

Obese Women's Perceptions of Their Physicians' Weight Management Attitudes and Practices

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Background: Obesity has reached epidemic proportions in the United States. Primary care physicians will see increasing numbers of patients with long-term weight management problems.

Objective: To examine obese women's perceptions of their physicians' weight management attitudes and practices.

Design and Setting: Women who participated in obesity trials at a university clinic completed a questionnaire that assessed their views of weight control provided by their primary care physician.

Participants: The patients were 259 women whose age was 44.0 ± 10.0 years; weight, 96.7 ± 13.2 kg; and body mass index (calculated as weight in kilograms divided by the square of height in meters), 35.2 ± 4.5 (all data given as mean \pm SD).

Main Outcome Measures: Using 7-point scales (1 indicates low; and 7, high), patients rated their satisfaction with care provided for their general health and that for their obesity. They also identified methods their physician recommended for weight management and the fre-

quency of negative interactions with their physician concerning weight control.

Results: Participants were generally satisfied with the care they received for their general health and with their physicians' medical expertise (mean scores, 6.1 and 6.2, respectively). They were significantly ($P < .001$) less satisfied with care for their obesity and with their physicians' expertise in this area (mean scores, 4.1 and 4.3, respectively). Almost 50% reported that their physician had not recommended any of 10 common weight loss methods, and 75% indicated they looked to their physician a "slight amount" or "not at all" for help with weight control. Only a small minority of patients (0.4%-8.0%) reported frequent, negative interactions with physicians concerning their weight.

Conclusions: The last finding helps allay concerns that obese patients are routinely treated disrespectfully by physicians when discussing weight. The challenge, however, for primary care physicians appears to be providing patients better assistance with weight management.

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AMERICA'S HEALTH care providers are confronted by an epidemic of obesity. Fully 22% of US adults are obese, as judged by a body mass index (BMI) (calculated as weight in kilograms divided by the square of height in meters) of 30 or more, and an additional one third are *overweight* (defined by a BMI of 25.0-29.9).¹ Thus, practitioners can expect that 1 of every 2 patients potentially will need assistance with weight control. Despite the scope of this problem, remarkably little is known about the management of obesity in primary care

practice.²⁻⁴ In an article titled "Futility and Avoidance: Medical Professionals in the Treatment of Obesity," Frank⁵ lamented that many physicians do not recognize obesity as a significant medical condition. Instead, this disorder is frequently thought to result from lack of self-control, self-indulgence, or other personal failings.⁶⁻⁹ These perceptions, coupled with high relapse rates and marginal reimbursement for weight management, appear to have led many practitioners to neglect the management of obesity.⁵

Studies have suggested that patients are aware of and may be adversely af-

PATIENTS AND METHODS

PATIENTS

The patients were 259 obese women who sought treatment in 1 of 3 randomized clinical trials at the University of Pennsylvania's Weight and Eating Disorders Program, Philadelphia. This is a tertiary care unit that accepts for treatment only obese individuals (BMI ≥ 30) who have a history of weight loss and regain. Patients were consecutive enrollees in 3 randomized trials conducted between September 1996 and June 1998. Nearly all participants (96%) were self-referred; they responded to television or print coverage that described the research studies. The remaining patients (4%) were referred by their physician. This sample was selected for the present study because we thought that patients with a history of treatment failure would be the most likely to have experienced negative weight-related interactions with their physician. This study was approved by the Institutional Review Board of the University of Pennsylvania School of Medicine, and all patients gave informed consent to participate.

PROCEDURE

Before treatment, weight and height were measured on all patients, who were dressed in light clothing, without shoes. Respondents completed the Beck Depression Inventory II (BDI-II),¹⁸ a 21-item self-report measure of mood. Each item is scored on a 0 to 3 scale, with higher total scores (0-63) indicative of greater symptoms of depression. Patients also completed a "Health Care Questionnaire," developed by us. A set of background items inquired about demographic variables (age, educational level, and ethnicity) and history of weight loss, which was assessed by having patients record all weight reduction efforts on which they had lost 4.5 kg or more (≥ 10 lb). This method has been shown to have acceptable reliability for the number of diets reported and total lifetime weight loss with these efforts.¹⁹ Patients reported whether their general medical care was provided by a primary care physician (defined as a "family physician," "general practitioner," or "internist"), a gynecologist, or a nurse practitioner. They also noted their average number of medical visits per year, years with their present physician, and their type of health coverage. All information in this background section was obtained by self-report and was not independently verified by us.

The Health Care Questionnaire continued with a first series of 7 items that asked patients to rate their satisfaction with various aspects of the care their physician provided for their general health. Participants, for example, were asked, "How satisfied are you with your doctor's degree of

medical expertise concerning your health?" Satisfaction was rated on a scale from 1 to 7, in which 1 indicates very dissatisfied; 2, moderately dissatisfied; 3, slightly dissatisfied; 4, neutral or neither satisfied nor dissatisfied; 5, slightly satisfied; 6, moderately satisfied; and 7, very satisfied. A second parallel set of 7 items, on a separate page of the questionnaire, asked patients to rate their satisfaction with the same components of care but as they related to their weight (or weight control) rather than to their general health. Thus, patients were asked, "How satisfied are you with your doctor's medical expertise concerning your weight?" This method allowed us to compare directly patients' satisfaction with care for their general health with that for their weight. A third group of 2 items asked how frequently physicians discussed weight control with patients and the extent to which respondents looked to their physician for help with weight management. A fourth series of questions presented a list of 10 weight loss methods and asked patients to check those that their physician had ever prescribed for them. These ranged from provision of a diet plan to use of medication to recommendation of a commercial weight loss program. A final group of 10 items inquired about the frequency of patients' negative interactions with physicians concerning their weight. Participants, for example, were asked to respond to the statement, "I have been very upset by comments that doctors have made about my weight," by selecting 1 of 5 responses: (1) always, (2) usually, (3) sometimes, (4) rarely, or (5) never. For this set of questions only, patients were instructed to respond in reference "to all of the doctors you have seen over your lifetime." This was done to increase the likelihood of detecting negative patient-physician interactions concerning weight.

STATISTICAL ANALYSES

Differences between patients' satisfaction with treatment for their general health, compared with that for their weight, were analyzed using parametric (paired *t* tests) and nonparametric (Wilcoxon signed rank tests) tests. The *P* value for each of the 7 comparisons was set at $\leq .007$ (ie, $0.05/7 = 0.007$) to control for multiple tests. The results of the parametric and nonparametric analyses were identical; thus, only the parametric results are presented. Pearson product moment correlations were used to assess patients' satisfaction with weight control in relation to continuously distributed variables, including patients' age, BMI, and BDI-II score. An analysis of variance was used to assess possible differences in patient satisfaction that were related to ethnicity, physicians' sex, and related variables. Alpha levels were adjusted in all cases to control for multiple tests. Data are given as mean \pm SD unless otherwise indicated.

ected by physicians' reportedly negative attitudes toward obesity.¹⁰ Rand and MacGregor,^{11(p1395)} for example, found that 78% of severely obese patients who sought bariatric surgery reported that they were always

or usually "treated disrespectfully by the medical profession" because of their obesity. Additional investigations¹²⁻¹⁴ found that obese women delayed or avoided obtaining medical care, including clinical breast exam-

Table 1. Demographic and Other Characteristics of the 259 Women Studied

Variable	Value*
Age, mean ± SD, y	44.0 ± 10.00
Education, mean ± SD, y	15.2 ± 2.4
Weight, mean ± SD, kg	96.7 ± 13.2
Height, mean ± SD, cm	165.8 ± 6.3
BMI, mean ± SD†	35.2 ± 4.5
No. of diets (with loss ≥4.5 kg), mean ± SD	3.3 ± 2.6
Total lifetime weight lost on diets, mean ± SD, kg	36.5 ± 26.8
Beck Depression Inventory II (score), mean ± SD	8.6 ± 7.0
Minimal depression (0-13), %	80.2
Mild depression (14-19), %	11.5
Moderate depression (20-28), %	6.2
Severe depression (29-63), %	2.2
Race, %	
White	65.6
African American	27.0
Other	7.4
Time with current physician, mean ± SD, y	5.7 ± 6.3
No. of physician visits per year, mean ± SD	2.8 ± 2.5
Patients' health care coverage, %	
Managed care plan	63.5
Traditional insurance	29.0
Self-pay	6.3
Medicare or Medicaid	1.2
Physician's sex, %	
Male	60.3
Female	39.7

*Percentages may not total 100 because of rounding.

†BMI indicates body mass index (calculated as weight in kilograms divided by the square of height in meters).

Table 2. Patients' Satisfaction With Care Provided by Their Physician for Their Health Compared With Their Weight*

Patients Were Asked, "How Satisfied Are You With . . ."	Health		Weight	
	Mean	SD	Mean	SD
"Your doctor's degree of medical expertise concerning your"	6.2	± 1.2	4.3	± 1.7
"The overall care your doctor provides for your"	6.1	± 1.4	4.1	± 1.6
"The degree to which your doctor explains things about your"	6.0	± 1.4	4.3	± 1.7
"How your doctor talks with you about your"	5.9	± 1.4	5.1	± 1.6
"The degree to which your doctor listens to you discuss your"	5.9	± 1.6	4.7	± 1.7
"How well your doctor understands your feelings about your"	5.7	± 1.5	4.6	± 3.1
"The amount of time your doctor spends discussing your"	5.7	± 1.6	4.1	± 1.7

*Data are given as the mean ± SD. All items were rated using 7-point scales, in which 1 indicates very dissatisfied; 2, moderately dissatisfied; 3, slightly dissatisfied; 4, neutral or neither satisfied nor dissatisfied; 5, slightly satisfied; 6, moderately satisfied; and 7, very satisfied. For each item, satisfaction with care for general health vs weight was assessed using paired sample t tests. For all 7 pairs of items, patients reported that they were significantly (P<.001) less satisfied with the aspects of care related to their weight than with those related to their general health.

inations, gynecologic examinations, and Papanicolaou smears. This avoidance has been attributed to patients' embarrassment about their weight¹⁴ and to physicians' purported bias against obese individuals.^{15,16}

These reports are cause for concern but do not provide a full picture of patients' attitudes. Surprisingly, we were unable to identify any studies that had assessed, in detail, patients' satisfaction with weight management provided by their primary care practitioner.^{3,14,17} Thus, the present study assessed patients' satisfaction with treatment for their obesity, compared with their satisfaction with their overall medical care. In addition, patients reported the frequency with which their physician discussed weight management during office visits and identified the weight control methods that they had been prescribed.

With the exception of the Rand and MacGregor¹¹ study, which was limited to only one question, we also could not find any studies that assessed how patients believed they were treated interpersonally by their physician concerning their weight. Thus, obese participants in the present investigation responded to several questions concerning their physicians' attitudes and behaviors toward them, including the Rand and MacGregor item about being treated disrespectfully because of their obesity.

RESULTS

PATIENT CHARACTERISTICS

The characteristics of the 259 women are presented in **Table 1**. Their mean BDI-II score of 8.6 ± 7.0 indicated "minimal" symptoms of depression.

Most patients (85.3%) reported that they had a primary care physician; a gynecologist or nurse practitioner was identified as the primary provider by 8.9% and 2.3% of participants, respectively. The 3.5% of respondents who did not have a primary care physician (including a gynecologist or other provider) were instructed to respond to the questionnaire items with regard to their previous experience with physicians.

RELIABILITY OF THE HEALTH CARE QUESTIONNAIRE

Fifty-seven patients completed the Health Care Questionnaire on 2 separate occasions, 2 to 3 weeks apart, to provide estimates of item test-retest reliability. Pearson product moment correlations were used to calculate reliability for all questions that used 5- or 7-point scales. For the 14 items in **Table 2** that measured satisfaction with care for general health and weight, reliability coefficients ranged from $r=0.62$ to $r=0.79$ ($r=0.71$ for both mean and median). The coefficients for the 2 items in **Table 3** were $r=0.72$ and $r=0.65$, respectively. For the 10 items in

Table 3. Patients' Description and Evaluation of Physicians' Weight Control Counseling

Variable	% of Patients
"How often does your doctor discuss weight control with you?"	
At every visit	15.8
At almost every visit	12.0
At about every other visit	5.4
Once in a while	39.0
Never	27.8
"How much do you look to your doctor to help you with weight control?"	
Not at all	45.5
Slight amount	29.7
Moderate amount	18.7
Great amount	4.1
Very great amount	2.0

Table 4, which assessed negative weight-related interactions with physicians, reliability coefficients ranged from $r=0.54$ to $r=0.74$ ($r=0.66$ for both mean and median). The reliability with which patients reported the weight loss methods that their physicians had prescribed was assessed by percentage agreement. For each item, we determined the percentage of respondents who gave the same answer (yes or no) on both test administrations. Percentage agreement ranged from a low of 83.6% for physician "provided a diet plan" to a high of 100% for physician "referred you to a dietitian" and "referred you to a commercial weight loss program." The mean was 93.3%, and the median was 92.7%. The values for the 4 different sets of items, previously described, indicate that the questionnaire had acceptable test-retest reliability.

PATIENTS' SATISFACTION WITH CARE

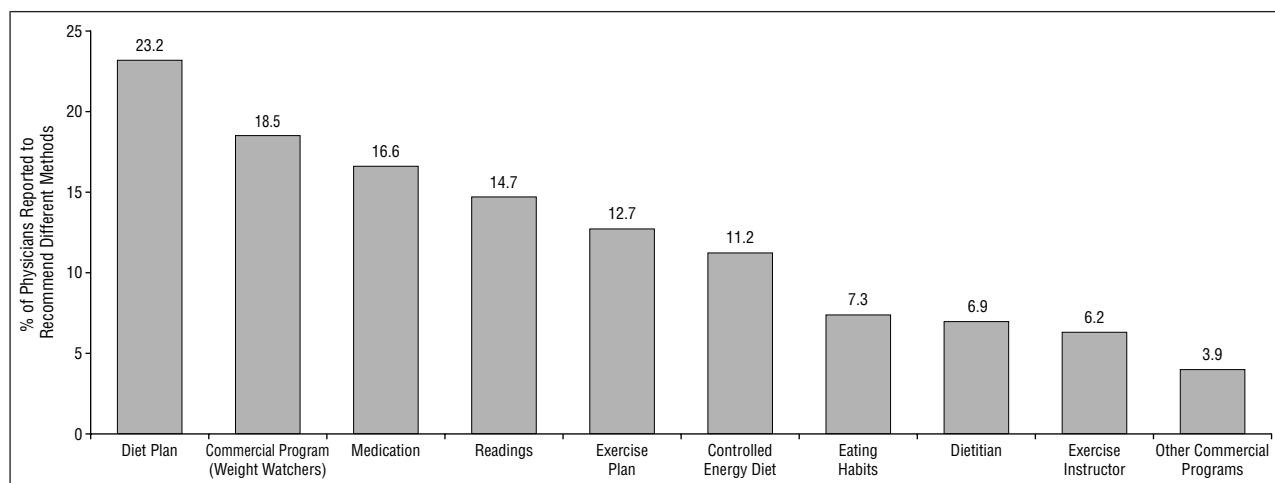
Patients reported that they were generally satisfied with the medical care their physician provided for their general health. As shown in Table 2, mean ratings for each of the 7 items were in the moderately satisfied range. The highest 2 satisfaction ratings were for "your doctor's degree of medical expertise" and for "the overall care your doctor provides." Even for the lowest-rated item, "how well your doctor understands your feelings about your general health," respondents were still close to moderately satisfied.

By contrast, patients' satisfaction with care they received for their weight fell only in the neutral to slightly satisfied range. For example, satisfaction with overall care their physicians provided for their weight was rated neutral. Data in Table 2 show that for all 7 pairs of items, patients reported that they were significantly ($P \leq .001$) less satisfied with the aspects of care related to their weight than with those related to their general health.

Table 4. Patients' Reports of Negative Interactions With Physicians Concerning Weight

Variable	% of Patients*
"When I lost weight and regained it, doctors criticized me for not trying harder"	
Always	0.0
Usually	0.4
Sometimes	9.7
Rarely	14.9
Never	75.0
"Doctors have said critical or insulting things to me about my weight"	
Always	1.2
Usually	0.8
Sometimes	11.2
Rarely	15.3
Never	71.5
"I have been very upset by comments that doctors have made about my weight"	
Always	1.6
Usually	2.8
Sometimes	17.7
Rarely	31.0
Never	46.8
"I feel that I have been treated disrespectfully by the medical profession because of my weight"	
Always	0.8
Usually	7.2
Sometimes	14.5
Rarely	21.7
Never	55.8
"Doctors have tried to scare me into losing weight by warning me about health risks associated with being overweight"	
Always	2.8
Usually	4.0
Sometimes	24.2
Rarely	25.0
Never	44.0
"I feel that I cannot speak freely with doctors about my weight"	
Always	3.2
Usually	10.9
Sometimes	20.6
Rarely	23.8
Never	41.5
"I feel that doctors don't believe me when I tell them that I don't eat that much"	
Always	5.8
Usually	5.4
Sometimes	24.0
Rarely	18.2
Never	46.7
"I feel that doctors don't treat overweight people as nicely as they do average-weight people"	
Always	2.0
Usually	8.5
Sometimes	28.5
Rarely	21.1
Never	39.8
"Doctors have told me that I need to lose weight without my asking them"	
Always	3.2
Usually	16.1
Sometimes	39.1
Rarely	16.5
Never	25.0
"I feel that most doctors don't understand how difficult it is to be overweight"	
Always	8.1
Usually	19.0
Sometimes	36.8
Rarely	17.0
Never	19.0

*Percentages may not total 100 because of rounding.



The percentage of physicians who, according to their patients, recommended each of 10 weight loss methods. Patients were given no additional information about the weight loss methods than that shown.

CORRELATES OF SATISFACTION WITH CARE

Patients' degree of satisfaction with the care they received for their obesity was examined in relation to several variables, shown in Table 1, including depression (as measured by the BDI-II) and patients' weight. Each variable was correlated with the 7 items shown in Table 2. Only correlations significant at $P \leq .007$ (ie, $0.05/7 = 0.007$) were considered statistically significant. Patients' BDI-II scores correlated negatively with all 7 weight satisfaction items, with r values ranging from -0.18 to -0.27 ($P < .007$ for all). Thus, the more symptoms of depression patients reported, the less satisfied they were with the components of care they received for their obesity. No relations were found between the 7 items and patients' BMI, years with their physician, or number of office visits per year. An analysis of variance revealed no significant ($P > .23$) differences in satisfaction with obesity care in relation to patients' ethnicity, physicians' sex, or type of health care coverage. There were no significant ($P > .37$) relations between these same variables (shown in Table 1) and patients' satisfaction with their general medical care.

PHYSICIANS' WEIGHT MANAGEMENT PRACTICES

Data presented in Table 3 reveal that patients did not appear to rely on their primary care physicians for weight management. Almost half (45.5%) of the participants reported that they did not look to their physician "at all" for help with weight control, and 29.7% indicated that they did so only a "slight amount." One third of patients reported that their physician discussed weight control with them at least at every other visit. However, 39% responded "once in a while," and 27.8% reported "never."

Almost half (44.8%) of the respondents indicated that their physician had not prescribed any of the 10 weight control methods shown in the **Figure**; 21.6% reported that

their physician had prescribed 1 intervention; 17.0%, 2 methods; 7.7%, 3 methods; and 5.0%, 4 methods.

Nearly one fourth (23.2%) of the physicians were reported (by respondents) to have prescribed a diet plan, with a commercial weight loss program (Weight Watchers), medication, readings, and exercise the 4 next most commonly prescribed interventions. Physicians, according to patients, made few referrals to dietitians, exercise instructors, or other commercial weight loss programs. No significant relations were found between patient characteristics (including BMI) and the number of weight loss methods that physicians were reported to have prescribed.

PATIENTS' REPORTS OF NEGATIVE INTERACTIONS WITH PHYSICIANS

Findings presented in Table 4 indicate that patients generally did not report negative interactions with physicians concerning their weight. Nearly 80% of the respondents indicated that they rarely or never had been "treated disrespectfully by the medical profession because of my weight." Similarly, approximately 80% indicated that they rarely or never: (1) had "been very upset by comments that doctors have made about my weight," (2) had physicians say "critical or insulting things to me about my weight," or (3) had "doctors criticize me for not trying harder" when patients lost weight and regained it.

In contrast to these generally favorable findings, nearly two thirds of the respondents indicated that their physicians "don't understand how difficult it is to be overweight" (as indicated by responses of "always," "usually," or "sometimes"). About one third of patients indicated that "doctors don't believe me when I tell them that I don't eat that much."

CORRELATES OF NEGATIVE INTERACTIONS

No significant ($P > .41$) relations were found between patients' reports of negative interactions with physicians and

participants' BMI or depression score. Similarly, none of the 10 items in Table 4 was significantly related to physicians' sex. White and African American women differed significantly on only one scale. White women were more likely than African American women to report that "I cannot speak freely with doctors about my weight" (score, 4.3 ± 1.1 vs 3.8 ± 1.1 ; $P < .003$).

COMMENT

Results of this study provide encouragement for the treatment of obesity in primary care practice, while also raising concerns. The encouraging news is that the great majority of obese women did not report being treated disrespectfully or insensitively by their physicians when weight management was discussed. This finding presents a welcomed contrast to the anecdotal portrait of a hostile practitioner who berates patients for not losing weight.^{9,20} The concern, however, is that most practitioners, according to their patients, offer little or no guidance for weight management. In this regard, the findings support the contention of Frank⁵ that many physicians avoid the treatment of obesity.

This study was undertaken because of concerns that obese patients might be treated disrespectfully by health care professionals (who, for the purposes of weight management, include dietitians, exercise specialists, nurses, physicians, and psychologists). Several of us (T.A.W., D.A.A., G.D.F., and D.B.S.) have encountered patients who reported that they were criticized by their physician for failing to lose weight, for supposedly lying about what they ate, or for simply not trying harder. We were troubled by these reports and sought to repair any damage to patients' self-esteem. We also wanted, however, to determine the prevalence of such occurrences in a well-defined sample. The results of this study indicate that a small minority of patients do believe that they are routinely (always or usually) criticized or treated disrespectfully by health care professionals, as revealed by responses to the first 4 items in Table 4. This finding is cause for concern. The prevalence, however, of such complaints, which ranged from 0.4% to 8.0%, was far lower than we had feared, based on anecdotal reports. Thus, even though the patients we studied were significantly overweight and had a history of failed weight loss efforts, 90% reported that their primary care physicians had rarely or never criticized them for not trying harder or said critical or insulting things about their weight. These results contrast with those of Rand and MacGregor,¹¹ 78% of whose patients reported having been treated disrespectfully. The difference between these 2 studies may have been related to the greater obesity of Rand and MacGregor's patients (ie, their mean BMI was 45.4) and to their potentially greater distress with weight management. High distress or frustration may be factors that lead patients to choose bariatric surgery. However, Rand and MacGregor surveyed only 57 patients and assessed negative patient-physician interactions

using only a single item. These findings need to be replicated in a larger sample of patients who undergo bariatric surgery, using more questions, as in the present study.

The obese women we studied appeared to be generally satisfied with their overall medical care and with their physicians' expertise pertaining to their general health. As expected, however, they were significantly less satisfied with their care (and their physicians' expertise) related to weight management. Ratings of each of these items fell in the neutral range (ie, neither satisfied nor dissatisfied). Moreover, as shown in Table 2, patients were significantly less satisfied with each of the components of care provided for their weight than for their general health.

We had expected patients to report greater dissatisfaction with their physicians' weight-related attitudes and practices. Two factors may have minimized such complaints, the first which is overweight individuals' tendency to blame themselves for their obesity and for their inability to lose weight.⁹ Many obese individuals view their obesity as a personal failing. Second, these women did not appear to expect their physicians to provide weight counseling; 75% reported that they did not look to their physician at all or only a slight amount to help them with their weight. According to patients, almost half of their physicians had not prescribed any of the weight loss methods shown in the Figure, and more than two thirds of physicians never or only once in a while broached the topic of weight control. Thus, for many of these women, the treatment of obesity appears to have ended in a stalemate; patients have few expectations of receiving assistance from their physicians, and few practitioners offer significant help.

It is possible that a review of patients' medical records (or transcripts of office visits) would reveal that more physicians had, in fact, discussed the importance of weight loss and recommended appropriate methods of weight reduction. Unfortunately, we were unable to conduct such a review. If this finding were obtained, it would suggest that primary care physicians would need to either discuss weight control more frequently or tailor their messages so that patients would be more likely to hear them.

The generalizability of our findings is open to question, given that they were obtained with patients in a research clinic. It is possible that obese patients who were surveyed in primary care practices would be more likely to report negative weight-related interactions with physicians. Our sample, however, was selected specifically to increase the likelihood of identifying patients who had failed to control their weight with their physicians' assistance, thus increasing the likelihood of unfavorable patient-physician interactions concerning weight. Similarly, we thought that assuring patients' confidentiality, and assessing them at a site removed from their physician's office, also would increase reports of negative, weight-related interactions. Apparently, it did not. Another explanation for our relatively low rate of complaints is that if patients had been offended by their physicians' re-

marks, they might be unlikely to seek weight reduction at a research clinic such as ours. This would prevent us from assessing individuals who potentially would report the most negative physician-patient interactions concerning weight. A final explanation is that negative physician attitudes toward obesity, reported 10 to 30 years ago, may have improved in light of important discoveries concerning the roles of genetic²¹ and neuroendocrine²² factors in the regulation of body weight. Physicians may treat obese individuals with greater respect and understanding than they did before such discoveries.

Physicians in this study were defined generically as "primary care physicians" and were identified, as such, by their patients. In future studies, each practitioner's area of specialization should be identified and verified independently. Differences, for example, in patients' satisfaction with weight management might be observed based on whether their physician specialized in family medicine, internal medicine, gynecology, or other areas.

Further studies are needed to determine whether patients who are less obese than our participants, or who have not sought weight management in a specialty clinic, have different views of physicians' weight control attitudes and practices. Such investigations might best be completed using a randomly selected national sample that includes men and women and individuals of varied ethnicity and socioeconomic status. It would also be useful to assess physicians' perceptions of their own weight control attitudes and practices, compared with patients' reports of these factors.

In the meantime, the good news from this study is that primary care physicians do not appear to have routinely alienated their obese patients by making critical or offensive remarks about weight. The challenge, however, for physicians, raised by Frank,⁵ is to determine how they can help obese individuals reduce their initial weight by 5% to 15% and, thus, improve physical and psychological health.^{1,23-26} New treatment guidelines and approaches^{1,4,25,27} should be of assistance to this end, as should physicians' communicating that they recognize the substantial effort that many obese individuals have already devoted to weight control.²⁸

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