Obesity

The Obesity (Under) Treatment Conundrum

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This issue of *Obesity* includes an article by Saxon et al. (1) in which the authors demonstrate the low frequency with which drugs are prescribed by primary care providers for the treatment of adult obesity. Using electronic health record data from more than 2 million adults with BMI > 30 or BMI between 27 and 29.9 with an obesity-associated comorbidity, the authors found that only 1.3% of the cohort was prescribed a medication approved for obesity treatment. Phentermine accounted for more than 75% of all prescriptions, more than half of the phentermine prescriptions were prescribed for more than 120 days, and almost 34% of prescribers filled prescriptions for more than a year despite US Food and Drug Administration (FDA) approval of the drug for only short-term use. Of those few providers who prescribed medication, 24% wrote almost 90% of all prescriptions that were filled.

These observations illustrate the obesity treatment conundrum: why, despite five effective FDA-approved drugs for weight loss, is the highly prevalent problem of obesity undertreated? A variety of factors contribute to the conundrum. The first may be lack of recognition. Although Saxon et al. (1) established the diagnosis of obesity from electronic health records, they did not assess whether the diagnosis of obesity was recognized and recorded by a provider and whether a treatment plan other than pharmacotherapy was specified. Therefore, we do not know the frequency with which any treatment plan was prescribed or the frequency with which pharmacotherapy was used compared with other treatments, such as counseling. In a chart review of data collected in 2010 and 2011, medical residents were knowledgeable about how to assess obesity, but BMI was not reported in either the admission or discharge note. Furthermore, obesity was noted in the admission note or assessment plan only in 6% of patients with obesity and 15% of patients with severe obesity (BMI > 40) (2). If obesity is not recognized, it should be no surprise that it is not treated.

A second problem may be the lack of patient demand. Among patients with obesity, less than 10% sought help for weight loss from a health professional, although more than 50% tried to lose weight on their own (3). Because more than 80% of patients with obesity reported that they are completely responsible for their weight (4), patients may not expect or ask their provider for advice regarding weight loss.

Provider knowledge, attitudes, and bias may also contribute to the conundrum. In a 2016 survey, less than 20% of internists, family practitioners, obstetricians, and nurse practitioners knew the guidelines for the duration of obesity therapy recommended by the US Preventive Services Task Force, the appropriate BMI cut points for the use of pharmacotherapy, or the duration of pharmacotherapy (5). Only 8% of providers correctly identified the recommended threshold for the initiation and continuation of pharmacotherapy for obesity (5). In addition, 69% of people with obesity reported experiencing weight bias from physicians, and the frequency with which people with obesity experienced bias increased with the severity of obesity (6). The perception that people with obesity are responsible for their weight is a bias that may contribute to low rates of treatment.

Even if a provider is knowledgeable and the patient engaged, time and cost may be additional barriers. Few providers and patients may be able to meet the recommendation of the US Preventive Services Task Force that patients with obesity receive intensive behavioral therapy delivered in 12 to 26 visits over the course of a year (7). As with state employee and Medicaid plans, health insurance plans may limit the frequency of counseling and may not cover pharmacotherapy at all (8). Even when pharmacotherapy is included in a plan at low or no cost, providers and patients may not be aware of the benefit, which may account for low rates of the use of pharmacotherapy (9).

Although treatment alone will not end the obesity pandemic, resolving the treatment conundrum will be essential to improve the lives and reduce the costs of those people already affected. Resolution of the conundrum will require the integration of multiple strategies, including empowerment of people with obesity to demand appropriate and effective care, overcoming bias and stigmatization, documentation of obesity, shared decision-making about care with competent providers (10), adherence to a standard of care (11), and inclusion of pharmacotherapy in health plan formularies. Federal and state policy makers should work to ensure that public insurance programs, such as Medicaid and state employee health plans, cover FDA-approved drugs for obesity. None of these efforts alone is likely to improve obesity care. The most effective strategy may be to recognize that obesity is a disease and needs to be treated as such and to hold providers accountable for the care that they provide—or don't. O

References

1. Saxon DR, Iwamoto SJ, Mettenbrink CJ, et al. Antiobesity medication use in 2.2 million adults across eight large health care organizations: 2009-2015. *Obesity (Silver Spring)* 2019;27:1975-1981.
2. Srivastava G, Johnson ED, Earle RL, Kadambi N, Pazin DE, Kaplan LM. Underdocumentation of obesity by medical residents highlights challenges to effective obesity care. *Obesity (Silver Spring)* 2018;26:1277-1284.
3. Stokes A, Collins JM, Grant BF, et al. Prevalence and determinants of engagement with obesity care in the United States. *Obesity (Silver Spring)* 2018;26:814-818.
4. Kaplan LM, Golden A, Jinnett K, et al. Perceptions of barriers to effective obesity care: results from the national ACTION study. *Obesity (Silver Spring)* 2018;26:61-69.
5. Turner M, Jannah N, Kahan S, Gallagher C, Dietz W. Current knowledge of obesity treatment guidelines by health care professionals. *Obesity (Silver Spring)* 2018;26:665-671.

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6. Puhl RM, Brownell KD. Confronting and coping with weight stigma: an investigation of overweight and obese adults. *Obesity (Silver Spring)* 2006;14:1802-1815.
7. Moyer VA; U.S. Preventive Services Task Force. Screening for and management of obesity in adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2012;157:373-378.
8. Jannah N, Hild J, Gallagher C, Dietz W. Coverage for obesity prevention and treatment services: analysis of Medicaid and state employee health insurance programs. *Obesity (Silver Spring)* 2018;26:1834-1840.
9. Thomas DD, Waring ME, Ameli O, Reisman JI, Vimalananda VG. Patient characteristics associated with receipt of prescription weight-management medications among veterans participating in MOVE! *Obesity (Silver Spring)* 2019;27:1168-1176.
10. Kushner RF, Horn DB, Butsch WS, et al. Development of obesity competencies for medical education: a report from the Obesity Medicine Education Collaborative. *Obesity (Silver Spring)* 2019;27:1063-1067.
11. Dietz WH, Gallagher C. A proposed standard of obesity care for all providers and payers. *Obesity (Silver Spring)* 2019;27:1059-1062.