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ORIGINAL ARTICLE

Physician knowledge about and perceptions of obesity management



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Summary

Objective: Approximately 35% of US adults are obese. The purpose of this study was to assess the knowledge and practice patterns of primary care physicians (PCPs), endocrinologists (ENDOs), cardiologists (CARDs) and bariatricians (BARIs) regarding obesity.

Methods: A case vignette survey was distributed to 1625 US-based PCPs, ENDOs, CARDs, and BARIs via email and fax in February 2013. Results were analysed with PASW Statistics 18.

Results: Respondents included 100 PCPs, 100 ENDOs, 70 CARDs, and 30 BARIs. The majority agreed obesity is a disease as defined by the AMA, however, half of PCPs, ENDOs, and CARDs also agreed obesity results from a lack of self-control. Familiarity with select obesity guidelines was low. Nearly all respondents used body mass index for obesity screening. No consensus as to when to initiate weight-loss medication was observed. Many physicians expected a larger weight loss with pharmacotherapy than is realistic (~30%) or were unsure (~22%). A majority of PCPs, ENDOs and CARDs expected less excess weight loss with gastric bypass surgery than is realistic, BARIs had a more reasonable expectation.

Conclusions: Overall, respondents demonstrated knowledge gaps for obesity guidelines and pathophysiology and generally lacked understanding of obesity medication efficacy, safety and MOA.

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Introduction

Obesity is defined as having a body mass index (BMI) ≥ 30 kg/m² and is recognised by the American Medical Association (AMA) as a disease involving the presence of an excessively high level of body fat in relation to lean tissue putting people at health risk [1,2]. The latest data (2011–2012) from the National Health and Nutrition Examination Survey, National Center for Health Statistics find that 35% of adults in the United States (US) are obese [3]. Obesity is the second leading cause of preventable death in the US and is a leading cause of morbidity, disability, healthcare utilisation, and healthcare costs [4]. Annual medical costs for individuals who are obese are 42% higher than for people with normal weight [5]. The medical costs of obesity in the US may be as high as \$186 billion, with 17% of national health expenditures used to manage obesity-related conditions [6].

Patients who are obese have an increased risk of comorbidities such as type 2 diabetes, cardiovascular disease, hypertension, dyslipidaemia, osteoarthritis, certain types of cancers, benign prostatic hyperplasia, reduced fertility, asthma, obstructive sleep apnoea, and other respiratory problems [7,8]. Obesity in adults is also associated with psychosocial complications such as emotional distress, prejudice, discrimination (in employment, healthcare, education, interpersonal relationships, the media), reduced quality of life, and social stigmatisation [9].

Despite the association of obesity with psychosocial complications and other comorbid conditions and the availability of weight management guidelines, physicians' rates of screening, diagnosing and management of obesity are low. In a 2007 study of 140 primary care physicians (PCPs) by Bardia et al., only 19.9% of obese patients had a recorded diagnosis of obesity and 22.6% had a documented obesity management plan [10]. Boardley et al. ascertained that the 47 family medicine physicians they studied had calculated a BMI for 63.5% of patients with a BMI >25 kg/m² and half or less of these patients had received education on weight loss through diet and exercise [11]. Ma et al. performed an analysis of the 2005 and 2006 National Ambulatory Medical Care Survey (NAMCS). Half of office visits to physicians with specialties of primary care or cardiovascular disease lacked enough data to screen for BMI, thus 70% of patients who are obese were not diagnosed, and 63% received no counselling about diet, exercise, or weight reduction [12]. Bleich et al. analysed data from the 2005 NAMCS and determined that 28.9% of obese adults in the practices studied (63% PCP, 10% cardiology and

internal medicine, 27% other) received an obesity diagnosis, and one-quarter or less were counselled about weight reduction, diet, and exercise [13]. Smith et al. surveyed 1211 PCPs and found that less than half regularly recorded BMI or always provided specific guidance on diet, exercise, or weight control [14]. However more than 70% of respondents had prescribed pharmacologic treatment for overweight patients and 86% had referred patients for evaluation for bariatric surgery [14]. With the exception of the Bleich study, which included cardiologists (CARDs), there have been no recent studies of the practice patterns of CARDs and endocrinologists (ENDOs) with respect to the diagnosis and management of obesity. PCPs, ENDOs, and CARDs manage patients with a variety of health conditions, which may lead to obesity being a lower priority. However, as obesity is a significant risk factor for many other conditions, the early diagnosis and management of obesity are essential.

Bariatric medicine is a growing specialty performed by physicians with a specific interest in obesity. The American Board of Bariatric Medicine was established in 1970 so that bariatricians (BARIs) could obtain credentials for their practices. Currently, BARIs, who come from a diverse background including PCPs, CARDs, and ENDOs, comprise physicians who are credentialed by the American Board of Obesity Medicine (ABOM). There are 850 BARIs certified by the ABOM, far fewer than are needed to manage all patients who are obese.

Patients who are obese may be diagnosed and/or managed by their PCP or by specialists who manage their comorbid conditions such as type 2 diabetes or cardiovascular disease, such as ENDOs or CARDs, or by BARIs. The field of obesity management is rapidly changing and PCPs, ENDOs, CARDs, and BARIs need to keep abreast of these changes. This study explored the primary educational needs, attitudes, practice patterns and barriers facing US-based PCPs, ENDOs, CARDs and BARIs, with respect to obesity screening and management to provide information on the educational gaps of these physicians.

Methods

Four similar survey instruments for PCPs, ENDOs, CARDs, and BARIs were developed to examine the attitudes, knowledge and decisions about, and barriers to the management of obesity for PCPs, ENDOs, and CARDs, who may not practice bariatric medicine, in addition to BARIs. The surveys presented several hypothetical patients in progressive case vignettes, and included questions addressing

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