Rethinking obesity education

A guide for UK healthcare professionals to discuss weight management

This guide was developed by Novo Nordisk for UK healthcare professionals and is intended to raise education and understanding of obesity as a disease.

This is not a real patient but only an illustration.
Welcome and introduction

Obesity is a complex disease influenced by environmental, genetic, physiological, and psychological factors.\textsuperscript{1,2}

In fact, the Royal College of Physicians (RCP) has called for obesity to urgently be recognised as a disease by the government and the broader health sector. Until then, the prevalence of obesity is unlikely to be reduced.\textsuperscript{3}

As a UK healthcare professional, you are uniquely qualified to initiate and guide your patients through the process of behavioural change for weight loss, weight maintenance, and the management of weight-related comorbidities (such as hypertension or type 2 diabetes).\textsuperscript{1}

- Physician-initiated discussions and advice regarding weight loss encourage patients to change their behaviour\textsuperscript{1}
- Collaboration, counselling, and medical support from healthcare professionals help patients achieve clinically significant and maintained weight loss\textsuperscript{1}
- Achieving and maintaining weight loss requires long-term intervention\textsuperscript{1}

Simply by recognising the complexities of excess weight and the potential benefits of weight loss, you are ready to help your patients improve their weight and other weight-related conditions (e.g., hypertension, type 2 diabetes).

Content overview

To facilitate a good discussion with your patients, it may be helpful to use techniques including motivational interviewing and behavioural therapy. The aim of this education booklet is to present a foundation for these techniques that will hopefully enable you to have an effective consultation around weight with your patients.

Furthermore, this education booklet is a background resource for the discussion guide *Rethinking your obesity discussions*, which provides specific talking points and questions that can be used directly in consultation with patients.

The following sections address these topics:
- Motivational interviewing
- Keys to successful conversations
- Behavioural therapy
- Treatment overview

Recommended resources and additional information are provided throughout this booklet.

Goals and objectives of rethinking obesity education

The aim of this resource is to enable you to:
- Utilise strategies and principles of motivation [interviewing](#)
- Have successful conversations with your patients
- Implement [behavioural therapy](#) in the time frame of existing appointments
- Gain a better [understanding of treatment](#) guidelines
Assessing obesity and weight-related risks

Obesity Class (I–III) is based on BMI and is a measure of height relative to weight.1

\[
\text{BMI} = \frac{\text{weight (kg)}}{\text{height (m)}^2}
\]

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI cut-off points for white European patients (kg/m²)</th>
<th>BMI cut-off points for Asian patients (kg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.5</td>
<td>&lt;18.5</td>
</tr>
<tr>
<td>Healthy range</td>
<td>≥18.5 and &lt;25</td>
<td>18.5–22.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>≥25 and &lt;30</td>
<td>≥23.0</td>
</tr>
<tr>
<td>Obesity</td>
<td>≥30</td>
<td></td>
</tr>
<tr>
<td>Obesity class I</td>
<td>≥30 and &lt;35</td>
<td>27.5–32.4</td>
</tr>
<tr>
<td>Obesity class II</td>
<td>≥35 and &lt;40</td>
<td>32.5–37.4</td>
</tr>
<tr>
<td>Obesity class III</td>
<td>≥40</td>
<td>≥37.5</td>
</tr>
</tbody>
</table>

Interpret BMI with caution in highly muscular adults as it may be a less accurate measure of adiposity in this group. Some other population groups, such as people of Asian family origin and older people, have comorbidity risk factors that are of concern at different BMIs (lower for adults of an Asian family origin and higher for older people). Use clinical judgement when considering risk factors in these groups, even in people not classified as overweight or obese.4

Waist circumference provides additional information.5

Waist circumference risk threshold:

<table>
<thead>
<tr>
<th>Classification</th>
<th>White European patients</th>
<th>Asian patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>≥ 94cm</td>
<td>≥ 90cm</td>
</tr>
<tr>
<td>Women</td>
<td>≥ 80cm</td>
<td>≥ 80cm</td>
</tr>
</tbody>
</table>

People with obesity are at high risk of developing significant comorbidities

Many of these comorbidities, listed below, have corresponding clinical symptoms and signs that can be used in assessing the presence and severity of the comorbidity.1

- Type 2 diabetes
- Hypertension
- Dyslipidaemia
- Coronary heart disease
- Stroke
- Osteoarthritis

This is not a real patient but only an illustration.
The 5As of obesity counselling

The 5As model was originally designed as a behavioural intervention strategy for smoking cessation in patient consultations. The model was modified for obesity counselling for healthcare professionals to use as a framework to guide a conversation. The 5As model has been associated with increased patient motivation and behavioural change when used by physicians in weight management consultations with patients.

The 5As for obesity counselling are as follows:

1. **ASK**
   - Ask for permission to discuss weight
   - Explore readiness for change

2. **ADVISE**
   - Advise on obesity risks
   - Explain benefits of modest weight loss
   - Explain the need for long-term strategy
   - Discuss treatment options

3. **ASSIST**
   - Address drivers and barriers
   - Provide education and resources
   - Refer to appropriate provider
   - Arrange follow-up

4. **ASSESS**
   - Assess obesity class and stage
   - Assess for drivers, complications, and barriers

5. **AGREE**
   - Agree on realistic expectations
   - Focus on behavioural goals (SMART)
   - Agree on treatment plan

Adapted from Vallis MI, et al. (2013).

Motivational interviewing

**Summary**

Motivational interviewing is an engagement strategy that aims to enhance self-efficacy and personal control for behaviour change. As a method of communication, motivational interviewing is inherently collaborative, employing empathy and active listening to build trust and rapport between patients and healthcare professionals.

Through the strategies of motivational interviewing, healthcare professionals can collaboratively explore patients’ motivations for change and goal setting. The strategies of motivational interviewing include:

- Open-ended questions
- Affirmative statements
- Reflections
- Summary statements

It can be helpful to use the acronym OARS to remember these strategies. The talking points and questions provided throughout the Rethinking your obesity discussions guide model the motivational interviewing approach to help guide healthcare professionals in application with their patients.
Defining motivational interviewing

Motivational interviewing is a collaborative, goal-oriented approach to communication to elicit behaviour change in patients. The approach is designed to identify and resolve a patient’s ambivalence towards a specific goal by connecting necessary changes to incentives that reduce barriers for change.

Principles of motivational interviewing

There are 4 key principles that guide the practice of motivational interviewing in weight management with patients.

**Expressing empathy**
This reassures your patients that you are listening to them and seeing their point of view on the problem. As a result, patients are more likely to honestly share their experiences and perspectives.

**Supporting self-efficacy**
Motivational interviewing is based on patients’ existing capacity for change. By focusing on previous successes, they will feel capable of achieving and maintaining their desired change.

**Rolling with resistance**
Resistance can occur when patients realise a need for change in their behaviour patterns. It is best to sidestep or “roll with” any resistance and to avoid trying to fix or solve each problem.

**Developing discrepancies**
Throughout discussions of weight management, you and your patients will begin to see the differences between where they are (current habits) and where they want to be (goals). Help patients realise these discrepancies and guide them to self-identify ways to bridge the gap.

The OARS Motivational Interviewing Strategy

The practice of motivational interviewing involves some specific skills and strategies to help patients reduce ambivalence and advance their readiness to make changes. One model for motivational interviewing is the OARS strategy, which is a simple way to generate the intended benefits of motivational interviewing.

<table>
<thead>
<tr>
<th>O</th>
<th>Open-ended questions</th>
<th>How do you feel about your health right now?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Affirmative statements</td>
<td>Recognise and support your patient’s personal strengths, successes, and efforts to change. This will help promote a collaborative relationship.</td>
</tr>
<tr>
<td>R</td>
<td>Reflections</td>
<td>Use reflective listening and respond thoughtfully by paraphrasing. Confirm that the patient has been heard and validate his or her point of view.</td>
</tr>
<tr>
<td>S</td>
<td>Summary statements</td>
<td>Use statements that recount and clarify the patient’s statements and identify specific points to act upon.</td>
</tr>
</tbody>
</table>

Expressing empathy

This reassures your patients that you are listening to them and seeing their point of view on the problem. As a result, patients are more likely to honestly share their experiences and perspectives.

Rolling with resistance

Resistance can occur when patients realise a need for change in their behaviour patterns. It is best to sidestep or “roll with” any resistance and to avoid trying to fix or solve each problem.

So what I’m hearing is that you have struggled with weight for most of your adult life. Let’s discuss some strategies to develop a plan to help you address your concerns.
Questions for consideration

Ask yourself a few questions before getting started:

• On a scale from 1 to 5, my current motivational interviewing skill level is _____
  (1 meaning very low skill level in motivational interviewing to 5 meaning very proficient in motivational interviewing)

• How often do I currently use motivational interviewing with my patients?

• How can I use motivational interviewing more frequently with my patients when discussing weight?

• Do my staff know what motivational interviewing is and how to use it in patient interactions?

Keys to successful conversations

Summary

Collaboration, counselling, and medical support from healthcare professionals may help patients achieve clinically significant and maintained weight loss. Studies have shown that successful conversations with healthcare professionals help patients to be more successful with their weight loss goals.¹

The weight discussion can be an uncomfortable one, which makes word choices especially important.¹² Consider using more descriptive terms like “healthy eating habits” and “physical activity routine” in place of terms like “diet” and “exercise.” Other communication strategies like active listening, empathy, and encouragement can promote productive dialogue and healthy relationships with your patients.¹
Introduction

A successful conversation with patients about healthy lifestyle choices can increase motivation, encourage action, and sustain changes when compared to a didactic delivery of recommendations from a healthcare professional. There are a few key points to incorporate in your communications with patients about their weight.

Preferable terms and phrases

Research has shown that choice of words plays an important role when discussing weight management. Certain words should be avoided and other words can have different implications in a different context:

- **Weight or healthy weight** instead of fat or fatness. Patients may feel more comfortable having a discussion about weight or excess weight rather than a discussion of obesity
- **Activity** instead of exercise. Increasing activity levels can take many forms. A patient doesn’t need to join a gym or begin running, which might be what they think of when they hear “You need to exercise more”
- **Healthy eating plans, habits, and lifestyle** instead of diet, which can imply a short-term fix by cutting out foods. Plans, habits, and lifestyle can better indicate chronic management required for long-term healthy weight
- **Obesity and obese** are both clinical terms intended to describe a patient’s condition, but can also sound judgmental or labelling in a different context. Referring to a patient as obese is something to avoid

Other terms to avoid

- Fat
- Fatness
- Excess fat
- Heaviness
- Large size
- Weight problem

Addressing weight bias

Research indicates that patients with excess weight feel stigmatised in many areas of their life, including healthcare settings. The language you use and your environment are two key components to successful weight management. To promote successful interactions with your patients, it is important to consider the following checklist:

<table>
<thead>
<tr>
<th>Equipment for waiting area</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open-arm chairs that can support more than 135 kg</td>
<td>Body mass index (BMI) chart</td>
</tr>
<tr>
<td>Weight-sensitive reading materials</td>
<td>Self-administered medical questionnaire</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment for exam room</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body weight scales with a capacity up to 200 kg</td>
<td>Eating pattern questionnaire</td>
</tr>
<tr>
<td>Height meter</td>
<td>Physical activity pattern questionnaire</td>
</tr>
<tr>
<td>Large gowns</td>
<td>Graphing your weight-history chart</td>
</tr>
<tr>
<td>Step stools with handle bars</td>
<td>Food and activity diaries</td>
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<tr>
<td>Large adult and thigh blood pressure cuffs</td>
<td>Pedometers</td>
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<tr>
<td>Tape measure</td>
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<tr>
<td>Wide examination tables, preferably bolted to the floor</td>
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<tr>
<td>Consider a hydraulic tilt, if possible</td>
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</tbody>
</table>

It is also recommended that scales be placed in a private area and that practice staff only discuss a patient’s weight within a private exam room.

Adapted from Kushner RF. (2003).
Questions for consideration

Ask yourself a few questions to assess your attitude toward patients with excess weight.

• How do I feel when I work with patients of different body sizes or excess weight?

• Do I make judgements about a person’s character, intelligence, or abilities based solely on their weight or appearances?

• Consider your body language when discussing weight with your patients. Are your arms crossed over your chest? Do you make any empathetic gestures? Are you standing or sitting?

• When discussing weight with a patient, am I using person-centred language and avoiding labelling and judgemental terms?

Behavioural therapy

Summary

Behavioural therapy in weight management aims to increase a patients’ capacity for self-control, by understanding behaviour as the correlation between stimulus and response. Implementing behavioural therapy can increase motivation, empower patients, and promote self-care with the goal of increasing efficiency in patient appointments.

There are several skills and strategies commonly associated with behavioural therapy including:

• Self-monitoring
• Stress management
• Stimulus control
• Behavioural substitution
• Social support
• Problem solving
• Cognitive reframing
• Goal setting
**Introduction**

Obesity is a chronic disease influenced by physiological, psychological, environmental, and genetic factors, often requiring long-term management. Weight loss is challenging for many patients and behavioural therapy is an important component of the treatment of obesity.

Implementing behavioural therapy techniques can increase your patient’s motivation and ability to engage in self-care, which may generate positive clinical results. The strategies and skills for behavioural therapy provided throughout this resource are also embedded into many of the talking points and questions provided in the Rethinking your obesity discussions guide.

**Goals of behavioural therapy for weight management**

In a clinical setting, behavioural therapy can be successful when healthcare professionals achieve the following goals:

- Promote the patient’s confidence and ability to engage in active self-care
- Initiate behavioural changes that are productive for achieving the patient’s stated goals
- Educate the patient to maintain long-term behavioural changes

**Defining behavioural therapy for clinical weight management**

Behavioural therapy in weight management is a technique that enables an individual to recognise and understand the relationship between the stimuli (internal or external) that initiate behaviours associated with poor weight management.

**Strategies and skills of behavioural therapy**

To reach the potential benefits of behavioural therapy, it is important to pass along and build upon a skill set for your patients.

<table>
<thead>
<tr>
<th>Self-monitoring</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The simple practice of recording a patient’s eating and physical activity habits, as well as thoughts or feelings connected to those habits, enables patients to track progress toward goals and gain perspective over behaviour patterns.</td>
<td>Daily food and activity tracking.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stress management</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying areas of habitual stress and typical responses with the goal of implementing healthy coping with stress.</td>
<td>Relaxation techniques that don’t involve eating or drinking, like meditation, or low-intensity activity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stimulus control</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>After patients learn to identify the stimuli in their common environments that prompt incidental behaviours, they can modify the environment to limit their exposure to those stimuli.</td>
<td>Listing common food cues and modifying the environment to reduce those cues such as removing high-calorie foods from accessible areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioural substitution</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying cues to eat that are not related to hunger and substitute alternative behaviours for eating.</td>
<td>Listing common food cues and substitute responses like cleaning or other low-intensity activities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social support</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designating other helpers to appropriate support roles.</td>
<td>Practising assertiveness to ask for help or designating a walking partner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem solving</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>These are skills that help patients to identify current problems or anticipate potential problems, devise and implement solutions, and assess the effectiveness of the solution.</td>
<td>Most of the examples listed are examples of problem solving.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cognitive reframing</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ways that patients view themselves and their behaviours can influence their ability to initiate and sustain behaviour changes. Reframing a negative attitude into a positive one encourages patients to focus on progress as a habit rather than on setbacks.</td>
<td>If patients set 4 goals and achieve 3 of them, they should feel positive about the achievements and not consider the setback.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal setting</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting goals for behavioural weight management should focus on progress and achievement over time. More about discussing goals can be found in the Rethinking your obesity discussions guide.</td>
<td>Setting a goal to cook most meals at home for 2 weeks with an incentive of dining out at the end of that time period.</td>
</tr>
</tbody>
</table>
Benefits of behavioural therapy

Successful behavioural therapy sessions between healthcare professionals and patients can generate beneficial results, such as:

- **Self and situational awareness:** Through self-reflection and situational analysis, patients begin to recognise the disconnect between their automatic tendencies and their behavioural goals.

- **Gradual and sustainable changes:** Behaviour change can be an overwhelming and often time-consuming process. Behavioural therapy promotes a gradual process to build sustainable change.

- **Patient empowerment:** Behavioural therapy allows patients to come to their own conclusions and realisations about the stimulus-response relationships in their lives that are enabling detrimental behaviours. This, in turn, promotes accountability and autonomy.

Treatment overview

Summary

The 2014 Obesity: Identification, Assessment And Management clinical guidelines were developed by the National Institute for Health and Care Excellence to provide guidance and support to healthcare professionals (HCPs) diagnosing, managing, and preventing overweight and obesity. Regardless of your patient’s obesity stage, healthy eating and physical activity should be included in any treatment plan. HCPs play a significant role in guiding patients to incorporate healthy eating and physical activity habits into a lasting routine. Patients may run into some challenges as they begin and maintain their healthy eating and physical activity plans. Be sure to begin by discussing those challenges and managing their expectations for weight loss.

As you begin, encourage patients to start with realistic, measurable first steps and set reasonable expectations for safe and sustainable weight loss. Included in this guide are some best support practices for supporting healthy eating and physical activity.

Important message

- A weight loss of 5%–10% of body weight is beneficial.
- Weight maintenance and prevention of weight regain should be considered as long-term goals.
Common patient challenges to healthy eating and physical activity

As you create a plan for healthy eating and physical activity with your patient, it may be helpful to discuss common challenges patients often face.17

- All-or-nothing mind-set
- Time
- Portion management
- Special events
- Diet and fitness myths
- Cost
- Access
- Unrealistic expectations
- Safety
- Self-consciousness
- Confusion
- Self-doubt

Strategies for improved healthy eating habits

Consider some of the following strategies to achieve calorie deficits that patients can maintain over an extended period:1

- Consistently eating three meals per day
- Practising mindful eating
- Eating a balanced diet
- Reducing portion size
- Keeping track of daily foods and drinks (counting calories is optional)

If you feel that patients need more guidance, consider referring to dietitians or nutritional counsellors.

Healthy eating and physical activity planning

Initiating healthier eating and activity habits is a fundamental step in weight management. Regardless of your patient’s disease stage, healthy eating and physical activity plans are recommended. Even if more aggressive treatment options like surgery are decided upon, a healthy eating and physical activity plan needs to be initiated.1,4

Understanding your patients, their unique perspectives, experiences, and feelings about their current eating and activity habits is essential. As you plan with your patient, be sure to discuss common challenges patients face when initiating a physical activity and healthy eating plan. You may want to refer back to their answers during your weight history discussion about previous plans and activities they have tried.

NICE obesity management in adults4

1. Adult who is overweight or obese
2. General principles of care
3. Female with a BMI over 30 before, during or after pregnancy
4. Assess lifestyle, comorbidities and willingness to change
5. Consider referral to tier 3 (specialist) services
6. Lifestyle changes
7. Drug treatment
8. Surgery and other interventional procedures
Best practices for supporting healthy eating and physical activity

Start with the realistic steps
By eliciting your patients’ goals, you can help them to determine realistic and achievable targets. The steps should be measurable and build on each other over time.

Not always about knowledge
Focus on broad strategies and basic techniques for better nutrition and physical activity.

Set expectations
As a patient sets goals for change, make sure they are attainable and realistic. You should also discuss a healthy weight loss rate, which for most is 0.5 to 1.0 kg per week over the course of the first 6 months.

Focus on progress
Your patient will likely face a setback or two along the way. Instead of focusing on those setbacks, always discuss the progress your patient has made over time.

Revisit long-term goals
Throughout the process, connect the patients’ long-term goals to actions they can take.

As you discuss plans with your patients, be sure to point out that increasing activity levels is not simply getting exercise. Reducing time spent sitting, adding time spent walking, doing extra housework, or active play with children are all ways to increase activity levels.

References

12. Wadden TA, Didie E. What’s in a Name? Patients’ Preferred Terms for Describing Obesity. Obesity Research. 2003;11(9):1140–1146
We are adopting a circular mindset, designing products that can be recycled or re-used, reshaping our business to minimise consumption and waste, and working with suppliers who share our ambition. We call this Circular for Zero.