y	Y	Y	Y	Unclear	Y	Y	Y
Gleinister et al., (2017)	Y	Y	Y	Y	Y	Unclear	Y	Unclear	Y
Allen et al., (2015)	Y	Y	Y	Y	Y	Y	Unclear	Y	Y
Brown et al., (2006)	Y	Y	Y	Y	Y	Unclear	Unclear	Unclear	Y
Leske et al., (2012)	Y	Y	Y	Y	Y	Unclear	Unclear	Y	Y
Ely et el., (2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y

1.3 Results

The aim of this meta-ethnography was to explore adults living with obesity experiences and perceptions of consultations with HCP when addressing weight. The objective was to explore elements of the process that individuals identified as facilitators and/or barriers to the discussion. From the fifteen studies analysed (Table 2), six themes were identified: *Shaped by Experience: Patient Perceptions of Needing Care*, *The Trusted Partner: Expectations of Primary Care*, *Treat Me with Respect*, *The Security of a Trusting, Collaborative and Caring Relationship*, *Promoting Ownership, Not Stigma* and *Navigating the Limited Scope of Care* (Figure 2).

Figure 2

Six themes identified from the analysis of fifteen papers

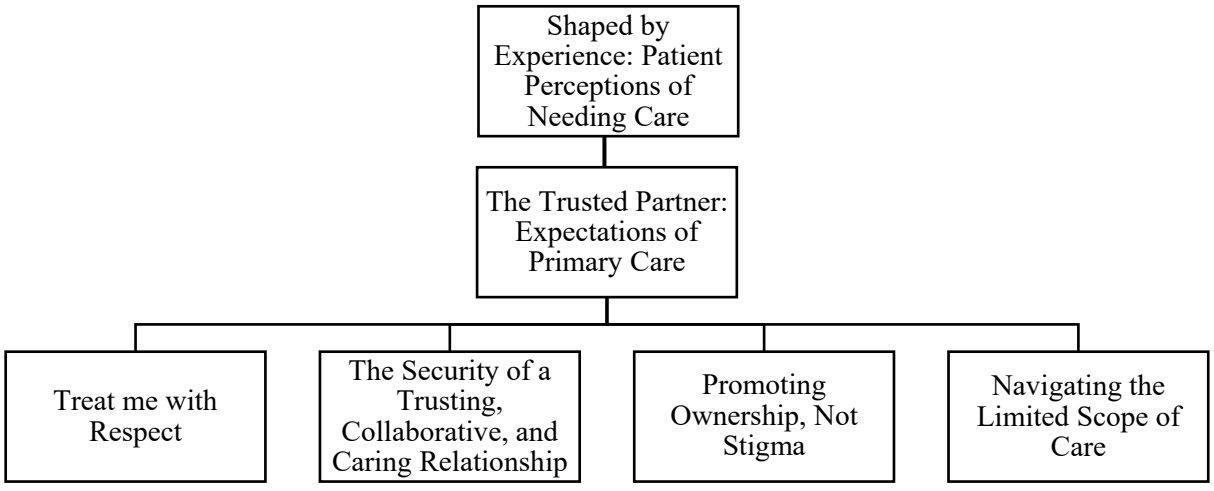


Table 2

Study Characteristics of Included Papers

Author	Country	Sample	BMI	Recruitment	Data Collection	Method of Analysis	Themes
Heintze et al., (2012).	Germany	15GP 15patient	>25kg/m^2	General Practices	Semi-structured Interviews	Content Analysis	General views regarding weight management Important practical aspects Role of the GP practices from the patients' point of view
Ward et al., (2009).	US	43	>30kg/m^2	Primary medical provider	Focus groups	Grounded theory	Dislike of the word obese Importance of the physician manner and timing when discussing weight Necessity of a personalised approach in discussing weight management issues Variable response to scare tactics
Zevin et al., (2019)	Canada	17GP 15patient	Class II (35-39.9 kg/m^2	Family physicians	Focus groups & Interview	Inductive emergent Thematic Analysis	First order barriers to change • Resource supports • Logistics • Lack of knowledge Second order barriers to change • Root causes of obesity • Motivation • Perceptions of bariatric surgery
Ragsdale et al., (2017)	US	20	>25kg/m^2	University based family medicine clinic	Semi-structured Interviews	Semantic Thematic Analysis	Attitudes & knowledge of weight loss Role of physician Past experiences with physician & weight loss What patients desire from their doctor

Wangler & Jansky (2023)	Germany	32	>25kg/m^2	Online health forum	Qualitative Interviews	Content Analysis	Incidental or late discovery of obesity Absence of continuous weight counselling No agreement on specific weight reduction goals No referrals to help and support services Insensitive discussion
Buxton & Snethen (2013)	US	26 Women	>30kg/m^2	Unknown	Semi-structured Interviews	Colaizzi Phenomenological research method	Perceptions of health & healthcare Respect me as a person Establishing a healthcare connection Assertiveness is necessary
Banerjee et al., (2018)	US	20 women	>30kg/m^2	Weight loss program	In-depth interviews	Modified Grounded theory	Framing the problem of obesity in the context of other health problems provided motivation Having a full discussion around weight management was important An ongoing conversation and relationship was valuable Celebrating small successes was beneficial for ongoing motivation Advice was helpful but self-motivation was required in order to make a change
Alarab & Antoun (2022)	Lebanon	25	>25kg/m^2	Primary care clinics	Interviews	Thematical Analysis	Patients' knowledge and awareness of obesity are based on their own experience There is ambivalence or conditional acceptance of obesity as a chronic disease The role of physicians in obesity management is related to complications Obesity management is as simple as eating less and exercising more
Yunus et al., (2022)	Malaysia	22	≥27.5 kg/m^2	Primary care clinics	Interviews	Reflexive Thematic Analysis	Moving from perceiving the need to seek obesity care is a non-linear process

							Providers words can inspire patients to change Patients' needs and preferences are not adequately addressed in current obesity care Over focusing on weight by patients and healthcare providers can lead to self-blame and loss of hope for patients Obesity healthcare can have consequences beyond weight loss
Chugh et al., (2013)	US	33	>35 kg/m^2	Already enrolled in a parent Cervical/Cancer screening study	Semi-structured Interviews	Grounded theory Approach	Giving specific weight loss advice and individualized plans for weight loss Addressing weight in an empathetic, compassionate, nonjudgemental, and respectful manner Providing encouragement to foster self-motivation for weight loss
Gleinister et al., (2017)	Australia	7	Not reported	Health clinics	Semi-structured Interviews	Thematic analysis	Lack of effective treatment options Uncertainty about appropriate language Lack of time Concern about patient readiness Patients mental health
Allen et al., (2015)	UK	29	≥28 kg/m^2	Commercial weight loss program	Semi-structured interviews	Narrative Analysis	Accounts of usual primary care The GP letter The significance of receiving vouchers The value of clinical measurements Attending the commercial program as a patient trial participant
Brown et al., (2006)	UK	28	>30 kg/m^2	General Practices	Semi-structured Interviews	Thematic analysis	Levels of support Ambivalence and ambiguity Personal responsibility and stigma

							Attributing all problems to weight Avenues for development
Leske et al., (2012)	Australia	21	>25kg/m^2	Health Clinics & Radio	Semi-structured interviews	Grounded theory	Patient and practitioner characteristics Patient Collaboration Perceived power dimensions Openness Patient trust Relational trust Informational trust Credible trust Empowerment Goal ownership Perceived utility of changes
Ely et al., (2009)	US	31	>30 kg/m^2	General Practices	Focus Groups	Thematic analysis	Lack of support from primary care providers Primary care offices as community resources Lack of resources for promoting dietary change but adequate resources for physical activity The importance of group support and inclusiveness A need for more intensive interventions for weight control.

Theme One: Shaped by Experience: Patient Perceptions of Needing Care

This theme highlights how individuals living with obesity perceive their need for healthcare, which in turn influences their decision to seek support. Several factors were reported to influence this decision, including personal definitions of obesity, the emergence of comorbid conditions or decline in overall health, and expectations of care shaped by previous weight-related consultations. With healthcare increasingly focused on preventative measures, it is important to consider the factors that encourage or discourage adults living with obesity from seeking help.

Studies reported on how patients conceptualised obesity and how this influenced their decision to seek help. Some patients' viewed obesity as a disease that affects their overall physical health, can lead to chronic comorbid conditions and impacts their psychological wellbeing. Others expressed views in terms of satisfaction or dissatisfaction with their body image (Alarab & Antoun, 2022; Ragsdale et al., 2017). However, others were less able to link excess weight to specific medical conditions such as diabetes, hypertension, or high cholesterol. Some demonstrated vague recollections of how obesity was defined in terms of BMI or waist circumference (Alarab & Antoun, 2022), and were unable to accurately perceive their weight classification. For example, while many individuals identified themselves as overweight, the majority met the BMI criteria for obesity and had little understanding of what constituted a healthy or ideal weight (Ragsdale et al., 2017). This suggests that many individuals living with overweight or obesity had a limited understanding of the medical classification and health implications of excess weight. Instead, their perception of weight was based on how they viewed their body size and general health, rather than on clinical indicators such as BMI or the risk of comorbid conditions.

Views on health and healthiness appeared to influence individuals' perceived need for weight management. The concept of health was defined by how they felt, what they were able to do, and whether they had any chronic medical conditions (Buxton & Snethen, 2013). While individuals stated that they would not delay seeking healthcare when a problem was identified, there was general agreement that support would only be sought once the issue had developed (Yunus et al., 2023). Those who had developed a chronic condition, they appeared to be more cautious about their health and felt that its presence led them to take their healthcare 'more seriously' (Buxton & Snethen, 2013). This suggests that although individuals had an awareness of and perceived need for weight reduction, only a few actively sought healthcare for weight management (Ragsdale et al., 2017; Yunus et al., 2023).

Individuals held preconceived ideas about treatment that would be offered, which influenced their perceived need for weight management. Many believed weight-loss required greater self-control and willpower, framing it as a personal responsibility involving diet and exercise (Zevin et al., 2019). This suggests that people living with obesity often view it as a self-managed condition. Such beliefs can increase feelings of shame and self-blame, while also reducing the likelihood of seeking support from HCP, who may not be seen as responsible for offering weight management assistance.

Previous experiences of weight-related discussions with HCPs also influenced individuals' decisions to seek further help. Positive encounters encouraged motivation and engagement, while negative experiences reduced engagement with healthcare and increased the likelihood of discontinuing with services (Ragsdale et al., 2017; Wangler & Jansky, 2023; Ward et al., 2009). Discussions were viewed negatively when HCPs appeared to lack empathy, provided vague or unhelpful guidance, or were perceived as rude, arrogant, or insulting (Ragsdale et al., 2017; Wangler & Jansky, 2023). Some described a feeling of anxiety and fear when going

to see their GP about their health (Buxton & Snethen, 2013). This suggests that past interactions can leave a lasting impression on how individuals perceive future healthcare support and advice, either positively or negatively.

Theme Two: The Trusted Partner: Expectations of Primary Care

This theme highlights the role of PC and the expectations of HCP in supporting with weight management. Views differed on whether PC was best placed to address weight and provide treatment. This was influenced by whether obesity was seen as a chronic medical condition or a personal responsibility. Expectations of HCPs also varied, including who should initiate the discussion about weight and whether they should provide weight-related support or refer to external support services.

Studies reported differing views on whether PC was best placed to support adults with weight management (Brown et al., 2006; Ely et al., 2009; Wangler & Jansky, 2023). Supporters cited its accessibility, established patient-provider relationships, and role as a community resource (Brown et al., 2006; Ely et al., 2009). Others were ambivalent or disagreed. This seemed to be influenced by whether individuals viewed obesity as a medical disease (Zevin et al., 2019). Some did not see excess weight as a medical issue and considered seeking help in PC a burden on GPs, preferring external services (Allen et al., 2015).

This suggests that acceptance of obesity as a chronic condition may influence whether individuals see PC as appropriate for weight management. Individual perspectives varied, from agreement to ambivalence or outright rejection (Alarab & Antoun, 2022; Allen et al., 2015; Brown et al., 2006; Heintze et al., 2012; Ragsdale et al., 2017). Those who accepted obesity as a disease acknowledged genetic causes, related health risks, life impact, and possible need for medication. Those who rejected the view saw obesity as the individual's

responsibility, believing the notion to be offensive as it was a personal choice. Those who expressed ambivalence struggled to reconcile obesity as a disease with the need for personal control. They expressed a sense of personal responsibility for their size, questioning whether HCPs could help as they already knew what was needed in terms of behavioural change (Brown et al., 2006; Ragsdale et al., 2017). This further contributed to ambivalence about seeking support from HCP.

Interestingly, despite this discourse, many reported that it was the HCP's responsibility to initiate discussions and provide education on the health consequences of obesity most relevant to the individual (Ely et al., 2009; Ward et al., 2009; Yunus et al., 2023). In some cases, participants expressed the desire for HCP to raise the topic of weight and discuss the associated health risks before another health condition developed (Ely et al., 2009). One study explicitly highlighted the need for HCPs to invite patients into the discussion by asking whether they would like to talk about their weight (Ward et al., 2009).

For those seeking weight management, there were varying expectations regarding how their HCP could be actively involved. Expectations ranged from providing weight-related counselling, specific nutritional and exercise advice, setting weight-loss goals, offering motivation and encouragement to continue progress, and referring individuals to external services for further support (Allen et al., 2015; Brown et al., 2006; Ely et al., 2009; Ragsdale et al., 2017; Ward et al., 2009; Yunus et al., 2023). While some individual’s recognised the potential benefits of specific professionals, like dieticians, they were unclear about the role of general HCPs, such as GPs or nurses. As such, individuals felt HCP should only be involved when medication issues or comorbidities arose (Alarab & Antoun, 2022; Brown et al., 2006; Ely et al., 2009; Ward et al., 2009).

Theme Three: Treat me with Respect

Individuals with obesity emphasised the need for their HCP to treat them with respect during consultations. They wanted to be seen as a person, and felt respected when HCPs listened to their story, acknowledged barriers, addressed concerns, answered questions, and offered personalised advice to the individual's needs, preferences, and comorbidities. HCPs were seen as disrespectful when they focused solely on weight-loss, attributed all health problems to weight, offered vague advice, or were perceived as insensitive.

Many individuals expressed the need for their HCP to see them as a person, not just a number or as someone who is obese (Buxton & Snethen, 2013; Chugh et al., 2013; Ely et al., 2009; Ward et al., 2009; Yunus et al., 2023). They felt valued when their HCP took time to listen to their unique story, showed interest in their personal and health histories (Heintze et al., 2012), asked about their circumstances, and addressed their concerns (Buxton & Snethen, 2013; Ragsdale et al., 2017; Ward et al., 2009).

Understanding the individual's unique circumstances was also considered necessary for the HCP to offer tailored nutrition and activity advice and personalised weight management plans (Ragsdale et al., 2017). The intervention also needed to consider the individual's unique challenges and obstacles to weight loss, as many had unsuccessfully attempted to lose weight in the past, leading to a lack of motivation and hope for further attempts (Ragsdale et al., 2017). Individuals faced various challenges, including the high costs of a healthy diet, emotional eating, life changes, lack of mobility, low energy, balancing exercise with family demands, boredom with the same diet, external food temptations, and poor weight loss knowledge (Ragsdale et al., 2017; Yunus et al., 2023). Interventions also needed to consider mobility, comorbidities, age, and financial circumstances (Glenister et al., 2017). For women, unique challenges that needed to be considered included roles in caregiving, managing the home, and cooking for the family while working full-time (Ely et al., 2009). When pathways

were personalised to an individual's motivators and barriers, individuals reported an increased likelihood to apply the knowledge to their daily lives. This not only impacted their health but was also seen to increase their self-esteem and self-efficacy, reinforcing efforts to become healthier both physically and mentally (Yunus et al., 2023). General advice was deemed unsatisfactory (Wangler & Jansky, 2023), with individuals seeking concrete, actionable steps on how to achieve their goals (Chugh et al., 2013; Ward et al., 2009).

HCP communication skills were highlighted as important, with the tone of voice considered as important as the content. A respectful tone made individuals feel seen as a person, not just as someone with a disease (Heintze et al., 2012; Ward et al., 2009). HCP who demonstrated this were perceived as providing high quality care, boosting motivation, emotional wellbeing, and treatment engagement (Buxton & Snethen, 2013). The language used also mattered. Participants in Ward et al., (2009) expressed a strong dislike for the term "obese" due to its negative connotations and associations with discrimination. Few recognised it as medical terminology and preferred that HCPs avoid using it when discussing their health or weight.

Barriers were reported for individuals to feel respected by their HCPs, particularly when they were overly focused on weight-loss or attributed all health problems to weight (Brown et al., 2006; Glenister et al., 2017; Ward et al., 2009). While individuals recognised that their weight could impact their health, they expressed frustration when their primary complaint was overlooked and weight-loss suggested as the only treatment option (Ward et al., 2009). When specific advice was not offered, it was perceived as generalising the issue and grouping all individuals with obesity together (Chugh et al., 2013; Glenister et al., 2017).When individuals perceived their HCP to hold negative, stereotypical beliefs about obesity, such as viewing them as 'lazy' or lacking willpower, it led to feeling dehumanised (Wangler &

Jansky, 2023), frustrated (Ward et al., 2009), as well as a sense of being a burden on services (Buxton & Snethen, 2013).

Theme Four: The Security of a Trusting, Collaborative, and Caring Relationship

This theme emphasised the professional-patient relationship as a pre-requisite for open, honest discussions about weight. Patients were more likely to perceive difficult discussions positively if they felt the HCP genuinely cared about their health. Key factors facilitating this relationship included continuity of care, clinician characteristics and communication styles, perceived expertise, collaboration on treatment goals, and acknowledgment of even 'small' successes. When present, this relationship positively influenced individuals' efforts to make sustained lifestyle changes, engagement, and health outcomes.

There was an expressed desire for an established rapport with their HCP based on trust, collaboration, and a caring attitude. Individuals seeking support spoke of a strong bond of trust with their HCP (Heintze et al., 2012). Leske et al., (2012) reported that trust developed through relational and informational trust. Relational trust was based on the HCP's character and interpersonal skills, while informational trust was based on the belief in the HCP knowledge and advice. This trust enabled individuals to feel more comfortable sharing sensitive, often shameful information about their lifestyle habits (Glenister et al., 2017; Heintze et al., 2012) and reduced anxiety when visiting their HCP (Buxton & Snethen, 2013). Trust built through continuity of care also allowed HCP to notice weight changes. When clinicians commented on these changes, it increased the individual's pride and motivation to continue their weight-loss efforts (Banerjee et al., 2018; Ward et al., 2009). A lack of continuity with HCP was described as confusing and unhelpful, with multiple doctors repeating the same advice (Banerjee et al., 2018). The established relationship also moderated

the perception of insensitive comments from HCP (Banerjee et al., 2018; Buxton & Snethen, 2013; Chugh et al., 2013).

A collaborative relationship was developed throughout the consultation, where individuals felt able to contribute and express their preferences on treatment options (Buxton & Snethen, 2013; Leske et al., 2012). Power dynamics influenced collaboration, with patients expressing a desire for equity of power. This was established when the HCP provided open, honest information and rationales, empowering individuals to make informed treatment decisions (Leske et al., 2012). It also involved mutually agreeing on weight loss goals, realistic timeframes, and negotiating outcomes (Ely et al., 2009; Leske et al., 2012; Ragsdale et al., 2017; Wangler & Jansky, 2023), encouraging individuals to assert their treatment preferences (Buxton & Snethen, 2013; Leske et al., 2012; Yunus et al., 2023). This was especially important when considering culturally or religiously relevant weight management interventions (Yunus et al., 2023).

A caring relationship was built when HCPs were personable, took an interest in lifestyle changes, and showed compassion (Buxton & Snethen, 2013). HCPs who facilitated this environment were seen as going out of their way to demonstrate care (Chugh et al., 2013). This was influenced by whether HCPs possessed qualities such as empathy, trustworthiness, compassion, non-judgment, encouragement, honesty, and sensitivity (Buxton & Snethen, 2013; Chugh et al., 2013; Heintze et al., 2012; Ward et al., 2009). Personal qualities like thoroughness and genuine concern for wellbeing were also valued (Heintze et al., 2012; Ward et al., 2009).

Theme Five: Promoting Ownership, Not Stigma

This theme highlights the delicate balance HCP must maintain in encouraging individual ownership for lifestyle change while avoiding stigma and discrimination. Studies highlighted that individuals believed weight management was their personal responsibility (Alarab & Antoun, 2022; Allen et al., 2015; Brown et al., 2006; Ragsdale et al., 2017). Beliefs ranged from obesity being a personal choice (Alarab & Antoun, 2022), caused by a lack of self-control (Yunus et al., 2023; Zevin et al., 2019), to needing strong willpower for success (Yunus et al., 2023). The impact of these beliefs varied. For some, they contributed to internalised negative stereotypes and increased shame (Brown et al., 2006). For others, recognising personal responsibility helped motivate and empower individuals to make informed decisions, build self-efficacy, and increase belief in their ability to succeed (Banerjee et al., 2018; Leske et al., 2012; Yunus et al., 2023).

It was recognised that individuals needed support from their HCP to develop the motivation required for weight management (Banerjee et al., 2018). Individuals valued HCPs acknowledging small weight losses and positive behaviour changes (Banerjee et al., 2018; Ward et al., 2009). The language used during consultations could also inspire change, with individuals desiring personalised invitations, open discussions, and treatment options with rationales (Allen et al., 2015; Leske et al., 2012; Ward et al., 2009). This helped with goal ownership, empowering individuals to set meaningful and realistic goals. Such interactions with HCPs were seen as empowering, increasing individuals' readiness to embrace change (Ely et al., 2009; Ragsdale et al., 2017).

However, HCPs needed to assess whether the individual was ready for weight management (Ward et al., 2009). For those who were not ready, advice or referrals to external services were perceived as ineffective (Zevin et al., 2019), with individuals feeling coerced into changing behaviour (Yunus et al., 2023) and blamed for their inability to control their weight

(Alarab & Antoun, 2022). Repeated attempts to counsel were perceived as ‘hounding’ and ‘harping on,’ which negatively impacted both confidence and willingness to change (Ward et al., 2009).

Thus, there is a delicate balance between HCP motivating individuals without blaming them for their weight. For example, scare tactics used by HCP polarised individuals on whether they were motivating or stigmatising. Some found them motivating (Banerjee et al., 2018; Yunus et al., 2023), while others perceived them as intimidating, offensive, and counterproductive (Glenister et al., 2017; Ward et al., 2009). The perception of such tactics often depended on their delivery. If framed positively, tailored to the individual's health condition, and presented in a caring manner, the advice was seen as motivating and empowering (Yunus et al., 2023). However, many reported HCP insensitively expressed health risks, leading to frustration, anger, and reinforced ambivalence and shame in using services (Glenister et al., 2017; Ward et al., 2009).

Studies also reported experiences of weight-stigma and negative stereotypes from their HCP. Alarab & Antoun (2022) participants described being fat-shamed by their HCP, feeling blamed for their inability to control their weight. HCPs who viewed obesity as a lack of control or willpower were seen as insensitive to the broader aspects of the individual's situation (Buxton & Snethen, 2013). This resulted in reported increased dissatisfaction and distrust in the service (Buxton & Snethen, 2013) and increased feelings of hopelessness, dejection, and futility (Ward et al., 2009; Yunus et al., 2023). Some individuals felt isolated in their weight struggles (Wangler & Jansky, 2023), reducing their motivation to pursue weight-loss (Glenister et al., 2017). This was also linked to a higher likelihood of avoiding future care and ending the relationship with their HCP (Alarab & Antoun, 2022; Ward et al., 2009).

Theme Six: Navigating the Limited Scope of Care

This theme highlights the perceived limitations in current PC practices in supporting adults who want to discuss their weight and seek weight management support. Barriers to care include HCP practices during consultations, systemic challenges in PC, and a lack of evidence-based, effective resources and treatment options. The current system often left individuals feeling isolated, demotivated, ashamed, and dismissed by the HCP they believed could support them on their weight-loss journey.

Studies highlighted several challenges during interactions with HCP about weight. In some cases, discussions were described as brief and off-handed (Ely et al., 2009; Wangler & Jansky, 2023). Glenister et al., (2017) reported that some individuals' GPs had never weighed them, or if they were weighed, the results were not communicated clearly. In the absence of clear explanations, participants often filled in the gaps themselves, usually imagining the worst. A lack of in-depth discussions about the link between obesity and comorbid conditions delayed obesity diagnosis until comorbid conditions had developed (Ely et al., 2009; Wangler & Jansky, 2023). Additionally, some doubted HCPs' ability to diagnose and manage obesity due to perceived gaps in training and knowledge (Chugh et al., 2013; Ely et al., 2009).

Studies reported a perceived lack of weight management support from HCPs. The most common experience was HCPs pointing out weight as a problem without providing ongoing counselling, set weight-loss goals, or provide adequate advice to achieve such goals (Allen et al., 2015; Ely et al., 2009; Wangler & Jansky, 2023). There was also a lack of referrals to external support, leaving individuals frustrated with the lack of actionable guidance (Brown et al., 2006). There was also a perceived lack of evidence-based weight-loss interventions with a desire for greater dietary (Ely et al., 2009) or activity-based resources (Wangler & Jansky, 2023). Overall, there was consensus on the need for more intensive interventions that offered regular support, encouragement, expertise, and accountability in weight loss efforts.

Organisational challenges in PC included a lack of time and financially viable treatment options (Brown et al., 2006; Ely et al., 2009; Glenister et al., 2017; Zevin et al., 2019). Time constraints were seen as a barrier to in-depth conversations about weight, the desired guidance and providing continuity of support (Brown et al., 2006; Glenister et al., 2017). Restrictive time slots also left participants feeling dismissed or that their weight-related issues were downplayed. The cost of weight management services was another barrier, with participants unable to afford services, gym memberships, or healthy food (Glenister et al., 2017; Ragsdale et al., 2017; Zevin et al., 2019). This led to frustration and reduced motivation to pursue weight loss support.

1.5 Strengths and Limitations

This meta-ethnography examined studies from seven countries, and despite the variations in healthcare services, consistent themes were identified. While the findings offer valuable insights into the patients' experiences of PC for weight management, they have limited generalisability. For example, the sample was predominantly female, with limited reporting on participants' ages and obesity classification. It is possible that those classified with class I, II or III obesity may have different experiences of consultations, and the treatment options offered (NICE, 2014, 2023). Future research should explore how gender, age, and obesity classification affect the consultation process and treatment options in PC.

1.6 Rational for Research Aims

The findings from this meta-ethnography suggest individuals living with overweight and obesity often expect HCP in primary care to initiate discussions about weight. Within the theme, *Shaped by Experience: Patient Perceptions of Needing Care*, individuals expressed that they would only seek help from an HCP when a problem had emerged or when they

perceived a deterioration in health, but would rely on the HCP to initiate the discussion. These findings align with assumptions in many theoretical models of health behaviour, which suggest that the awareness of obesity and deterioration in health are strong predictors of the need for help (Bunt et al., 2017; Ciao et al., 2012; Steenhuis et al., 2006). However, there is a growing concern that the higher prevalence of overweight and obesity may contribute to visual normalisation, which may undermine the recognition of being overweight, delaying seeking help from healthcare services (Muttarak, 2018). This has several implications for HCP, who are responsible for raising awareness of a patient's weight, associated comorbid conditions and providing clear, personalised treatment plans (NICE, 2025). As many participants only sought support after a health issue had developed, HCPs may need to consider using existing comorbidities to initiate the discussion regarding weight, where appropriate and with patient consent (Ciao et al., 2012).

The Trusted Partner: Expectations of Professionals explored differing views on whether PC is the appropriate setting for obesity-related discussions and treatment. This theme highlighted the tension between framing obesity as a medical condition requiring PC intervention and as a personal choice, placing responsibility for individuals to manage themselves (Farrell et al., 2021; Grannell et al., 2021; Hofmann, 2001). Those with a strong sense of agency over their weight, are shown to be more inclined to pursue self-guided approaches rather than professional help (Ciao et al., 2012). However, the narrative of personal responsibility is often linked to stigmatising assumptions about people with obesity (Puhl & Heuer, 2009). Interestingly, studies revealed that many individuals viewed obesity as a personal responsibility, created uncertainty about whether primary care could support weight management. This uncertainty can increase HCP own ambiguity of their role in weight management, leading to a perceived lack of authority in this area (Henderson, 2015).

Although opinions varied on the role of PC in delivering weight management treatment, the final four themes emphasised the individuals' experiences with HCP, including the perceived facilitators and barriers to weight-related discussions and accessing treatment. Individuals expressed the desire for HCP to ask whether it was appropriate to initiate a discussion regarding health and weight. It may be helpful for HCP to begin such conversations with an invitation, which the individual can either accept or decline (Ragsdale et al., (2017). Many were keen to discuss weight with their HCP but wanted their HCP to see them as unique individuals with rich backgrounds, rather than being solely defined by their weight or BMI. Thus, highlighting the need for HCPs to conduct a thorough assessment, asking exploratory questions about their daily lives and the unique challenges they may face. Current guidance remains unclear on the best way for HCP to link a person's weight to their health (Ananthakumar et al., 2020), but evidence suggests that a focus on health and wellbeing including nutrient-rich diets, engaging in regular physical activity, ensuring sufficient sleep, and emotional wellbeing may support HCP in these discussions (Westbury et al., 2023).

Furthermore, *Security of a Trusting, Collaborative and Caring Relationship*, was described as a necessary for having the open and honest discussions about weight with their HCP. When present, it appeared to moderate the impact of potentially uncomfortable or insensitive communication about weight. Patients were more likely to perceive difficult discussions favourably if they felt the HCP genuinely cared about them and was concerned for their health. Individuals also expressed the need for HCP to encourage ownership and motivation for behaviour change, while avoiding the perpetuation of stigma and blame. This required the HCP to assess readiness for change, as if an individual was not ready or willing, attempts to motivate could be perceived as coercive and counterproductive to weight-loss efforts.

Finally, theme six, *Navigating the Limited Scope of Care* emphasised the barriers present in current primary care practises. While pointing to the need for more comprehensive, individualised and effective treatment options offered by HCP, the restrictive time slots and financial costs present were perceived to leave the individual feeling isolated, demotivated, and dismissed by the HCP.

While this evidence suggests adults living with obesity view HCP weight management efforts favourably, the available research suggests HCP feel inadequately educated regarding appropriate language to use and treatment options available, with many unfamiliar and uncertain regarding the field of obesity management (Metcalf et al., 2017). While this review explored the individual living with obesity's perspective it is important to consider the HCP own views on the discussion and treatment options available. Thus, the combined results of this study may begin to bridge the gap between policy, research, and practice, supporting the delivery of effective initiatives and practical solutions in obesity management.

Research Aims

The results of the literature review suggest that individuals living with obesity perceive primary care staff to have an important role in initiating weight related discussions and offering weight management, although there were some variances in how this could be achieved. Indeed, this places HCP in a position to offer weight-related support. Yet HCP weight management practice may be influenced by a wide range of factors, including political, cultural, historical, and organisational ones (Hunter et al., 2014). Therefore, it is important to understand HCP's views on the discussions they have with adults living with obesity and what they feel influences their decision-making. The primary aim of this qualitative study is to explore how HCP conduct the discussion with adults living with

obesity, from the stage of referral to treatment. Secondary aims were to explore any factors that might influence staffs' ability to work effectively with this population.

Methodology

2.1 Epistemological Positioning

Epistemology is the theory of knowledge and requires examining the nature of the 'known' world. With philosophical underpinnings, it is concerned with understanding 'how and what can we know' (Ormston et al., 2013). This research adopts a critical realist epistemology which is primarily focused on understanding social realities. Critical realism emerged through the work of philosopher Bhaskar, (1975) who stated that the evidence we observe brings us close to a 'reality', but this is always an imperfect, social and subjective account (Sturgiss & Clark, 2020). It positions itself as an explanatory approach, in that we should seek causal explanations of phenomena but cautions that these are an individual's 'account of reality' (Bhaskar, 2008). Critical realism draws upon the distinction that ontology (i.e. what is real) is not reducible to epistemology (i.e. our knowledge of reality), treating the world as theory-laden, but not theory-determined (Fletcher, 2017).

Research into primary care occurs within an observable social reality. It is embedded in how people and their actions influence the multiple interconnected parts of a social system and how each part of such a system and its patients are influenced by the actions of people (Sturgiss & Clark, 2020). Critical realism is considered to be a promising paradigm for studying primary care as it encourages researchers to look beyond surface appearances to search for the underlying process that counts for natural and social phenomena (McEvoy & Richards, 2003).

Thus, by adopting a critical realist paradigm, it suggests researchers are situated and partial knowers, whose claims are inescapably mediated by available conceptual resources but equally, are committed to making ontological claims about what happened and what works (Moore & Kelly, 2024). It maintains that there is a 'reality' that exists largely independently of our experience of it, thus policies, cultural influences and relationships do exist and can have causal effects on events in the social world, regardless of whether we are aware of them or what we think about them (Bhaskar, 2008). Furthermore, the search for causal reasoning can help researchers to explain social events which can then inform policy and practice (Fletcher, 2017). This fits with the present research aim, which seek to develop a generalisable understanding of HCP consulting with those living with obesity and the decision-making process involved in treatment decisions.

Seeking to qualitatively understand the practices of HCPs working with those living with obesity has usually been divided by two poles. If this research assumed a realist/positivist pole, it would specifically focus on obesity as a biomedical fact, pathologising adiposity and drawing attention to the individuals eating and exercise behaviours. Such an approach views obesity as an epidemic to be fought, offering individualistic solutions to weight gain through willpower and lifestyle changes (Kanagasingam, 2022). The constructionist pole asserts that obesity is socially engendered rather than a pre-existing truth, focussing on how obesity is produced through politically motivated discourse and specific cultural values (Patterson & Johnston, 2012). This pole focusses on the role of social stigma of bigger bodies and adopts a critical view of obesity as moral panic driven by political interests and cultural values.

However, Patterson & Johnston (2012) emphasise the need for a hybrid perspective, allowing the integration of both medical and cultural perspectives to understand body weight. The critical realist perspective integrates and accepts the impact that these two interacting systems

have on an individual. By adopting this position to the research, it allowed the assumption that our knowledge of an external world consists of subjective interpretations that are informed by the context the individual experiences (McEvoy & Richards, 2003). This would allow for an understanding that obesity is a 'reality' within the NHS and can be defined. However, obesity cannot be reduced to any one of its constituent parts (biology or culture) but acknowledges the range of mechanisms that modify the effects of weight on the individual (Kanagasingam, 2022). It also acknowledges individuals hold different meanings and beliefs about this which will impact how they interact with the experiences and issues that result from living with obesity. For example, it allowed for the focus of both social stigma and medical conditions, such as diabetes and how this impacts the HCP interactions with patients, rather than the exclusion of one.

2.2 Design

This research used a qualitative research design, where participants were interviewed using a semi-structured interview schedule. Qualitative research is designed to explore individual subjective experiences and/or attitudes towards certain phenomenon. It usually rejects a positivist approach, favoured by quantitative research which is concerned with the study of a universal objective reality (Kivunja & Kuyini, 2017). Instead, qualitative research is more interested in examining the personal meanings and subjective interpretations of each participants conceived 'reality' (Barker et al., 2016).

As such, HCPs may have varied interactions with adults living with obesity and thus provide different treatment options based on their own subjective experiences in which these arise, which can be explored using semi-structured interviews. A distinguishing feature of critical realist science is its commitment to achieving a better grasp of the 'reality of the social world' by asking epistemological questions on how people make sense of things (Moore & Kelly,

2024). Thus, the semi-structured interview was designed to understand what has influenced the participants view of working with people living with obesity from the discussion to treatment options. The data generated from such interviews are seen as socially constructed, that does not sit apart from the complex open social world but are social events within that same world (Kanagasingam, 2022). In other words, the interview data can be understood as co-constructed interactions between the lead researcher and participant, but the data generated is evidence of experiences and processes (Moore & Kelly, 2024). This practice would allow the researcher to make inferences about HCP consultation practices, which can then be further explored in future research (Moore & Kelly, 2024).

A qualitative research approach was chosen as it was felt to be more congruent with the aims of the current study. Experiences, events and causal mechanisms are three concepts thought necessary for qualitative research in line with a critical realist epistemology (Bhaskar, 2008). *Experiences* are the perceptions and feelings of participants as they work with adults living with obesity. *Events* are the mechanisms experienced; the consultation process itself including the discussions held and treatment offered. *Causal mechanisms* produce the event i.e. they cause the event to occur. Thus, the second research aim was focussed on the influences on staff and how they may shape the participants interactions. Its nature is considered exploratory and would seek to explain the ‘how’ and ‘why’ a particular phenomenon operates as it does in a particular context.

Alternatively quantitative research, which is grounded in the positivist ontology, concentrates on the testing of hypothesis to generate patterns and produce predictions about particular phenomenon. Such a design might have used a scale survey to examine HCP’s attitudes of weight-loss treatments. However, using such an approach might have failed to capture the rich detail of HCP’s experience of working with adults living with obesity, as it does not go

beyond the boundaries of what can be observed and downplays any gap between the nature and our experience of the world (Kivunja & Kuyini, 2017). Qualitative research is necessary for the advancement of health research as it offers the best chance of producing transformative knowledge on the subjective experience of human realities (Sandelowski, 2004), although it has been argued that without following evidence-based guidance, qualitative research cannot always provide generalisable results (Sandelowski, 1997).

2.3 Procedure

This study worked with the National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN) to recruit eligible participants. Working with the lead NHS trust's local CRN, the CRN disseminated details of the research to all Primary Care Network's under the lead trust's area. The CRN dissemination included directly emailing all employees with the research recruitment poster (see Appendix B) or displaying an advert in their monthly communications newsletter or staff employment sites. After no responses from possible participants, the local CRN then shared the study nationally.

Those interested in taking part in the study contacted the lead researcher directly via email, who then responded with further details of the study including the participant information sheet (PIS, see Appendix C), screening and demographic form (see Appendix D) and consent form (see Appendix E).

Upon enrolment, participants were asked to complete a Screening and Demographic Form (see Appendix D). Eligibility was based on whether participants had worked with adults living with obesity from referral to treatment. HCPs who were currently in training were also eligible. Any participant who did not have experience of working with adults living with obesity was ineligible to take part. If eligible, participants were asked to enter their

demographic data, including the participants' age, sex, ethnicity, current profession and how long they had been working in their position (see Appendix D).

Participants were invited to an interview at a mutually agreed time and date. Interviews were conducted between July 2024 and November 2024. All fifteen interviews were conducted online via MS Teams, lasted 60 minutes and were digitally recorded. At the start of each interview informed consent procedures (see Appendix E) were reiterated, including their ability to withdraw from the study at any time. A debriefing session at the end of the interview was offered to provide an opportunity to ask any questions and give feedback on the interview process.

All data was stored on a secure password-protected NHS server compliant with current data protection regulations (Data Protection Act, 2018; General Data Protection Regulations, 2018). Participant data was given a pseudonym, and each document was password protected. The lead researcher transcribed the audio recordings within a timely fashion, at which point the interview audio recording was deleted. The transcribed data would be stored securely for five years if questions were raised about the research findings and consultation was with the raw data. Participants who had consented to future contact (see Appendix E) were emailed if they would like to receive a copy of the results.

2.4 Participants

The sample size for this research was 15 HCPs. The views of all professions employed in primary care was sought, including GPs, nurses and, through the additional role reimbursement scheme, physiotherapists, physician associates, dietitians, nursing associates, social prescribers and health and wellbeing coaches. In qualitative research, the sample size is usually recognised to be small, but 15-25 participants were considered adequate to identify

patterns and themes that may be present within the data collected (Clarke & Braun, 2013). The adequacy of the sample size was determined by data saturation, which is the criterion for judging when to stop sampling as additional data fails to generate any new information. This is dictated by the judgement and experience of the researcher (Tran et al., 2017). However, due to the nature of this thesis report, data collection was stopped after 15 interviews and was satisfied during the coding process where no new codes were generated at the 15th interview (Guest et al., 2020).

2.5 Data Collection

The semi-structured interview schedule (see Appendix F) was developed by the lead researcher and was used to ensure all aspects of the topic were covered, guiding the conversation but not administered rigidly. The schedule was informed by the two research questions and designed to understand the HCP's practice when working with adults living with obesity from referral to treatment. It also contained questions to elicit the HCP's own beliefs, clinical knowledge and interest in supporting this population and how this might impact their practice with this population.

Following guidance from Barker et al., (2016), the initial interview questions were designed to be kept general and build rapport with participants. Rapport between the interviewer and interviewee was deemed important for follow-up questions to be asked that clarify meaning and probe for deeper and richer responses (Braun & Clarke, 2019). It also allowed for enough information to be gathered to make judgements about the validity of the respondent's self-report (Barker et al., 2016). The questions were designed to be open-ended, non-leading and clear, precise, simple and unambiguous (Braun & Clarke, 2022). However, the open-ended nature of semi-structured interviews can result in leading questions. There is always a relational aspect of qualitative research, which is produced in the act of affecting and being

affected by another person (Bispo Júnior, 2022). It is possible that the language chosen by the lead research, such as adults' living with obesity, highlighted the views and perspectives of the researcher thus, influencing how the GPs responded to the questions in the interviews.

The draft interview schedule was reviewed and refined by the thesis supervisor and secondary supervisor (a Registered Nurse Practitioner working in the field of obesity). The interview schedule was piloted with the first few participants to evaluate the quality of information elicited and assess the overall structuring of the interview. It was also used to gauge the participant's experience of responding to these questions and whether any changes to the interview schedule needed to be made. The first five participants felt the questions were clear and did not offer any feedback that suggested the questionnaire needed to be refined further.

2.6 Data Analysis

The data was analysed using reflexive thematic analysis (TA) as described by Braun & Clarke (2006, 2019, 2022). TA was chosen as it emphasises an exploratory and creative process, whereby the findings evolve through the researcher's systematic process of data coding to develop themes (Braun & Clarke, 2022). TA can be applied across a range of different theoretical and epistemological approaches as it is independent of specific theories and epistemologies (Braun & Clarke, 2006). This research sought to understand HCP's views, perspectives and consultation behaviour and whether there were any shared influences and/or patterns in the consultation process and treatment offered. Reflexive TA involves the practice of critical reflection on the role of the researcher, the research practice and process, to develop, analyse and interpret patterns across a dataset (Braun & Clarke, 2022). These elements fit with the aims of this research and thus reflexive TA was chosen.

The research considered using other analytical approaches to the data analysis including grounded theory (Glaser, 1992) and Interpretative Phenomenological Analysis (IPA; Smith et al., 1999). Grounded theory sets out to discover or construct a new theory from the data set (Chun Tie et al., 2019). Whilst this research wanted to identify themes in the data it was not seeking to derive a new theory from the research. IPA involves the detailed examination of an individual's life world and how they make sense of their personal and social world (Smith & Osborn, 2003). This approach was not considered appropriate, as it sought to explore the shared practice of many HCPs, rather than the detailed examination of a few. Furthermore, the focus of this research was to understand HCP's practice, perspective and behaviour when working with adults living with obesity rather than their own subjective experience of weight. Finally, the lead researcher considers themselves to be a relatively inexperienced in qualitative research and TA is considered to be an easily accessible method of analysis for beginners (Braun & Clarke, 2019).

The approach to data analysis followed Braun and Clarke (2006) six phases of TA. Familiarisation of the data involved the lead researcher's immersion in the data. This was enabled by the initial collection of the data set, listening to the audio tapes, transcription of the interview and then reading and re-reading the transcripts. At this stage full verbatim was used, where transcription accurately captured the spoken content including every filler word and repetition.

Coding involved the production of initial codes (Appendix H). The codes were selected if they identified an interesting feature in the data that organised it into meaningful groups. Using Microsoft Word, the transcript was placed into a two-column table. The first column held the transcript and the second held the corresponding code. I ended up coding the dataset twice. The first set of codes labels were too specific to the transcript. The second attempt at

coding, allowed the codes to be refined. They were kept broad, could be grouped and checked for no overlapping or repeated code.

The third phase involved searching for themes. This was where the interpretative analysis of the data occurred. At this stage, the researcher had a long list of codes identified which were printed, cut out and then organised into theme piles (Appendix J). At this stage, no codes or potential themes were abandoned as it was uncertain whether the themes needed to be combined, refined, separated or discarded.

In the fourth phase, reviewing themes, a set of candidate themes had been identified. The entire data set was re-read to make sure the themes 'worked' and to code any additional data that might have been missed in the earlier stages. By the end of this stage, a final thematic map of the data was produced. This led to the fifth phase where the themes were defined and named in a way that captured the essence of the data. On occasion, the name of the themes were slightly amended to better explain the data and fit the overall 'story'.

The final phase involved producing a concise, coherent and logical account of the data presented. The final report included extracts that were vivid examples deemed to capture the essence of the theme and made a compelling account of the argument. It was at this stage that smart verbatim transcription was used to edit the extracts and produce a more concise version of the content.

This study predominately used an inductive approach as themes were derived from the data provided by participants (Braun & Clarke, 2022). Both a semantic and latent approach were used when analysing the data, where themes were produced from the explicit meaning in the data and beyond the data, to the underlying ideas and assumptions that may inform the participant's view (Braun & Clarke, 2006).

Central to TA is the researcher's reflexivity. Reflexivity involves a practice of critically interrogating what is done as a researcher, and the impact this has on the research (Braun & Clarke, 2022). As such, the lead researchers own personal, philosophical and theoretical assumptions inform the research. To guide this, the lead researcher engaged in a reflexive journal to reflect on the personal aspects of self, life experiences, research knowledge and training and how these shaped engagement with the research (Braun & Clark, 2022). The method of a 'critical friend' was employed to encourage reflexivity by challenging the construction of themes presented (Costa & Kallick, 1993). The researcher approached individuals outside of the academic environment, who encouraged the researcher to make their thought processes explicit and aided in the reflexivity required (Finlay, 2002).

Triangulation was also considered, where multiple methods, sources and/or investigators are employed to increase the validity and transferability of the results (Farmer et al., 2006). The study recruited various HCPs who had experience working with adults living with obesity. Each profession would have had different qualifications, training options available, professional guidelines, roles and experiences that would contribute to their decision-making process for treatment. Investigator triangulation is where multiple researchers aid in the analysis of the data which reduces the risk of observer bias. The lead researcher was responsible for the data analysis, and the research supervisors then checked and agreed upon the final themes drawn.

2.7 Researcher Reflexivity Statement

I am a 35-year-old white British, able-bodied, female, currently in training on the Clinical Psychology Doctorate. I grew up watching the women in my family struggle with their weight post childbirth and have seen all try various diet fads over the years, with some undergoing weight-loss surgery, whilst also maintaining a full-time job and being a mother. I

live in a ‘normal sized body’ and was raised to prioritise a balanced diet and encouraged to engage in exercise. I also do not have children. Living in an able body has meant I have been privileged to be able to maintain a reasonably ‘healthy’ weight. However, I have always felt ambivalent towards strict and extreme ‘dieting’ as I have not seen these to be successful for those in my family who have engaged in such measures.

Across 13 years of working within the mental health service, I have also worked with clients who have lived with obesity. Clients have struggled to manage their weight for a variety of reasons including, depression, comfort eating, low self-esteem, medication side effects and physical health difficulties. One client I supported had been diagnosed with Class III obesity after being placed on Olanzapine (an antipsychotic medicine with known side effects of weight gain and increased appetite). After a year of being discharged from our service, we were informed they had passed away in their sleep due to obesity-related symptoms. This experience shaped my belief that individuals should not be held solely responsible for their weight, nor expected to manage it through motivation and willpower alone, particularly when other contributing factors (such as medication) are beyond their control.

These experiences sparked my initial interest in the topic area and so will undoubtedly inform multiple elements of the research. I have an ‘insider’ perspective where I have watched the woman in my family struggle with their weight and also been a HCP working with adults living with obesity. However, I am also an outsider, in that I live in a ‘normal’ sized body and given this, it has been imperative that I reflect on my assumptions, biases and judgments about what it means to be an HCP supporting adults living with obesity.

2.8 Ethical Considerations

The research was approved by the Health Research Authority [REC ref: 23/HRA/4451; Appendix K] and the University of Essex, Research Ethics Sub Committee [ETH2223-1216; Appendix L].

Informed Consent

Signed informed consent was gained from each participant before the interview commenced (see Appendix E). As the interviews were conducted online, participants were asked to email an electronically signed consent form to the researcher to ensure participants understand the research conducted and the possible risks it may entail (Manti & Licari, 2018). Every participant was provided with a PIS to ensure they could make fully informed decisions on their participation (see Appendix C). Due to the nature of qualitative research, informed consent could only be given to the broad aim of the research because it is often unclear exactly what the results will be (Clarke & Braun, 2013).

Confidentiality

Confidentiality refers to the participant's right to anonymity, (Barker et al., 2016). After each interview, the audio file was encrypted on an NHS laptop and once transcribed it was deleted. All participant documents were stored as password-protected documents and any identifiable information removed from the transcripts. Participants were made aware that only the researcher and research supervisors would have access to the data files during the research process and kept securely for five years. Participants were provided with a pseudonym to maintain anonymity. This was assigned to their transcripts, demographic data and sections of monologue used in the final report. Qualitative research uses sections of participant monologues which makes anonymity more difficult (Clarke & Braun, 2013). When writing

up the results, the researcher was sensitive to the quotes included, how they may break the anonymity and whether the quote was necessary to use.

Risk of harm

A risk assessment was conducted and revealed a low risk to the lead researchers and participants' welfare in taking part in the study. Participants may have wished to reflect on emotive experiences or discuss beliefs, assumptions or biases that may elicit shame. However, all participants were briefed in the PIS on their right to privacy and to withdraw from the research at any time. The researcher also monitored the level of distress throughout the interviews and a debriefing space at the end of the interview was offered. However, no participant accepted this invitation. In regard to the lead researcher's welfare, all interviews were conducted remotely minimising lone working risks. The risk of fatigue and the emotional response of listening and carrying emotive topics, was mitigated by their training as trainee clinical psychologist. Monthly supervision was also used to with academic supervisors.

2.9 Quality Assurance

This research was guided by the Consolidated Criteria for Reporting of Qualitative Research (COREQ, Tong et al., 2007). It is a valuable tool for researchers to report on important aspects of the research, study methods, context of the study, findings, analysis and interpretations (Peditto, 2018). The checklist consists of 32 criteria (Appendix G) but for the nature of this report, two items will be discussed.

Domain 1: Research team and reflexivity: There was no prior relationship between researcher and participant at the beginning of the interviews. Inherent in the activity of information gathering is the researcher's commitment to establishing a personal connection with

participants, building trust, respect, consent, a sensitivity to power relations and the co-construction of knowledge (Prior, 2018). The interview-schedule was organised to build rapport in the first few questions, with simple open-ended questions exploring their role in supporting people living with obesity. Participants were encouraged to be frank from the outset and questions asked were not always asked in the same way, adopting a natural and authentic approach by asking the 'topic question' when this came up in the participants narrative. This might have meant that the question may have meant different things to different people, or in some instances, required the exploration of topics that resonated with the interviewee, rather than prescriptively following the interview-schedule. However, listening back during the transcribing process this method appeared to facilitate reasonably informal conversations that avoided making participants feel interrogated and allowed participants to reflect and share their stories at their own pace.

Domain 3: Data Analysis: The lead researcher was the primary coder of the data. Overall, the themes were derived from the data, rather than identified in advance. However, with some subthemes, such as *'the omnipresence of weight stigma'*, the researcher had come into the interviews with the expectation that interviewee would discuss the presence of weight stigma. This required an exploration of whether the theme was present in HCP narratives. However, as this was not a specified question asked and came out naturally in participants narratives, the theme was kept.

Results

3.1 Participant Demographics

Twenty-four primary care staff initially expressed interest in participating in the research. Of these, fifteen took part. Of the nine who were not interviewed, seven did not respond to

follow-up communication, one requested no further contact, and one failed to attend their scheduled interview without further explanation. Participant demographic information is presented in Table 3. To protect anonymity, especially among individuals working in the same team, the data has been grouped and tallied into categories.

The sample included a range of roles within primary care services, with an average time in post of 17 years and 3 months. The sample was predominantly female, with only three male participants. While no firm conclusions can be drawn about the low male participation rate, such a sample distribution might reflect the gendering of weight management as a feminist issue.

Table 3

Participant demographics

Demographic	**Category and Number of Participants (N)**							
Job Title	General Practitioner N = 5	Advanced Nurse Practitioner N = 2	Nurse Practitioner N = 2	Health & Wellbeing Coach N = 3	Clinical Pharmacist N = 1	Pharmacist Prescriber N = 1	Dietician N = 1	
Time in Service (Years)	0 – 5 N = 4	6 – 10 N = 2	11 – 15 N = 1	16 – 20 N = 1	21 – 25 N = 1	26 – 30 N = 3	31+ N = 2	N/A N = 1
Ethnicity	White British N = 8	White Eastern European N = 1	Pakastani N = 1	British Indian N = 1	Hindu N = 1	Mixed White & Black Caribbean N = 1	Mixed Asian British N = 1	N/A N = 1

Age	25 -34	35 – 44	45 – 54	55 – 64	65 +	N/A
	N = 3	N = 4	N = 3	N = 3	N = 1	N = 1
Gender	Female	Male				
	N = 12	N = 3				

3.2 Researcher Reflexivity Statement

When I reflect on my experience of the participant interviews, I often felt confused about the most appropriate language and the role of HCP in supporting adults living with higher weight. I believe this confusion was driven by several factors, including my own implicit biases, the fear of causing harm to this population through stigmatisation or discrimination, cultural and societal norms regarding body weight and health, and the expectation placed on professionals to help people with weight-loss. I realise this confusion was also mirrored by the participants I interviewed. They spoke of the limited training available to support people, with current guidelines described as outdated and unclear, and consultations guided by intuition and experience. However, I do believe I sensed their compassion and desire to support all those attending, with each participant engaging in the interview to help develop our understanding of this area.

I wondered how my position as a clinician and Trainee Clinical Psychologist influenced the interviews. I considered whether there were perceived similarities as 'professionals', which might have made participants feel safer in expressing their views and speaking freely about their experiences working with this population. However, in several interviews, participants mentioned the need for more psychological input in services. I wondered if this was raised due to my role as a psychologist and their hope that it would be included in the final report. Possibly because of this professional role, I also noticed feeling ‘bad’ for taking up the time of the NHS staff I interviewed. Participants cited time pressures and increased workloads as barriers to their work, and I sensed that I was being a burden to those I interviewed. I tried to keep in mind that participants had volunteered, but I was still highly conscious of keeping interviews to 60 minutes.

Reading through my reflexive notes, I found it interesting to reflect on what stood out in the interviewees' narratives and why. I entered the interviews with expectations, such as believing there would be differences in how HCPs offer support to men and women. This expectation stemmed from my own experiences as a woman managing societal body image pressures. However, this was not as prominent in HCP narratives as I anticipated. In fact, I wonder if gender differences only emerged because I specifically asked about them. By interview seven, I realised my focus on gender was limiting my curiosity about other information that emerged unexpectedly. For instance, I was surprised by the consistent mention of medication and surgery as treatment options, often sought outside the NHS when patients were ineligible.

3.3 Thematic Analysis

The analysis identified six themes and fifteen sub-themes (Table 4).

Table 4

Overall themes and subthemes

Main Theme	Sub-theme
'It is not all about weight': Holding the discussion with the person in the room	Does the person want to talk about their weight?
	Weight is just the tip of the iceberg: Hearing the full story
	Finding the hook for engagement
Fostering a respectful and stigma-free environment	The omnipresence of weight stigma
	The mindful use of language
	Drawing upon the power of rapport

Weight is only one piece of the treatment puzzle	Aligning treatment with patient preferences and clinical judgement
	Weight management has no 'quick fixes'
	Intervention requires a holistic approach
The struggle of navigating weight management services	A system of closed doors: limited services, strict criteria and long waitlists
	The weight of failure: frustration in a system set up for failure
The problem with contemporary weight narratives	Obesity needs a public health message, just not this one
	Debunking weight and weight-loss treatments
The route to knowledge and expertise	Training is limited, so I trained myself
	The clinical use of personal experiences of weight

3.3.1 Theme one: 'It is not all about weight': Holding the discussion with the person in the room

This theme explored factors that HCPs consider when holding weight-related discussions with their patients. The three subthemes highlight different aspects, including '*Does the person want to talk about their weight?', 'Weight is just the tip of the iceberg: Hearing the full story', 'Finding the hook for engagement.'*

Does the person want to talk about their weight?

Participant responses were varied in how, when and why the discussion around weight was initiated. However, many reflected on the importance of first determining whether the patient

was willing to have this discussion. This was considered straightforward when the patient initiated the discussion themselves, either coming through in the referral or during the discussion. In these instances, patients were viewed as being motivated to lose weight as they were either dissatisfied about their weight or concerned about their health and were requesting for advice, support and/or treatment from the HCP to achieve their weight-related goals.

"With the patients who book an appointment because they want to discuss obesity, that's usually quite different. They've usually got an idea of about what they'd like help with it, and ... those patients may come because they want to get a referral to the gym, which is easy enough." Lucas

When patients did not raise the topic of weight, there was a consensus across HCPs that it was their role to initiate the discussion. However, there were differences across participants in how they did this. Many spoke about raising the discussion tentatively, assessing whether the individual wanted and was comfortable to discuss their weight. As Lucia expressed *"I kind of tentatively dip my toe in the water"* or with a question posed to patients such as *"would you be happy if we talk about your weight"* (Valerie). However, others talked about talking a direct approach, "*I'm just brutally honest with patients"* (Terrance); some used the patients' comorbid conditions present "*have you considered weight as a factor"* (Amy); and some used a health assessment template. For others, they raised the discussion about overall health, "*how else has it affected your health"* (Leona).

Many acknowledged the need to tailor their delivery to the person in front of them, adapting their approach based on whether they perceived the patient to be comfortable with the discussion or not. This set the expectation for what HCPs were allowed to discuss and what

support might be most appropriate to offer. This was raised as important due to the sensitivity of the topic and the potential risk of offending or blaming patients.

"For people who are up front, well then you can have up front conversations. But the ones that look really, really uncomfortable, I think you've just got to tread very carefully. Well, I try to tread very carefully so that you don't, they're not offended, or you didn't put them off." *Lucia*

The reasons for initiating the discussion were also varied. Often this was in relation to protecting the health of their patient, when identifying weight as a risk factor for other chronic conditions or symptoms. Some expressed the importance to raise the discussion due to the isolation and loneliness experienced by their patients or the shame in speaking about and asking for help regarding their weight.

"So, we could then appropriately signpost him to weight-loss services and he was really grateful to have had the opportunity to open up that conversation whereas, you know, he admitted himself he would have never had the confidence to come and talk openly about his weight." Valerie

It seemed that the variance in responses could be due to the differences in the profession and context in which participants were employed. For example, the nurses employed to conduct long-term condition reviews often raised weight through their assessment tools. Others cited raising weight in connection to the primary comorbid condition referred for which directly related to obesity or 'opportunistically' as part preventative healthcare to address the risk factors associated.

"The long-term condition review isn't necessarily a set of questions. It's just areas that you have to cover…So obviously weight and BMI, are part of that…if somebody tells me their

weight and then I pressed my little button and I can see that they are obese, then that obviously tells me that is then a discussion point." Louise

Difficulties arose when the patient did not want their weight discussed, making it a 'tricky' and 'delicate' issue for HCP to navigate. Some expressed feeling disappointed and seemed to need to accept that all they could do was raise awareness of the health condition that their patient might have in connection to weight. Others expressed the need to respect the patient's decision not to discuss their weight, expressing empathy. This was often raised when the HCP perceived the patient's weight was connected to psychological or social factors such as mental health and trauma. Overall, most expressed the importance of initiating the discussion and having this declined, rather than not addressing weight. This was due to the perceived importance of raising the awareness of weight, offering an opportunity for the discussion or planting the seed for future discussions.

'So, I'm not gonna force you to be like you need to lose weight. Just gonna say if your cholesterol is high…you're very close to being diabetic, but if you're happy, then all you can do is raise the awareness of the situation.' Charles

Weight is just the tip of the iceberg: Hearing the full story

Participants spoke about weight being 'the tip of the iceberg' when it came to the discussion with patients. Participants acknowledged obesity as a *'complex'* condition recognising the multiple underlying causes, including psychological, biological, lifestyle, societal, and environmental. Participants regarded it important to start from the patient's perspective, emphasising the need to listen compassionately to the patient's full story. This included seeing the '*whole person'*, understanding their unique context, challenges, needs and influences of their culture, family narratives and gender. This was deemed especially

important considering the complex connection between a person's weight, sense of self and the factors that might have shaped their journey.

"When you look at your patient as a human, as an individual, you gotta realise, because everybody's stories are gonna be different and you've gotta almost try and understand what it's like to be in their shoes, to understand what level of support they might need." Ruby

This approach required HCPs to ask exploratory questions, taking careful note of the strategies that the patient had applied in the past or was now applying. The discussion was often described as *"not an easy one to navigate"* (Leona), not only in gathering the information needed to inform a tailored treatment plan but also considering the significant time-constraints some were bound by. Participants discussed tools used to gather the information needed to understand the patient's story and preferred treatment options. These included ICE (Idea's, Concerns and Expectations) and person-centred approaches.

"I suppose the discussion would focus around where are they at in terms of how their weight, how big a problem is it?... what are their underlying health conditions…What is their diet like? What's their exercise like? What's their understanding like? What is their family history? … How mobile are they? So, it's really a background of what they've already done, where they're at and what they think I might be able to do…In our 10 minutes, I will try and find out what they've already done." Amy

Some participants felt the need to not focus on weight and/or weight-loss during the discussion, instead focussing on overall health and wellbeing. This was expressed in consideration to the limitations of BMI to assess health and the emotional impact weight discussions can have on mental health, self-esteem and confidence. Some avoided weighing patients in initial consultations to reduce anxiety. Instead, they discussed focussing on

lifestyle factors like diet and exercise in a way they felt implicitly addressed weight without directly commenting on it.

"I don't even weigh them on the 1st appointment, like I don't even entertain it and just so they know that's not what I'm here because a lot of them do come to me guarded as well or they'll put off the appointment." Rhiannon

Finding the hook for engagement

An important element of the discussion discussed was to engage and motivate the individual in the support and treatment available. Whilst many acknowledged that the motivation for change rests with the patient, they saw their role in facilitating engagement and encouraging motivation. Participants described the need to find a "hook" that resonated with the individual, finding personalised ways to motivate and make lifestyle changes feel achievable and meaningful. This was expressed across the professional roles interviewed.

"You look for that little thing, that little hook that's gonna, get that patient to listen and follow through and yeah just try and give them, just the right information that they're gonna need." Wendy

Participants spoke of the different methods they used to increase motivation and engagement. Most commonly, motivational interviewing (MI), SMART goals and offering follow-up appointments were discussed. A few spoke about the need to 'spark joy' in the weight-loss journey, emphasising sustainable habits that made their patients feel good about themselves and were enjoyable. This included moving their bodies in a way that was right for them and/or finding eating habits that they enjoyed and were sustainable. As expressed by Freya, *'I like them to leave the room feeling, ohh I'm doing well.'* This suggests, others prioritised boosting their patient's self-esteem and self-worth during the discussion by focussing on positive changes or something patients are doing well.

"Finding out what brings a patient joy, something that won't feel like hard work... It can be literally as simple as I would just say to them when you put that kettle on while it's boiling, you're going to jog as fast as you can on the spot and they'll say, well, that actually that sounds quite simple." Ruby

Promoting patient autonomy was also discussed, where HCP encouraged their patients to make informed decisions regarding their care. By facilitating choice rather than taking a prescriptive and directive approach, some participants felt they could increase patient empowerment, increasing their engagement and likelihood of success. This was facilitated by providing tailored information and resources that the patient could either accept or decline.

"But in a basic way they're not just being told to do stuff because of the coaching approach they're buying into it and they're sort of deciding what they're working on. You're just facilitating them really to do it. I think that it empowers them to make the changes." Leona

Some participants discussed the use of scare tactics, with mixed perspectives on their effectiveness. Some viewed scare tactics as useful for directly communicating the health risks associated with obesity, believing that the honest discussion could serve as a motivating factor to behaviour change. Others highlighted the negative consequences of the approach, including damaging trust, inducing fear and anxiety, and failing to consider the patient's personal experiences. It seemed that participants felt it was their responsibility to assess who scare tactics might be effective for and who might experience unintended, psychological harm.

"The point was that I was trying to make was that… a whole load more risk factors and things that you do have to potentially take a lot more seriously. And she did get the hump with me and give me the whole well, it's alright for you, but looking back at that experience I can understand that it must be quite hard to hear." Louise

A small number of participants expressed the preference to work with patients who were already perceived to be motivated. There seemed to be a narrative where HCPs felt it unfair to allocate substantial time to patients who were not motivated, when others were ready and willing to engage. This preference could be linked to the pressures faced by HCPs, including time constraints and high patient caseloads.

"You kind of wanna be working with the patients that want to do something about it, because, you know we are, we're under the cosh so to speak, in terms of time and number of patients. And I don't think it's fair to those patients that are motivated to do it..." Terrance

Some participants reflected about the limitations of personal responsibility and motivation for weight management. While participants acknowledged the role of motivation to facilitate lifestyle changes, they also reflected about the environment and food industry makes it difficult for individuals to sustain motivation over a long period of time. As Lucas implies, willpower alone was not seen as an effective solution, and that people should not blame themselves for their struggles with maintaining weight-loss.

"We are living in a world full of ultra processed food and the whole environment is geared to making people put weight on and it's very difficult to lose weight and keep it off. So, trying to make sure that people know that it shouldn't be something that they're stigmatised with because willpower doesn't work." Lucas

3.3.2 Theme two: Fostering a respectful and stigma-free environment

This theme explored the importance of fostering a respectful and stigma-free environment during consultations due to *'the omnipresence of weight stigma.'* The two subthemes *'mindful use of language'*, and *'The power of rapport'* described how HCP facilitated a stigma-free environment.

The omnipresence of weight stigma

Participants expressed an awareness of the unfair stigmatisation and prejudice their patients face living in their body and the effects this has on their mental health, self-esteem and increased levels of shame. As Wendy expressed "*I struggled to put the words together because I'm shocked how hurtful people can be."* This highlights the disbelief at the level of cruelty and hurt those living with obesity face by others, especially online. Participants also acknowledged the weight-biases and stigma present within the healthcare system. As a result, they felt their patients came to the clinic appointment expecting to be judged, dismissed or mistreatment, which was described as a barrier to the consultation.

"The big barrier is always "Am I gonna get…weight stigma off this person, [are they] just gonna tell me to eat less and move more"…and if, for example, a doctor's just said you need to lose weight and then send them on the way, they're then gonna think this person is probably gonna tell me the same thing, but just in a longer appointment." Charles

Participants reflected on the consequences of such experiences on the discussion. Some expressed the view that patients avoided the discussion or provided limited information about diet and activity, due to feeling ashamed. They spoke about how their 'usual' method of enquiry could be experienced differently when a patient had prior experiences of stigmatisation. This included patient perceptions that the HCP was probing too much, scrutinising their lifestyle choices and subsequently were perceived to be defensive towards any further exploration of weight.

"Yeah, they might hold back because they might feel like, I might be judging them because sometimes they do say that, maybe I shouldn't have said that because someone might judge me about it." Wendy

This seemed to create an atmosphere of '*fear'* that the patient would feel judged, criticised or shamed by the HCP. HCP also expressed their own desire to not judge or offend their patients, perceiving this to compromise the therapeutic relationship and weight-related discussion. Below, Freya described her own personal development in recognising and addressing their biases to reduce harm and prevent perpetuating stigma. Anti-bias training was described as important in this development, which encouraged the exploration of implicit biases and influence on obesity care. In Freya's reflection, assumptions about willpower, eating habits and personal responsibility led to feeling distrustful towards the patient. For some, those who were aware of their own weight biased attitudes also felt responsible to address this when their colleagues expressed such attitudes.

"I think I am less judgmental. I try not to be, but I was. I still am probably, but I try to live with the idea that some people are big and a lot of it is genetics…. So, I'm trying to be very open minded and accepting and I do actually believe them. People used to sit there and say, oh, I don't eat very much and I wouldn't believe them. But now I do, I think they're all people, eat very little and still gain weight." Freya

Conversely there were expressions of weight bias present in professionals' narratives, even if unintentional. Some seemed to recognise the biases held by prefixing their dialogue with a recognition of how it might sound critical or judgemental. This came through in narratives emphasising the individual's *'self-control'* and a blame-based perspective suggesting the individual was at fault for their condition. When patients reported their diet or exercise habits, but their perceived weight did not align with the information, participants assumed they were being dishonest or withholding information.

"And then I suppose you do have the judgement coming in because when they get to be that overweight, you just think how do they let themselves get to that stage?" Lucia

The mindful use of language

Participants spoke about the sensitivity surrounding the language used when discussing weight. Almost all expressed an avoidance of using the term 'obese' with their patients due to the stigmatising association this term has and the potential to negatively affect the patient's emotional well-being. It seemed that this was a personal choice, disliking the word because they felt mean or harsh and believed the term could be perceived as judgemental and stigmatising. This was seen as preventing HCP's from having full, open discussions in which support could be explored.

"I think the word obesity is horrible, and all the patients hate it as well. It's a really nasty label and some people don't really see themselves as being obese... and that isn't always positive and a very kind thing." Leona

Instead, participants spoke about the use of non-judgemental, non-blaming, empathetic and supportive language which was thought to encourage a safe and supportive environment to hold the discussion. Many discussed using clinical language, such as BMI, whereas others expressed just using *'weight,' 'overweight'* or *'weight loss/reduction'*. Louise expressed the need to make clinical language *'fluffy'*. This indicates an attempt to soften the impact of medical language that avoids sounding judgemental and reinforcing negative stereotypes whilst still raising awareness of weight.

"We would use weight-loss. We wouldn't use obesity… like some people can see it quite differently, and they might feel uncomfortable with that term. So, I think weight-loss or weight reduction is probably what we would use." Karina

The use of BMI was often used in terms of a number rather than the related categories associated. However, even the use of BMI appeared to be nuanced. Charles describes "*I'll just*

say you're BMI is under 24. That's what?" implying the use of BMI is only effective when the patient understands what the number means for weight and health.

"I talk about their BMI, so as in a number… I wouldn't necessarily mention morbidly obese to them, but I don't even know what the categories are… I would never really say your weight is in the obese range…I'd say your BMI is this and we are trying to get it down to this number." Holly

There was also a preference to use the language the patient volunteered, thus using collaborative, person-centred language. Amy described the need to focus on patient agency by using "you" instead of "I", reinforcing patient autonomy while offering encouragement and shared problem-solving.

"I would say things like, great, it's really good that you want to embark upon this journey, and I can see you're motivated…and you have to use the word you rather than I. So rather than how I can help with that, it's like, let me see how I can help you to achieve that. So, it's the language that you use, and you know saying, you are in control of this." Amy

Drawing upon the power of rapport

Building rapport was discussed as crucial for HCPs to hold meaningful discussions around weight and health. Participants acknowledged how discussing weight could be sensitive, where patients can feel uncomfortable, judged, blamed or stigmatised. Yet rapport was felt to allow for an open discussion of the patient's story, including the underlying root causes and barriers to weight-loss. Rapport was important in hearing the patient's story, including the underlying root causes and barriers to weight-loss. If the HCP had touched upon a sensitive issue that the patient was not ready to address, rapport allowed the patient to understand that the clinician raised this for their best interests. Rapport was also thought to encourage a patient to feel more comfortable in the room. This enabled the delivery of potentially difficult

information regarding risk and allowing an open and honest discussion where patients could share personal experiences, struggles and barriers.

"I think they're quite difficult conversations for patients to be having and…they pick up the phone and you're telling them that this is high, this is high, this is high. So, they're already feeling a bit let down. And I think it's about building trust really and trying to understand what the root of these problems are." Ruby

There were several factors discussed that were thought to facilitate rapport including, establishing trust, active listening, and respecting autonomy. As Wendy described offering a "*positive, comfortable, safe space"* through empathy, acceptance, unconditional positive regard and a non-judgmental attitude. This enabled participants to navigate the challenges present when their patient became defensive or frustrated from the weight-related discussion. Trust was described as a foundation for ensuring that the patient felt understood and listened to, understanding that the HCP wanted to support them with their health.

"I think people need to feel like they're in a safe space and they can talk to you about anything and that you can hold that there for them and not judge them…That's what the first appointment is all about. It's trying to build that rapport and really understand them. And so that they feel they can trust you and work with you, and that they're in safe hands." Leona

Continuity of care and length of time available in sessions also helped to build rapport. By providing ongoing support and commitment helped to demonstrate to patients that they were valued and also allowed the HCP to gather richer information about the person's circumstances which could then inform the treatment plan.

"I mean it's sort of an underappreciated fact of general practise and that's continuity of care, and knowing your patient, seeing the same patient, following them up, is so important… That's where the continuity of care is vital because every time you come in, they don't have to

tell you the story from scratch…They also become a little bit more relaxed with you and share a little bit more…" Yasmin

3.3.3 Theme three: Weight is only one piece of the treatment puzzle

This theme explores HCPs considerations when creating tailored treatment plans. The three subthemes highlight the different factors assessed including, *aligning treatment with patient preferences and clinical judgement, weight management has no 'quick fixes'* and *intervention requires a holistic approach*.

Aligning treatment with patient preferences and clinical judgement

HCP acknowledged the need to identify the treatment wanted and needed by their patients. This was especially important for those employed as GP's, nurses and pharmacists when patients came with another primary presenting problem that was associated with weight. They expressed the need to identify whether the patient solely wanted treatment for the primary condition presented or whether they were willing to explore weight management options. If weight-management was identified as appropriate, HCP spoke about creating a tailored treatment plan influenced by the patient's own preferences. Patient preferences included whether they wanted medication or surgical options or were open to available local resources such as gym concessionaries, dieticians, health & wellbeing practitioners or other available commercial weight-loss programs. Some cited the importance of understanding the social demographics of the individual to ensure advice and suggestions were tailored to the individuals' circumstances.

"We've got really varied demographic where I work. So, there are some patients who are affluent and quite well educated, and there are some who socioeconomically deprived and

don't have access to gyms and diets. So, I would never say to one of them. Well just go to the gym twice a day and read this book and listen to this podcast." Amy

The HCP clinical judgement seemed to be influenced by the assessment of comorbid conditions, emotional state and eligibility. This was when clients presented with comorbid conditions that required weight-loss interventions to be safe. The presence of comorbid conditions seemed to make treatment decisions easier or more complicated, depending on the condition present. For example, the presence of diabetes, made it easier to prescribe medication with weight-loss as a secondary side-effect and referring to national programmes. Conditions such as hypertension and arthritis required the treatment plan to safely manage the condition. Yasmin stressed the importance of addressing mental health, particularly depression, which was seen as a barrier to weight management. Instead of focusing solely on weight, she emphasises the need to consider the impact of obesity on the patient's emotional well-being. When such dilemmas were present, HCP focus shifted to managing the immediate risk first.

"I think the other complication that sticks out in my mind are the ones that actually have started to become depressed with their condition. And then really, that's my job as a GP to identify that quickly and sort of move the conversation away from weight, weight, weight to how is this making you feel, is this affecting your work, your relationships?… because unless you treat that, you won't really get anywhere with the obesity." Yasmin

The interventions HCP spoke about were varied and seemed to depend on their knowledge of available resources. Participants spoke of a range of different sources of information including apps, leaflets, websites and groups. Providing the right information was thought to give patients the knowledge, direction and motivation needed to make meaningful lifestyle changes. It needed to be tailored to the individual needs and preferences, otherwise the

information was seen to alienate or perpetuate unhelpful narratives about weight-loss. Some participants spoke of the balance between giving enough information and too much, which was thought to overwhelm patients.

"I don't want to overwhelm them with information…So I usually say to them, OK, having looked at the food diary, what do you think could be changed to see if there's anything that they've thought about and they might say?... I'll send them a comprehensive email with the food diary and then the British Dietetic Association does, like food fact sheets…So, I'll always pick out relevant ones, send them all the information, give them the links to, for example, the NHS food scanner app." Rhiannon

The weight management intervention also varied depending on profession. For example, GP's were more likely to discuss medication interventions and nurses in supporting referrals to external services. Dieticians and Health & Wellbeing Coaches spoke more specifically about the weight management interventions they offered such as nutritional advice and Cognitive Behavioural Therapy (CBT). However, across professions, HCP spoke about the use of techniques to elicit behaviour change. Participants spoke about the use of SMART goals, MI and offering follow-up appointments to review progress. Some also spoke about leveraging the individual's support system, encouraging the involvement of family, friends and support groups where appropriate.

"And often they do say that peers have helped them... So, I always talk about SMART goals with them. There's no good saying that you're going to do this every day because that's going to be hard to meet, whereas you can say to yourself that you're going to do it three times a week, which is more realistic compared to doing it every day in the week…So starting off small and then building that up." Wendy

There was an emphasis on acknowledging that not all patients were immediately ready to act on the recommendations suggested, explaining there was *'no point'* in offering weight management options if the individual did not want this. This left the clinician having to accept the decision but was at odds with their desire to do something to support.

"It's all down to the patient. The choice is always theirs. We can't force them to do anything, so if they say no, 'I'm fine as I am', then I have to respect that choice… It's their choice, and as long as they're informed about the choices they make, I can't do much more than that, I suppose." Ruby

Weight management has no 'quick fixes'

HCP expressed how some patients came to their clinic for 'quick fixes,' offering patients quick and easy results for weight-loss. Whilst many felt that the desire for quick fixes was not a new phenomenon, referencing FAD and restrictive diets, they expressed concern regarding the new rise in demand for medications and surgical options. Many HCP held strong opinions, expressing a strong dislike for medication, mostly due to the potentially harmful side effects and concern that this would take patients away from implementing healthy lifestyle changes. Furthermore, HCP reported an absence of clear guidelines on prescribing medication after a patient's weight decreased or their co-morbid condition resolved, along with concerns about potential weight regain if lifestyle changes were not implemented alongside. Others acknowledged the role medication could have in supporting an individual's weight-loss journey. For the patients eligible, participants spoke about using medication as a tool, 'kick-starting' the weight-loss journey if explored alongside other lifestyle treatment options.

'I've read the draft NICE guidance for Manjaro…it's still difficult because I can't find any official guidance about what you do when somebody with diabetes and obesity, when they've

been using it and they're weight is normal or starting to head towards low and they're diabetes is perfect… But I think to deal with the underlying sort of problem that evolutionarily programs us to eat all the food that's available…all these people who have got these hunger hormones screaming at them…I think we're in the right direction with medication to treat it'. Lucas

Whilst some blamed social media for the rise in 'quick fix' treatments, many acknowledged why patients desired this option when they had full and stressful lives to contend with or had previous experiences of unsuccessful weight-loss. As Ruby reflects, weight management takes time and effort *'to embed…healthy lifestyle habits into their day-to-day routine, and by doing smaller, more sustainable changes'*. Charles spoke about patients requiring a '*clear runway*' for weight management and reflected on those who face considerable personal challenges. Furthermore, HCPs described the weight-loss journey as '*not easy*' and '*difficult'* full of barriers including the role of hunger hormones, financial barriers to interventions, physical barriers in increasing activity levels, emotional stress, mental health difficulties, family responsibilities, or lack of social support.

"They might have a lot going on in their lives too, like kids, family, sick parents, disabled children or what have you. And they haven't got time to come to clinic and sometimes just want a quick fix to be honest with you…" Lucia

Identifying the individual's barriers to weight-loss was thought to allow the HCP to understand which factors were modifiable and within the patient's power to change, and which were non-modifiable that needed to be accepted. While empathy and motivation were deemed important for the HCP to offer, there seemed to be consideration of establishing realistic expectations for changes and weight-loss. The acknowledgement of such barriers

was thought to result in the creation of sustainable and realistic treatments plans towards the patient's health goals.

"I will say right, what are our modifiable risk factors and what are the non-modifiable and so then the patient can understand that, OK, these are the things I can actually tick off. But these are the things I can't do anything about…Like, what is their capacity in terms of physical activity, we need to factor in their dietary preferences…and then you've gotta accommodate that. So yeah, so I think you've got to look at the whole picture because if you don't… I've struggled to engage the patient because they didn't feel heard." Ruby

Intervention requires a holistic approach

As discussed, participants described the complexity of obesity as a condition with multiple underlying causes and the importance of understanding the patient's unique story. Such a view allowed the HCP to see the patient beyond their weight, ensuring that aspects of their life were considered when developing holistic treatment plans tailored to the individual's needs.

"That just means looking at the whole patient, not just looking at them as a number on the scales… So, is it a mental health component here that we need to deal with? Holistically meaning… it's just understanding the bigger picture for each patient, and what their journey is gonna look like …" Ruby

HCP discussed the need for a holistic approach using a multidisciplinary team. This was often because HCP's felt one role was not enough to address the multifactorial root causes underlying obesity and requires the expertise of a team that includes specialists from different medical fields. Professionals that participants found helpful included dieticians, psychologists, GP's and exercise specialists. Identifying their own professional role within the Multidisciplinary team was also important to understand, including what their role could

offer and its limitations. Additionally, the importance of collaboration between various professionals was highlighted, where different disciplines needed to work together in a coordinated manner.

"I know my limits in that ultimately to have the most impact with these patients, you need to work as part of a multidisciplinary team. You need the exercise specialist. You need the psychologist, so I'm there to essentially do the initial assessment, make sure there's no underlying eating disorder." Rhiannon

Many participants spoke of the need for greater psychological support to address disordered eating, emotional eating, trauma, mental health conditions and behavioural patterns underlying an individuals' weight. It seemed that each locality was different in their ability to access psychological input. For some practices, they had health and wellbeing practitioners in which to refer to whereas others had to refer to community services, some of which required payment or had long-wait lists.

"He was kind of early 30s, but morbidly obese, and he really was starting to get a lot of problems associated with obesity… we took that opportunity to speak about his weight and it became clear that there was a lot of kind of psychology and difficult past experiences in childhood that that probably had resulted in his overeating." Valerie

3.3.4 Theme four: The struggle of navigating weight management services

This theme depicts the organisational challenges present in the weight management system including that impact the HCP discussions and weight management options. These include the subthemes, *'A system of closed doors: limited services, strict criteria and long waitlist's'* and *'the weight of failure: frustration in a system set up for failure'.*

A system of closed doors: limited services, strict criteria and long waitlists

Participants spoke of the challenges faced by both HCPs and patients in accessing and navigating weight management services. Such challenges included strict eligibility criteria, specialist services with extensive waiting periods and closed services due to funding cuts. The lack of accessible support was felt to leave patients weight difficulties unaddressed and contributed to their own and patient frustration, mistrust in the system and deteriorating health.

"And everywhere I go… they just say no or you're not meeting the criteria or it's not available on NHS… And there's so little trust in the system…So yeah, it's very frustrating. The frustration does affect patient care, effects patient mental health…. As I'm talking to you, all these patients are just drifting in and out of my head. There's so many. There's so many. So many patients who are desperately trying to lose weight." Yasmin

Participants viewed the current system as a constant barrier to early intervention and effective support, shifting focus of care from proactive prevention to reactive management. As a result, patients either had to wait to develop additional health conditions or continue to gain weight to meet the eligibility threshold, forcing HCPs to focus on managing the associated comorbidities rather than preventative measures. Participants viewed the current system as a frustrating cycle of barriers.

"So they're in that gap before they've developed, pre diabetes or diabetes, but they're still in that obese category, but they just haven't quite struck the criteria. And what I found quite frustrating is, for example, NHS digital weight management program which is a 12-week program. If you've got type 2 diabetes or hypertension, then you qualify for it... So, it's almost like waiting for people to become sick for them to be able to access the service." Rhiannon

Another consequence discussed was the extreme measures patients were taking to lose weight outside of NHS provision. This included going privately, paying for weight-loss medications

over the internet or going abroad for bariatric surgery. Whilst participants spoke about understanding how the system created the need to find alternative provision, they shared concerns regarding patient health and the impact on the NHS to manage the complications such measures could result in.

"I've seen patients who've gone and… almost taken a chunk out of a roll of fat and just literally sliced it off...it's really shocking... So, people resort to these things because there's no option on the NHS…and then go elsewhere for these horrendous operations…So, I suppose the NHS at the moment is turning a blind eye to it. But what is waiting in the wings for us with botched procedures." Yasmin

The evidence base of current weight management services was also questioned. As Lucas implies below, they feel frustrated and uncertain about the effectiveness and quality of external weight management options based on the negative feedback from patients about their experience of the service. Furthermore, the evidence-based guiding advice for lifestyle changes were also questioned, as Louise reflects *"it's just like plucking words at the air, isn't it? …where is your validated evidence-based source?"*

"If I'm gonna refer them anywhere or signpost then it will be to either the tier two or three services which always has, I'm sure intentionally complicated long forms to put us off doing those referrals... I'm gonna refer them on and then it's someone else gonna be giving them all the now slightly out of date advice …we've had the referral schemes to Slimming World and I'm not quite sure how up to up to date that is and I think a lot of patients will say I've tried that and it didn't work." Lucas

As a result, participants spoke about the challenges they faced to fill the gap, offering their patients the support they needed and the limitations of their roles. They spoke of managing caseloads beyond their capacity, their limitations in expertise and feeling stretched and

unsupported in addressing complex cases. Whilst some talked about strictly adhering to the criteria, others talked about what they could do by bending the rules to get their patients the care they need.

"I think where we can't offer patients options, it just becomes much more tricky really…It's really hard and I think you know with those patients we, try to support them and reassure them we're doing our part, so you might write to the clinic to see if there's any chance that they can expedite the appointment and that kind of gives the patient reassurance we're on their side and in the meantime just try to set small, manageable goals." Valerie

The weight of failure: frustration in a system set up for failure

Participants spoke of the frustration experienced from repeated cycles of weight-loss and regain. This influenced the discussions participants felt they could have with patients. The discussions were described as 'difficult' and 'challenging' as patients returned to services feeling defeated and distrustful that the service could support them. Furthermore, patients who had tried multiple methods to manage their weight, were felt to blame themselves for this perceived failure, resulting in feeling frustrated and hopeless in their ability to lose weight. In some instances, this was felt to contribute to the development of mental health difficulties. The sense of blame and hopelessness was also mirrored in HCP view of their role or the system in being able to help their patients. Some participants blamed themselves for not having the answers and described feeling ill-equipped to assist patients in successful weight management.

"I think it becomes harder when you have patients who are who come to you at the point at which they're frustrated. They've seen everybody, spoken to everybody, tried everything and everything you ask is like I've tried that…You know you're getting the brunt of years and years and years of frustration and at that point it's not about me imparting

information…because everything that we have said has been useless or hasn't worked." Yasmin

Participants spoke of the inadequacies of the current tiered weight-loss system. This was discussed as a problem in accessing specialist services, where patients must fail one tiered intervention to then access another type of intervention, contributing to patients' sense of failure

"So, it's very clear from the weight-loss program is this. You go on the Tier 1, 12 week program, then that if you're still not achieved your goal, you go on the Tier 2 and then you go on the Tier 3 and they will come off and come back and say well already done that and that didn't work, and I already tried all this." Amy

As a result, participants described the need to find something that might make a difference for their patients. Whilst participants acknowledged the importance of their role in offering ongoing support, for some, this needed to be balanced with their capacity to support. This included the time they could offer patients, the support available and their services own criteria.

"I think it's just respecting my boundaries…I can't help with everything, we can't do everything. I'm comfortable with what I can help with… So we see a lot of people we shouldn't really be seeing just because there's isn't anybody else. There's no one to go to other than me, and so that's tough. It's just realistic expectations of who we are… you do need to be mindful of your little circle of help that you can give them." Charles

Participants spoke of ways in which they could support their patients with repeated weight-loss attempts. As Leona expressed, it "*it's important to engage with that frustrated patient"* suggesting the need to have the discussion with patients, regardless of past failures. Additional facilitators include acknowledging the patients' efforts and struggles without

judgement, highlighting successes, building rapport and holding open discussions that explored the potential factors contributing to the failure. Amy spoke of the need to raise the patient's self-esteem and self-worth through psychological intervention before embarking on further weight-loss interventions again. The use of MI was also discussed as helpful in encouraging motivation in patients that presented hopeless at their perceived failure.

"I think it can impact them mentally. Some of the patients feel quite down because they've tried something for a long time or, you know, they persevered, and it's not worked. But I think sometimes talking to a HCP that actually understands and says actually, no, you can still do it and give that motivation is really key." Karina

3.3.5 Theme five: The problem with contemporary weight narratives

This theme explored the influences current weight narratives can have on HCP-patient interactions when addressing weight. Such influences were discussed in two subthemes *'obesity needs a public health message, just not this one'* and *'debunking weight and weight-loss treatments.'*

Obesity needs a public health message, just not this one

The lead researcher offered participants two types of messages, 'eat less, move more' and Health at Every Size (HAES). Both public health messages were seen to aid or hinder the discussions participants had with their patients as they shaped the societal narratives about health and weight, of which the HCP and their patient were exposed to.

In response to the 'eat less, move more' initiative there was an agreement that this was often unhelpful and ineffective in supporting adults living with obesity towards healthier lifestyle choices. Described as "*one-size-fits-all,*" participants reflected that such a message reduced obesity to individual behaviour that ignored the nuances of obesity as a complex condition

and failed to address environmental barriers associated. For example, there was an emphasis that the food industry needed greater regulation and restrictions placed by the government for such initiatives to be influential in weight management. Some participants expressed the belief that this message may unintentionally promote unhealthy behaviours, either through extreme restriction or FAD diets, rather than promoting long-term, sustainable lifestyle changes.

"I don't think it's very helpful, because it's not just what you eat, it's how you eat, when you eat and the types of food you eat. We've come as a society where we rely on processed foods so much… So there's telling people to move more and eat less, just doesn't cut it when you're being bombarded with all these messages, that these things are actually healthy to eat when they're not." Leona

Participants spoke of how the message was not effective in targeting or engaging specific groups of people and did not always align with individual's circumstances or needs, thus excluding or isolating certain populations living with obesity. This was present with messages of increased physical activity, which was thought to be open to a varying range of interpretation and missed how movement could be significantly impacted by physical health difficulties such as lymphedema or joint pain. However, some expressed the need for the message to educate patients towards weight-loss that was simplistic and accessible, to reduce the growing obesity problem and cost on the NHS.

"I couldn't quote the evidence, but as I understand it, you know there's certainly studies showing that you can't maintain any sort of real restriction in in what you eat long term. Eventually, your body's gonna sort of ramp up the hunger hormones and make you eat and the move more is good for fitness, but it doesn't necessarily make you lose weight…but when

you've got someone who's BMI is over 40 or even over 30, It may be that the obesity is making real exercise very difficult and painful." Lucas

The HAES message divided participants. Some participants expressed ideas in line with the HAES movement where they felt weight did not necessarily equate ill health. They expressed a need to be careful not to assume health, citing how weight and BMI can be flawed in predicting lifestyle behaviour. Participants also acknowledged that such messages could reduce stigma and discrimination. This was viewed positively, where the message could remove the barriers imposed by weight stigma and reduce the shame present when discussing health and weight. For a few, there was a desire to support the movement which had been sparked by their own experience of growing up in a society who valued a 'thin or slim' body size.

"That's a great example that you've given…I feel like that's what kind of puts it across as normalising it. Instead of looking back in the days where they just used to use really thin models and just saying, 'Oh well, that's how everyone should be'…Yeah, that's definitely, you know, been kind of a barrier, but I feel like, yeah, the movements have helped quite a lot compared to what it was before. And I really do support these movements I wish I could do something like that as well." Wendy

For others, it was felt this needed to be balanced with not promoting obesity. The normalisation of obesity was thought to prevent individuals seeking health care as individuals wouldn't feel different from those in their community. As a result, there was an expressed concern for the development of additional comorbid health conditions associated should higher body weights be normalised. This was also felt to impact HCP ability to raise weight clinically, where it was perceived to be more difficult for HCP to raise the topic of weight as a risk, increasing patient's perception of being judged by their HCP. It was thought that those

who raised weight may actively enforce stigma, compromising the therapeutic relationship and contributing to the development of poorer health outcomes for their patient.

*"It's great that they are have this… like say body positivity, but also the reverse of that is you cannot say anything because it's then construed as criticism or shaming…What I said, I think it was something fairly benign about one of my friends who's got like a hip condition and I think I said something like it's a real shame because if she wasn't carrying excess weight she'd probably be able to do something about it, and I've got absolutely ********* by my kids for fat shaming…I see that they're definitely more inclusive and accepting of each other, which is great, but in the long term, not that helpful for those who do struggle with weight." Amy*

Participants agreed that there needed to be a public health message, expressing a shift to a health-centric approach, focussing on nutrition, physical activity, mental health and overall wellbeing rather than solely on weight. By aligning public health messages with evidence-based, compassionate health focussed approaches, it was felt they could positively influence their discussions and contribute to better care. There was an emphasis for the message be inclusive, encourage wellness and positivity and not stigmatise or shame people for their weight. However, participants acknowledged that this was no easy task for public health educators and required a long-term agenda uninfluenced by changes in government structure.

"That's what it's all about at the end of the day, you should just be feeling well. You should be confident in who you are and I think that's what patients appreciate rather than, if they come in and say I didn't get that 1Kg lost this month… We're always trying to find something else to be positive about so this message is important." Ruby

Debunking weight and weight-loss treatments

Participants spoke about how such narratives influenced patients' perception for the ideal body shape, weight-loss and treatment desired. This was often described as a societal 'pressure', dictating what was desirable in which individual bodies were expected to conform. They spoke of the toxic culture of body shaming online, where those living in bigger bodies, were attacked and verbally abuse, amplifying fatphobia and negative attitudes toward body diversity. The consequences were thought to lead to the development of body dysmorphia and eating disorders, as well as perpetuating weight stigmatisation and discrimination.

"I know how social media can be, in terms of commenting on people's body image and stuff like that. And I know how hurtful it can be… In terms of how it affects the behaviour, so often goes to avoidance…I mean, I've seen it myself in terms of what comments people make, on like plus size models that embrace people being overweight." Wendy

Participants believed that the urgency to conform to societal body ideals were driving patients to extreme, unsafe and/or unregulated methods in their pursuit of weight-loss. Patients who might have tried a multitude of different weight-loss methods and been unsuccessful were often described as desperate for the same dramatic weight-loss social media personalities publicised. Thus, the more 'dramatic' interventions, such as surgical or weight-loss medications were ultimately viewed as the only solution.

"Media celebrities…they've had the weight-loss injections, and you see that they have their dramatic results, don't you? And patients see this and they're like, oh, if I could just get to that…I think it's awful of the media, isn't it? It's not come from health professionals or health information because I would say never say to them yeah, go on that your sorted for life." Amy

Consequently, participants spoke of navigating the influence of societal narrative in the discussions with patients. HCP had to clearly explain the eligibility criteria for NHS-supported weight-loss treatments, managing the frustration when patients were not eligible. For some patients, participants were able to offer and engage patients in other resources and services for weight-loss. For others, this increased the likelihood to disengage, seeking interventions through private clinics or accessing 'unregulated' medication over the internet which was thought to place the patient at further risk of developing health issues.

'Another lady come to see me with... it was just a normal problem… But she told me, and it's not on the medical records, but she'd been to Turkey for the sleeve gastrectomy…so she lost eight stone. But you're talking six months post-op, and she's not had any follow up bloods or anything. Then we have to do all of those investigations, and they're all deranged…' Lucia

Participants spoke about the need to re-educate their patient's, correcting misconceptions and providing guidance for the most realistic amount of weight-loss achievable. This included the need to warn their patients against unsafe weight-loss methods and offer safe alternatives tailored to the patient's health needs. Participants spoke of the need to provide access and signpost to multiple resources that offer a focus on holistic health including physical activity, mental health and dietary advice that could produce weight-loss long-term.

"We know how hard it is to lose weight…I think what I try and do is acknowledge, it's difficult, it's hard, it's challenging and it's not a quick fix, it's a long-term thing. You're not gonna lose 10 kilograms in a week. You're gonna slowly, slowly, slowly look at building up habits that you can sustain and that you can keep going with." Freya

3.3.6 Theme six: The route to knowledge and expertise

This theme illustrates how factors, such as a lack of training, education and clear guidelines left HCP to navigate this learning on their own. Ways in which they overcame such barriers were detailed in the subthemes '*training is limited, so I trained myself'* and '*the clinical use of personal experiences of weight'*.

Training is limited, so I trained myself

Participants expressed a lack of specific obesity training available to aid their role in weight management. This was important considering the views of obesity as a complex health condition requiring expertise and knowledge. For many, the training they had received was often in connection to comorbid conditions associated with obesity, such as diabetes. This was prevalent in the more generalised medical professionals such as GP's and nurses.

"So, there was no training really on obesity management in medical school other than a refer people to a dietitian, getting them doing more exercise." Amy

Six participants had initially trained in their respective roles over 20-years-ago. They spoke of the dramatic change in the current understanding of obesity over the course of their employment. One described how their initial learning on obesity was rooted in very little knowledge and a message of just 'eating less' but has now developed to encompass everything from endocrine physiology to social and psychological factors. The development in understanding, and evidence-base was echoed in other participants who expressed the speed of medical advances and struggle to keep up to date with best practice.

"When I was at medical school, most of the research hadn't been done that has led to all of the current understanding. Just all the basic science that they've been doing…You wouldn't have even heard of any of them when I was at medical school…I would like to see the medical

students and the current GP'S get filled in on all the up-to-date basic science behind it and then on a practical level upskilling all the GP's." Lucas

Consequently, participants expressed a lack of knowledge and clarity concerning the most up to date research, evidence and guidelines to base their consultations and the treatment plans. Whilst NICE guidelines for obesity management were discussed as a critical part of training but were perceived as outdated and far removed from clinical practice, inconsiderate of ethical dilemmas and complexity of patient's needs. Furthermore, the current, fast producing obesity research and evidence base was not without its flaws. Participants cited contradictory information or evidence open to varying degrees of interpretation. Such a lack of clarity and consistency across clinical advice was felt to have significant implications for patientcare, including opportunities for treatment, emotional well-being and trust in the healthcare system.

"Because what is actually is an achievable weight-loss, what is actually a safe weight-loss?... Well, the government, they say sign posting healthy eating, but there isn't actually a resource that's actually the gold standard of this is what we should do… nice guidelines recommend exercise and diet as a way of modifying blood pressure, but there is nowhere that tells you what exercise, how long for, how often, there's nothing." Louise

Terrance expressed this as a *'huge failing of the NHS education system'* leaving HCP to train themselves on obesity management. This was echoed in others who expressed feeling left alone to navigate the literature themselves and feeling fully responsible in their task on preventing and supporting adults living with a hugely complex condition without the much-needed guidance and knowledge to do so.

"I'm not aware of the programmes are out there that I can refer patients to. I feel like I've been doing my own navigation in in terms of that. So yeah, I feel like it's quite independent. I haven't really been given those resources or knowledge…that would help." Wendy

Considering this, it didn't seem to influence participant's confidence or comfort in engaging and supporting their patients. This might be explained by the fact that HCP spoke of seeking additional knowledge out of their own motivation and interest. This was described as self-taught and/or self-funded and appeared to come from a variety of sources including the available research, training providers but also from social media.

"I've always done a lot of reading and self-taught and attended webinars, seminars and things like that. I think it's a lot more in social media now as well about weight-loss…They could have done some sort of work out, but it's all on YouTube." Ruby

Participants discussed how they drew upon years of experience to aid the discussion, informing the language used and knowing what might or might not work for each patient. For some this was expressed as 'intuition' or a 'pattern' of routine care.

"I think obviously lived and seeing people with Obesity for a long time is the best learner. There should be a course as I do like to read a lot outside on this… When you're started going through uni, you are like a young pup and you think I've got the big thing down, but then you start to experience working, and it's not that simple. So yeah, experience during the job." Charles

For those who have a multidisciplinary team present, participants spoke of approaching colleagues to aid their learning. This was often discussed as seeking knowledge of resources and advice that might be available to support their patients.

"We've got social prescribers on our team as well. So, some of them have been doing it for a considerable amount longer time than we have and so they're aware of some of the resources. So, if I've got a particular patient, we might ask them, do you know anything that's happening that would suit this person in the area? We gradually build up our knowledge of what's going on locally…" Leona

The responses varied in terms of what HCP wanted training to focus on. Responses included the desire to know more about the underlying causes of obesity, trauma-informed perspectives and how to identify the presence of mental health difficulties or eating disorders. Other requests included the need for training on the most current research, evidence and guidelines and what this meant for clinical practice. Another area was around developing their clinic room skills including communication, using the most appropriate language, person-centred support, MI and counselling skills.

"And the training would be something on how you could support, to get the patient to engage in lifestyle choices, if possible…That is the training you'd have, that would help you engage and have those conversations with the patients." Lucia

The clinical use of personal experiences of weight

This subtheme illustrated how the participants own body weight and personal experiences of weight and/or weight-loss entered patient consultations. Where participants did not feel they had adequate education and training on which to guide weight management care, instead, participants drew upon their own 'self-learning' through personal experiences.

"All of your lifestyle messages, because the yoga meditation, the mindfulness, I do practice it as well. And I just feel it comes from sort of personal experience as well because I sometimes talk to them… I drip feed the wisdom from the yoga community." Lucia

It seemed that the HCP's weight entered the discussion regardless of if they appeared to be of a 'normal' weight or overweight, and could either facilitate or hinder this. For the HCP who described themselves as 'overweight,' they expressed patient distrust and disbelief that they would be able to advise and support them to lose weight. Those whose weight was described to be 'normal' or 'slim' expressed two possibilities; either the patient trusted the advice given, acting as a 'role model' or again, distrust that they had the experience of weight-loss to draw upon. Effectively, this placed participants in a position to manage the influence their weight had on the discussion and seemed to force participants to 'prove' their competence to support outside of their weight and body size.

"Some people before you even open your mouth sort of like say 'oh you've never had to do this, so why should I listen to you', and you're already coming from the back foot. Well, the opposite is someone who's just lost weight once, has no qualification, no degree, nothing… I'll just say I've done this for a long time, and I've seen thousands of people…" Charles

Some participants described using their experiences as a tool to aid their consultations. Their personal experiences was used to relate to their patients, offering greater empathy and reminding the HCP of the person in front of them. It was also seen to offer a chance to build rapport and acknowledge the difficulty that can be experienced when living in a bigger body. For those who had their own experience of successful interventive weight-loss, this was used to provide advice, diets or handouts that they had found helpful.

"I know how it feels to struggle with weight, whether it's being underweight or having too much weight and how it affects your overall confidence and like you're judged. Yes, it's quite a sensitive topic." Wendy

For those who described their body size as 'slim' or 'normal,' this was seen to offer an opportunity to provide advice through leading by example. However, a balance was spoken about offering patients a helpful role-model and not preaching a healthy lifestyle.

"I'm really active and I'm pretty slim and fit… you have to try to find a line between going 'oh, look at me I can do it' and going, actually it's about the little things that you can change… And I suppose you can lead a little bit by example, but not be patronising…It's like, you have to be careful not to alienate people." Amy

Discussion

4.1 Summary of Findings

Using reflexive thematic analysis, six main themes and fifteen subthemes were identified. Themes one, two and three demonstrate the influences of the HCP-patient interactions in the clinic room, including *'it is not all about weight: holding the discussion with the person in the room'*, *'fostering a respectful and stigma free environment'* and *'weight is only one piece of the treatment puzzle'*. Themes four and five describe the organisational factors that were seen to influence the discussions and treatment options offered including *'the struggle of navigating weight management services'* and *'the problem with contemporary weight narratives.'* Theme six, *'the route to knowledge and expertise'* describes how HCP overcame a lack of training to guide their role in weight management. The interpretations made within this chapter are both semantic and latent, informed by the research epistemology, research discussed in the introduction and the researcher's positionality.

4.1.1 'It is not all about weight': Holding the discussion with the person in the room

The HCP interviewed spoke about what they considered important for holding effective discussions with patients living with obesity. Within the theme '*Does the person want to talk about their weight?'* all HCP expressed that it was their responsibility to raise the discussion, if this had not already been raised by the patient. For HCP, their responsibility seemed to be led by the view of their role in initiating the conversation, in raising health awareness, and of possibly offering patients support, education and/or a referral to weight management services. This finding is interesting, considering previous qualitative studies have found that primary care staff do not believe discussing weight and offering weight management is their responsibility (Blackburn et al., 2015; Brown & Thompson, 2007). This finding offers a promising change in how HCP view their role in weight management and align with current guidelines and initiatives, which increasingly position HCPs to raise and educate individuals about weight (NICE, 2025). This also reflects patients' preferences for their HCPs to initiate discussions (Hughes et al., 2021).

Indeed, the notion of responsibility is interesting in weight management. Often the argument concerning HCP responsibility in weight management has been discussed in terms of diagnosis and medicalisation (Bowerman et al., 2001; Maryon-Davis, 2005; Nolan et al., 2012). Epstein & Ogden, (2005) found that, overall, GPs conceptualised obesity in terms of responsibility, where many believed that their patients were primarily responsible for their weight. Paradoxically, they also viewed obesity as a medical issue that should be managed by the doctor. Furthermore, there is evidence that HCP may be more willing to discuss weight when they 'medicalise' it (Dewhurst et al., 2017; Tham & Young, 2008) and when it is considered as a routine aspect of clinical practice (Atlantis et al., 2022). The medicalisation of obesity as a disease presents a complex issue. It may facilitate more structured policy development, increased funding, and improved access to evidence-based treatments through streamlined services (Bray et al., 2017). However, it raises concerns around defining what

qualifies as a disease, the risk of further stigmatising individuals, and the possibility of diminishing personal responsibility for lifestyle changes (Luli et al., 2023). The results of this study suggest progress in HCP views that initiating weight management discussions is part of their responsibility, however the link to the medicalisation of obesity is unclear in this instance. Further research is needed to explore HCPs' views on the medicalisation of obesity and how this influences their sense of responsibility in initiating weight-related discussions.

Whilst HCP expressed their responsibility to raise the discussion of weight, the majority expressed the importance of assessing whether, *'Does the person want to talk about weight?'* By asking whether the patient was willing to talk about weight, they felt they could assess how comfortable their client was with the discussion and whether weight management options would be appropriate. Others assessed the patient's comfort through non-verbal cues and their perceived willingness to engage in the conversation. This suggests that many HCPs prioritised the patient relationship, promoting patient autonomy, and viewed this as a way to approach the topic of weight more sensitively. This is in line with evidence suggesting the professional-patient relationship is fundamental for weight-management discussions due to sensitivity when discussing weight (Blackburn et al., 2015; Dewhurst et al., 2017; Oshman et al., 2023). Due to this sensitivity, previous research has found HCPs often avoid initiating the topic for fear of offending their patients. (Blackburn et al., 2015; Jeffers et al., 2024) and only addressed weight when there was a clear health-related reason (McHale et al., 2020; Tham & Young, 2008). Although this study relied on self-reported practices, the HCPs interviewed did not indicate avoidance of the topic. However, many acknowledged the challenging nature of initiating such sensitive conversations, expressing concerns about potentially offending patients or reinforcing stigma through the act of raising the issue or the language used. For some this was thought to be managed by offering patients the invitation to discuss their weight.

There were varying approaches expressed in how to initiate the discussion, from direct 'honesty' to more tentative approaches, such as linking weight to general lifestyle. This suggests that there is a variance in how the discussion of weight is raised based on the clinical preference of the HCP. There have been calls for standardised, step-by-step guidelines to support HCPs in initiating weight-related discussions sensitively and guiding conversations to explore the multifaceted causes of obesity. This has often been cited, as current guidelines are perceived to offer limited clinical support to HCPs (Nolan et al., 2012) and fail to reduce the variability in weight management care delivered by practitioners (Dewhurst et al., 2017). The implementation of standardised guidelines for managing obesity is also found to raise HCP awareness of the key factors to address, helping them to recognise comorbidities associated with obesity as interconnected issues that could not be overlooked (Gunther et al., 2012). The nurses in this study employed to conduct health reviews all cited the use of the standardise template to guide their assessment and discussion about weight. However, such an approach may restrict the delivery of person-centred care during consultations (Jeffers et al., 2024), as a one-size-fits-all strategy does not account for individual differences (Gray et al., 2011). Unsurprisingly, many HCP expressed using aspects of patient-centred care such as empathy and partnership to facilitate discussions. However, due to the HCP concern of offending their patients, there remains an argument towards specific tools and techniques designed to support HCP to navigate weight-related discussions with more ease and less likelihood of offending.

HCP emphasised the importance of seeing the whole person, and hearing the patient's full story within the subtheme '*Weight is just the tip of the iceberg: Hearing the full story'.* HCP expressed the complex nature of obesity, demonstrating an awareness that each person living with obesity was uniquely different. They expressed how such an approach helped to establish a therapeutic relationship with the patient and is in line with patient preferences outlined in theme two of the systematic literature review, *'treat me with respect.'* This theme

highlighted how patients wanted to being treated like a human by their HCP and appreciated when the beginning of the conversation started with the patient's story (Buxton & Snethen, 2013; Chugh et al., 2013; Ely et al., 2009; Ward et al., 2009; Yunus et al., 2023). When patients are seen as individuals by their HCP, this is reported to help them feel valued, allowing for collaborative identification of root causes and contextual factors (Luig et al., 2018). This suggests HCP are incorporating a more nuanced approach to understanding weight, rather than the more traditional and blame-based narratives where weight is solely caused by a poor diet and lack of physical activity. Instead, HCP discussed wanting to understand the individuals' personal patterns of life events, their emotional wellbeing, their culture and appraisals towards food and eating. Ogden et al., (2009) highlighted that individuals' perceptions of life events and their use of food as a coping mechanism are linked to weight gain or loss. Therefore, effective weight management also necessitates addressing emotional issues directly and supporting the development of alternative coping strategies. (Ogden et al., 2009b). These results offer a promising shift in HCP perceptions of weight, reflecting the growing efforts of HCP to address weight management through a holistic lens.

The exploration of the patients' contextual factors of obesity was also deemed important, as HCP felt more able to offer tailored interventions and advice based on the individual's unique experiences, challenges, and needs. This also equipped both HCPs and their patients with a clearer understanding of which aspects of weight management were within the patient's control and which were not. There is evidence that by accepting what could not be changed helped individuals maintain their weight-loss attempts instead of giving up in frustration (Forman et al., 2016). Understanding a patient's cultural background, personal context, and the root causes of their weight-related challenges enables HCPs to create tailored management plans that were thought to be more meaningful and sustainable. This approach may enhance patient engagement, trust, and outcomes by aligning interventions with

individual needs and lived experiences (Wharton et al., 2020). However, time seemed to influence how much information could be explored within the consultation. Health and Wellbeing Coaches and Dieticians reported having an hour in which to gather this information, whereas GP's and nurses reported 10 minutes. Instead, GP's and Nurses used techniques such as the Idea's, Concerns and Expectations tool (ICE) in which to gather the information the patient felt most important to discuss. HCP use of such person-centred care adds to the current evidence emphasising the importance such approaches can have in obesity management, including quality of care, patient satisfaction, self-management and self-care (Bąk-Sosnowska et al., 2022). These results suggest HCPs are adopting a more holistic understanding of obesity, recognising it as a complex condition influenced by a combination of biomedical, psychological, environmental and sociological factors.

Within the subtheme *'finding the hook for engagement,'* HCP across professions explained their perceived role in motivating and encouraging patient engagement in possible weight-management treatment. The offer to motivate patients was initially provided during the initial discussion and continued throughout the intervention. HCP often viewed motivation as one dimensional, varying in amount, emphasising motivation as a facilitator and lack of motivation as a barrier to weight-management efforts (Teixeira et al., 2012). One professional expressed their preference to only spend time on those perceived to be truly motivated, alluding to the opinion that people are either motivated or they aren't. The majority of participants were more concerned with increasing and maintaining motivation levels required for continued engagement. The perception of patient motivation has been shown to positively influence healthcare professionals' provision of weight-related support (Hughes et al., 2021), is considered key to patients' engagement in lifestyle changes (Dicker et al., 2021; Greener et al., 2010; Trujillo-Garrido & Santi-Cano, 2022; Williams et al., 1996) and crucial in achieving long-term weight maintenance (Spreckley et al., 2021, 2023). Webber et al. (2010)

found individuals who achieved 5% weight-loss after a 16-week intervention reported sustained motivation for the whole period, whereas those who did not, had shown decreased motivation over time. Furthermore, these findings are in line with the theme, *'Promoting ownership, not stigma'* where patients recognise and accept the role HCP can have in facilitating motivation in weight management. In light of these findings, it is encouraging that HCPs recognise their role in encouraging patient motivation and engagement in weight management efforts.

There were varying approaches used to motivate and engage patients, and seemed to depend on the patient and clinician's preference. This was described in the need to find a hook that resonated with the individual, finding personalised ways to motivate and make lifestyle changes feel achievable and meaningful. This approach is suggestive of drawing upon more autonomous forms of motivation. This can be developed when people feel a sense of autonomy in treatment decisions, are competent to understand how to attain these goals; and feel respected and cared for by HCP and important others (Deci & Ryan, 2000). This is suggested by the HCP's who described the importance of weight-management that "*brings a patient joy"* and "*getting them feeling good"*. This aligns with key factors found to enhance motivation for weight-loss among adults living with obesity, including self-efficacy, setting specific goals, and having a positive, trusting relationship with HCP (Dicker et al., 2021). Furthermore, HCP described supporting the patient to recognise their own strengths and successes in weight-management. The individuals interviewed in Luig et al., (2018) study reported how recognising strengths opened up a space for identifying strategies that they could succeed at, enjoy and find meaningful for their life, positively impacting patients confidence, self-worth and hope.

This approach was not used by all, where some HCP referenced the use of offering more controlled forms of motivation. This included the use of scare tactics or verbalised pressure to act in connection to the potential development of risk factors. As one HCP reflected, '*if you don't do something about this'* who used this form of communication to share with their patients the health risks associated and not downplaying the possible consequences. There is contrasting evidence regarding the effectiveness of such an approach. On the one hand, direct and decisive communication detailing the potential consequences of weight on health can motivate patients to make positive lifestyle changes (Garip & Yardley, 2011; Ward et al., 2009). However, for others, even mild warnings, such as scare tactics, can have a negative impact on motivation and self-esteem (Glenister et al., 2017; Matthews et al., 2009). Where such approaches to motivate are often used by HCP (Hansson et al., 2011; Jeffers et al., 2024), the majority of HCP in this study expressed caution with this technique, assessing which patient may find this helpful, and those who wouldn't. This was often achieved by assessing the patient's comfort with the discussion, as well as considering their personal context, including the presence of mental health difficulties.

Finally, it seemed many HCP in this study described either intuitively assessing motivation or used specific tools, such as Motivational Interviewing (MI). This seemed dependent on whether the HCP had training in MI. However, there were a few HCP who expressed caution in assuming the role of motivation as the only component for weight management. Some HCP reported the limitations of willpower and motivation alone considering the obesogenic environment and biological mechanisms initiated by weight-loss. Thus, while encouraging patient motivation is shown to be beneficial (Barnes & Ivezaj, 2015; Michalopoulou et al., 2022), this should not be considered the only part of the puzzle in weight management and warrants further exploratory research of the genetic, behavioural, physiological and environmental homeostatic systems associated (Dabas et al., 2024). This suggests that while

HCP recognise the value of fostering patient motivation in weight management, they also understand its limitations when viewed in isolation. This underscores the importance of combining motivational support, such as MI, with broader, evidence-based strategies that consider genetic, behavioural, and environmental influences.

4.1.2 Fostering a respectful and stigma-free environment

HCPs emphasised the importance of fostering a respectful, supportive, and non-judgemental environment, recognising that the *'omnipresence of weight stigma'* often creates barriers to open discussions about weight. Many HCP spoke about how the patients' previous experiences of weight stigma entered the discussion they could have. Patients were seen to avoid discussions or offer limited information about their diet and activity due to feeling ashamed. HCPs noted that their typical lines of enquiry could be perceived differently by those with prior experiences of weight stigma, with some patients interpreting questions as overly probing or critical. This was seen to lead to defensiveness and resistance to further discussion around weight.

It seemed that HCP viewed weight stigma to be internalised within the patient and shared their observations of its impact during the healthcare appointment. HCP narratives could be mapped onto the three overlapping processes proposed by Phelan et al. (2015). *Identity threat* occurs when patients experience situations that make them feel devalued because of their weight, increasing the individual's awareness for rejection or derogation. This was shown in narratives where patient consistently apologised for living in their body and attempting to cover themselves up to avoid judgement. *Stereotype threat* occurs when an individual becomes preoccupied with detecting stereotyping and so, monitors their own behaviour to ensure that it does not confirm group stereotypes. HCP described some to withhold information regarding diet and exercise, possibly in response to not wanting to confirm group

stereotypes or be judged on their lifestyle choices. Finally f*elt stigma* describes the expectation of poor treatment based on past experiences of discrimination (Phelan et al., 2015). Again, HCP provided examples of how they perceived their patient to come to the clinic appointment expecting to be judged and criticised. Therefore, the consequence of weight stigma on an individual's identity is carried out in everyday situations they interact with, with health appointments no exception to this.

The omnipresence of weight stigma had significant implications for how the HCP approached the consultation. Many described a 'fear' of being perceived as judgemental and of causing offence, alienating their patients during the weight-related discussion. Many expressed shock and disbelief at the level of weight discrimination present online, instead wanting to offer their patients care and compassion. HCP acknowledged the harmful consequences of stigma on the individual including higher levels of shame, blame and stress (Salas et al., 2019), lower self-esteem, increase mental health difficulties, including depression and, anxiety (Puhl & Brownell, 2001) and negatively impact the patient's health motivation and compliance (Hayward et al., 2020). Yet the HCP interviewed were not free from weight biases and is in line with previous research where HCP hold explicit and implicit negative opinions about individual's living with obesity (Darling & Atav, 2019; Miller et al., 2013; Phelan et al., 2015; Schwartz & Brownell, 2004). While HCP are unlikely to intentionally discriminate against their patients, demonstrating a commitment to providing healthcare, such attitudes can influence HCP clinical practice, including reduced person-centred communication, (Odom et al., 2010), offering less respect, time spent with patients (Bąk-Sosnowska et al., 2022), and increased risk of patient mistrust and disengagement (Gupta et al., 2020). A few HCP expressed the awareness of their own judgements and weight biases, often noting when they felt they sounded critical or judgemental whereas others undergoing anti-bias training had been more explicit in their previously held biases. However, there were a few comments

raised which indicated others seemed less aware of their biases, relating obesity solely to a lack of motivation and willpower or the ease in which people should be able to lose weight.

The described fear of offending or judging those who live in a bigger body appeared to conflict with the HCP felt responsibility to offer weight-related care and desire to protect the individual's health. For some this initiated the HCP to undertake their own anti-bias training, exploring their biases and increasing the awareness of the impact such attitudes have on their discussions. Such examinations of weight-biases are shown to increase empathy and encourage a weight-inclusive approach (Ryan et al., 2024). Phelan et al. (2015) summarise strategies to improve HCP attitudes towards weight, including enhancing empathy through perspective-taking, changing perceived norms around negative stereotypes, and educating on the multifactorial causes of weight gain and loss. These strategies aim to encourage HCPs to reflect on their explicit beliefs, reduce weight bias, and improve attitudes towards people living with obesity. Indeed, several HCPs interviewed expressed a desire for further anti-bias training to support weight-related discussions with patients in a way that avoids causing offence or appears judgmental.

The HCP interviewed in this study discussed two factors that they felt mitigated the influence of weight stigma including the *'mindful use of language'* and *'the power of rapport'*. Nearly all HCP discussed the mindful use of language regarding weight-related discussions. They explained that they would not use the term 'obesity' with patients due to the negative connotations associated. This was often expressed as feeling mean or judgmental if used during the discussion. The term obesity is often perceived as derogatory and reinforce negative weight-related attitudes (Puhl & Heuer, 2009; Tailor & Ogden, 2009; Thomas et al., 2008). When used by HCP, those living with obesity have reported feeling less motivated to

weight-loss, more frustrated and hopeless (Ward et al., 2009), and thus close down the conversation regarding weight (Wadden & Didie, 2003).

Instead, HCP expressed a preference for using *BMI* or *weight* and *weight-loss*. In one instance, an HCP cited the need to make clinical language 'fluffy' for the patient when holding weight-related discussions. This implies that HCP may feel the need to soften or modify clinical language to make discussions less confronting for patients. It suggests an awareness of the sensitivity around weight-related discussions and a desire to avoid triggering shame, discomfort, or stigma. Others expressed using person-centred language, emphasising a tone of empathy, collaboration and empowerment. HCP felt this minimised the possibility of offending their patients but was also deemed crucial in facilitating respectful, open and honest discussions regarding weight (Bąk-Sosnowska et al., 2022). There is evidence encouraging practitioners to use more patient-friendly terms such as 'weight' and 'BMI' to avoid the potential to stigmatise their patients (Volger et al., 2012) and has found to have a positive effect on the patients' satisfaction, self-management, and perceived quality of care by HCP (Rathert et al., 2013). The study's findings highlight how HCPs intentionally adapt their language to reduce the emotional discomfort associated with weight-related discussions and highlights a broader effort to uphold patient dignity through empathetic and person-centred communication.

The choice of language used presented some HCPs with a dilemma in balancing clinical accuracy and compassionate communication. For example, the use of BMI was seen as ineffective to communicate the health risks associated if the patient had little understanding of what it meant clinically. The use of medical terms, such as obesity has been shown to be beneficial in communicating the risk-factors associated that is understood by the patient (Tailor & Ogden, 2009). Thus, HCPs face a challenge in choosing language that balances

clinical clarity with sensitivity to patients' understanding and emotional responses. It highlights the importance of using terminology that not only communicates medical risk effectively but also aligns with broader efforts to redefine obesity in a way that supports person-centred weight management discussions.

The language used appeared to be guided by HCP own negative experience of using the term obese in weight-related discussions and the patient's own language preferences. To understand the patient's language preferences, HCP assessed and adapted their language according to the language used by the patient (Lang, 2012). Interestingly only one HCP cited the use of the Language Matters report. This report identified relevant language features highlighted as important by individuals living with obesity, including person-first language (Albury et al., 2020). During the interviews the lead researcher used person-first language throughout, however, this was not replicated in HCP narratives. This may indicate that the report has not been widely disseminated among primary care staff. Alternatively, it could suggest that HCP have not integrated the language into their everyday practice outside the clinic setting. While clinicians may express a desire to provide person-centred care, their perceptions may not align with their actual practice (Cox et al., 2011; Crocker & Smith, 2019), and non-person-centred language continues to be frequently used in major medical and obesity-focused journals (Griffin et al., 2023). Therefore, the results imply that HCP may be relying on personal experience and patient cues rather than formal guidance to shape their language in weight-related discussions.

In the *'the power of rapport'* HCP described how the professional-patient rapport was the foundation for holding sensitive, weight-related discussions. It was seen to facilitate a safe environment, encouraging the patient's comfortability in the room and mitigating the risk of offending or upsetting patients when raising the topic of weight or conveying the health risks

associated. Rapport appeared to help patients understand that the HCP's motivation for raising the topic of weight was rooted in care and support, with their best interests at heart. These findings align with systematic review evidence on the *Security of a Trusting, Collaborative and Caring Relationship*. Individuals living with obesity viewed the relationship as essential for open, honest discussions about weight and felt more likely to respond positively when they believed the HCP genuinely cared about them and their health. Such findings are in line with previous evidence highlighting the role of rapport as key to holding effective discussions for weight management (Dewhurst et al., 2017; Ross, 2013), acting as a foundation for trust (Leslie & Lonneman, 2016) and is closely linked to empathy and respect (Lang, 2012). It is shown to encourage patients to feel at ease during stressful circumstances (Belcher & Jones, 2009), positively impacts patient outcomes, increasing satisfaction and improving adherence to treatment (Lang, 2012; Leach, 2005).

HCP also considered the importance of rapport when exploring the causal factors contributing to the patient's weight and barriers to weight management. This was especially important when a patient presented with mental health difficulties, trauma, previous failure or shame. Two HCP discussed identifying the link between their patients' past experiences of sexual abuse trauma and weight after the rapport had been established. This was deemed possible by the trust they had built and set a new focus for treatment (i.e. referral for therapy). Thus, this in turn supported the development of a tailored treatment plan that addressed the individual's underlying causes and was realistic within the context of their daily life (Dewhurst et al., 2017; Luig et al., 2018). Therefore, rapport was seen as essential in putting patients at ease when exploring the underlying causes of their weight and barriers to weight management, particularly in cases involving mental health difficulties and trauma, enabling more open conversations and the development of tailored, sensitive treatment plans.

The HCP in this study cited several factors they thought important in the development of rapport. These included establishing trust, active listening, showing empathy, unconditional positive regard, respecting autonomy and creating a supportive, non-judgmental environment. The continuity of care with the same HCP at each appointment was also discussed, where patients did not have to repeat their story to multiple HCPs at every appointment. HCP expressed protecting this continuity, with some explicitly stating to patients to ask for them name. Such features expressed link with the current knowledge of rapport which cites involving empathy and interpersonal skills such as listening and communicating (Mercieca et al., 2014), confidence, compassion, frankness, respect, thoroughness (Ross, 2013), collaboration, reciprocity, parity and growth (Leach, 2005). The HCP in this study described using rapport to help prevent offending or upsetting patients during weight-related discussions. However, it raises the question of whether additional effort is required to build rapport with patients who have previously experienced weight stigma in healthcare settings. However, this was not explored within this study and warrants further research.

4.1.3 Weight is only one piece of the treatment puzzle

This theme highlights the factors influencing HCP in the creation of tailored treatment plans for their patients. In the subtheme *Aligning treatment with patient preferences and clinical judgement,* HCP discussed the need to assess whether the patient was interested in weight management interventions and if so, what type of intervention they were interested in. For the patients who did not want weight management interventions, HCP spoke of their disappointment but the need to respect their patient's decision. This was especially important when their patient had attended the appointment for a different, but related presenting medical problem. HCP discussed wanting to address a patient's weight due to its link with several health conditions they presented with but ultimately respected the patient's decision

to focus treatment on the issue they sought support for. The findings align with recommendations that advise HCPs to prioritise the patient's primary presenting complaint, first assessing whether a discussion about weight is appropriate, rather than assuming the patient requires or desires weight-loss advice (Dewhurst et al., 2017).

For the patients who wanted to explore weight-loss interventions, HCP discussed the need to understand the treatment the client desired and was willing to engage in. This was relatively straightforward when the patient came to the appointment with an intervention or referral in mind. However, for others, HCP had to explore what the patient had previously tried, the barriers to weight-loss and what the patient was willing to engage with again. However, this was only one part of the treatment puzzle. Once the patients' preferences had been identified, the HCP expressed the need to assess whether the patient fit the eligibility for the intervention requested. Service eligibility criteria often included meeting the weight parameters of the programme, presence of comorbid health conditions and whether the patients had previously engaged in the intervention. The referrals mentioned by HCPs included external tier 2 weight management services, dietitians, gym concession schemes, health and wellbeing practitioners, social prescribers or therapeutic services. For HCPs authorised to prescribe medication, this option was only considered if it aligned with current prescribing guidelines. Tier 3 and 4 options were considered if the patient met the criteria and was prepared to wait up to two years on a waiting list. In such cases, HCPs also offered access to tier 2 services while the patient waited.

HCP also spoke of the need to assess risk and make sure the intervention was safe for the patient. For example, the identification of comorbid conditions such as diabetes, cardiovascular disease or mental health difficulties were then seen as a priority to manage rather than focussing solely on weight-loss. This was expressed by one HCP, whereby a

referral to mental health services to treat the depression was deemed more appropriate than weight management. As such, HCP expressed the need to assess and explore the person's full story either through the discussion or use of diary monitoring to identify the most appropriate treatment plan.

All of the HCP in this study all reported offering some form of intervention. The most common form of intervention offered was advice and information delivered through the discussion, in leaflet form or signposting to apps or websites. HCP often spoke of using leaflets and websites that they previously had experience with, drawing upon national services to offer the patient advice on dietary or activity changes that could be made. Other forms of intervention offered depended on the HCP professional role and expertise. These included, the use of dietary and activity diaries, SMART goals, MI, CBT and offering follow up appointments to monitor progress. Some also spoke about leveraging the individual's support system, encouraging the involvement of family, friends and support groups where appropriate, understanding the need for social involvement to aid weight management (Dahl et al., 2016). These findings are interesting considering previous research has often reported HCP to be unwilling or neglect to offer weight management support (Allen et al., 2015; Ely et al., 2009; Wangler & Jansky, 2023), but such counselling can increase patient's motivation towards weight-loss (Aveyard et al., 2016; Jackson et al., 2024). These results are promising, considering all HCP interviewed all cited the use of some form of intervention to aid their patients weight management efforts.

The treatment was also guided by the HCP own opinions and views of lifestyle and medical interventions. This was often expressed in terms of the efficacy base of weight management interventions, where many felt sceptical about referring patients to lifestyle programmes due to belief that they might not work (Kirk et al., 2014). Regarding medication, whilst most

accepted this could aid weight-loss, HCP described their *'dislike'* for the approach due to the numerous side-effects, lack of clear guidelines and perception that they only treat the symptom of obesity rather than the root cause (Dewhurst et al., 2017). Another contributing factor was due to the ever *'evolving'* guidance that guide HCP on the most up-to-date advice on nutrition and activity, suggesting a sense of confusion at which diets to advice or what intervention to offer (Bornhoeft, 2018b; Henderson, 2015). Instead, HCP appeared to suggest advice and interventions based on their own personal knowledge of nutrition and dietary information, rather than from evidence-based guidelines. This calls for clearer protocols and education to help HCP deliver evidence-based treatment and refer patients to appropriate programs (Oshman et al., 2023).

Within the subtheme *Weight management has no 'quick fixes'* HCP expressed their opinions on what they deemed to be *quick fix* interventions for weight-loss. This was often regarding the rise in requests for medication and surgical options but also FAD, *extreme* or *restrictive* diets. The reason why HCP had such strong views on quick fix interventions seemed to be based the view that such measures were ineffective towards sustainable, long-term weight management. They cited concerns that the newly available medication and surgical interventions would take patients away from implementing lifestyle changes that could also be beneficial for health. Instead, HCPs appeared to prefer lifestyle interventions over medication alone, although they acknowledged the benefits of combining both approaches. This aligns with evidence suggesting weight-loss interventions incorporating both a reduced-energy diet, exercise and weight-loss medications led to a mean 3-6% weight loss maintained over 48 months (Franz et al., 2007). HCP seemed to empathise with the patient's desire for such interventions, where quick weight-loss was perceived to be driven by the societal pressure to lose weight quickly and achieve the socially desired body. They acknowledged the need for patients to see quick weight-loss results when they were dissatisfied with their

body image and how this could impact the individuals' motivation and engagement in weight management (Spreckley et al., 2021; Thomas, Hyde, Karunaratne, Kausman, et al., 2008).

Instead, HCP seemed to iterate to their patients that sustainable weight-loss was difficult, requiring effort and motivation long-term. During the discussion, it seemed HCP wanted to their patient to convey the difficult challenge they had embarked on, whether the timing was right and setting realistic weight-loss goals. This was often expressed with empathy, reinforcing the patients' successes and consistent efforts towards lifestyle changes, attempting to alleviate the presence of blame patients might experience for being unable to maintain weight-loss. Such views were replicated in Greener et al. (2010) where HCP discussed the 'sizeable challenge' faced by individuals in sustaining their original motivation to lose weight over longer periods of time, becoming de-motivated after initial quick successes and unrealistic expectations about the total weight-loss sought after.

However, Dewhurst et al., (2017) interpreted such comments as HCP lack of hope for weight-loss success. Whilst their HCP also recognised that it was a constant battle for patients to sustain motivation, participants expressed feeling lasting behaviour change and weight-loss maintenance was unlikely. Furthermore, Dewhurst et al., (2017) questioned whether this negative reaction from clinicians may serve to perpetuate a sense of learned helplessness within patients who find weight management a constant challenge. This is reflected in the current evidence demonstrating a positive association between obesity and mood and anxiety disorders (Mather et al., 2009) and the role psychological and mental state can have in determining successful behaviour change in weight management (Teixeira et al., 2015; B. Zhu et al., 2022).

The HCP in this study focused on creating a treatment plan that was sustainable, incorporating the patients' needs and existing barriers to weight-loss. HCP acknowledged

barriers to weight-loss could vary widely depending on individual circumstances, but some common ones cited included biological, physical, psychological, social, economic and practical (such as lack of time or knowledge). Many accepted their role in assessing the barriers pertinent to the individual and identifying which ones could be modified through intervention such as setting SMART goals, realistic expectations, CBT, advice and information or referral to external services. This finding suggests HCP should have a thorough understanding of the individual's barrier, its cause, and what can be done to overcome it (Roberts et al., 2015). While HCP expressed the importance of being aware of barriers, they did discuss limitations in fully understanding and addressing them in practice due to time restraints, lack of resources and training and the complexity of weight management, where each patient's experience and obstacles are unique and require tailored solutions.

Intervention requires a holistic approach underscores the value HCP place for a multidisciplinary team in weight management. One role was thought to be inadequate in supporting patients considering the opinion obesity is a complex condition with multiple underlying causes. Weight and weight-loss was therefore seen as only one part of the treatment plan and required a holistic approach targeting the multiple underlying causes. HCP cited the need for psychological input, dieticians, exercise specialists and other specialist teams when comorbid conditions were present (such as diabetes and/or cardiovascular services). These studies findings are in line with previous qualitative results where HCP have valued a multidisciplinary team approach (Hayes et al., 2017; Jeffers et al., 2024; Oshman et al., 2023) allowing for a more holistic approach to weight management (Bischoff et al., 2017).

Within the need for a MDT, there was also an expressed desire for greater psychological input in weight management services. This was often in reference to support with disordered or emotional eating, mental health difficulties, trauma, and understanding the behavioural patterns underlying an individuals' weight. Health and Wellbeing coaches reflected on their role offering low intensive, short-term CBT support but even they expressed feeling overwhelmed and lacked the speciality to treat the more untrenched eating patterns. Perriard-Abdoh et al., (2019) call for more psychologically informed policies, standards and guidelines, training and supervision in weight management services. They express how psychologists in weight management can play an additional role in assessing and addressing mental health difficulties, supporting with behaviour change as well as supporting HCP in stigma-free communications and knowledge to support their patients living with obesity (Perriard-Abdoh et al., 2019). Changing lifestyle habits, including diet and exercise is difficult and requires knowledge of problem-solving techniques, cognitive restructuring to improve self-control, and self-monitoring essential for both weight-loss and maintenance (Jensen et al., 2014; Kushner & Ryan, 2014). In essence, HCP felt weight management would benefit from greater access to psychological expertise, imbedded across Tier 2, 3, and 4 services.

The effectiveness of an MDT approach for weight management is currently being established (Wadden et al., 2011), whereby weight management MDTs are shown to be more influential in increasing the weight-loss success rate and improving the patients over health (Yu et al., 2021). The MDT was shown to combine their expertise and knowledge to support the individual, but also offer ongoing supervision for each patient, aiding adherence to long-term lifestyle interventions and supporting weight maintenance (Yu et al., 2021). However, HCP cited the need for collaboration and coordination between the different disciplines and services. For the HCP who primarily refer their patients on to external services there appears

to be a lack of communication and up-dates on client progress leaving the HCP to wonder whether the treatment plan was sufficient and effective for the patient. The use of multidisciplinary approaches has been criticised for lacking clear accountability within practice teams regarding responsibility for weight management (Jeffers et al., 2024). Team members may be unclear about their roles, with little agreement on who should take the lead in overseeing ongoing treatment and management (Hayes et al., 2017; Mercer & Tessier, 2001). While some HCP interviewed described using follow-up appointments to check in with patients and review treatment plans, for many, coordination appeared to be limited once a referral was made, or treatment ended. Ongoing engagement only occurred if the patient was re-referred to the surgery for another underlying condition or appointment. Thus, further clarity is needed to better understand which professionals are best placed for the various components of obesity care; especially regarding the long-term supervision of individuals living with obesity (Bleich et al., 2012).

4.1.4 The struggle of navigating weight management services

This theme depicts the impact of current organisational challenges present in weight management systems and its influence on the treatment options available for patients. In the subtheme, *'a system of closed doors: limited services, strict criteria and long waitlist's',* the main challenges expressed included strict eligibility criteria, specialist services with extensive waiting periods and closed services due to funding cuts. When discussing available treatment options for patients, HCPs frequently questioned the eligibility criteria for each service, often expressing uncertainty about current guidelines, whether a service was still running in their area, or if funding had been cut. Such challenges have been consistently reported across studies where services are experienced as fragmented and inconsistent across different locations, with variations in approach, eligibility criteria, and waiting times (Ells et al., 2020;

Hazlehurst et al., 2020; Metcalfe & Sasse, 2023; Watkins et al., 2023). HCP expressed several implications such challenges had on their role. Firstly, HCPs expressed frustration at a system that was seen to leave patients without access to specialist care and positioned them to 'fill a gap' in the available services. For GP's, nurses and pharmacists this resulted in the focus on managing patients' associated comorbidities, whereas, dieticians and health & wellbeing practitioners described managing caseloads beyond their capacity. Ultimately this was perceived to leave weight-related issues unaddressed, contributing to both professional and patient frustration, eroding trust in the system, and potentially leading to a decline in patients' health.

The HCP in this study also described how their patients were turning to external, potentially unsafe sources for weight management due of the gap in NHS service provision. This is a novel finding of the study, whereby HCP expressed concern that their patients were resorting to more extreme measures available over the internet, privately and abroad for surgical intervention. Present within HCP narratives was the distress experienced when recalling patients whose health and mortality had been significantly compromised due to the use of unregulated and unsafe weight management options. This possibly speaks to the moral distress felt by HCP who want to support their patients safely but lack the resources or services to offer effective care, leaving them unable to meet patient needs. Not only did this raise concerns over patient safety but also the additional strain this may pose on the NHS due to the potential rise in complications.

HCP also described the difficulties engaging patients who have faced repeated failures, in the subtheme *'the weight of failure: frustration in a system set up for failure'*. HCP empathised with the challenges faced by adults living with obesity when attempting weight-loss and acknowledged the emotional and psychological impact of engaging in repeated weight-loss

attempts unsuccessfully. Thomas et al. (2008) qualitative study reported individual's feel like a *"failure"* when they had not succeeded in commercial weight-loss programs, whilst others reported feeling "*depressed*", "*angry*" or "*cross*". When individuals experiencing obesity ultimately "fail", or do not lose a predetermined amount of weight, these failures can make individuals feel that they are not normal or cannot be healthy until weight is lost (Dixon et al., 2025). The impact of such failures are thought to play a significant role in preventing adults living with obesity from taking actions aligned with their goals (Ingels & Zizzi, 2018), feel less confident at succeeding in weight-loss (Evans et al., 2018) and can lead to disordered eating or excessive exercise (Miller, 2005).

However, HCPs described past failure as challenging the discussion around further support and alternative weight management options with patients, particularly when patients felt they had already exhausted all available approaches. HCPs highlighted how patients' sense of failure can become ingrained in their identity and self-esteem. In light of this, the HCP interviewed felt it was especially important to support and engage these patients, offering encouragement, acknowledging successes and exploring the potential barriers the patient faces. They cited the need to find something that might make a difference for their patients. This is important given that adults living with obesity often return to weight-loss programmes despite previous unsuccessful attempts (Thomas et al., 2008).

HCPs expressed the view that the current system contributes to this sense of failure, as patients are required to fail before they can access and progress to the more specialist services they need. This has often been a criticism of the four-tiered weight management system, where progression through the tiers requires all other treatment options to have been attempted and found ineffective (Hazlehurst et al., 2020). There seemed to be a narrative of

blame and powerlessness in HCP narratives, where HCP and patients blame themselves, each other and the system.

This also came through in the HCP uncertainty around the efficacy of weight management options. Although this did not appear to influence HCP's decisions to refer patients to services, the effectiveness of medication, surgical options, and behavioural weight interventions were questioned for various reasons. Khattab, (2024) explored the factors contributing to the failure of weight-loss programmes, concluding that impractical dietary restrictions, potential metabolic effects, limited emphasis on lifestyle changes, genetic predispositions, psychological influences, socioeconomic factors, and underlying medical conditions. HCP uncertainty regarding the effectiveness of weight management has previously been attributed to biased beliefs, with some professionals holding the view that obesity is primarily the result of a lack of patient self-control (Van Dillen et al., 2013). This did not seem to apply to the HCP interviewed in this study, who often expressed a degree of distrust in the current system and the services available to support their patients with weight management. There appeared to be a lack of confidence that the system could provide effective, specialist, and preventative support before comorbidities and further health risks emerged.

These results paired with the wider evidence discussed in the introduction point to a critical need for the expansion and development of NHS weight management services, ensuring services are more accessible, timely, and comprehensive, to prevent patients from seeking alternative, potentially harmful weight-loss measures. The current short-term funding and restrictive commissioning processes of services, particularly tier 2, has been criticised in preventing sustainable and innovative weight management practices (Hazlehurst et al., 2020). The impact of this has been shown to be detrimental to patients, falling short of addressing

health inequalities and negatively impacting overall health and wellbeing (Beaumont et al., 2024). The HCPs interviewed called for improved access to specialist services, including psychological support, as part of early intervention rather than waiting for patients to meet Tier 3 criteria. Hazlehurst et al. (2020) put forth a more integrated system of weight management composed of two tiers, a tier for prevention and a tier for treatment, with the treatment tier (encompassing current Tiers 2, 3, and 4) streamlining access to the necessary expertise and a range of treatment options to meet individuals' needs. Such a system could also encourage greater flexibility to meet the needs of a diverse patient group, including preferences shaped by age, socioeconomic status, and geographic location, as well as personal preferences (Adams, 2020; Kalra et al., 2020; Watkins et al., 2023).

4.1.5 The problem with contemporary weight narratives

The subtheme *'Obesity needs a public health message, just not this one'* was important to include. Whilst it did not seem to be explicit in the discussions HCP had with their patients, such forms of social and public messaging seemed to influence the discussions and treatment options they felt they could offer.

The 'eat less, move more' paradigm was offered as a well-known, traditional approach. However, HCP described the initiative to be unhelpful and ineffective in supporting adults towards healthier lifestyle choices, due to its "*one-size-fits-all,*" approach focussed solely on individual behaviour. Some described the message as counterproductive to weight-loss efforts where, the message may unintentionally promote unhealthy behaviours and prioritise quick weight-loss, rather than promoting long-term, sustainable lifestyle changes. Furthermore, the HCP discussed how the message did little to equip individuals with the specific information needed to support the patient to make lifestyle changes. Furthermore, HCPs felt the messaging excluded certain groups, especially regarding the message to increase physical

activity. This was seen to exclude those with physical health difficulties who may not be able to access increased exercise.

The HCP criticisms of the approach reflect the wider literature surrounding the public health message. Where public health is positioned to intervene on a wider scale to influence individual choices, typically, these campaigns involve a message, directed at a particular behaviour associated with obesity (e.g. excessive energy intake) along with the potential consequences of being overweight or obese (Couch et al., 2018). Whilst the message is simple, easy to communicate, and supported by basic science (Dixon et al., 2025), which was seen as desirable by HCP in this study, it ignored the influence of biological, genetic and social influences (Penney & Kirk, 2015) as well as the increasing obesogenic environment of today's society (Swinburn et al., 1999). HCP felt the food industry needed greater regulation by the government in its marketing of 'healthy foods'. The fact that one participant asked whether this research was sponsored by Nestle, implies the conflict of interest where food and drink manufacturers are driving public health agendas (British Medical Association, 2012).

Such public narratives were seen to set expectations on the treatment options that might be offered by HCP. This could explain why HCP felt the message was counterproductive to weight management, as it seemed that HCP had to 'debunk' such expectations to lose weight. Furthermore, HCP recognised that the message does not address the diverse needs of different population groups and reinforces the narrative that weight is solely an issue of personal choice or willpower. This was felt to complicate HCPs' efforts to promote more compassionate, holistic care, which could lead to frustration and a sense that such messaging undermines their clinical efforts.

The HAES movement was divisive within HCP narratives, with conflicting views on whether the moment offered opportunities or greater challenges during weight management discussions. Those in support, recognised the message could be helpful to reduce weight stigma and promote body acceptance, in line with the underpinning of the movement (Bombak, 2014). This was felt to lead to more inclusive, less stigmatising consultations, reducing patient shame and improving engagement with their patients (Puhl & Heuer, 2009). HCP also expressed such weight-inclusive messaging, citing the need for patients to find joy in their lifestyles and engaging in enjoyable dietary and physical activity, rather than solely focused on weight-loss as the primary goal. For some, the HAES principles focussing on health-promoting behaviours, such as improving nutrition, increasing physical activity, enhancing mental wellbeing was seen as a facilitator to engage patients in behaviours that promote health.

However, some expressed the concern that the weight-neutral approach could provide a barrier to addressing weight. This was explicit in the HCPs who felt the movement could prevent a discussion regarding weight as patients might perceive the HCP as fat shaming, discriminatory or stigmatising. Furthermore, some HCP expressed concern that the message could inadvertently normalise obesity and disagreed with the view that it is possible to be truly healthy at every size, minimising the health consequences of excess weight (Muttarak, 2018). This view is understandable considering HCP's medical training, where excess weight has explicitly been linked to a variety of potential physical health risk factors (Abdullah et al., 2010; Földi et al., 2020). At present, HAES offers an alternative approach to medical models (Penney & Kirk, 2015), which clash with weight-centric guidelines and frameworks that target BMI thresholds for intervention. HCP narratives imply a conflict between patient-centred care and the institutional pressures to focus on weight metrics to ascertain health. Their narratives also suggest the need for more nuanced communication skills to hold such

discussions sensitively, without inadvertently promoting weight stigma or minimising serious health risks. The HAES philosophy is relatively new, and it seemed that some of the HCP may have misinterpreted the HAES as anti-health or anti-invention, when in fact its philosophical underpinning supports proactive, compassionate care (Bombak, 2014). If the HAES model continues to provide promising evidence to support adults living with obesity towards living a healthier lifestyle (Bombak, 2014; Clayton et al., 2017), and becomes integrated within public health policy, these findings suggest HCPs may require additional training to fully understand and implement it effectively.

The findings question the 'helpfulness' of the current narratives around obesity in supporting HCP in their role. Public health interventions aim to improve the health of individuals and populations through efforts to promote acceptable behaviours and encourage behaviour change (Couch et al., 2018). For this reason, HCPs expressed a need for public health messaging to support their work but felt that current messages were ineffective and contributed to dissatisfaction with how weight and weight-loss efforts are understood and portrayed (Greener et al., 2010). Instead, HCP advocated for a shift in public health messaging, one that was evidence-based, compassionate, and focused on holistic well-being. They stressed the importance of a non-stigmatising, supportive approach that acknowledges individual circumstances, fosters realistic and sustainable health behaviours, and moves away from rigid, harmful weight-loss ideals. Thus, HCP seemed more aligned with weight-inclusive, holistic care, which was felt to positively influence the discussions they could have with their patients, minimising the influence of weight-stigma and contributing to better care.

Promising evidence supports a shift to weight-inclusive approached with improvements in individuals' psychological health, weight-loss, physical health (Clifford et al., 2015; Mauldin et al., 2022). Thus, HCP emphasised the message be inclusive, encourage wellness and

positivity and not stigmatise or shame people for their weight. However, participants acknowledged that this was no easy task for public health educators and required a long-term agenda uninfluenced by changes in government structure. Weight-centric approaches are so well established within society that the adoption of newer, proven paradigms are challenging to implement (Mauldin et al., 2022), making the shift to weight-inclusive care requiring action across the health system, food industry, education, public health, government, societal and the individual (Berry, 2020).

'Debunking weight and weight-loss treatments' highlights how HCP feel they must navigate the societal myths and perceptions surrounding weight and weight-loss. HCPs spoke about how patients attended healthcare appointments with expectations of achieving a desired body shape, leading to unrealistic weight-loss goals and increased demand for specific weight-loss interventions. Social media was seen to encourage patients' desire for a 'quick fix' to weight-loss, increasing demand for weight-loss medications and surgical interventions. It is well known that celebrity and social media influences largely shape aesthetic trends, with evidence suggesting a sharp rise in public demand weight-loss medications, such as Ozempic (Basch et al., 2017; Han et al., 2024). This raised concerns among HCP regarding the eligibility of such interventions on the NHS for weight-loss alone and the consequence of patients seeking such treatments privately or online. Thus, HCPs felt they had to challenge widespread societal myths and misinformation about weight and weight-loss within the clinical interaction.

HCP discussed the need to educate their patients and provide evidence-based guidance for the most realistic amount of weight-loss achievable. This was especially important in describing the current NHS prescribing criteria for medication and surgical options. Advice and information has frequently been highlighted as an important part of HCP role in weight management (Bornhoeft, 2018b; Brown & Thompson, 2007; Jeffers et al., 2024) and patients

often expect their HCPs to provide this knowledge, provided it is tailored to them (Ragsdale et al., 2017; Yunus et al., 2023). However, there were variances in the professional's capacity to offer such advice within their role. Dietitians and health and wellbeing coaches felt they were able to verbally provide more in-depth knowledge during consultations. Whereas GPs and nurses reported relying on tools and signposting to external sources to support the dissemination of this information. This suggests HCP feel a large part of their role is to share their knowledge surrounding healthy lifestyle changes that could support their patients in weight management.

A few HCPs mentioned that social media personalities could support their efforts in educating patients on lifestyle interventions. Two professionals specifically highlighted the work of Dr Rangan Chatterjee, noting that they directed patients to their content. While incorporating social media into weight management interventions is relatively new, it is increasingly recognised as a viable platform for delivering weight-management support (Hawks et al., 2020; Jane et al., 2018), with evidence suggesting that adults use such platforms for health information when attempting to change health behaviours, such as improving diet (Dahl et al., 2016). Social media can also provide empowerment through social support, find positive meaning in their efforts, and provide encouragement to others on a similar journey (Dahl et al., 2016). This suggests, HCPs can and do use social media as an additional tool in their practice by signposting patients to credible content and trusted figures. It can supplement their advice and help bridge the gap between appointments, especially where time and resources are limited. However, with mixed evidence on efficacy (Shiyab et al., 2023) and the presence of misinformation online, it's vital that they guide patients toward evidence-based and professionally checked sources to avoid harm or unrealistic expectations.

4.1.6 The route to knowledge and expertise

The HCP interviewed expressed how current training was limited in offering the knowledge needed to support their patients living with obesity. This finding is not new to the field of obesity. A lack of training has continuous been reported as a barrier to obesity care (Bleich et al., 2015; Jeffers et al., 2024; Olson et al., 2023), where a lack of knowledge has been shown to affect HCP confidence to hold discussions (Kolasa & Rickett, 2010). HCP are shown to be less likely to discuss diet or exercise if these topics were not covered during medical school or professional training (Forman-Hoffman et al., 2006). As a result, patients may not have access to care provided by obesity-trained HCP (Washington et al., 2023). Many HCP in the present study referenced the NICE guidelines available to guide clinical practice but described these as outdated and far removed from clinical practice. This reflects the current criticism of obesity-related policy, where they are not transferrable to clinical practice (Theis & White, 2021). This suggests that obesity-related training has changed little over time and can still be described as fragmentary or disconnected in its approach to educating professionals (RCP., 2010). Given obesity training has shown to improve obesity care (Forman-Hoffman et al., 2006), improvements to medical and postgraduate education is critical.

Unlike previous research, the HCP in this study did not cite a lack of training affecting their confidence in supporting adults. This may be explained by the fact that HCP often sought out their own knowledge expressed in *Training is limited, so I trained myself*. This highlighted how professionals' approach to gather the much-needed knowledge was sought through self-funded training courses, self-learning, social media, learning from colleagues or gathering expertise through experience. Self-found training HCP referenced included MI, anti-bias training and courses to increase education on the causes of obesity, including psychological and biological understanding. Whilst this study did not explore the providers or hosts of such training, evaluations of short, obesity-related training modules have been associated with

increased professional confidence, knowledge, skills, and attitudes (Maguire et al., 2019) and increased practice concordance with clinical guidelines (Gudzune et al., 2021). However, HCP did still express a lack of clarity and confidence in the available advice to offer patients. This could imply that regardless of the learning sought, HCP are still unclear on the best lifestyle advice and resources to offer. Furthermore, such an approach to training could mean obesity education and management practice is inconsistent across the learning of HCP tasked with supporting this population (RCP., 2010).

For the HCP who had access to a MDT, they spoke of a form of collaborative learning with their peers to aid their knowledge and skill. HCP spoke of using their colleague's knowledge around appropriate resources and services to aid their patient's treatment plan. This potentially calls for a team-based learning environment, where meaningful learning is combined with HCP clinical experiences (Mohammed et al., 2021). Team-based learning provides professionals with the opportunity to practice team-based clinical problem-solving skills and is shown to improve obesity knowledge (Olson et al., 2023), and increase familiarity of the different roles who could be of aid (Sanchez-Ramirez et al., 2018). However, it's implementation requires the collaborative effort across an MDT. These results could therefore strengthen the argument discussed in Theme Three, *Intervention requires a holistic approach* and assist HCP's learning and knowledge required for obesity management (Jeffers et al., 2024).

HCP also described drawing upon the years of experience gained in their professional role to aid their knowledge of working with adults living with obesity. Whilst it was not in the scope of this study to explore the correlation between length of service on expertise and knowledge, HCP narratives implied that over time, they gained practical, hands-on experience working with patients that contributed to the refining of skills to assess, advise, and manage weight-

related concerns. HCP also described learning what works and what does not in their clinical practice. This was often described in reference to deciding upon the most appropriate language to use and conduct of weight-related discussions. For some, HCP described a trial-and-error process to experience, learning from consultations that might not have been conducive to the patients' needs and weight-loss efforts. These findings are in line with the current qualitative literature which suggests HCP perceive greater experience to positively influence their ability to discuss weight with patients (Jeffers et al., 2024) and offer weight-loss counselling (Ferrante et al., 2009). In two separate studies, nurses reported finding it easier to have conversations surrounding weight from experience of talking to patients about lifestyle changes (Blackburn et al., 2015; Holmgren et al., 2019). Whilst these studies, rely on HCP self-report of perceived confidence in offering weight management, it does highlight how the length of service and experience influences HCP knowledge and ability to hold weight-related discussions and treatment.

If the government and NHS England continue to promote PC as the frontline service for obesity management, the results continue to contribute to the evidence suggesting HCP need greater support and knowledge. Although this subtheme highlights examples of how HCP overcame the lack of training and gaps in knowledge regarding evidence-based interventions, all HCP emphasised their active interest in supporting adults living with obesity, demonstrating their motivation and professional conduct to increase their knowledge in this area. However, they also expressed feeling felt alone to navigate the literature themselves and feeling fully responsible in their task to support this population. McQuigg et al. (2009) suggests the appointment of a specific staff member allocated in PC to take responsibility for structuring educational activities and engaging other staff regarding obesity treatment. Whilst this may be of benefit for interprofessional learning, the HCP must feel equipped and knowledgeable to undertake such a role.

HCP also expressed how they used their own personal experiences of weight, weight-loss and lifestyle behaviours to aid their consultations with patients, described in the *clinical use of personal experiences of weight*. HCP spoke of how their own weight, whether described as 'normal', overweight or obese, entered the interactions with their patients. HCPs described either being conscious of their own weight during discussions or having it brought to their attention by patients. This seemed to place HCP in a position to manage the influence their weight had on the discussion. These results are similar to previous qualitative research where HCP own weight status and personal health beliefs are perceived to influence interpersonal interactions within the clinical environment (Aboueid et al., 2022; Blackburn et al., 2015; Jeffers et al., 2024). However, the available research does not show a clear pattern as to whether this helps or hinders the discussion and consultation process.

For many of the HCP, they discussed how they used their experience of weight as a tool to aid their knowledge of holding discussions and/or guiding treatment options. For those who shared their weight to be overweight, they described using this experience to enhance the therapeutic relationship, offering greater empathy and reminding the HCP of the difficulties they may face living in a bigger body. One HCP described this as learning through lived experience of having tried and '*been through'* all the different interventions to aid their personal weight-loss journey. The findings reported are supported by a qualitative synthesis conducted by Jeffers et al. (2024) where HCP reported a perceived greater empathy, knowledge of weight stigma and the ability to offer advice and guidance based on their own personal experience of weight loss. HCP, much like the general population, are not immune to overweight or obesity (Miller et al., 2008). Within mental health services, there is a growing body of research on the value of experiential knowledge. Lived-experience practitioners understand themselves as compassionate and empathetic who work to hold the needs and experiences of their clients in mind (Cleary & Armour, 2022). Indeed, these results

suggest HCP with experiences of over-weight drew upon such experiences to aid their discussions.

HCP also expressed their favour to certain lifestyle behaviours and weight-loss programs after their own experience of engaging in such practice. For the HCP who described themselves as having a 'normal' weight or 'slim' body size, they reported role modelling and disclosing their own lifestyle behaviours during weight discussions. For those who had their own experience of successful interventive weight-loss, this was used to provide advice, diets or handouts that they had found helpful. These findings complement the following results from previous research. HCP personal experiences of weight-loss interventions are shown to increase HCP attitudes towards such interventions (Mercer & Tessier, 2001), guide obesity treatment recommendations (Oshman et al., 2023) and increase the likelihood of HCP offering weight counselling in their clinical role (Frank et al., 2000). Furthermore, the disclosure of the HCP own health lifestyle habits could motivate patients to replicate such changes (Frank et al., 2000).

However, the HCP weight was also seen to provide a barrier to the discussion. For those who reported themselves to be overweight, they expressed concern that their patient may not trust or believe their advice or recommendations due to their perceived weight. For those in smaller bodies, they described concern that their patients might not trust that they had the experience of weight-loss to draw upon. These findings are similar to those of Brown & Thompson. (2007) who reported smaller bodied nurses believed that they must manage the impression that they lack empathy and authentic experience in relation to obesity. Whilst those living in a bigger body felt they must manage impressions that they are poor role models or that they are giving advice which they themselves have not taken (Brown & Thompson, 2007). Some HCP do not like to discuss their own weight due to the personal

nature of such discussions, which in turn influenced their ability to discuss the topic within consultation (Aboueid et al., 2022; Blackburn et al., 2015). Indeed, some HCP interviewed referenced the need to be tough and secure in themselves, when their weight was raised during patient appointments.

Research concerning patient attitudes towards HCP body weight replicates this complicated relationship between a HCP's weight and patients' perceptions of their credibility and support in weight management. While some studies suggest that HCPs perceived as overweight or obese may face biased attitudes from their patients affecting trust and advice uptake (Puhl et al., 2013), others report mixed patient views, with many considering a HCP's weight irrelevant (Ananthakumar et al., 2020). Experimental studies have shown only small differences in patient satisfaction and no differences in advice recall based on HCP weight status (Čadek et al., 2023). However, there remains a small but significant trend for higher patient confidence in advice from HCPs not living with obesity (Hash et al., 2003).

Whilst the HCP did express using their experience of weight and/or a healthy lifestyle to aid their knowledge and weight management advice, caution must be taken by this method of weight management care and may be questioned due to reliance on personal experience as opposed to research and evidential advice. This study cannot make inferences about whether the HCP own weight is associated with increased knowledge, practice and attitudes. Zhu et al., (2011) findings suggest HCP with normal weight reported higher confidence in their weight management role, more positive outcome expectations, stronger professional role identity and fewer perceived barriers to weight management practices than the HCP with overweight. However, positive beliefs about individuals living with obesity and emotional response appeared to be related to being overweight. In contrast, Ferrante et al. (2009) found HCP own weight was not significantly associated with their knowledge, practice and attitudes

towards patients living with obesity. This suggests there's a distinction between *doing* something (like losing weight) and *understanding* it from a clinical perspective. In this case, someone may have lost weight but might not be equipped to explain how or why it happened, or how to help others do the same. Whilst the findings of this study suggest HCP place importance on their own experience to aid discussions, further research is required into the mechanisms and effectiveness of such an approach.

4.2 Limitations and Reflections

There are certain limitations to consider when interpreting the findings of this study. Participants may have had a specialist interest in obesity, influencing their decision to take part and introducing potential selection bias (Negrin et al., 2022). Participants were motivated to increase their learning and desire to support this population. Those who volunteered may have held stronger views or experiences (Clark, 2010), believed in the value of the research, and felt they had useful insights to share (Negrin et al., 2022). Gaining insight from engaged or confident professionals may be beneficial, as the study aimed to explore how HCPs facilitated and hindered discussions about weight and treatment. However, it would have been valuable to include HCPs with less interest or awareness of obesity-related issues. People may avoid research participation if they feel they have little to contribute (Coyne et al., 2016), meaning this study may have missed differing or indifferent perspectives. Thus, the findings may not fully represent the wider HCP population's views on supporting adults living with obesity. However, the researcher made efforts to recruit a variety of HCPs to capture a broad range of views and experiences. This included consulting with the NIHR to guide recruitment. Participation was open to all HCPs within PCNs, with a small monetary incentive, which may have encouraged engagement (Kelly et al., 2017).

Fifteen participants were interviewed for this study, in line with recommended guidelines for research using reflexive thematic analysis (Clarke & Braun, 2013). This is notable given their roles as NHS primary care staff, many of whom spoke of time pressures and workload constraints. However, the sample size may still be considered small given the recruitment process. Initially sent to one local primary care CRN, recruitment materials were later distributed nationally after two months with no expressions of interest. While it is unclear if all primary care staff received the materials, 26 individuals expressed interest, with 15 ultimately interviewed. This suggests a barrier to participation, with several factors influenced this. HCP limited time and heavy workloads may pose challenges to participate in research, as reflected in the theme *'A system of closed doors: limited services, strict criteria and long'*. While incentives such as protected research time or Continuous Personal Development credits exist, this study fell outside of those frameworks. If primary care staff are willing to participate but prevented by institutional barriers, valuable insights are lost. This is particularly relevant in obesity-related research, where HCP can help understand the challenges they face, enhance patient care, and inform policy and practice (Greener et al., 2010).

The sample was relatively homogeneous in terms of gender and ethnicity: thirteen participants identified as female, and eight as White British. Demographic characteristics can influence attitudes and perceptions of obesity. For example, men and women often occupy different societal roles and hold differing views on body weight (Ostlin et al., 2007). Cultural background can also shape how HCPs approach obesity, affecting perceptions, treatment strategies, and patient interactions (Capoccia et al., 2025). However, these groups are not homogenous and factors such as age, socio-economic status, religion, and professional training may also play a role. It is also possible that professional training has a greater influence than personal identity, cutting across gender and cultural differences (Darling &

Atav, 2019). This study did not examine variations in attitudes and practices across gender or ethnic groups, and further research would be needed to explore these differences.

Additionally, the researcher's own views and perspectives may have influenced either how GPs responded during interviews or how the data was interpreted. Participants self-reported how they approach discussions around weight and weight-loss. The way professionals intend to approach discussions may differ from how these conversations are enacted in real-world settings. Although an open dialogue was encouraged, a more objective evaluation, such as using audio or video recordings of actual consultations, alongside patient feedback, could have offered a more comprehensive and balanced view.

4.3 Trustworthiness and originality of findings

Qualitative research is often criticised for lacking transparency in its analytical processes. Acknowledging this, the lead researcher approached the thematic analysis with openness and honesty, as outlined in Appendix H–J. Although other researchers may have interpreted the data differently or taken an alternative analytical approach, demonstrating how the themes were developed is essential to ensuring the robustness of the findings. Member checking was not conducted due to time constraints; however, the two research supervisors, reviewed and consulted on the final themes.

The results were further enriched by the varied occupations and years of service held by the participants. This diversity can be seen as both a strength and a limitation. For example, while treatment options varied depending on role, GPs and pharmacist practitioners could access medications and surgery, whereas dietitians and wellbeing coaches focused on lifestyle interventions. All participants highlighted similar facilitators and barriers to accessing these options. This diversity may support the transferability of findings due to the representation of

multiple professional perspectives (Shenton, 2004). This enabled multiple voices showing similarities and dissimilarities to be heard, contributing to a broader understanding of the knowledge present within this group. Individual viewpoints and experiences could be compared and contrasted, helping to build a rich picture of the attitudes, needs, or behaviours constructed on the contributions of a range of professions (Shenton, 2004). It also meant that given the distinct training and responsibilities of each role, some participants held notably different viewpoints, shaped by their position within the team and their wider professional context.

The process of reflexivity allowed the researcher to recognise their own preconceptions and biases when interpreting individual transcripts. A reflexive journal was maintained throughout each stage of the study, from the development of the research aims to the writing of this report. Reflexivity supported the development of themes that accurately reflected participants' responses and meanings, rather than the researcher’s assumptions, thereby contributing to the dependability of the themes. These strategies aimed to minimise bias and enhance the trustworthiness and rigour of the findings (Shenton, 2004).

There are a number of qualitative studies exploring HCP views of working with adults living with obesity, likely due to the increased focus on research and preventative measures for the condition. The results do complement previous qualitative research exploring HCP views on obesity management in primary care including fear of damaging the patient relationship (Dewhurst et al., 2017) and lack the training and skills to address and treat weight (Huang et al., 2004; Jeffers et al., 2024). However, this study offers a number of novel findings.

This research involved interviews with a wide range of professionals working within primary care, highlighting commonalities across individuals from diverse training backgrounds and job roles, all tasked with supporting adults living with obesity. Limited training in obesity

management has consistently been identified as a barrier to holding weight-related consultations (Dewhurst et al., 2017; Jeffers et al., 2024), and little progress appears to have been made in this area. However, this study identified how HCPs have attempted to overcome such barriers, by seeking their own training and drawing on personal experiences of weight. Another novel insight to emerge is the personal dimension of weight-loss discussions, which appears to influence HCPs' views. The majority of participants felt that their own body weight and personal beliefs about weight loss could shape interactions with patients. While the literature presents a complex and nuanced relationship between clinician weight status and attitudes (Brown & Thompson, 2007; Aboueid et al., 2022; Čadek et al., 2023), it remains important to explore how HCPs navigate the lack of formal training and increased pressure to deliver weight loss advice, and how their personal values may influence practice. Although this raises concerns regarding consistency in clinical practice and the use of evidence-based interventions, it also underscores the need for further research to understand how these alternative routes to knowledge shape weight-related discussions.

4.4 Reflexive Statement

Reflecting on the overall process of writing this thesis, I realise how many of my own biases have been highlighted and altered. Coming into researching this topic, I mostly had an interest in the topic obesity for personal reasons, thinking about the women in my family struggle to maintain a 'healthy' weight. As such, I already held several assumptions around how HCP interact with their patients when discussing weight, including assumptions that all professionals equate weight with health, over-reliance on the medical model and a lack of empathy. Yet I was taken back by the participants reflections and surprised at the systemic and institutional challenges contributing to these issues. I felt a sense of compassion for my participants, whose professionalism and motivation to support the individual often came at a

personal cost for them; by paying for additional training or an emotional cost; through experiencing guilt or hopelessness when their consultation was perceived to have had a detrimental effect on their patient. It made me reflect on my own role as a clinician, including how difficult and confusing it might feel when practise is influenced by such dominant social discourses, vague policies and guidelines and conflicting scientific evidence. This might explain why discussions and referrals to treatment are so varied for the individual living with obesity. However, I am left with a sense of hopefulness, as I hope this report showcases the compassion and dedication NHS staff exhibited.

I am also aware of my development as a qualitative researcher. This was my first experience in using qualitative methods and am proud in my achievements. However, I acknowledge the need to develop my practice. One area is in conducting interviews using the semi-structured approach. For example, I may have led participants, and such instances could introduce social desirability bias into the results (Bergen & Labonté, 2020). These moments prompted me to examine my judgements, feelings, and potential influence on the interview. While bias cannot be fully eliminated, incorporating reflexivity here is aimed to enhance transparency and honesty, offering clarity about how the results were shaped (Bispo Júnior, 2022).

Perhaps naively, I hoped this research would contribute to the policy and guidance for professionals. However, I was unaware of the gravity of such a goal and the systemic issues it must overcome. For example, there was a huge variance in the allocation of professionals, services, funding and initiatives each HCP had available in their area. This is likely explained by how primary care networks are set up and funded but has resulted in a postcode lottery of treatment options available for patients living in each network. This is further complicated by the variance in patient demographics including social, financial and cultural factors of each

population. It makes me reflect on the appropriateness of one blanket approach for such a varied and complex area such as obesity.

4.5 Implications and Recommendations

The findings of this study provide valuable insights into how practitioners can be supported to discuss weight with patients. Unlike previous qualitative research, the HCP interviewed acknowledged the importance of their role in weight management and in raising the topic with their patients. Yet, they expressed a concern about the negative consequences of raising this with those who did not want their weight addressed and those who had multiple experiences of failed weight-loss attempts. There seemed to be a concern to raise the topic for those whose weight was intrinsically linked to their self-esteem and identity. In this study, HCP expressed the need to prioritise the identification of mental health difficulties and refer to psychological therapy over weight management. Given that living with obesity is associated with an increased risk of depression and reduced psychological well-being (Renehan et al., 2008;Pereira-Miranda et al., 2017) this is understandable. However, the cause-and-effect relationship between weight and mental health is difficult to discern. The increased role of psychologists was repeatedly raised as important to address disordered eating, emotional eating, trauma, mental health conditions and behavioural patterns underlying an individuals' weight. However, it seemed that each locality was different in their ability to access psychological input. Previous research has suggested HCP express 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 (Blackburn et al., 2015). Thus, the equitable distribution of psychologists within weight management services could offer patients the support they need to address their weight alongside their mental health, if appropriate to do so.

A lack of specific training to aid their role in supporting adults living with obesity was also cited. To mitigate this lack of training, HCP sought their own learning or used their own experiences of weight or weight-loss to guide their discussions. Whilst medication and surgical options appeared to be guided by policy and accessibility, knowledge of lifestyle interventions such as dieting or exercise often came from their own experiences rather than their knowledge of evidence-based interventions. This suggests patients may receive varying advice on lifestyle changes depending on the HCP's own knowledge. Not only does this express the need for more specialised and accessible training including MI and lifestyle approaches, but it also acknowledges the need for access to the most up-to-date, evidence-based research into effective lifestyle interventions. This could be facilitated by a single point of reference in which to access the often fast-past clinical research in this area. Jain (2005) suggested a database housed by a global organisation, such as the World Health Organisation, with funding from national governments.

Additional ways to enhance care could be to adopt a multi-disciplinary team-based approach within each PC service. This approach was seen to enable continuity in care, shared learning across professions and requires the co-operation of other stakeholders, such as local authorities, commercial weight-loss organisations and specialist obesity services. Whilst this is being implemented across the UK, there were geographical discrepancies of the professionals HCP had access to. HCP expressed a desire for greater input from psychologists, dietitians, and exercise specialists to provide holistic support. Furthermore, the MDT approach currently requires clarity in the roles and responsibilities of professionals working within the team to ensure accountability, collaboration and coordination is achieved for the patient (Bleich et al., 2012).

Future research may wish to explore insights from the study that require further exploration. For example, it was noted that HCP held strong, but varied opinions regarding certain societal and public health messages. It seemed that the narratives patients and HCP were exposed to influence the acceptability of weight being raised within consultations. The inclusion of exploring HCP views of societal narratives was a novel aspect of this study, however, there are limitations in deducing a cause-and-effect relationship. This area would benefit for further research exploring both patient and HCP views on such narratives and its possible influence on weight-related discussions.

Finally, some HCP appeared to incorporate a more health-centric approach to weight management. For those that adopted this approach, it was felt to reduce the discomfort and stigma surrounding weight and increase the patient's motivation and psychological wellbeing. Firstly, further research is needed to understand how a health-centric approach can be implemented in clinical practice. Furthermore, there is little research into how patients receive a health-centric approach by HCP's. The systematic literature review conducted, suggest this could be favourable for individual's living with obesity but may obscure the delivery of risks associated by HCP, which is sometimes seen as motivating. Therefore, further research is needed to understand patient views and perspectives on whether this will equate to a favourable response in PC practice.

4.6 Dissemination

The final thesis report was written up for the University of Essex Thesis project. Given the importance of the research findings for HCPs working with adults living with obesity, the results will be disseminated to the participating Primary Care Networks and Clinical Research Networks. Such organisations may gain a greater understanding of the experience and training needs of staff working in this area which could inform policies, local

commissioning strategies and staff training. In collaboration with senior university research staff this report should be amended for dissemination to appropriate UK or international conferences via a poster or oral presentation. Publication in a peer-reviewed journal could include those who specialised in obesity including the Clinical Obesity journal, or more general medical journals including the Primary Health Care Research & Development.

4.7 Conclusion

This study aimed to explore how HCP working in primary care conduct the discussion about weight with adults living with obesity, from the stage of referral to treatment. It also sought to explore any factors that might influence staffs' ability to hold such discussions. Across 15 qualitative interviews, six themes and 15 sub-themes were created. These reflect how HCP facilitated meaningful and sensitive discussions about weight, subsequently informing the creation of tailored, holistic treatment plans that were inclusive of the individuals' preferences and needs. HCP cited the need for the individual to be invited to discuss weight and acknowledged the many underlying influences that can contribute to weight-gain. This required HCP to conduct a thorough exploration of the individuals own unique circumstances and offer motivation and engagement towards changes. HCP also considered how the presence of weight stigma hindered the ability to hold open discussions about weight and how this was mitigated through the careful use of language and presence of rapport.

This research has shed light on some of the wider influences on such discussions, including societal narratives, current public health messaging and organisational challenges. These can all impact how discussions are conducted and the treatment options available. For example, societal narratives and public health messaging can place unrealistic expectations on weight and weight-loss, providing little practical information on how to achieve this. HCP therefore needed to offer realistic weight-management advice and information that was safe for the

individual to achieve. This study highlights how the HCP sought to attain the knowledge and expertise required when the training provided is limited. This included seeking their own knowledge and experiential learning. However, these factors combined were seen to influence the quality and variance of care HCP were able to offer.

There are novel findings to this research which has generated new insights that require further exploration. For example, many HCP spoke of using a health-centric approach to discussions, but further research is required to explore how this is received by their patients. The research has generated numerous implications and recommendations for HCP supporting adults living with obesity. This includes the greater need for education and evidence-based resources available to aid HCP role. The increase in provision of specialist professionals using an MDT approach across all tiers of service could also help foster a preventive approach to weight management before the development of comorbid conditions.

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Appendices

Appendix A: Introduction Literature Review: Data extraction for the 6 subthemes

Key Concept: Theme	1st Order Construct: Quotes	2nd Order Constructs: Primary Author Interpretation
Shaped by Experience: Patient Perceptions of Needing Care	I do the female yearlys. Of course I have to do that, but like regular health, if I need to go, I go.	Participants did not avoid healthcare when there was a perceived problem (Buxton & Snethen, 2013).
	‘When I had a stroke, I was referred to a doctor. He assessed everything and the doctor said, if I want to get better fast, I have to lose some weight. So obesity management is his suggestion.	Despite acknowledging excessive weight had health complications, and the perceived need for weight reduction, only a few participants instigated obesity healthcare from healthcare facilities. Instead this was initiated by the HCP. (Yunus et al., 2023).
The Trusted Partner: Expectations of Primary Care	“I believe that the general practitioner is the best possible authority to turn to, for only he/she knows me well enough and is aware of the problems I have. He/she is who I trust most.”	Many respondents emphasised that the GP is in the best position to “pick up patients at their own situation” (I-2 m) and to support them in their overweight management on the basis of an established relationship of trust in the long Term (Wangler & Jansky, 2023).

	"I've often thought that if he (i.e., PCP) would say to me, "Before you come in again, I would like to see three pounds." I mean I need to set a goal. But if he (i.e., PCP) sets a goal, I think I might be more apt to strive for that because I wouldn't want to let him down."	Furthermore, these participants felt strongly that their PCP should raise the issue of weight control more often, and should help them set specific weight control goals (Ely et al., 2009).
	She helped me a lot just by talking and tellin' me different things to do. She gave me like a paper to do exercise and everything; to take home and just do the exercise.	Participants wanted a thorough discussion of the factors that might be contributing to their weight, and they wanted concrete help from the PCP (Banerjee et al., 2018)
Treat me with Respect	They should look at everyone as individuals and not just look at my medical records but get to know me as a person…and take care of me. Suggest different ways of doing things.	The discussion about how physicians could best help patients begin to control their weight often focussed on the importance of a personalised approach. Participants recognised that individuals differ with respect

	Suggest a way to exercise or…better nutrition. Have your chart where they're graphing your weight… I could go there three times a [week] and get weighed and have my weight on a chart because that will force me to deal with it… It's drawing your attention to it. If you're losing, it's an immediate positive feedback and that gives you the energy to get past the hunger… You do a diet history… you have a doctor checking what you eat all the time so that they can make specific recommendations about your food, that would help.	to motivators and barriers to lose weight (Ward et al., 2009). Subjects mentioned frequent weight monitoring, graphic charting, specific dietary inquiry and recommendations, and providing reference materials and resources, as forms of individualized plans that they wanted from their physician (Chugh et al., 2013).
The Security of a Trusting, Collaborative, and Caring Relationship	I've been going to her for twelve or thirteen years-time passes quickly-yes, for twelve or thirteen years. I have to sat that she is really a doctor I trust (…). So you do have to have a certain bond of trust (to talk about overweight). I don't have anything against the practice personal, but I feel that would be going too far (for comprehensive counselling).	A special bond of trust between themselves and their physicians attached more importance on the GP practice in weight management (Heintze et al., 2012).

	I think just to be caring and understanding because being overweight is a disease also and I just think that if they care, show some compassion for people and really go out of their way to try to make them comfortable 'cause they're already uncomfortable with the way that they're, you know, that they feel, they're already uncomfortable about it. So if they were to show some compassion and caring towards people that are overweight, I think that might be a good thing. That would be helpful.	Both AA and white participants indicated that they were more likely to have favourable weight related interactions with physicians who possessed certain qualities such as being: empathetic, sensitive, respectful, trustworthy, compassionate, non-judgmental, encouraging, honest, and comforting (Chugh et al., 2013).
Promoting Ownership, Not Stigma	It's more encouraging when you have a doctor telling you, "You're doing good, keep up the good work…" It's nothing like a doctor standing behind you, encouraging you.	Participants were encouraged to continue their efforts at weight loss when the physician noticed small weight losses and positive behaviour changes (Banerjee et al., 2018).
	One woman said, "The only time he's (i.e., PCP) ever said anything to me about my weight is he came in one day and he said, "Do you really weigh that much?" I said,	Participants reported wanting more encouragement and directive support on weight control from their primary care providers (PCP) (Ely et al., 2009).

	"Yeah." He said, "Oh. You might want to lose some weight." And that was it." "I felt that he was cracking little jokes on me, saying something like: everything will soon collapse under you should you go on like this."	Ten respondents mentioned that they felt that there had occasionally been a lack of empathy on the part of GPs when dealing with the weight situation. Situations were described in which rude, arrogant or insulting behaviour on the part of the physicians became apparent. In two cases, this stigmatising behaviour resulted in the termination of the physician-patient relationship (Wangler & Jansky, 2023).
Navigating the Limited Scope of Care	'Don't tell me to lose weight while they are going out the door'.	A significant portion of each discussion centred on the importance of the timing of weight management discussions. The primary concern was that physicians take enough time to counsel patients in detail (Ward et al., 2009) General comments to 'lose weight' were perceived to be ambivalent and lacked clarity

	‘you should lose some weight’	in their communication about their weight as a health issue (Ely et al., 2009) Participant perceptions of rushed and underdeveloped services (Brown et al., 2006).
	‘I think they are very busy and they’ve only got a limited time, so you know, it is their job? Are they right is just saying, “go away and lose weight”? I don’t really know’	Frustration with the currently available referral options and lack of effective care (Glenister et al., 2017).
	‘She [GP] could have referred me to the dietcian, but then my partners done to the dietician and found him useless’	

Appendix B: Recruitment Poster for Proposed Study

Appendix C: Participant Information Sheet

Participant Information Sheet

Project Title: Health Care Professionals' Experience of Working with Adults Living with Obesity.

Introduction

Before you decide to take part in the current research study, it is important for you to understand why the research is being done and what it will involve. Please take some time to read the following information carefully. If you have any further questions about the study after reading the following information, please contact the researcher and they will be happy to answer your questions.

Who is conducting this study?

The lead researcher is Carly Jackman Trainee Clinical Psychologist, University of Essex. The lead researcher is conducting this study as part of their professional doctorate in Clinical Psychology. The researcher is supervised by two qualified Supervisors:

- **Academic Supervisor:** Dr John Day, Lecturer in the School of Health and Social Care (Clinical Psychology), Department of Psychology, Essex University.
- **Second Supervisor:** Tracey Scarth, Registered General Nurse, Lecturer in the School of Health and Social Care, Essex University

What is the purpose of this study?

The purpose of this study is to understand your experience of consulting with adults who are living with obesity from the stage of referral to treatment decision-making.

Why have I been asked to participate?

You have been invited to take part in this research because you are a health care professional working in a primary care setting working with adults living with obesity. It is hoped that your experience will contribute to the current understanding of working with this population and their needs.

Do I have to take part?

Taking part in this study is voluntary and you do not have to participate if you do not wish to. If you decide to take part, you are able to withdraw at a later date without giving a reason. You do not have to answer any questions that you do not wish to. If you do choose to take part there will be a £20 gift voucher to reimburse you for your time.

How do I withdraw from the study?

If you decide to take part in this study and wish to withdraw, you are free to do so at any time without giving a reason, but we will keep information about you that we already have. You can stop being part of a research study at any time, without giving a reason, but the research team will keep the research data about you that they already have. You can find out what would happen with your data before you agree to take part in a study.

In addition, the lead researcher needs to manage your records in specific ways for the research to be reliable. This means that they won't be able to let you see or change the data they hold about you. Research could go wrong if data is removed or changed.

If you wish to withdraw from the study, please contact the main researcher, Carly Jackman, by email (carly.jackman1@nhs.net) within two weeks of taking part.

What will happen to me if I take part?

To participate, you will be asked to take part in one interview recorded via Microsoft Teams (for purpose of transcription) lasting around 60-90 minutes in a comfortable setting, which could be your own home. The interview will involve talking to the lead researcher (Carly Jackman) about your experience of working with adults living with obesity, from referral stage up until discharge. If you consent, you may be contacted at a later date to ask if you would like to hear about and comment on the research analysis. You can decline this offer without giving a reason.

If you were to say anything that led me to be concerned about your safety I may signpost you towards options for further support and discuss this with my research supervisor. I would keep you informed throughout this process.

Please note participation within this study is completely voluntary, your employer will not be informed of your decision to participate within this study.

What are the possible advantages of taking part?

There are no direct benefits for you in taking part in this research. It is hoped that the findings from this research project will be used to contribute to the current understanding of working with this population and their needs. This will guide the development of recommendations and educational material for supporting health care professionals and their work with adults living with obesity. You will be reimbursed for your time in taking part in this research.

What are the potential risks of taking part?

The study will involve answering questions about your clinical practice with adults living with obesity. If you find any of the questions particularly difficult or intrusive you do not have to answer them. You will be reminded that you can ask to stop, take breaks, reschedule the interview or withdraw from the study at any time. There will be a space for debrief at the end of the interview and you will also be given information on relevant sources of support. There are no special precautions that you need to take before, during or after taking part in the study.

Following participation in the study, if you feel like you need further support, we would advise you to seek support from a supervisor, or equivalent that you trust in the first instance, as they will be in the best position to offer help.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your name, contact details, age, sex, ethnicity, profession and how long you have been in your profession. People will use this information to do the research to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to the sponsor's Data Protection Officer on dpo@essex.ac.uk, or
- by ringing us on 07958126944.

Your anonymity will be preserved at all times.

All data that is collected will be anonymous to ensure that you cannot be identified from any information. On completion of the interview, you will be asked to provide a pseudonym name which will be stored securely and separately from your research data in a password protected 'link document'. This will enable your pseudonym name to be linked to your data. To reduce any risk of you being identified indirectly from identifiable information, the researcher will redact any information they or the research team and yourself may feel would lead to identification. The research team is aware that even if data is technically anonymous, some parts of the information may be rendered identifiable in combination with other contextual pieces of information within this project.

In the interests of transparent and open research practices, some research publications request that researchers share their raw research data when publishing their findings. This is so that other researchers can make judgements about the quality of the research. In the event that the research is published in a scientific journal, your data may be used to summarise the findings of the research, however, your data will be fully anonymised at all times. In addition, the anonymised transcripts may be used to support other research being conducted on the Doctoral programme in Clinical Psychology in the future and may be shared anonymously with other researchers within this team.

How do I find out about the results of the study?

We are very grateful to you for taking part in this study and we welcome your interest in our research findings. From April 2025 onwards, you are welcome to contact the researcher using the contact details below to find out about the results of the study.

What if I am unhappy or if there is a problem?

If you are unhappy or if there is a problem, please contact the main researcher, Carly Jackman in the first instance. If you have a complaint that you do not wish to talk to the researcher about, you could contact the following:

- Dr John Day on John.day@essex.ac.uk

- Professor [redacted] (Director of research for Health and Social Care) on [redacted]

If you are still not satisfied, please contact the University's Research Integrity Manager, Dr [redacted] on [redacted]

Who is organising and funding the research?

The research is being carried out by a doctoral student at University of Essex. The research is sponsored by the University of Essex. The research forms part of the academic requirements of the doctorate in Clinical Psychology programme and it is not funded.

Who has approved the research?

The research has been approved by the Health Research Authority [REC ref: 23/HRA/4451] and the University of Essex, Research Ethics Sub Committee [ETH2223-1216].

Ok, so what happens now?

If you wish to take part in the research, please contact the main researcher **Carly Jackman** via email carly.jackman1@nhs.net to provide your consent to taking part in the study.

Further information and contact details

For further information, please contact the main researcher (Carly Jackman) by email on carly.jackman1@nhs.net during office hours.

If you wish to speak to the academic supervisor of the project (Dr John Day), please use the following email during office hours [redacted].

Appendix D: Screening and Demographic Information

Screening and Demographic Information Form

Screening

Are you a health care professional employed by a primary care network who is currently working with adults living with obesity?	
Yes	No

If answered yes, please continue to complete the following questions. If answered no, I thank you for your time but unfortunately your experience is not suitable for this study. Please contact the lead researcher Carly Jackman for more information.

Demographic Information

Which of the following best described your age? *Please select one.*					
18-24	25-34	35-44	45-54	55-64	65 over

Which of the following sex do you most identify with? *Please select one.*			
Male	Female	Intersex	Prefer not to say

How would you describe your ethnicity?
What is your current profession? *Please specify your title.*
How long have you been working in your profession? *Please specify how many years you have been working in your profession.*

Once completed, please send to Carly Jackman at carly.jackman1@nhs.net

Appendix E: Consent Form

IRAS ID: 325826

Participant Identification Number:

CONSENT FORM

Project: **Health Care Professionals' Experience of Working with Adults who are Living with Obesity.**

Name of Researcher: **Carly Jackman**

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by initialling each box below I am consenting to this element of the study. I understand that it will be assumed that un-initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

	Please initial or sign
1. I confirm that I have read the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and these have been answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, but we will keep information about you that we already have, as it would already have been analysed.	
3. I understand that the transcription of the interview will be stored securely. It might be used to support other research in the future, and may be shared anonymously with other researchers.	
4. I understand that any identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.	
5. I understand that the final report may use direct quotes provided in the interview. Such quotes will be anonymised.	
6. I understand that my fully anonymised data will be used for the purposes of data collection and analysis as part of their professional doctorate in Clinical Psychology. It may also be used in an article to be published in an academic journal.	

7. I agree to take part in the above study	

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix F: Interview Schedule

Interview Schedule

Topic 1: Clinicians experience of weight related conversations with adults.

The aim of this topic is to understand the clinicians experience of weight related conversations with adults from referral to treatment options.

- Could you talk to me about how your role supports adults living with obesity?
- Could you talk me through your process when you receive a referral for an adult living with obesity?
    - What would you be looking out for?
    - What might influence how you hold the consultation?
- What do you think is important when you hold a discussion about an individual's weight?
    - What facilitates or hinders having this conversation?
    - What language would you use?
    - Do you have any standout experiences where this discussion has gone really well or has been difficult?
- How often do you refer adults to weight management services?
    - What support do you currently offer for weight loss?
    - How comfortable/confident do you feel in offering weight management?
    - What helps facilitate this conversation? Are there any barriers to having this conversation?
    - What would you be mindful of when making treatment decisions?
- How much training do you feel you have had to support adults living with obesity?
    - Is there anything missing from the training you have had?
    - What would you like training to provide?
- How do you think your patients experience your consultations around weight?

Topic 2: Clinicians beliefs/clinical knowledge of obesity

The aim of this topic is to understand the clinicians' own beliefs, clinical knowledge and interest in supporting adults living obesity and how this might impact the treatment they offer.

- How interested are you in supporting adults living with obesity?

- How comfortable do you feel supporting adults living with obesity?
    - What do you think has contributed to this level of comfort?
- What extent do you feel your own personal views about obesity has impacted your consultations and treatment decisions?
    - What do you think has informed your own personal values/views about obesity?
    - What personal experiences of obesity might you have had?
- Public health messages, such as eat less, move more, offer specific advice about weight management.
    - How helpful do you feel these messages are for you and your patients?
    - Does it impact your practice?
- HAES is currently a rising narrative on most media and social platforms.
    - How helpful do you feel these messages are for you and your patients?
    - Does it impact your practice?
- Do you feel weight management is a gender sensitive issue?
    - What are your views about this
    - Does it impact your practice?

Follow up questions will be used to add greater depth and richness to the data. In some cases, I might ask the clinician to elaborate on parts of their answer.

<u>Pilot Questions:</u>

These questions will be asked at the end of the first two interviews to the refine the interview schedule further if necessary.

- Were there any questions you found to be difficult to answer?
- Is there anything you felt had been left out?
- Is there anything you wanted to say but felt unable to say, given the interview questions?
- Do you have any ideas on how my interview questions could be improved?

Appendix G: COREQ Analysis of Present Study

Domain 1: Research team and reflexivity	
Personal Characteristics	
1. Interviewer/facilitator	The lead researcher/author conducted all interviews.
2. Credentials	The lead researcher was enrolled on the Doctorate for Clinical Psychology at the time of the study. They had completed a BSc in Psychology and Masters in Child and Adolescent Psychology.
3. Occupation	The lead researcher was employed as a Trainee Clinical Psychologist on the NHS funded Doctorate which required a split academic and clinical role. The research was conducted as part of the third-year thesis project.
4. Gender	The researcher was female.
5. Experience and training	The lead researcher had undertaken the two-year Clinical Research modules involving conducting and analysing qualitative research. They had also attended the free webinars on conducting 'Thematic analysis' hosted by Braun and Clarke. Experience included completing a meta-ethnography and a qualitative secondary data analysis and so had some experience analysing qualitative research. However, this was the first experience of conducting their own qualitative research, including interviewing participants.
Relationship with participants	
6. Relationship established	No relationship with participants was established prior to the study.

7. Participant knowledge of the interviewer	The participants were made aware of the goals and research for the research. This was made explicit in the PIS form, highlighting the research was undertaken as part of the Doctoral thesis project. However, most participants expressed their desire to take part in the researcher for their own interest and acknowledged the need for more research on the topic.
8. Interviewer characteristics	The interviewer tried to be as transparent as possible with their own characteristics, biases, interests and positioning. This information was detailed in the reflexive extracts in the Methods and Results section of the report.
Domain 2: study design	
Theoretical framework	
9. Methodological orientation and Theory	The methodological orientation is detailed in the ontology and epistemology section of the Method.
Participant selection	
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email Participants were approached via email. The CIHR sent the research information to all participants on behalf of the lead researcher.
12. Sample size	15 participants enrolled to take part in the study.

13. Non-participation	Twenty-Four primary care staff expressed an initial interest in participating in the research. Of these, fifteen people participated. Of the nine who were not interviewed, seven did not respond to communication after making initial contact, one requested no further contact, and one did not attend their planned interview with no further communication given.
Setting	
14. Setting of data collection	The data collection took place online via MS Teams. Participants took the interview call at a setting of their preference.
15. Presence of non-participants	No other individual was present during the interview.
16. Description of sample	The demographic information was collected in the Screening and Demographic Questionnaire. This was completed by participants prior to the interview. This is detailed in the Methods section.
Data collection	
17. Interview guide	The interview guide was semi-structured and checked by the research supervisors. It was pilot tested with the first few interviews who provided no feedback to amend the questions asked.
18. Repeat interviews	No repeat interviews were carried out.
19. Audio/visual recording	The data collection took place online via MS Teams. All interviews was recorded and transcribed using the MS Teams function.
20. Field notes	Field notes were made during and after the interview as detailed in the Quality Assurance section on the Method.
21. Duration	All interviews were 60 minutes long.

22. Data saturation	Data Saturation was discussed in the Methods section.
23. Transcripts returned	The transcripts were not returned to participants for comment or correction. This was decided due to the time pressured nature of completing the research for the Doctoral Thesis.
Domain 3: analysis and findings	
Data analysis	
24. Number of data coders	The lead researcher coded the transcripts. See data analysis section of the Method.
25. Description of the coding tree	A thematic map of the codes was presented in the Results section.
26. Derivation of themes	The themes were derived from the data, rather than identified in advance. However, with some subthemes, such as '*The presence of weight stigma and discrimination in the room*', the researcher had come into the interviews with the expectation that interviewee would discuss the presence of weight stigma and discrimination.
27. Software	Microsoft Word was used to analysis and manage the data provided.
28. Participant checking	No participant provided feedback on the findings.
Reporting	

29. Quotations presented	Participant quotations were presented to illustrate the themes identified. Each quote was checked to protect anonymity. They were named using a pseudonym.
30. Data and findings consistent	Overall, there was consistency between the data presented. This is detailed in the Results and Discussion section of the report.
31. Clarity of major themes	The major themes were clearly presented in the Results section of the report.
32. Clarity of minor themes	The minor themes were clearly presented in the Results section of the report. Where appropriate there was a description of diverse cases.

Appendix H: Example Reflexive Thematic Coding Extract

Transcript	**Code Label**
Interviewer 1:36 Yeah. So I suppose in terms of your role, what what would you be thinking about in terms of how you could support a person living with obesity? What sort of things come up?	
PARTICIPANT 6 1:40 Mm hmm. So I'm a health and well-being coach as well. So what I look out for is the diet, are they aware of, you know, the nutrition? How much calories are they taking? Are they, for example, give them like a food diary to have at hand as well, and then we explore that together? And most of the time, some of them are not aware of actually how many calories they're eating per day, and that it's too much or once we start looking at the food diary, you can see that there's quite a lot of, you know, unhealthy foods on the list. That's what I do. I help them identify the foods that they're eating, providing psychoeducation around it, as well as trying to implement so you know some behavioural approaches.	Assessment and exploration: diet Tools used: food diaries Role to raise awareness and offer psychoeducation Role to implement behavioural approaches
Interviewer 2:39 OK. What sort of behavioural approaches would you be considering?	
PARTICIPANT 6 2:44 I'm so mindfulness eating, for example, so kind of obviously aware of what they're eating try not to eat too fast as well. And what else did I do? So I send them out the food diary and looking out for foods so say for example, if they're having three packets of crisps per day, can we change that up so you can have those two packet of crisps and maybe about one of the packets of crisps could be replaced with something healthier so a different food choice may be a fruit that they might like?	Tools used: - Mindful eating - Making small changes - Diet swaps
Interviewer 3:08	

And you mentioned so like you mentioned at the beginning like comfort eating, how do you feel that fits in with your work?	
PARTICIPANT 6 3:36 So in terms of comfort eating, so I get patients that come with, for example, anxiety and depression, usually the comfort eating comes with trying to help with emotional regulation and then tends to be kind of sexual abuse in the past as well that leads to this comfort eating.	Assessment and exploration: comfort eating Knowledge of causes: Mental health and abuse
Interviewer 3:57 OK. Oh, so with those when that's present, is there anything different that you'd do in terms of your work together?	
PARTICIPANT 6 4:11 If in terms of, sorry I I didn't catch that.	
Interviewer 4:13 Well, so as you mentioned, if they're comfort eating, have anxiety and depression, or a history of abuse, is there any difference in your work with the client?	
PARTICIPANT 6 4:30 Umm, so do I change my approach? Do you do you mean that?	
Interviewer 4:32 Yes. Yeah.	
PARTICIPANT 6 4:36 Umm. So when there's, you know, sexual abuse, so there's I guess more precaution needs to be taken but most of it happened during childhood and it's just continued throughout the years. You know, sometimes they don't tell this to the therapist. Sometimes they do one of them, for example, didn't open up for 65 years, only until now. You know, she was able to tell me about it. So, yeah, I guess it's just really depends. I still continue doing the same kind of. What's it called? Behavioural changes	Discussion requires extra precaution when mental health present Caution around what is said

and stuff like that. Terms of implementing that, but I guess you know, with, with sexual abuse you need to be a bit more precautious, like in terms of what you say and just making sure that they don't talk about some, they they don't feel comfortable with.	Making sure patient feels comfortable during discussion
Interviewer 5:26 Hmm. When you say kind of, you take more precautions, could you give maybe an example of that or maybe what you would be more cautious about.	
PARTICIPANT 6 5:45 Yes. So it's the kind of language that I use. So I might say, would you like to tell me a little bit more about that? So I tried to use person centred, what's it called person centred tools as in terms of being empathetic, showing unconditional positive regard. And yeah, just trying to do that for the use of language that I use. So like I said, it'll be like, OK, so could you kindly tell me a little bit more about that if if not, then we can talk about, you know, something else that you feel comfortable in terms of talking about or once you're ready to tell me a little bit more, you know you can or or I always kind of emphasise that this is a safe space, for them, and I'm here to listen and and not judge them as well, just to emphasise that 'cause sometimes,	Tools used: Person centred, empathetic, UPR Awareness of language used: tentative, invitation to discussion Discussion requires a safe space
Yeah, they might hold back because they might feel like, you know, I might be judging them because sometimes they do say that. Oh, you know or maybe I shouldn't have said that because you know someone might judge me about it. And that's when I emphasise that it's, you know, positive, comfortable, safe space for them to be able to open up.	Patients hold back information in fear of HCP judgement. HCP role to offer non-judgement and listening to support patient to talk
Interviewer 6:54 So it's like really trying to build that rapport and that kind of like you said, safe space.	
PARTICIPANT 6 7:09 Yep, exactly. We are rapport building.	Discussion requires rapport building

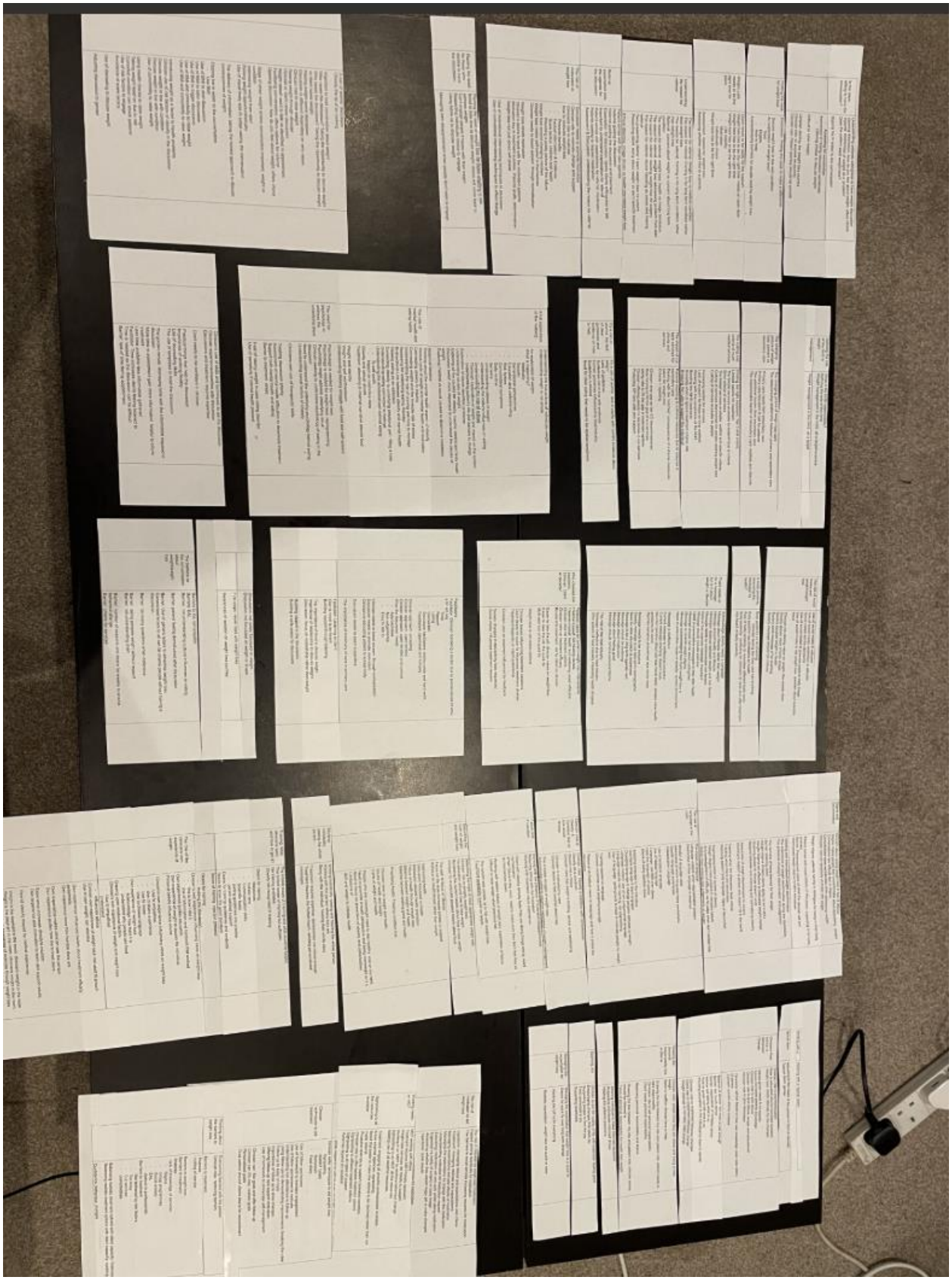
Appendix I: Excerpt Initial Codes to Concept Process

Concept	Code Label
The reason for referral: Weight loss vs medical condition	Referral: Asking for obesity help Referral: health conditions associated with obesity Weight loss to resolve diabetes: Getting back to 'normal' BMI = no longer diabetic Patients motivated to take treatment for weight loss: Patients committed to weight loss Others just want to resolve the medical disease
Having the resources available	Education on resources available for referral Resources that are free of charge/ subsidised Health coaches important Programs that do both gym and dietary advice Supporting patients with exercise advice is straightforward Use of BBC to share knowledge about BASIC healthy lifestyle
An exploration of weight: What is happening? - Medically - Socially - Generational perspectives	Discussion: I've tried to lose weight and I can't Discussion about what they have tried Discussion: previous help Exploration of what is happening in diet and activity Exclude other medical causes that explains why not able to lose weight Complete a number of physical health checks as routine Dependent on whole family perspective Patients beliefs about food & how has this been passed down from generations How is food used within the family? Takes talking around patients believe that they've aways been this way
Finding the right treatment: Tier 3 and criteria	If weight loss not successful, refer tier 3 Tier 3 resources: medication, surgical intervention Treatment referral: Tier 3 requires criteria Treatment: patients specifically coming for surgical intervention Professionals can't do anything about criteria but explain and stick to it
Knowing when to ignore treatment criteria: risk	Usually led by the criteria unless co-morbid health conditions increase risk i.e. diabetes Need to reduce the risk now

Exploring medical vs social causes to determine treatment	Treatment Consideration: Menopause Once medical causes excluded social treatment options can be decided Treatment moving away from eating and exercise to also include other factors Emotional support = referral to counselling Social treatment options should be considered if medical causes identified plus treatment for medical cause
Clinician can: Set goals and offer follow up	Setting 2 or 3 goals Need for little successes quickly Making small changes to add up and make a difference Treatment: required to keep things simple for people Treatment: offering follow up appointment to discuss changes Follow up: discuss changes and results in weight loss
Treatment requires expertise: diet/exercise not robust enough	Treatment: requires professional help Previous help: just said eat healthier/increase exercise *sense this is not enough for individuals – requires more* Treatment: now have more time to exercise as children older
Working with the presence of frustration/disappointment and need to give explanation	Patient disappointed when there's no medical explanation to explain inability to lose weight Patient needs another explanation for unsuccessful weight loss due to disappointment Patient needs medical explanation as it is easier to take a pill for condition rather than lose weight Patients are frustrated about the criteria
Easier to take the pill: clinician views on weight loss	Critical biases: easier to take pill
Weight loss is not rocket science	*Sense that people think its complicated to lose weight* Changes can be basic: not rocket science Belief that it is not hard for people to eat breakfast later: connected to belief that if I can do it so can others *Drawback of own experience: If I can do it so can others/ belief that small changes are easy to implement* Overall there isn't a reason why people shouldn't be making the simple/basic changes *Belief: people who are overweight do not take responsibility for their health*

Clinician view that weight is limiting, severe and debilitating	Current life due to weight limiting for patient ~~F~~ear of future illnesses for the patient: can be severe and debilitating Belief: overweight patients get more medical conditions and die earlier Not ok to be overweight: using body composition and fat distribution to provide factual information and evidence to get point across If you eat more of the 'better' foods you;8 eat less overall Belief that there are better and worse foods
Clinician is motivated by care	Care: don't want my patients to experience this Opening up a whole new life ~~F~~ear of future illnesses for the patient: can be severe and debilitating

Appendix J: Thematic Analysis Process using Concepts



Appendix K: Health Research Authority Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Carly Jackman
Trainee Clinical Psychologist
Essex Partnership University Trust: NHS
The Lodge, Lodge Approach,
Runwell, Wickford
United Kingdom
SS11 7XXN/A

Email: approvals@hra.nhs.uk

02 January 2024

Dear Miss Jackman

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Health Care Professionals' Experience of Working with Adults who are Living with Obesity.**
IRAS project ID:	325826
Protocol number:	N/A
REC reference:	23/HRA/4451
Sponsor	**University of Essex**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix L: University of Essex Ethical Approval

From: ERAMS <erams@essex.ac.uk>
Sent: 19 January 2024 12:59
To: Jackman, Carly L <cj22620@essex.ac.uk>
Subject: Decision - Ethics ETH2223-1216: Miss Carly Jackman

University of Essex ERAMS

19/01/2024
Miss Carly Jackman
Health and Social Care
University of Essex
Dear Carly,

Ethics Committee Decision

Application: ETH2223-1216

I am pleased to inform you that the research proposal entitled "Health Care Professionals Experience Working with Adults Living with Obesity" has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,
Alexandra Kaley

Ethics ETH2223-1216: Miss Carly Jackman

Appendix M: Participant transcript

Lead Interviewer0:15
And so just to kind of start off with, could you share a little bit about how your role supports adults living with obesity and what that kind of looks like?

Participant 2 0:26
OK, so I'm in advanced nurse practitioner in primary care, so I do long term condition reviews, not for diabetes and not for asthma, but everything else. So AF and coronary heart disease, hypertension, CKD et cetera. So I don't work, I don't specifically, but have, and you know a group where I'm working with obese adults, but obviously within that review, I do come across quite a few. So that's my experience.

Lead Interviewer0:53
So yeah, so when you do come across somebody who is living with Obesity and has that long term chronic condition that you've explained about, would your role just focus on the long term condition or would you think about the effects of obesity at all?

Participant 2 1:02
Yeah. So, so all of it really, because I hate to say it, but it is all a quaff target. So there are lots of things that you have to go through as part of the review and weight management and BMI is all part of that. So every patient that is willing because obviously you don't, not everybody wants to but will provide you with a weight and working out BMI calculation which obviously you need then to do your Q risk. So that is something that we would then discuss as part of the review and about lifestyle modification.
Obviously that's one of the risk factors for hypertension so that would be something that would definitely be discussed for every for every review.

Lead Interviewer1:52
OK, sorry. You mentioned something I've not heard before. You said a Quaff.

Participant 2 1:57
Yeah. So that's the the quality framework for primary care. So that's how they get their payment.
That's how they get their money from. The government, I don't really how you'd explain it. So you have to you have to meet certain Quaff targets, so you have to be doing certain things, meeting certain targets in certain areas so, like immunization smears and and long term condition reviews, as is part of as one of the Quaff targets as well.

Lead Interviewer2:21
Yeah. OK, so I thank you for explaining that to me.

Participant 2 2:28
Yeah. No, that's all right. That's primary Care World.

Lead Interviewer2:31
Yeah. Yeah. So you mentioned something about if everybody's willing to take, you know, await, BMI, that sort of thing.

Participant 2 2:40
Yeah.

Lead Interviewer2:40
How do you work out whether somebody is willing or not?

Participant 2 2:45
So I mean it, it's just part of the of the question for the long term condition review. It's a, It's a template that you work through, so I would just ask somebody how much do you weigh at the moment and if they don't want to tell me how much they weigh, then they won't. It's as simple as that, but you're very rarely get anybody that doesn't, to be honest.

Lead Interviewer3:02
OK, OK. So then you started talking about, let me just go through the notes. Somebody say is willing to talk, to share it or not, do you have a conversation around weight or is it quite a strict set of questions that you?

Participant 2 3:14
Yeah. Yes. Yeah, because it's part of, so. So the long term condition review isn't necessarily a set of questions. It's just areas that you have to cover, so there's no sort of set script for it and everybody does it differently but as long as you've covered everything, all the things that form part of your lifestyle risk factors for cardiovascular disease is basically what a long term condition review is. So obviously weight and BMI, are part of that. So if you don't get somebody's up-to-date weight, that's not not hitting a QUAFF target as far as I know. But not having a up to take blood pressure is. Say say it's a bit of a tricky one, really, but obviously it is a risk factor, so it is something you did you know that you would discuss so. So for example, if somebody tells me their weight and then I pressed my little button and I can see that they are obese, then that obviously tells me that and then that is then a discussion point.

Lead Interviewer4:21
Hmm. Umm, OK. So could you kind of describe to me a little bit of like the discussion say the person is willing and it's your button said, yes, this person is obese, what would the conversation look like between you?

Participant 2 4:33
Umm.
So it's and so patients are eligible for various management strategies, so. We say we have a care coordinators at our surgery who do all those kinds of things for us because it just isn't enough hours in the day filling in all these forms and all the rest of it. So for me it's quite a simple one. I just say, you know, did you know you're eligible for weight management and lots of people are quite interested in what that is. So there's one that's Slimming World. There's one that's active, you know, it's more like a concessionary gym membership. There's there's others that are absolutely free just depends on your risk factors, what your BMI is, and whether you've ever had anything input in the past. Because I think you only get one chance at it, unfortunately. And then most people

say, yeah, that's something that they would like to hear more about. So I let the care coordinators know and they'll give them a call.

Lead Interviewer5:42
OK, so I'm alright saying yours more signposted into the care coordinators if that conversations OK? Umm, within that kind of discussion, because I suppose you are still determining whether where a person's at, would you say there's anything in particular that helps you facilitate that conversation to help sign post people on.

Participant 2 6:09
Most of the time, they've already said it themselves I find because they do this review process every single year, so they kind of know or they know that that's gonna be that's gonna come up and most people will say, oh, you know yeah, I haven't lost any weight or have put on a bit of weight or whatever. I don't. It's actually very rare that somebody tells you their weight and it works out that they're obese, that they haven't already mentioned that to be honest. And most people are quite willing to have a conversation about it, especially because we're also talking about cholesterol and Q risk and all the rest of it. So the whole kind of thing fits together.

Lead Interviewer6:44
Yeah. OK, so so you say somebody has come like say, yeah, it's every year, is that weight has been like changed, it's stayed the same or got worse. What would you sort of be talking about then, do you think?

Participant 2 7:08
Again, you see, it just really depends on what the the patients views are. So I would. I just generally sort of have a conversation about how people feel about their weight, what they think they, you know, you know, based on the sort of risk factors and everything else that's been going on, what they've tried in the past, what they're actually eligible for in terms of things that I can refer them to and have that conversation. I I always have that conversation with them. You know, you know what? You know, what do you feel you need to do about it?
If anything, you know what can we help you with? And I would say that most of the time you, Unless unless I'm asking the care coordinators to give them a call to discuss referrals, if you have somebody that's already been through that process and they've and they, you know, they tell you that they've tried everything and invariably the thing it just gets left. To be honest, yeah, like if there's nothing more than I can do about that, it's a bit.

Lead Interviewer8:05
What? What the conversation gets left, OK?
Umm.

Participant 2 8:11
It is a bit of a tricky 1 because if somebody wants to have, I don't know, like a weight management plan with their GP while you know they're trying medication and that kind of thing, that's something that they have to speak to their GP about themselves.

Lead Interviewer8:13
So like, there's a question here, but I'm trying to grasp it, sorry.

Participant 2 8:35
Yeah, it's it's a really difficult. It is a really difficult area, I think, especially for long term condition reviews because they're not approaching me and most of the time and saying, you know, I I need to lose weight. This is a part of a process that a lot of people see is something that they have to go through every year.

Lead Interviewer8:53
Yeah. So it's more like. Are you saying it's more like a tick box and they're just each year they they have? OK.

Participant 2 9:01
I think so for a lot of people. It is. Yeah, yeah, I think it is. I think I think it's a shame because I think it has become a little bit that way as well. So pharmacists, for example, you know, they don't, they can't give can't renew pathfinders prescriptions and all the rest of it until they've been updated and they only get updated as somebody's been reviewed. So in some respects, although it's a really a useful thing because you get a set of annual bloods and get to talk about any issues, etcetera. So for some people, that's absolutely great. For other people, is is a bit like. Again, if you go again, I think it depends. Yeah. Who you are and whether you actually want to have those conversations. I think because like I say, they're not coming to me. It's almost like you're being forced into the corner of being reviewed because of getting you all tablets or whatever.

Lead Interviewer9:57
Yeah, it must be quite a tricky trick, is it? Especially if you also said like persons kind of gone through weight loss before and then are not eligible for further like treatment.

Participant 2 10:16
Yeah, it's quite a strict criteria. So if you've already had a referral, you're not eligible. I mean doesn't mean that you obviously can't seek out these things yourself, but for a funded place on one of these and weight management programs, you're not and you have to have, I think it's BMI above 30 with two or more cardio risk factors or 35 and one risk factor.

Lead Interviewer10:46
Hear something similar in in quite a few different areas. These sorts of criterias. What do you think those criterias are? Come, come in place.

Participant 2 10:55
And turn and where do they come from? I don't know.
I don't, I don't know really, because it doesn't really because that to me is a bit silly, isn't it?
Because that's like you're already you're already more risk if you're at that point, then it shouldn't it be for people that are not at that point. But I don't know. Surely it's harder, the further down the line you are, I don't know. But that's I guess they just have to, It's all about money, isn't it, at the end of the day, about what's available.

Lead Interviewer11:28
Do you have many secondary care options in your area for people with obesity?

Participant 2 11:40
Umm. Umm, not that I know of, but I think probably the GP's would know better than me, like if they're consulting with patients that have that have specifically asked for that, then yes, I imagine they do have secondary care options and we do have a few research options because we do research at our surgery, So there was a GP one study. So think so things like come over the name of Study now, but things but things like that do come up every, you know, every once in a while. I know they're doing well that one of our neighbouring surgeries where they've got patients that are in the intervention arm that are coming in for their injections.

Lead Interviewer12:25
The weight loss injections and yeah, OK.

Participant 2 12:32
Yeah.

Lead Interviewer12:35
OK, that's not available in well in the UK, is it through the NHS?

Participant 2 12:39
No.
So this is a clinical trial.

Lead Interviewer12:41
Yeah, OK, OK.
It's just in terms of going back to the conversation and I know yours is interlinked with like the long term conditions, but do you feel like there are any barriers at all to having the conversations with individuals about their weight?

Participant 2 13:03
I can tell you one that so when we used to do our reviews face to face. Because like I say, it's not some you have, You have to have that conversation where you can't. It's not something you can skip over.
I used to find where we did those when I did those appointments face to face.
That was a harder because you did often find people saying things like, well, it's easy for you etcetera, etcetera, because clearly I'm not overweight. Whereas if you're on the phone, people don't know what you look like, so there's already that kind of assumed empathy because they and it is, I think that is really difficult for somebody who is not overweight for somebody that is overweight to be hearing it from somebody that isn't. I've always thought that and also vice versa. Like if you have somebody that is quite overweight, that's telling you to lose weight. Like I can remember taking my dog to the vet once and this is very, very, very obese vet telling me that my dog was overweight and I was thinking really, do you know, you don't tend to take it seriously do so I think doing it over the phone takes that away because you don't know, you automatically feel a bit resistant, don't you, depending on who's talking to you, I think.

Lead Interviewer13:57
Where do you think that comes from?

Participant 2 14:17
I don't know.
I don't know.
I think it's. I think it's just that you think that person can't really empathise, so they either can't empathize, or they're a hypocrite. Because how can you have somebody, This is just from my point of view, even when I'm thinking about the vet. How can you have somebody that's, you know, clearly very overweight telling me?

I know it was about my dog, but he shouldn't eating this. He should be doing this doing this and you're thinking, well, clearly you do that. It's that kind of thing, isn't it? Which I know is really wrong, but you think well actually if it's so good, why aren't you doing it?

Lead Interviewer14:55
The this kind of like is where like a role modeling type saying that.

Participant 2 14:59
Umm. Yes, it definitely, yeah, definitely role modelling, yeah. Is that I think it's a really difficult one for, you know, for anybody in, in any kind of health situation when you're being told something by somebody that clearly really wouldn't understand or clearly is in the same position, but clearly isn't doing that, do you know, I didn't know.

So doing things over the phone, I think is actually quite helpful.
That's probably one of the few things that doing it over the phone is really quite helpful because you can't see each other.

Lead Interviewer15:32
Yeah.
When I it's it's it's a, it's a pro, isn't it?

Participant 2 15:40
Yeah, yeah, I think it probably is. And but no going so.
So going back to the conversation, I think that does that is, that is definitely a tricky one, but obviously that's not so much of an issue now because it is done over the phone. But I also think it depends on who you are as a person, because I can remember, I'm going to get something out the fridge while one of my colleagues was doing the long term condition review and sort of listening in to what she was saying and I came away thinking she's so much more forthright than I am. She, which she used the word you are obese and I don't think I could ever do that.

Lead Interviewer16:09
OK, so like there's differences in languages between.

Participant 2 16:27
Definitely and.

Lead Interviewer16:29
Wait, why do you think that is?

Participant 2 16:31
I just think that depends on who you are as a person because it's black and white. So obviously whoever she was speaking to was obese. But for me that seems really mean. I would put it some, some something you know, a bit gentler than that.

Lead Interviewer16:46
Could you give me an example?

Participant 2 16:47

Yeah, I can. So I would never say you are obese cause that just happens really horrible. I would be inclined to say something more along the lines of, you know, if you look at a BMI chart and you've got your different categories, you do fall into the obese category.

Lead Interviewer17:00
Yeah. OK, OK. So you're kind of taking a step away from the individual a little bit more.

Participant 2 17:08
I'm I'm making it a Clinical language and making it sound fluffy.

Lead Interviewer17:12
Umm. OK. So yeah, where do you think you're like, that's something about yourself as well, if you don't mind me asking about.

Participant 2 17:21
Yeah.
No, it isn't it.

Lead Interviewer17:23
Yeah, using word, you are obese, where do you think that's come from for you?

Participant 2 17:31
I'm I think probably I'm not maybe as confrontational as my colleague and I think for her at the end of the day, she's black and white, she's doing the job. That's that.You're, you know. I just think it's like it is a person thing, isn't it? It's about what kind of language you speak to and what you use and how to get the best out of somebody because it doesn't really always work I don't think speaking to people like in that way, I don't think it does.

Lead Interviewer18:00
Why do you think it doesn't?

Participant 2 18:05
Because I think at that make that makes it sound like you're blaming them.

Lead Interviewer18:09
OK. Yeah. Yeah, I think that's quite big issue in in with people living with obesity and having the blame placed on them.

Participant 2 18:18
Yes, like a blame culture. Yeah, definitely.

Lead Interviewer18:21
Umm. OK, so how do you think then you said like you prefer to use the more of the clinical and you fall into the obese category. How do you think that's experienced by the individual then for you?

Participant 2 18:37
I don't. So if it was me, I think I would much rather hear it that way. And and possibly much rather have had a conversation before that about somebody's lifestyle. Because if you go launching into somebody and telling them that they're obese and then actually in the next phase you find out that actually, you know, they run half marathons and they go to the gym and and then because you know that that he's actually quite plausible, isn't it? So you are it's then difficult, isn't it? Because you've already taken away that part of of the patients of having the autonomy. You I think I think you're really leading yourself into the into suggesting that you've just made an assumption.

Lead Interviewer19:27
Like. Yeah, OK. OK, So what sort of things would you ask in terms of lifestyle? You mentioned kind of like exercise. Are there any other kind of things?

Participant 2 19:35
Yeah. So yes, of diet. You know what? What? Your diets? Like what you sort of understand by healthy eating and five a day and fruit and veg intake and then obviously because we've got blood results or a conversation around cholesterol. UM, you know what the understanding of that is.

Lead Interviewer19:57
OK, OK. So you really get kind of getting quite a lot like a wider picture of what's happening with the person, OK. And is it? Do you have any stand out. Experiences where the discussion has gone really well, or maybe it's been really difficult and hasn't gone so well that you could maybe share?

Participant 2 20:23

So I've definitely got one that did not go so well and that was one of those. Well, that's all it's alright for you type things, but this lady was. So that was when we were doing it face to face and she was very borderline diabetic and refusing to go back and have the retest. I think you know, because she just particularly want to know. And I think at the time, the point was that I was trying to make was that, you know, that is the policy, you do recheck it and if you are diabetic, it's a different ball game, a different review, a whole load, more risk factors and things that you do have to, you know, potentially take a lot more seriously. And she did get the hump with me and give me the whole. Well, it's alright for you, but looking back at that experience I can understand that I must be quite hard to become diabetic, especially if you do know what that you know. If I think ignorance is bliss, isn't it? If you don't really know what that means, but clearly you know clearly she did. And then I've had, uh, quite a positive experience of somebody recently who didn't actually know that they are eligible for all this help. So he is now got a subsidized gym membership and he's doing really, really well and that, you know, in the end of the day, that's all he ever really wanted to do. Couldn't couldn't afford it was kind of like, stuck in a rut with finances and you know, that kind of thing. So that you know that's been a really good thing for him.

Lead Interviewer21:53
Umm, that sounds like that’s really paid off, and he's engaged really well with it.

Participant 2 22:00
I don't think people do realize that they are eligible for referrals and things do they? Because it's not. It's if you look around like a waiting room, you know all the propaganda you've got, all your you know, your adverts with your AAA scan and you know, and the fecal blood test and all of these things and smears and all the rest of it. But is there anywhere that says that you're eligible for weight management? I don't think there is.

Lead Interviewer22:26
Yeah. I'm gonna have to look at the GP’S.

Participant 2 22:30
Yeah, I don't think there is cause I don't actually think it's necessarily that it's free. I think that it comes out of out of out of the primary care budget somewhere, doesn't it?

Lead Interviewer22:40
OK. So do you think that's why it's not so much so publicized as much?

Participant 2 22:46
Yeah, probably. Yeah, because the other thing as well, it's like I'm doing my masters at the moment for my ANP, and I wrote my prescribing assignment on hypertension and it just makes me laugh today. But the guidelines talk about so much about lifestyle intervention, weight loss, exercise, blah, blah, blah blah. That's your first line. That's your first line, and in reality it isn't, is it? It gives somebody medication.

Lead Interviewer23:15
Hmm. OK. Yeah. Yes, as gonna that comes a bit later but whilst it's come up like, yeah, the public health messages kind of the NHS guidelines is I suppose a big one that I always say.

But I know there are other ones but eat less move more, those sorts of really big but eat 5A day those sorts of messages. I was just wondering like how helpful do you feel they are for you and your patients?

Participant 2 23:44
So I think they are really, really helpful because I think you know they they are right, aren't they and their evidence based and they are right. But I think you've got a varying amount of interpretation, so I can speak to somebody and say how active are you and they can tell me I'm really active, I walk a mile every day.
Well, that's not really active, is it? And you know, it's not really that far, is it? I'm thinking that, but if you've got somebody that's, you know, going for a run or going out on their bike, it's an entirely different kind of cardiovascular exercise, but the the, but the difficulty is, is that not everybody's actually capable of being that cardiovascular active. So I suppose that if you went on a health promotion, you know, down that road, you're excluding so many people before you've already started. So you've kind of got to have, I don't know, it's just it is, I mean obviously it is helpful, but I think you've also got the other side of it where people think because they are going for a walk every day that they're that, that's enough. And actually in reality, it really isn't this it not in terms of a radical lifestyle changes it's gonna mean that you don't need to take medications or whatever.

Lead Interviewer24:59
Yeah.Yeah. What do you think might need to change for it?

Participant 2 25:08
It's just, I don't know. I just think it's you just get so many kind of variations in so people's understanding. So I think it is it's an education thing, isn't it at you know, at the end of the day? About actually knowing what those you know how important those things are and but will we ever achieve that? You don’t know do we.

Lead Interviewer25:36
Please. It's thinking about where their education comes from, isn't it really? And and who's responsibility? Where does that lie?

Participant 2 25:44
Yeah. No, absolutely because you know, if you, I mean, if you look at nice guidance for any for anything for like a whole load of topics, a lot of it is all about self management isn't it? But but realistically people, you know, the public's expectation and not just the mean for everybody, it is surely there's gotta be something I can take to get rid of this is a real thing, isn't it, in health care.

Lead Interviewer26:07
People. Are you seeing that more recently that kind of like?
So I suppose I'm thinking about people coming to you with a treatment, or maybe it might be different in your role, but like some people are coming now and specifically want the medication rather than.

Participant 2 26:26
Yes, you do get that quite a lot. My friend had something that her doctor gave her and I would like that you get that a lot, yeah.

Lead Interviewer26:29
What sorts of conversations would you be having then?
Do you think?

Participant 2 26:43
So then that's really a conversation about the fact that you have to start with a treatment pathway. So just because your friend got given such and such, you know your case is different and you would be better off starting with you know this and then working your way up to that if you do need it, because otherwise you're gonna end up taking something that's. It's more expensive and more detrimental more side effects that you perhaps didn't need, it's just managing expectations.

Lead Interviewer27:11
How do you think that goes?
So you mentioned like having a treatment pathway like how, how do you think thats received for people?

Participant 2 27:19
Mm-hmm. I think that's always a difficult one. I mean the the classic one for that isn't is the old chest infection, isn't it the antibiotics? Alright, so so so I never used to, but now I actually ask people if they think they need antibiotics because you can't really second guess it's because because a lot of people you'd be surprised a lot of people actually don't want them. You'd think it was the other way round. But I think there's just this assumption that people come are coming in, into the coming they're phoning up and telling you they've got this really nasty chest and you just assume all you know, they want antibiotics that probably aren't gonna work. But actually lot of the time it's the other way around. They actually don't. They just want reassuring that they don't. So that's all consultation skills, isn't it? I think and that's a a big part of what we are taught, what medical students are taught, isn't it, you know, asking what your ideas are, your concerns and your expectations. I think you do have to do that for everything, because you're not really putting the patient, Yes, about the patients wishes, isn't it at the end of the day.

Lead Interviewer28:32
Umm could you tell me a little bit more about like your, you know, the consultation skills you mentioned about like talking them through what they expect that they'd like? They're any other skills there that you feel like quite important to you that you use all the time in discussions?

Participant 2 28:52
Umm. So in those kind of consultations where you're, you know, you're making a treatment decision, I think we all kind of go through the, the you know, the Socrates acronym where you go, yeah, go through all of those bits and pieces. And yeah, the the ICE as they call it, questions. So that is the ideas, concerns and expectations question. So I went to see, I took my son to see a GP about two years ago and there was a GP registrar and she actually said she actually said it, and what are your ideas, concerns, and expectations that I'd never heard it said like that before? And I you know, what do you think it is by the blah blah? And I remember thinking, I thought she'd done it completely wrong because it almost felt like, well, I don't know. I'm not. You know, you're so I think the way that you say it. So one of my colleagues says it in a way, he says. So there's this whole concept in medicine about putting the patient at the centre and really finding out what the patient's feelings and what the patients wishes are, and it's called ideas, concerns and expectations. And then he asks the questions, and I think that's brilliant and how he does that.

Lead Interviewer29:59
OK. Umm, gives a little bit more of a kind of prologue in into it.

Participant 2 30:04
Yeah.

Lead Interviewer30:06
Yeah. Is that how you?

Participant 2 30:08
You got somebody a bit difficult. Yeah, yeah.

Lead Interviewer30:10
You were gonna say especially you've got somebody a bit difficult. OK. How do you feel like that helps? Then if somebody's a bit difficult?

Participant 2 30:23
Because I think you're then kind of explaining that there is a reason for asking.

Lead Interviewer30:28
OK. Yeah. OK, so it gives that a rationale as such for them.

Participant 2 30:33
Yeah.

Lead Interviewer30:40
Umm, going back to like the treatment pathways and things.

Participant 2 30:46
Yeah.

Lead Interviewer30:49
Yeah. Is there any other things that like? What would you be thinking about then? If you are in a position to refer an adult to kind of your the weight loss services, what sorts of things would you be thinking about for them or with them?

Participant 2 31:06
I think I'd be thinking about whether it was actually going to work, whether it was something that was actually, you know, feasible something that you know, is it going to work and is it actually what they want? Because a lot

of the time, so if you take like the National Diabetes Prevention program for example, and we send that letter to everybody, that's got a raised HBA 1C and when you when speak to to people when you do their review and you say so, did you get the letter, a lot of people don't really kind of understand why they were sent to it, what it actually, how it's actually relevant. And and then and I I just don't, I just think referrals to those kind of services shouldn't really be done without a conversation?

Lead Interviewer32:00
Umm, how often does that happen? That just getting a letter sent out? Or is it just around NHS? Yeah.

Participant 2 32:04
All the time.
Ohh time yeah and quite it's been quite badly written letters as well.

Lead Interviewer32:16
Yeah.
What do you think the impact that has then on on you guys?

Participant 2 32:22
So sometimes so. So say you have somebody that has no idea what that means, like the raised HBA 1C. So this maybe is somebody that's had that test for as part of an NHS health check. And so they haven't had that done because they're being annually reviewed. That's a different thing. So it's just your bog standard NHS health check some people get quite angry about it. Because it because I suppose it's all of a sudden Oh, you know, we've discovered something, Something's wrong, but there's no kind of like explanation as to what that means, and actually, you know, it's not terrible. It's not, it's not your fault. It's just a letter saying you're a prediabetic, phone this number. Basically, it's just really badly written. The I think the letter is really badly written, but that's just my my [opinion] Yeah, and I don't think it makes people want to do it.

Lead Interviewer33:14
Yeah.
So it it's sounds like setting up a bit of a barrier.

Participant 2 33:19
Yeah, I think it does. But and it's a 16 week or 12 week programs, it's quite a long. It's quite a commitment. It's quite a commitment for something you might not really understand. That's my thought.

Lead Interviewer33:38
Yeah. So you mentioned like how do you kind of assess for like whether it's going to work, so you, you kind of said there's two things you're thinking about, is it gonna work?Is it what they want?

Participant 2 33:55
So so the so the people, I think it works for are people that are quite tech savvy because a lot of these things are online. So there's no point sending this letter to people really that are in their 80s and don't know how to use mobile phones. Not gonna work, but still. It's a standard letter that goes out, so I think people that are quite tech

savvy and people that are also interested in their numbers and know that that's, you know, something that could that needs to be sorted. Also, there's an A group of patients as well. Who? Who have these?
If if you've got, I've always find one that's quite interesting. If you've got a husband and wife who've got like the same long term condition, it's almost gets a bit competitive. Now who's got the best blood results this year. There's quite a lot of that sort of thing, but also people that have, you know, had a raised HBA 1C and then they've made some dietary changes and then they see it improve. I think if you see that kind that happen, I think those people are the ones that are gonna be more successful.

Lead Interviewer35:01
Yeah. OK. So kind of noticing those small improvements.

Participant 2 35:08
Yeah.

Lead Interviewer35:09
Ohh big improvements as it were OK and yeah, you have talked about it but and if they don't want it, where does that leave you then?

Participant 2 35:26
Is not an awful lot you can do about that really just have to document it.

Lead Interviewer35:30
Yeah. OK, what happens if they to go? You said it's really tricky, but this was a right beginning of our conversation. But those that have already gone through kind of the funded placements and they still want support, but let's financial restraints what happens then?

Participant 2 35:43
Umm. Yeah. So so you. Well, I they are. They, like I say, they are really those one time funded and I think you could possibly get somebody a place if you kind of, like if things have changed in terms of their cardiovascular risk. So they were because the three questions on the form do explicitly say and you know, you have to put BMI risk factors, et cetera, et cetera. And then the last question is, has this person been referred previously? And if the answer is yes, then you are not you're not supposed to send it. But I'm not really sure how strict they are the other side of that not accepting them. It's a difficult one, isn't it, that because you've got somebody that wants it, then why wouldn't you just take them? But.

Lead Interviewer36:49
Yeah, I supposed to consider it as well Like there is a message of the obesity epidemic. I know it comes and goes throughout society over time, but is that supports not there for people who are willing to do it and it like you've talked about education and awareness and these sorts of things. It's a really tricky.

Participant 2 37:14
It is really tricky. You know, I don't know how many years ago it was now, but we used to do smoking cessation stuff, didn't we? In primary care, we don't do that anymore. We used to have the the Desmond Group as well for

diabetics, which was a a face to face group where they used to come in every week and do their way in and we don't do that anymore. It's all about money, isn't it, really?

Lead Interviewer37:37
The things that like getting cut back because of the finances, yeah.

Participant 2 37:45
It's a shame really.

Lead Interviewer37:47
Umm. Are there any like any other comorbid clinical presentations that might impact you having a conversation with a person around their weights and weight loss?

Participant 2 38:02
I don't think so. No, no.

Lead Interviewer38:04
No. Do you see a particular type of client come through your doors in terms of like how needing to have the conversation around weight loss, an image of a person at all?

Participant 2 38:22
Have to say it does usually tend to be younger men or ladies in their 50s and 60s. I don't know why. But that's, I don't know, that's always. What I think of when I think about those those groups of patients.

Lead Interviewer38:45
Yeah. When you say younger men.

Participant 2 38:49
Umm, he's a 40, 40 year olds. And I think that's because the men, because men don't go to Gp's, do they? They really don't get picked up with blood pressure problems. Until they're in their 40s, when they've come for an NHS health check or they've had some kind of medical at work. Whereas ladies, I think we get picked up a lot sooner because we are in and out all the time with the kids or Women's Health or whatever. I think that's definitely true with men.

Lead Interviewer39:26
Umm yeah.
There are gender differences in seeking help, isn't it?

Participant 2 39:34
Umm.

Lead Interviewer39:36
Does it? Do you feel like it impacts your conversation that you'll have, but between genders?
Is there a particular approaches you might take with men and women or?

Participant 2 39:48
No, no, I I wouldn't have thought so. So I think it, yeah, it is the same.
I think there is a kind of and it is wrong, but you do tend to it is a bit biased and that you automatically think that younger person is more likely to get on with an exercise referral than an older person, and that's really not true, but you do automatically think that, don't you?
But just because you're referring somebody to a gym doesn't mean that they're gonna be training for a marathon, does it? It's just those kind of thought processes, but yeah, but they are open to everybody.

Lead Interviewer40:29
I was just thinking about like we all come with our own kind of we we all have our own assumptions over things. Where do you think yours has come from in terms of like that idea of exercise?

Participant 2 40:43
I don't know really. I just think it's just an assumption that you kind of make, don't you, when you think about people that go to the gym. It does tend to be well, it doesn't tend to be younger people. That's not true. I know my gym. It's not younger people, but in terms of the people that are, you know, the ones that are really fit and putting in the effort. As as a definite, there's a definite group of people there, a definite demographic.

Lead Interviewer41:05
Yeah. OK, so suppose yeah, it's kind of like thinking about norms, aren't they, or what you expect expect to see? Do you have any other kind of expectations around or norms around weights and weight loss for people?

Participant 2 41:16
Yeah. No, I just think that people just needing, you know, they're just needs to be that support and and that encouragement and I think that's probably you know where it does lack. I think every every week when I do this clinic, I will identify somebody who is, you know what on a BMI chart overweight, obese or whatever, but a lot of the time there isn't really much I can do for them because they don't meet the criteria. Apart from, say, have you, you know, have a word with GP.

Lead Interviewer41:57
OK. So suppose you're still trying to sign post people to to something as much as you can.

Participant 2 42:03
Umm.
As you can, yeah.

Lead Interviewer42:08

Is there anything you do in in your role to maybe try and support and encourage people like maybe it might not look like referring, but anything you feel like you do in the conversation at all.

Participant 2 42:21
I think, well, just generally just when we're sort of having the conversation, UM, you know, you don't have to. So blood test is a difficult one because there's certain interval you know intervals that they won't retest bloods in, but you don't necessarily have to wait a whole year to review somebody again if you want if you wanted to see them sooner, so lots of people do like that, I bring lots of people in before a year, especially if they if they're, you know, they want to make some changes and you know, speak to them again in a couple of months. See how things are going? I do that quite a lot.

Lead Interviewer42:54
Umm, what do you think? So you have those like regular touch bases as it were. I can't think of another way of describing it. What do you think that does for the client?

Participant 2 43:05
I think it's much better. I mean, I probably shouldn't be doing it because we've really got very limited appointments because we've got very few nurses doing it. But take for example, I mean, this isn't actually about weight management. Well, actually it kind of is. I had a lady of the day whose blood pressure is over Target. This was the week before last. She is overweight umm and so So the life, the life style intervention thing, if you look at the guidance, that is what you're supposed to go with first and it's almost like saying, you know, so I think we are reviewing, we're gonna meet up again in September, but until then, you know, she's saying to me, right, I'm gonna make some changes. I'm gonna do this. I'm gonna do that. And you know, we really, you know, really going to see some differences. And if that works, that's really good. Rather than just saying OK, this is this is your problem. Have some tablets to bring in medication down because I just think it doesn't actually give you any ownership, does it? And this particular lady actually she she lost quite a bit of weight about three years ago. So she does know that it that it works.

Lead Interviewer44:10
Yeah.
So she's had that past experience.

Participant 2 44:12
Yeah.

Lead Interviewer44:13
Yeah. And is there also maybe a maybe I might be leading here a little bit, but like in terms of like a bit of validation like she's coming to you more regularly, I suppose like to kind of show you oh look this is what I have done.

Participant 2 44:26
Yeah. Yeah, and this is what, you know, this is what we can do. I mean other than that, so when I see her in September, when I speak to her in September, I am gonna get some bloods done. Umm, which again youre not supposed to, but just because I just think that will make the point to her. This is how much this has improved with the queue risk, the blood pressure, cholesterol, all the rest of it. But then I won't be able to do anything

before the next review is due. And then you just kind of gotta hope that actually that part works and then it continues to work. And then if it doesn't, so as a clinician, if I see her again in September and she's still got an over target blood pressure, I will have to treat that or at least say to her we, you know, I can't just say, oh, well, that's fine. Just because I can't. So it's it's almost like saying, well, you know, there's a chance to, you know, try and sort this out yourself really.
But it's so difficult.

Lead Interviewer45:28
So when you say Oh yeah.

Participant 2 45:29
It's really difficult.
It is.

Lead Interviewer45:32
Yeah.
It's like constantly moving puzzle, isn't it?

Participant 2 45:36
Yeah.

Lead Interviewer45:39
In terms of like in terms of your own training to support adults living with Obesity, do you feel like the training you've had is adequate, that you've had only at all?

Participant 2 45:46
Hmm.
I don't think I've had any at all really. To be honest.

Lead Interviewer45:56
If you were, if you were to have training, what would you like?

Participant 2 46:03
So it would be interesting actually, or would be nice as a group of staff because we're all doing these reviews and we're all reviewing blood results and whatever. So we know what we know from our experiences and what we've learned, but actually to have something where you actually do sort of know what is achievable.
Because you know what is actually an achievable weight loss, what is actually a safe weight loss? Because that's nothing makes me a lot of it's like, well, the government, they say, you know, sign posting healthy eating, but there isn't actually a a resource that's actually the gold standard of this is what we do because that's what I did my assignment on was that the guidelines are nice guidelines recommend exercise, diet and diet as a way of modifying blood pressure, but there is no where that tells you what exercise, how long for, how often there's nothing. So it's just like plucking words at the air, isn't it? So go on a diet and do lots of exercise. But as a clinician, it's that's really difficult because because where is your validated evidence based source that you can

give to that patient? So that would all really fit in, wouldn't it? With sort of, you know, weight management education. It's like a little a little package of OK, so this is what you should be recommending, this is your good diet because I think at the moment everybody gets their information and the resources from somewhere different.

Lead Interviewer47:40
Yeah. Yeah, which give different advice resources.

Participant 2 47:45
Different advice? Different. Yeah, just I don't, And I don't understand that.

Lead Interviewer47:49
Yeah.So it sounds like yes, having something that is evidence based that that gives you that kind of like rule of thumb to offer clients.

Participant 2 47:55
Umm.Yeah, but having written that assignment, I do understand now that it's because it's not actually, so it is true that it reduces blood pressure, but it's not actually. Hasn't what research there is hasn't actually shown it to be that effective. Say that in itself is a can of worms, isn't it?

Lead Interviewer48:27
Yeah, I think that's one of the things. So obviously I've been trying to have been doing a lot of research into Obesity. It's causes like in health and health to help and and there's lots I feel for my I've read and there's lots of conflicting messages in terms of in terms of the evidence. So one of them is around actually more harmful to have the weight cycling so and actually for those individuals it might be safer to to stay at the current weight because the the constant losing weight, putting it on it's quite harmful. And that led me down a bit of a worm hole in terms of like then the idea of, like, health at every size and body positivity. I don't know is that coming into your discussions or conversations with people at all?

Participant 2 49:20
I think that definitely does come into it. Yeah, definitely. Cause like you know, as I said to you earlier, you could have somebody that's you know, technically obese on a BMI chart, but yet they're still able to run an exercise in and actually BMI isn't necessarily that adequate or accurate as it for somebody that does a lot of. So the cardio not cardio. The other type of exercise resistance exercise. And yeah, and also I had a patient a few weeks ago say to me that Slimming World shouldn't be an authenticated Weight loss program because it's not addressing the reasons why people don't, why people eat badly. So having your days where you don't eat carbs isn't actually a sustained a sustainable way of living. So it loses weight, but as soon as you stop doing it and I don't know how true that is. But I was thinking about that afterwards I was thinking it's that's possibly right, isn't it? And then she was also saying that Weight Watchers is also rubbish because it just encourages you, encourages you to eat processed food. Like you, I can't win.

Lead Interviewer50:31
No. Suppose what? What do you think about that in terms of like the causes of obesity like? What are your thoughts around that?

Participant 2 50:44
I think healthy food is expensive. So yeah, if you so our local tescos is a really good example of a processed food paradise. You go in there and you've got all your ready meals on the very first row that you go to, and then you followed by the pizzas and then the vegetables are right at the back. And I just think it's so much easier in in this day and age when people are leading a busy life to just get food that's easy to cook, and it's not necessarily that a ready meal or a processed meal or whatever is bad for you. But it's that kind of then, the the less you're cooking something with fresh ingredients and knowing what's actually going into it. And the whole thing is quite a cycle, isn't it really? Is, I don't know it's. I also think as well that kids eat way more sweets and processed rubbish than they used to. Might my kids, you know, they're not that bad, but they are bad compared to how we were that. But Why is that? I don't know.

Lead Interviewer51:52
Yeah. So suppose you kind of like it sounds like you're own experiences with food as well.
Comes into it like. Sounds like you didn't have so much sweets when you were a kid.

Participant 2 52:03
No, we didn't. No, we were allowed. However, we did have the mentality of you everything on the plate. Eat everything on the plate and that's not good either, so I don't know the whole things just so there's just so many elements, isn't there? So many psychological things that are sort of part of it, but I think if you think I from thinking about sort of a a nation and perhaps why we are getting bigger, I definitely think the fast food market does have a lot to do with it and the cost, the cost of food. It's just so expensive, isn't it too?
If you just wanna eat fruit and vegetables all the time, that's just not, you know, it's just not cost effective.

Lead Interviewer52:47
No, I keep seeing this meme about parents who are kind of like if I stopped feeding my kids fruit, they'd be signs and they've got, like, this lavish lifestyle of a yacht or something. And just kind of the price of fruit and strawberries and what have you, so.

Participant 2 53:00
Yeah.
Yeah. And just probably true. I said I don't know, it's difficult, but then also I think they do far more physical activity at school than than we ever did, definitely.

Lead Interviewer53:10
Yeah. Hmm. OK. So there there are changes.

Participant 2 53:20
But.
Yeah, but just, yeah, it's just difficult, isn't it? Really, it's it's it is a tricky 1 because I think a lot of the time there's more to it than just what somebody eats.

Lead Interviewer53:31
Umm yeah. Yes. What do you think? Like has informed your own views around obesity. Like, where do you think that like knowledge has come from for you?

Participant 2 53:50
Umm. It's. I just think that I a real tricky one, because I think it would be quite easy, wouldn't it?
Just to think how well your blood pressure is high because you're overweight. So that's your problem. But it really is never that black and white, you know, and I think, like you said earlier about this, sort of yo yo dieting, weight loss then not weight loss, I think it just goes to show that somebody does have the potential to not be overweight but yet but they are and then they're not and they are and and all of that I think is more psychological. So I think I think for me, I just don't really. I'm not particularly judgmental. I just think well at the end of the day that that's it's my job just to give the right advice. So I'm not going to be and not seeing somebody face to face does make that a lot easier. Definitely, because otherwise I think the person just assumes that you're being judgmental, but at the end of the day, you're you are just giving the right advice in terms of what your guidance is, aren't you? And and you know that a healthy lifestyle is going is going to make you healthier, that at the end of the day, that's the only message that we're trying to give isn't it, but. Is it is a, it is a tricky 1.

Lead Interviewer55:08
Yeah. With not many answers at the moment as opposed.

Participant 2 55:15
No, no, no. I don't think there are. Yeah. And for some people, it's harder work than it is for others.

Lead Interviewer55:27
Umm, OK, where do you? What? What? What makes you say that? Do you think?

Participant 2 55:34
I think it's definitely true that some people are naturally smaller than others, so you know, lots of people will can much easily gain weight than others. That's definitely true. Or have the ability and the motivation to actually lose weight. Some people do and some people don't. So again, that all comes down to Psychology, doesn't it?

Lead Interviewer55:56
Umm yeah. Also kind of people genetics as well.
A little bit man.

Participant 2 56:03
Umm, yeah, yeah. Definitely.

Lead Interviewer56:06
Umm do you think that's it?

Participant 2 56:07
Yeah, it's a tricky.

Lead Interviewer56:09
NHS. Sorry.

Participant 2 56:09
No glass to say is I think it's a really interesting subject.
It's just quite, you know, it's never black and white is it.

Lead Interviewer56:12
Umm. Yeah.
Especially like towards the end of our conversation, you kind of talked about psychology and the psychological implications of obesity potentially like. Is there anything in your area that brings in psychology at all or in terms of like treatment or referral options?

Participant 2 56:37
See, I'm unfortunately not. No, not for us. I think in primary care, no, not for us because we are, like I said, sort of working through those templates and the risk factors, So it really is just a a black and white conversation. You know, as a conversation, yes, definitely. Where you are left with knowing whether somebody wants to be referred or you know whether you're going to speak to a GP or or say, I can I book you in with your GP or how far you're willing to take something. But it's, but from a psychology point of view, for us I don't think for for us it is more than that.

Lead Interviewer57:18
Yeah. OK, that's understandable because it's not, it just sounds like it's not your role.

Participant 2 57:21
It's hard, yeah.

Lead Interviewer57:23
Yeah. OK, OK. I'm just aware of time we come up to an hour. Do you feel like I've missed anything? In any questions or any questions you expected to be asked and I didn't.

Participant 2 57:42
No, I don't think so. I think it probably be quite useful for you to speak to actual general practitioners from for their so side of it.

Lead Interviewer57:50
Yep. Yeah.

Participant 2 57:54
You know who they identify, how they identify them.

Lead Interviewer57:58
Yeah. Yes. Now I've got quite a nice range at the moment, so GP's, health and well being coaches as well, so they kind of sound a little bit like your care coordinators and at nurses and some pharmacists as well.

Participant 2 58:19
Because I I wonder as well, I come across quite a lot of patients that are on, I can't remember the name of it. The medication, is it oras or something like that orastat?

Lead Interviewer58:26
Orastat, yes.

Participant 2 58:28
So we used to when I was a practice nurse, we used to get every so often the patient in for a weight and BMI check.

Lead Interviewer58:34
Yeah.

Participant 2 58:34
That's that was taking that and I did often wonder, and I never actually asked the question, who identifies that as as the root? I'm assuming the patient goes to the GP and says I want to lose weight.

Lead Interviewer58:50
Again, I think it varies from from the conversations I've been having. Yeah, it is very ohh, especially in terms of availability and cause.

Participant 2 59:00
Yeah.

Lead Interviewer59:02
From my understanding, some people. Yeah. I I could go on like it's some people don't want it. Some people really do, and that's what they come in for. But they've got underlying medical conditions where it's like, it's too risky.

Participant 2 59:16
Yeah.
Umm.

Lead Interviewer59:23
Yeah, some people are on it for two years and I think that's as long as you can take it and then gets taken away.

Participant 2 59:30
Something like that, yeah.

Lead Interviewer59:31
Yeah.
So yeah, it's a.

Participant 2 59:35
And it's taken away without addressing the underlying problem I think isn't it?

Lead Interviewer59:42
I don’t know.

Participant 2 59:42
I don't know.

Lead Interviewer59:43
Yeah, but it's a bit like what that Lady said.

Participant 2 59:44
Difficult one.

Lead Interviewer59:46
Kind of did like connect with something. She said that you shared around well, they don't like we can eat all of this healthy food, but it doesn't address the actual psychological aspect of it. Yeah.

Participant 2 59:57
Problem. Yeah.

Lead Interviewer59:59
So I suppose orlistat is just another way of eating healthy in a in a way that makes sense just another.

Participant 2 1:00:04
Yeah.
Yeah. Yes, it did.
Yeah, it's it's such a big area, isn't it?

Lead Interviewer1:00:13
Yes, but no thank you for taking the time.

Participant 2 1:00:16
No, that's alright. No problem. I did have a friend actually who lost. Ohh I can't remember how much it was more than 12 stone on Slimming World. A few years ago and she always said that, you know, she she only did it because she was ready to. And I think it's like giving up smoking, isn't it? And they're actually kind of in that frame of mind where you're going to do it, then it's not actually going to work. It's like anything you can go to the gym, but we're gonna work very hard. Does it? You gotta be in the frame of mind.

Lead Interviewer1:00:46
Yeah. Well, yeah, there is that kind of personal responsibility for, for taking it on. Cool.
So I've got a few more. And Interview. So in terms of the voucher, so 20 pound voucher, but I was gonna block by them once I finish them, so I've got.

Participant 2 1:01:08
Oh, thank you. Yes. But you've done. Yeah. No, that's fine. Whatever you need to do, that's fine. Yeah.

Lead Interviewer1:01:16
Is that right? And yes, you should send them out over the next month or so.

Participant 2 1:01:21
OK, perfect. Thank you, but.

Lead Interviewer1:01:22
And also I think you've ticked the box on the M consent form, but yeah, if I have some preliminary results, would you like to see them at all?

Participant 2 1:01:30
Oh, absolutely. Yeah, definitely. I find these things really interesting.

Lead Interviewer1:01:34
Yeah. OK, good. So I'll, yeah, I'll, I'll share them out.

Participant 2 1:01:35
That'd be great. Thank you.

Lead Interviewer1:01:38
Hopefully if they get done in time.

Participant 2 1:01:40
Yeah.

Lead Interviewer1:01:42
But then no.
But thank you very much.
It's been really interesting, OK.

Participant 2 1:01:44
That's alright.
No problem, no problem at all.
And yeah, and anything else?
Yeah.
Give me a shout.

Lead Interviewer1:01:49
Brilliant.
Thank you.
OK.

Participant 2 1:01:50
No worries.
Nice to meet you.

Lead Interviewer1:01:52
Take care.
Yeah, you too. Bye.

Participant 2 1:01:53
Thanks.
Bye, bye.