ELSEVIER

Surgery for Obesity and Related Diseases ▮ (2015) 00–00

SURGERY FOR OBESITY AND RELATED DISEASES

Original article

Primary care physician decision making regarding severe obesity treatment and bariatric surgery: A qualitative study

Luke M. Funk, M.D., M.P.H.[a,b,*], Sally A. Jolles, M.A.[a,b], Caprice C. Greenberg, M.D., M.P.H.[a], Margaret L. Schwarze, M.D.[a], Nasia Safdar, M.D., Ph.D.[b,c], Megan A. McVay, Ph.D.[d,e], Jeffrey C. Whittle, M.D.[f,g], Matthew L. Maciejewski, Ph.D.[e,g], Corrine I. Voils, Ph.D.[e,g]

[a]*Department of Surgery, Wisconsin Surgical Outcomes Research Program (WiSOR), University of Wisconsin-Madison, Madison, Wisconsin*
[b]*William S. Middleton Veterans Memorial Hospital, Madison, Wisconsin*
[c]*Department of Medicine, University of Wisconsin-Madison, Madison, Wisconsin*
[d]*Department of Psychiatry and Behavioral Science, Duke University Medical Center, Durham, North Carolina*
[e]*Durham VA Medical Center, Health Services Research & Development, Durham, North Carolina*
[f]*Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin*
[g]*Department of Medicine, Duke University Medical Center, Durham, North Carolina*

Received July 22, 2011; accepted November 26, 2015

Abstract

Background: Less than 1% of severely obese US adults undergo bariatric surgery annually. It is critical to understand the factors that contribute to its utilization.

Objectives: To understand how primary care physicians (PCPs) make decisions regarding severe obesity treatment and bariatric surgery referral.

Setting: Focus groups with PCPs practicing in small, medium, and large cities in Wisconsin.

Methods: PCPs were asked to discuss prioritization of treatment for a severely obese patient with multiple co-morbidities and considerations regarding bariatric surgery referral. Focus group sessions were analyzed by using a directed approach to content analysis. A taxonomy of consensus codes was developed. Code summaries were created and representative quotes identified.

Results: Sixteen PCPs participated in 3 focus groups. Four treatment prioritization approaches were identified: (1) treat the disease that is easiest to address; (2) treat the disease that is perceived as the most dangerous; (3) let the patient set the agenda; and (4) address obesity first because it is the common denominator underlying other co-morbid conditions. Only the latter approach placed emphasis on obesity treatment. Five factors made PCPs hesitate to refer patients for bariatric surgery: (1) wanting to "do no harm"; (2) questioning the long-term effectiveness of bariatric surgery; (3) limited knowledge about bariatric surgery; (4) not wanting to recommend bariatric surgery too early; and (5) not knowing if insurance would cover bariatric surgery.

Conclusion: Decision making by PCPs for severely obese patients seems to underprioritize obesity treatment and overestimate bariatric surgery risks. This could be addressed with PCP education and improvements in communication between PCPs and bariatric surgeons. (Surg Obes Relat Dis 2015;▮:00–00.)

The research described in this manuscript was supported by a 2014 ASMBS Research Grant to Dr. Funk. This work was also supported by grant UL1 TR000427 from the Clinical and Translational Science Award (CTSA) program through the National Institutes of Health National Center for Advancing Translational Sciences and by resources from the Department of Veterans Affairs (DVA). The design and conduct of the study, data collection, management, analysis, approval of the manuscript, and decision to submit were made solely by the research team.

*Correspondence: Luke M. Funk, M.D., M.P.H., Assistant Professor of Surgery, University of Wisconsin School of Medicine and Public Health, Department of Surgery, 600 Highland Avenue H4/728 Clinical Science Center, Madison, WI 53792-7375, USA.
E-mail: funk@surgery.wisc.edu

http://dx.doi.org/10.1016/j.soard.2015.11.028
1550-7289/

Keywords: Primary care physicians; Obesity treatment attitudes; Bariatric surgery

Although the overall rates of obesity have stabilized in the United States in recent years, the prevalence of severe obesity (body mass index [BMI] of $\geq$35 kg/m^2) has increased by 70%, to 18 million, over the past decade [1]. This increase has resulted in significant costs to the US healthcare system. Although they comprise only 37% of the employed population with obesity (BMI $\geq$30), individuals with a BMI $\geq$35 generate nearly two thirds of the annual excess costs to employers, attributable to obesity, which amounts to >$40 billion per year [2].

Bariatric surgery is the most effective treatment for severe obesity. It achieves substantial and sustained weight loss, co-morbidity resolution, and improvements in quality of life and is associated with extended lifespan [3–5]. A systematic review has indicated that it is cost effective [6,7]. All professional societies that represent physicians who manage severely obese patients—the American College of Cardiology/American Heart Association [8], American Association of Clinical Endocrinologists [9], the Obesity Society [9], the American Society for Metabolic and Bariatric Surgery [9], and the American Academy of Family Physicians (AAFP) [10]—recommend bariatric surgery referral and evaluation for morbidly obese patients considered appropriate surgical candidates. Despite these data, <1% of severely obese US adults undergo bariatric surgery annually [11].

Given that a relatively small proportion of eligible patients receive bariatric surgery, it is critical to understand barriers and facilitators to the utilization of bariatric surgery. A recently published systematic review found that both patients and referring practitioners had significant concerns about the outcomes and safety of bariatric surgery, although they admitted they had limited knowledge about obesity treatment options in general [12]. Only 1 study included practitioners as participants and did not assess how the providers made treatment decisions with regard to severe obesity. Rather, it focused on barriers to referral faced by primary care physicians (PCPs) [13]. Another study included in the systematic review found that PCP recommendations were identified as an important predictor of whether a patient would consider bariatric surgery [12,14].

To better understand how PCPs make treatment recommendations for their severely obese patients, we conducted focus groups with PCPs in Wisconsin. We sought to better understand how PCPs prioritize the recommendations made to severely obese patients. We also investigated how PCPs approach bariatric surgery as a treatment option and the challenges they encounter during the referral process.

Materials and methods

Study design and recruitment

We conducted 3 focus groups with PCPs who were members of the Wisconsin Research and Education Network (WREN), a statewide practice-based research network of 200 primary care clinicians and >200 researchers [15,16]. Interested clinicians were asked to complete a short eligibility survey online. Of the 27 clinicians who completed the survey, the 26 who met our eligibility criteria were MDs or DOs, managed adult patients (>50% of their practice), and had evaluated at least 5 severely obese patients (BMI >35 or higher) in their clinic over the past 6 months. A member of the University of Wisconsin (UW-Madison) Survey Center team called all 26 eligible PCPs and invited them to attend upcoming focus groups scheduled in Mauston (population 4423), Madison (population 233,209), and Milwaukee (population 594,833) [17].

Focus group procedures and guide

After obtaining written informed consent from participants, a trained moderator facilitated discussion, using a script with prespecified questions and discussion topics (Appendix). The focus group script followed a questioning route [18], which was guided by our study's primary objectives. Participants were given a clinical vignette describing a severely obese (BMI 46) 52-year-old male, who was attending his first PCP visit. His co-morbidities included type 2 diabetes (T2D), hypertension, obstructive sleep apnea, and anxiety. He smoked 1 pack of cigarettes per day. The PCPs were asked how they would prioritize treatment of his multiple health conditions and when, if ever, they would include bariatric surgery as a treatment option. The moderator then asked the participants to discuss their approach to treatment of severe obesity more generally, using open-ended probes to ensure that the key themes were addressed.

The duration of each focus group session was approximately 90 minutes. Upon completion of the session, participants completed an anonymous questionnaire, which included questions on demographics. All sessions were audio-recorded and transcribed. Each focus group participant received $150 upon completion of the focus group session.

Qualitative data analysis

Focus group sessions were analyzed by using a directed approach to content analysis [19]. Three research team