The Journal of Health Design

EDITORIAL

# Doctors have a limited role in managing obesity

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**To Cite:** Jiwa M, Krejany C, Kanjo E. Doctors have a limited role in managing obesity. JHD. 2021;6(1):356–359. https://doi.org/10.21853/JHD.2021.128

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**SUMMARY**
Obesity management is one of the greatest challenges in medicine. While the obesity epidemic continues to grow, there is increasing pressure on doctors to do more to curb these trends. National bodies offer guidelines and action plans; however, these miss the mark within the constraints of modern practice. While urgent change is needed to combat the health challenges that global obesity raises, medical practice is generally ill-equipped to make an effective change for patients. Significant innovation is needed to be able to deliver strategies that will work in a healthcare context.

**Key Words**
Obesity management; obesity; primary health care; general practice; lifestyle change

## INTRODUCTION

In Australia, by 1995, 64.9 per cent of males and 49.4 per cent of females were overweight or obese. However, in 2014–2015 the proportions had climbed to 70.8 per cent of males and 56.3 per cent of females.[1] In other words, most Australian adults are now overweight. Obesity has a multifactorial aetiology. The drivers that maintain the population as overweight or obese include poverty[2], increasing sedentary lifestyles[3], the availability of cheap, calorie-dense food[4], a lack of food literacy[5], and a plethora of psychosocial factors that have redefined our relationship with food so that eating is now about pleasure, comfort, and rituals, and not just about nutrition and the need for sustenance.[6]

Obesity is a known risk factor for many human ailments, including but not limited to, cardiovascular disease, diabetes, osteoarthritis, and cancer. Overweight and obesity was responsible for 7.0 per cent of the total burden of disease and injuries in Australia in 2011.[7] Essentially that means that the overweight and obese are likely to have a chronic illness and are therefore more likely to attend doctors. In May 2018, the Royal Australasian College of Physicians (RACP) drafted a review of action to prevent obesity and reduce its impact across the life course.[8] The recommendations for the role of doctors in regard to obesity included:

- Appropriate nutrition and physical activity advice with the goal to managing treatable risk factors, such as hypertension and diabetes;
- Building understanding of the positive consequences of weight loss while acknowledging the potential for weight regain and weight cycling;
- Incorporate a respectful understanding of people's social, cultural, economic, and whanau [family] contexts; and
- Regular monitoring of weight, nutrition, and physical activity levels for all adults to ensure that weight management strategies can be implemented before people develop obesity.[8]

The report acknowledges the following:

> *Obesity is a condition caused and sustained by people, with their inherent biological, psychological, social and economic susceptibilities, interacting with obesogenic environments such as food environments dominated by unhealthy foods and transport environments dominated by cars. The resulting behaviours, such as the passive overconsumption of unhealthy foods and beverages, low physical activity and sedentary lifestyles, lead to accumulated unhealthy weight gain over years and decades.*[8]

The challenge in medicine, especially in primary care, is that the average consultation length differs across the world, ranging from 48 sec in Bangladesh to 22.5 min in Sweden (14.9 mins in Australia).[9] In addition, the patient raises more than two problems or concerns per consultation[10]; therefore, the scope to hold detailed discussions of the kind recommended in the RACP report are very limited.[8] Also, as has been raised in multiple studies, doctors are reticent to raise the issue of obesity.[11] Blackburn et al succinctly summarised this reticence:

> *Uncertainty about obesity, concerns about alienating patients and feeling unable to raise the topic within the constraints of a 10 min consultation, is adding to the reluctance of GPs and nurses to broach the topic of weight. Addressing these concerns through training or by providing evidence of effective interventions that are feasible to deliver within consultations may lead to greater practitioner engagement and willingness to raise the topic.*[12]

Patients also find weight loss a particularly difficult topic to address in the context of seeking medical care mainly due to the stigma associated with being overweight. Patients reported to researchers in the following terms[13]:

*"It was slippery on the wooden path and I fell and twisted my knee. I saw my doctor because the knee was painful. Before I was given the chance to tell the story, she said–'you are terribly heavy.'" (Mark)*

*"'For a period, I was enrolled in an activity group where weight reduction was a goal. Afterwards, my GP was expected to provide follow-up, with motivation and weighing. But after a while, she became so busy that she did not have the time to talk with me. I was put into a room on my own with the scale, expected to do the measurements myself. But the room was often unavailable due to lab tests, and I really felt dismissed.'" (Steven)*

Therefore, the challenge includes finding an acceptable segue into the topic of weight management during the course of a routine consultation; the scope to raise the topic in a way that respectfully addresses the ideas, concerns, and expectations of the person who is seeking medical advice; an intervention that is both feasible, effective, and acceptable to both parties and can be delivered within an already brief and busy doctor's visit.

There is no doubt that medicine has a role in alerting people, when possible, to maintain a healthy body weight. However, the primary focus of the medical consultation for those who are overweight is likely to be dealing with the impact of that condition on that individual. Within the 15 mins available in the consultation in primary care in Australia, the doctor may have to tease out the reason(s) the patient has chosen to seek advice, any issues from a previous consultation that need attention; conduct any necessary physical examination; organise any tests

that are mandated; prescribe and explain any medication that is warranted; or write any referral letters that are needed. In terms of health promotion, that doctor might then review the patient's blood pressure, address their cigarette smoking habits, update their alcohol consumption, check the patient's height and weight if not previously recorded, advise on other preventive measures including cervical, bowel, or breast screening tests, and then address the issue of obesity as well as any other risk factors for chronic illness. There is a lot to accomplish in the time available. In addition, those patients who are already chronically ill experience a significant burden due to their illness. Therefore, attending to health promotion activities may be a less than urgent priority.[14]

On this basis, medicine has a very limited role in the management of obesity without further innovation into the delivery of an effective and implementable weight management strategy. Such a strategy would need to be delivered effectively within the context of the short visit that the average person makes to their doctor a mere five times per year.[15] Pitted against these efforts are the ubiquitous factors that drive sedentary habits and the consumption of calorie-dense foods and beverages. The patient will have vastly more influences impacting their decision of what, when, and how much to eat than those impacted by the effect of the briefest visit for the guidance of a medical practitioner on one of a handful of occasions during the year.

## REFERENCES


1. Australian Bureau of Statistics, National Health Survey: First results, 8 December 2015 [cited 2020 Nov 9]. Available from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001
2. Templin T, Cravo OHT, Thomson B, et al. The overweight and obesity transition from the wealthy to the poor in low- and middle-income countries: A survey of household data from 103 countries. *PLOS Medicine* 2019;16(11):e1002968. Doi: 10.1271/journal.pmed.1002968
3. Barnes AS. Obesity and sedentary lifestyles: risk for cardiovascular disease in women. *Texas Heart Institute Journal*. 2012;39(2):224–7. PMID: 22740737; PMCID: PMC3384027.
4. Lampuré A, Castetbon K, Deglaire A, et al. Associations between liking for fat, sweet or salt and obesity risk in French adults: a prospective cohort study. *International Journal of Behavioral Nutrition and Physical Activity*. 2016; Jul 4;13:74. doi: 10.1186/s12966-016-0406-6
5. Rush EC, Yan MR. Evolution not Revolution: Nutrition and Obesity. *Nutrients*. 2017 May 20;9(5):519. doi: 10.3390/nu9050519
6. Van der Valk ES, Savas M, Van Rossum EFC. Stress and Obesity: Are There More Susceptible Individuals? *Current Obesity Reports*. 2018 Jun;7(2):193–203. doi: 10.1007/s13679-018-0306-y
7. Australian Institute of Health and Welfare. Impact of overweight and obesity as a risk factor for chronic conditions: Australian Burden of Disease Study. Australian Burden of Disease Study series no.11. Cat. no. BOD 12. BOD. Canberra: AIHW; 2017 [cited 2020 Nov 9]. Available from https://www.aihw.gov.au/reports/burden-of-disease/impact-of-overweight-and-obesity-as-a-risk-factor-for-chronic-conditions/contents/table-of-contents
8. Royal Australasian College of Physicians. Action to prevent obesity and reduce its impact across the life course. RACP Position Statement on Obesity. RACP; 2018 [cited 2020 Nov 9]. Available from https://www.racp.edu.au/docs/default-source/advocacy-library/racp-obesity-position-statement.pdf
9. Irving G, Neves AL, Dambha-Miller H, et al. International variations in primary care physician consultation time: a systematic review of 67 countries *BMJ Open*. 2017;7:e017902. doi: 10.1136/bmjopen-2017-017902

10. Salisbury C, Procter S, Stewart K, et al. The content of general practice consultations: cross-sectional study based on video recordings. *British Journal of General Practice*. 2013;63(616): e751–9. Doi: 10.3399/bjgp13X674431
11. Mazza D, McCarthy E, Carey M, et al. "90% of the time, it's not just weight": General practitioner and practice staff perspectives regarding the barriers and enablers to obesity guideline implementation. *Obesity Research and Clinical Practice*. 2019;13(4):398–403. doi: 10.1016/j.orcp.2019.04.001
12. Blackburn M, Stathi A, Keogh E, et al. Raising the topic of weight in general practice: perspectives of GPs and primary care nurses. *BMJ Open*. 2015 Aug 7;5(8):e008546. doi: 10.1136/bmjopen-2015-008546
13. Malterud K, and Ulriksen K. Obesity in general practice. *Scandinavian Journal of Primary Health Care*. 2010;28(4):205–10. Doi: 10.3109/02813432.2010.526773
14. Sav, A, Whitty, J.A, McMillan, SS, et al. Treatment Burden and Chronic Illness: Who is at Most Risk? *Patient*. 2016;9:559–69. Doi: 10.1007/s4027-016-0175-y
15. Australian Institute of Health and Welfare. Frequent GP attenders and their use of health services in 2012–13. Canberra: AIHW; 2015 [cited 2020 Nov 9]. Available from: https://www.aihw.gov.au/reports/primary-health-care/frequent-gp-attenders-use-health-services-2012-13/contents/summary

## ACKNOWLEDGEMENTS

None

## PEER REVIEW

Not commissioned. Externally peer reviewed.

## CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

## FUNDING

None

## ETHICS COMMITTEE APPROVAL

None