Patient Attitudes Toward Physician Treatment of Obesity

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Background. Family physicians are frequently faced with the problem of caring for overweight patients since 30% to 40% of American adults are overweight and 10% are obese. The traditional approach of physicians treating obese patients, which includes diet instruction, dietitian referral, and supportive therapy, has demonstrated little success.

Methods. A focus group of obese patients was formed to discuss weight-loss therapy from a patient viewpoint. Three sessions were completed, one each for patients' feelings and life experiences, exercise, and eating habits. The traditional medical approach to weight-loss therapy was discussed.

Results. All participants reported having failed physicians' attempts to aid them in weight loss. Similarly, all related negative life experiences, job discrimination, and derogatory remarks that they attributed to their weight. Participants were not supportive of physicians' traditional approach to aiding patients with weight loss.

Conclusions. The results suggest that the traditional approach to treating patients' excessive weight is not helpful from the patient viewpoint. Study participants were more supportive of a group approach to the treatment of obesity that would include group exercise and modification of currently used foods rather than new low-calorie recipes. The issues of transportation and child care must be addressed by weight-loss programs.

Key words. Obesity; focus groups; weight loss; diet; overeating. (*J Fam Pract 1994; 38:45-48*)

Obesity continues to be a problem for patients in the United States. If obesity is defined as a body mass index (BMI = weight in kg/m^2) of 30 or more and overweight is defined as a BMI of 25 to 30, then 30% to 40% of American adults are overweight and more than 10% are obese.[1,2] Many organizations exist solely for the purpose of treating obesity, such as TOPS (Taking Off Pounds Sensibly), Weight Watchers, and Overeaters Anonymous, yet obesity continues to be a problem for many patients.

The conventional approach of family physicians treating obese patients consists of individual sessions of weight checks and physician encouragement, referral to a dietitian for nutritional education, and occasional referral to a counselor or behavioral therapist for assistance in achieving weight loss.[2–4]

Physicians are concerned about overweight patients because excess weight is a health risk.[2,5,6] Medical conditions associated with excessive weight include arthritis, non–insulin-dependent diabetes mellitus (NIDDM), coronary artery disease, hypertension, hypercholesterolemia, cancer, and sleep apnea.[2,5–8] Similarly, there are social implications associated with being overweight. American society labels obese people as weak-willed, ugly, and awkward, and there is evidence that obese people are discriminated against because of their weight.[7,8]

Since women make more physician visits and have greater levels of obesity than men, physicians are confronted daily by female patients who have an excessive weight problem.[1,9] This is especially true of those between the ages of 24 and 44, as this group has the highest incidence of major weight gain.[1]

Despite a tremendous amount of research on the subject, there is still no satisfactory treatment for obesity

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that achieves sustained weight loss.[6,10] Studies have shown that the most successful treatments combine nutritional intervention, behavior modification, and exercise.[6] However, even the best of these programs fail to achieve long-term maintenance of weight loss.

Because weight loss remains an elusive goal for patients despite the efforts and interest of individual physicians, a plan was conceived to investigate why the physician's traditional approach has not been successful in helping patients achieve and maintain weight loss.

Methods

The approach of this study differs from previous research by focusing on patients' perceptions of why traditional weight-loss treatment plans are unsuccessful. This approach assumes that incorporating patient suggestions into a treatment regimen may improve weight-loss results or at least reveal weaknesses in the traditional approach. The focus-group format was selected for this study in an effort to understand participant behavior and thinking because it allows individuals to express their attitudes and knowledge without forcing them to choose responses, as with a written questionnaire.[11] It also avoids time restraints that often prevent physicians from fully discussing obesity with patients. Similarly, focus groups create a group environment in which participants may feel more free to express opinions, as opposed to being one-on-one with a physician in a traditional office setting.

A focus group is typically composed of 8 to 12 participants who discuss a specific topic for 1¼ to 1½ hours. It is led by a noninterventional moderator who allows the discussion to take its own course while covering key points delineated before the group meeting.

Study participants were recruited by self-selection from among the general clinic population. Signs announcing a weight-loss study were posted above each scale in the clinic during the month of April 1992, and the study was explained to the clinic physicians in an effort to solicit patients to participate in the focus group. All patients to whom the study was explained volunteered to participate. Participants then were asked to fill out a questionnaire, and measurements of patient height, weight, abdominal girth, chest, and hips were taken. Patients then were asked to indicate the most convenient time to attend a meeting: morning, noon, or evening. Although no patient declined to participate in the study when the opportunity was offered, not all patients volunteering for the study attended scheduled meetings.

A total of 26 participants enrolled, and two separate groups were formed based on the participants' choices of the most convenient time to meet. Eleven patients were enlisted for the morning group, and 15 for the evening group. Each group met three times, enabling participants to devote one meeting to each of three separate topics. The first meeting focused on patient feelings and experiences with obesity, the second on diet, and the third on exercise.

Table. Characteristics of Volunteers for a Focus Group on Obesity and Weight-Loss Methods

Characteristic	Attendees (n = 17)	Nonattendees (n = 9)	Total (N = 26)
Mean age (y)	41.1	35.6	39.2
Mean height (in)	64.9	64.6	64.8
Mean weight (lb)	229.1	260.9	240.1
Mean BMI*	38.5	43.1	39.5
Marital status			
Married or living with someone	7	5	11
No live-in companion	10	4	15
Number of people in the household (average)	2.18	2.11	2.15
Personal assessment of their weight			
Thin	0	0	0
Average	0	0	0
Little overweight	2	0	2
Heavy	7	2	9
Dangerously overweight	8	7	15

**Overweight is defined as a body mass index (BMI) of 25–30, and obese as a BMI of ≥30.*

Results

Physical measurements and demographic and social information were gathered when the patients enrolled in the study. Therefore, information was obtained from all patients, some of whom later failed to attend the group meetings. Data are presented for group comparison among all enrollees, actual attendees, and nonattendees in the Table. Other than nonattendees being somewhat younger and heavier than attendees, the groups were similar.

Life Experiences and Feelings

Participants were asked to name the main problems that they attributed to their weight. They were encouraged to discuss their feelings about obesity and about their life experiences related to being overweight. Patient experiences were surprisingly similar. All participants felt that society, especially the social context of eating, had contributed to their obesity. Most agreed that teachings such

as "Eat everything on your plate," and the use of food as a reward, as exemplified by "Eat all of your dinner and you can have dessert," encouraged their weight gain. Several participants reported being conditioned to relate feeling good to eating through the old adage "Eat. You will feel better."

All participants felt that society penalized them for being overweight. For example, they told of difficulty in finding fashionable clothes in their size, getting out of overstuffed furniture, and squeezing into chairs. They also reported job hiring discrimination. Several participants stated, "My self-esteem is terrible," and "I feel unattractive." All had experienced derogatory comments alluding to their weight and all expressed a desire to lose weight.

When asked to identify behaviors that contributed to weight gain, participants responded that staying at home (not working outside the home or being out of the home participating in some activity) meant easy access to food. Unstructured time associated with being at home also contributed to excessive eating. Participants linked having children with gaining excessive weight: "I gained all this weight when I was pregnant," or through cooking frequent meals for the children, eating with them, or both. Stress also was identified as a factor in eating behavior that leads to overweight: "Stress makes you eat."

Participants felt that group activities focusing on weight loss, such as Weight Watchers or TOPS, could aid in weight loss. Expressions of feelings about group activities such as "I need a buddy to stick with me" and "I need someone to force me to exercise" were heard. At the same time, there were problems associated with attending group activities: "I don't have a way to get there" and "I need a baby-sitter for my kids" embodied concerns about lack of child care and transportation problems that prevented them from attending meetings. Many working participants did not have child care or transportation concerns but did not want to take time away from their nighttime family activities to attend evening meetings.

Diet Modification

Participants were asked specifically about experiences with physicians and dietitians. All subjects had been given diet sheets and low-calorie recipes by their physician and dietitians, but stated they always threw them away because "they never seem appetizing." All participants appreciated the physician's interest but felt that the individual approach would not work. Participants did not want to speak with a dietitian again and did not want diet sheets or more low-calorie recipes: "I don't want someone telling me to eat salad and drink water." They all felt they had sufficient dietary education: "I know what to eat."

Participants were reluctant to change their current eating habits, citing food texture and taste as very influential in their food selection. Remarks such as "I want to enjoy what I'm eating" and "I am going to cook the way I cook" expressed the general feelings of the group. Participants were more open to modifying currently used recipes to lower caloric content as opposed to receiving new low-calorie recipes.

Several participants felt that dieting causes feelings of deprivation, which lead to overeating. Dieting failure causes feelings of low self-esteem, followed by anger, then overeating, as exemplified by participant comments such as "Diets run on guilt" and "Diets make me angry."

Exercise

Exercise was a confusing topic for study participants. None of the subjects wanted to exercise, yet group members were generally aware of the fact that lack of exercise contributed to weight gain: "I know I should exercise, but I always find an excuse not to do it." Exercise was viewed as boring. Group members also viewed exercise as difficult because "the more you gain, the less you feel like doing anything." Patients cited many physical complaints they believed kept them from exercising: " . . . knee pain, back pain, shortness of breath, and fatigue."

Working participants felt it was difficult to go home after work, then leave home to go out to exercise. They felt exercise should be available "on the way home." All participants agreed that exercise is necessary to achieve weight loss and that group exercise or a buddy system, as opposed to individual exercise, would make exercise more likely to occur. Remarks such as "I don't enjoy exercising by myself" and "Exercise is boring unless you have someone to talk to" reflect the group consensus on exercise.

Discussion

All participants had a desire to lose weight and had tried many different weight-loss strategies. In evaluating these plans, participants stated that they preferred a group approach over individualized weight-loss efforts, such as visits to a physician or dietitian. Participants did not want recipes or diet sheets, as they always ended up trying these once, if at all, then throwing them away. Food taste and texture were important to participants and were used to determine food acceptability. Finally, participants were not interested in exercise, even though they recognized exercise was necessary to lose weight.

The study was limited in several ways. Since the groups were composed of volunteers, they may not represent a general obese population. Also, the groups were not randomized but rather were divided according to each person's ability to attend either a morning or evening session. More blacks than whites volunteered for the study. Of those who volunteered, a greater percentage of blacks than of whites did not attend any of the meetings.

The experiences of the patients in this study paralleled those found in the literature. All participants had been exposed to a variety of weight-loss techniques with mixed initial results and eventual failure. All participants had received dietary education from a dietitian and weight-loss counseling from a physician without achieving long-term weight loss.

The significance of the study is that it calls into doubt the physician's standard practice of offering advice on dietary modification, providing diet sheets or recipes, and referring the patient for counseling on dietary or behavior modification or both. All participants expressed abhorrence for this standard approach. All patients in the study had been treated in this fashion and all had failed the regimen.

In accordance with the information gathered in this study, an approach that may offer a better chance for success would include (1) group therapy, (2) group exercise that is available "on the way home" for working patients, (3) new approaches to transportation and child-care issues, (4) instruction in modification of currently used recipes, and (5) dietary modifications that address issues of food taste and texture, not just caloric content.

References

1. Targeting weight-reduction programs. Nutr Rev 1990; 48: 414–6.
2. Leaf DA. Overweight: assessment and management issues. Am Fam Physician 1990; 42:653–60.
3. Wolf GR, Trozzolino LA, Kern PA. Exogenous obesity: what really works? Hosp Med 1993:112–9.
4. Flodmark CE, Ohlsson T, Ryden O, Sveger T. Prevention of progression to severe obesity in a group of obese schoolchildren treated with family therapy. Pediatrics 1993; 92:880–4.
5. Methods for voluntary weight loss and control. National Institutes of Health Technology Assessment Conference Statement, March 30-April 1, 1992. Nutr Rev 1992; 50: 340–5.
6. Caterson ID. Management strategies for weight control eating, exercise and behavior. Drugs 1990; 39(suppl 3):20–33.
7. Kaplan HI, Sadock BJ. Comprehensive textbook of psychiatry, No. V. Baltimore, Md: Williams & Wilkins, 1985:1180.
8. Levy BT, Williamson PS. Patient perceptions and weight loss of obese adults. J Fam Pract 1988; 27:285–90.
9. Kumanyika SK, Ewart CK. Theoretical and baseline considerations for diet and weight control of diabetes among blacks. Diabetes Care 1990; 13(suppl 4):1154–62.
10. Wilson MA. Southwestern Internal Medicine Conference: treatment of obesity. Am J Med Sci 1990; 299:62–8.
11. Stewart DW, Shamdasani PN. Focus groups. Newbury, Calif: Sage Publications, 1990.