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## Counselling patients about behaviour change: the challenge of talking about diet

### Abstract

#### Background

As obesity levels increase, opportunistic behaviour change counselling from primary care clinicians in consultations about healthy eating is ever more important. However, little is known about the approaches clinicians take with patients.

#### Aim

To describe the content of simulated consultations on healthy eating in primary care, and compare this with the content of smoking cessation consultations.

#### Design and setting

Qualitative study of 23 audiotaped simulated healthy eating and smoking cessation consultations between an actor and primary care clinicians (GPs and nurses) within a randomised controlled trial looking at behaviour change counselling.

#### Method

Consultations were audiotaped and transcribed verbatim, then analysed inductively using thematic analysis. A thematic framework was developed by all authors and applied to the data. The content of healthy eating consultations was contrasted with that given for smoking cessation.

#### Results

There was a lack of consistency and clarity when clinicians discussed healthy eating compared with smoking; in smoking cessation consultations, the content was clearer to both the clinician and patient. There was a lack of specificity about what dietary changes should be made, how changes could be achieved, and how progress could be monitored. Barriers to change were addressed in more depth within the smoking cessation consultations than within the healthy eating encounters.

#### Conclusion

At present, dietary counselling by clinicians in primary care does not typically contain consistent, clear suggestions for specific change, how these could be achieved, and how progress would be monitored. This may contribute to limited uptake and efficacy of dietary counselling in primary care.

#### Keywords

communication, behaviour change counselling; communication; healthy eating; primary care.

### INTRODUCTION

Rising levels of obesity are of major concern in the UK.<sup>1</sup> Levels of obesity in adults have risen to over 25% of men and 28% of women in England.<sup>2</sup> Although there was a general reduction in cholesterol levels between 1994 and 2008,<sup>2</sup> there has been little reduction in saturated fat intake (which is still, typically, above recommended levels<sup>2</sup>) and only a small increase in daily fruit and vegetable portions.<sup>2</sup> Rising levels of obesity impact on morbidity and mortality, particularly in relation to cardiovascular disease; consequently, health promotion and behaviour change consultations are increasingly important.

Clinicians in primary care are well placed to provide opportunistic and cost-effective behaviour counselling about healthy eating and weight reduction.<sup>3,4</sup> Patients consult their GP on average 5.5 times a year<sup>5</sup> and, if clinicians do not engage in health promotion there is the risk that patients assume there are no concerns.<sup>6</sup> Smoking levels have dropped in the UK over the last decade, whereas obesity rates have risen;<sup>2</sup> talking about healthy diets, physical activity, and other factors relating to obesity are, therefore, a pressing challenge.

Implementing dietary changes to reduce weight and cholesterol is challenging. Studies have explored individual factors, such as increasing one's intake of fruit and vegetables and reducing saturated fats, salt, and sugar; most reports show limited

benefits with small effects on cholesterol levels and other outcomes.<sup>7</sup> This uncertain evidence base is further complicated by the misinterpretation of public-health messages<sup>8</sup> and the complex interaction between food beliefs, attitudes towards healthy eating, and associated behaviours.<sup>9,10</sup> Furthermore, there is variability in clinicians' confidence in raising and providing adequate information.<sup>11-13</sup>

A useful structure to follow when considering providing patients with information is to think about what is said to patients (the content) and then how this information is provided; this is called the process of information provision.<sup>14</sup> To improve how health professionals provide advice, researchers have adapted behaviour change techniques for healthy eating counselling, derived from motivational interviewing.<sup>3,15</sup> Successful use of this technique regarding reducing alcohol intake and quitting smoking suggests this approach could be used for dietary concerns.<sup>16</sup> However, how information is provided is unlikely to lead to significant change if there is a lack of clarity regarding what dietary changes to recommend and implement.

The PRE-EMPT (Preventing disease through opportunistic, Rapid Engagement by Primary care Teams using behaviour change counselling) study designed an intervention using behaviour change counselling derived from motivational

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## How this fits in

Obesity is a growing problem and clinicians need to discuss healthy eating with patients as effectively as possible. This study shows that, in contrast with smoking cessation consultations, clinicians lack clarity and consistency in the advice they give patients about dietary change. Stressing the shorter-term, more immediate benefits of dietary change, and the close monitoring of change seem to be particularly important.

interviewing for use by clinicians. The primary aim was to examine the efficacy of using such counselling during consultations by reporting the proportion of patients making changes in one or more of four behaviours: smoking, alcohol intake, eating, and exercise.<sup>3</sup>

Although the emphasis of the PRE-EMPT trial was on how practitioners advised patients through recordings of simulated consultations by clinicians, it also provided an opportunity to study what advice was given. This article reports on an analysis of audiotaped consultations between simulated patients, and GPs and nurses, which enable a contrast between the content of smoking cessation and healthy eating consultations to be made.

## METHOD

### The PRE-EMPT study

The method of this cluster randomised controlled trial has been reported elsewhere.<sup>3</sup> Twenty-nine general practices in Wales were recruited and randomised to usual care or to the intervention arm; one doctor and one nurse from each practice participated. The intervention involved clinician training in behaviour change counselling using a blended learning programme. The main trial focused on four risk behaviours: smoking, excess alcohol intake, low physical activity levels, and unhealthy diets. After training in behaviour change counselling for the intervention group, each practice in both arms of the trial recruited up to 40 patients; primary outcomes were patients' self-reporting behaviour change at 3 months.

### Simulated consultation generated from the intervention training

The blended training for the main trial included a seminar at the practice followed by an e-learning programme. This was

complemented by a further seminar on skills and strategies. To complete the training, the clinicians in the intervention group undertook an audiotaped consultation with an actor. Six months later, a further simulated consultation occurred for clinicians in the intervention arm, enabling feedback on their use of behaviour change counselling.

Clinicians in the intervention group were asked to choose one of the four behaviours to discuss during the simulated training consultations. Four scenarios had been developed<sup>3</sup> and different actors played each scenario. This consultation was undertaken at clinicians' surgeries during a normal clinic session and audiotaped and transcribed verbatim.<sup>17</sup>

The purpose of the research study reported here was to test the content of what was discussed in smoking cessation consultations compared with that discussed in the healthy eating consultations. Eleven transcripts were available for the scenario of a patient who had a raised cholesterol level and was overweight, with the counselling focus to be on healthy eating. Twelve transcripts were available for the scenario of a young woman who was pregnant and continuing to smoke.

### Analysis of simulated consultations

The audiotaped simulated training consultations were transcribed and anonymised by a researcher not further involved in this study. Data analysis followed a thematic approach.<sup>18</sup> After initial inspection, a thematic framework was developed by one of the researchers; this was discussed and modified by the research team. Five main thematic categories emerged:

- what change would be beneficial;
- how to change;
- how change would be demonstrated and monitored;
- what the benefits of change would be; and
- barriers to change.

The data were then coded according to the framework. A second researcher double-coded a third of the transcripts to check levels of agreement.

Both the initial and 6-month simulated consultations were included in the analysis. It was decided that data analysis would not match consultations for each clinician in instances when the scenario was repeated.

Data analysis focused on clinician talk relating to change within the five thematic categories. The actors are referred to as patients within this study because the intention was that they should be as similar as possible to real patients.

## RESULTS

Exemplary data extracts from the simulated consultations are used to illustrate key themes. There was no notable difference in content between consultations in the first phase of the study and those repeated after 6 months.

Smoking cessation consultations took a mean time of 7.9 minutes to conduct during a routine surgery (range: 5.4–9.4 minutes). Consultations about healthy eating were, typically, longer and took a mean time of 12.2 minutes (range: 6.2–21.4 minutes).

### What to change

Discussing what to change within the smoking cessation consultations provoked a universal agreement that stopping smoking completely was the ideal goal:

**Clinician (C):** *So you're keen to cut down and, ideally, stop?*

**Patient (P):** *Ideally, yeah.*  
(Smoking 4)

For the healthy eating consultation there was less agreement between clinicians regarding what to change; some offered no specific advice on what to change in the diet, focusing more on an assumption of the patient's prior knowledge of what constituted healthy eating:

**C:** *I suppose what I would say is that most people consume a bit more bad diets than what they think they do, and I bet that if I got you to write a list of things you thought were bad on one sheet of paper and [a] list [of] what you thought were good on another sheet you wouldn't be far off the mark. It's about how you incorporate that into your daily routine ...*  
(Healthy eating 11)

Other clinicians concentrated on reducing fats in a diet or increasing fruit and vegetable intake, and a few consultations took the approach of advocating balanced diets with a discussion of which foods to increase or avoid. There was little similarity between clinicians in what was recommended, compared with the consultations on smoking cessation, and advice on what to change was often unclear or superficial:

**P:** *I mean it's how it's [food] cooked I suppose, it's all greasy stuff and ... I suppose that's a big factor in it [improving diet] if that's the case with cholesterol. But I just don't know how to address that really ...*

**C:** *Well, really, as I said, if we were focusing on the dietary sort of things, it's, as I said, to be aware of what cholesterol is, what foods contain the cholesterol and just try and address it from that point of view really.*  
(Healthy eating 7)

Although some clinicians discussed only diet, others mentioned changes in diet within a context of more general lifestyle changes, such as increasing exercise:

**C:** *Um, and then you can have a think as well about, um, you know, areas in your — you know diet and exercise is very much linked and perhaps we can make another appointment for you to come back in and have a chat about exercise.*  
(Healthy eating 4)

A few clinicians also addressed weight as a factor that would be influenced by both dietary changes and increasing exercise, and as important factor in reducing the risk of cardiovascular disease.

### How to change

Unsurprisingly, given that what to change was clear, many of the smoking cessation consultations focused on how to achieve the desired target of stopping smoking. In most consultations, in line with the e-learning programme, discussion included eliciting how confident the patient was about stopping smoking, and advice was given regarding setting targets and dates. Previous experiences with smoking cessation were discussed and individual problems addressed. The emphasis was on individual preferences to make it work for the patient.

Most clinicians challenged personal and social perpetuating factors. Therefore, discussion on how to change was detailed and consistent. Discussion on how to quit was patient centred in the majority of consultations and reflected a complex behaviour, of which the patient was clearly aware:

**C:** *What have you done to try and cut down so far? What kind of things have you managed to do?*

**P:** *Just breaking the routine sometimes, you know, when I feel like one [a cigarette] it's just willpower isn't it, you know? That's why I haven't managed to cut it out totally*

*because I haven't found that willpower enough ...*

**C:** *So I wonder if, whether we can have a think of some other ways that we can help you try and stop completely.*

(Smoking 3)

Medication and advice regarding cravings were discussed, although smoking cessation services were not always offered. Some clinicians provided written information to the patient.

The healthy eating consultations also included information on how to change, but this was more variable and delivered in a variety of ways. Clinicians advised eating in moderation, eating a balanced diet, having smaller portions, or being organised and planning meals in advance. Some clinicians referred the patient to a dietician or practice nurse for specific food information. It was notable that, in contrast with the smoking cessation consultations, in which patients were encouraged to find their own solutions, in the healthy eating consultations the clinicians were quick to come up with solutions for patients:

**P:** *But it's like you say, I've got to find the healthy alternatives really, haven't I?*

**C:** *Yeah and, um, if you can't take it [your lunch] with you, I mean you could probably take some fruit with you, if you're worried about it, you know, going off, if you're out and about all day.*

**P:** *Yeah.*

**C:** *And you can buy those little cool bags can't you with, um, the little coolers to put in, to help keep the food cooler if you're taking sandwiches or salads, um, so I think, you know, to start with that, you know, that's ... see how you go.*

(Healthy eating 10)

Some clinicians focused on increasing the intake of fruit, vegetables, and fibre; others included more specific advice on foods within the 'bad' and 'good' categories:

**P:** *I do have a lot of margarine but I do eat quite a lot of cheese because I like cheese.*

**C:** *OK, right. So if you were to sort of cut down on, obviously cheese is quite full of ... quite a lot of fat.*

**P:** *Yeah, yeah.*

**C:** *So how would you feel about maybe cutting down on the cheese?*

**P:** *Yeah, yeah I could do that ... um, what, would it be advisable to put something in its place instead of it?*

(Healthy eating 9)

The example above shows that the clinician is trying not to direct, but rather to engage, the patient in addressing lifestyle issues and guide them through the process of initiating change. This is consistent with the behaviour change counselling training received on how to discuss the topic, but the narrow focus on cheese illustrates that what is being discussed is limited for both patient and clinician.

Dietary advice was often supported by written information sheets, which the patient could take home.

Advice on how to increase exercise was offered during two consultations using divergent approaches. One clinician offered advice on how to increase opportunities within an existing lifestyle, while the other recommended an average quantity of exercise that should have an impact on the patient's health each week.

#### **How change is demonstrated and monitored**

In the smoking cessation consultations clinicians offered options for regular review, which was either arranged fortnightly (especially if starting medication) or as required and to be determined by the patient. Goals were left to the patient, but the message of setting a target of cutting down, with an endpoint of stopping, was clearly communicated in all the smoking cessation consultations:

**C:** *So, what would be your ... what's your next goal? What's your next plan?*

**P:** *Well, I'm on about, I think I'm smoking about 10 a day, so ... I reckon I'd cut down by about half anyway ... I mean, like I say, I would like to stop altogether ...*

(Smoking 4)

Most clinicians felt that reviewing dietary changes with a follow-up consultation was important; repeating cholesterol tests was the main focus for monitoring. The timing of repeating this test, however, ranged from between 1 month and 6 months, with no formal follow-up planned for the interim period. The wide range of time given by various clinicians for follow-up depended on the interim specified for repeating cholesterol testing and reflected an uncertainty and lack of clarity on how to further manage the case:

**P:** *So when would be the best time to have another check?*

**C:** *I think if, what we tend to do is to give you*

*3 months, um, to maybe take this home, have a look at your diet and the drinking, um, just look at small changes, reasonable changes that ... I mean you might like to chat with your wife, talk them through, something reasonable, um, and then maybe we can re-do your cholesterol in about 3 months' time?*  
(Healthy eating 4)

A few clinicians, however, suggested weight loss as a means of monitoring change, proposing monthly reweighing at the surgery as a way of maintaining motivation and demonstrating change:

**C:** *The other incentive I try to make is, if people want to lose weight if they want to come and just weigh once a month.*

**P:** *Oh right.*

**C:** *To see if they are sticking to their diet and to see if that's any help because, obviously, the weight loss will help as well.*  
(Healthy eating 3)

#### Benefits of change

The benefits of stopping smoking were discussed in terms of benefits to the patient and her pregnancy and baby. All clinicians discussed antenatal risks associated with smoking, focusing on growth restriction and underweight babies at delivery. Childhood asthma was addressed in most consultations, which was an opportunity for clinicians to express the importance of continued cessation after pregnancy. In this scenario, the patient reported being aware of risks to her health from smoking; in some consultations, however, the cardiovascular risks were reiterated and the benefit of smoking cessation quantified. Financial benefits and the benefits of reducing stigma associated with smoking were also raised:

**C:** *What sort of negatives, would you say, could you see with your smoking? Is there anything in particular you dislike about your smoking?*

**P:** *I don't like, well, obviously, I don't like the fact that I'm pregnant now and I'm still doing it and it can harm my baby, so that's the biggest thing, but I also don't like the fact that I smell to other people. I'm constantly chewing mints and all of that because I don't like, I hate that, you know, the smell of it.*  
(Smoking 1)

If opportunities arose to promote smoking cessation among others at home

or socially, clinicians took these:

**P:** *Perhaps my mum should think about it as well.*

**C:** *Yeah, yeah, yeah. I mean if mum, could give up as well, then you will be doing it together.*  
(Smoking 8)

Within the healthy eating there was less emphasis on the benefits of change for the individual. Clinicians focused on the importance of preventing heart disease and stroke generally, but often without clear reference to individual risk profiles for that particular patient.

The second point noted with all clinicians was that, although major longer-term benefits for reducing cholesterol levels and eating healthier diets were discussed, shorter-term gains were not used as an incentive. In the smoking interactions, changes in smells and finances were strong immediate benefits with the goal of a longer-term healthy pregnancy, baby, and better health in the future. There was no apparent parallel discussion for the healthy eating consultations:

**P:** *OK. I mean how dangerous is it? I mean I, I — it just worries me when I hear about things.*

**C:** *Yeah, of course, yeah. It's not detrimental in that it's life threatening right now, it's usually ... cholesterol builds up in your arteries over a long period of time, so, you know for somebody your age, you know, we are looking sort of 10, 15 years, you know, down the line.*

**P:** *Yeah.*

**C:** *Some possible damage to the coronary arteries.*

**P:** *Right.*

**C:** *So, you know, every small step you take right now will definitely help to, you know, sort that problem out and get it [cholesterol level] lower a bit.*  
(Healthy eating 5)

The simulated patient presented to the study with a family history of high cholesterol and cardiovascular disease; however, the importance to the patient of modifying this risk behaviour was often not delivered:

**C:** *OK. Um, how do you feel about the fact that your father has got high cholesterol and the implications that it might have on you?*

**P:** *Um ...*

**C:** Long term, I mean now.

**P:** I haven't really thought about it, um ... I mean he hasn't had any problems.

**C:** Hasn't he, no?

**P:** No, but [it's] only initially that he has been told he has high cholesterol.  
(Healthy eating 5)

Those clinicians who discussed exercise within the consultation mentioned both the short- and long-term benefits of increasing exercise. This had more similarities with discussions that took place in the smoking cessation consultations than the healthy eating ones.

### Barriers to change

The smoking cessation consultations provoked discussion from both clinicians and patients regarding the problems associated with quitting. These included physical addiction, and fears of cravings and weight gain on stopping. Positive aspects of smoking were raised by both clinicians and patients, including enjoyment, relaxation, and the fact that it is often sociable and a part of routine and habit. Clinicians demonstrated an ability to address these barriers, drawing solutions from the patient in line with behaviour change counselling:

**P:** I do enjoy smoking.

**C:** Is it a social thing?

**P:** It is a social thing. Most of my friends smoke. Um, my mum smokes and I live with my mum.

**C:** Right ... Well that's quite difficult then.

**P:** So yeah, so it's kind of like, you know, it's in the house so it's not really when I go out with my friends, it's in the house as well, my mum smokes. Um, so that's it really, they are then negatives because I do enjoy it and, as I say, my friends and stuff. So it is quite a social thing.

**C:** Do you think it would affect your relationship with your family and your friends if you give up? Is that something that's in your mind?

**P:** I would, I suppose. Maybe it wouldn't affect it ...  
(Smoking 2)

The healthy eating consultations also raised discussions regarding barriers to change. The time involved with planning meals, shopping for fresh food, and in food preparation was perceived as an extra task within an already full lifestyle and, therefore, difficult to maintain. Access to fresh, healthy food was also discussed. Previous diets not maintained were seen as experiences that

negatively affected patients' confidence in their ability to successfully initiate any new changes. Whereas the clinicians appeared to anticipate barriers to smoking cessation, in the healthy eating consultations they used fewer opportunities to discuss accommodating change:

**C:** I mean, obviously, you've got a lot going on at the moment, you've got two jobs and, you know, busy active life at the moment so, maybe if things calm down in a few months we can, you know, you can come back and we can go through things again at a later date and, you know, if you're ready then to make some changes to look at your diet and lifestyle and we can, you know, sort of make some, put some plans in action for you.  
(Healthy eating 5)

## DISCUSSION

### Summary

This qualitative analysis identifies particular, complex challenges of discussing healthy eating compared with smoking cessation in primary care consultations. This could explain the longer consultations recorded for healthy eating interactions.

Although all clinicians were trained to improve how behaviour change is discussed with patients, there were clear differences regarding what was discussed. In the smoking cessation consultations, the clinician and service user were both clear on:

- what to change;
- how to change and monitor this;
- what the barriers were; and
- the benefits of change.

There was less consistency and clarity in consultations regarding healthy eating. Individual clinicians focused on different elements of dietary change and gave idiosyncratic advice on how change could be achieved, thereby directing, rather than guiding, patients.

Monitoring was not clearly planned in the healthy eating consultations. Benefits of healthy eating were presented for longer-term health gains, in all but one consultation, without reference to benefits that could encourage the patient in the shorter term, such as weight loss if the patient were overweight.

Clinicians appeared less able to anticipate and discuss barriers to dietary change than to smoking cessation.

### Strengths and limitations

This study is limited by the use of simulated



consultations. However, the simulated patients did consult during routine clinical sessions and had no 'out-of-role' interaction with the clinicians, which adds considerable authenticity to the process. Feedback confirmed that the consultations were accepted as authentic by the clinicians within the study. These clinicians may already have had an interest in behaviour change, be research minded and, thus, atypical of primary care clinicians; in addition, they had all undergone training in behaviour change counselling. The topic was chosen by the clinician and may have been a perceived area of strength, leading to improved performance in the consultation; conversely it may also have been a weaker area in which they hoped to improve.

The patient-generated content of the consultation may lack originality, but what the study does provide is a measure of clinician management of a standardised consultation. Simulated consultations can produce realistic stress physiological responses in clinicians and can, therefore, be realistic.<sup>19</sup> The clinician-initiated material within the consultation is comparable between consultations and, consequently, data analysis has focused on the clinicians' talk.

A patient with high cholesterol levels was used in this scenario as a model for a consultation in which healthy eating advice was needed. This was the pre-designed scenario, but offers a realistic scenario that occurs on a frequent basis in primary care. The patient in the scenario was overweight; this may not necessarily be the case in reality and highlights the importance of ascertaining patient-centred goals and short-term benefits that can result from behaviour change.

The particular scenarios used could be criticised for using dissimilar patients, thereby reducing comparison potential. However, it is arguable that clinician knowledge of smoking cessation or healthy eating needs to be robust enough to adapt to individuals' personal circumstances; this study demonstrates, overall, that there is less ability to do this in the healthy eating scenario than in the smoking one.

The number of consultations used within the analysis is small and may limit the breadth of thematic material available. Each clinician had two consultations with the actor and, given that no two consultations are identical, including both was felt to be acceptable. The findings reported were consistently represented across the consultations.

### Comparison with existing literature

Clinicians in primary care have acknowledged that smoking cessation consultations are straightforward, whereas there is more variability in the conceptualisation of those related to healthy eating.<sup>11</sup> They have been identified as differing consultations — success for smoking is measured as an absolute (smoking cessation), but success for healthy eating traverses along a continuum, measured by various factors (such as weight loss<sup>11</sup> and reduced cholesterol level). The current study is in agreement with others that suggest a need for clinicians to improve their knowledge<sup>20</sup> and more detailed assessments of patients' eating habits and perceptions of food and health.<sup>8</sup>

Current literature reports that, beyond superficial screening, clinicians are reluctant to discuss healthy eating and weight management with patients.<sup>11,12</sup> It has been reported that offering support and setting follow-up for weight loss and healthy eating consultations is done poorly.<sup>21</sup> These points are mirrored within this study.

Two trials have reported little effect in cholesterol reduction as a result of dietary advice interventions.<sup>22,23</sup> Uptake of healthy diets and reductions in cholesterol levels were more sustained when patients were aware of illnesses and more motivated to change. These reports emphasise the potential of focusing on the benefits of change,<sup>24</sup> and personalising risk and gain for individuals that may increase motivation and sustain change. This study confirms that benefits of changes in diet are often not discussed in a way that patients immediately relate to, thereby failing to capitalise on motivating factors for change. Although clinicians focus on the important long-term considerations and risk of coronary or cerebrovascular disease, patients' motivation, may be driven by more immediate benefits.

Clinician variability and lack of engagement in healthy eating and weight-loss consultations are associated with clinicians' varying attitudes, the stigma relating to the issue, perceived competency in this area, and the perception of efficacy of the treatment that is available to the patient.<sup>11,12</sup> This study suggests that these factors relate to a deficit in what clinicians are including within their consultation.

Researchers have used techniques to enhance behaviour change in healthy eating consultations with only marginal success.<sup>21,25</sup> Models conceived for smoking

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### Ethical approval

Multi-Centre Research Ethics Committee for Wales, reference: 07/MRE09/11.

### Provenance

Freely submitted; externally peer reviewed.

### Competing interests

The authors have declared no competing interests.

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cessation such as the Stages of Change model and the American-based 5As model have had translational difficulties,<sup>21,25</sup> and only show small effects when used to promote healthy eating. However, what this study indicates is that training clinicians in how to deliver information is advancing without fully exploring the lack of the knowledge and conceptualisation of the problem. The two concerns, perhaps, need to be addressed in relation to each other in future research.

#### **Implications for practice and research**

This conceptualisation has practical implications and can help develop ways in which clinicians can improve their ability to motivate patients and facilitate sustained improvements. Clinicians appeared less able to anticipate and discuss barriers to dietary change than to smoking cessation.

This lack of clarity over healthy eating discussions may partially explain primary care clinicians' unsuccessful attempts to encourage behaviour change and requires attention if clinicians are going to make an improved contribution to reducing obesity and promoting healthy eating.

Comparing healthy eating consultations with those on smoking cessation in terms of what is discussed in relation to change suggests a need for improved clarity from clinicians in general practice. Guidance on how to change diets, together with personalising risks and benefits of change, are potential areas that should be focused on in order to secure improvement. The role of behaviour change counselling to improve how we manage discussions regarding healthy eating is exciting, but unlikely to succeed unless clinicians are clear about what information needs to be discussed.



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