Divergence of patient and clinician perceptions of obesity and weight management

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Background

- Obesity is a chronic disease associated with significant morbidity, for which few affected individuals receive adequate medical care. Prior research demonstrates multiple barriers preventing patients from seeking treatment for obesity.[1–5]
- The ACTION (Awareness, Care & Treatment In Obesity MaNagement) study was designed to identify barriers reported by people with obesity (PWO) and clinicians that may hinder the initiation of health care.

Methods

- Six 2-hour focus groups were conducted with PWO in three US cities: New York, Dallas, and San Francisco. Two groups were conducted for each obesity class (class I, II or III) and divided by gender (one for women, one for men). Participants were over age 18 years and met criteria for obesity diagnosis. The focus group leader elicited patient experiences of obesity, including their perceptions of obesity, interactions with clinicians, and weight loss efforts. A purposive sampling strategy was used, and market research firms facilitated recruitment.
- 1-hour interviews with clinicians from two groups, Primary Care Providers (PCP) and Obesity Specialists, were conducted by telephone. Both groups included physicians and nurse practitioners; physician obesity specialists were American Board of Obesity Medicine (ABOM)-certified. The interview leader elicited clinician perceptions of obesity, its treatments, their interactions with patients, and observations of patients' weight loss experiences. A purposive sampling strategy was used, and market research firms facilitated recruitment.
- The focus groups and interviews were audiotaped and transcribed. The transcripts were coded thematically using the mixed-method qualitative analysis system Dedoose® (www.dedoose.com). Statements made by PWO and Clinicians were compared, with attention on barriers to care resulting from PWO and Clinicians' differing perceptions of obesity, its importance and treatment.

Results

- Forty-three PWO were recruited, 20 (47%) male, with a mean age of 44 years, representing a range of ethnicities. Most PWO (81%) had experienced some college or achieved a college degree, and all income categories were represented (Table 1).
- 75% of PWO perceived themselves as 'healthy' by providing a personal health rating of Good, Very Good, or Excellent, although nearly three-quarters of the sample had obesity-related comorbidities (Table 2).
- Twelve PCPs (8 MDs; 2 nurse practitioners [NPs]; 2 physicians assistants [PAs]) and 12 Obesity Specialists (10 MDs; 2 NPs) were recruited, representing all four continental US regions. The mean clinical practice experience was 17.5 (range 5–31) years, representing a range of disciplines, board certifications, and practice settings (Table 3).

PWO and clinician divergence in perception of obesity

What is obesity?

- Clinicians (96%) define obesity by body mass index (BMI), adhering to diagnostic guidelines. PWO (9%) rarely define obesity by BMI and often criticize it as an evaluation method.
- Both PWO and clinicians consider obesity a combination of disease and lifestyle, but their emphasis differs: 65% of PWO consider obesity primarily a lifestyle issue compared to 88% of clinicians who consider it a disease.
- A large proportion (44%) of PWO think it is possible to be healthy despite obesity, as long as there are no comorbidities present. Only 4% of clinicians share this perspective (Figure 1).

Table 1 Patient demographics.

	Male (n=20)	Female (n=23)	Total (n=43)
Age, y			
Mean	44.3	43.3	43.8
Median	46.5	44	46
(range)	(22–64)	(23–66)	(22–66)
Ethnicity, n (%)			
Black/African-American	4 (20)	4 (17)	8 (19)
Hispanic/Latino	3 (15)	4 (17)	7 (16)
Native American	0 (0)	1 (4)	1 (2)
White/Caucasian	11 (55)	11 (48)	22 (51)
Asian	1 (5)	3 (13)	4 (9)
Other	1 (5)	0 (0)	1 (2)
Work Status, n (%)			
Work full time for pay	15 (75)	18 (78)	33 (77)
Work part time for pay	2 (10)	5 (22)	7 (16)
Not working (retired)	2 (10)	0 (0)	2 (5)
Not working (other)	1 (5)	0 (0)	1 (2)
Education, n (%)			
High school or technical school	2 (10)	3 (13)	5 (12)
Some college	8 (40)	13 (57)	21 (49)
College	8 (40)	6 (26)	14 (33)
Masters/professional or more	2 (10)	1 (4)	3 (7)
Income, n (%)			
$25,000 to $49,999	5 (25)	5 (22)	10 (23)
$50, 000 to $74,999	2 (10)	7 (30)	9 (21)
$75,000 to $99,999	5 (25)	6 (26)	11 (25)
$100,000 to $149,999	5 (25)	2 (9)	7 (16)
$150,000 to $199,999	1 (5)	1 (4)	2 (5)
$200,000 or more	2 (10)	2 (9)	4 (9)

Table 2 Patient health characteristics.

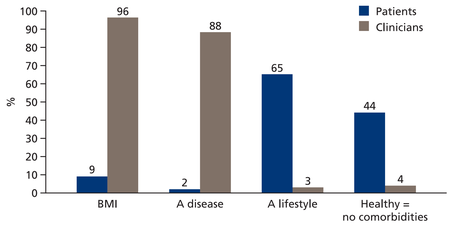
	Male (n=20)	Female (n=23)	Total (n=43)
Overall Health, n (%)			
Excellent	0 (0)	2 (9)	2 (5)
Very good	3 (15)	8 (35)	11 (26)
Good	11 (55)	8 (35)	19 (44)
Fair	6 (30)	4 (17)	10 (23)
Poor	0 (0)	1 (4)	1 (2)
Age at obesity diagnosis			
Mean	34.1	30	31.65
Median	37.5	25	32.5
(range)	(12–53)	(10–50)	(10–53)
Other health diagnoses, n (%)			
Cardiovascular diseases	1 (5)	1 (4)	2 (5)
Depression	1 (5)	3 (13)	4 (9)
Dyslipidemia	3 (15)	3 (13)	6 (14)
Hypertension	8 (40)	9 (39)	17 (40)
Sleep apnea	7 (35)	3 (13)	10 (23)
Osteoarthritis	1 (5)	0 (0)	1 (2)
Reflux diseases	3 (15)	2 (9)	5 (12)
Chronic back pain	3 (15)	2 (9)	5 (12)
Asthma	2 (10)	2 (9)	4 (9)
Stomach or intestinal problems	1 (5)	0 (0)	1 (2)
High blood sugar (pre-diabetes)	1 (5)	1 (4)	2 (5)
Type 2 diabetes	4 (20)	4 (17)	8 (19)
Other	3 (15)	0 (0)	3 (7)
None of these	4 (20)	5 (22)	9 (21)

Table 3 Clinician demographics.

	PCPs (n=12)	Obesity Specialists (n=12)	Total (n=24)
HCP type, n (%)			
MD	8 (67)	10 (83)	18 (75)
NP	2 (17)	2 (17)	4 (17)
PA	2 (17)	0 (0)	2 (8)
Specialty, n (%)			
Family Medicine	5 (42)	1 (8)	6 (25)
Internal Medicine	4 (33)	1 (8)	5 (21)
Gastroenterology	0 (0)	1 (8)	1 (4)
Obesity Medicine	0 (0)	3 (25)	3 (13)
Multiple Specialties	3 (25)	6 (50)	9 (38)
Years' experience			
Mean	18.5	17.4	17.5
Median	18.5	15	17.4
Range	(7–28)	(5–31)	(5–31)
Geographic region, n (%)			
Eastern US	6 (50)	6 (50)	12 (50)
Western US	3 (25)	1 (8)	4 (17)
Southern US	1 (8)	2 (17)	3 (13
Central/Midwest US	2 (17)	3 (25)	5 (21)

HCP, healthcare professional; MD, medical doctor; NP, nurse practitioner; PA, physician's assistant.

Figure 1 Obesity definitions.



Respondent quotes:

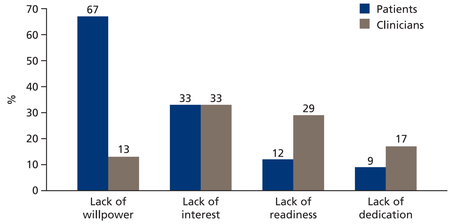
Clinician: *It is a disease definitely and it's very prevalent disease. It's a metabolic dis-balance and some of it is a genetic predisposition and on top of it of course there's an environmental and social kind of issues.*

PWO: *I think you can change it, it can be managed and it can be controlled if you have the willpower to do it. So it's just what type of foods you're eating, what type of lifestyle you have as to the choices of food you select. […] So that's why I say it's part of your lifestyle.*

What makes weight loss so difficult?

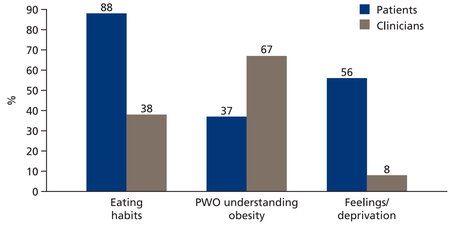
- Emotional/personal barriers: PWO and clinicians agree (77% vs. 75%, respectively) that motivation is a key barrier to weight loss, with PWO emphasizing lack of willpower specifically (67%). Clinicians identify lack of readiness to make changes as an important factor (29%) (Figure 2).

Figure 2 Motivation barriers.



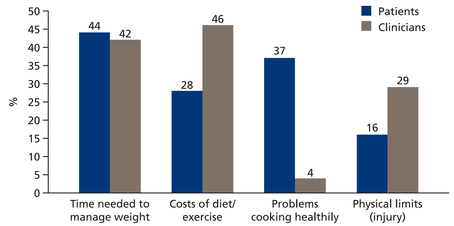
- Nearly all PWO (88%) talked about individual eating habits (food preferences or addictions) as a barrier and clinicians endorse this less frequently (38%). Related to this, 56% of PWO noted feelings of deprivation while dieting as a key barrier (Figure 3).
- Clinicians (67%) emphasized limited patient understanding of their condition as a strong barrier and PWO endorsed this less frequently (37%) (Figure 3).

Figure 3 Other emotional/personal barriers.



- Practical barriers: PWO and clinicians agree on the top practical barrier to weight loss: time in daily life (44% and 42%, respectively). PWO note that cooking healthy meals for themselves is also difficult (37%) but clinicians do not report this difficulty often (4%). Clinicians, in turn, emphasize the cost of food, diet programs, or exercise (46%), a view shared by a smaller proportion of PWO (28%) (Figure 4).
- Social barriers: PWO (79%) emphasized social relationships with people who resisted their weight loss efforts more frequently than did clinicians (38%). Spouse or partner relationships were identified most frequently (44% of PWOs) as presenting obstacles to weight loss. Spouses or partners liked the PWO at a higher weight or resisted dietary change. In some cases, PWO enjoyed socializing with food and had difficulty making changes within these relationships (data not shown).
- System barriers: most clinicians noted that uncovered services (63%) and medication costs 71%) were primary and fundamental barriers to weight loss and treatment. These concerns were rarely noted by PWO (9% for uncovered services and 2% for medication costs) (data not shown).

Figure 4 Practical barriers.



Respondent quotes for barriers:

Emotional/personal barriers, willpower: *PWO: I just want chips. I always tell myself I'm immature because it's just that, I want it right now.*

Emotional/personal barriers, readiness: *Clinician: It's not just telling them what to do. It's them deciding this is what I'm ready to do.*

Practical barriers, costs: *Clinician: It's not as simple as eating and lifestyle for a lot of these people. I think it's cheaper to eat badly than it is to eat healthy.*

Practical barriers, cooking healthy meals: *PWO: It's just easier to stop and pick something up on the way home than it is to cook for one.*

Social barriers: *PWO: Eventually I got tired of making two whole meals because he wouldn't touch it if there were vegetables or fruits […] eating with him, no matter how much I exercised, at the end of the day eating how unhealthy he was, the calories I burned canceled out.*

System barriers: *Clinician: Well, surely the elephant in the room is reimbursement coverage for treatment of obesity.*

References

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Conclusions

- Perceptions of obesity appear to vary between persons with obesity and clinicians. These two groups differ on basic definitions of 'health' and 'obesity', and have distinct perspectives on what presents obstacles to successful weight loss. This discordance may be a barrier to effective communication and treatment, and thus contribute to suboptimal patient–clinician interactions.
- This qualitative association provides the basis for quantitative examination of these perceptions and their causes, the understanding of which could enhance patient–clinician collaboration in the treatment of obesity.

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