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REVIEW ARTICLE

Clinical OBESITY WILEY

Clinical encounters about obesity: Systematic review of patients' perspectives

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Summary

Guidelines recommend clinicians intervene on obesity but it is unclear how people with overweight react. In this systematic review, we searched 20 online databases for qualitative studies interviewing people with overweight or obesity who had consulted a primary care clinician. Framework synthesis was used to analyse 21 studies to produce a new theoretical understanding. Consultations in which patients discussed their weight were more infrequent than patients would have liked, which some perceived was because they were unworthy of medical time; others that it indicated doctors feel being overweight is not a serious risk. Patients reported that doctors offered banal advice assuming that the patient ate unhealthily or was not trying to address their weight. Patients reported doctors assumed that their symptoms were due to overweight without a proper history or examination, creating concern that serious illness may be missed. Patients responded positively to offers of support for weight loss and active monitoring of weight. Patients with overweight internalize weight stigma sensitizing them to clues that clinicians are judging them negatively, even if weight is not discussed. Patients' negative experiences in consultations relate to perceived snap judgements and flippant advice and negative experiences appear more salient than positive ones.

KEYWORDS

obesity, primary care, qualitative synthesis

1 | BACKGROUND

Globally, over 2.5 billion adults have overweight or obesity, representing almost 40% of the world's population.[1] Overweight and obesity increase the risk of vascular disease, diabetes mellitus, cancer and are associated with poor mental health.[2] Weight loss can mitigate these risks.[3] Physician intervention is effective, so guidelines recommend clinicians support patients to achieve a healthy weight through evidence-based interventions.[4]

Many clinicians fear that if they discuss weight with patients, some will find this unwelcome or offensive.[5] People in society, including many clinicians, hold stigmatizing views of people who are overweight, believing them to be generally less capable and weak-willed.[6-8] Clinicians talking to patients about being overweight is therefore not necessarily morally neutral and a person may feel criticized by their clinician, whether intended or not.

Both a patient and the clinician's weight status are obvious to the other. Many healthcare professionals with overweight fear it undermines their credibility in tackling weight.[9] Conversely, many people report they want advice and support from someone who has experienced their same behavioural issue as them,[10] and there is some evidence this is the case with overweight.[11]

A trial showed that primary care physician brief interventions to motivate weight loss were well-received by patients and led to weight loss.[12] Doctors believe that brief smoking cessation interventions are contextually more appropriate and effective when the presenting

condition is caused by smoking.[13-15] However, patients are most likely to show explicit resistance to advice on smoking in contexts where it is medically relevant, perhaps because patients feel that they are being blamed for their illness.[13] Doctors' may also give weight loss advice when clinically relevant. We examine whether this generates the same kind of resistance from patients because this could inform practice.

The aim of this review is to assess patients' reactions to consultations in which excess weight could have been or was discussed. In particular, we also assess the role that the physicians' own weight status plays in framing these reactions and how the perceived relevance of the health condition to excess body-weight shapes those reactions. In doing so, we aim to develop a theoretical understanding of what is motivating these responses. This could guide physicians to have interactions on weight that appear respectful, appreciated and motivate patients to address weight problems.

2 | METHODS

We synthesized qualitative studies. The review was conducted following PRISMA and ENTREQ criteria using Word software.[16,17] The protocol was pre-registered on PROSPERO (CRD42015026734). It was implemented with one clarification of intent, where we excluded reactions from consultations in a weight management clinic or in pregnancy care.

2.1 | Eligibility criteria

Participant: Adults (aged ≥18 years) with overweight or obesity who consulted a clinician and discussed their weight or where the participant perceived weight was relevant and could have been discussed.

Outcome: Description of how excess weight was raised in the consultation, was made an issue in the consultation for example through medical equipment and the participant's thoughts and feelings about the consultation/s and how discussion influenced subsequent behaviour or weight-related health outcomes.

Setting: Patients describing their experiences of primary healthcare, defined as community clinics providing the first point of access to healthcare services. Patients' reactions to consultations in weight management clinics or pregnancy care services were excluded. Reports that recruited participants from weight management programmes were included if participants described consultations in primary care.

2.2 | Information sources and search

From inception to June 2018 we searched the listed databases, supplemented by forward and backward citation searches (Table 1). The search strategy was constructed with a specialist librarian, then developed iteratively. It included a mix of subject headings and text word searches, modified appropriately for each database.

TABLE 1 Databases searched

Medline
Embase
The Cochrane Library
CINAHL
Web of Science
LILACS (Latin-American and Caribbean Center on Health Sciences Information)
SPORTDiscus
Sociological Abstracts
Trials registers including Controlled Trials, National Research Register, clinicaltrials.gov, UK Clinical Research Network, World Health Organization International Clinical Trials Registry Platform (ICTRP)
ProQuest Dissertations & Theses
OpenGrey
Conference Papers Index
Health evidence, Canada
NHS Evidence
The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI Centre) database of health promotion research
Google

2.3 | Study selection and data items

We excluded duplicate texts before two reviewers independently completed two rounds of screening, first at title and abstract and then full text stage. A consensus was reached between three reviewers on the final list of included studies.

Two reviewers independently extracted descriptive data and data relevant to quality of each study using an extraction form. The data for analysis included either verbatim quotes from participants or the authors' findings and reflections.

2.4 | Quality assessment in individual studies

The Joanna Briggs Institute checklist was used given it has been deemed most appropriate for this use.[18,19]

2.5 | Summary measures and synthesis of results

We used an a priori "framework" informed by prior reading and team discussions to extract and synthesize findings.[20] We modified this following inductive analysis of emerging themes. All reviewers interpreted the data by creating hypotheses about the relationships between themes, testing these with the data.

3 | RESULTS

The database search yielded 2985 papers, including 787 duplicates. Forty-two were read in full and 21 included (Figure 1). Eleven were conducted in North America, seven in Europe and three in Australia and New Zealand (Table 2) and the studies interviewed 466 people. The participants in all but one study had a body mass index of more than 25 kg/m^2 but in most studies it was more than 30 kg/m^2 and in two studies participants identified themselves as overweight. There was a mix of purposive and opportunistic recruitment strategies (Table 2). Most studies had a tacit or explicit aim to assess what patients might want from future encounters and few focused on participants' responses to previous interactions with clinicians and none on particular encounters.

3.1 | Quality assessment

The studies were generally appropriately conducted (Table 3), although almost none commented on the context of the researcher or impact of the investigator on the study findings, hindering judgements of how the investigators may have influenced the results presented.

3.2 | Synthesis

There were nine themes and the data supporting these themes is presented in Appendix S2. The initial framework was expanded to include an emergent theme on the meaning of not discussing weight and the impact of the clinical environment.

3.2.1 | The meaning of not discussing weight

The overwhelming theme was that interactions between patients and doctors about being overweight and weight loss were rare. For participants, not discussing these issues had several meanings and was not simply neutral. The most profound was that people who were overweight felt stigmatized and assumed others, including the doctor, were judging them negatively. Some participants felt the doctors' silence reflected a perception that person was not worthy of their time, or as meaning being overweight was not a serious health risk. One report noted: "A man aged 30 increased his weight by 40 kilos in one year. He remarked that his GP, whom he saw regularly during this year, could have intervened. Instead, he imagined the doctor regarding him only as fat and lazy, and not worthy of comment."[33] Others regarded it as a failure of the doctor's duty to warn patients of future

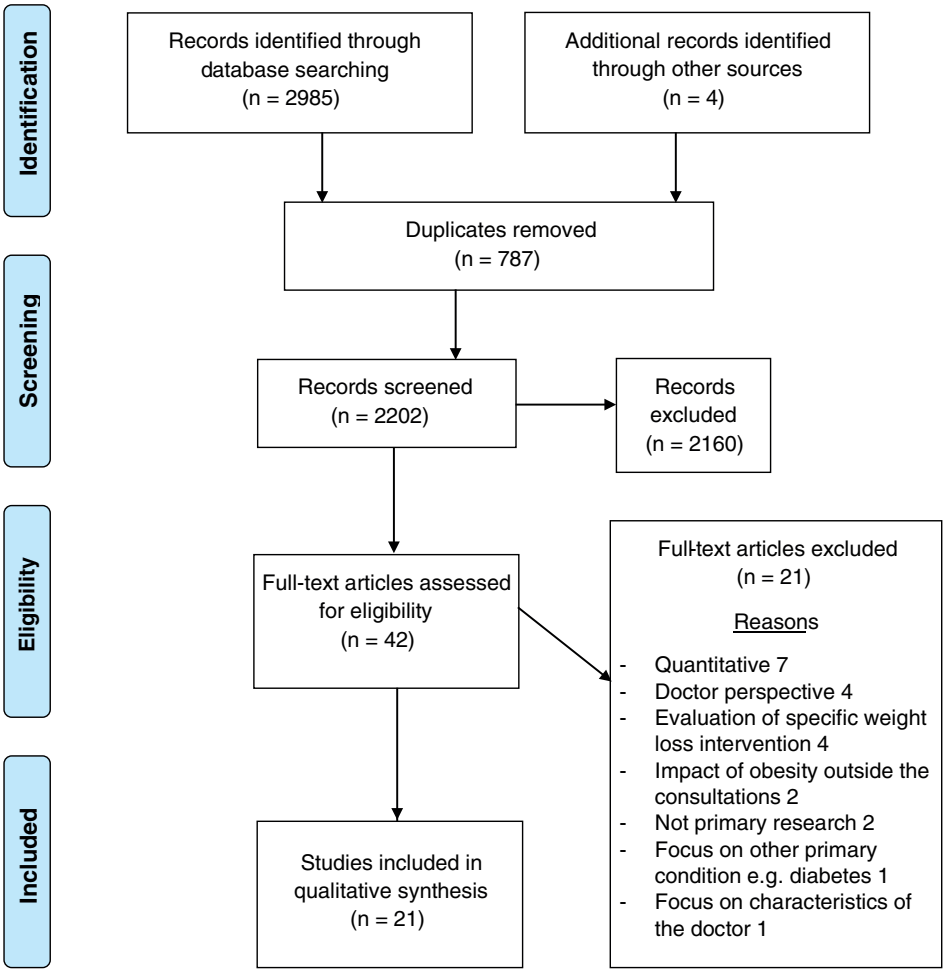

FIGURE 1 Prisma flow diagram

TABLE 2 Study characteristics

Author, year	Sample size	% (f)	Country	BMI	Methodological approach	Method of recruitment	Focus	Age range
Allen, 2015[21]	29	69	UK	≥28	Narrative analysis	Recruited purposively from attenders and non-attenders at a commercial weight loss programme as part of a randomized trial	Experiences of the weight loss programme	>18
Buxton, 2013[22]	26	100	United States	>30	Phenomenological approach using Colaizzi method	Not described though seems to have involved primary care	Experiences with regard to stigma in healthcare, including discussions with primary care clinicians	27-66
Brown, 2006[23]	28	64	UK	>30	Thematic analysis	Searching GP electronic records to find patients who had discussed weight with a GP followed by mail from GP.	Experiences discussing weight with primary care clinicians	>18 years
Chugh, 2013[24]	33	100	United States	>35	Thematic analysis	Advertising in health clinic/retail establishments	Experiences discussing weight with primary care clinicians	40-74
Ely, 2009[25]	31	100	United States	>30	Thematic analysis	Physicians in rural Kansas enrolled patients by personal invitation	Experiences discussing weight with primary care clinicians	>18
Forhan, 2013[26]	11	73	Canada	>30	Thematic analysis	Posters advertising study in GP waiting room	Experiences discussing weight with primary care clinicians	>18
Glenister, 2017[27,28]	7 patients	Not reported	Australia	Not given	Thematic analysis	Posters in public places and health clinics	Experiences discussing weight with primary care clinicians	>18
Gray, 2011[29]	34	47	UK	>25	Framework approach	Participants in an unrelated cohort study invited by letter	Reaction to words used to convey weight status	>35
Gunther, 2012[30]	9	89	UK	>25	Thematic analysis	GPs recruited patients that they had supported to lose weight	Experiences discussing weight with primary care clinicians	>20
Heintze, 2011[31]	15	73	Germany	>25	Content analysis	GPs were asked to recruit consecutive	Future of obesity care in primary care	43-72

(Continues)

TABLE 2 (Continued)

Author, year	Sample size	% (f)	Country	BMI	Methodological approach	Method of recruitment	Focus	Age range
						patients from who a purposive sample was selected based on gender and BMI		
Janke, 2016[27]	30	20	United States	Mean = 37	Thematic analysis	Referred by clinicians and posters in the clinic	Management of chronic pain in the context of obesity	87% aged ≥50 years
Leske, 2012[32]	21	67	Australia	>25	Grounded Theory	Advertising in health clinics and on radio	Searching for empowering clinician-patient relationship to influence weight	20-70
Malterud, 2010[33]	13	62	Norway	>40 or BMI > 35 with additional weight related problems	Thematic analysis	Participants were taking part in an obesity programme	Experiences discussing weight with primary care clinicians	30-55
Merrill, 2008[34]	8	100	United States	Self-identified as overweight	Hermeneutic phenomenology	Newspaper and community advertisements	Feminist understanding of women's experiences of interacting with clinicians	>18
Russell, 2013[35]	10	100	New Zealand	Self-identified as overweight	Thematic analysis	Local newspaper advert, recruitment through local primary care organization, and snowballing	Feminist understanding of women's experiences of interacting with clinicians	>18
Seaton Banerjee, 2018[36]	20	100	United States	≥30	Thematic analysis	Patients who had lost 10% of body weight identified from GP records	Experiences discussing weight with primary care clinicians	18-64
Stewart Higgins, 2010[37]	10	100	United States	≥30 (mean = 42)	Thematic analysis	Clinicians referred patients	Experiences discussing weight with clinicians	Mean = 51
Torti, 2017[38]	28	68	Canada	≥25	Thematic analysis	Participants who had participated in a primary care weight loss programme	Experiences of the weight loss programme	>18, median age 58
Visram, 2009[39]	20	75	UK	>25 with co-morbidity	Thematic framework	All participants referred by clinicians to a weight loss programme were invited to take part and those who completed a reply slip were enrolled	Weight management generally	21-70

(Continues)

TABLE 2 (Continued)

Author, year	Sample size	% (f)	Country	BMI	Methodological approach	Method of recruitment	Focus	Age range
Ward, 2009[40]	43	63	United States	>30	Thematic analysis	Consecutive attenders recruited opportunistically or referred by GP after consultation	Experiences discussing weight with primary care clinicians	18-65
Woodruff, 2018[41]	40	100	United States	Mean 30.9, range 18.8-73.2. 67.5% BMI > 25	Thematic analysis	Posters and in-person recruitment	Young women's feelings about their weight	20-29

Abbreviation: BMI, body mass index.

health problems related to excess weight. Some speculated that if the doctor had raised the issue of weight and set a goal, they would have been more motivated to try to achieve it than if they were losing weight only for themselves; "At least bring it up once in a while. "How are you doing with it?."[24] Participants reported that when a doctor had remarked on even small weight losses, this served as a potent motivator to further efforts to lose weight.

3.2.2 | Initiating the discussion about weight

There was uncertainty and mixed views about whose responsibility it was to bring up weight in a consultation. Some participants thought doctors ought to ask permission to discuss weight before starting a substantive conversation on the topic. However, no participants reported clinicians ever doing this nor did anyone report a negative reaction to the fact that clinicians had not done so. There was evidence in several studies that participants wanted clinicians to initiate the discussion of weight, in part motivated by shame at being overweight and an inability to lose weight. "Just say, we are concerned for your health and as your weight gets higher these are some of the complications. Say, I am your doctor and I am concerned about you and I want to make sure we don't have to deal with these complications. If I was a car going to my mechanic, the mechanic would not have a problem saying this is what is wrong with your car and this is what you need to do to fix it and why."[26]

3.2.3 | Using the word "obese"

Where it was mentioned, most participants reacted negatively to doctors describing them as obese. For most, it seemed to carry its lay meaning of being enormously overweight and be associated with other negative qualities; "When I hear the word 'obesity' I feel discriminated against. The first thing they think is that you eat all day. The second thing they think is that you're lazy, you smell."[40] In some cases the word demotivated participants to lose weight because they felt hopeless. A few recognized the technical meaning of obese and that using this term did not convey negative judgement; "If it's a doctor or a nurse then they're qualified to say that, whereas if it's a friend I think it's more of an opinion."[29] One person felt that its use in a consultation may have been instrumental in her deciding to take action on her weight.

3.2.4 | The tone of the consultation

The tone of voice and manner in some consultations created negative feelings for many participants, which undermined motivation to lose weight. Some women in one study reported that they had deferred consultations that would involve exposing their body because of past comments from clinicians. "Of those currently overdue for routine cervical screening, most had a history of experiences with a smear taker who made inappropriate comments, grunted and sighed excessively or demonstrated facial expressions that implied the women were a nuisance; some had even been told that it would be a lot easier if they were smaller."[35] Participants wanted doctors to sound like they cared for them as a person. Some participants reported that this was indeed their experience, with doctors being described as "open" and "there for me" and participants had often experienced both types of encounters with different doctors.

3.2.5 | Clinicians' advice that patients regard as banal and unhelpful

In some consultations, doctors had given direct weight loss advice but responses varied. A recurrent theme across studies was that doctors often assumed a person who was overweight must have an unhealthy diet. These assumptions reflected a common belief that people who are overweight eat a lot of "junk food" and are not physically active. Doctors had sometimes offered advice that participants felt was banal, which carried the implication that a participant was stupid not to have already thought of this and enacted it. "Frequently, they just

TABLE 3 Summary table for quality assessment using the Joanna Briggs Institute Checklist

Congruity	Paper																						
	Allen, 2015[21]	Buxton, 2013[22]	Brown, 2006[23]	Chugh, 2013[24]	Ely, 2009[25]	Forhan, 2013[26]	Glenister, 2017[27,28]	Gray, 2011[29]	Gunther, 2012[30]	Heintze, 2011[31]	Janke, 2016[27]	Leske, 2012[32]	Malterud, 2010[33]	Merrill, 2008[34]	Russell, 2013[35]	Seaton Banerjee, 2018[36]	Stewart Higgins, 2010[37]	Torti, 2017[38]	Visram, 2009[39]	Ward, 2009[40]	Woodruff, 2018[41]
Congruence of philosophy with methodology	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Congruence between methodology and objectives	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Congruence between methodology and methods	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	–	–
Congruence between methodology and analysis	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Congruence between methodology and interpretation	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Context of researcher	–	–	–	–	–	–	+	+	–	–	–	–	–	+	–	–	–	–	–	–	–
Impact of investigator	+	–	–	–	–	–	–	+	+	–	–	–	–	–	–	–	–	–	–	–	–
Representation of participants in results	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Ethical approval	+	+	+	+	+	+	+	+	–	+	+	+	+	+	+	+	+	+	–	+	+
Conclusions represent data	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+

Note: +, criterion met; –, criterion not met.

jump to conclusions: "eat less, move more." But nobody really asked me what I actually was eating and what my daily activities had been. Nobody asks—they just know the answer."[33] Some participants reported that they had made sincere and determined, yet unsuccessful, efforts to lose weight and had found doctors did not believe that they had tried, leading to an impasse. Alternatively, acknowledging weight loss efforts and reacting positively was reported as sustaining motivation.

3.2.6 | Responses to offers of help

The studies provided very little evidence on patients' reactions to clinicians' advice because they reported few consultations where active weight loss help was offered and discussed. Participants reported that they wanted to be listened to and offered a range of options for weight loss. The amount of time allocated to weight discussion related to participant satisfaction. Participants reported contrasting experiences between doctors with "time to do it properly," compared to others who rushed and simplified the topic, leaving participants feeling dismissed.

3.2.7 | Linking weight to medical disorders

Across the studies, many participants reported attending consultations with symptoms that may have been related to excess weight. However, their experience was that the symptoms were immediately presumed to be weight-related, sometimes without a history or examination; "It got to the point that everything about you was your weight. Whether you were sick, whether you went in for something like an infection on your leg—everything was about the weight"[35] This left participants feeling dismissed and anxious that a more serious cause for their symptoms might go undetected. Participants also knew that losing excess weight is a slow process and unlikely to improve their symptoms in the short-term. They felt that they had been denied other treatments and were being made to suffer in a punitive manner because of their weight.

Participants had mixed views about risk communication. Some expressed a wish to be told about risks of future weight-related non-communicable disease in a matter-of-fact manner but threatening or scolding by doctors was not appreciated. However, some participants expressed a view that doctors ought to be able to know who would respond to fear-arousing messages and who would not, though only one participant claimed to want to be scared himself. Participants reported having consultations about weight loss as a means to avoid chronic weight-related disease, but more commonly this was discussed only on diagnosis of such a disease. One participant reported this increased motivation to act. Some participants reported that it was only on confirmation of the disease that the risk seemed real. Others reported that they had been warned and so could not blame the clinician for them developing such a problem.

3.2.8 | Clinician factors

Participants found discussions about weight loss and being overweight were easier with a clinician they trusted and that this trust motivated them to act on the doctor's advice: "I've been going to her for twelve or thirteen years…I have to say that she is really a doctor I trust (…). So you do have to have a certain bond of trust [to talk about overweight]."[31]

A clinician's weight status is obvious to patients, but participants only rarely commented on this as being relevant. Where they did so, participants had mixed views on whether they would prefer to see a clinician who was overweight her- or himself or would value advice more from a clinician who was slim and therefore "successful." One participant reacted negatively to a clinician who claimed to have understood her difficulties when the clinician had no experience of being overweight herself; "Saying you understand when you don't is a lie. You don't understand, you can't understand because you never went through it. It's strange how words can have such a large effect."[26]

3.2.9 | The clinical environment

Some features of the clinical environment could make participants who were particularly overweight feel uncomfortable and different, for example chairs or blood pressure cuffs being too small. Participants felt stigmatized and discriminated against when clinicians remarked on not having the appropriate equipment to hand or available at all. "No one likes to hear, well, oh, we have a larger cuff that we will use to take your blood pressure today. That can be awkward particularly if they say, oh, just a minute, I need to get the larger cuff."[26]

4 | DISCUSSION

Participants had only occasional interactions with clinicians about their weight and the most salient and most commonly reported, were negative experiences. Not discussing weight could trigger negative emotions through perceived stigma. Where interactions addressed weight, the language used, the tone of the consultation, and the nature of the advice were critical. Participants reported being given advice that was unhelpful or that implied they were stupid. On occasions, participants reported discussions about weight loss options available and this was universally appreciated. The health risks of obesity appeared to have been relatively often discussed. While there were mixed views on how these should be presented, no one appreciated being scolded about being overweight or made to feel personally responsible for symptoms potentially related to weight. Some participants felt their health problems were dismissed as obviously weight-related and left unexplored and untreated as a result.

4.1 | Strengths

The strengths of the study include the rigorous search criteria and systematic approach to analysing and synthesizing the existing data. Qualitative meta-synthesis has been criticized because, in summarizing evidence across studies, it may obscure the important context of the original research.[42] However, a reflective integration of evidence from across qualitative studies can "reveal a more comprehensive and integrated understanding of that which constitutes a larger theoretical whole."[43] We believe we have been able to provide a richer overview of peoples' experience of excess weight discussions than any individual study by comparing findings across research settings and providing results that can be applied across a wide range of primary care settings.

4.2 | Limitations

There was important heterogeneity between studies in healthcare settings, participant characteristics, and the study methods. Although one might assume context to be crucial, we actually found striking consistency of themes across settings, social groups, and research methods. Using an a priori framework could limit the findings, but we adapted ours using inductive analysis. Most studies recruited participants through advertisement, so may have attracted people with stories to tell about being overweight and its impact on their lives. This may mean that many people who were overweight and did not have particularly salient experiences were not interviewed. In general, patients expect to be treated with dignity and respect by clinicians and, when this occurs, this may not be as remarkable as when this respect is not accorded. This could explain the preponderance of negative experiences being related. These studies generally had a broad scope of enquiry and were not specifically focused on the clinical encounters, so the information related to consultations was limited. This synthesis therefore brought forward reactions to clinical encounters that were often buried in the original investigations. Many studies were oriented towards service improvement, meaning that they tacitly or explicitly encouraged participants to discuss what they may find helpful, rather than reporting experienced encounters, which limited data availability. The studies did not report deeper enquiries into patients' reactions, so that underlying reasons why some of these consultation factors pertain was not apparent. We might speculate, for example, that trust has built up from evidence that a clinician is on the patient's "side," so that when trusted clinicians offer weight loss support, patients presume this to be motivated by the clinician acting in her/his best interests. However, there were few instances of probing to understand the factors underlying these responses.

4.3 | The theme of stigma

It is possible to integrate most of the themes derived from participants' accounts through the lens of stigma, as described by Goffman.[44] He postulated that stigma related to managing spoiled identity, which being overweight is an example of in our society, where being overweight is viewed as a failure of self-control. The solution to being overweight is located within the person, rather than

as a function of biology interacting with the macro-level social and political forces that shape societal values fail to regulate the market.[45,46] Perceived stigma explains why not discussing weight, when both the clinician and patient know it is relevant to health, can be viewed as negative. Failure to address weight could represent a perceived devaluing of the patient by the clinician and generates in her or him feelings of shame and unworthiness. Similarly, responses to active intervention, such as advice to lose weight, could also reflect the stigma of obesity. Advice that is banal, which might otherwise be shrugged off as unhelpful, acquires its emotional charge from the notion that a person is not trying to look after her- or himself. Conversely, discussing a range of options available or noticing minor weight changes acknowledges the will and the effort to change, which has a moral valence because it indicates active efforts to manage stigma. Using the word obese or not having appropriate equipment draws attention to the otherness of the patient, which, through this stigma lens, is connoted with a negative judgement. Likewise, stigma appears reflected in the reported practice of some clinicians towards people with obesity by allowing jokes and inappropriate comments. That obesity is an important risk factor together with the belief that obesity is a failure of willpower appears to reflect in clinicians' "harsh" words that criticize, scold, or offer banal advice and that patients regard as demeaning.

4.4 | Relation to other literature

To our knowledge, two previous reviews have covered this same area, which integrated practitioner and patient perspectives and published in 2015 and 2011.[47,48] Only two studies in the 2015 review concerned patient perspectives, both of which were included in our review. The synthesis focused on the roles and responsibilities of practitioners, rather than on the content of the consultation. Like our synthesis, stigma emerged as an organizing construct, albeit more directly from the seven studies that had interviewed practitioners that were included in that review. Those studies included examples of practitioners making disparaging remarks about people with obesity and doubting the ability of people with obesity to achieve change. The 2011 review comprised mainly survey data and again documented evidence that practitioners have negative or ambivalent feelings towards people with obesity.

4.5 | Implications for practice

Importantly, many patients were keen to discuss weight with their clinician, despite previous negative experiences. We know that most people who are overweight are taking action to try to lose weight and, over the short-term, are likely to lose weight, while people who are a healthy weight are likely to gain weight.[49,50] It may be helpful to start a discussion with the assumption that a person may well be taking action and that what is required is guidance and encouragement towards more effective interventions. Moreover, clinicians might consider that a person's harshest critic of weight status could well be the person her- or himself and avoid statements that may be interpreted as a judgement carrying moral connotations.[45] It remains uncertain how best a clinician might link a person's weight to their health. The study on smoking where there was clear evidence that this was unhelpful was very different from these studies.[13] The smoking study was based upon conversation analysis of consultation recordings, not reflections over a lifetime of consultations, as was in the studies in this review. Nevertheless, there was sufficient concern raised to merit further investigation of this issue, perhaps best by analysing consultation recordings. In the meantime, it may be best for clinicians not to assume that the only appropriate time to raise a person's weight is in the context of presenting with a weight-related illness and there is evidence that doing so outside this context is well-received by patients.[12] If clinicians are to intervene on weight in the context of weight-related illnesses, then it is likely to be important to be seen to consider other possible causes and to focus on solutions to the problems the patient faces rather than its causes.

5 | CONCLUSIONS

The stigma of obesity means not discussing weight can connote a negative judgement on a person. Brief advice predicated on untested assumptions about eating or activity or that overlooks the efforts many people are already making to lose weight is received negatively and may undermine motivation to lose weight. Clinicians should take care when linking weight to a presenting medical issue and discuss weight loss as one of a range of treatment strategies rather than presenting excess weight as the cause of the problem and weight loss as the only cure. Patients are likely to respond well to clinicians enquiring into current efforts to lose weight, even if this discussion is initiated unrelated to a current health problem. Weight loss discussions are more likely to be successful when they involve a trusted clinician, who gives time to share options for weight loss in a non-judgemental manner.

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CONFLICTS OF INTEREST

PA is a co-investigator on an investigator-initiated trial examining the effectiveness of a total diet replacement programme funded by Cambridge Weight Plan. PA has spoken at a clinical symposium on weight management funded by Novo Nordisk. Neither activity led to

payments to him personally. All other authors have no other competing interests.

AUTHOR CONTRIBUTIONS

TA and PA conceived the article and all authors contributed to the protocol, data extraction, and data analysis and write-up.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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