PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Changing the narrative around obesity in the UK: a survey of people with obesity and healthcare professionals from the ACTION-IO study
AUTHORS	Hughes, Carly Anna; Ahern, Amy; Kasetty, Harsha; McGowan, Barbara; Parretti, Helen; Vincent, Ann; Halford, Jason

VERSION 1 – REVIEW

REVIEWER	Tsai, Adam Kaiser Permanente Care Management Institute
REVIEW RETURNED	09-Dec-2020

GENERAL COMMENTS	This paper is part of the well known ACTION study, results from the US have already been presented at ObesityWeek and published. The current study evaluates data from the UK. The paper is well done. I have a few comments Abstract: given the average of 9 years from from start of weight struggle to discussion, it would be helpful to document what percentage of the time the discussion was initiated by the patient vs by the clinician. Results: states that eligibility rate for HCPs was 53% but numbers in the table are 886 respondents and 387 who qualified. Is the percentage correct? In Table 1, it appears that you only have BMI measurements on 77.1% of the HCPs? Is that correct and if so why? Table 1 states that 52.9% of HCPs considered themselves to be obesity specialists. That seems like a very high percentage to me. What are the corresponding numbers from the U.S. study? The criteria to be an obesity specialist are fairly loose (judging from the footnote to the table) Pages 10 and 11: per patient report, patients initiated the conversation about weight 47% of the time, and per HCPs, patients initiated 35% of the time. This seems within the range of reasonable error given that patients and HCPs are estimating it. Would report these numbers in the abstract. Results, page 10: the average amount of time for the patient and HCP to discuss weight was longer in the UK compared to other places. This suggests more weight bias and/or more of an ethic of individual responsibility for

	weight in the UK. This deserves a comment in the discussion. Page 12, top: I know that the feelings after the weight discussion are complex, but was there any difference by type of provider seen (PCP/nurse/dietitian)? Page 12, middle: the fact that British HCPs have only 10 minutes for consultation is shocking. There is no way to get anything meaningful done in 10 minutes, especially a discussion about a complex topic such as weight. Speaking as an American primary care physician (internist), I can say this firsthand. This deserves a comment in the discussion. (It is commented upon briefly on page 15 near the bottom.) Page 16, 2nd paragraph: the discussion on referral options is entirely appropriate. Here would be a good place to comments that no way on God's green earth will British GPs be able to manage obesity successfully with 10 minute consultations.

REVIEWER	Tobin, Anne-Marie St Vincent's University Hospital
REVIEW RETURNED	02-Jan-2021

GENERAL COMMENTS	This is an important work which outlines difficulties and misalignment of patient and healthcare provider perceptions and expectations. Page 4: Need to define what severe and complex obesity consititute

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

This paper is part of the well known ACTION study, results from the US have already been presented at ObesityWeek and published. The current study evaluates data from the UK. The paper is well done. I have a few comments.

Abstract: given the average of 9 years from start of weight struggle to discussion, it would be helpful to document what percentage of the time the discussion was initiated by the patient vs by the clinician.

Response

Thank you for the suggestion. If exceeding the 300-word abstract limit is permitted, we'd like to add the following underlined sentence to the abstract:

"Among the 47% of PwO who discussed weight with an HCP in the past 5 years, it took a mean of 9 years from the start of their struggles with weight until a discussion occurred. HCPs reported that PwO initiated 35% of weight-related discussions; PwO reported they initiated 47% of discussions."

Just to note, and as you describe below, the survey of PwO was separate from the survey of HCPs; so each group reported on its own perceptions, and the reported percentages differ between the two groups.

Results: states that eligibility rate for HCPs was 53% but numbers in the table are 886 respondents and 387 who qualified. Is the percentage correct?

Response

The percentage was derived from those who completed the screening questions. This has been clarified in the text, and a row has been added to the table for those who completed the screening questions.

In Table 1, it appears that you only have BMI measurements on 77.1% of the HCPs? Is that correct and if so why?

Response
That is correct. HCPs were not required to provide their height and weight for the calculation of BMI. There were some HCPs who declined to answer this question. We have added a footnote to the table to explain that the percentages for the HCP BMI categories were calculated from those who answered the question.

Table 1 states that 52.9% of HCPs considered themselves to be obesity specialists. That seems like a very high percentage to me. What are the corresponding numbers from the U.S. study? The criteria to be an obesity specialist are fairly loose (judging from the footnote to the table)

Response
The reporting of obesity specialists in Table 1 did indeed use broad criteria and these are presented in the Table footnote. These were the same criteria used for the definition of obesity specialists in the primary publication of the full ACTION-IO study (Caterson ID, *et al. Diabetes Obes Metab* 2019;21;1914–24). More HCPs than expected from the experience of the UK investigators described themselves as specialists. In the UK, there is no recognised pathway to train as an obesity medicine specialist, unlike in the USA, and there are very few bariatric physicians in the UK. A wide range of physicians have some extra training in obesity, but not to a recognised accredited standard. Obesity clinics may employ a range of specialist doctors and primary care doctors with some additional training.

The following underlined sentence has been added to the 'Strengths and limitations' section of the Discussion:
"A higher proportion of HCPs than might be expected self-identified as obesity specialists using the broad criteria specified in table 1."

The ACTION US study was done a little differently in that HCP recruitment was stratified to sample primary care physicians and obesity specialists in a 5:1 ratio. Of the 606 HCPs who participated in the US study, 83% were primary care physicians and 17% were obesity specialists. In the US study, obesity specialists were those who self-reported as an obesity/weight loss specialist and/or those who saw at least 50% of their patients for obesity (Kaplan LM, *et al. Obesity [Silver Spring]* 2018;26:61–9).

Pages 10 and 11: per patient report, patients initiated the conversation about weight 47% of the time, and per HCPs, patients initiated 35% of the time. This seems within the range of reasonable error given that patients and HCPs are estimating it. Would report these numbers in the abstract.

Response
Thank you for the suggestion. These percentages will be reported in the abstract as described above, if exceeding the 300-word abstract limit is permitted.

Results, page 10: the average amount of time for the patient and HCP to discuss weight was longer in the UK compared to other places. This suggests more weight bias and/or more of an ethic of individual responsibility for weight in the UK. This deserves a comment in the discussion.

Response
We agree that this is worthy of comment and have added the following underlined text to the Discussion:
"Moreover, for the PwO who did have a weight discussion, it took a mean of 9 years after they first started struggling with their weight before having the discussion (compared with 6 years globally).[24] This delay is particularly important as it may create an opportunity for significant obesity-related complications to develop. This long delay may also reflect a higher degree of obesity stigma in the UK[28] and a culture of individual responsibility for obesity.[29 30] Indeed, a focus on individual responsibility is reflected in UK government policy on obesity.[31] Reducing the time gap by initiating earlier weight management discussions may ben effective strategy for improving obesity treatment and preventing the development of comorbidities."

Page 12, top: I know that the feelings after the weight discussion are complex, but was there any difference by type of provider seen (PCP/nurse/dietitian)?

Response
We agree that this would be an interesting question to examine but unfortunately, we do not have data at this level of granularity.

Page 12, middle: the fact that British HCPs have only 10 minutes for consultation is shocking. There is no way to get anything meaningful done in 10 minutes, especially a discussion about a complex topic such as weight. Speaking as an American primary care physician (internist), I can say this firsthand. This deserves a comment in the discussion. (It is commented upon briefly on page 15 near the bottom.)

Response
Thank you, we agree that short consultation times are an important limitation on the ability of GPs to manage obesity successfully and we have now highlighted this in our discussion of challenges for GPs per the below response.

Page 16, 2nd paragraph: the discussion on referral options is entirely appropriate. Here would be a good place to comments that no way on God's green earth will British GPs be able to manage obesity successfully with 10 minute consultations.

Response
We have inserted the following underlined sentence into the discussion:

"Indeed, HCPs report insufficient management options and scepticism about their efficacy.[56 57] This is further compounded by limited consultation times for UK GPs.[50 51] The limited availability of weight management services, effective treatments and coherent, joined-up strategies in the UK health system are significant barriers to providing effective obesity care.[55]"

Reviewer: 2
This is an important work which outlines difficulties and misalignment of patient and healthcare provider perceptions and expectations.
Page 4: Need to define what severe and complex obesity constitute.

Response
Thank you. In the UK, severe and complex obesity is the preferred term replacing morbid obesity. We have now added BMI criteria (40 kg/m^2) to clarify what we mean:

"The number of people with obesity (PwO) in the UK continues to rise, and severe and complex obesity (body mass index [BMI] ≥40 kg/m^2) increased from less than 1% in 1993 to nearly 4% in 2017.[10]"