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THE BIG ISSUE

Discussing weight loss in general practice

NEW ZEALANDERS ARE GETTING FATTER. That's a fact. When a problem is getting worse, it is time to reassess the methods we are using to solve it. Is general practice addressing obesity and weight loss in the right way?

The biggest barrier that patients must overcome in losing weight is in owning up to the problem in the first place. This is much more achievable for patients who have a non-judgemental and supportive environment in which to do this. Do not mistake being fat for being ignorant - most overweight people know that being thinner is healthier, they just do not know how to achieve it.

Dr Robyn Toomath, Endocrinologist and spokesperson for Fight the Obesity Epidemic and Dr Gabrielle Ruben, GP and weight management specialist, speak about dealing with weight loss in general practice.

Obesity is reaching epidemic proportion worldwide. What is the situation in New Zealand and what do you see as the main reasons why this problem is getting worse?

It is estimated that over half of the adult population of New Zealand is overweight or obese. The National Children's Nutritional Survey 2002 identified that overall 29% of boys and 34% of girls in New Zealand were overweight or obese. This figure was even higher for Pacific children (52%), Māori children (41%) and children from the most deprived quintile (40%).

Dr Toomath notes that there has been an upward trend in obesity rates and she believes that most New Zealanders are now overweight or obese.

The reasons why obesity rates are increasing are complex and multifactorial. Both Dr Toomath and Dr Ruben place a large proportion of blame on the obesogenic environment in which we now live.

"People are living more sedentary lives. Work environments are stressful, people tend to eat on the run leading to bad food choices. Ipods, remote controls and cell phones all contribute to the inactive way in which we live. Media advertising of food can be seductive and young people are particularly vulnerable to this. Stress and depression also play a significant role in peoples' eating habits. Eating becomes habitual, providing comfort and is frequently not associated with hunger." – Dr Ruben

One of the most difficult challenges that primary health care providers face is when, and how, to bring up the issue of weight loss with patients. What advice can you give about this? Are there any particular communication methods that work best?

A non-judgemental, supportive and careful approach is imperative. People who are overweight or obese generally know so and often feel dismayed, frustrated, embarrassed, guilty and have poor self-esteem. A clinician who

disapproves, scolds and blames is likely to only succeed in making the patient feel worse and still not address the problem.

"I don't ever ask people to lose weight – I am more inclined to explain the drivers that have resulted in their being overweight so that the blame is shifted away from them as much as possible." – Dr Toomath

"I emphasise that I see the issue of being overweight as very much a medical problem which often has genetic predispositions. I define it as a disease type because I think this takes the heat out of the problem and removes moral judgements and allows patients to talk about the problem in a more relaxed way. We need to move away from the attitude that patients are weak, lazy or simply overeaters and be more supportive in helping them on what is a long term journey." – Dr Ruben

When to approach the matter of weight loss with patients should be individualised. It is important to know where a person is in time – are they still gaining weight or have they already lost a significant amount? Dr Ruben says it is important to find out the journey that the patient has been on, prior to coming to see you. She tends to avoid using the word "obese" with younger patients as it often makes them fearful or ashamed. Dr Ruben prefers to bring up the weight issue sooner rather than later. For example, if she sees that a child is gaining a lot of weight, it is helpful to speak to the mother about lifestyle and eating habits for the whole family. Depression and anxiety should be considered before raising issues about weight. Dr Ruben often waits for a cue from the patient that talking about weight is okay.

Often successful weight loss is achieved after a motivational trigger such as a medical scare. What motivational tools could be used by primary healthcare providers to initiate weight loss in overweight patients? Is there any evidence that discussing weight loss with patients actually works?

Dr Toomath does not believe that there is evidence that any sort of motivation from healthcare providers results in sustained weight loss.

Dr Ruben believes that there is evidence that discussing weight loss with patients can work. Impaired blood sugar or overt diabetes is usually a key trigger for people wanting to address their weight. Dr Ruben encourages small incremental steps and achievable weight loss goals, often starting with a single behaviour change, such as not eating after the evening meal. If the patient slowly begins to lose weight, then this acts as reinforcement, bringing about positive lifestyle change.

Discussing weight maintenance early is also important, says Dr Ruben. Self monitoring may include regular weight checks, pedometer use and keeping a food diary. Identify a key support person e.g. partner or close friend who can reinforce messages at home. Other tools that can be used are to avoid high risk situations with food and counter conditioning where an alternative is substituted for anxiety related eating. The patient can set personal goals and reward themselves when they have been achieved.

Most people would agree that weight loss is achieved by overall lifestyle changes, however food obviously plays an important role. What dietary advice should primary healthcare providers advocate? Low kilojoule? Low fat? Low carbohydrate? Low protein? Or is it up to the patient to find the diet that works best for them?

Dr Toomath prefers to emphasise exercise over food restriction. She advises patients to consume a wide range of low-calorie foods and fresh fruits and vegetables.

"No diet works best for weight loss. They all work in the short term and they all fail in the long term. I concentrate on people adopting a life-style that is optimal irrespective of their weight. Incidental or work-related exercise, e.g. walking to work or taking the stairs, is more likely to be

sustainable as a habit than recreational exercise e.g. going for a walk/run on nice days." – Dr Toomath

Dr Ruben tries to encourage everybody to learn to eat less. She thinks most New Zealanders eat too much, even of the right types of food. In general it does not make a difference what type of diet is adopted, it is just whether total energy has been reduced. Dr Ruben recommends a diet rich in fruit and vegetables, reduced animal fats and including protein in every meal or snack. Carbohydrates in the diet are fine, as long as they are not primarily derived from starch. Severely restrictive diets are not sustainable in the long term.

"I generally tell people don't start doing anything today or this week that you are not prepared to continue doing for the rest of your life". – Dr Ruben

As well as the types of food that are eaten, the time in which food is eaten is important too. Dr Ruben advocates planning a healthy late afternoon snack to combat poor food choices that often arise from people feeling vulnerable after long periods of not eating.

At what point are lifestyle, exercise and dietary advice not enough? When should pharmacological or even surgical interventions be considered?

Pharmacological aids such as sibutramine (Reductil) and orlistat (Xenical) may help some people with weight loss, but they are generally not considered first-line treatment.

"Pharmacology doesn't seem to have lived up to early promise. Metformin has been shown to produce sustained weight loss of 2 kg on average over a long period of time and is worth considering early in people with impaired glucose tolerance. I don't use the other drugs any more." – Dr Toomath

Both doctors agree that surgical intervention is a good option for some people.

"Surgery is a good option for those who have a life of obesity related problems ahead of them i.e. if they are young and otherwise fit but have type 2 diabetes and a BMI of 35 or if they have a BMI of 40 or more."– Dr Toomath

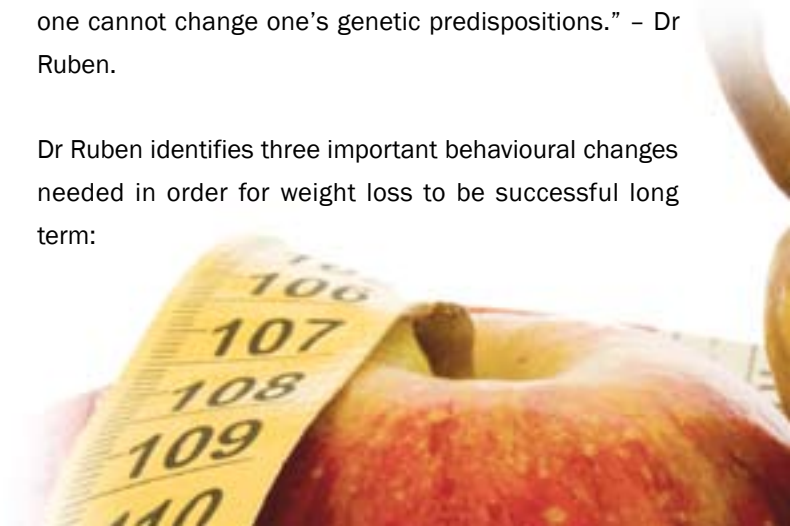
"Surgical intervention definitely has a place for those who have been obese for a very long time and who may also have serious complications associated with obesity such as severe hypertension, diabetes, heart disease, joint problems, obstructive sleep apnoea, musculoskeletal issues and most particularly, psychological problems. Of course there are risks associated with surgery but there are equally serious risks associated with chronic and severe obesity." – Dr Ruben.

Is "misuse of food" an addiction just like alcohol or drugs? Is there a role for behavioural therapy or counselling in achieving weight loss?

According to Dr Ruben there is definitely an important place for behavioural therapy and counselling in weight loss. Some of the thought processes that may assist with behavioural change have previously been discussed. Dr Ruben identifies body image as a key area in which counselling can be useful.

"Many people, particularly women, have a very poor body image and even when they lose weight, their body perception does not improve. They think 'well I have lost weight and I am still not happy with the way I look so I may as well eat like I did before'. Counselling or behavioural therapy can be useful to help people appreciate that their body weight and fat is only one aspect of themselves and one cannot change one's genetic predispositions." – Dr Ruben.

Dr Ruben identifies three important behavioural changes needed in order for weight loss to be successful long term:



1. To develop a healthy and positive attitude towards food
2. To address the problem of non-hungry eating
3. To address the problem of body image

Dr Toomath does not believe that "misuse of food" is an addiction that can be treated with behavioural therapy.

The final word...what is your key piece of advice for primary healthcare providers in overcoming the growing obesity epidemic?

"Become activists in support of your overweight patients. Treat them with compassion and petition the government to introduce public health measures to reduce the obesogenic environment." – Dr Toomath

"Look at families, look at children and try to help parents address problems sooner rather than later. Look at the environment in which the person lives, the family, the school and external influences via media and advertising. Look at animal fat, total energy and carbohydrate/protein balance. Emphasise the importance of daily activity – 30 minutes a day, four days per week is absolutely minimal. Be kind, be empathetic. Think of obesity both as a disease and as a symptom." – Dr Ruben

References

1. Hash R, Munna R, Vogel R, Bason J. Does physician weight affects perception of health advice? Prev Med 2003;36(1):41-4.
2. Forman-Hoffman V, Little A, Wahls T. Barriers to obesity management: a pilot study of primary care clinicians. BMC Fam Pract 2006;7:35.

Do patients listen to overweight doctors?

Do you expect a hairdresser to have a good haircut? Do you expect a teacher to know everything? Do you expect a gardener to grow the greenest plants? Do patients expect their doctor not to be fat?

Recent debate has emerged in the US after Dr Regina Benjamin was appointed Surgeon General. She is highly accomplished in her field, extremely well qualified and capable of the job, however she is overweight. The choice of Dr Benjamin has been strongly criticised for sending the wrong message because she is a public figure responsible for, among other things, addressing the obesity problem in the US.

Does body size make a difference when delivering healthcare advice to patients? Are overweight doctors and nurses less likely to address weight issues in their patients? Are patients less likely to listen to advice from overweight healthcare providers?

A US-based study has found evidence that patients with non-obese doctors had more confidence in general health counselling and treatment of illness than those who had obese doctors. Interestingly, there was no significant difference between the two groups in confidence in weight and fitness counselling.[1] Another study found that clinicians who watched their own diets vigorously were more likely than other clinicians to calculate BMI for obese patients (42% vs. 13%).[2]

Healthcare professionals should not shy away from addressing and promoting discussion around a patient's weight purely because they are embarrassed about their own size. In fact, patients may feel more comfortable receiving advice from a person whom they can relate to and who may even share similar struggles.