

Clinical encounters about obesity: systematic review of patients' perspectives

Authors

Thanusha Ananthakumar, Nicholas R Jones, Lisa Hinton, Paul Aveyard

Affiliation

Nuffield Department of Primary Care Health Sciences

University of Oxford

Radcliffe Primary Care Building

Radcliffe Observatory Quarter

Woodstock Road

Oxford OX2 6GG

UK

Corresponding author

paul.aveyard@phc.ox.ac.uk

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 internalise weight stigma sensitising 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.

Key words

Obesity, primary care, qualitative synthesis

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 stigmatising 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 criticised 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.

Methods

We synthesised qualitative studies. The review was conducted following PRISMA and ENTREQ criteria using Word software.[16, 17] The protocol was pre-registered on PROSPERO (CRD42015026734).[18] It was implemented with one clarification of intent, where we excluded reactions from consultations in a weight management clinic or in pregnancy care.

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.

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.

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.

Quality assessment in individual studies

The Joanna Briggs Institute checklist was used given it has been deemed most appropriate for this use.[19, 20]

Summary measures and synthesis of results

We used an a priori 'framework' informed by prior reading and team discussions to extract and synthesise findings.[21] 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.

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 BMI of more than 25 kg/m² but in most studies it was more than 30 kg/m², 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.

Quality assessment

The studies were generally appropriately conducted (Table 2), 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.

Synthesis

There were nine themes and the data supporting these themes is presented in Appendix 2. The initial framework was expanded to include an emergent themes on the meaning of not discussing weight and the impact of the clinical environment.

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 stigmatised 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.' [26] Others regarded it as a failure of the doctor's duty to warn patients of future 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?"*. [23] 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.

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”*[22]

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.”*[24] In some cases the word demotivated participants to lose weight because they felt hopeless. A few recognised 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.”*[25] One person felt that its use in a consultation may have been instrumental in her deciding to take action on her weight.

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.’*[27] 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.

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 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."*[26] 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.

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.

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”*[27] 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.

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].”*[28]

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."*[22]

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 stigmatised 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."* [22]

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.

Strengths

The strengths of the study include the rigorous search criteria and systematic approach to analysing and synthesising the existing data. Qualitative meta-synthesis has been criticised because, in summarising evidence across studies, it may obscure the important context of the original research.[29] 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'.[30] 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.

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.

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.[31] 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.[32, 33] 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 criticise, scold, or offer banal advice and that patients regard as demeaning.

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.[34, 35] 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 organising 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.

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.[36, 37] 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.[32] 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.

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.

Contributors

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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Competing interests

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.

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Figure 1 PRISMA flow diagram

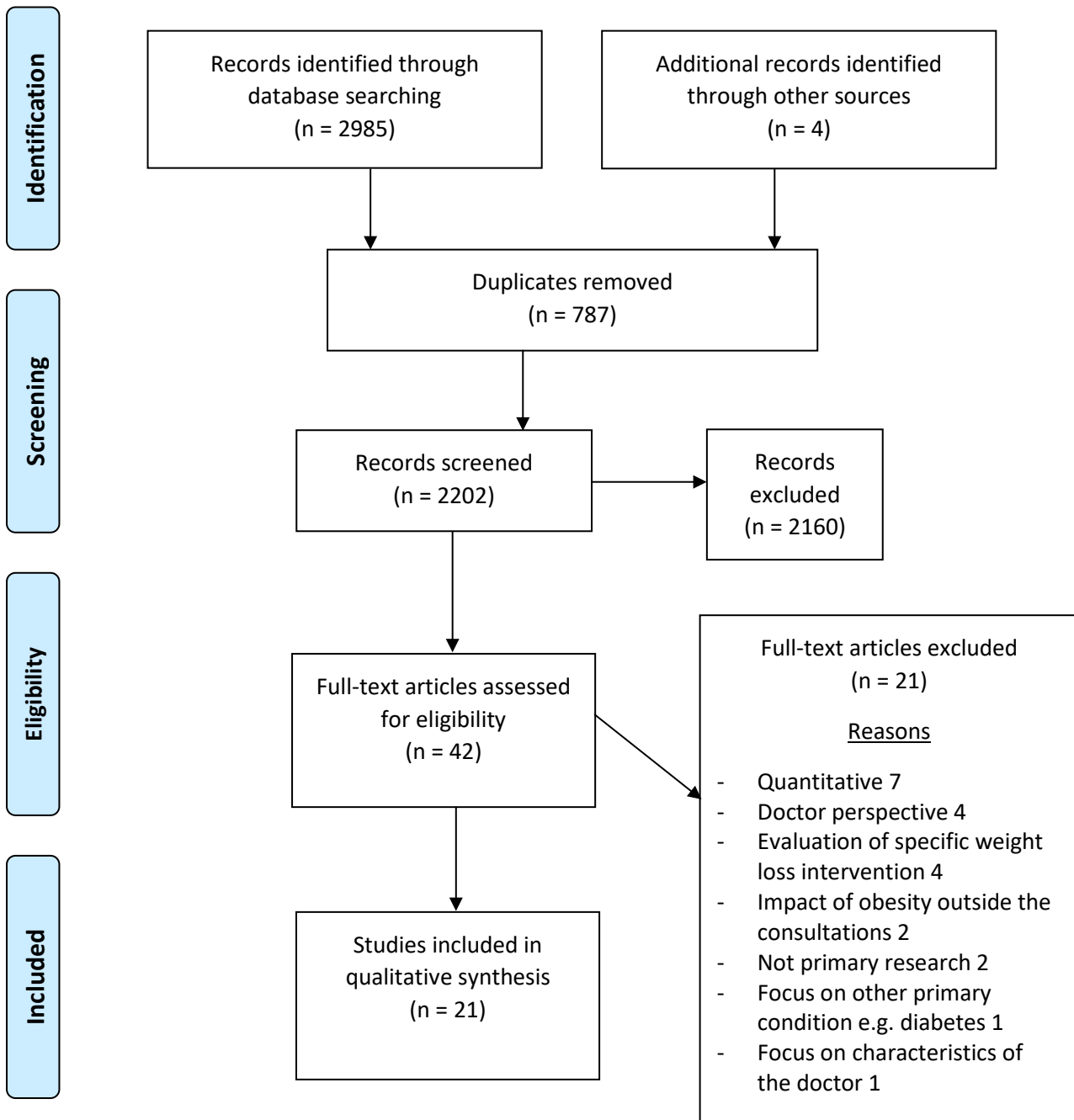


Table 1: Databases searched

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

Table 2: Study characteristics

Author, year	Sample size	% (f)	Country	BMI	Methodological approach	Method of recruitment	Focus	Age range
Allen, 2015[38]	29	69	UK	≥28	Narrative analysis	Recruited purposively from attenders and non-attenders at a commercial weight loss programme as part of a randomised trial	Experiences of the weight loss programme	>18
Buxton, 2013[39]	26	100	USA	>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[40]	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[23]	33	100	USA	>35	Thematic analysis	Advertising in health clinic / retail establishments	Experiences discussing weight with primary care clinicians	40 - 74
Ely, 2009[41]	31	100	USA	>30	Thematic analysis	Physicians in rural Kansas enrolled patients by personal invitation	Experiences discussing weight with primary care clinicians	>18
Forhan, 2013[22]	11	73	Canada	>30	Thematic analysis	Posters advertising study in GP waiting room	Experiences discussing weight with primary care clinicians	>18
Glenister, 2017[42, 43]	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[25]	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[44]	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[28]	15	73	Germany	>25	Content analysis	GPs were asked to recruit consecutive patients from who a purposive sample was selected based on gender and BMI	Future of obesity care in primary care	43 - 72
Janke, 2016[42]	30	20	USA	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[45]	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[26]	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[46]	8	100	USA	Self - identified as overweight	Hermeneutic phenomenology	Newspaper and community advertisements	Feminist understanding of women's experiences of interacting with clinicians	>18
Russell, 2013[27]	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[47]	20	100	USA	≥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[48]	10	100	USA	≥30 (mean=42)	Thematic analysis	Clinicians referred patients	Experiences discussing weight with clinicians	Mean=51
Torti, 2017[49]	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[50]	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
Ward, 2009[24]	43	63	USA	>30	Thematic analysis	Consecutive attenders recruited opportunistically or referred by GP after consultation	Experiences discussing weight with primary care clinicians	18-65
Woodruff, 2018[51]	40	100	USA	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

Table 2 Summary table for quality assessment using the Joanna Briggs Institute Checklist

Paper	Allen, 2015	Buxton, 2013	Brown 2006	Chugh 2013	Ely 200920	Forthan 2013	Glenister, 2017	Gray 2011	Gunther, 2012	Heintze 2011	Janke, 2016	Leske 2012	Malterud 2010	Merrill 2008	Russell, 2013	Seaton Banerjee, 2016	Stewart Higgins 2008	Torti, 2017	Visram 2009	Ward 2009	Woodruff, 2018
Congruity																					
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	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+

+ criterion met, - criterion not met

Appendix 1 Search strategy (for Medline)

1. exp Overweight/
2. overweight.ti,ab.
3. obes*.ti,ab.
4. body mass index/
5. ("body mass index" adj3 high*).ti,ab.
6. ("body mass index" adj3 >25).ti,ab.
7. ("body mass index" adj3 "25").ti,ab.
8. ("body mass index" adj3 "26").ti,ab.
9. ("body mass index" adj3 "27").ti,ab.
10. ("body mass index" adj3 "28").ti,ab.
11. ("body mass index" adj3 "29").ti,ab.
12. ("body mass index" adj3 "30").ti,ab.
13. ("body mass index" adj3 "31").ti,ab.
14. ("body mass index" adj3 "32").ti,ab.
15. ("body mass index" adj3 "33").ti,ab.
16. ("body mass index" adj3 "34").ti,ab.
17. ("body mass index" adj3 "35").ti,ab.
18. ("body mass index" adj3 "36").ti,ab.
19. ("body mass index" adj3 "37").ti,ab.
20. ("body mass index" adj3 "38").ti,ab.
21. ("body mass index" adj3 "39").ti,ab.
22. ("body mass index" adj3 "40").ti,ab.
23. fat.ti.
24. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23
25. Primary Health Care/
26. exp General Practice/
27. general practitioners/ or physicians, family/ or physicians, primary care/
28. general pract*.ti,ab.
29. family physician*.ti,ab.
30. Family Practice/
31. family pract*.ti,ab.
32. exp Nurse Practitioners/
33. nurse practi*.ti,ab.
34. (nurs* adj3 practi*).ti,ab.
35. Office Visits/
36. office visit.ti,ab.
37. clinic.mp.
38. clinics.mp.
39. 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38
40. qualitative research/
41. qualitative.ti,ab.
42. interview/
43. interview*.ti,ab.
44. Focus Groups/
45. focus group*.ti,ab.
46. Questionnaires/
47. questionnair*.ti,ab.
48. 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47
49. 24 and 39 and 48
50. Body Image/
51. body imag*.ti,ab.
52. experience.mp.
53. experienc*.ti,ab.
54. exp Motivation/
55. motivat*.ti,ab.
56. Perception/
57. percei*.ti,ab.

58. percep*.ti,ab.
59. barrier.mp.
60. barrier*.ti,ab.
61. attitude/ or exp "attitude of health personnel"/ or exp attitude to health/
62. 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61
63. 49 and 62
64. limit 63 to "all adult (19 plus years)"

Appendix 2 Direct quotes from the authors, often including direct quotes from participants illustrating the themes

Meaning of not discussing weight

Implies a doctor's negative judgement of the person

Participants described carrying pre-conceived thoughts about health providers' beliefs and attitudes toward persons with obesity with them to their visits. Although these thoughts were not always directly triggered by an experience with the family health team, the thoughts accompanied the participants to every clinical visit. *'I guess I wonder if they may think why I don't make the extra effort. That might be on the back of their head but they never actually say so. But, you get good at reading people when you are obese. You see it and you kind of know what they are thinking'* (participant 4) FORHAN[22]

About two-thirds felt that nothing had ever been said in explanation of why weight had been gained. In this relative vacuum of explanations participants would fill in the gaps themselves with a strong tendency to imagine the worst must be thought of them:

BROWN[40]

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. MALTERUD[26]

Others perceived that providers did not inquire about comorbid pain or weight symptoms, and viewed this as a lack of compassion and engagement with their medical care. JANKE[42]

Implies not a serious health problem

Participants described feeling as if their obesity was ignored as a health concern and that this was an indication that it was not an important issue to be addressed. 'I am looking at myself and thinking, this can't be right. Why are the red flags not going up in their head? I guess if he or she is not worried about it (obesity) why should I be worried about it' (participant 3) FORHAN[22]

Doctor is failing in their duty.

They wanted their providers to clearly explain which risks were most pertinent to them as individuals. "If you know what this person is predisposed to then you can try to steer them away from the things that will complicate the situations that they already have." WARD[24]

Undermines or supports motivation to lose weight

I've often thought that if he (i.e. PCP) would say to me, "Before you come in again, I would like to see three pounds." I mean I need to set a goal. But if he (i.e., PCP) sets a goal, I think I might be more apt to strive for that because I wouldn't want to let him down." ELY[41]
[It would be helpful if the doctor said] "I need you to lose this amount of weight in this amount of time." "I don't know what my weight goal to help the diabetes is." WARD[24]

However, they noted the need for added encouragement from their physician to help foster their own self-motivation: 'At least bring it up once in a while. "How are you doing with it?"' CHUGH[23]

Further, participants reported an appreciation of verbal recognition from their providers regarding small amounts of weight lost (even 2 to 3 pounds) and that this recognition served as a potent motivator to continue with their weight loss efforts. WARD[24]

'Participants were encouraged to continue their efforts at weight loss when the physician noticed small weight losses and positive behavior changes. QUOTE It's more encouraging when you have a doctor tellin' you, "You're doing good, keep up the good work...." It's nothing like a doctor standing behind you, encouraging you. [My doctor] was proud, when he saw the weight loss he called me, and he told me about it, and he was happy SEATON BANERJEE[47]

Using the word obese

Negative reaction to the word obese

Although many participants self-identified as being obese, there was universal dislike for the term used by a medical practitioner. For many it carried connotations of being grossly overweight and was associated with stigma. “There are all kinds of negative pictures of being obese.” “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.”

Apart from dislike, the use of the word in a medical context seemed to demotivate action.

Both men and women expressed feeling less motivated to attempt to lose weight and more frustrated and hopeless when physicians used the terms ‘obese’ or ‘obesity.’ WARD[24]

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. GRAY[25]

Calling [patients] ‘Obese’ I don’t think helps. It’s not quite insulting but it’s getting that way, and it’s got nothing to do with health GRAY[25]

I think that was one of the doctors in the [hospital] [...] They didn’t mean it unkindly. I think I had said something like, ‘Oh, I don’t even want to know what weight I am.’ And she said, ‘Well, you’re actually in the obese category now’ she said, ‘not morbidly obese, but obese.’ I just thought, ‘Oh no!’ , I just wanted the ground to open up and swallow me. GRAY[25]

Recognising the technical meaning

I’m educated enough now to know that being clinically obese actually is a lot less than what you would [think] GRAY[25]

“If I’m with my nurse then she’ll talk about weight issue or being a wee bit overweight. I’m not a wee bit overweight, I’m morbidly obese, but no professional that I sat with... my GP at

no point told me I was morbidly obese. [...] I think the new one, the new guy, he's really young, I think he mentioned the word 'Obese'; and this was just before I kind of started to lose weight" WARD[24]

Although all participants acknowledged that they were overweight, the vast majority with a BMI >30kg/m² did not recognise themselves as being obese. In contrast to themselves, participants described obese individuals in extreme terms such as 'elephantine', (Male, 63), 'housebound and [needing] someone else to wash them', (Male, 63), unable 'to get out of bed ... or go to the toilet', (Female, 34), 'like [you see on] these American [television] programmes', (Female, 59). Unlike the term 'overweight', patients associated 'obesity' with what they considered were far more serious health consequences. Therefore they expressed surprise when they were told that their weight would classify them as obese. As a result, some reported feeling more motivated to lose weight because their problem was suddenly one associated with ill health. ALLEN[38]

The tone of the consultation

“And if he showed some concern and passion...at least he’s caring about my health.”

WARD[24]

Physicians that were perceived to be threatening or scolding were also reported to be less effective. ‘Don’t scold me...’ WARD[24]

The majority of women [felt] that their doctors' approach to discussing weight was understanding and supportive, and further suggested their doctors were "open" to discussing weight issues. I think my doctor is willing to search any option and will support me with anything I try, even if I may gain 2-3 pounds. He doesn't beat me, he just says "You know how you lost it before, just pick it back up." I'm very satisfied with the support that I get from doctor... STEWART HIGGINS[48]

I'll compliment my doctor with, basically, being there...I appreciate the honesty. STEWART HIGGINS[48]

Participants indicated that they were more likely to have favourable weight related interactions with physicians who possessed certain qualities such as being: empathetic, sensitive, respectful, trustworthy, compassionate, non-judgmental, encouraging, honest, and comforting. STEWART HIGGINS[48]

‘I think just to be caring and understanding ... and really go out of their way to try to make them comfortable ‘cause they’re already uncomfortable with the way that they’re, you know, that they feel. So if they were to show some compassion and caring towards people that are overweight, I think that might be a good thing. That would be helpful.’ CHUGH[23]

Just the tone of their voice. Just have that caring attitude, the approach that they use towards you, you know, that you’re not someone with a plague or something. Just, you know, just to see a caring smiling face sometimes is, you know, is good enough when it

comes down to how you approach people so it doesn't have to be, you know, with an attitude or just being nasty for no reason. People have all kinds of illnesses. Obesity is one of them. CHUGH[23]

'Patients could recall occasions (sometimes decades previously) when a health professional had offended them when speaking about overweight' GLENISTER[43]

'there was distinct disappointment that weight bias was also something they had to face within the confines of a consultation with a medical professional. QUOTE: It's this old judgmental thing coming in to it. They don't have the right to do that. Everybody is equal, doesn't matter what size they are, what culture, what anything... you know, stop doing that. You're a professional. You've been trained in medical school for how long to help people... a person who judges people because they are big, to me, is narrow minded and shouldn't be in the profession because that's not what they are there for. (#8) . RUSSELL[27]

Several women disclosed incidences when their general practitioner had made inappropriate 'jokes' about their size. One woman shared the following comments made to her in the course of seeking care from her previous GP: QUOTE Have you tried swimming? Cos you would definitely float! QUOTE Did you think you would bounce? [post a fall with suspected fracture] QUOTE You're healthy, no undernourishment there! QUOTE Pheeww there is a lot of you. You're a big girl. . RUSSELL[27]

She reflected on these experiences and stated: QUOTE The GP sort of joked about my weight like it was an 'in joke' between the two of us—but [he/she] was the only one laughing. (#2) . RUSSELL[27]

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. RUSSELL[27]

Part of it is how they talk to you. [My doctor] he talks to you like someone who actually cares. And if he doesn't understand your answer you gave him, he's actually listening to you enough, even if he's looking at the screen, to say, "Ok, the doctor you saw last time said this, and what I think you said to me is this, and they don't seem to be telling me the same thing. What am I missing, here?" type thing. He acts like he listens. JANKE[42]

Many of the women in this study admitted to either delaying or avoiding personal examinations, such as cervical smears and breast examination, fearing embarrassment and potential humiliation with body exposure. Only two women stated that they felt comfortable to approach their HCP for a personal examination. QUOTE I choose not to go for certain things. I will avoid anything that will expose my imperfect body or go to the utmost extreme lengths... smears and all that exposing type thing unless I really have to. Probably it's due to the fact of how many bad times I've had with people that I just don't feel comfortable... you're constantly looking for responses. (#1) RUSSELL[27]

Women in this study want PCPs to know who they are and to see them as people, not numbers on charts or as only obese women. It is important to these women that their PCPs know their personal and health histories... "Care should be very personal.... PCPs are very personal. They are interested in how you are doing and what you are saying... they [PCPs] know your story. I think that is the most important thing." BUXTON[39]

If the PCP did not provide the care the women wanted, they were assertive enough to seek another provide. One participant described her assertiveness this way: "My previous PCP said he could handle obese people, but really and truthfully, deep down, he didn't like

obesity. I was an extra burden to him.... I found another PCP who can handle me and who cares about me." BUXTON[39]

Clinicians' advice that patients regard as banal and unhelpful

Some experiences dealt with feelings of not being believed by the doctor when participants had reported their efforts since the last visit. Several of them admitted that although their eating problems represented some level of self-deception, they felt belittled when the doctor dismissed their presentation of programme compliance. A man who had experienced bullying due to his weight over several years, said: Frequently, they just 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. MALTERUD[26]

“The doctor said, ‘Well, your blood pressure is high. You need to lose weight’. And I said, ‘I realize that’. He said, ‘Well, you just have to stop eating’. And I said, ‘If it would have been easy for me, I would have done it a long time ago’. And he said, ‘Well, you just need to learn how to do that’. And so to me it was like an impasse...I walked out of there, and he told me what I needed to do, and I thought, ‘The hell I will!’ (laugh)...So just because he treated me so pathetically, like I was just a nothing, so I changed internists.” MERRILL[46]

Participants expressed a desire for their physicians to recognize their efforts even when they were unsuccessful. Physicians who were interpreted as making the assumption that their patients were not trying or didn't care about themselves were perceived to be acting as another barrier to weight loss attempts. Conversely, patients felt encouraged to continue lifestyle changes when their doctors acknowledged their efforts. “That you are making an effort and they act like they don't believe it.” WARD[24]

“When it looks like a person is not losing weight or they're not doing anything, the worst thing you could do is stop being supportive to that person.”

“Even if we say we're doing it and you came back a month later and you didn't lose any weight, then it's sad if they say ‘you're not trying.’” WARD[24]

Degrading or moralizing attitudes and messages were reported by participants as especially subversive when they came from doctors, who were expected to mediate between support and compassion. Various stories were told of GPs whose communication was perceived as humiliating. Examples were contemptuous or suspicious comments when vigorous lifestyle efforts from the patient did not lead to the expected results, indicating that the patient was, after all, a lazy or a greedy person who would never be capable of achieving any goals.

MALTERUD[26]

At the first level a health professional had pointed out (and often continued to point out), that their weight was a 'problem': raising awareness but little more. There was dissatisfaction within our sample about this, particularly where it was not followed up by more practical advice and support: 'I suppose I feel a bit disappointed really because there I am trying to lose weight and just being told, "you need to lose weight", and ... that's it.

There's no follow through with it.' BROWN[40]

But they [doctors] are not listening when I say...that I don't drink soda and I don't eat fast food...that I don't do that, I do this. I feel like they are not listening. They don't care. It's like they are too busy to stop and listen. MERRILL[46]

She [GP] said 'You've just got to be aware of what you eat', which is very easy to say ... she didn't really discuss it. – Patient 5. He [GP] didn't tell me anything new!– Patient 4

GLENISTER[43]

I remember this one explicitly [10 years ago], the anaesthesiologist ... she said I was lazy ... I didn't even know this person, I don't see why she had the right to even start commenting. –

Patient 5 GLENISTER[43]

Some participants expressed frustration about the banality of the information that was provided in primary care settings commenting that it did not extend beyond what they

already knew but struggled to apply in their daily life. As one participant stated, 'I mean I already knew everything...I know what I'm supposed to eat. I like spinach, I like turkey, fish, and chicken. I'm not a meat eater. I like vege-tables. That's how you're supposed to eat...I do eat that way. But then I screw up, okay?'(Pt #16).Similarly, others found information provided to be repetitive, uninteresting and/or to lack relevance to their everyday lives. One participant described information provided as 'Pretty generic... (Pt #4). 'All they gave me were some papers of the food groups and what I should and shouldn't eat. I'd throw that away. I knew I could eat what I wanted to eat, just have to eat less'(Pt #17) JANKE[42]

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QUOTE My family physician would give me the standard, 'Eat less fat, eat less sugar (chuckle), exercise more,'- and that's not going to cut it" (Patient 2) TORTI[49]

QUOTE "They were like, 'Okay, cut your calories and exercise, 'and that was their only thing...Eat less and exercise more isn't the end-all-be-all. I'm looking for more concrete strategies. TORTI[49]

Did she even ask what your diet was like before offering to refer you to a dietitian?

(Researcher) No. She assumed, because I am big... but I didn't go. (#8) RUSSELL[27]

Likewise, participants who were informed of their weight status but did not receive additional information from their PCP expressed frustration and abandonment.

they just told me, you know, "You're overweight. You gotta do something about it." I'm like,

"Okay, that's it? SEATON BANERJEE[47]

Responses to offers of help

'So, practical advice, none. I'd go as far as—not apart from the sheet ... the diet sheet — but then I appreciate how busy they are.' 'I think they are very busy and they've only got a limited time, so, you know, is it their job? Are they right in just saying, "Go away and lose weight,"? I don't really know. BROWN[40]

The primary concern was that physicians take enough time to counsel patients in detail.

WARD[24]

Primary care providers [should] possess the knowledge and skills necessary to manage obesity. WARD[24]

A man said that he had asked his GP whether anything would be helpful for him, and the doctor responded by asking him whether he was willing to put in great efforts. He said:

"Finally, someone stepped forward and took responsibility". MALTERUD[26]

Participants described how their efforts related to diets and exercise did not work without sufficient follow-up schedules. GPs had neither the time nor the enthusiasm for this kind of work, they thought. Follow-up was simply weight measurement, without talking with anyone. Such schedules were not experienced as a treatment plan, especially when appointments for further consultations were left to the patient's initiative. A 32-year-old man explained: For a period, I was enrolled in an activity group where weight reduction was a goal. Afterwards, my GP was expected to provide follow-up, with motivation and weighing. But after a while, she became so busy that she did not have the time to talk with me. I was put into a room on my own with the scale, expected to do the measurements myself. But the room was often unavailable due to lab tests, and I really felt dismissed.

MALTERUD[26]

Most of the women were satisfied with the amount of time their doctors spent with them discussing their weight. As expressed by one participant, "He'll talk about it as long as I want to. I don't feel like he's rushing me because he has somebody waiting. I feel like he's in tune and he's very personal. STEWART HIGGINS[48]

"He actually spends ample amount of time with me going over my weight and my other medical problems. If I need to see a dietician, he'll make an appointment to that dietician. If I feel I have a problem." STEWART HIGGINS[48]

In 10 of the 15 interviews, patients expressly stated their wish for a stronger involvement of GPs in comprehensive weight management. HEINTZE[28]

Participants who received specific advice on behavior changes, information handouts, and referrals to nutritionists reported that these were both helpful and empowering. QUOTE
She helped me out a lot just by talkin' and tellin' me different things to do. She gave me like a paper to do exercise and everything; to take home and just do the exercise. Well they broke it down to the point where they broke it down to the grams, to the, you know, to the portion sizes, to what could clog your arteries all this stuff. SEATON BANERJEE[47]

Participants who received specific advice on behavior changes, information handouts, and referrals to nutritionists reported that these were both helpful and empowering. SEATON BANERJEE[47]

Although a small minority of the women in the study did not feel that weight or weight control is the responsibility of the PCP, most women want a PCP to talk to them about their weight and offer ways to manage their weight. They appreciate specific guidance regarding diet and exercise and are encouraged when the PCP recognises weight loss efforts.

Therefore, many of the participants discussed the importance of having a PCP who is "up to date" on the current research and treatments for obesity. BUXTON[39]

Linking weight to medical disorders

Presuming that excess weight is the cause of symptoms

You go to the doctors and the first thing they say...you tell them you have an ingrown toenail—lose weight.” WARD[24]

“Don’t blame everything I talk about on my weight. My headache may not be because I’m fat.” WARD[24]

“Don’t scold me and tell me everything is due to the weight.” WARD[24]

They described being dismissed by healthcare professionals in many ways – from not being believed to receiving no treatment for their health complaints and having their weight addressed as the problem instead: “I had heard they could do wonders with arthritis...I went to a chiropractic doctor and he had me fill out a questionnaire and everything and took my weight and my measurements and took one look at me and said, ‘All you need to do is lose weight, and that would solve all your problems’. He didn’t bother with X-rays or an examination or anything (laugh), so it was amazing to me that he could know that just from reading over the questionnaire and looking at me. I weighed 230 pounds. The time it would take me to lose 80 pounds or so to get within a normal weight range – am I supposed to suffer all that time?” MERRILL[46]

A woman, visiting for back problems, had been told that a clinical examination was not necessary, since weight loss in any case would be the solution. She felt she was not allowed to mention that her symptoms had begun long before her weight increased. One of the men, a teacher in his forties, experienced a knee problem after an accident during exercise. He told what happened when he presented the symptoms: “It was slippery on the wooden path and I fell and twisted my knee. I saw my doctor because the knee was painful. Before I was given the chance to tell the story, she said– ‘you are terribly heavy’. His worries about

prostate cancer were not even given the time for discussion, because his problems were interpreted as obesity side effects by the doctor before any history was taken.

MALTERUD[26]

“I think there are some doctors who are more obsessed [with] everything that happens to you, ‘Oh, it’s your weight’. If there’s anything wrong with you, you see, she’ll put it all down to your weight and that gets me annoyed because ... just because you’re overweight and I ... you know, and you are overweight ... And so she used to really get my goat and I didn’t like going ... at all, I never liked going to see her, but ... and then it gets you a bit paranoid then, you see because then you think, ‘Well, nobody’s going to tell you what’s wrong if you’ve got something wrong with you because they’re putting everything down to your weight,’ and to me that’s wrong.” BROWN[40]

The women described their sense of frustration, anger and disappointment when their GP dismissed or belittled their presenting problems. Many felt that their body size distracted the GP’s attention away from the presenting complaint and erroneously placed their body size at the forefront of any diagnostic reasoning. QUOTE 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. (#2) RUSSELL[27]

It was nasty! [The GP said] ‘Do you want to see your kids grow up?’ It was quite harsh! I broke down in tears. – Patient 3 GLENISTER[43]

Non-communicable disease risk and weight loss and the risks of being overweight

They believed it is the physicians’ responsibility to initiate this discussion and to educate patients in a straightforward fashion about the impact of weight reduction on health.

Participants repeatedly stated that “ignoring it” was one of the worst things their doctors

could do. While most participants expressed an understanding of some of the health risks associate with obesity and a desire to be healthier and live longer, they wanted their providers to clearly explain which risks were most pertinent to them as individuals. Some participants reported that it was only after they developed a condition such as diabetes or heart disease and their physician discussed the connection to their weight that they finally understood. “If you know what this person is predisposed to then you can try to steer them away from the things that will complicate the situations that they already have.” WARD[24]

“Make you see exactly, even if it’s in the test results, what I’ve been trying to tell you has finally come, and this is what you need to do.” WARD[24]

“All the time she’s been telling me this, but until the lab work actually confirmed it, that’s what scared me. It wasn’t her scaring, but it was in black and white and I could actually see it.” WARD[24]

Both men and women had mixed reactions to the use of scare tactics by physicians for the purpose of encouraging weight loss. They felt that their physicians should be able to identify which patients might respond well to this tactic versus those who would respond negatively.

“I like to be scared. Scare me with all the bad things that can happen if I don’t lose weight.”

“I look at it as a threat. The only thing the doctor should do is encourage.” WARD[24]

A woman stated that when her diabetes was diagnosed her eating problems finally caught the attention of the doctor, who quickly referred her to group therapy. One of the male participants in his fifties said: “Seven years ago, my diabetes was diagnosed. Then suddenly my GP said that something had to be done, because he was competent on diabetes. I was sent to an education programme, and that was my first achievement. Finally, I received some help.” MALTERUD[26]

Physicians [sometimes] initiated discussion, particularly when co-morbid conditions, such as high blood pressure, were diagnosed : “She has, and that's when my diabetes.. .when I was first diagnosed with diabetes. That's when she really initiated, "you know you have to watch your weight" type thing. STEWART HIGGINS[48]

Mine just basically explains with my health. You know, they're good at that because I have arthritis, and he sat there and told me and said, "You got a choice. You can keep that pain in your knee or you can try to lose some weight off of it. I can't tell you no other way."

STEWART HIGGINS[48]

Referral by a health professional seemed to legitimize their concerns and ensure greater commitment to their weight management efforts. VISRAM[50]

Interviewer: “And what was it that motivated you to want to lose weight?”

Respondent: ‘The doctor telling you you’re not well. [...] when somebody says “you’ve got seriously high blood pressure and it’s your life” type of thing, you get off your backside and you try to do something about it.” VISRAM[50]

Some participants also perceived ambivalence on the part of health professionals and ambiguity in the communication about their weight as a health issue: “And maybe they were a bit embarrassed about bringing the subject up. I mean it didn’t bother me, but you know, maybe they just felt a bit embarrassed about bringing the subject ... I don’t know.”

BROWN[40]

“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” (participant 7) FORHAN[22]

A majority of participants reported feeling motivated to lose weight if their PCP discussed the impact of weight on health problems, including stopping, reducing, or avoiding medications. QUOTE When I walked out of his office, I said, “You know what? I’m just gonna do this [lose weight] because he sayin’ my blood pressure was really out of control, and the medication that they had me on was really too much.” SEATON BANERJEE[47]

Patients reported that health care providers gave direct advice to lose weight that was framed in terms of health-related concerns (e.g., the importance of maintaining a healthy weight during pregnancy, reducing existing pain, chronic disease prevention). Generally, women reported positive or neutral reactions to this advice, including being receptive to it, agreeing with it, or acting on it. WOODRUFF[51]

Initiating the discussion about weight

Some participants also believed that their doctors should first assess if patients want to discuss their weight and if they are at a point where they feel ready to and have a desire to make changes in order to lose weight. WARD[24]

Some participants noted that they looked to their doctors to help with weight loss and were currently working on this issue, while others stated the opposite. STEWART HIGGINS[48]

They believed it is the physicians' responsibility to initiate this discussion. WARD[24]

The stigma of obesity was an important influence on the patients' willingness to raise the issue of weight with their healthcare professional. Patient seeing the practice as a last resort. 'I don't want to go out and ask for the help, because they are ashamed of what their size is and things like that.' GUNTHER[44]

Similar calls for [the doctor to initiate the discussion] were raised by most participants, who had felt too shy to initiate discussions of their body weight with their GPs. Their own restraints did not mean they did not want to talk about it. MALTERUD[26]

Only four of the participants had presented with concerns about their size directly themselves. More typically participants reported reluctance and ambivalence about raising concerns about weight themselves even though concerns were present: "I didn't like going and asking again because I thought, 'Oh, he's going to think I'm a right ...' I don't know. 'Oh, she's not bothered,' and I were bothered." BROWN[40]

QUOTE *I said 'I wouldn't mind having a chat with someone about my weight', and she [GP] said 'We'll talk about it later', because everything's always rushed.*— Patient 1 GLENISTER[43]

Indeed, participants specifically commented on their desire for more prompting from their physicians, particularly because they felt uneasy bringing up topics without such queries.

JANKE[42] they believed that it is the responsibility of the family physician to initiate the

conversation about weight management, and to do so in a non-judgmental, knowledgeable and respectful manner. TORTI[49]

Not all women in the study report that they are comfortable asserting their needs, but they do it anyway to have their needs met. They believe they have a responsibility to say what they want and to seek it out. For example “I believe at some point it becomes the responsibility of the person, the patient, to say ‘this is what I want.’” Other participants shared that they need to be direct to so that the PCP knows what issues they are facing.

BUXTON[39]

Clinician factors

Trust

Most patients felt that trust between them and the health professional was a key enabler in helping them to lose weight. 'You need to trust someone. Sometimes you don't get the same nurse and sometimes you don't see the same person, I tried to stick with Doctor [x], she knows my history otherwise you have to explain everything over and over.' (Patient 2)

GUNTHER[44]

Patients who spoke of a special bond of trust between themselves and their physicians attached more importance to the GP practice in weight management. 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]. HEINTZE[28]

Participants stated they were more likely to follow through with treatment recommendations when they had developed trust with their healthcare provider. "It's all about finding that trusting doctor. If you don't trust whom you are talking to or you don't feel like they are listening to you then you don't want to come. I don't feel different or awkward here" (participant 4) FORHAN[22]

Patients discussed the importance of mutual trust and respect in facilitating effective conversations. GLENISTER[43]

'Most participants reported the importance of having a weight-related discussion with a PCP who knew them well and cared about them. They discussed that they received support and accountability through this relationship. SEATON BANERJEE[47]

Clinicians' weight status

Patients lacking in motivation identified with health professionals who had a similar weight status to them, finding this person credible and consequently a source of inspiration.

Gender also appeared to be a moderator with female patients admiring practitioners who were able to empathise with them and validate their personal circumstances. In contrast, some men respected practitioners who practised healthy eating and exercise habits themselves, while women who did not consider themselves fit or healthy found this intimidating. LESKE[45]

According to some of the women, it was indicated that their physician's own weight (overweight or thin) could influence their motivation. For example, they felt it would be hypocritical for their doctors to recommend weight loss if they were overweight themselves. As one woman noted, "That really gets me every time. How are you going to harp about my weight and you're just as overweight as I am!" Paradoxically, some women felt their doctors would be less understanding of the weight loss process if they were thin. "My doctor is very thin, very in control of her diet and is able to push herself away from the table when she wants to, and she expects the same from me...It's different when you're really struggling with it versus genetically, she's probably never ever had a weight problem."

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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' (participant 3) FORHAN[22]

Clinical environment

'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' (participant 9) FORHAN[22]

"My doctor does not even have a scale with sufficient range for weighing me. I hate that. I have asked her to buy one, but she says I must buy it myself." MALTERUD[26]