VIEWPOINT

Obesity Treatment, Beyond the Guidelines
Practical Suggestions for Clinical Practice

Scott Kahan, MD, MPH
Department of Health Policy & Management, Johns Hopkins Bloomberg School of Public Health, Washington, DC; and National Center for Weight and Wellness, Washington, DC.

JoAnn E. Manson, MD, DrPH
Department of Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts; and Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, Massachusetts.

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Corresponding Author: JoAnn E. Manson, MD, DrPH, Brigham and Women's Hospital, Harvard Medical School, 900 Commonwealth Ave, Third Floor, Boston, MA 02215 (jmanson@rics.bwh.harvard.edu).

Counseling patients about weight management may be one of the most challenging aspects of primary care. Clinicians widely perceive that they have a responsibility to address obesity, although this has not generally translated to clinical practice. According to a study of 1500 health care practitioners, 97% responded that they have a responsibility to ensure that patients are counseled about obesity.[1] In another study of 606 clinicians, 96% "agree" or "somewhat agree" that they should contribute to patients' weight management, 88% acknowledged that moderate weight loss is "extremely beneficial" for patients with obesity, and 80% recognized obesity as a disease.[2]

Despite these perceptions and clear guideline recommendations, however, clinicians seldom discuss, diagnose, or document overweight or obesity.[3] Only 4.9% of primary care visits are for weight management, despite more than 70% of adults in the United States having a body mass index (BMI) greater than 25.[3] Up to 90% of persons with BMIs of 30 to 35 do not receive a formal diagnosis of obesity.[3] Some studies point to declining rates of weight counseling.[3] Although Medicare covers behavioral counseling for obesity, less than 1% of eligible patients receive this benefit.[3]

This paradox is not new, but is understandable because clinicians receive little training on obesity or nutrition. Few medical schools meet curriculum recommendations for nutrition and obesity education, and obesity topics are rarely tested on licensing examinations.[3,4] Other barriers to managing obesity in primary care include limited time, inconsistent insurance reimbursement, and a sense of futility.[3,5] Moreover, confusion and mixed messages in the media can impede motivation to address these issues. Information overload challenges patients and clinicians alike; for instance, a Google search for "weight loss" reveals 894 million entries.

But, the landscape is improving. Evidence-based guidelines and practical resources are available. Access to specialist referrals and community resources is increasing, easing the time burden on busy clinicians. Reimbursement is improving. Medical schools are devoting more time to obesity and nutrition, and some training programs and certifications in obesity medicine, nutrition, and even culinary medicine are becoming available.

The potential benefits of compassionate, coordinated obesity treatment are clear. In 2018, the United States Preventive Services Task Force (USPSTF) reaffirmed its 2003 and 2012 guidance on the effectiveness of, and imperative for, behavioral counseling for obesity.[5] Several practical strategies could be helpful to structure an approach to obesity management in clinical practice, using a convenient "ABCDEF" framework (**Table**).

A. Ask "permission" before discussing obesity. It may seem awkward to ask patients for permission to discuss a clinical issue, but doing so supports patients' autonomy and is a respectful and strategic way to broach a sensitive topic. Patients who decline counseling will nonetheless know that they can seek support when they are ready.

B. Be systematic in the clinical workup. Advising patients to "just eat less and exercise more" is unhelpful, especially for patients affected by binge eating disorder, adverse childhood experiences and trauma, medication-induced weight gain, and other common contributors to weight gain. A clinical problem-solving approach should be used, with an eye toward identifying causes and leverage points. Elicit a weight history and explore the patient's weight trajectory, what has contributed to weight gain, what has or has not worked in the past, and barriers that may get in the way of sustained behavioral changes.

C. Counseling and support improve weight loss perceptions (eg, awareness of weight status, motivation to manage weight) and outcomes (eg, short- and long-term weight loss, improvement in weight-related conditions).[2] For example, in a trial of 415 patients with cardiovascular risk factors, patients randomized to receive primary care counseling maintained greater weight loss over 2 years, compared with self-directed weight loss (11.2 lb vs 1.7 lb).[6] Support motivation by appealing to patients' interests, values, and preferences. Because current evidence does not define a "best diet," patients should be counseled on how to strategically decrease energy intake within a dietary pattern that is reasonably appealing and convenient. It remains important to encourage intake of whole foods and minimize ultraprocessed foods and added sugars. Helping patients manage expectations is important; whereas achieving a "normal" weight is unrealistic for many patients, sustained weight loss of 5% to 10% is often achievable and improves health. Then, aiming for additional weight loss and positive behavioral changes over time is still an option.

D. Determine health status. Patients should be evaluated for weight-related health conditions (eg, diabetes, hypertension, sleep apnea, osteoarthritis), disability, and impaired quality of life so that intensity of treatment can be aligned with severity of disease. Obesity treatment is indicated when a patient's weight affects health, quality of life, or functioning. In contrast, some excess weight beyond normative levels or societal norms in the absence of adverse health effects does not necessarily demand management beyond preventive monitoring.

E. Escalate treatment when appropriate. According to the USPSTF, current evidence is insufficient to recommend pharmacotherapy in healthy individuals, despite elevated weight.[5] However, when excess weight is complicated by health risks and if a patient does not achieve enough improvement in weight and health with counseling alone, then obesity medications (BMI ≥27)

Table. An "ABCDEF" Approach to Guide Weight Counseling in Primary Care

Steps	What to Do
Ask "permission"	• Assess patient readiness to discuss weight issues. Consider begining the conversation with questions such as, "Your weight has been increasing over the years, which could lead to diabetes and other health problems. Would it be okay if we started working together on this?"
Be systematic in the clinical workup	• Elicit weight history, motivations, barriers, and social determinants. • Medications that may cause weight gain include some antidepressants, antipsychotics, insulin, sulfonylureas, steroids, and pain medications.
Counseling and support	• A wide range of dietary patterns can help weight management. • Physical activity, even just walking, is essential for health. • Use free online tools and resources, such as Dietary Guidelines for Americans, obesity treatment guidelines, and the Diabetes Prevention Program curriculum and handouts.
Determine health status	• Evaluate for weight-related health conditions (eg, diabetes, sleep apnea), physical limitations, and decreased quality of life.
Escalate treatment when appropriate	• Consider medication (BMI ≥27) or bariatric surgery (BMI ≥35) when weight-related health conditions are present. • Medication options for long-term use include orlistat, lorcaserin, phentermine/topiramate-extended release, naltrexone/bupropion-sustained release, and liraglutide.
Follow up regularly and leverage available resources	• Create a care team by identifying local obesity specialists (eg, obesity medicine physicians, registered dietitians), community programs (eg, YMCA-based diabetes prevention program), and other resources (eg, commercial weight-loss programs, health coaches, digital or telehealth platforms). • A few minutes at the end of an unrelated appointment can be used to check in on patients' progress and offer support. • Utilize medical assistants and other office staff to save time by assisting with patient education, monitoring, and coordinating care.

approved by the US Food and Drug Administration (FDA) or bariatric surgery referral (BMI ≥35) should be considered. Medications and surgery lead to more weight loss and health improvements than behavioral counseling alone. In patients with type 2 diabetes mellitus (T2D), obesity medications combined with counseling improves hemoglobin A_{1c} by 0.5% to 1.6%—as much improvement as with many FDA-approved diabetes medications; for patients at risk of T2D, medications decrease the risk for progression to T2D by as much as 40% to 80% over 2 to 4 years.[7] Bariatric surgery improves numerous comorbidities and decreases mortality.[8]

F. Follow up regularly and leverage available resources. Obesity will not be solved in a single clinic visit, yet only 24% of 3008 patients in a recent survey reported having a follow-up appointment scheduled after an initial weight loss discussion.[2] Clinicians should offer support and monitor weight and other metrics, such as changes in waist circumference and weight-related risk factors, as well as subjective improvements in energy, mobility, and chronic pain symptoms. Frequent counseling is essential, but clinicians need not provide this alone. When expertise or time demands exceed the clinician's capacity, referral of patients to other practitioners or services, such as obesity medicine physicians, registered dietitians, behavioral therapists, commercial or community programs, or digital and telehealth programs, should be considered. Increasingly, these services are becoming more available throughout the United States and many are covered by health plans. A trial involving 1882 patients and 137 primary care physicians in the United Kingdom showed that a basic, 30-second intervention, in which physicians screened patients and offered referral to a community weight loss program, led to more weight loss than in the control group (5.4 lb vs 2.2 lb over 12 months).[9]

This ABCDEF approach, although not formally validated, is based on published guidelines and is meant to be practical and useful for clinicians. Although coordinated policy, as well as environmental and societal changes, will be required to reverse the obesity epidemic, clinicians have an integral role. Even modest steps can significantly improve patients' health; for example, a 7% weight loss decreases the risk of diabetes by 58%, even if half of the lost weight is regained over several years.[10]

Still, clinicians should appreciate that weight loss is not the only important factor in the obesity epidemic. Many patients experience weight stigma, profound shame, and hopelessness. Clinicians are often frustrated that they cannot "solve" patients' weight problems in the same way they may resolve or "cure" other conditions. Attempts to achieve effective obesity management will be frustrating at times, both for patients and clinicians alike. Treating each patient with respect, offering attention and support, and developing individualized treatment approaches will be important steps to making progress.

ARTICLE INFORMATION

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