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Primary care providers' communication with patients during weight counseling: a focus group study

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Abstract

Objective—Primary care providers (PCPs) are encouraged to counsel their obese patients about weight loss. We used focus groups to explore how PCPs communicate with patients about weight management.

Methods—During the summer of 2010, we conducted five focus groups of community-based PCPs who had patients enrolled in a practice-based, randomized controlled weight loss trial in Maryland. Focus groups were audio-recorded and transcribed verbatim. Two investigators independently coded transcripts for thematic content using editing style analysis.

Results—Twenty-six PCPs from six different practices participated. Mean years in practice were 16.4 (SD 11.7) and 77% practiced internal medicine. We identified three communication-based themes about weight loss counseling: 1) Motivating patients to lose weight, 2) Partnering with the patient to achieve weight loss, and 3) Handling challenges that arise during weight counseling.

Conclusion—PCPs use a variety of strategies to communicate with their patients about weight loss. Some PCPs already use patient-centered approaches to communicate with their patients about weight loss, suggesting that future weight counseling interventions should be tailored to build upon this strength.

Practice implications—PCPs' weight loss counseling may be improved by using techniques with demonstrated behavior change effectiveness such as the 5 A's or motivational interviewing.

Keywords

obesity; counseling; patient-provider communication; focus groups

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1. Introduction

Despite the U.S. Preventive Services Task Force recommendation that providers counsel obese patients to lose weight [1], patients have failed to report increased rates of weight loss counseling [2]. A recent systematic review showed that behavioral interventions in a primary care setting could result in modest weight losses of 3 kg over a 12-month period [3]. This review also found that weight-loss treatment prevented the development of diabetes and hypertension in at-risk patients. Despite these benefits, providers have identified multiple barriers to providing the recommended weight counseling including inadequate training in weight management and lack of time during primary care visits [4-6]. Consequently, only 20-40% of obese patients report receiving any type of weight loss counseling from their primary care provider (PCP) [7-10].

While weight counseling may occur infrequently, certain communication strategies have been shown to effectively promote weight loss. Using the 5A's – Ask, Advise, Assess, Assist, Arrange – as a weight counseling strategy has been associated with increased motivation to lose weight [11] and increased weight loss [12]. However, studies show that PCPs do not properly use the 5A's strategy in clinical practice [12-13]. The technique of motivational interviewing (MI) can also effectively promote weight loss [14-15]. Patients' whose PCPs employed MI consistent techniques during counseling demonstrated greater confidence to change their diet [16]. However, few PCPs utilize MI techniques during weight counseling [16-17]. These previous studies suggest that few PCPs are using the 5A's or MI, raising the question of how PCPs actually communicate with their patients about weight loss.

Few studies have characterized PCPs' communication strategies and techniques regarding weight loss. In this study, our objective was to use focus groups and qualitative methods to explore PCPs' usual practices as part of weight counseling to identify how PCPs communicate with their patients about weight loss.

2. Methods

2. 1 Design and participants

During June-July 2010, we conducted focus groups of community-based PCPs who had patients enrolled in the Practice-based Opportunities for Weight Reduction (POWER) trial at Johns Hopkins. Details of the study design have been published previously [18-20]. Briefly, POWER randomized 415 patients to one of three arms to evaluate the effectiveness of two behavioral weight loss interventions compared to usual care [20]. Unlike other weight loss trials, the POWER trial gave PCPs distinct roles including referring their patients into the trial, receiving updates about their patients' progress, and providing support during routine patient encounters. As a sub-study, we conducted focus groups of POWER PCPs to explore their usual practices with obese patients, communication about weight management, and perceptions of the trial's interventions. Because little is known about how PCPs communicate with their patients during weight counseling, we elected to use focus groups as this methodology facilitates exploration of participants' attitudes and subjective experiences through open conversation and debate [21].

PCPs from participating practices were invited to participate in a focus group if they had ≤4 patients enrolled in the study. PCPs practiced at one of six different community-based primary care clinics in Maryland. Four practices were community-based primary care clinics affiliated with an academic medical center, and two practices were private, community-based primary care clinics. Each focus group included between 3-8 participants and lasted approximately 60 minutes. We offered participants a $50 gift card as compensation. The

Institutional Review Board of The Johns Hopkins University School of Medicine approved this study. All participants gave informed consent.

2.2 Data collection

One of the study investigators (WLB) moderated all focus groups using a semi-structured moderator guide. This guide was pilot tested among three PCPs and modified accordingly. This guide included open-ended questions about PCPs' usual obesity management practices, attitudes towards obese patients, and perceptions about the POWER intervention. PCPs were asked to describe a typical visit with an obese patient that focused on encouraging weight loss. Prompts embedded within this question included what was usually discussed, identifying the challenges that PCPs face when discussing weight loss, and describing general feelings when seeing an obese patient and discussing weight loss. The moderator used reflective probes to clarify statements and encourage participants to expand on their remarks. We conducted 5 focus groups based on the scheduling needs and locations of the 30 eligible PCPs. We reached thematic saturation during the analysis. In addition, all participants completed a questionnaire to obtain demographic information.

2.3 Data analysis

All focus groups were audio-recorded and transcribed verbatim. Two investigators (KAG and WLB) independently reviewed the transcripts and coded them for thematic content using an editing analysis style to identify meaningful sections of the text [22]. We used the first focus group to develop a codebook. The two reviewers independently applied the codebook to the remaining focus groups and expanded it as the analysis proceeded. A third investigator was available to resolve any conflicts (none existed). Quotes and final codes were discussed between three of the study investigators and organized into conceptual themes using a consensus process. We used Atlas.ti 6.2 qualitative software to facilitate data management and analysis.

3. Results

3.1 Participant characteristics

Of the 30 eligible PCPs, 26 participated in one of five focus groups for this study. Four PCPs did not participate due to last minute scheduling conflicts. Table 1 shows the demographic characteristics of the 26 providers. The majority were physicians (92%) and practiced internal medicine (77%). The mean number of years in practice was 16.4 (SD 11.7).

3.2 Themes on patient provider communication regarding weight counseling

We identified three themes focused on PCP communication with their patients as part of weight counseling. We present PCPs' reflections about weight management by theme to illustrate how they communicated with obese patients along with representative quotations for each theme. Table 2 lists the themes and subthemes, as well as the number of focus groups in which each theme and subtheme was discussed.

3.2.1 Theme 1: motivating patients to lose weight—In all five focus groups, PCPs described using communication techniques to motivate their patients to lose weight. We considered a subtheme to represent "motivating" if the PCP employed the strategy to initiate the weight loss discussion or promote continued changes to lose weight. Most of these strategies represent brief remarks from the PCP to the patient. One common "motivating" subtheme involved the PCP praising and acknowledging weight loss success, especially in the setting of the trial. "The [patients] were very eager to let me know that, 'Hey, look, I lost

weight. And how have my numbers changed?' They were always really excited to show off their achievement." PCPs believed that acknowledging any degree of weight loss success provided important positive reinforcement. "'You've lost six pounds since you were here last.' [Patients] really need that positive feedback that we're paying attention to what they're doing." Another common "motivating" subtheme was highlighting how weight loss can improve medical co-morbidities. PCPs believed that the potential to discontinue medications or avoid being prescribed a new medication was a strong motivator for patients to both initiate and promote continued weight loss.

> Sometimes the weight loss is a little slower to come than some of the other physiological parameters. But reducing your risk of diabetes, reducing your cholesterol, reducing your blood pressure, those are all goals. So it's not just the weight, it's health. And I think that that keeps them motivated and they're more excited to come and see me [even] if they've not lost the weight, because they know I'm going to check their blood pressure and I'm going to check their cholesterol and I'm going to talk about health. And I think that keeps them motivated.

We identified two "motivating" subthemes highlighting how PCPs connect with their patients: sharing of negative emotions and sharing positive personal weight loss stories. PCPs used these strategies to initiate interest in weight loss and promote continued behavior changes. For example, one PCP described how she shared her own negative emotions with her patients: "I express frustrations to my patients sometimes… I think they have to see us getting a little bit upset or angry… I think some patients are moved by that, and I think it does get them going a little bit." Another PCP shared positive personal stories about her own struggles and triumphs with weight loss, in order to express empathy and motivate her patients. "At one point in my life … [I] ended up having to lose 70 pounds. So when my patients would look at me and go, 'What do you know about losing weight?' … I can say, 'Well, actually—.' So it gave me an opportunity to share some of that, which made it very real for them."

The final "motivating" subtheme was PCP communication to improve patients' self-esteem and self-efficacy for weight loss, thereby enabling them to make significant behavioral changes.

> I also tell [patients] that [your weight loss plan is] going to work for a few weeks or months, and then you're going to go back to your same old bad old habits. When you fall off the wagon it doesn't mean that you go and eat the half-gallon of ice cream... You have to say, "Okay, I fell off the wagon, I'm not a bad person," stop all the negative stuff – tomorrow, you get back on the program.

3.2.2 Theme 2: partnering with the patient to achieve weight loss—In four of the five focus groups, PCPs described partnering with the patient to achieve weight loss. We considered a subtheme to represent "partnering" if the strategy emphasized a dialogue between patient and PCP or capitalized upon the patient-provider relationship. PCPs reported using these methods to tailor their weight loss advice to the individual patient. The most common "partnering" subtheme was helping patients realize that they already possess the skills needed to lose weight.

> A middle-aged man who is obese who may have very good skills in other venues, like they may have very good accounting skills; they manage their budget really well, and creating an analogy between counting calories and staying on a calorie budget with maintaining a financial budget makes it possible to stay within a certain framework of a total number for the day. That seemed to really connect with a lot of people who didn't really think about it that way before.

Several PCPs promoted using a "calorie budget" to make weight management concepts more tangible for patients by demonstrating how they can apply their financial and managerial skills that many already use in their occupation.

Another subtheme was collaborating with the patient to set weight loss goals and a weight loss plan. PCPs reported tailoring their weight counseling towards the individual patient's needs.

> You actually come up with a plan with your patient and say, well, if you can do this for three days a week or five days a week, just 30 minutes, and you both figure out a way to do it, watch your favorite sitcom and get on your elliptical or something silly like that, keep your calorie count for six weeks and come back. So I think they're willing to take small steps, and it's a finite amount of time that they're willing to work with it. And it's not that I'm releasing them out into the woods for six months and come back.

Some PCPs tried to better understand their patients' day-to-day routines, which guided recommendations about realistic behavioral changes. "Getting to know what [the patient's] day-to-day routine is, who they live with, what their life is like, then you can better advise them."

The final "partnering" subtheme was PCPs recognizing the value of an established, long-term relationship with their patients as the foundation for discussing weight loss. "I think probably it helps to know someone for a while and to kind of get into the head of your patient a little bit and get to have a comfort level with them. I'm not sure if you can achieve that if you change docs a lot." Another PCP described weight counseling as a "*continuous conversation over many years*," reflecting on how weight counseling recurred over the duration of the patient-provider relationship. Therefore, this PCP described how she tried "to understand where [the patients] are right now: "How are your weight issues going? How are you doing with your eating?" Something that's kind of non-judgmental and allows them to let me know what their current issues are and what their goals are."

3.2.3 Theme 3: handling challenges that arise as part of weight counseling—In all five focus groups, PCPs described how they handled challenges as a part

of weight counseling. For example, PCPs described how addressing patients' unrealistic weight loss expectations was a challenge. One subtheme involved tempering these expectations by aiming for accomplishable, short-term goals.

> I find that refocusing – when they think that they've got to lose 40 or 50 pounds it's so unreasonable and unattainable and you get discouraged after three weeks. But if you say, 'If you took you five years to gain it and you're okay with losing it in two years, then if you lose two pounds per month, and as long as you weigh yourself once a month and you see progress then maybe it'll keep them [going].' The 50 pounds is just so elusive when you're trying to lose it. Sometimes focusing on shorter-term goals rather than the whole long-term goal helps.

By using this approach, patients may feel less frustrated and have more success reaching their weight loss goals.

Another common challenge PCPs reported was managing conflict between the patient's desired weight loss plan and the PCP's own beliefs about the most effective weight loss strategy. We identified this subtheme as addressing conflicting patient and provider beliefs about weight loss.

> When you're not offering the pill that takes it down immediately, then it's an argument that you have to have with the patient… You have to really show the patient the interest is not whether or not I want you to lose weight. What is the most effective, long-lasting way of losing weight?

One PCP indicated that he capitalized upon patients' requests for fad diets or weight loss medications to discuss healthier ways to lose weight. This PCP said, "[Patients are] coming to me saying they want this or that or the other, and that of course opens the forum of the things that I think are reasonable for therapy."

Under the "challenges" theme, we identified two subthemes illustrating tactics that PCPs use when they lack time, have insufficient knowledge, or try balancing multiple medical priorities. In one subtheme, PCPs reported using standardized messages or materials to promote weight loss, instead of individualizing their messages as described in Themes 1 and 2. PCPs indicated, "I have some handouts that I use for weight loss coaching that I find helpful." For some, these standardized messages were used due to lack of time during the visit or limited knowledge about nutrition and exercise: "It can be stressful when [patients] start asking a lot of specific questions… I don't feel like I have the time to sit there and give them private counseling on basics. I say, 'Here's some websites, look at this." In another subtheme, PCPs avoided discussing weight and weight loss entirely when trying to balance multiple priorities during the patient visit. PCPs avoided discussing weight and instead focused on the patients' co-morbidities: "Most of these people do have co-morbidities, and those co-morbidities often overwhelm the visit. It's actually easier to get people to take another pill… than it is to try to make a lifestyle change."

The final "challenge" was how PCPs' handle patients' negative reactions and emotions when discussing weight. One subtheme was to reframe weight loss recommendations in terms of what patients need to do "*to be healthy*." PCPs avoided using the term "weight loss" when discussing the purpose of diet and exercise changes, and instead described these changes as improving health more generally. PCPs who used this technique believed that it helped their obese patients feel more comfortable, and reduced anxiety by not specifically stating weight loss.

4. Discussion and Conclusion

4.1 Discussion

PCPs used a variety of strategies to communicate with their patients about weight loss. Three themes emerged: motivating patients to lose weight, partnering with patients to achieve weight loss, and handling the challenges that arise as a part of weight counseling. The most commonly cited strategies to motivate weight loss included "praising and acknowledging weight loss success," and "highlighting how weight loss can improve medical co-morbidities." Partnering with patients to achieve weight loss was accomplished most commonly by "helping the patient realize that he or she already possessed the skills needed to make the behavior changes necessary to lose weight."

While many of these communication strategies could be considered patient-centered, not all PCPs engaged in such methods. Some PCPs shared negative emotions and frustrations to motivate patients to lose weight. When challenges arose as part of weight counseling, some PCPs reported using non-patient-centered techniques including "standardized messages," "avoiding the discussion," and "reframing the discussion to focus on health rather than weight."

Prior studies have focused on identifying the barriers PCPs face when counseling their obese patients on weight loss. Previous focus groups of physicians have identified several barriers

to providing weight loss counseling such as insufficient knowledge, lack of counseling skills, insufficient time, and pessimistic attitudes towards weight loss [5-6]. While these barriers are important to address, understanding the communication strategies that PCPs currently use when counseling their patients about weight loss will help target interventions to improve counseling skills. Prior focus groups of physicians described providing basic nutrition and exercise education and encouraging patients to set small goals as part of their weight counseling routine [6]. Our study expands upon these results by examining in-depth how PCPs communicate with their patients as part of weight loss counseling. Many of our PCPs were attempting to integrate a patient-centered approach to weight management in their practice, which has been suggested as an important strategy for weight counseling [23].

In general, effective patient-provider communication during patient encounters may have a positive influence on patients' emotional well-being and symptom resolution [24]. Communication behaviors including reassurance and support, positive reinforcement, humor, psychosocial talk, and information sharing, as well as global characteristics like provider empathy, friendliness and courtesy have been linked with increased patient satisfaction and compliance [25]. Our findings indicate that a foundation of positive communication exists and upon which future programs could build, as many of our PCPs communicated with their patients using strategies like positive reinforcement, empathy, and providing reassurance and support.

Future interventions should capitalize on the highlighted strengths of PCPs, but new programs need to be tailored to the challenges of the primary care work environment. This sentiment has been echoed by others discussing behavior change counseling in general. Whitlock and colleagues proposed encouraging PCPs to use a consistent approach to behavioral counseling, such as the 5A's [26]. Applying a single counseling technique to multiple patient behaviors may lend familiarity and efficiency to PCPs' weight loss counseling, thereby reducing barriers like lack of knowledge and counseling skills [5-6, 27]. While this strategy may reduce some barriers, others remain unaddressed like lack of time or desire to avoid the discussion.

The 5A's were initially developed for smoking cessation counseling [28] and have been designated as the standard for smoking cessation treatment by the U.S. Public Health Service [29]. Many physicians are familiar with the 5A's; however, few physicians use the complete technique. In a national survey, most PCPs reported performing 4A's (Ask, Advise, Assess, Assist) when counseling on smoking cessation, but less than 25% of PCPs arranged follow up [30]. Similarly, PCPs have been found to most frequently "ask" and "advise" when using the 5A's technique for weight loss counseling [12-13], although assisting and arranging are the components that have been associated with dietary change and weight loss [12].

The 5A's have become particularly important for U.S. physicians, as the Centers for Medicare and Medicaid recently announced new coverage for obesity screening and counseling, which stipulates that the 5A's framework be used when PCPs provide intensive behavioral counseling for obese Medicare patients [31]. This new benefit may alleviate time pressures from physicians, as Medicare will now cover visits focused solely on weight loss counseling. This benefit may also provide financial incentive via reimbursement for PCPs to raise this topic with patients, rather than avoid it. In addition to such system-level changes, practice-level changes may also be necessary to facilitate PCPs' completion of the 5A's in order to lead to better weight outcomes [11-13]. For example, counseling checklists or electronic prompts in an electronic medical record have been effective in increasing PCP performance of the 5A's with respect to smoking cessation [32]. Similar strategies will likely be needed to encourage complete use of the 5A's technique in weight loss counseling.

Another weight counseling approach for PCPs could be using MI, which has promise with respect to patients' weight loss and lifestyle changes [14-15]. One PCP in our study raised concerns about using MI in practice: "I think [PCPs are] sort of motivated to get outcomes and results now... But to truly change people's behavior and do real intensive motivational interviewing that maybe gets people to change their behavior, it takes a long time." Given that our study results highlight how PCPs may revert back to standardized messages or avoid the discussion altogether with mounting pressures, MI may need to be tailored to meet PCPs' needs. It remains to be seen how the new Medicare benefit specifying the 5A's may influence PCPs' adoption of MI for weight loss counseling in the future.

Our qualitative study has several limitations. First, PCPs self-reported how they communicate about weight loss during focus groups, and we did not assess the patient's perspective of physician communication skills surrounding weight loss. While we attempted to facilitate an open dialogue among PCPs, a more objective evaluation of actual behaviors such as with audio or video recording could have provided more objective data along with patients' assessments of PCP communication skills. Second, the POWER trial and its focus on weight loss may have influenced how these PCPs communicated with patients about weight loss. In fact, a few PCPs commented on how they changed their practice with patients after they learned about the counseling methods used in the trial: "Learning my patients' experiences in POWER… has made a huge difference for me, so I now counsel all my patients about obesity management." Because the PCPs were involved in facilitating the participation of their patients in the POWER weight loss trial, their views may not be representative of other PCPs. Their willingness to take part in the POWER trial may indicate a greater interest in weight management, and may influence these PCPs to present their communication in a more favorable light. However, the medical director, and not the individual PCP generally made the decision for the practice to participate. Despite these limitations, this is the first study to describe how PCPs actually communicate with their patients about weight loss. This study provides a basis for understanding providers' communication as part of weight counseling and has implications on how future interventions could improve PCPs' weight counseling skills.

4.2 Conclusion

PCPs are well positioned to provide weight loss counseling to their obese patients given the potential to build a therapeutic relationship over time. Our findings suggest that PCPs currently use a variety of strategies to communicate with their patients about weight loss. Future programs should build upon the strength of the relationship between patient and PCP, as well as the positive communication that many PCPs already employ as part of weight loss counseling.

4.3 Practice implications

Many PCPs are attempting to integrate a patient-centered approach to weight management. However, the effectiveness of their weight loss counseling may be improved by using a technique like the 5A's that increases patients' motivation to lose weight and likelihood of weight loss success. PCPs could readily adopt this technique, as many are familiar with the 5A's from smoking cessation counseling and can apply it to other behaviors including weight loss.

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Table 1

Provider characteristics

		Providers (n=26)
Age in years	Mean (SD)	46.4 (10.7)
Sex	Female	15 (58%)
Race	White	15 (58%)
	Asian/Pacific Islander	6 (23%)
	Black	3 (12%)
	Other	2 (8%)
Provider type	Physician	24 (92%)
	Nurse practitioner	2 (8%)
Specialty	Internal Medicine	20 (77%)
	Family Practice	6 (23%)
Years in practice	Mean (SD)	16.4 (11.7)

Table 2

Themes and subthemes

Theme 1: Motivating patients to lose weight (5) *
Subthemes:
• Praising and acknowledging weight loss success (4) *
• Highlighting how weight loss can improve medical co-morbidities (3) *
• Sharing your negative emotions or frustrations with your patient (3) *
• Sharing positive personal weight loss stories with your patient (2) *
• Improving patients' self-esteem and self-efficacy for weight loss (2) *
Theme 2: Partnering with the patient to achieve weight loss (4) *
Subthemes:
• Helping patients realize that they already possess the skills needed to lose weight (4) *
• Collaborating with patient to set goals and a weight loss plan (3) *
• Establishing a relationship with the patient can build foundation for weight loss discussion (2) *
Theme 3: Handling challenges that arise as part of weight counseling (5) *
Subthemes:
• Tempering expectations towards accomplishable weight loss goals (3) *
• Addressing conflicting patient and physician beliefs about weight loss (3) *
• Utilizing standardized messages to discuss weight loss (3) *
• Avoiding the discussion (3) *
• Reframing the discussion to focus on health rather than weight (2) *

* The number inside the parentheses denotes the number of focus groups in which that theme or subtheme was mentioned out of all of the five focus groups.