

Identifying and Mapping Canadian Registered Dietitians' Perceptions and Knowledge of, and Experiences with, Weight-Related Evidence in Nutrition Care: A Scoping Review Protocol

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Abstract

Objective: The objective of this scoping review is to identify and map the currently available peer-reviewed and grey literature exploring Canadian registered dietitians' (RDs') perceptions and

knowledge of, and experiences with, weight-related evidence in nutrition care. **Introduction:** Weight, skin fold calipers, body mass index (BMI), and other means of measuring and describing body size, have been associated with risk, progression, and nutrition intervention success with several disease states. Interpretation and application of weight-related evidence can be impacted by several non-medical factors, including practitioner perspective, evidence interpretation and application, lived experience, and bias. Each of these outcomes may differ between RDs and are not easily described or understood. **Inclusion Criteria:** Original peer-reviewed studies and grey literature published in English that explore Canadian RDs' perceptions of, knowledge of, and experiences with weight-related evidence in nutrition care will be included. **Methods:** Following the JBI scoping review design and associated methodology, including the three-step search strategy process, four databases will be searched: CINAHL (EBSCO), MEDLINE (Ovid), Embase (Elsevier), and Scopus (Elsevier). Grey literature will be searched using Google Scholar, Google, and Microsoft Bing, and a search strategy specific to grey literature has been developed in partnership with the research team's librarian (MR). Screening and extraction will be led by two independent reviewers (RW, AM), and conflicts will be resolved either by discussion or through a third reviewer (SG). Data will be presented using diagrams and/or tables, including a narrative summary. The Delphi method will be used for community consultation, that will occur throughout this study.

Keywords: dietitians, weight evidence, perception, experience, knowledge

Introduction

Body weight or mass, as measured in pounds or kilograms, can be influenced by several factors, including psychological, physiological, environmental, societal, and economic factors (Kopelman, 2010; Vandebroek et al., 2007). Non-medical factors impacting health and disease risk, or social determinants of health (SDoH), also impact body weight, but are often excluded in body size assessment, wellness programming, and policy (Alberga et al., 2018; Chumpunuch & Jaraepapal, 2022; Medvedyuk et al., 2018; World Health Organization, n.d.; Young et al., 2016). SDoH exclusion has been associated with weight bias and discrimination in the health care system, both of which are associated with unfavourable health outcomes and reduced person-centred and accessible care (Obesity Canada, n.d.). Several health care professions are taking strides to address weight bias. For instance, Dietitians of Canada and several other groups have publicly endorsed the *Joint International Consensus Statement for Ending*

Stigma of Obesity (Rubino et al., 2020) and made pledges to address and/or eliminate weight bias within and beyond their profession(s).

Weight and size are conceptualized, measured, and described in several ways. For instance, body mass index (BMI; weight in kilograms divided by height in metres squared) has been associated with disease risk (Davies et al., 2022; Health Canada, 2021; Khan et al., 2018; National Heart, Lung, and Blood Institute, n.d.). Originally developed by insurance companies as part of enterprise risk management and client assessment, when BMI categorizes bodies as "obese" and "underweight," they are deemed to have higher risks. Body weight, and thus BMI, is one of many markers of nutrition status and/or risk, including for malnutrition and being underweight, often included in all components of nutrition care (Raymond & Morrow, 2020). Nutrition care is often guided by the Nutrition Care Process, which includes four steps: nutrition assessment, diagnosis, intervention, and monitoring/evaluation. Nutrition care is provided in diverse practice settings such as clinical, public health, private practice,

community, industry, and not-for-profit food settings. Dietetic practice is rooted in common core competencies, as defined by Partnership for Dietetic Education and Practice (Partnership for Dietetic Education and Practice, 2020). There are seven main competency areas (2020), and body size and weight can be relevant to all practice and competency areas (Swan et al., 2017).

Interpretation and application of current weight-related evidence is a point of divergence and debate within the dietetic profession, as both interpretation and application can be impacted by practitioner perspective, awareness of evidence, lived experience, and bias. For instance, some registered dietitians (RDs) view obesity as a disease and a significant risk factor for other chronic disease and medical diagnoses, associated with complications and decreased quality of life, while other RDs reject the concept of increased weight and size as an indicator of health and promote body acceptance (Mechanick et al., 2017; Penney & Kirk, 2015).

Clinical practice guidelines (CPGs) inform dietetic practice (Hand et al., 2021; Wharton et al., 2018). RDs rely on several CPGs as their primary reference to support and provide guidance for best practices in many clinical areas of practice (Maxwell et al., 2019a, 2019b; Rasmussen & Yaktine, 2009; Wharton et al., 2018, 2020). Recent CPG updates from Diabetes Canada (2018), the Society of Obstetricians and Gynaecologists of Canada (2019), and the Canadian Association of Bariatric Physicians and Surgeons and Obesity Canada (2020; Maxwell et al., 2019a, 2019b; Wharton et al., 2018, 2020), devote multiple chapters to the topic of weight and “weight management.” Despite this, evidence continues to suggest health care providers do not feel comfortable with or capable of discussing weight with patients, and/or are struggling to avoid harmful bias during these discussions (Alberga et al., 2019; Brown & Flint, 2013; Dewhurst et al., 2017; Huang et al., 2004). For

example, a recent questionnaire (2021) of Canadian RDs, as part of Dietitians of Canada’s endorsement process of the new Adult Obesity CPGs (2020), concluded 58% of membership supported endorsement and the remaining membership declined endorsement. Contradictions and lack of practicality were key areas of concerns highlighted by RD members (Dietitians of Canada, 2021). One contradiction highlighted was the act of suggesting patients should lose 10% of their body weight, while also telling providers not to use weight as a “goal” or main focus with patients (Wharton et al., 2020). Other guidelines have been similarly criticized for using weight as a goal, intervention, or marker of health risk, while simultaneously discouraging weight-centric practice (Maxwell et al., 2019a, 2019b; Rasmussen & Yaktine, 2009; Wharton et al., 2018, 2020).

In recent years, many professions, like RDs, have had to move their practice online in outpatient settings, due to increased infection risks related to the COVID-19 pandemic. This has created compounded impacts on evidence translation and communication from provider to patient and vice versa (Rasmussen & Yaktine, 2009; Tewksbury et al., 2021; Weissman et al., 2020). In the media, COVID-19 has demonstrated how, now more than ever, misinterpretations, misunderstandings, and miscommunications of research and science have impacts on perception of evidence and evidence use (Else, 2020; Gleick, 2020; Lin et al., 2020; Tang et al., 2021). Many academic publications and media posts have surfaced on weight-related evidence during the pandemic (e.g., “obesity increases risk for COVID-19,” “quarantine 15”), and while some are evidence-based, some are deemed to be “rushed science” (Bessey & Brady, 2021; Else, 2020; Schwartz, 2020; Wang et al., 2021). It is unclear how RDs have responded to or engaged with this, and as the pandemic continues (2019–present), identifying and mapping their perceptions and knowledge of, and experiences with, weight-related evidence could help inform future

weight-related research.

Based on inconsistencies in recommendations and varied weight perspectives, it is important to identify and map Canadian RDs' perceptions and knowledge of, and experiences with, weight-related evidence in practice, which will be the aim of this scoping review. "Weight-related evidence" is an ambiguous term, used purposefully, to include a range of perceptions, experiences, and knowledge in various practice areas. Definition of the term will be explored in a subsequent survey of Canadian RDs, which the results of the review will inform. Additionally, the terms knowledge, perception, and experience have been defined by the co-authors for use in this study (Appendix C). Included literature (peer-reviewed and grey) will be examined for mention of the COVID-19 pandemic to identify and map perceptions and knowledge of, and experiences with, any relationship(s) between weight-related evidence and the unprecedented impacts of the pandemic on dietetic practice. A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews, and JBI EBP Database was conducted, and no current or underway systematic or scoping reviews on the topic were identified. Internationally, research has explored perspectives of weight-related practices among health care providers; however, it appears that there is limited research focusing on RDs (Bocquier et al., 2005; Cade & O'Connell, 1991; Steeves et al., 2015). This review will focus on Canada specifically, as the health care system's funding and policies are unique to Canada. In Canada (2004–2019), it appears research is lacking on RDs' views of weight-related evidence in practice areas other than weight/obesity management (Aboueid et al., 2019; Barr et al., 2004; Chapman et al., 2005; Marchessault et al., 2007).

Research Question

What evidence is currently available on Canadian RDs' perceptions of, knowledge of, and

experiences with weight-related evidence in nutrition care?

Inclusion Criteria

Population

The population of interest is Canadian RDs and registered nutritionists (the latter not recognized by all provincial regulators) who provide nutrition care (Dietitians of Canada, n.d.). Both terms (RDs, nutritionists) will be included in the search strategy (Appendix A), and all results will be reported as RDs. Articles including "nutritionists" will be included only if the participants are registered in a province where "nutritionist" is recognized by the dietetic provincial regulatory body (Nova Scotia Dietetic Association, n.d.).

Concept

This review will consider studies and sources that explore RDs' perceptions of, knowledge of, and experiences with weight-related evidence in nutrition care for inclusion. The research team has co-created definitions for the three primary outcomes, which are perceptions, experiences, and knowledge; these three terms can be seen as socially constructed concepts, related to power and discourse in society (University at Buffalo, n.d.). Perception is informed by experience and knowledge, can be described as an individual's point of view, paradigm, or outlook on a topic or issue, and is informed by their perspective (Cambridge University Press, n.d.). Experience is seen as any event(s) occurring in the past tense, when the individual was awake and/or cognizant. Recall and description of experiences are limited to working memory (Merriam-Webster, n.d.). Lastly, knowledge is awareness and recall of a concept or phenomena. Knowledge informs skill in nutrition care and beyond (Encyclopædia Britannica, n.d.). The research team acknowledges that all three concepts can inform one another within an individual (Figure 1). More review- and topic-specific definitions can

be found in Appendix C.

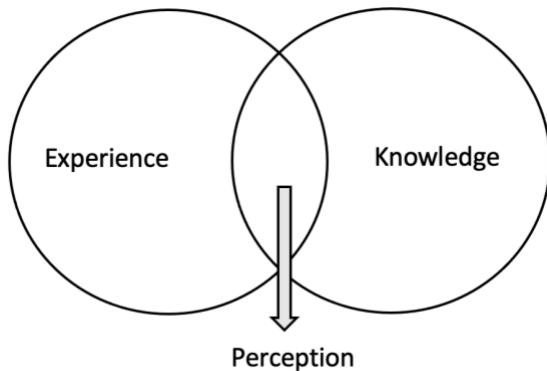


Figure 1 Venn Diagram of How Experience and Knowledge Inform Perception in an Individual

This review will consider weight discussed in terms such as but not limited to the following: weight management, weight as assessment measurement/tool, use in screening and risk assessments, use in caloric needs assessments, monitoring of disease progression, weight loss or gain, malnutrition, use and understanding of BMI categories, weight bias or discrimination, and use and/or comprehension of weight-related CPGs and surrounding research.

Context

This review will consider studies that include RDs’ perceptions and knowledge of, and experience with, weight-related evidence in nutrition care across all practice settings (e.g., clinical, public health, education, research) in Canada. All provinces and territories in Canada will be included, and any studies outside of Canada will be excluded.

Information/Types of Sources

This scoping review will consider peer-reviewed and grey literature, including, but not limited to, primary research studies, systematic reviews, reports, dissertations, conference abstracts, opinion texts, reports, websites or blogs, and online newspaper articles. Online newspaper articles from reputable sources (e.g.,

Canadian Broadcasting Corporation, CTV Television Network) will be considered if they are an interview with or written by an RD. Both quantitative and qualitative research will be considered for inclusion.

Methods

This scoping review will be conducted in accordance with the JBI methodology for scoping reviews (Levac et al., 2010; Peters et al., 2020; Peters et al., 2021).

Search Strategy

The search strategies aim to locate published, unpublished, peer-reviewed, and grey literature. The database/peer-reviewed search strategy was developed by a JBI-certified librarian (MR). First, an initial search of MEDLINE (Ovid) and CINAHL (EBSCO) was conducted to identify articles on the topic. The text words contained in titles, abstracts, and index terms were then used to develop a full search strategy for CINAHL (EBSCO; Appendix A). Next, the search was sent to a second librarian trained in systematic review searching for Peer Review of Electronic Search Strategies (PRESS). After PRESS, the final search was adapted/translated to the four databases to be searched for this review: CINAHL (EBSCO), MEDLINE (Ovid), Embase (Elsevier), and Scopus (Elsevier). Prior to closing out the review, the reference lists of included articles will be screened for additional papers prior to community consultation. Only articles published in English will be included. This may be a limitation, as French is Canada’s second official language; however, English is the primary language of the research team. There will be no restriction on article publication date. A grey literature search strategy was also developed in partnership with the team’s librarian (MR), where Fuller et al. (2021) and *Grey Matters: A Practical Tool for Searching Health-Related Grey Literature* were consulted (Canadian Agency for

Drugs and Technologies in Health, 2019). Grey literature will be searched using Google Scholar, Google, and Microsoft Bing.

Study Selection

Following the search, all identified citations will be uploaded into Covidence (<https://www.covidence.org/>), and duplicates will be removed. Titles and abstracts will be screened by two independent reviewers (RW, AM) for assessment against the inclusion criteria. Next, articles will be retrieved in full and reviewed in Covidence against the inclusion criteria by the same two reviewers (RW, AM).

Source Selection

For grey literature sources, a template by Stapleton (2015, as cited in Fuller & Lenton, 2018), *How to Find & Document Grey Literature*, will be used. Both reviewers will search for grey literature using this template. Potentially relevant citations will be uploaded into Covidence, and duplicates will be removed. Titles and abstracts (e.g., for dissertations) or brief descriptions (e.g., for blogs) will be screened by two independent reviewers (RW, AM) for assessment against the inclusion criteria. After title and abstract screening, potentially relevant sources will be retrieved in full and added to Covidence, where the full text of selected citations will be assessed in detail against the inclusion criteria by the same two independent reviewers (RW, AM).

Study Data Extraction

Included articles will be extracted by the same reviewers (RW, AM) in Covidence using a co-created data extraction tool specific to the review. The extraction table (Appendix B, Table B1) will be piloted prior to data extraction with two to three select articles, and modifications and revisions will be made accordingly before going ahead with extraction. Some rows of the table have been included to highlight nuance specific to the topic such as “credentials,” “funding,” “conflicts of interest,” and “weight

paradigm,” as all four can inform experiences and knowledge and thus perceptions related to weight. Other rows such as “guiding framework,” “stage of nutrition care,” and “practice setting” have been included to provide context and aid in mapping the results when the review is completed. COVID-19 is not included as its own extraction row, as it is a tertiary outcome and will be sorted underneath the appropriate perception, experience, or knowledge primary outcomes, as applicable. If appropriate, authors of studies and sources will be contacted to request missing or additional data, where required.

Source Data Extraction

For extraction, the included dissertations, reports, or conference abstracts will be extracted in Covidence, whereas websites and blogs will be extracted in Microsoft Excel using an adapted extraction tool for these sources (Appendix B, Table B2). Extraction will be completed by the same two independent reviewers (RW, AM). Specific to this extraction tool, rows such as “target audience” and “main topic of the blog” have been included to provide context for the primary outcomes of the review. “Weight paradigm disclosure in the article or blog” is included with the goal of identifying and mapping if and/or how dietitians are sharing their weight-related perceptions, experiences, and knowledge publicly.

Data Analysis and Presentation

Reasons for exclusion of full-text papers not meeting the inclusion criteria will be recorded and reported in the full scoping review manuscript. Any disagreements that arise between the reviewers at each stage of the scoping review will be resolved through discussion, or if unable to be resolved through discussion, with a third reviewer (SG). The results of the search will be reported in full in the final scoping review manuscript. Results of study identification, screening, and included

articles will be presented in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Page et al., 2021). The PRISMA extension for Scoping Reviews (ScR) checklist will be used to direct reporting of the results (Tricco et al., 2018). The results will be presented in diagrams and/or tables to map the data responding to the review's research question, along with a narrative summary.

Community and Expert Consultation

The Delphi method is an acceptable approach for community consultation among scoping reviews, and will be used for consultation and to seek agreement that the review is comprehensive to community members (e.g., individuals with lived experience) and experts (e.g., experienced RDs and researchers; Clayton, 1997; Green, 2014; Hemming et al., 2011; Peters et al., 2020; Pollock et al., 2022; Williams & Webb, 1994). Informed by Hemming et al. (2011) and Williams and Webb (1994), Delphi method will be conducted online using a series of email rounds, aiming to identify any gaps, seek feedback on the applicability of the results to its population, and to guide dissemination. Panelists will be provided with the full scoping review manuscript prior to round one. During round one, panelists will be asked to do the following: (a) comment if they notice any missing literature, (b) comment on the practical applications of the findings to RDs, and (c) provide any recommendations for dissemination. Following this, the facilitator (SG) will collate and circulate all feedback into an anonymized summary report to the team for discussion (round two). Additional rounds may be warranted if consensus (i.e., agreement) is not reached; however, consensus is not always possible. If consensus is not reached after two rounds, all feedback will be collected and level of agreement/disagreement will be shared in the full scoping review manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Appendix A

Search strategy for CINAHL (EBSCO). Search date: October 13, 2021.

No.	Query	Results
1	(MH "Dietitians of Canada") OR (MH "Dietitians") OR (MH "Dietitian Attitudes") OR (MH "Nutrition Services+")	9,108
2	TI (dietitian* OR nutritionist* OR dietician* OR "RD" OR "R.D." OR "P.Dt" OR "Dt.P" OR "RDN" OR "R.D.N." OR "Nutrition specialist*" OR ((nutrition* OR dietetic*) N2 (professional* OR specialist* OR practitioner* OR practice*))) OR AB (dietitian* OR nutritionist* OR dietician* OR "RD" OR "R.D." OR "P.Dt" OR "Dt.P" OR "RDN" OR "R.D.N." OR "Nutrition specialist*" OR ((nutrition* OR dietetic*) N2 (professional* OR specialist* OR practitioner* OR practice*)))	14,318
3	(MH "Body Mass Index") OR (MH "Body Weight")	111,843
4	TI ("Body weight" OR "Body Mass" OR "BMI" OR "B.M.I." OR obes* OR overweight OR "over-weight" OR weight OR "underweight" OR "IBW" OR "I.B.W." OR "ABW" OR "A.B.W." OR "AdjBW" OR "Adj.B.W." OR fat OR heavy OR "large* bod*") OR AB ("Body weight" OR "Body Mass" OR "BMI" OR "B.M.I." OR obes* OR overweight OR "over-weight" OR weight OR "underweight" OR "IBW" OR "I.B.W." OR "ABW" OR "A.B.W." OR "AdjBW" OR "Adj.B.W." OR fat OR heavy OR "large* bod*")	352,789
5	(MH "Practice Guidelines") OR (MH "Practice Patterns") OR (MH "Professional Practice, Evidence-Based") OR (MH "Professional Practice, Research-Based") OR (MH "Professional Practice, Theory-Based") OR (MH "Health Beliefs") OR (MH "Professional Knowledge+") OR (MH "Job Experience") OR (MH "Attitude") OR (MH "Attitude of Health Personnel") OR (MH "Dietitian Attitudes") OR (MH "Attitude to Obesity")	226,691
6	TI ("clinical practice" OR framework OR knowledge OR attitude* OR view* OR value* OR belief OR believ* OR perception* OR perceiv* OR philosoph* OR opinion* OR bias OR stigma OR strateg* OR discuss* OR approach* OR counsel* OR practice* OR suggest* OR guid* OR "best-practice*" OR skill* OR experienc* OR train* OR "evidence-based" OR evidence OR "EBP" OR "E.B.P." OR "evidence-informed" OR tool* OR refer* OR "CPG" OR "C.P.G." OR "health at any size" OR "HAES" OR diet* OR food* OR eat* OR restriction* OR decision* OR "body neutrality" OR ("calori* N1 (count* OR deficit* OR surplus*))) OR AB ("clinical practice" OR framework OR knowledge OR attitude* OR view* OR value* OR belief OR believ* OR perception* OR perceiv* OR philosoph* OR opinion* OR bias OR stigma OR strateg* OR discuss* OR approach* OR counsel* OR practice* OR suggest* OR guid* OR "best-practice*" OR skill* OR experienc* OR train* OR "evidence-based" OR evidence OR "EBP" OR "E.B.P." OR "evidence-informed" OR tool* OR refer* OR "CPG" OR "C.P.G." OR "health at any size" OR "HAES" OR diet* OR food*	1,112,752

	OR eat* OR restriction* OR decision* OR "body neutrality" OR ("calori* N1 (count* OR deficit* OR surplus*))	
7	(MH "Canada+")	106,376
8	TX (canad* or "british columbia" or "Colombie britannique" or alberta* or saskatchewan or manitoba* or ontario or quebec or ("new brunswick" not "new jersey") or "nouveau brunswick" or "nova scotia" or "nouvelle ecosse" or "prince edward island" or newfoundland or labrador or nunavut or nwt or "northwest territories" or yukon or nunavik or inuvialuit or Abbotsford or Airdrie or Ajax or Aurora or Barrie or Belleville or Blainville or Brampton or Brantford or Brossard or Burlington or Burnaby or Caledon or Calgary or Cambridge or "Cape Breton" or Chatham or Kent or Chilliwack or Clarington or Coquitlam or Drummondville or Edmonton or "Fort McMurray" or Fredericton or Gatineau or Granby or "Grande Prairie" or Sudbury or Guelph or "Halton Hills" or Iqaluit or Inuvik or Kamloops or "Kawartha Lakes" or Kelowna or Kingston or Kitchener or Langley or Laval or Lethbridge or Levis or Longueuil or "Maple Ridge" or Markham or "Medicine Hat" or Milton or Mirabel or Mississauga or Moncton or Montreal or Nanaimo or "New Westminster" or Newmarket or "Niagara Falls" or "Norfolk County" or "North Bay" or "North Vancouver" or North Vancouver or Oakville or Oshawa or Ottawa or Peterborough or Pickering or "Port Coquitlam" or "Prince George" or "Quebec City" or "Red Deer" or Regina or Repentigny or (Richmond not Virginia) or "Richmond Hill" or Saanich or Saguenay or "Saint John" or "Saint-Hyacinthe" or "Saint-Jean-sur-Richelieu" or "Saint-Jerome" or Sarnia or Saskatoon or "Sault Ste Marie" or Sherbrooke or "St Albert" or "St Catharines" or "St John's" or "Strathcona County" or Surrey or Terrebonne or "Thunder Bay" or Toronto or "Trois-Rivieres" or Vancouver or Vaughan or ((Halifax or Hamilton or London or Victoria or Waterloo or Welland or Whitby or Windsor) not (UK or "United Kingdom" or Britain or England or Australia)) or Whitehorse or Winnipeg or "Wood Buffalo" or Yellowknife)	909,745
9	1 OR 2	20,320
10	3 OR 4	385,919
11	5 OR 6	1,235,550
12	7 OR 8	909,748
13	9 AND 10 AND 11 AND 12	502

Note. Geographic filter comes from *Filter to Retrieve Studies Related to Canada, Canadian Provinces, and the One Hundred Largest Canadian Centres from the EBSCO CINAHL Database*, by S. M. Campbell, 2022, John W. Scott Health Sciences Library, University of Alberta (https://docs.google.com/document/d/16s3Z0Xf0E94UilGO4cf7RIJlIRb0_dD3gs_ppe7354/edit).

Appendix B

Data Extraction Tools

Table B1

Data Extraction Instrument for Research Articles, Dissertations, Reports, and Conference Abstracts (Covidence).

<u>Data Extraction Tool</u>	
General Information	
Article title:	
Author(s):	
Date of publication:	
Journal name, volume, issue, pages:	
Study Details	
Objective(s):	
Research question(s):	
Methods:	
Sampling method: (if applicable)	
Inclusion/Exclusion Criteria	
Clerical	
What is the source? (e.g., peer-reviewed study, blog, report, conference abstract)	
If peer-reviewed research study, what was the study design (if applicable)?	
Author(s) credentials:	
Funding source:	
Conflict(s) of interest:	
Population	
Were the participants registered dietitians?	
Number of registered dietitian participants (n=)?	
What province/territory were the participants registered/located in?	
Other info about the sample: (e.g., demographics, years of experience)	
Do any dietitians disclose their weight paradigm? If so, how many in the sample?	
Context	
Was the study conducted in Canada? Where in Canada?	

What practice setting was the study focused on (e.g., clinical, public health, education, research)?	
Concept	
What type of weight evidence is used/discussed? (e.g., BMI, body weight, weight loss/gain)	
What framework is used in practice? (e.g., Nutrition Care Process (NCP), knowledge translation (KT), program development, policy statement)	
What stage of the NCP did the dietitian base their response on? (e.g., Assessment, Diagnosis, Intervention, Evaluation or Management)	
What were the discussed perception(s) of weight (if applicable)?	
What were the dietitians' experience(s) with weight evidence (if applicable)? (e.g., BMI, body weight, weight loss/gain)	
What was the weight-related evidence knowledge used/discussed (if applicable)?	
What is the discussed weight paradigm?	
Key Findings	
Results	
Limitations	
Other relevant details	
Miscellaneous notes	

Table B2

Data Extraction Instrument for Websites and Blogs (Microsoft Excel).

Article No. (e.g., #)	
General Information	
Blog article title	
Author(s)	
Link to article	
Date of publication	
Date of update(s) (if applicable)	
Name of blog	
Population	
Credential(s)	

What province/territory are the participants registered/located in?	
Other info about the sample: (e.g., bio included on blog, demographics, years of experience)	
Does the dietitian disclose their weight paradigm: 1) in the article, or 2) on the blog?	
Context	
What is the target audience of the blog? (e.g., other dietitians, other health care providers, general population)	
What practice setting was the blog focused on (clinical, public health, education, research etc.)?	
What was the main topic of the blog? (e.g., gestational weight gain, youth, body image)	
Concept	
What type of weight evidence is used/discussed? (e.g., BMI, body weight, weight loss/gain)	
What framework is discussed in the blog? (e.g., NCP, KT, program development, policy statement)	
At what stage of NCP was weight-related evidence discussed? (e.g., Assessment, Diagnosis, Intervention, Evaluation or Monitoring)	
What were the discussed perception(s) of weight evidence (if applicable)?	
What were the dietitians' experience(s) with of weight evidence (if applicable)? (e.g., BMI, body weight, weight loss/gain)	
What was the weight-related evidence knowledge used/discussed (if applicable)?	
Key Findings	
Summary of blog	
Other relevant details	
Extracted by: (initials)	
Miscellaneous Notes:	

Appendix C

Glossary of Terms

Experience¹: An event that occurred in the past when awake and/or cognizant. Recall and description of experiences are limited to working memory (Merriam-Webster, n.d.).

Knowledge¹: Awareness and recall of a concept or phenomena. Knowledge informs skill (Encyclopædia Britannica, n.d.).

Map: Compiling a summary of the available evidence rather than critiquing (i.e., critical appraisal) the quality of the evidence. “Mapping” evidence also allows more specific research questions to be developed for future research (Peters et al., 2020).

Nutrition Care Process: In 2003, the Academy of Nutrition and Dietetics (formally the American Dietetic Association) created the Nutrition Care Process (NCP) to improve the consistency and quality of individualized care for patients and the predictability of patient outcomes (Hammond et al., 2014). The four steps of the NCP are Assessment, Diagnosis, Intervention, and Monitoring/Evaluation (Raymond & Morrow, 2020).

Partnership for Dietetic Education and Practice (PDEP) competency areas: There are seven main competency areas (2020), which are (a) food and nutrition expertise, (b) professionalism and ethics, (c) communication and collaboration, (d) management and leadership, (e) nutrition care (process), (f) population health promotion, and (g) food provision (Partnership for Dietetic Education and Practice, 2020).

Perception¹: Informed by experience and knowledge, an individual’s view, paradigm, or outlook on a topic or issue (Cambridge University Press, n.d.).

Systematic Review: Includes systematic reviews with meta-analysis, scoping reviews, narrative reviews, mixed methods/mixed studies, and rapid reviews (University of Wollongong Australia Library, 2022).

Weight bias: Weight bias comprises any negative attitudes toward people based on their weight status (Obesity Canada, n.d.).

Weight discrimination: Weight discrimination comprises any action(s) toward individuals that stem from one’s preconceived notions or attitudes about weight status (Obesity Canada, n.d.).

¹Perception, experience, and knowledge are all related to power and/or discourse in society and can be seen as socially constructed concepts. All three concepts can inform one another within an individual (University at Buffalo, n.d.).