Author’s response to reviews

Title: Support needs of patients with obesity in primary care: a practice-list survey

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Version: 2 Date: 04 Nov 2017

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Response to reviewer comments

Reviewer reports:

Elizabeth Ann Sturgiss, FRACGP FHEA B.Med MPH MForensMed (Reviewer 1):

This is a population survey from England of adult patients who were identified as having obesity in their GP record. It was a postal survey.

1.1 It is unclear how recently, or how frequently, these patients have accessed their GP and this is a weakness that is impacting on the interpretation of the data and the implications it has for practice.

We agree and we have now added this as a limitation of the study to the Discussion section (pg 17, ln 395). As described further under point 1.19, we were unable to link survey responses back to individual health records (which would give details of patient’s use of primary care) due to the requirement for anonymity, which was a condition of ethical permission. It is implied, by specifying that participants must have received a code of obesity in the previous 12 months in the inclusion criteria, that these individuals have had some contact with primary care in their relatively recent history.
1.2 Overall please consider person first language in the writing of this paper. (see here for more information http://www.obesitnetwork.ca/people-first) The current writing of the paper is not in line with best practice for reducing weight stigma and bias.

We have revised the paper to include person-first language and we thank the reviewer for calling it to our attention.

1.3 This is very important work and adds to the body of knowledge.

I am not aware of any other work that attempts to capture patient's current strategies for losing weight. I welcome this work.

We really appreciate the reviewer’s comments and the recognition of our attempts to capture information about the activities and experiences of a population that has not previously been investigated in this way.

1.4 There needs to be re-think of the conclusions drawn from the data as they seem to reach further than the data would allow.

Thank you for this comment: we have addressed this in detail, and describe changes made in response to it, under points 1.8a, 1.22 and 1.23 (below).

1.5 The population surveyed needs to be better defined as this impacts on the conclusions and implications for practice.

Thank you for this comment: we have addressed this, and describe changes made in response to it, in detail under points 1.9, 1.10 and 1.13 (below).

Abstract:

1.6 Please add the aim of this study to the abstract.

We have added the (revised) aim of the study to the Abstract (pg 2, ln 31-33).

1.7 ?77% had attempted to lose weight either currently, or in last 12 months; please make this sentence clearer.
1.8a Conclusion - "We identified the need for informational, structural, and weight loss maintenance specific support for GP patients with objectively-recorded obesity." Can this be drawn from this data?

We do believe that this conclusion can be drawn from the data: participants in our study either explicitly or implicitly demonstrated a need for the forms of support described (see below).

Our statement that our study participants ("GP patients with objectively-recorded obesity") were in need of "informational, structural and weight loss maintenance support" is drawn from the data in the following ways:

(i) Informational support: there was a high prevalence of use of ineffective weight loss strategies (such as drinking more water) and this indicates a need for provision and communication of accurate information on effective strategies.

(ii) Structural support: few participants had utilised a structured weight management programme (commercial, local authority or via primary care) but those that had found it helpful and effective, suggesting that structured programmes might benefit others in similar positions.

(iii) Weight loss maintenance specific support: participants reported lower confidence and success in weight loss maintenance than in weight loss. This indicates an area in which support should be prioritised, because the health benefits of weight loss largely depend upon its maintenance.

Whether or not this support can, or should, come from the GP is a more complex question and one which our data cannot answer. We entirely agree with you that individuals’ perspectives on GP attendance / non-attendance to receive such support are not included in our data (see 1.8b below).

1.8b The data points to many patients trying to lose weight, with few approaching their GP. But the reasons for this are not in the data. Please see below for further input into this.

In our paper, we do not speculate on reasons why few patients approach their GP for weight loss support, although we highlight the features of individuals who reported having previously sought support from their GP. We have responded in more detail to the Reviewer’s points, below.
Methods

The methods section is brief.

1.9 If the interest was in patients presenting to primary care, could an explanation be given for the postal survey?

We are extremely grateful that the reviewer has pointed out the inaccuracy with which the aim of our study was previously expressed. Our interest has always been in patients recorded as obese on primary care health records, and we fully accept that this is not the same as the population of patients that presents to primary care. We have rephrased the study aim to clarify this, removing any reference to patients ‘presenting’ (pg 5, ln 83-84).

The postal methodology was adopted precisely because we wanted to capture the experiences of patients recorded as obese, rather than those in this category attending the surgery within a particular window of time. The best way to do this was to contact patients by post.

1.10 Is this population the same as patients presenting to primary care? Would a more appropriate target population be patients sitting in GP waiting rooms? How does the choice of the survey population impact on the data interpretation?

As discussed under point 1.9, we completely agree that the study population is not the same as patients presenting to primary care and apologise for introducing unintentional ambiguity in our previous study aim.

As regards the impact of the survey method upon the data interpretation, we cannot say that all of these people have attended for weight-specific reasons in the past, nor that they would (or be willing to) in the future.

1.11 Please add the method you used for coding the free-text into your methods section. It is currently not mentioned at all.

We have added details of the coding strategy used to the Data analysis section (pg 7, ln 136-138).

1.12 Please add in ethical approval for the project.

We had provided details of the ethical approval under the subsection ‘Ethics approval and consent to participate’, but have now added these details under Procedure as well (pg 5, ln 98-100).
Results

1.13 - Is the survey population representative of the patients presenting to primary care? Can you please give a comparison with an appropriate database. (It looks that your survey has much higher proportion of men than usually present to GP care).

We have clarified the aim of the study in relation to this point (see point 1.9) and commented on this in Discussion as a study limitation, including a relevant citation (pg 17, ln 395-398). One would not expect a sample of individuals with recorded obesity, recruited to the study for this reason, to be exactly representative of patients presenting to primary care.

1.14 - Was the self-reported "highest weight" for women to include pregnancy? Could this account for why they had higher "highest weights" than men?

We have now clarified that pregnancy was specifically excluded (pg 5, ln 106 and pg 8, ln 171).

1.15 - The percentage of participants who reported ever trying to lose weight was 93%. Did your participant information sheet specifically ask for people interested in/worried about their weight? Were you aiming for a population in general survey, or a survey directed at people worried about weight?

We specifically phrased the content of the information sheet and the invitation letter as neutrally as possible, and did not ask for people worried about their weight, or those that had ever attempted to lose weight. Potential participants were informed that their GP had contacted them about the study because their weight was recorded as being in the obese category on their medical record. We were aiming to recruit from the general population of individuals whose weight was recorded in this way, rather than those with a particular interest or experience in the area. The overall lifetime prevalence of weight loss attempts in the study sample is less surprising than it might first appear, given that the 12 month point prevalence of weight attempts in European general population samples with obesity is ~ 55-65%, a figure consistent with Health Survey for England data. Even assuming that many of the same people repeat weight loss attempts, year on year, there will be others that only try once or twice in their lifetime, cumulatively amounting to a large majority of individuals.

1.16 - Could you provide confidence intervals in your tables instead of p-values? This would be more helpful for the reader to interpret the range of values.

We have added confidence intervals to the values in Table 2; no p values or inferential statistics were present in Table 1.
1.17 - The results point to many participants wanting to lose weight due to unhappiness with their body shape. It could be worthwhile to include in the background papers related to weight stigma. Unhappiness with body shape and experience of weight stigma, increases a person's trajectory of weight gain and reduces their likelihood of losing weight. Your data is very important for primary care - health professionals need to be aware of the very high prevalence of body dissatisfaction, and ensure their approach to obesity does not make this situation worse.

We agree and we have added a citation and comment in the Introduction to reflect this (pg 4, ln 74-77).

1.18 - Physical activity is a great way to improve overall fitness and health, but is not a strategy for reducing body weight. Can you please explain why it was included in the survey?

Physical activity was included in the survey because it is widely regarded as a strategy for reducing body weight (as, indeed, is drinking water) by many members of the public and often undertaken for this purpose. We were also interested in characterising the physical activity of this participant group in and of itself, using the IPAQ. Finally, we were interested in individuals seeking to maintain their weight: physical activity is extremely important for the maintenance of weight loss, once attained, and thus we also probed it from this perspective.

Discussion

1.19 - The first sentence of your discussion says "users of UK primary care services" - do you have any information on how often the survey participants are accessing their GP practice? This is important for the implications of this data. If these people do not go to the GP often, it would not be possible to access them easily via the GP. Your data is high in male respondents and would suggest they are a different population to the usual "user of UK primary care services".

We have amended this sentence in order to clarify our conclusions (pg 13, ln 300).

We do not have data on frequency of GP practice use for individual participants in the current study because survey completion was anonymous i.e. we explicitly could not link back to the practice records, once the surgeries had distributed the questionnaires using their lists, as a condition of our ethical permissions. We agree that attendance is important to determine whether primary care channels are indeed a feasible route for the delivery of weight management support to the population in most need of it. However, we also believe that eligible patients could
feasibly be encouraged to attend primary care (e.g. invited to a health check) for this purpose. As mentioned earlier, the requirement for a read code to have been recorded in the preceding 12 months for participating patients suggests that patients had relatively recent contact with primary care – because we had no access to records to confirm this, however, we have not made any assertions about patients’ frequency of attendance in the manuscript.

1.20 Care to be taken with the following statement: "The former finding suggests that primary care staff should be sensitive to the importance of body image and drive to improve fitness amongst younger patients, and may suggest alternative 'ways in' to discussing weight control with these individuals." I am not aware of any literature that promotes "body image" as a sensitive way to bring up weight management. There is a lot of literature on the harms of weight stigma and discrimination, particularly in the healthcare setting. The author's suggestions would add to this stigma in my view. Please provide supporting references to this statement, or make a different interpretation of the data. This is particularly pertinent when we know that lifestyle intervention is unlikely to lead than to more than 3-5 % of weight loss, so advocating weight management as a way to improve "body image" is fraught.

We agree with the reviewer’s concerns and we have, on reflection, entirely removed the part of the sentence which refers to ‘alternative ways in’ (pg 16, ln 371-372).

1.21 A strength of the paper is stated to be the high male response rate. However, if you are interested in patients that present to the GP clinic, this may in fact be a limitation and point to your survey capturing a different population to the one you are interested in.

We agree with the statement and hope that our responses under 1.9 and 1.13 address this issue. We were interested in patients recorded as obese at their GP practice, rather than those that attend said practice with any particular frequency (as pointed out by the reviewer, postal survey would not have been an appropriate way to access these specific populations).

Conclusion

1.22 “GP provision of demonstrably-effective brief referral interventions to structured weight loss support [8] is likely to be acceptable to these patients, to augment their current weight management activities and to optimise limited GP time and resources.” Your data did not explore what patient preferences would be in relation to the support provided by their GP. This conclusion is an overreach based on the collected data.
In the light of the constraints of the data, which do not specifically show that patients wish to receive brief interventions vs any other form of support, we have rephrased to say that such provision ‘may’ be acceptable to these patients (pg 17, ln 407).

References


"GP weight loss support was acceptable and useful but underutilised, indicating that screening and brief referral interventions to structured programmes have the potential to augment obese patients' current weight management activities and meet key support needs whilst optimising limited primary care resources."

We have now included this reference (pg 14, ln 323).

In this conclusion, "GP weight loss support" is considered by the research team to mean "brief interventions". Do you have evidence in the data that this is what the patients also mean? Or are they thinking about a different strategy from their GP?

The reviewer is correct to indicate that we don’t have enough evidence in the data to suggest exactly which GP strategies would be welcomed by participants. ‘Brief interventions’ are mentioned here because they are presently (to our knowledge) the highest-quality pragmatic, evidentially-supported GP weight loss support measure available.

Christos Galanakis (Reviewer 2): Dear Authors,

Thanks for the valuable opportunity to read this interesting manuscript.

The topic caught my attention and I was interested in reading your article immediately.

The overall structure of the manuscript is concise, clear, comprehensive, and convincing.

I also believe that the broader message that we could apply to our primary care practice come through clearly with a direct conclusion.

I regard this article to be of high interest to the BMC Family Practice target audience, decent methodological quality and posing important research questions.

We greatly appreciate the reviewer’s comments and the time taken to read this paper and respond.
Catherine Spooner (Reviewer 3): This is an interesting, useful and well-written article.

We thank the reviewer very much for their helpful suggestions to improve the manuscript.

My only suggestions for improvement are below.

3.1 Firstly, it is sometimes not clear what time scale is used for the questions, without referring to the questionnaire. A number of times I wondered if the time scale was "ever" or "in the past 12 months?" e.g. in:

- the abstract: Only 20% of the sample had sought GP support for weight loss
- the methods: previous weight loss and weight loss maintenance success

Ensuring the time scale of any question is recommended.

We have revised this throughout the manuscript and thank the reviewer for bringing it to our attention.

Second, additional discussion of the limitations of the study are recommended:

3.2 - while sampling from those with recorded obesity is described as a strength, it is also a source of bias. We know that BMI is not always recorded by general practices, so the sample is likely to not represent all patients with obesity. It might, for example, only represent patients whose obesity concerned the GP sufficiently for that GP to record BMI.

We agree that this is a definite limitation of our study, and we have added a comment to this effect to the Discussion (pg 17, ln 387-388).

3.3 - The study is cross-sectional so relationships can only be described, causality cannot be asserted.

We have now explicitly acknowledged this as a limitation in the Discussion (pg 17, ln 394).