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Controversies in bariatric surgery

Obesity as a disease: has the AMA resolution had an impact on how physicians view obesity?

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Abstract

Background: In 2013, the American Medical Association (AMA) passed a resolution characterizing obesity as a disease. It is unclear whether primary care physicians (PCPs) agree with this characterization and how their agreement or lack thereof affects their treatment of patients with obesity.

Objectives: We sought to understand PCP opinions about the AMA obesity resolution and how it has affected management of patients with obesity.

Setting: Small, medium, and large communities in Wisconsin

Methods: Focus groups were conducted with PCPs in Wisconsin. PCPs were asked whether they considered obesity a disease and what they factored into this consideration, including the AMA decision. A directed approach to content analysis was used to analyze the data. A taxonomy of consensus codes was developed, coding summaries were generated, and representative quotes were identified.

Results: Three focus groups comprising a total of 16 PCP participants were conducted. Not all PCPs were aware of the AMA resolution. PCPs held divergent opinions on whether obesity represented a disease, primarily focusing their considerations on obesity as a risk factor versus a disease. They also discussed how considering obesity as a disease affects the patient–doctor relationship, insurance coverage, physician reimbursement, and research.

Conclusion: The AMA resolution did not appear to have made a significant impact on PCP opinions or management practices in our focus groups in Wisconsin. Follow-up surveys that quantify the prevalance of these opinions and practices at the state and national levels would be highly informative. (Surg Obes Relat Dis 2016;12:1431–1435.) Published by Elsevier Inc. on behalf of American Society for Metabolic and Bariatric Surgery.

Keywords: Health services; Obesity; Public health

More than 2 years have passed since the American Medical Association (AMA) joined with 7 professional societies in recognizing obesity as a disease [1]. The AMA's Council on Science and Public Health noted at the time that there was overwhelming evidence supporting obesity as a "multimetabolic and hormonal disease state" that was closely associated with numerous co-morbidities such as diabetes and cardiovascular disease. The decision to classify obesity as a disease was widely supported by public health experts and clinicians who largely felt that this classification would improve care for patients with obesity by compelling payors to increase coverage of behavioral, pharmacologic, and surgical obesity treatments.

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Obesity treatment is often led, and coordinated by, the primary care provider (PCP). Consequently, PCPs heavily influence which treatment patients pursue, including bariatric surgery [2]. Understanding the impact of the AMA decision on PCP attitudes and practices regarding obesity care is critical. We conducted focus groups with PCPs about their experiences caring for patients with severe obesity [3]. Here, we report data on PCP awareness of, and agreement with, the AMA decision to treat obesity as a disease, as well as how the decision has affected their management practices.

Methods

PCP members of the Wisconsin Research and Education Network (WREN) received an e-mail invitation to participate in a focus group study on treatment of severe obesity. The technique of purposeful sampling of PCPs interested in advancing primary care research and education in Wisconsin was used to identify information-rich participants [4]. Focus groups were conducted in 3 communities in Wisconsin: Mauston (population 4423), Madison (population 233,209), and Milwaukee (population 594,833). Inclusion criteria assessed by e-mail and confirmed via telephone included: M.D. or D.O. degrees, practices comprising $>50\%$ adults, and evaluation of at least 5 patients with a body mass index (BMI) ≥ 35 over the past 6 months.

A moderator facilitated discussion using a structured script (Appendix). Participants were asked whether they considered obesity a disease, what they factored into this consideration, and how the AMA decision affected this consideration. Questions were subsequently asked regarding how the severity of obesity (according to BMI) and presence of co-morbidities affected PCP opinions regarding obesity as a disease. These questions were open-ended and allowed for conversation between participants (i.e., "Is there a specific point along the obesity spectrum where you consider obesity to be a disease? A BMI cutoff? Quality-of-life cutoff? Presence of certain co-morbidities?"). PCPs were then asked how they would make management decisions as part of a clinical vignette involving a severely obese patient in clinic. Findings from the vignette portion of the focus groups were previously reported [3].

Each focus group lasted approximately 90 minutes. Three focus groups were conducted because thematic saturation was achieved after the third focus group (i.e., no new information emerged during the last focus group) [5]. All sessions were audio-recorded and transcribed. Each focus group participant received $150 upon completion of the session.

Qualitative data analysis

A directed approach to content analysis was applied [6]. This analytic technique involves reviewing transcripts and identifying key concepts as initial coding categories that are informed by existing literature and then defined. To perform this analysis, 3 research team members (L.M.F., S.A.J., C.I.V.) coded the first transcript independently for emergent themes and then met to discuss each coded phrase. This procedure was repeated for each subsequent transcript using the technique of constant comparison. Ultimately, a taxonomy of consensus codes was developed and code summaries were aggregated to higher order themes. Representative quotes were identified for each theme. ATLAS.ti qualitative data analysis software was used to manage the data (ATLAS.ti7, Scientific Software Development, Berlin, Germany).

The UW-Madison Education and Social/Behavioral Science Institutional Review Board approved the study protocol in March 2014.

Results

Twenty-seven PCPs responded to the invitation, of whom 26 were eligible. Sixteen were scheduled for and attended a focus group. Their mean age was 45.7 years ($\pm$ 11.3), 94% were white, and 50% were female. The number of participants in Madison, Mauston, and Milwaukee were 3, 7, and 6, respectively.

Some PCPs were not aware of the 2013 AMA resolution that declared obesity a disease. Those who were knowledgeable had opposing views on whether obesity should be classified as a disease (Table 1). In support of the view that it should, PCPs stated that it meets the criteria for a health condition that should be considered a disease; characterizing obesity as a disease would create a framework to discuss treatment options with patients; it would encourage treatment by improving physician reimbursement for obesity-related services; and it would help foster research and innovation.

In support of the view that obesity should not be considered a disease, PCPs stated that obesity is a risk factor for disease but not a disease itself; patients would lose accountability for their behavior; it would not lead to better coverage of obesity treatment; and it may negatively affect patient–physician interactions. Overall, participants reported that the AMA decision had not had a major impact on how they manage their patients with obesity.

Discussion

Our focus groups suggest that not all PCPs are aware of the AMA position that obesity should be treated as a disease. Among those who are aware, PCPs have reasons why they think obesity should or should not be considered a disease. In providing these reasons, PCPs revealed strikingly divergent opinions on the meaning and impact of being obese. These findings may suggest why obesity treatment in the United States continues to struggle to gain

Table 1
PCP opinions on whether obesity should be considered a disease

Concept	Quote
Obesity should be considered a disease because:	
1. It meets the criteria for something that should be considered a disease	"It seems to me that many of the other diseases or conditions or ailments, with regard to co-morbidities, stem from the first place from obesity, overweight, morbid obesity, super obesity, whatever. That, in and of itself, seems to really lead to all these other issues and factors that are called separate conditions, illnesses, diseases. So, to me it seems, if this is at the root of all that, that's what disease is: It's pathology that leads to these other factors." "It's pretty clear that it's something that will shorten your life, compromise your life. Using those criteria, it's a disease." "I think a lot of what we're learning, too, about the biology of people who are morbidly obese, the interplay of different hormones, it has to be a disease, of course. The biologic functioning of someone who is morbidly obese is different than people who are not, apart from any secondary diseases related to their obesity."
2. It creates a framework to discuss treatment options with patients	"I think if physicians look at [obesity] as a disease, they will address it when they see patients. I try to put it in my patient's problem folder every time I see that. It's something that I talk about. 'How are you doing with the exercise plan?' That's something that keeps it on our mind, because we're a disease-focused profession." "Having it identified as a disease, so patients are aware that they have it….many of my patients aren't aware that they are overweight or obese until we talk about it. I think it's, 'Oh. Not me, everybody else. This is a big problem in our society, but it's not me.' Until we label it and call it what it is."
3. It will encourage treatment by improving physician reimbursement for obesity-related services	"As physicians, it's advantageous to have it be a disease. Because then you track it and you can bill for it. The one problem is right now, because of the fee-for-service models that we're mostly under, we often don't have the time necessary to help with the motivational change and other things that's required, and it's very costly."
4. It will help foster research and innovation	"The other advantage of tracking it as a disease is that you actually can look at more population health versus individual encounters. Now you have a structured field that you can find, you can search out, and you can draw out and those kinds of things." "I guess the positive aspect of considering it as a disease, referring to it would get your attention. And I guess it destigmatizes it in a way and also creates the opportunity for better research and study funding than just considering it a social problem."
Obesity should not be considered a disease because:	
1. It is a risk factor for disease but is not itself a disease	"I don't think of it as a disease per se; I think of it as a major risk factor for a lot of diseases. But you know, technically, obesity is excess fat deposit in certain parts of your body and being over a certain percentage of what you should weigh. Now, I mean, is that a disease that per se? It doesn't make people sick, but there are so many things associated with it—you know, insulin resistance, pressure on the joints, vascular complications of diseases that are linked to being obese. But to call obesity itself a disease? It's really plugged into some very dysfunctional lifestyles and habits. So in that sense, maybe it would be like calling alcoholism a disease. But, I don't know, I tend to think of a disease as something that's more directly affecting the body's function or causing pain or disability. Obesity, unless it's massive, usually doesn't do the trick. I think indirectly. So, I'm not sure I would think of it as a disease." "It is unclear if obesity is a cause or effect. We have a lot of patients with not very many coping strategies. If they're depressed, they'll eat, if they are lonely, they'll eat, if they're under stress, they'll eat."
2. Patients may lose accountability for their behavior	"If they don't have ownership of it, it's something they can't change. Sometimes you throw up your hands and say, 'Well, it's not my fault; it's my genetics.' Or I've heard people say that, 'Oh, my mom was fat, my dad was fat, I'm destined to be fat. So, I'm not going to go out and exercise or try to lose weight.'" "You get rid of the responsibility, too, don't you think? It's not your fault; you have this disease. So, don't be motivated to do anything about it, because it's out of your hands."
3. It will not lead to better coverage for obesity treatment	"I almost feel like I have the opposite kind of experience where, even if I put obesity as a diagnosis, it's not going to matter for a lot of my patients based on their insurance. I still can't get them into nutrition. It doesn't do anything for them. I think of it more, when you talk about coding—that was my first thought or response was, it doesn't do anything for us! I think that's changing with, now maybe with Medicare at least. But, that's a huge frustration."
4. It may have a negative effect on patient-physician interactions	"I realized that people are reading our problem lists through MyChart and getting offended [that obesity is included on their problem lists]. So now, I just put 'overweight' and I'll put the ideal weight in there in a little box and you can see how much over the [ideal weight you are]. I don't call it obesity because I think it's got a pejorative implication for a lot of people. They don't like it."

widespread acceptance. Many people, even physicians, remain uncertain if it represents a disease, a behavior, an addiction, or something else.

Regardless of what obesity represents at its core, little progress, if any, has been made over the past several years with respect to obesity treatment coverage in the United States. Three-fourths of patients do not have coverage for obesity treatment, including visits with dieticians (72% not covered), medical weight management programs (77% not covered), and bariatric surgery programs (76% not covered), or coverage for obesity medications (84% not covered) [7]. Our recently published systematic review reported that lack of insurance coverage continues to be a major barrier for bariatric surgery referrals [8]. Several professional societies recently filed a complaint against a group of insurers alleging that the lack of obesity treatment coverage was discriminatory [9]. Though it may be too early to draw conclusions, our data provide some evidence that the AMA resolution may not have changed how the medical community approaches obesity treatment like the AMA had hoped it would.

Some have referred to the AMA resolution characterizing obesity as a disease as the "medicalization of obesity." Although this has obvious positive consequences, such as helping to legitimize its medical and surgical treatment, our findings suggest that there are potential unintended consequences. One of the themes identified in our focus groups was that patients might lose accountability for their behavior if they feel they have a disease, and instead look for "excuses" (e.g., "It's my genetics.") rather than solutions to their obesity. Another concern that PCPs raised was the potential negative impact of characterizing obesity as a disease on the patient–physician relationship. Our focus group participants noted that obesity is a sensitive topic for many patients. When patients see "morbid obesity" or even "obesity" in their charts, they often react negatively. This may be unavoidable to a certain extent, but providers should be mindful about this sensitive topic.

One area that we were unable to investigate with our focus groups was the impact that unconscious or implicit bias may have had on PCP opinions. Implicit bias occurs when beliefs or attitudes affect behavior without individuals being consciously aware of their impact. Implicit bias against people with obesity has been found to exist amongst providers (of all specialties) [10,11] medical students [12], and the general public [13]. In 1 cross-sectional survey of 399 U.S. physicians, nearly half reported that they had a negative reaction to the appearance of obese patients [14]. It is not known if this implicit bias existed in our participant cohort or affected whether providers considered obesity to be a disease.

Our study has limitations. Whereas the qualitative design of this focus group study allowed us to explore PCP opinions in-depth, it did not allow us to estimate the prevalence of these opinions. That would require a large survey of PCPs, which would also have limitations, such as traditionally low response rates, response bias, and a more superficial level of investigation [15]. The findings from this focus group study, however, could be used to generate a survey to characterize PCP opinions in a diverse sample of PCPs. Given that PCP opinions regarding severe obesity treatment and the AMA resolution are largely unknown, a focus group study was appropriate because it facilitated identification of new themes with open-ended questions and discussion. A second limitation of this study was that all of our PCP participants practiced in Wisconsin and nearly all were white. Nonwhite PCPs or PCPs in different states might have provided different explanations regarding their consideration of obesity as a disease.

Conclusion

With PCPs providing reasons why obesity should or should not be characterized as a disease and insurers seemingly in agreement that it does not matter what obesity is considered for coverage purposes, a reinvigorated effort is needed to support evidence-based treatment options for patients with obesity. This should include new educational efforts led by state and national professional societies aimed at patients, providers, and policymakers. Advocacy at the state and federal levels will continue to be critical. The current paradigm is not allowing our patients with obesity to receive the evidence-based treatments they deserve.

Disclosures

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Appendix A. Supplementary material

Supplementary data associated with this article can be found in the online version at http://dx.doi.org/10.1016/j.soard.2016.05.009.

References

[1] Recognition of Obesity as a Disease - Resolution: 420. American Medical Association House of Delegates [cited 2015 Dec 15]. Available from: http://media.npr.org/documents/2013/jun/ama-resolution-obesity.pdf.

[2] Wee CC, Huskey KW, Bolcic-Jankovic D, Colten ME, Davis RB, Hamel M. Sex, race, and consideration of bariatric surgery among primary care patients with moderate to severe obesity. J Gen Intern Med 2014;29(1):68–75.

[3] Funk LM, Jolles SA, Greenberg CC, et al. Primary care physician decision making regarding severe obesity treatment and bariatric surgery: a qualitative study Epub. Surg Obes Relat Dis. 2015 Dec 2.

[4] Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Adm Policy Ment Health 2015;42(5):533–44.

[5] Marshall MN. Sampling for qualitative research. Fam Pract 1996;13(6):522–5.

[6] Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res 2005;15(9):1277–88.

[7] Kyle T, Nadglowski J. Abstract T-OR-2053. Consumers report that health insurance does not often cover obesity treatment, even when wellness programs target BMI. Presented at ObesityWeek; 2015 Nov 2-6, 2015; Los Angeles, CA; 2015.

[8] Funk LM, Jolles S, Fischer LE, Voils CI. Patient and referring practitioner characteristics associated with the likelihood of undergoing bariatric surgery: a systematic review. JAMA Surg 2015;150(10):999–1005.

[9] Obesity groups say states denying bariatric surgery violate ACA. Medpage Today, Endocrinology [cited 2015 Dec 18]. Available from: http://www.medpagetoday.com/Endocrinology/Obesity/54723.

[10] Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes Rev 2015;16(4):319–26.

[11] Sabin JA, Marini M, Nosek BA. Implicit and explicit anti-fat bias among a large sample of medical doctors by BMI, race/ethnicity and gender. PLoS One 2012;7(11):e48448.

[12] Phelan SM, Puhl RM, Burke SE, et al. The mixed impact of medical school on medical students' implicit and explicit weight bias. Med Educ 2015;49(10):983–92.

[13] Andreyeva T, Puhl RM, Brownell KD. Changes in perceived weight discrimination among Americans, 1995-1996 through 2004-2006. Obesity (Silver Spring) 2008;16(5):1129–34.

[14] Jay M, Kalet A, Ark T, et al. Physicians' attitudes about obesity and their associations with competency and specialty: a cross-sectional study. BMC Health Serv Res 2009;9:106.

[15] Johnson TP, Wislar JS. Response rates and nonresponse errors in surveys. JAMA 2012;307(17):1805–6.