



## Roadmaps for Clinical Practice

Case Studies in Disease Prevention and Health Promotion

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### **Assessment and Management of Adult Obesity:**

A Primer for Physicians

# Communication and Counseling Strategies

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*Assessment and Management of Adult Obesity: A Primer for Physicians* is not intended to function as a clinical guideline, standard of medical care, or definitive resource for the assessment and management of obesity. The instruments included in this publication are clinical tools, not research tools. Consequently, they have not been evaluated to establish reliability and validity. The American Medical Association neither endorses nor encourages use of the programs and resources listed in this document. They are meant to be a starting point and are not intended to be an exhaustive list of educational resources for physicians or patients seeking medical information.

Medical care is determined on the basis of all the facts and circumstances involved in an individual case and is subject to change as scientific knowledge and technology advance and patterns of practice evolve. This publication reflects the view of the experts and reports in the scientific literature as of 2003.

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# Preface

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In the United States, increasing trends in morbidity and mortality related to chronic diseases and injuries have led the American Medical Association (AMA) and others to address strategies for promoting health and preventing disease and disability. Over the past decade, the AMA has launched national campaigns against violence, alcohol abuse, and tobacco use. Recently, the AMA launched national programs to address low health literacy, patient safety, and disparities in health services and outcomes.

To further address the health challenges facing our nation, the AMA is developing a series of case-based publications for physicians as part of a new program titled *Roadmaps for Clinical Practice: Case Studies in Disease Prevention and Health Promotion*. The Roadmaps project fulfills an AMA and US Department of Health and Human Services (DHHS) partnership established through a Memorandum of Understanding (MOU) signed by both organizations in the year 2000. The series concentrates on the *Healthy People 2010* objectives, which were developed by the US Public Health Service to help professionals address the leading causes of morbidity and mortality in this country. The series also supports the goals of the DHHS *HealthierUS* initiative which was established in 2003 to help Americans lead longer, better, and healthier lives. This primer, produced with support from The Robert Wood Johnson Foundation, is part of the Roadmaps series.

The Roadmaps series aims to help physicians prevent or reduce injury and chronic disease through early detection and disease management in addition to promoting healthier lifestyles through their medical practices and communities. Emphasis is directed at promoting personal behaviors that have both immediate and long-term health benefits and at modifying behaviors that cause the greatest burden of suffering. According to the US Preventive Services Task Force, counseling patients about personal health practices (smoking, diet, physical activity, drinking, injury prevention, and sexual behavior) remains one of the most underused but important parts of the health visit.

This primer focuses on the rising prevalence of a serious, chronic health condition—obesity. Two weight-linked behaviors—physical inactivity and unhealthy eating—are given important consideration. It is estimated that 300,000 preventable deaths occur each year in the United States due to diet and physical inactivity, both of which contribute to obesity—only tobacco use causes more preventable deaths in this country. Growing scientific consensus on the health risks of physical inactivity and improper diet mandates that physicians become informed and prepared to assist patients in leading more active and healthy lives. Physicians have an important opportunity to encourage improvements in health behaviors and outcomes, including influencing motivation and success with weight loss treatment. **It is never too late to start and have a favorable impact on health. Patients of all ages can and will benefit.**

We encourage you to review this primer and to participate in the accompanying continuing medical education (CME) program. Please also take some time to complete and return the evaluation form that accompanies this primer. Your feedback is valuable for updating this publication and for planning future physician education programs. We invite you to use these resources and take action—in your practice and community—to promote healthier lifestyles among your patients, colleagues, and neighbors.

# Contents

## Assessment and Management of Adult Obesity: A Primer for Physicians **Booklet 8 • Communication and Counseling Strategies**

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- iii Preface
- 1 Objectives
- 2 Case presentation
- 3 What are the general principles of effective obesity counseling?
- 7 How do I approach the topic of weight with my patients?
- 9 What skills should I help my patients attain?
- 12 How do I address non-adherence to recommendations?
- 13 References
- 14 Suggested additional reading

# Objectives

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This primer is designed to educate primary care physicians about providing medical care to overweight and obese adults. It is presented in a modular format to facilitate its use as an educational and teaching tool. Patient scenarios are included for self-evaluation and to reinforce information presented. A continuing medical education (CME) component worth 4.5 credit hours is also offered. After completing this program, physician participants should be able to:

- identify overweight and obesity in their patients
- describe the medical and public health implications of adult overweight and obesity and identify opportunities for patient, family, and community intervention
- incorporate assessment and management of adult overweight and obesity into their clinical practices
- identify specific patient comorbidities and health risks that are caused and/or exacerbated by overweight and obesity that may interfere or even contraindicate treatment
- understand the appropriate application of diet, physical activity, behavior changes, pharmacotherapy, and surgery in obesity treatment
- locate information about culturally and linguistically appropriate strategies and resources to prevent and treat adult overweight and obesity
- enhance personal and office practices to optimize sensitivity to the needs and concerns of overweight and obese patients

This primer is not intended to function as a clinical guideline, standard of care, or definitive resource for the assessment and management of obesity. However, more detailed information is available in the references and resources listed in each booklet of this primer.

### Case presentation

Donna, an obese 34-year-old African-American woman, comes to your office complaining of “frequent heartburn.” She is new to your practice. While providing her history, Donna tells you that she is a single parent with a 2-year-old daughter, and that she works full time. Frowning, Donna further states that she gained 60 pounds during pregnancy but has lost only 20 pounds since delivery. You infer from Donna’s frown that she is unhappy with her weight and you note that she quickly changes the subject.

Wanting to be helpful, you explain to Donna that she should be able to lose weight through diet and physical activity management. You recommend that she engage in more physical activity and reduce her daily calories. Avoiding eye contact, Donna simply nods in response, and you begin to address other concerns.

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any patients look to their physicians for lifestyle recommendations. However, time constraints and lack of training often make it difficult for physicians to effectively communicate this information and help their patients promote behavior change.

As discussed in Booklet 1, achieving and maintaining a healthy weight is a difficult and lifelong process for many adults. In the case study above, the advice is sound, but Donna may be unable to initiate and adhere to any meaningful behavior changes without additional counseling and support from her physician and physician’s staff. Furthermore, because weight tends to be a sensitive issue, Donna’s physician may feel uncomfortable talking to her at length about her weight and counseling her on weight loss.

This booklet augments the previous booklets in this primer by providing recommendations for optimizing obesity communication and counseling. In particular, this booklet describes general principles of obesity counseling, strategies for approaching the topic of patient weight, and counseling approaches to help patients initiate and adhere to behavior change.

## What are the general principles of effective obesity counseling?

In a large quantitative study of 824 patients who completed a pre-visit and post-visit questionnaire pertaining to their physician’s consultation style, patients valued three elements of the office encounter; namely, communication, partnership, and health promotion.<sup>1</sup>

These three elements, along with sensitivity to anti-fat bias, form four general principles of obesity counseling. These four principles are described in the following section.

**Communicate empathically** Counseling your patients about obesity management is most effective when your patients feel understood. Empathy enables you to establish a rapport with your patients and demonstrates that you understand your patients’ situations, perspectives, and feelings. Furthermore, empathy promotes diagnostic accuracy, therapeutic adherence, and patient and physician satisfaction in a time-efficient manner.<sup>2</sup> Empathic communication includes several components, which are described in Figure 8.1.

**Figure 8.1 Components of Empathic Communication**

**Active listening** includes using nonverbal skills to convey interest in what your patients are telling you. Examples include nodding, mirroring facial expressions, making eye contact, and leaning toward your patients.

Framing or sign posting to demonstrate that you understand what your patients are telling you (eg, “Let me see if I have this right: you began to gain weight when you started a new job,” or “So in other words, you gained back the 10 pounds and an additional 5 pounds.”)

Reflecting the emotional tone of your patients’ statements demonstrates that you understand how they feel (eg, “It sounds to me like you’re unhappy with your weight,” or “Yes, I can imagine that it’s very frustrating for you.”)

Requesting or accepting correction from your patients to acknowledge that they are important partners in their own care (eg, “Is there anything I left out today?” or “Does that sound right to you?”)

Source: Coulehan JL, Platt FW, Egner B, Frankel R, Lin C, Lown B, Salazar WH. “Let me see if I have this right...”: words that help build empathy. *Ann Intern Med.* 2001;135:221–228.

Empathy is especially important for counseling obese patients, given the social stigma and discrimination commonly experienced by this population. In addition, empathy can be useful for communicating with patients of different ethnic and cultural backgrounds, who might otherwise feel alienated and misunderstood.

**Establish a patient–physician partnership** The patient–physician relationship is the most important aspect of any therapeutic encounter, and obesity counseling is no exception. In a beneficial relationship, physicians and patients work together as partners, not only in assessing the problem and pursuing a diagnosis but also in developing treatment plans and solutions.

In terms of obesity management, a patient–physician partnership involves the use of empathic communication to ensure that your patients’ concerns are heard and then tailoring treatment to patient preferences, abilities, and stage of readiness to change (see Booklet 3: *Assessing Readiness and Making Treatment Decisions*). In contrast to the more traditional directive approach, in which the physician simply tells patients what to do, encourage your patients to discuss lifestyle patterns, motivating factors, and barriers to change and to contribute to development of treatment plans.

**Deliver health counseling effectively** Health counseling includes targeted patient messages that feature strategies about how to stay healthy and reduce risks of future illness. Messages that reflect patients’ values and beliefs are generally more acceptable and better understood. For example, messages about obesity prevention and management are more likely to be accepted if your patients believe that excess weight is unhealthy and are less likely to be accepted if your patients believe that “big is healthy.”

When delivering health promotion messages to your patients, it may be useful to:

- understand your own cultural and professional values and biases
- develop an understanding of your patients’ cultural values, health beliefs about weight and nutrition, and illness behaviors
- check back frequently to determine whether your patients accept these health messages

In addition to accepting health promotion messages, it is also important for patients to understand them. A useful technique for determining understanding is the “teach-back method” through which patients are asked to explain or demonstrate what they have just been told. For example, say, “Now I want you to explain to me what I just told you, so I can be certain that I explained it to you correctly.” This method is also useful when explaining medication instructions or instructions for completing food diaries and physical activity calendars. Note that the teach-back method should replace the more common practice of asking your patients, “Do you understand?” Experience shows that patients often answer yes, even when they do not understand at all.<sup>3</sup>

**Be sensitive to bias against overweight and obese individuals** Although most people do not like to admit it, it is exceedingly difficult — if not impossible — to be immune to our contemporary culture’s bias against overweight and obese people. This bias occurs in employment, education, and health care settings.<sup>4</sup> In fact, in questionnaires completed by more than 400 physicians, obesity ranked (among dozens of categories) behind only drug addiction, alcoholism, and mental illness in patient characteristics that aroused feelings of discomfort, reluctance, and dislike.<sup>5</sup>

Bias may have a negative impact on overweight and obese patients’ health care experiences and influence their willingness to seek treatment. Among obese women, studies have found that the likelihood of canceling appointments increases and the likelihood of using preventive services decreases as BMI rises — possibly due to fear of being weighed or having to disrobe.<sup>6,7</sup>

You and your staff can take several steps to guard against bias in your practice. These steps are described in Figure 8.2.

### Figure 8.2 Strategies to Reduce Bias Against Overweight and Obese Patients

**Recognize that obesity is a chronic medical condition**, not a product of laziness or low willpower. Keep in mind that obesity has social, psychological, and physiological determinants. As such, patients cannot be expected to lose weight on demand.

Do not blame obese patients for their health problems (ie, “Your knees wouldn’t hurt so much if you’d only lose some weight.”), even if you believe they are related to obesity. It is more appropriate to treat the medical condition before approaching the topic of weight in a tactful manner.

**Improve your knowledge of nutrition, multi-disciplinary treatments, and community resources** in order to offer solid recommendations and support to your patients. By taking obesity treatment seriously, you reinforce your message that obesity is a medical condition, not a shameful characteristic.

**Create a friendly office culture and atmosphere.** Improve your patients’ sense of acceptance and comfort by providing armless chairs, larger examination gowns, and a private place for weighing. Booklets 9 and 10 provide additional recommendations and resources for setting up the office environment.

**Treat the overweight and obese population with respect and support.** Remember to treat your overweight and obese patients with as much respect as you would your other patients and to take obesity management as seriously as you would management for any other chronic medical condition.

After Donna’s visit, you realize there are several ways you could have improved your communication with her about her weight. First, you could have communicated empathically by reflecting Donna’s emotion: “Donna, it looks as if you’re not happy about your weight.” Next, you could have explored her attitudes and concerns by asking, “Would you like to tell me more about it?” Framing Donna’s words would have assured her that you understood what she was saying.

You resolve to approach the topic of Donna’s weight at her next visit. If Donna tells you that she is interested in pursuing treatment, the two of you will work as partners to tailor the treatment to Donna’s preferences, abilities, and readiness for behavior change. By employing the teach-back method, you will ensure that Donna understands all of your instructions and messages.

You and your staff decide to make it a priority to deliver friendly, professional treatment to all patients, including overweight and obese patients. As you make plans for improving the comfort of your office environment, you reflect that effective communication and counseling are more likely to help your patients lose weight than simply telling them to lose weight.

### How do I approach the topic of weight with my patients?

Because of the social stigma and shame surrounding overweight and obesity, some patients may be reluctant to discuss their weight with physicians, and some physicians may avoid the topic altogether. Nonetheless, if your patient’s weight is a health issue, you should not hesitate to approach the topic.

The following strategies may help you and your patients feel more at ease when discussing the health effects of excess weight and management of obesity.

**Acknowledge your patients’ chief complaint, independent of weight** Even if it appears obvious to you that your patients’ presenting conditions are related to weight, remember that chief complaints are always defined by patients themselves. Listen to and explore your patients’ chief complaints, including their impression of the underlying causes, without forcing the diagnosis of obesity on them. Only after addressing your patients’ concerns should you approach the topic of weight.

### **Assume that obese patients know they are overweight**

Most overweight and obese individuals are already aware that they have excess weight, although they may not necessarily understand its impact on their health. Rather than telling patients that they are overweight and exploring their reactions to this statement, it is better to focus on how your patients' weight affects their health. For example, instead of asking your patients, "Do you know you weigh too much?" It is more constructive to say, "I'm concerned about your weight because I think it's causing health problems for you. Do you think your weight is causing problems for you?" This is especially important when overweight contributes to other chronic diseases such as osteoarthritis, hypertension, and hyperlipidemia.

**Base the discussion on your patients' readiness** Patients are more likely to engage in discussions that are tailored to their stage of readiness and understanding. For example, patients who do not believe that their weight is problematic are unlikely to be interested in messages about losing weight through dietary management and physical activity. Rather, focus on educating these patients about health risks associated with overweight and obesity. Additional information about appropriate interventions for each stage of readiness can be found in Booklet 3: *Assessing Readiness and Making Treatment Decisions*.

**Offer unconditional acceptance** Because of the bias encountered by many overweight and obese individuals, they may also fear their physician's disapproval. In addition to the strategies offered in Figure 8.2, it may be helpful for you to offer your patients unconditional acceptance. Acknowledge that weight management is a challenge (eg, "It's hard to avoid snacking when you're stressed out.") Remember to offer praise for any efforts your patients may have made, regardless of whether or not it was successful (eg, "I think it's great that you tried to walk for 20 minutes a day.")

Donna returns to your office 2 weeks later. She tells you that the medication and behavior changes you prescribed at the previous visit have alleviated her symptoms somewhat but that she is still suffering frequent heartburn. In addition, she wants to talk to you about the pain in her left knee.

After you finish addressing her health complaints, you say to Donna, "I'm concerned about your weight because I think it's contributing to your heartburn and knee pain. Do you have any concerns about your weight?" Donna nods her head and begins to cry. She tells you that she is unhappy with her weight and her inability to lose weight after her pregnancy. She also says, "I want to lose weight so badly because I don't like the way I look, but I'm too busy to do anything about it."

You acknowledge that Donna must be very busy with her work and her 2-year-old daughter and you say, "It sounds like you want to lose weight, but you aren't certain how to get started." Donna nods and says that she would like your help with losing weight.

### **What skills should I help my patients attain?**

In the course of obesity management, not only is it important to counsel your patients on dietary management (Booklet 4) and physical activity (Booklet 5) but it is also critical to counsel them about skills required to maintain behavior changes for a lifetime. The following five skills can help your patients take a more active role in their obesity management.

**Self-monitoring** It is useful for your patients to monitor, on an ongoing basis, their weight, diet, physical activity, thoughts, and/or behaviors regarding food and activity. (Sample food and physical activity diaries are provided in Booklets 4 and 5, respectively.) By engaging in self-monitoring, patients learn more about their dietary and physical activity patterns and behaviors and are able to track progress. This, in turn, helps patients exercise more control over their behaviors and provides motivation to maintain lifestyle changes.<sup>8</sup>

**Stimulus control** Patients can modify their environment to control exposure to high-calorie foods and to facilitate physical activity. They should first identify cues that stimulate thoughts about food within their home, work place, and social environments, then develop strategies for modifying them. For example, patients who constantly snack on potato chips and ice cream can clear their home of these "problem" foods, and patients who often succumb to fast food on

their way home from work can alter their route to increase walking and avoid passing by fast-food restaurants. Other strategies include packing a gym bag at night to take to work the next day; keeping a water bottle at the desk to avoid purchasing soda; posting a reminder on the computer to take a 5-minute walking break every hour; and bringing healthy snacks to parties.

It is also very important that patients and physicians have a shared understanding about what behavior is to be changed, and to identify when, where, and how the behavior is to be performed. For instance, instead of suggesting the patient simply increase physical activity, physicians can ask their patients to take the initiative in establishing the parameters of activity. A useful dialogue might look like this:

**Physician:** “Donna, what activity might you engage in to be more active?”

**Donna:** “Well, I do want to walk more, especially since the weather has been nice.”

**Physician:** “That sounds great, but many of my patients find that being more specific helps them follow through. I know your schedule is very busy right now, so let’s start small. How much time do you think you can set aside for walking, and how often might you do it?”

**Donna:** “I do have a lot going on, but I think I could walk at the park by my house for twenty minutes two times each week.”

**Physician:** “Wonderful. Why don’t you keep a note of the times you walk in the park and bring it the next time you see me?”

Once the “basics” of such behaviors are clearly established, additional strategies such as self-monitoring, stimulus control, cognitive restructuring, goal setting, and problem solving are easy to teach and quite helpful to patients working to modify their dietary and physical activity behavior.

**Goal setting** Goal-setting skills allow patients to develop realistic expectations for weight loss and attainable strategies for achieving weight loss. Patients should first learn to accept that certain “magical” weight loss goals, such as losing 5 pounds a week or attaining pre-wedding weight, may be unrealistic or achievable only through long-term maintenance of behavior changes. With time, they can also learn to set small goals for achieving weight loss (eg, walking 10 minutes more each day), to reward themselves for successes (eg, buying a new pair of walking shoes after fulfilling a physical activity goal), and to set new goals as needed (eg, training for a 5-mile walk).

**Cognitive restructuring** Through cognitive restructuring, patients learn that thoughts influence both mood and behavior and that positive thoughts are more constructive than negative thoughts. In particular, have patients focus on attainable goals, specific plans for attaining these goals, and belief in success (eg, “I know I can lose 4 pounds next month if I stick to my diet and physical activity plans”). Patients should also learn not to abandon their goals with each relapse (eg, “I can’t believe I ate all that ice cream; I’ll never lose weight now”), but to “forgive” themselves and move on (eg, “I’ll just have to be extra diligent to make sure I don’t do that again”).

**Problem solving** Problem-solving skills allow patients to identify a current or potential problem, devise a solution, implement it, and evaluate its effectiveness. Problems can include triggers for unhealthy eating, environments inhospitable to dietary management or physical activity, and social and cultural pressures. As patients identify these problems, have them draw on their past experiences and understanding of the current situation to devise personalized solutions. For example, a patient who has difficulty being physically active during work travel may resolve to walk in airports during layovers, and a patient whose parents frequently invite her to lavish home-cooked meals may avoid offending her parents by eating small portions and asking to bring leftovers home.

For the past 6 months, you have been helping Donna manage her obesity through dietary changes and physical activity. As you continue to counsel her on these lifestyle changes, you also begin to introduce her to skills that will enable her to play a larger role in her weight management. As Donna becomes more adept at self-monitoring and goal setting, two key strategies that are important to keep her on track, she feels empowered to assume responsibility for more and more of her management. You continue to offer your encouragement and support.

## How do I address non-adherence to recommendations?

Even the most compliant patients will at times fail to adhere to your recommendations. Although this may be discouraging to both you and your patients, a number of strategies are available to help you reduce your mutual frustration.

**Do not blame your patients** Although you may feel inclined to label your patients as “undisciplined,” “non-compliant,” “difficult,” or “lacking willpower” for failing to adhere to recommendations, this can lead to more frustration and damage the patient–physician partnership. Instead, work with your patients to determine the cause for non-adherence.

**Apply problem-solving skills** After you and your patients have determined the cause for their non-adherence, apply problem-solving skills to develop an effective solution. For example, if your patients did not complete a food diary because they did not understand the directions, re-explain them to your patients and use the teach-back method to ensure that they understand. Also, it is possible that your patients did not understand the importance of adhering to recommendations, that the recommendations were unrealistic, or that there were unanticipated barriers. In each case, work together with your patient to either develop strategies for adherence or develop new recommendations.

**Continue to provide encouragement** Your continued encouragement can help your patients initiate and adhere to recommendations. Keep in mind that many patients find it difficult to adhere to their physician’s advice and that lifestyle changes, in particular, are very challenging.<sup>9</sup> Your encouragement and support can go a long way toward helping your patients achieve success.

When you and Donna first began to manage her obesity, she was sometimes unable to follow your recommendations. For example, Donna initially failed to complete a food diary because she did not make the time for it, and she resisted dietary changes for several weeks until she realized the importance of reducing calories. Each time, you and Donna worked together to address these situations and find solutions for them.

It has now been 1 year since you first met Donna, and she is continuing to work toward achieving her goal weight. Donna feels confident about her progress, especially with the skills she learned from you. She now says, “Thank you so much for all your help and support! I couldn’t have done it without you.”

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# Strategy for treatment of overweight and obesity

## Evaluate your patients for current and potential health risks related to weight (Booklet 2)

- Measure body mass index (BMI)
- Measure waist circumference
- Assess for presence/extent of suspected comorbid diseases

## Talk to your patients about weight loss (Booklet 3)

- Explain the importance of weight loss
- Assess your patients' readiness to make behavior changes
- Work with your patients to establish realistic treatment goals

## Help your patients manage weight through dietary management (Booklet 4)

- Collaborate on strategies for reducing calories and balancing the diet
- Recommend weight loss programs and resources as needed
- Follow up with your patients to monitor progress and provide support

## Help your patients manage weight through physical activity (Booklet 5)

- Collaborate on strategies for increasing physical activity in the daily lifestyle
- Recommend physical activity programs and resources as needed
- Follow up with your patients to monitor progress and provide support

## If indicated, help your patients manage weight through pharmacotherapy (Booklet 6)

- Determine whether your patients are candidates for pharmacotherapy at this time
- If pharmacotherapy is an option, help your patients make and carry out treatment decisions
- Monitor your patients for weight loss and medication side effects

## If indicated, help your patients manage weight through surgery (Booklet 7)

- Determine whether your patients are candidates for bariatric surgery at this time
- If surgery is an option, help your patients and their bariatric team make and carry out treatment decisions
- Manage your patients post-operatively

## Optimize your communication and counseling style (Booklet 8)

- Establish an effective patient–physician partnership
- Help your patients obtain skills for self-management
- Be sensitive to anti-fat bias and approach the topic of weight sensitively

## Optimize your office environment (Booklet 9)

- Be more sensitive to your patients' needs by adapting office practices and the waiting room configuration
- Set up your office with the equipment needed to assess and manage your patients
- Facilitate patient care through a team approach

Adapted from Serdula MK, Khan LK, Dietz WH. Weight loss counseling revisited. *JAMA*. 289;1747-1750:2003.