



Talking delicately: Providing opportunistic weight loss advice to people living with obesity

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ABSTRACT

Obesity is a major worldwide public health problem. Clinicians are asked to communicate public health messages, including encouraging and supporting weight loss, during consultations with patients living with obesity. However, research shows that talking about weight with patients rarely happens and both parties find it difficult to initiate. Current guidelines on how to have such conversations do not include evidence-based examples of what to say, when to say it and how to avoid causing offence (a key concern for clinicians). To address this gap, we examined 237 audio recorded consultations between clinicians and patients living with obesity in the UK in which weight was discussed opportunistically. Conversation analysis revealed that framing advice as depersonalised generic information was one strategy clinicians used when initiating discussions. This contrasted to clinicians who made advice clearly relevant and personalised to the patient by first appraising their weight. However not all personalised forms of advice worked equally well. Clinicians who spoke delicately when personalising the discussion avoided the types of patient resistance that we found when clinicians were less delicate. More delicate approaches included forecasting upcoming discussion of weight along with delicacy markers in talk (e.g. strategic use of hesitation). Our findings suggest that clinicians should not avoid talking about a patient's weight, but should speak delicately to help maintain good relationships with patients. The findings also demonstrate the need to examine communication practices to develop better and specific guidance for clinicians. Data are in British English.

1. Introduction

Obesity increases the incidence of non-communicable disease (Dai et al., 2020; Di Angelantonio et al., 2016) and leads to substantially increased healthcare costs for health systems (Kent et al., 2017). Recent reports by the WHO (2020) suggest thirteen percent of the worldwide population are living with obesity, but the prevalence is much higher in some countries (36.2% in the USA and 35.4% in Saudi Arabia, (WHO, 2017).

While the high burden to individuals and society calls for population-level action to prevent obesity, this will not be sufficient for people already living with obesity (Busetto et al., 2022). The risks of obesity are proportional to excess adiposity (Whitlock et al., 2009), and weight loss reverses these proportionately to weight loss (Zomer et al., 2016). Most

people with obesity are attempting to control their weight. Providing weight loss treatment, mainly behavioural support programmes but also pharmacotherapy, improves the success of those efforts. Evidence of positive treatment impact includes improved weight loss (Hartmann-Boyce, Johns, Jebb, Summerbell, & Aveyard, 2014), reduced cardiovascular risk factors (Zomer et al., 2016), and improved wellbeing (Jones et al., 2021). Consequently, national guidelines ask health professionals to raise the topic of weight opportunistically and offer advice and/or treatment to people living with obesity (Department of Health and Social Care, 2020; NICE, 2014; US Preventive Services Task Force, 2018). For most people, general practitioners (GPs) are the main point of contact with health services and their role in supporting weight loss is therefore crucial.

Although talking to patients living with obesity about weight is an

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institutional priority, evidence suggests that conversations about weight may rarely happen (Booth et al., 2015; Jackson et al., 2013). This could be attributed to a number of factors. A systematic review and thematic synthesis found that primary care clinicians express reluctance to hold weight-related conversations with their patients as they fear causing offence (Warr et al., 2020). Clinicians also report other barriers to talking about weight, including a lack of training and time in consultations, along with a belief that weight loss interventions are ineffective or unavailable. Many clinicians reject the notion that they have any significant role in helping patients manage their weight (Warr et al., 2020). As a result, obesity is seen as a low priority topic in primary care consultations (Warr et al., 2020). Stigma and discrimination are commonly experienced by people living with obesity (Puhl & Heuer, 2010). Awareness of this stigmatisation may explain why healthcare professionals might be tentative about talking to patients about weight. A lack of engagement to manage obesity has also been attributed to clinical stigma, which is the belief that obesity is not a disease and is instead self-imposed (Busetto et al., 2022).

Patients report diverse experiences when clinicians talk to them about obesity, weight and weight loss. Post-hoc reflections suggest at times these conversations can be upsetting or stigmatising (Ananthakumar, Jones, Hinton, & Aveyard, 2020), but they can also be helpful, motivational and make patients feel cared for (Ananthakumar, Jones, Hinton, & Aveyard, 2020; Aveyard et al., 2016; Potter et al., 2001). Although there is variation in experience, many patients say they want GPs to talk to them about weight in routine consultations (Keyworth et al., 2020; Potter et al., 2001). Patient reflections suggest they may be more welcomed when weight loss was specifically related to have a positive impact on current health conditions (Keyworth et al., 2020). Equally when talking to patients with weight related health problems, conversations are welcomed if handled sensitively and in an understanding way (Talbot, Salinas, Albury, & Ziebland, 2021). Talking about weight is therefore not automatically 'bad' or stigmatising, and can be done in helpful ways.

Some countries' government agencies provide more detailed guidance that recommend how clinicians should discuss weight and weight loss in ways that are non-stigmatising. In the UK, the National Institute for Health and Care Excellence (NICE) recommend that professionals should 'ensure the tone and content of all communications is respectful and non-judgemental' (NICE, 2014). More recent guidelines aimed at GPs and other healthcare professionals who become Healthy Weight Coaches in England add in the need to be 'fair' to 'avoid weight stigma and discrimination' but without defining how this may be achieved (Office for Health Improvement & Disparities, 2021). However, guidelines and recommendations tend to only briefly discuss the content of what is said in interventions (Office for Health Improvement & Disparities, 2021) if they cover specifics of what to say at all (US Preventive Services Task Force, 2018). Overall, guidance on what to say and how GPs should approach opportunistic discussions about weight is not covered.

Examinations of how GPs talk to patients with obesity about weight are rare and seldom focus on how to start weight loss discussions. A small study in New Zealand found that GPs would take a delicate approach when raising weight (e.g., when GPs hedged and were hesitant in their talk), but did not explain how patients responded to this delicacy (Gray et al., 2018). Other researchers have focused on what words patients find acceptable to describe weight status (Puhl, 2020), but do not explain how they should be deployed in conversation. McHale et al. (2019) found that patients engage in discussions if weight is constructed as a problem for the patient, but did not show evidence of what specifically should be said by GPs. To supplement the current guidelines on obesity management evidence is needed about how GPs can start weight loss discussions with patients in ways that do not occasion responses (such as resistance displays, Stivers (2005)) that may be associated with offence.

In this paper we address this evidence gap. We investigate how GPs can talk to patients' living with obesity about their weight, when there is little guidance on what acceptable conversations look like and the potential for clinical stigma (Busetto et al., 2022). Uncovering how these

conversations are done is best achieved through examination of real talk between clinicians and patients. Conversation Analysis (CA) is well-established as a method for examining naturally occurring interactions between doctors and patients (Barnes, 2019; Drew et al., 2001), including examining how sensitive topics are discussed (Silverman & Peräkylä, 1990; Weijts et al., 1993). CA examinations of talking about sensitive matters have already found that clinicians use specific strategies, including mentioning matters in preliminary discussions (Stortenbeker et al., 2021), and that patients use humour to manage talk about delicate issues (Beach & Prickett, 2017). Examining how patients respond, and if they demonstrate alignment or passive resistance in the conversation (Heritage & Sefi, 1992; Steensig, 2019), can highlight which strategies tend to work well. Guidance and training for clinical interactions can then be developed (CARM, Stokoe, (2014); Real Talk, Parry et al. (2018)), providing specific interactional techniques to use that move beyond general advice to 'be respectful'. As such, using CA we aimed to uncover how clinicians can start talking to patients living with obesity about their weight. We accessed recordings collected as part of a trial, where GPs were tasked to opportunistically talk to patients living with obesity about weight.

2. Method

2.1. Context – the BWEL trial

Consultation recordings were collected as part of the brief interventions for weight loss (BWEL) trial Aveyard et al. (2016). Between June 4, 2013 and Dec 23, 8403 patients visiting 57 GP surgeries across England were weighed by the BWEL trial team. Anyone with a BMI ≥ 30 kg/m² (25kg/m² if Asian) and a raised body fat percentage was invited to enrol and over 80% agreed (Aveyard et al., 2016). Participants were randomised to receive one of two brief opportunistic interventions: either offer of treatment to support weight loss, or very brief weight loss advice. Interventions were delivered after doctors dealt with participants' presenting complaint. The analysis reported here focuses only on consultations where patients were randomised to receiving *advice* to lose weight, not those who were offered *help* to achieve weight loss. Participating GPs were provided with video training but were asked to use their own words to advise weight loss to benefit health (Lewis et al., 2013). Patients were followed up at 3 and 12 months to see if they had attempted weight loss and in what way. Half of the participants receiving brief weight loss advice were randomly selected to have the intervention audio recorded. The recorder was started by the GP after the usual business of the consultation but before initiating the brief weight loss advice. Participants were aware of recording and could decline, or request deletion afterwards. We had access to 237 of the recorded brief discussions between GPs and patients, involving 83 GPs (see Fig. 1).

The BWEL trial is registered with the ISRCTN Registry; ISRCTN26563137. Full details are available in the trial report (Aveyard et al., 2016). Ethical approval was granted by the NHS Research Ethics Service (reference: 13/SC/0028).

2.2. Analysis

Conversation analysis (CA) was used to explore the interactions between GPs and patients. Recordings were transcribed using Jeffersonian conventions (Hepburn & Bolden, 2017), which captures the minutia of talk including intonation, speed and overlapping talk.

Analysis was led by the first author, (MT), a qualitative researcher and conversation analyst. MT first mapped the interactions, detailing which conversational actions were carried out (for example advice-giving and communicating risk) and the order in which these could be delivered. They then identified and categorised the different ways GPs started the weight loss interventions, and analysed how each approach was subsequently responded to by patients (e.g. displaying alignment or resistance to what the GP had said, leading to progress or troubles in the

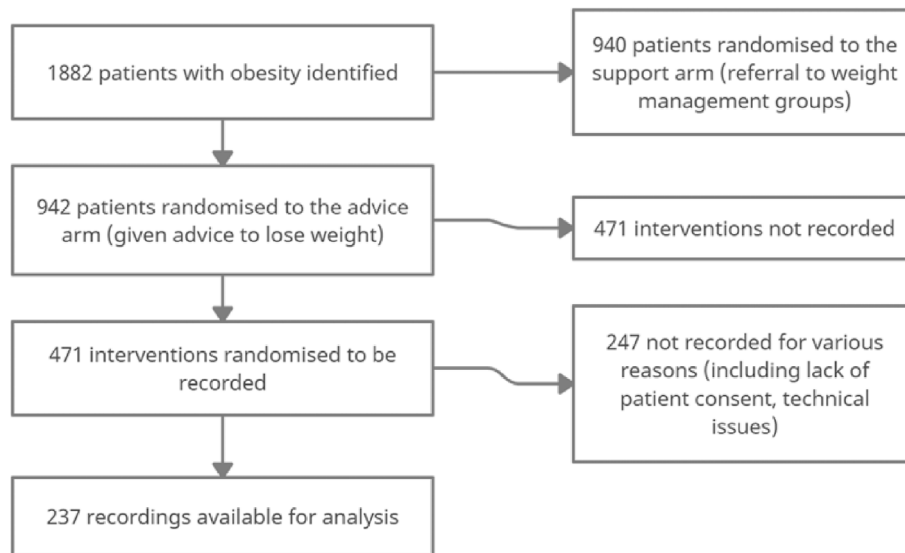


Fig. 1. Flow of available recordings for analysis.

conversation). Alignment here is defined as responses that support the structure of the interaction, accepting presuppositions in the talk and interactional roles (e.g. advice giver and receiver, Steensig (2019)). We focused on both explicit and passive resistance displays during analysis (Bergen, 2020; Hepburn & Potter, 2011; Heritage & Sefi, 1992; Silverman, 1987). The different ways that GPs started talking about weight were organised in collections and we provide the number of

consultations in each collection in the results. These are provided as an indication only. Drawing hard boundaries between some of the collections could be seen as arbitrary when considering the dynamic nature of these consultations. For this reason we did not reduce the observed behaviour and responses to codes as per Stivers (2015), especially as we were not planning to examine relationships to other variables. Instead, we show the strengths of the claims through the detailed analysis

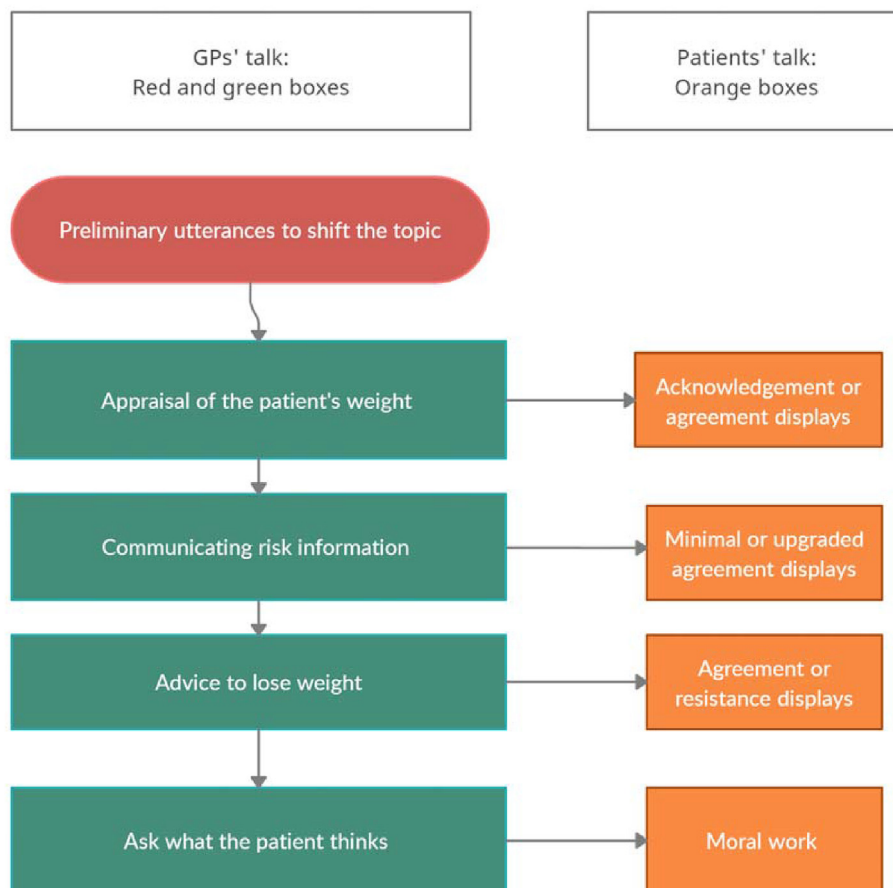


Fig. 2. Interactional components of the brief interventions.

presented. The ‘next turn proof procedure’ (NTPP, Sidnell (2010)) was key for analysis of both resistance displays and alignment. NTPP is an evidentiary procedure through which the analyst discerns the action and meaning of any given turn through the response it receives. Analysis was developed in meetings between the research team (with MT, CA, HW, ES, PA and SZ). Rigour and trustworthiness was maintained through data sessions (ten Have, 2007) and from the NTPP. CA is not an interpretative or subjective method; rather, the task is to make explicit the interpretations and ‘subjectivities’ of parties to interactions (via the NTPP procedure). Anonymised excerpts are used to illustrate and exemplify findings.

3. Results

Analysis showed brief weight loss advice interventions typically followed four phases after GPs' preliminary utterances to shift the topic: appraisal of the patients' weight, communicating risk information, advice to lose weight and asking what the patient thinks. These phases were found repeatedly across the recordings, however not all GPs used all of the phases, or used them in the same sequence. Patients would often have opportunity to respond to, or ask questions of, what the GP had said after these phases.

We now focus on how GPs started to talk to patients about weight. This ‘start’ included the interactional activities in the GPs preliminary utterances and the first three interactional components in Fig. 2. The two key claims that we make are:

- 1) Personalisation of recommendations, through appraisal of the patient's weight, tended to prompt alignment to discussing weight loss. Generic recommendations tended to prompt passive resistance to the advice.
- 2) A lack of delicacy features in the GP's talk also tended to prompt passive resistance to the advice.

First, we will be providing examples of the GPs' conversational features that depict how they did personalisation and delicacy. These features are used in the analysis we subsequently present to support our claims.

3.1. Conversational features

Personalisation of recommendations was seen through a number of conversational features in the GPs talk. These are: tailoring, referencing back and appraisal, detailed in Table 1.

We found GPs' talk would orient to the sensitivity of opportunistically discussing weight with a patient through the use of ‘delicacy features’.

Table 1
Personalisation features.

Marker	Description	Example
Tailoring	Use of the patient's name or personal pronouns	“ok ay Mrs Berry, (0.6) you've been weighed today” 08-02-08
Referencing back	Reference to something that the patient has previously seen the GP about, or spoken to the GP about. This includes talking about what has happened just before the intervention or consultation (e.g. that the patient has been weighed).	“↑So- (0.5) obviously you've- (0.9) come today and we lo- talking about your brea:thlessness, So:- (0.4) and I think what we need to thi:nk about is how your breathlessness relates to you:r (.) weight.” 46-01-02
Appraisal	Describing the patient's weight	“↑So: um: (.) the nurses weighed you a:nd you're overweight” 22-01-11

Table 2
Delicacy features.

Marker	Description	Example
Neutralisation of footing	GPs could talk about the trial and give advice as if they were delivering it on behalf of another person or the state. In this way, they could distance their own role in the delivery of the message (Clayman, 1992; Goffman, 1981) accounting for the reason they are discussing weight and managing stance in the conversation, potentially as a way to prevent patient resistance.	“..you're in advice arm of the trial, which means that I have to advise you..” 47-03-06
Minimisation	GPs could say things to manage patient expectations, setting limits on the extent of the advice that they are giving in the consultation (Drew, 1992). In this way it can be seen as an attempt to prevent an extended interaction.	“↑u::m (.) and this is really just to say that,” 25-07-04
Softening	‘Softening’ moderates the GPs message, for example by making weight loss seem achievable (‘a little bit’), orienting to the potential resistance of patients saying that losing weight is an insurmountable task.	“Did you ↓kno::w that if you did lose a little bit of weight,” 51-04-08
Meta-assessments	Meta-assessments were when GPs explicitly, and at times pre-emptively, negatively assessed the conversation. By pre-emptively stating their own assessment of talking about weight, GPs could manage potential patient resistance, and set the scene for how patients should respond (Sacks et al., 1992).	““>>it's ghunna be a bit of a << >awkward conversation” 05-02-16
Hesitation and perturbations	Hesitation in the GPs' talk could be seen through pauses, re-starting incomplete words/phrases and self-repairs of words. This type of hesitation is often seen in talk that is discussing something ‘delicate’ (Silverman & Peräkylä, 1990; Weijts et al., 1993; Yu & Wu, 2015).	“we- ↑um we have- ↓talked about- about weight quite a bit before” 31-04-58

These are: neutralisation of footing, hesitation, minimisation, softening, and meta-assessments, detailed in Table 2.

3.2. Personalising recommendations: enhancing delicacy

When starting to talk to patients about weight, personalisation of the message tended to prompt alignment (Steensig, 2019). However, personalisation could be done in more or less delicate way. The level of delicacy in the GPs' turn was observed to impact on if patients' responses aligned to the GPs' activity when starting to talk about their weight. The less delicate approach was similar to what Speer and McPhillips (2013) termed ‘announcing’. This was often when GPs used the first turn at talk to address the patients' weight, with minimal markers of hesitancy. We found 55 instances of GPs starting in this way. Next we show analysis of extracts that demonstrate different ways that GPs were minimally delicate when personalising the recommendations, first with Extract 1.

Extract 1. 06-05-07 (DOC: Doctor; PAT: Patient)

01 DOC: >I ↑jus wan:ited t< say: to you about your
 02 weight (.) you ar:e ov:er:weight, it is a
 03 w:orry to me: .hh >because of< the r:isks
 04 that you then r:un (.) of de:veloping
 05 h:eart disease an dia:betes. .hhh um:
 06 (0.2)
 07 So: I'd be very keen for you to try: an
 08 lo:se weight that's (0.3) al- >that's
 09 really< my ov:er:riding message for you,
 10 ohkay:.=
 11 PAT: =Yeah.

Extract 1

Starting with 'I just wanted to say' (line 01), the GP in Extract 1 treats what they are going to say as accountable, before announcing the topic of weight ('about your weight' (line 01 + 02)). The way that the GP starts with 'I just wanted to say' may also be working to minimise the action of starting a new topic (Vinkhuyzen et al., 2005). After a micro pause (line 02) they then go on to appraise the patient's weight status 'you are overweight' in their first turn at talk. The 'are' is marked, producing the announcement as a contrast with a potential alternative state of affair (that the patient is not overweight) as well as an epistemic marker of the GP's certainty in their appraisal. The GP then continues to talk about the risks of being overweight. Within the GP's extended turn, there is a place (line 06) where it could be appropriate for the patient to speak, or use continuers, to signify alignment to the GP's project of talking about the risk associated to their weight (Stivers, 2008). However, the patient only responds after the GP closes the discussion with an 'okay' (White, 2015) line 10). This closing 'ohkay' sets an expectation of the patient responding with yes or no to completing the project of talking about weight. Thus, although the patient responds with a 'yeah' (which could mark some passive resistance (Heritage & Sefi, 1992)), it is not to the advice. Instead it is in response to the topic closure.

Extract 2 is another example of starting to talk to patients about weight by personalising the recommendation, but without many delicacy features. In this extract the GP first appraises the patient's weight status and announces that they are 'overweight' (lines 01 + 02).

Extract 2. 26-1-56

01 DOC: As I'm ↑sure you::'re a↑ware you ↑a:re,
 02 (0.4) over↑↑weight,
 03 (0.4)
 04 DOC: U::m (0.4) and (0.4) ↑it (0.4) ↑is (0.6)
 05 ↑bad for your ↑hea:lth,
 06 (0.3)

Extract 2

Unlike in Extract 1 when the GP owns the appraisal of the patient's weight, the GP in Extract 2 frames the appraisal as a fact the patient will already know ('As I'm sure you're aware' line 01). After this announcement, there is a potential space for the patient to respond, however they do not. The GP's talk features some markers of hesitancy, for example the pauses in line 04, and the pause before 'overweight' (line 02). This hesitancy orients to the delicacy of the topic (Silverman & Peräkylä, 1990), but the hesitancy is the only delicacy feature as the GP starts to talk about weight. The GP then continues and moves from appraising the patient's weight to discussing the associated health risk (lines 04 and 05, in a similar pattern to the GP in Extract 1). Afterwards, on line 06, there is

Ext 3. 07-02-25

01 DOC: .pt You've just been wei:ghed and it showed that
 02 your body mass index: i:s thirty one point eight,
 03 PAT: mm[hmm].
 04 DOC: [A::nd er what we kno:w, .hh (.) for people
 05 that a::re er overweight and °that puts you into
 06 an obese category°
 07 PAT: [mmhmm].

Extract 3

another space in the interaction where it could be appropriate for the patient to respond, but there is no response. The lack of response marks a lack of alignment from the patient.

Along with a lack of response as seen in Extract 2, patients were also found to respond to minimally delicate weight appraisals with minimal continuers. Minimal continuers have previously been linked to a demonstration of patient resistance (Heritage & Sefi, 1992). In Extract 3 below the patient responds with minimal continuers to the GP's announcement of the patient's BMI, which they go on to link to the obese category (line 05).

In Extract 3, the GP frames the appraisal in a different way to Extract 1 and 2, using an external object as responsible for the weight appraisal ('it showed', line 01). This may work to enhance some neutrality in the GP's assessment (Pillet-Shore, 2006). Although it is framed in a different way, similarly to Extract 1 and 2 the first thing the GP does is talk about the patient's weight with minimal delicacy features. The GP then moves to begin to talk about the associated risks with being overweight, orienting to the delicacy of the appraisal of 'obese' through a quiet delivery on line 05–06.

Overall, starting to talk about weight using personalised recommendations that are minimally delicate were responded to with minimal uptake and passive resistance from patients, often demonstrated through an absence of response. The lack of alignment may suggest that the patients are not engaging with the GPs project of discussing weight (Peräkylä et al., 2021).

In contrast, recommendations which were personalised and delicate in their approach tended to prompt alignment from patients. More delicate approaches seemed to orient to sensitivity through the use of more 'delicacy features' (see Table 2), and often a staged entry that worked to forecast the upcoming discussion of the patient's weight. Forecasting has previously been highlighted as a technique that doctors use when they are giving bad news to patients (Maynard, 1996). Patients tended to align with the progressivity of the GPs' talk or affiliate to the content of the GPs' talk (Stivers, 2008) in their responses to more delicate approaches. This was seen through patients' positive receipt markers (e.g. non-delayed agreements and continuers) and collaborative completion of the GPs talk (as seen in Extract 4; Lerner (2004)). There were 83 consultations in our collection of more delicate personalised approaches to talking about weight.

Extract 5 06-07-30

01 DOC: So (.) erm .h you've seen the researcher today?
 02 PAT: °Uh[uh:..°
 03 DOC: [A::nd she found that your ahm (1.3) ↑weight
 04 was ninety seven kilos and your BMI was >thirty
 05 six.=I< ↑know you've already .h been very
 06 successful in losing a significant amount of
 07 weight, which will have really helped your↓ (0.3)
 08 general heal[th life expectancy and so on.
 09 PAT: [mmhmm ° It has (mhm)°
 10 DOC: .h uhm (0.6) However (.) if you: lost some mo:re
 11 .h you would further help your weigh[t and you=
 12 PAT: [hmmmm.
 13 DOC: =know that particularly with your diabetes and
 14 your blood pressure, that would be (0.3) uhm (1.4)
 15 helpful for those particular conditions as well
 16 [so you've kind of got an [extra incentive.]
 17 PAT: [mmhmm [Course] Yeah.

Extract 5

Extract 4. 08-08-08

01 DOC: .hh um (0.4) Mr Williams as you know you
 02 spoke to the lady [earlier and you
 03 PAT: [yeah, yeah.
 04 DOC: mentioned a bit about your ↓weight.
 05 PAT: Ye:ah.
 06 DOC: As we've been talking about your ↓back
 07 .h One of the things that would re:ally
 08 help ↓yer back↓ (0.3)
 09 [is to lose some weight
 10 PAT: [Lose some weight
 Extract 4

In Extract 4 the GP first names the patient ('Mr Williams' line 01), before mentioning what they have just done ('spoke to the lady' line 02) and orients to the patient previously talking about their weight (line 02 + 04). In this way, the GP sets the scene based on the patient's experiences, whilst pre-emptively accounting for why they are talking about the patient's weight. This clearly forecasts that the GP will be talking about the patient's weight. The patient aligns with the GP's talk on lines 03 and 05 with 'yeah's. On lines 06 and 08, the GP continues to personalise what they are saying to the patient by referencing the patient's back problems. The forecasting this GP does allows the patient to project the advice the GP will be giving. This can be seen in the collaborative completion on line 10 (Lerner, 2004), when the patient states 'lose some weight' in overlap with the GP who is saying the same thing. Thus the use of personalisation and delicacy features by the GP prompts alignment from the patient.

The GP in Extract 5 uses a number of personalisation and delicacy features, also prompting displays of alignment from the patient.

In this example, the GP raises the patient's interaction with the researcher (line 01), so it is clear they are discussing something that is relevant to the patient (referencing back, [Table 1](#)). They then discuss the patient's weight and BMI, which they do delicately through the use of the forecasting in line 01 when they mentioning 'seeing the researcher', and hesitation in line 03. Throughout the extract the GP tailors, using personal pronouns and making it clear they are discussing the patient while displaying delicacy in talking about weight. The patient aligns with the GPs talk, providing continuers and agreement throughout. This provides

Extract 6 is an example of the depersonalised approach to talking about weight. The GP starts in Extract 6 by thanking the patient for taking part in the BWeL study. The GP then starts to talk about weight loss with the patient (line 03) by asking if they 'realise' that there are health benefits of losing weight (lines 03 to 05). There is no direct mention of the patient's weight, and the question could be interpreted as questioning the patients' general knowledge of the benefit of weight loss. The patient aligns with the question, producing the preferred response of yes, however the 'm' before the 'yes' marks the response as not a straightforward agreement.

Extract 6. 06-03-13

01 DOC: Thanks for: u:m (0.6) a:greeting t- take part:t
 02 in the study .hhh (0.4) Thee: (1.7) treat:ment
 03 ar:m that >ive gotta give< you: >is just u-<
 04 (0.2) basi'llly: (2.6) D'you >realise there are:
 05 (0.3) some good health (0.3) bhhenefits bout
 06 (0.5) lo:sing (0.2) some weight.
 07 PAT: My:es.
 08 DOC: An:d (0.8) °#yu- uh#° (0.3) grea:tly red:uces if
 09 >e:ven if you< lost a sto:ne you (0.2) grea:tly
 10 re:duce yu cha:nces of (1.4) get:ting dia:be:tes:
 11 (.) an:d (.) .hhh redu:ces your risk of heart
 12 diseas:e, ahn strokes,
 13 (0.7)
 14 An:d um: (0.9) it can actually re:duce yur blood
 15 pre:ssure.
 16 (0.4)
 17 PAT: I >do: know that<.

Extract 6

further evidence of personalisation and delicacy features prompting patient alignment.

3.3. Depersonalisation: delicate avoidance and passive resistance

Sometimes GPs would take a generic and depersonalised approach to talking about weight that did not explicitly reference the patient's weight (a key personalisation feature, [Table 1](#)). This approach often featured markers of delicacy whilst avoiding an explicit link between the patient and a weight that may be a health risk. We found 99 consultations that featured this approach. The depersonalised approach is similar to what [Silverman \(1996\)](#) referred to as information delivery sequences in HIV counselling.

The GP continues to provide more information about the benefits of weight loss, which could be interpreted as specific to the patient ('even if you lost a stone', lines 08 + 09) but could also still be interpreted as general advice. The generic approach is continued by the GP listing all the different health conditions that can be associated to obesity, without linking the conditions to the patient. In this instance the generic approach leads to some incipient resistance from the patient ([Koenig, 2011](#)) – seen in the extract through a gap in the interaction at line 13, and a statement from the patient that suggests the information the GP provides is redundant (line 17). As such, the patient resists the GPs project to discuss weight.

A further example of the depersonalised approach, with fewer sensitivity features, which avoids linking an issue of weight to the patient, can be seen in Extract 7.

Extract 7. 17-01-25

01 DOC: tch.hmm.H |Did you know |that losing weight
 02 will help reduce the risk of diabetes heart
 03 attacks strokes (0.2) various malignancies.
 04 PAT: °I did.° ()
 05 DOC: °You did?
 06 PAT: Hm
 07 DOC: Okidoke .hh That's all we need to do:.
 08 (0.3)
 09 PAT: O:k[ay.
 10 DOC: [hu hi heh

Extract 7

In Extract 7, compared to Extract 6, the GP does not preface what they say by thanking the patient for taking part in the study. Instead they take their first turn at talk to deliver the risk message. Again, the message, that health risks to the patient are reduced by weight loss, is embedded within a question. The question format here, ‘did you know’ (line 01), is grammatically designed for agreement. The approach is generic and there is no subject linked to losing weight. The patient answers on line 04 minimally with no delay by confirming they held this knowledge. The GP responds on line 05 with a checking question (‘you did?’), which the patient confirms minimally (line 06). On line 07 the GP evaluates and summarises the talk, which is receipted by a confirmatory ‘okay’. Finally, the GP laughs (line 10). This is notable, as laughter often orients to something delicate or troubled in the preceding talk, although often in doctor-patient interactions it is invited by the patient (Beach & Prickett, 2017; Haakana, 2002). The trouble the laughter may highlight is the passive resistance displayed by the patient.

The depersonalised, generic approach was not always housed within a question design, as can be seen in Extract 8. We join this extract after the GP has stated the patient’s randomisation number. Throughout the extract the GP does not reference the patient personally. Instead the GP references ‘patients nowadays’ (line 02), ‘people who are overweight’ (lines 03/04), and ‘everybody’ (line 08). The GP has designed their talk to construct the risk information as a general public health message. This is easy for patients to align with, as this patient does on line 12.

Extract 8. 31-01-25

```

01 DOC: We ↑have gone into >a little bit of a< ↑naɡ mode
02 about:t, (.) about weight for patients nowadays
03 be↑cause we ↑know that er people >who are
04 over↑weight< ↑a:re at ↑higher risk of developing
05 par↑ticularly type two diabetes and ↑hea:rt
06 disease
07 (0.4)
08 DOC: Er >so we’re very< keen to encourage everybody to
09 try and get down to optimum ↑weight so:: u:::m
10 It’s °a question of y’know° ↑good ↑die::t cut
11 down what you ↑ea::t[low ↑fa:t high=
12 PAT: [↑Yeah
13 DOC: =er fibre diet (0.4) and plenty of exercise
14 ↑really,
15: (0.4)
16: DOC: We kno:w that’s (.) important
17: PAT: £Yeahf `eh

```

Extract 8

The GP here also has delicacy features in their talk around the word ‘weight’, with a restart observable through the pause and repetition of ‘about’ on line 02. Although the patient in Extract 8 does align with the GP’s message (‘yeah’s on line 12 and 17), there are areas in the extract where it would be pragmatic for the patient to respond to what the GP has said (line 07 and 15). Equally the smiley ‘yeah’ (denoted by ‘£’s) and laughter particle (‘eh’) response by the patient on line 17 again potentially orients to some trouble in what the GP has said. Thus, there is again some incipient resistance to the generic depersonalised approach that the GP has taken.

4. Discussion

Our findings show what happens when GPs are told to give weight

loss advice to patients, without any communication training on how to deliver the advice. We found that patients systematically align, or passively resist, depending on how GPs deliver the advice. Alignment is prompted through personalised recommendations that are delicate in their approach. In contrast, generic, depersonalised approaches, or personalised and less delicate approaches, tended to prompt some resistance from patients. Overall, this demonstrates that one way GPs can approach talking to patients about weight loss is by providing personalised, delicate weight loss advice, using conversational features in Tables 1 and 2.

The ‘delicate features’ found when talking about weight loss to patients living with obesity are similar to what is seen in talk around other intrinsically delicate topics. For example, they have been shown to occur when counselling people about AIDS, talking about sex or talking about death (Silverman & Peräkylä, 1990; Weijts et al., 1993; Yu & Wu, 2015). It also has previously been observed that GPs construct talk delicately when raising weight in New Zealand consultations (Gray et al., 2018). By examining how patients respond to this delicacy, our findings suggest that being delicate in talk functions as an approach for GPs to discuss a patient’s weight in a way that does not lead to interactional resistance (which may indicate some offence). The forecasting in the ‘delicate’ personalised entry may also provide patients an early opportunity to demonstrate they do not want to talk about weight (although this was not observed in the data). The alternative, to be minimally delicate, is less well responded to, and could also reduce patients’ ability to pre-emptively close down their weight as a topic for discussion. This

reflects Speer and McPhillips (2018) findings, from examining interactions in gender identity clinics, that directly ‘announcing’ a patient’s weight is not well received.

Previous research on talking to patients about weight highlighted some variation in experience between clinicians and patients. Clinicians reported finding the conversations difficult (Warr et al., 2020), predicting they would be received negatively, and were concerned they may further stigmatise patients’ living with obesity (Blackburn et al., 2015; Michie, 2007). However, patients have reported wanting clinicians to talk about their weight (Keyworth et al., 2020; Potter et al., 2001) as long as discussions were handled sensitively (Talbot, Salinas, Albury, & Ziebland, 2021). Using a more delicate approach may be one way for clinicians to enact sensitivity when talking to patients about their weight.

Some studies indicate that conversations about weight were more welcomed when personalised (Keyworth et al., 2020; McHale et al., 2019), whilst others have shown that personalisation, through linking to current conditions, can lead to interactional resistance (Albury et al., 2019). Our findings help explain this contradiction, showing how GPs can personalise discussions in a way that may not lead to resistance (i.e. being personalised through an appraisal whilst orienting to sensitivity with delicacy features).

This paper draws on recordings from the advice arm of a trial. Evidence from the trial suggests that referrals to commercial weight management services are more effective in promoting weight loss in people living with obesity than just providing advice (Aveyard et al., 2016). Nonetheless, it is not always possible for clinicians to refer people to weight management programmes, depending on local commissioning. Even when it is possible, the first stage of the NICE care pathway in the UK is to provide advice to lose weight before any referral (NICE, 2014). The NICE care pathway guidelines for clinicians on how to talk to patients about weight are generic, drawing on notions of ‘fairness’ and ‘respect’ (NICE, 2014; Office for Health Improvement & Disparities, 2021). What might be seen as fair and respectful is clearly open to interpretation. We have provided detailed insight into what could be a fair and respectful approach, using an empirical examination of talk between clinicians and patients. This shows that a combination of both personalisation and delicacy in talk is responded to by patients in a way that suggests a lack of resistance to clinicians talking about weight.

The interactions we have analysed are undoubtedly shaped by being part of a trial, which included everyone participating being weighed. However, if clinicians are tasked to approach talking to patients opportunistically about weight, the interactions likely reflect what might happen in non-trial contexts. In ‘normal’ practice the discussion might occur at any phase of the consultation, rather than at the end. The approach the GP takes could then be endogenously shaped by other activities in the overall consultation. Some of the conversational features that enhance delicacy and personalisation depended on the fact that the patient had just been weighed. While it is not uncommon for practice nurses to weigh patients in advance of a consultation it is not standard practice in UK primary care. A limitation of the research is that we only had access audio recordings, and we could not analyse embodied action (such as head nods (Mondada, 2012)). Nonetheless, the strengths of the findings reported are that they are built from the observations of clinicians opportunistically discussing weight with their patients who are living with obesity. Although the findings are taken from a trial which asked GPs to talk about weight opportunistically with their patients, the GPs were free to choose their own words. Equally, although patients consented to taking part in a study, and had their weight taken before the consultation, they were not told that their GP would be talking to them about their weight.

Setting the tone of a conversation from the beginning is key to reduce patients feeling potentially stigmatised about their weight, but is only one part of a conversation. As it continues and unfolds, there are more opportunities for clinicians to talk to patients in ways that demonstrate respect and fairness. Future work should aim to develop the knowledge of talk about weight, and areas that result in patient resistance to understand how this can be avoided. Video and audio recordings are needed of consultations in which clinicians are implementing guidelines on talking to patients about weight. These could help verify if guidelines reflect the most effective way to talk about weight, and if clinicians are able to follow them. Guidelines often recommend the 5A's of counselling (Ask, Advise, Assess, Assist, and Arrange) as a model for weight loss management but this has rarely been observed in practice, which is problematic when evidence of its effectiveness for weight loss is lacking (Alexander et al., 2011). The model includes asking permission to discuss weight, but this was rarely done by GPs in the BWEL trial. This may be due to the trial context, where GPs may have been primed to enter the advice activity without asking, as they knew patients had agreed to participate. Nonetheless, it is not clear whether asking for permission

explicitly or tacitly is welcomed and perceived to be less stigmatising or offensive than raising the issue without such preamble. It may be difficult for patients to decline permission for their doctor to talk about their weight.

Our study of consultation recordings has shown that clinicians who speak in a delicate manner (using a neutral footing, hesitation, minimisation, softening, and meta-assessments) and present obesity as a personalised and relevant issue for their patient can facilitate a positive discussion. On the other hand starting the conversation by being less delicate (e.g. using the first opportunity to talk about weight with minimal markers of hesitation) can result in patients showing resistance to the discussion. Starting the conversation with a delicate, personalised appraisal gives clinicians an evidence-based approach to navigating a discussion that may otherwise be avoided.

CRediT author statement

Madeleine Tremblett: Conceptualization, Writing- Original draft preparation, Methodology, Formal analysis, Investigation. Helena Webb: Methodology, Formal Analysis, Writing – Review & Editing. Sue Ziebland: Methodology, Formal Analysis, Writing- Review & Editing. Elizabeth Stokoe: Formal analysis, Writing – Review & Editing. Paul Aveyard: Conceptualization, Funding acquisition, Writing – Review & Editing. Charlotte Albury: Conceptualization, Methodology, Writing-Review & Editing, Supervision, Project administration, Funding acquisition, Formal analysis.

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Talking delicately – Ethical statement

Ethical approval was granted by the NHS Research Ethics Service (reference: 13/SC/0028).

This original piece has not been submitted to other journals. The work has developed through oral conference presentations at the South West Society for Academic Practice 2021 and the Medical Sociology group of the British Sociological Association 2021.

Declaration of competing interest

PA spoke at a symposium for the Royal College of General Practitioners that was sponsored by Novo Nordisk, who paid his employees for this.

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