Tips for Communicating With Overweight and Obese Patients

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INTRODUCTION

A chronic disease such as obesity is primarily managed by the patient who will make decisions on a daily basis that affect their health outcomes. To effectively self-manage their disease, overweight and obese patients must have the necessary knowledge, skills, and motivation to implement a treatment plan that should be developed in collaboration with their health care team.[1] A 2013 survey of overweight patients and their physicians found that only half of these patients reported ever having discussed weight with their physicians. Yet, all physicians indicated they counsel their overweight and obese patients about diet and exercise.[2] These findings, which are relatively unchanged from a 2008 survey, indicate a disconnect in the patient-provider relationship, and suggest an opportunity to improve patient-provider communication regarding excess weight.[3]

The importance of good patient-provider communication cannot be overemphasized due to its significant impact on patient weight and attitudes related to weight management.[4-6] Moreover, a study of 824 patients who completed a previsit and postvisit questionnaire pertaining to their physician's consultation style showed that patients valued 3 elements of the office encounter: communication, partnership, and health promotion.[7]

This article describes various communication techniques that can be implemented in the primary care setting to foster good patient-provider communication as part of a collaborative decision-making process. The goal is to improve patient self-management and motivation, and to achieve better health outcomes. Although patient-provider relationships in conjunction with their health system influence patient-centered communication, the empahsis in this article is on provider factors involving a patient's weight management.[8]

DISCUSSING WEIGHT WITH PATIENTS

The societal stigma often associated with excess weight means that terms related to weight status may be offensive, misunderstood, and can disrupt the patient-provider relationship.[9] Thus, an initial challenge that the primary care provider faces when managing overweight and obese patients is how to begin the discussion and what terminology to use.

Initiating the discussion

There is no definitive approach when initiating a discussion about a patient's weight, since there are many factors to be considered. These factors include the reason for the patient's visit; whether the patient is new to the practice or they are an existing patient; their overall health status; and lastly, culture, age, and health literacy. For example, the reason for the patient's visit should be addressed first, even if it's unrelated to their weight. By addressing the patient's concerns first, the health care provider conveys the importance of the patient being heard while, at the same time, strengthening the patient-provider relationship.

Once the patient's concerns have been addressed, the topic of weight can be broached by asking if he or she would be comfortable discussing general health care issues such as weight. In some cases, a more direct approach can be taken. For example, if the patient's overall health status is adversely affected by being overweight or the patient has a weight-related condition, such as type 2 diabetes mellitus or hypertension, then the health care provider may want to ask, "Do you think your weight is contributing to your health problems?" or, "Do you have any concerns about your weight?" Both questions can open the way for a constructive dialogue.[10-12] Patients who do not understand that their weight is problematic and that it poses a health risk are unlikely to change their behaviors or even engage in a discussion about losing weight. It is, therefore, important that patients be educated about the health risks associated with obesity (see *Pathophysiology, Epidemiology, and Assessment of Obesity in Adults* in this supplement).[12]

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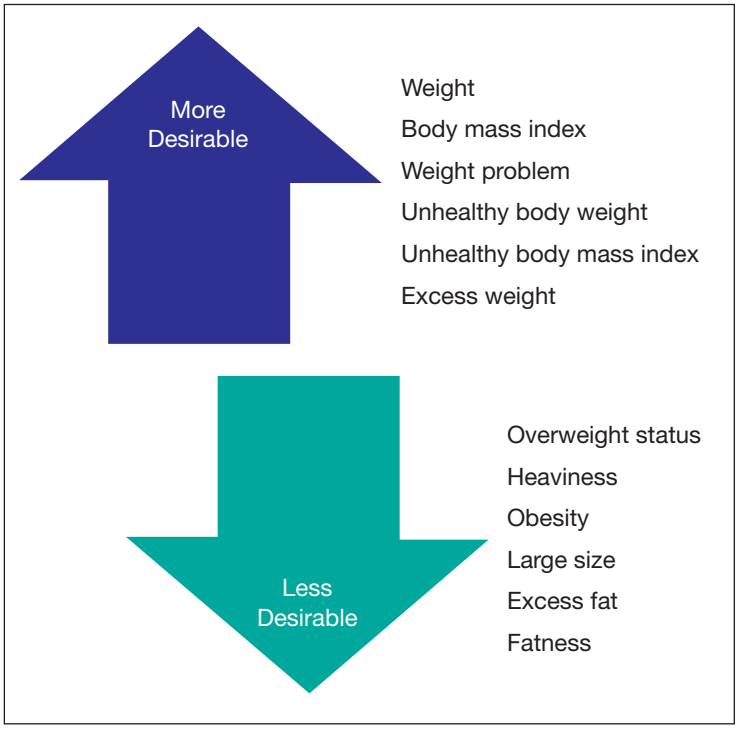
The initial goals for a discussion with the patient about weight are to inform the patient about his or her body weight related to health standards; clearly convey the health risks associated with excess weight; explore the patient's motivation and readiness to engage in weight control; identify previous attempts at weight loss; recognize the barriers to behavioral change; and lastly, establish practical lifestyle changes and short-term goals.[11]

When initiating the discussion about weight, it is helpful to be empathetic and communicate a nonjudgmental attitude that differentiates the weight problem from the patient with the problem. An example might be, "I know it is difficult to lose weight, but it is important for your long-term health." Such an approach establishes a rapport with the patient and demonstrates an interest in understanding the patient's situation, perspective, and feelings. This can be especially important for overweight patients because of their experiences with social stigmatization and personal frustration with previous attempts at weight loss. Empathy also promotes diagnostic accuracy, therapeutic adherence, and patient and provider satisfaction.[10,12]

FIGURE Patient ratings of terms to describe excess weight[13,14]



The importance of terminology

The old adage that words can hurt or heal definitely applies to obesity. The question is which words can heal? That is, which words are preferred by patients and will enable meaningful discussion about weight management? To answer this question, several investigations have been conducted that assesses the responses of overweight and obese patients to terms related to obesity that are commonly used by primary care physicians.[9,13,14] Similar findings were observed among each of the studies. Words such as weight and body mass index (BMI) were preferable vs adjectives that describe excess weight, particularly excess fat and fatness (**FIGURE**).[13,14] Patient ratings generally did not differ according to BMI, gender, or race and ethnicity, athough Caucasians rated the term "obesity" as significantly more undesirable than did African-American patients.[13,14]

ASSESSING MOTIVATION AND READINESS TO CHANGE

An assessment of the patient's motivation for weight loss and readiness to implement and continue with an agreed upon treatment plan is essential. The assessment should include the patient's reasons and motivation to lose weight; previous attempts at weight loss; expected support from family and friends; understanding the risks and benefits of weight loss; level of and attitudes toward physical activity; and potential barriers and previous difficulties or successes with weight loss.[10]

There are several techniques that can be employed to assess the patient's motivation and readiness to change. One is to simply ask the patient on a scale of 1 to 10 (with 10 being ready to take immediate action), how ready he or she is to lose weight. An answer ≤4 indicates that that the patient has very little intention of losing weight. An answer that rates between 5 and 7 indicates ambivalence about taking action to lose weight. In either case, the patient could be asked "What would have to happen for you to be more ready?" or "What would it take to increase your score?" The patient's response should lead the discussion toward identifying and addressing concerns or barriers. An answer between 8 and 10 indicates that the patient is very willing to take action to lose weight.[10]

Motivational interviewing (MI) is a technique increasingly used to assess and strengthen a person's motivation and commitment to change.[15,16] A central concept of MI is the identification, examination, and resolution of ambivalence about changing the patient's behavior. As such, MI does not impose change but rather supports change in a manner compatible with the person's values and concerns.[16] Three key principles of MI are collaboration (vs confrontation), evoca-

TABLE Sample MI questions for discussions with overweight patients[17]

Purpose	Examples of questions[a]
Assess ambivalence and motivation for lifestyle change	How ready do you feel to change your eating patterns and/or lifestyle behaviors?
	What kinds of things have you done in the past to change your eating?
	How much of you is not wanting to change?
	What makes you feel like you can continue to make progress if you decide to?
Readiness to change	People differ in how ready they are to make these kinds of changes. What about you?
	How would you like your health to be different?
	Some people don't want to talk about their weight at all, whereas some people don't mind at all. How do you feel about this?
Importance of change	Tell me how things would be different for you if you ___ (were at a healthier weight, etc).
	What would have to happen before you seriously considered changing?
	What concerns do you have about ___ (losing weight, eating healthier, exercising more)?
Building confidence	What would make you more confident about making these changes?
	How can I help you succeed?
	What are some practical things that you need to do to achieve this goal?
Barriers	What things stand in the way of your taking a first step?
	What barriers might impede success (eg, child care, transportation, distance, cost, accessibility)?

Abbreviation: MI, motivational interviewing.

[a]Reproduced with permission of Yale University Rudd Center for Food Policy & Obesity.

tion (vs imposing ideas), and autonomy (vs authority). Examples of specific questions to ask a patient with excess weight using MI are shown in the **TABLE**.[17] Motivational interviewing can also be used by the provider explicitly taking the negative (status quo) side of ambivalence by stating, "Am I correct in thinking that your current behavior is so important to you that you won't give it up—regardless of the cost?"[16]

While extensive implementation of MI may not be possible in the typical primary care practice, use of MI-consistent behaviors (asking permission, affirming, evoking change, providing support, and emphasizing patient control) is associated with greater patient confidence to improve nutrition and greater weight loss than use of MI-inconsistent behaviors by primary care providers.[4-6] The use of MI has also been shown to lead to significant improvement in weight-related behavior and obesity-related anthropometric measures over 14 weeks in obese children.[18] In a study, persistent benefits have been observed at 12 months of follow-up in some patients. In the study, patients were provided with standard exercise and nutrition information and they also participated in ≤5 face-to-face MI sessions that were delivered by a physical activity specialist and registered dietitian over 6 months.[19]

SETTING UP THE OFFICE ENVIRONMENT

Because the care of overweight patients often requires long-term multimodal therapy that is provided by a team of health care professionals—a systems approach is needed to fully support patients' needs for self-management. The systems approach may include support outside of the office environment, such as support groups, community-based programs, and community-based allied health care professionals. To be successful, the systems approach requires good communication between all providers and staff who have contact with patients. From the front door to the examination room, all team members must provide the same message and level of support. To do so, a system that supports good communication among team members is essential.

Communication with patients can occur outside the examination room and take place before or after the patient's visit. Using telephone, email, or other evolving technologies, patients can be sent reminders about treatment and be provided with 24/7 support. In addition, video-based education can be used in the waiting room using programs such as Emmi (http://www.emmisolutions.com/) that are available via the internet. If a spouse, partner, or family member is involved with buying and preparing the patient's food, it is useful for them to be included in any educational activities.

Another way to facilitate good communication, as well as patient education, is group medical visits. The use of group medical visits is an evolving way to support patients with better self-management of their obesity by enabling them to share their experiences with and learn from other patients, as well as the health care team. Group medical visits work particularly well when there is a mix of experi-

ence among the participants. As with other types of patient education, involvement of the family in group medical visits can facilitate good communication (see *Principles and Nonpharmacologic Management of Obesity in Adults* in this supplement).

CONCLUSION

Good communication between patient and provider, and the health care team in general, is important for effective patient self-management of obesity. The initial goals for a discussion about weight are the following: inform the patient about his body weight related to health standards; clearly convey the health risks associated with excess weight; explore the patient's motivation and readiness to engage in weight control; identify previous attempts at weight loss; elicit barriers to behavioral change; and establish practical lifestyle changes and short-term goals. Motivational interviewing is a valuable strategy to assess motivation and readiness to change and is associated with several weight management-related benefits. An office environment that supports the patient in the long-term management of obesity is essential. Good patient communication can also occur outside of the office visit and can be facilitated through the use of evolving technologies and group medical visits. ●

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