Treating obesity: How to individualize care

by **DEBORAH ABRAMS KAPLAN** *Contributing author*

Obesity, whether it's on the list of medical concerns or a stand-alone appointment, is difficult for physicians to treat during the 15 minutes or so allotted for primary care visits.

Even with time constraints, it's possible for primary care physicians to compassionately and effectively guide patients in decreasing their weight. Weight loss experts say obesity should have a treatment pathway in primary care settings like what was developed for smoking cessation and depression. Given the multi-factorial treatment approach, the key is individualizing care.

An estimated 39.8 percent of U.S. adults over age 20 have obesity, with another 31.8 percent considered overweight, according to the 2015-2016 National Health and Nutrition Examination Survey. Obesity increases the risk for many medical issues, including hypertension, diabetes, sleep apnea, cardiac disease, arthritis, hyperlipidemia, and certain cancers. The U.S. spends approximately $190 billion annually, or 21 percent of healthcare dollars, on obesity and related conditions.

"We need to start treating the largest disease in our country, as all other health issues go along with it," says Craig Primack, MD, board certified in internal medicine and obesity medicine, and co-founder of the Scottsdale Weight Loss Center in Arizona.

DISPELLING MYTHS AND ASSUMPTIONS

The first step is combatting two major false assumptions that many physicians and patients often have. They are that weight loss is a matter of "calories in, calories out" and that obesity is only due to patient behaviors, says Rekha Kumar, MD, assistant professor of medicine and attending endocrinologist at the Weill Cornell Medical College in New York City.

The American Medical Association declared obesity a disease in 2013, but many doctors still don't appreciate that and rely on stereotypes that patients with obesity are lazy or lack self control.

Decreasing weight is more than just changing diet and exercise routines. While there may be a behavioral component, Kumar says "there are things that go wrong in the body that perpetuate weight problems. There is significant appetite dysregulation with hormones and neurotransmitters."

There's no room for judgment when it comes to treating obesity, Primack says. "I take care of people who go to the gym five or six times a week and run marathons, and still have weight problems," says Primack. "You don't say a person with cancer is cancerous. A woman has obesity, she is not obese," Primack says.

Understanding obesity genetics is import-

HIGHLIGHTS

- **Start by asking the patient if obesity is something they are interested in talking about. Even if the patient isn't interested, it plants the seed for the future.**
- **Learning a person's triggers for eating too much or eating the wrong foods is another element in tackling weight loss.**

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ant for understanding how those with obesity issues may differ from those without. Hormone levels involved in body regulation signal if a person should be full or hungry, and these may not function properly in patients with obesity. Primack notes a landmark 2011 *New England Journal of Medicine* study measuring hormones related to weight. In the study, diet-induced weight loss changed the levels of hormones regulating weight. In the year after losing the weight, the subjects' bodies used less energy and their appetites increased, resulting in weight gain.

Genetics also affect the body's ease in losing weight. Since human bodies are programmed for survival, Kumar says, the brain's setpoint remembers a person's highest weight. When the person loses weight or burns too many calories, the brain perceives intense hunger and stores fat to survive.

"The human body is not engineered to lose weight," says Angela Fitch, MD, board certified in internal medicine and obesity medicine, and associate medical director of the Massachusetts General Hospital Weight Center in Boston. "If you're trying to lose weight, you're trying to be abnormal. It's normal to gain weight."

HOW TO TALK ABOUT OBESITY

Primary care physicians don't have to know everything about body regulation, says Kumar, but they should bring up obesity without blaming the patient. When approaching patients, experts recommend applying the five A's used for smoking cessation to obesity: ask, advise, assess, assist, and arrange. This gives physicians a framework to work from.

Start by asking the patient if obesity is something they are interested in talking about. Even if the patient isn't interested, it plants the seed for the future. The doctor can advise the patient on how much weight they recommend that the patient loses, and on the importance of exercise and diet. They can then assess whether the patient is interested in losing weight. The doctor can assist the patient by asking if they want to see a nutritionist or schedule time to come back to talk in more depth, and arrange follow-up with the primary care office or with a referral.

Some physicians are concerned about upsetting their patients, Fitch says. But "people want us to ask about it," she says. "We just don't, because we think they'll be offended."

After calculating the patient's BMI, physicians can tell patients if it's in a range that could contribute to their medical problems. She also brings up genetic and hormone connection to weight gain, and tries to find an appropriate balance between presenting medical information and addressing lifestyle factors.

Fitch encourages primary care clinics to come up with a treatment model that can be individualized to each patient. The patient chart should contain an action plan, showing what the patient will do to increase physical activity. The doctor can provide a handout with nutrition options, which can include meal replacement plans using information from the Look AHEAD study, or recommend a commercial plan like Weight Watchers. The physician can also prescribe anti-obesity medication. "If every primary care practice had that at a basic level—a handout, medication, and follow-up—that would produce significant results," Fitch says. "There are 2,500 board certified obesity medicine physicians, and 98 million Americans with obesity. Each one of us would have to care for 32,000 people. Some of the care has to be delivered at a different level."

A primary care physician likely won't provide all nutritional counseling and behavior support for obesity, but can track height, weight, and BMI, and encourage patients to maintain a healthy weight. It's appropriate to suggest a three month trial of lifestyle interventions, says Kumar. Treatment can and should involve healthcare extenders, as the physician likely won't have time to offer the needed education, accountability, and program structure. Referrals to a specialist are an option as well.

Treating obesity is like treating other chronic diseases. Different treatments are used until the right one works. Starting treatment with a primary care physician, and then escalating treatment to a specialist is appropriate, just as is done with diabetes, depression, and cardiac health. Obe-

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sity is something that should be addressed at every visit, but doctors should schedule separate appointments for treatment and follow-up if more time is required.

INDIVIDUALIZING TREATMENT

Nutrition

"We need to eat differently," says Tom Campbell, MD, board certified in family medicine and the medical director of the Weight Management and Lifestyle Center at the University of Rochester Medical Center's Highland Hospital.

He advises patients that food is essential to their health, and if they eat the standard American diet, they will not lose weight, as the food is calorie dense, and eating less of it will not be filling enough. "The idea of eating less has been overplayed. We need to eat different foods, whole natural foods." As long as the patient sticks to mostly whole, unprocessed foods, it doesn't matter which specific diet a patient chooses, be it Atkins, low-carb, Paleo, or vegan. "There's a lot more consensus in nutrition than people realize. The guidelines from established organizations are to eat more fruit and vegetables and less processed foods," says Campbell. Weight loss diets fall along the spectrum, from processed American foods at one end, and plant-based foods at the other end. Other diets are all gradations along the spectrum.

Though he says a plant-based diet is best, he recognizes that some people have lifelong eating habits that are socially and emotionally related. The nutritional plan should meet people where they are, or patients are less likely to change.

"The key is not which diet works. All diets work. It's which works for [the patient], that's the clincher," says Fitch.

Exercise

Exercise does not produce weight loss, Fitch says. It is important, though, and should be enjoyable, as the patient should maintain some form of physical activity during and after losing weight. Doctors can suggest different types of exercise that might appeal to the patient, whether it's walking, a group fitness class or swimming, for example. A patient may find motivation using a fitness tracker, counting steps, or by enrolling in a race and training for it.

Activity only accounts for up to 20 percent of weight loss, says Primack, with dietary changes accounting for the rest. Once the weight is gone, however, the metabolism slows down, so continuing to exercise is an important part of weight maintenance. Primack says that lack of exercise accounts for half of weight regained. The Look AHEAD study, which followed 8,000 subjects for eight years during and after initial weight loss, shows that those who successfully maintained a 10 percent weight loss reported "significantly more" physical activity than those who regained weight.

Behavior

Learning a person's triggers for eating too much or eating the wrong foods is another element in tackling weight loss. People feel bad if they don't have the willpower to avoid food, like the contents in a bowl full of candy, says Fitch. "It's normal not to be able to avoid it. That's why controlling the environment is important for people trying to lose weight," she says. The Look AHEAD study demonstrates that by providing more structure, patients can lose more weight and maintain it. That can include meal and snack replacements, as studies show that using them helps provide structure, so patients can sustain longer term weight loss. Otherwise they underestimate the number of calories in their food, and making food choices is difficult. The study also recommends providing the patient with a shopping list and detailed menu plan, which adds structure to help control their environment. Regular group and individual meetings with a lifestyle counselor provide structure, as did weekly physical activity goals, to exercise a certain number of minutes per week. Patients were also advised to record their daily food intake and exercise time. Physician can help their patients set up structures like these to help them stay on track.

Behavioral-based interventions were shown to significantly improve weight levels and type 2 diabetes in a September 2018 report by the U.S. Preventative Service Task Force, compared to the control group. Combining behavioral interventions with anti-obesity medications, however, yielded greater weight loss and maintenance over 12-18 months than just behavioral interventions.

ANTI-OBESITY MEDICATIONS

Medications are indicated when a person's BMI is 30 or higher, or 27 or more with relat-

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ed comorbidities, such as high blood pressure or diabetes. The medications can help patients lose 5 percent to10 percent of total body weight in most cases, says Kumar. "Most Americans that have obesity need to lose more than that," Kumar says, which is one reason the drugs are not frequently prescribed.

With medications alone, 60 percent of patients will lose more than five percent of their body weight, says Fitch. Adding them to the treatment paradigm with behavioral actions further improves weight loss.

Prescribing anti-obesity medications is appropriate for primary care physicians, but data doesn't show they're comfortable doing so, Kumar says, noting barriers like lack of medication education, high cost and lack of insurance coverage, and doctor and patient assumptions that medications are unsafe or a crutch.

The idea that medications are a crutch is an antiquated way of thinking, considering

Nine ways primary care physicians can address patient obesity

By **Kayla Matthews** *Contributing author*

Primary care physicians (PCPs) have a responsibility to their patients to help them stay healthy and safeguarded against the latest threats to their well-being. Therefore, it's crucial for them to tackle the growing problem of obesity.

A recent study of obesity prevalence indicated two in five American adults are obese, and the same is true for about 18.5 percent of kids. In addition, the percentage of obese patients is rising in both the adult and child populations.

How can physicians respond if their patients are obese or at risk for obesity?

Family doctors in the U.S. were polled about 10 chronic disorders, including obesity. They reported that the treatments for obesity were less effective than all but those for drug addiction. These findings suggest a need for PCPs to rethink their strategies when assisting obese patients. The following suggestions could help them do that.

Use the 5As Model of Obesity Management

PCPs can build a weight-loss framework by using what's known as the 5As Model of Obesity Management: assess, advise, agree, assist, and arrange.

During the assess phase, the PCP checks a patient's body mass index to see if it falls under the obesity category. Depending on the results, the PCP either advises weight maintenance or weight loss. The agree phase relates to checking for patient readiness to lose weight, while the assist phase encompasses physician-led counseling or other types of weight-loss programs.

Finally, the arrange stage requires the PCP to regularly communicate with a patient and their third-party providers about progress, pitfalls, and concerns.

Although many courses of action fall under each of those steps, following the model decreases the likelihood that PCPs might overlook a key component.

Determine Patients' Readiness to Lose Weight

(ASSESS)

A thorough discussion of obesity with patients includes assessing their willingness to change. One effective way to do that is by relying on a 10-point scale question. In this case, 10 means a patient is 100 percent ready to lose weight. A patient response from one to four indicates a minimal intention to lose weight, so the PCP might ask what it would take for the score to be higher.

A score from five to seven indicates the patient is uncertain. In that case, it's crucial for the PCP to suspend judgment and ask what would need to happen for a patient to be more on board with weight loss. A score from eight to 10 means a patient is very ready to lose weight.

Patients who score in the one to seven range are not fully ready to lose weight and may need more information and tools to equip them for success first.

Suggest Patients Use Personal Activity Monitors

(ASSIST)

Research shows that using personal activity monitors was as effective as working with a health coach for weight loss. When people combined their approaches by utilizing both health coaching and activity monitors, the results were especially notable.

Since many personal health devices are budget-friendly and models are widely available, the gadgets could give patients the kickstart they need to lose weight and maintain healthier lifestyles. Plus, such monitors act as obesity preventives.

Encourage Patients to Connect With Local Services

(ASSIST, ADVISE AND ARRANGE)

Besides giving encouragement during the initial discussion about weight loss, PCPs should recommend that patients seek support and treatment beyond what's offered during a primary care visit and follow up with patients to inquire about any actions taken.

PCPs can refer patients to specialists, such as nutritionists, weight management experts, and dieticians. In addition, regardless of where a patient lives, the community likely has specialty resources that provide weight loss interventions. A

the science behind them, says Kumar. Pharmacotherapy is not a cure for obesity, but an ongoing treatment for a chronic condition. Once the patient stops taking the medication, their appetite will return.

Less than 1 percent of eligible patients are prescribed anti-obesity medications. Insurance typically does not cover them as a standard treatment and only 30 percent of employer health plans cover these medications, Fitch says.

Surgery

Bariatric surgery is reserved as the last stage in the weight loss journey. It's been shown to have a dramatic benefit in weight reduction, quickly resolve diabetes, and also reduce cancer risk. "It's pretty effective for weight loss and related chronic diseases. There's absolutely a place for surgery for people who can't or won't change diet and lifestyle," Campbell says.

local weight loss support group, although not always professionally run, could give a patient the opportunity to share triumphs and struggles with others who are also going through similar scenarios. Combining community-based services with such specialized assistance could help patients reach their goals.

Consider Suggesting Medical Marijuana (ADVISE)

Provided it's legal in a patient's state, a PCP may suggest medical marijuana as an obesity intervention. A study of medical marijuana laws and the obesity impact found up to a $115-per-person annual reduction in obesity-related medical costs in places where the drug is legal. Moreover, the investigation discovered a 2-6 percent reduction in the probability of obesity in those areas.

Talk About Obesity Risks Early and Often (COULD ENCOMPASS ALL THE 5AS)

A surprising study found 65 percent of healthcare providers avoided talking about weight management with their patients for fear of embarrassing them. However, only 15 percent of patients said they didn't engage in such discussions because of embarrassment.

For PCPs to play a meaningful role in their patients' efforts to manage obesity, they must initiate conversations early and often, starting at the first warning signs of obesity and continuing as patients attempt to make worthwhile changes. It's essential for them to use a respectful approach and understand that patients may not be entirely open during the early discussions.

Coach Patients to Set Achievable Goals (AGREE)

Getting patients engaged in weight management means empowering them to make lasting changes. PCPs should aid patients in taking small steps by setting goals they can meet.

For example, it's not feasible for a person who has not exercised in a decade to start going to the gym every day, but a goal of taking a brisk stroll for at least 30 minutes on most days of the week is a good start.

Review Patients' Prescribed Medications at Every Visit (ASSESS)

It's essential that PCPs review their patients' charts to monitor which prescribed medicines they take and remember that some of those prescriptions may contribute to weight gain.

A study from King's College London found that individuals taking antidepressants were 21 percent more likely to put on weight than those in the control group that did not take antidepressants.

If patients report dissatisfaction related to the side effects of medications, PCPs must facilitate weighing the pros and cons of potential alternative treatments. They should also consider whether stopping a particular drug that causes weight gain is worth the broader outcomes of not treating an illness.

Furthermore, PCPs need to remind their patients of the dangers of suddenly ceasing to take any prescribed medication, as that approach could lead to withdrawal symptoms.

Be Specific About Recommended Exercise Changes (ADVISE)

Exercise is not a straightforward solution for weight loss, so PCPs must provide targeted guidance when advising patients about exercise regimens.

While a key component to a healthy lifestyle, exercise alone will not lead to weight loss. PCPs must emphasize that patients should not expect to lose weight with exercise if they are still maintaining high-calorie and unhealthy diets.

In addition, PCPs should consider factors, such as socioeconomic status and other health conditions, that can impact patients' ability to exercise successfully.

If a patient lives with other obese people and those individuals are not trying to lose weight, they could unintentionally become bad influences. Instead of recommending that the patient exercises at home, a PCP can suggest joining a neighborhood walking group or local gym to put the patient in the presence of encouraging people.

Some patients may lack access to a gym or feel unsafe exercising outside. If at-home exercises are not possible, a PCP can provide tips on how to incorporate exercise throughout the day, such as taking the stairs and choosing a parking spot further from the entrance to work or a store.

Health conditions could dictate the best kinds of exercise, too. A patient with arthritis may find swimming or other low-impact activities more suitable than running.