

Virtual Mentor

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CLINICAL PEARL

“Can We Talk About Your Weight for a Few Minutes, Mr. Jones?”

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The combination of obesity and physical inactivity ranks, after smoking, as the second leading cause of preventable death in the United States [1]. Obesity-related reduction in life expectancy in the U.S. is predicted to outstrip the life-expectancy gains achieved through the decrease in tobacco use [2]. Obesity is a root cause for many of the medical problems treated by primary care physicians (PCPs). Among the many diagnoses associated with excess weight are diabetes, hypertension, hyperlipidemia/dyslipidemia, coronary artery and cerebrovascular disease, sleep apnea, musculoskeletal problems, liver disease, polycystic ovarian syndrome, and erectile dysfunction. Medical professional societies and public health organizations recognize the consequences of the epidemic and have published guidelines for the evaluation and treatment of obesity [3-6]. The U.S. Preventive Services Task Force (USPSTF) recommends that weight-loss interventions be “high-intensity” (at least two visits per month for the first 3 months) [3]. Considering these facts, it should follow that primary care physicians would be actively involved in treating obesity.

Despite the incontrovertible facts about obesity, PCPs are not consistently able to provide the high-intensity treatment for obesity recommended by the USPSTF. Several studies show that less than half of patients who are obese receive weight-loss counseling [7-9]. Barriers to providing counseling include lack of time, physician training, and confidence in patients’ ability to change their eating and exercise behavior, as well as inadequate reimbursement [10-13]. With the increased complexity of the primary care visit, time may be the most important of these barriers [14]. PCPs have an average of 3.8 minutes to address each clinical item during a visit [15], and thus cannot reasonably be expected to provide high-intensity weight-loss counseling themselves.

Despite these limitations, we believe that PCPs can play a critical role in guiding their patients’ efforts at weight loss [16]. They can increase patients’ awareness of which medical diagnoses are weight-related. Most patients realize intuitively, for example, that knee pain is related to excess weight, but they may not be aware of the potential impact of obesity on other conditions such as non-alcoholic fatty liver disease. PCPs also can review the importance of a 5 to 10 percent weight loss, a modest but achievable goal that can have significant health benefits [17, 18].

One systematic approach to obesity treatment is the “5A” method. The 5As have been used widely for smoking cessation, and some evidence suggests that they can also be successful for weight loss [19, 20]. While this approach is not the intensive

intervention recommended by the USPSTF, it provides a framework for the PCP and patient to begin a worthwhile weight-management intervention.

The 5As

Assess. Assess the patient's body mass index (BMI), waist circumference, and other cardiovascular disease risk factors (fasting glucose and lipids, blood pressure). Most electronic medical record systems calculate BMI automatically, so that it is available at the point of care. Patients with a BMI equal to or greater than 25 should undergo routine screening with fasting lipids and glucose [21].

Ask/Agree. Ask permission to talk about weight and agree that the patient is interested in losing weight, avoiding use of the word "obese" in the initial approach. While some physicians do not agree that the word "obesity" should be avoided, research shows that patients dislike the term [22, 23]. Patients may misunderstand the word as connoting morbid obesity.

The conversation can begin like this: "Mr. Jones, could we talk about your weight for a few minutes?" Most patients will respond, "Yes, Doctor, I know I need to lose weight. I've been trying, but it's not working." If the patient does not wish to discuss his or her weight, the PCP should continue to evaluate and treat other risk factors for cardiovascular disease [16]. The conversation about weight management can be re-initiated at a later time.

Advise. Advise weight loss, personalizing it to the patient's comorbid conditions.

"Mr. Jones, we should increase the dose of insulin that you're taking so that we can get tight control of your diabetes and prevent complications. If you are able to lose 5 to 10 percent of your current weight, we might be able to use less insulin and still keep your diabetes well controlled. Losing 5 to 10 percent of your weight might not seem like a lot, but it's often enough to improve health."

It is important to briefly mention the clinical significance of a 5 to 10 percent weight loss, given that patients' expectations often are unrealistic [24].

Assist. Assist in making a referral. A brief assessment of the patient's previous weight-loss attempts can guide the conversation [5]. For example, if the patient's previous attempts have been self-directed, then referral to a structured program may be helpful. If the patient has already participated in several programs, more aggressive interventions should be considered. These could include medically supervised regimens, pharmacotherapy, or consultation for bariatric surgery.

Arrange. Arrange follow-up. Patients should be directed to high-intensity interventions, as recommended by the USPSTF. If a high-intensity intervention is not available, data from one study suggest that monthly visits with the PCP, combined

with weight-loss medication and the patient's use of food records, can lead to a clinically significant weight loss [25].

The 5A approach can be conducted in several minutes. Of the 5 model components, the most important is “assist”—where can the PCP refer the patient for intensive treatment? The recommendation will depend largely on the practice setting and available resources. PCPs who practice in integrated health care systems may have access to stepped care interventions that include intensive dietary counseling. The Veterans Health Administration MOVE (Motivating Overweight/Obese Veterans Everywhere) Program is one such intervention [26]. For PCPs in private practice, available resources may vary widely. All clinicians should become familiar with one or two local programs that offer high-intensity weight-loss services at a reasonable cost. Commercial programs, such as Weight Watchers, are widely available and moderately priced [27]. PCPs who practice in underserved areas should be aware of low-cost options available to their patients. The authors recommend nonprofit programs, such as Take Off Pounds Sensibly (www.tops.org). Other low-cost approaches include the self-directed use of meal replacements (Slim-Fast- and Glucerna-brand products are two examples) and Web sites with free information and self-monitoring tools (www.mypyramidtracker.gov; www.eatright.org; www.calorie-count.com). Weight-loss medication can be added to any lifestyle intervention, taking into account potential side effects (e.g., increased blood pressure). Of the available agents, phentermine is the least expensive.

PCPs have much to do during a visit, and the list continues to grow [28]. Clearly, not every indicated service can be provided to every patient at every visit. Clinicians have to decide whether weight management is a high enough priority for an individual patient before spending several minutes providing counseling. Even if primary care clinicians provide weight management, the current reimbursement structure of the U.S. health care system disproportionately favors procedures (e.g., bariatric surgery) over nonprocedural medicine (e.g., weight-loss counseling). Despite these challenges, we believe that PCPs have an important role in opening the discussion and in directing weight management for their patients.

References

1. Flegal KM, Graubard BI, Williamson DF, Gail MH. Excess deaths associated with underweight, overweight, and obesity. *JAMA*. 2005;293(15):1861-1867.
2. Stewart ST, Cutler DM, Rosen AB. Forecasting the effects of obesity and smoking on US life expectancy. *N Engl J Med*. 2009;361(23):2252-2260.
3. US Preventive Services Task Force. Screening for obesity in adults: recommendations and rationale. *Ann Intern Med*. 2003;139(11):930-932.
4. Bray GA, Wilson JF. In the clinic. Obesity. *Ann Intern Med*. 2008;149(7):ITC4-1-15.
5. Kushner RF. *Assessment and management of adult obesity*. Chicago: American Medical Association; 2003. *Roadmaps for clinical practice: case studies in disease prevention and health promotion series*.

6. National Heart Lung and Blood Institute (NHLBI). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults—the evidence report. National Institutes of Health. *Obes Res.* 1998;6 Suppl 2:51S-209S.
7. Jackson JE, Doescher MP, Saver BG, Hart LG. Trends in professional advice to lose weight among obese adults, 1994 to 2000. *J Gen Intern Med.* 2005;20(9):814-818.
8. Stafford RS, Farhat JH, Misra B, Schoenfeld DA. National patterns of physician activities related to obesity management. *Arch Fam Med.* 2000;9(7):631-638.
9. Ma J, Xiao L, Stafford RS. Adult obesity and office-based quality of care in the United States. *Obesity (Silver Spring).* 2009;17(5):1077-1085.
10. Huang J, Yu H, Marin E, et al. Physicians' weight loss counseling in two public hospital primary care clinics. *Acad Med.* 2004;79(2):156-161.
11. Kushner RF. Barriers to providing nutrition counseling by physicians: a survey of primary care practitioners. *Prev Med.* 1995;24(6):546-552.
12. Leverence RR, Williams RL, Sussman A, Crabtree BF. Obesity counseling and guidelines in primary care: a qualitative study. *Am J Prev Med.* 2007;32(4):334-339.
13. Tsai AG, Asch DA, Wadden TA. Insurance coverage for obesity treatment. *J Am Diet Assoc.* 2006;106(10):1651-1655.
14. Yarnall KS, Pollak KI, Ostbye T, et al. Primary care: is there enough time for prevention? *Am J Public Health.* 2003;93(4):635-641.
15. Abbo ED, Zhang Q, Zelder M, Huang ES. The increasing number of clinical items addressed during the time of adult primary care visits. *J Gen Intern Med.* 2008;23(12):2058-2065.
16. Tsai AG, Wadden TA. Treatment of obesity in primary care practice in the United States: a systematic review. *J Gen Intern Med.* 2009;24(9):1073-1079.
17. Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med.* 2002;346(6):393-403.
18. Pi-Sunyer X, Blackburn G, Brancati FL, et al. Reduction in weight and cardiovascular disease risk factors in individuals with type 2 diabetes: one-year results of the Look AHEAD trial. *Diabetes Care.* 2007;30(6):1374-1383.
19. Serdula MK, Khan LK, Dietz WH. Weight loss counseling revisited. *JAMA.* 2003;289(14):1747-1750.
20. Simkin-Silverman LR, Wing RR. Management of obesity in primary care. *Obes Res.* 1997;5(6):603-612.
21. Wildman RP, Muntner P, Reynolds K, et al. The obese without cardiometabolic risk factor clustering and the normal weight with cardiometabolic risk factor clustering: prevalence and correlates of 2 phenotypes among the U.S. population (NHANES 1999-2004). *Arch Intern Med.* 2008;168(15):1617-1624.
22. Wadden TA, Didie E. What's in a name? Patients' preferred terms for describing obesity. *Obes Res.* 2003;11(9):1140-1146.

23. Ward SH, Gray AM, Paranjape A. African Americans' perceptions of physician attempts to address obesity in the primary care setting. *J Gen Intern Med.* 2009;24(5):579-584.
24. Foster GD, Wadden TA, Vogt RA, Brewer G. What is a reasonable weight loss? Patients' expectations and evaluations of obesity treatment outcomes. *J Consult Clin Psychol.* 1997;65(1):79-85.
25. Wadden TA, Berkowitz RI, Womble LG, et al. Randomized trial of lifestyle modification and pharmacotherapy for obesity. *N Engl J Med.* 2005;353(20):2111-2120.
26. Veterans Affairs National Center for Health Promotion and Disease Prevention. Motivating Overweight and Obese Veterans Everywhere (MOVE). <http://www.move.va.gov>. Accessed December 15, 2008.
27. Tsai AG, Wadden TA. Systematic review: an evaluation of major commercial weight loss programs in the United States. *Ann Intern Med.* 2005;142(1):56-66.
28. US Preventive Services Task Force. Guide to clinical preventive services, 2008: Recommendations of the U.S. Preventive Services Task Force. <http://www.ahrq.gov/clinic/pocketgd.htm>. Accessed June 1, 2009.

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Disclosure

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