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## Facilitating Factors and Barriers to Weight Management in Women: Physician Perspectives

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<b>Purpose</b>	The complexity of addressing overweight and obesity in women has been an ongoing public health and health care challenge. While the mechanism for addressing overweight and obesity in women remains unclear, it has been speculated that disparities in overweight and obesity by race and gender contribute to the complexity. The purpose of the present study was to examine perceptions of primary care physicians when discussing weight management with their patients.
<b>Methods</b>	We conducted focus group discussions exploring facilitators and barriers to discussing weight management and weight loss among women patients. Participants included 18 family medicine and internal medicine physicians who were recruited using a snowball sampling technique from two large urban institutions. Focus group discussions were transcribed verbatim. Responses were then codified and analyzed in frequency of occurrence using specialized computer software.
<b>Results</b>	Nine themes emerged from group discussions. These recurring themes reflected three overarching critical points: 1) potential utility of the primary care setting to address weight management; 2) the importance of positive patient-provider communication in supporting weight loss efforts; and 3) acknowledgement of motivation as intrinsic or extrinsic, and its role in obesity treatment.
<b>Conclusions</b>	Physician perceptions of their own lack of education or training and their inability to influence patient behaviors play crucial roles in discussing weight management with patients. ( <i>J Patient Cent Res Rev.</i> 2018;5:18-27.)
<b>Keywords</b>	weight management; patient-provider communication; health promotion, women, physicians, medical education

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An extensive breadth of literature highlights the increasing prevalence of overweight and obesity in the United States, with upwards of 68% nationally.<sup>1-4</sup> The burden of overweight and obesity among men has ranged from 72.3% in years 2007–2008 to 73.9% in years 2009–2010 to 71.3% in

the 2011–2012 time period.<sup>4,5</sup> For women, prevalence of overweight and obesity has varied from 64.1% to 65.8% to 63.7% in 2007–2008, 2009–2010, and 2011–2012, respectively.<sup>4,6</sup>

Addressing overweight and obesity in both men and women has been a challenge for medical and public health practice, but perhaps more so in women given the race-by-sex differences observed for these conditions.<sup>5,6</sup> Using national data from 2011–2012, Ogden and colleagues reported age-adjusted overweight and obesity prevalence of 69.2%, 78.6%,

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and 71.4% among African American, Hispanic, and non-Hispanic white men, respectively, data that did not differ statistically. For women, however, prevalence did differ significantly by race, with higher prevalence in African American and Hispanic women of 82.0% and 78.6%, respectively, compared to their non-Hispanic white counterparts (63.2%).<sup>4</sup> Due to these differences, it has been postulated that in addition to addressing obesity from an energy imbalance standpoint alone, discussions surrounding social, cultural, environmental, and familial factors are more important for addressing obesity in women compared to men.<sup>5,6</sup> Consequently, women have been a focus of many weight management and obesity-prevention interventions, including family-based interventions, as they are frequently charged with grocery shopping, preparing meals for the family, and modeling healthy diet and physical activity behaviors for their children.<sup>7,8</sup>

Various factors have been documented as perceived barriers to managing weight and preventing obesity in women. James and colleagues conducted focus group discussions and a telephone survey with African Americans seeking to develop weight management resources using the Health Belief Model, a theoretical framework to predict health behaviors. The authors identified concerns surrounding social support and a lack of time as self-reported barriers.<sup>9</sup> Additionally, in a review article, Mauro and others highlighted the importance of addressing medical comorbidities, failure to self-identify as obese, and the lack of training for health care providers to appropriately address obesity.<sup>10</sup> Appropriate training for health care providers included understanding barriers to obesity prevention during medical school and residency training, recognizing obesity as a precursor to numerous chronic conditions, and identifying long-term strategies for weight loss and the prevention of weight regain.<sup>10</sup> Multiple factors exist, and it is a challenge to coordinate support for those individuals with this issue.

Primary care settings are potentially a prime environment to address overweight and obesity given the role primary care physicians may have in influencing health-related weight management behaviors. In 2012, the U.S. Preventive Services Task Force (USPSTF) reinforced and updated 2003 recommendations for screening all adults for obesity. In part, this recommendation states clinicians should

provide, or refer, intensive behavioral modification interventions to all patients who are clinically obese (body mass index  $\geq 30$  kg/m<sup>2</sup>).<sup>11</sup> Despite this recommendation, it is speculated that only 17%–25% of primary care visits in the clinic involve obesity screening.<sup>12,13</sup> The USPSTF acknowledges the difficulty and perhaps the impracticality of conducting intensive obesity prevention interventions within the primary care setting. Recommendations to explore the feasibility and benefits of conducting these interventions, including behavioral and/or pharmacologic components, within a community-based setting are warranted due to referrals of patients from primary care settings to community-based programs.<sup>14</sup>

The community setting also has been emerging as a promising context for intervention and management of weight. The ecological framework takes into consideration the context in which people live, work, and play. This framework includes social context, such as family and friends, as well as the policies that shape the environment and culture.<sup>15-17</sup> Clinic and community interventions are often viewed individually or can be combined into a comprehensive intervention. A comprehensive approach may be preferable for populations in which both obesity rates and social challenges are high.

A number of existing behavioral interventions that focus on the contexts in which people live, including social, cultural, physical, and environmental, have been used to address complex phenomena such as obesity; these include Bronfenbrenner's system theory, Bandura's social cognitive theory, and the model of community food environments by Glanz and colleagues.<sup>18-20</sup> In a literature review of lifestyle and behavioral modification strategies for addressing obesity in African American women, Walker and Gordon recommended incorporating an ecological approach into behavioral interventions.<sup>21</sup> For this demographic, the authors identified the importance of individualized tailored interventions (individual level), self-efficacy, "the core belief that one has the power to produce changes by one's actions"<sup>19</sup> (individual level), and the role of social support in weight loss (interpersonal level).<sup>19,21</sup> It is clear obesity management is a complex issue that requires a multifaceted approach to individual, organization, community, and policy barriers to effectively reduce rates of overweight and obesity.

The purpose of the current study was to describe weight-related attitudes, perceptions, and beliefs of physicians regarding weight management in women. The focus on physician perceptions may elucidate potential areas of disconnect between patient and provider perspectives. These areas of disconnect, although unintentional, may arise when patients and providers have different perspectives on what overweight and obesity looks like (eg, patients perceive themselves as “normal” weight when providers and objective body mass index suggests otherwise), patients’ lack of receptivity in receiving weight loss and weight management recommendations if the provider is overweight or obese, or if the patient perceives the provider as not understanding the patient’s lived experiences that may preclude weight loss efforts.

## **METHODS**

Focus group discussions were conducted with physicians working in clinical service areas of a large urban city. The discussion pertained to perceived weight management and weight loss among their female patients. Focus group questions included 1) What types of support do patients need to manage or lose weight? 2) How should weight be discussed in your clinic? 3) What would a successful discussion around weight look like in your clinic?

### **Study Participants**

For this study, we recruited primary care providers in an ambulatory setting whose patient panel included women who are overweight or obese (body mass index  $\geq 25$  kg/m<sup>2</sup>). Participants were family medicine and internal medicine resident physicians recruited from two hospitals in Milwaukee, Wisconsin. Physicians were recruited using a modified snowball sampling technique, whereby recruited participants provided contact information for other internal or family medicine physicians.<sup>22</sup> A total of 18 physicians agreed to participate in focus group discussions.

### **Focus Groups**

Focus group discussions were held between December 2015 and March 2016. Using a semi-scripted guide, we conducted two focus group discussions with physicians. Members of the research team, investigators trained and experienced in facilitating focus groups, conducted each group discussion. Focus groups were held in conference rooms within an academic medical center

and a primary care residency program affiliated with the same academic medical center. Group discussions were approximately 60 minutes in duration. With the participants’ consent, focus group sessions were audio-recorded. Physicians did not receive remuneration for providing their perspectives, insight, or time. Oversight for the project was provided by the Medical College of Wisconsin institutional review board.

### **Data Analysis**

The coding team, investigators trained and experienced in qualitative data analyses, reviewed transcripts independently and created codes based on text. Then, the coding team worked collectively to resolve differences in independent codes to reach consensus on codes to be used for data analysis. Each code reflected a unique concept related to the topic that was discussed in the focus group session. Quotations within codes were analyzed for recurring themes. Focus group transcripts were transcribed verbatim and analyzed using ATLAS.ti 6.0 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany).<sup>23</sup>

## **RESULTS**

### **Participant Characteristics**

In all, 18 physicians participated in the focus group sessions. Half of the participants were women. Nearly 78% of the participants were between the ages of 25–34 years. Participants represented two specialties: family medicine (13) and internal medicine (2), with 3 participants not revealing their specialty. Additional demographic characteristics are presented in Table 1.

### **Recurring Themes**

Examples of codes generated included accountability, holistic health, and weight loss incentives. Nine themes emerged from the focus group discussions as facilitators and barriers to weight management (Table 2). These themes emerged as the most frequently discussed concepts in the focus group discussions. The quotations that accompany each theme were selected to represent the sentiment of the participants related to the recurring theme.

### **Patient-Provider Relationship**

The patient-provider relationship highlights both positive and negative interactions patients have with providers. Participants expressed perceptions of judgment by patients stating their patients do not

**Table 1.** Participant Demographics

Demographic characteristic	n (%)
Sex	
Men	5 (28%)
Women	9 (50%)
Refused to answer	4 (22%)
Race	
Asian	3 (16.7)
Black	1 (5.6)
White	13 (72.2)
Refused to answer	1 (5.6)
Age (years)	
25–34	14 (77.8)
35–44	2 (11.1)
45–54	1 (5.6)
55–64	1 (5.6)
Marital status	
Married	10 (55.6)
Single	8 (44.4)
Specialty	
Family medicine	13 (72.2)
Internal medicine	2 (11.1)
Refused to answer	3 (16.7)

think physicians understand the lived experiences of their patients.

*“... And sometimes I think they just look at me and think, ‘Well what do you know about losing weight or the struggles I’ve had.’”*

On the other hand, participants spoke of the importance of encouraging patients to help them remain motivated.

*“I think praising them is very important and continuing to encourage them even when you don’t see the weight loss that you would expect.”*

Participants also were cognizant of the balance between reminding patients of the burden associated with overweight and obesity, and not being perceived as badgering the patient about his/her weight.

*“Most people recognize [they are obese] and they’re frustrated or embarrassed. They have five or six medical problems ... directly attributable to their obesity. We find them on blood pressure medicines and we’re talking about their knee arthritis or they’re not sleeping well and they have poor energy ... I hate to mention it again ... if you lost the*

**Table 2.** Recurring Themes From Focus Group Discussions

Theme name	Number of quotations
Patient-physician relationship	39
Health education	29
Individualized weight management plans	28
Lifestyle changes	27
Locus of control	18
Comorbidities	16
Motivation	16
Social support	16
Food choices	15

*weight.... Then you get sick of saying it. You know you’re just sort of beating them over the head with it, and now you feel like you’re nagging. At some point I want them to know that these are problems that are attributable to their weight, but you can only say it so many times that they’re going to be turned off to it, too. So, that’s one of the areas I really struggle with when I talk about weight and how I discuss weight. Because I want to say, ‘Yes, this is a health problem,’ but at the same time you can’t completely offend them. Otherwise you’re not on the same page and never make any progress in managing their condition.”*

### Health Education

Health education was discussed in two contexts. First, participants emphasized the importance of overweight and obese patients learning diet and exercise-related content. For example, one participant spoke of illustrations and demonstrations used to depict the amount of sugar in sugar-sweetened beverages and to explain calories.

*“In our staffing room we have examples of how much sugar is in juice and how much sugar is in soda. So I think I use that as a visual example for [the patient]. We talked about how many calories are in a bag of chips, which I don’t know if she completely understood that concept.”*

The second context was highlighting the benefit of having a multidisciplinary team of health care professionals (eg, nutritionists, exercise physiologists) to provide care.

*“If [patients] don’t understand the way I’m saying it, send them to a nutritionist versus a diabetic specialist versus exercise coach. Someone’s got to make it resonate to them or just understand the basic concepts. I think part of the issue is ... it’s a degree of health literacy ... that even though you’re going to pound them with brochures, talk to them, show them videos, it still does not sit with them for an extended period of time. So they may note it for a day, a week, but then when they see me in three months it’s gone again.”*

### **Individualized Weight Management Plans**

Individualized weight management plans were suggested as a possible intervention strategy. Individualized weight management approaches underscore the need for tailored interventions to meet the specific needs of each individual. These individualized plans are developed with attention to the personal, social, and environmental context in which the patient lives.

*“I sometimes try to get some history on patients a little bit outside of the medical field. If someone enjoys hanging out with their grandchildren, I try to circle around that with weight loss or activity. So, on the weekend instead of sitting at home, hang out with your grandchildren, go to the park. That’ll be more active than talking to them on the phone ... if you’re able to get a ride. I try to sometimes personalize it if I know enough about their lifestyle.”*

### **Lifestyle Changes**

Participants spoke of lifestyle changes in terms of the degree in which diet and physical activity behavior changes are required for sustained weight loss and weight management. Understanding the difficulties in changing health behaviors, participants spoke of small changes that could have a positive impact on weight loss and encourage the initiation of subsequent weight management behaviors.

*“They have to wake up early to eat healthier, and they probably have to cook more than they did before. They have to cook things they aren’t used to and it’s a lot; it’s a whole lifestyle change. That’s really what you want to advocate ... because I don’t want them to do a fad diet or something that they’re going to go down quickly and come back up 20 pounds heavier than they were. I’m advocating for them to change their life.”*

*“There’s little things too ... like stairs versus the elevator ... walk three blocks to the grocery store or go to something that’s close enough rather than hopping in a car ... parking further away. These are little things that can add up. These are just lifestyle things that are difficult to quantify but almost certainly add up.”*

### **Locus of Control**

Weight locus of control was identified as the patient’s internal ability to control one’s weight (as opposed to factors being outside of the patient’s control). Participants spoke of patients having fatalistic mentalities regarding their weight, suggesting their weight is predetermined and outside of their control. As a result, participants expressed little value in addressing weight management among patients with an external locus of control, due to the decreased benefit in successfully impacting patients who feel weight management is beyond their control.

*“People who believe in internal control will say, ‘I can impact a change.’ I think you got people who are like, ‘I’m the victim and I can’t,’ and that’s because of their upbringing; their parents [as] role model[s] ... or they’re like, ‘I can’t do anything. It’s just things happen to me. Do you have a pill for that?’”*

*“[Some people gain] weight after a baby ... and they feel like this is just how they are now, that they can’t be anything else, that they can’t control [their weight]. Older women especially — their metabolism is a lot slower — it’s a lot harder for them to lose weight. They don’t see results immediately after a week, and they feel that this is just something they can’t control anymore.”*

Participants provided examples of how patients with different loci of control would respond in situations that compromised weight management efforts.

*“[A patient with internal locus of control would say], ‘I had two and a half helpings of stuff last night for dinner and so I had a cup of coffee this morning for breakfast. I’m going to make sure I don’t have a big breakfast. I’m going to take steps today instead of elevators and I’m going to weigh myself and get back down to my goal weight.’ Whereas [a patient with external locus of control] would say, ‘It’s all happening to me, so I can’t [control my weight].’”*

## Comorbidities

When participants spoke of comorbidities, they described the challenges to addressing obesity. On one hand, participants identified more pressing health concerns such as diabetes- and cardiovascular disease-related complications that needed to be addressed immediately; on the other hand, participants spoke of the benefit of focusing on long-term weight loss in order to alleviate symptoms of existing chronic conditions.

*“We look at the patient who has osteoarthritis and has hypertension. They have a lot of problems that you have to manage. Sometimes you manage lighter problems with one intervention and getting it to work.”*

*“We’re talking about [patients’] hypertension, diabetes, and the weight doesn’t quite meet the cut. What I try to do for myself, making [weight] a priority to follow up on. I think it’s just being the patient advocate ... holding them accountable ... is also our role that we can provide without other resources.”*

## Motivation

Motivation was described as a key component to weight management efforts and sustained weight loss. Motivation can keep patients engaged in activities and serve to ensure that recommendations are followed. Participants spoke of the benefits in identifying factors (family, health, body image, etc) that could serve to motivate patients to lose weight.

*“I can give [patients] all the reasons in the world, but they have to find the reason with them to want to do it. And if we can work on that together, find a good reason for motivation for weight loss ... because I can show them in actual numbers and I can show them where they should be, but if they have something intrinsically like I want to look better, I want to sleep better, I want to be able to walk a mile and not completely [be] out of breath, I want to not be embarrassed when I go to my kid’s wedding, whatever it is. If we can find some reason together, I have a lot more success with motivating people and getting them to do things effectively.”*

## Social Support

The importance of social support was identified as a perception of how essential social interactions are in beginning and maintaining weight management activities. Participants spoke of the importance of

family, friends, and organized support groups serving as sources of social support.

*“I think [patients] also need family and friend support; if they have a strenuous situation at home it makes it a little bit harder to be cognizant of exercise and eating habits.”*

*“They do have Overeaters Anonymous ... where you have people around you who are struggling with you equally. It’s very hard to go to parties and family dinners, and everybody else there is eating, like, everything they want and you are the only one restricted. I think it’s nice to be able to talk to other people who are like, ‘Yeah, it’s like that [for me], too.’”*

## Food Choices

Participants stressed the importance of patients making healthy food choices in the fight against obesity. Furthermore, participants stressed the necessity of their patients learning to make healthy food choices given food that is affordable and available to them.

*“As physicians we can educate our patients on what healthy food choices are; a lot of times just the education of knowing what the Food Pyramid looks like and that chips and things like that are not ways to find your vitamins and proteins.”*

*“I see a lot of children of adult patients come in and they’re hyperactive ... the kid [was] drinking from the 2-liter bottle [of soda]. Everybody doesn’t do that, but I think part of it is culture and part of it is poverty and what you can afford. High-fructose corn syrup-based soda and other stuff is what’s available and cheap. You’re going to get that.”*

While some participants acknowledged the economic burden associated with making healthy food choices and consuming nutrient-dense foods, there was judgment and blaming the patient, on behalf of other participants. Frustration experienced by participants regarding poor diet “choices” of their patients was clearly noted.

*“I have a scenario where I have two sisters who are young 20s, so they see me and then their parents also see me. Even when I counsel them [together] ... it doesn’t resonate through anyone. There’s one person leading the show so the mother figure does everything. But the two children they also ... just sit and watch TV. And I give them specific suggestions — when you go grocery shopping with your mom why*

*don't you do X, Y and Z? Didn't you learn about it in high school? I can only repeat it so many times."*

*"I think a lot of people [say], 'So the holidays are coming up, and I'm going to have all these pies put in front of me.' And I'm like, 'You know that's true, [and] you can't control that. But, you certainly can control how much you're going to take in the holidays.' You can control it to some extent. You can shift your priorities. You can find time to exercise even if you're under stress or you have two jobs or whatever it is. There would be a way to potentially do that if you would ... shift your priorities. I'm certain that there's some ... people ... using some of these external factors as a way why they can't control themselves."*

## DISCUSSION

Our study sought to examine perceptions of physicians in discussing facilitating factors and barriers to weight management among their women patients. The focus on women was twofold. First, the greater racial disparity in overweight and obesity prevalence in women compared to men was of interest. Second, given the role women have primarily in obtaining food for their families and the implications for weight management for those she provides food for,<sup>24,25</sup> insight into familial factors associated with dietary practices might be ascertained. This responsibility of women has far-reaching implications in a city like Milwaukee since 44% of children younger than 18 years of age reside in a female-headed household (without a married or unmarried partner), compared to 6% of children less than 18 years living in a male-headed household (without a married or unmarried partner).<sup>26</sup>

Analyses of the focus groups revealed a number of factors influencing weight management as perceived by physician providers. Our findings affirm that providers acknowledge the complex, multifactorial barriers to weight management. Previous studies exploring physician barriers to weight management counseling have cited lack of time, inadequate training, and beliefs that behavioral counseling efforts yield modest results.<sup>27-29</sup> Our findings are consistent with the latter barrier regarding the limited efficacy of behavioral counseling. The nine recurring themes identified by our study can be summarized into three overarching and critical points.

First, the potential role of addressing overweight and obesity in a primary care setting is unclear. This lack of clarity is evidenced by the USPSTF clinical considerations for screening and management of adult obesity, which were based on systematic reviews of the literature.<sup>30,31</sup> Results of these reviews based on findings from adult obesity intervention studies show: 1) There is minimal harm to screening for obesity in primary care settings. 2) There are moderate benefits to primary care-relevant intensive behavioral interventions (12–26 sessions per year) on health outcomes, including reductions in adiposity, blood pressure, and total cholesterol. 3) There is inadequate evidence on the benefits of primary care-relevant behavioral interventions on cardiovascular disease, hospitalizations, and death.<sup>30,32</sup> One can argue that the intensive nature of these interventions and the required activities (eg, group sessions, setting weight loss goals, physical activity sessions) makes it challenging to accomplish in a primary care setting due to high burden, especially when the benefits are potentially modest.<sup>30,32</sup>

There is an ongoing debate about the appropriateness and feasibility of primary care physicians addressing weight. On one hand, when analyzing 2005–2008 National Health and Nutrition Examination Survey data, Post and colleagues observed that patients who were told by their physician they were overweight or obese were more likely to perceive themselves as that weight status, have more desire to lose weight, and were more likely to attempt weight loss.<sup>33</sup> On the other hand, studies suggest that primary care physician visits are less than ideal for addressing weight management.<sup>27,28</sup> These studies identify low expectations for patients to modify behaviors, lack of physician training, inadequate resources to support the patients, perceptions that obesity is a behavioral problem caused by sedentary behavior, and belief among physicians that obesity treatment is ineffective.<sup>27,28</sup>

Our findings are consistent with previous studies that question the appropriateness of primary care physician visits for weight loss effort. Specifically, our results indicate a level of frustration by physicians in discussing weight management in their patients. Physicians spoke of insufficient training to have a meaningful and impactful conversation with patients regarding weight. As a result, participants highlighted



the various techniques attempted to successfully impact weight loss and weight management efforts. For example, motivational interviewing approaches, scare tactics, considering referrals to nutritionists, and recommendations to incorporate small changes into dietary practices and activity levels were some of the many strategies employed in the absence of an obesity prevention curriculum. One participant even proposed, "Maybe physicians need common resources or other stuff to recommend." From the patient perspective, studies have shown that many patients do not seek weight management counseling from their primary care physician, and believe that weight management should be the role and responsibility of the individual.<sup>3,34</sup>

Second, the importance of patient-provider communication emerged as an overarching theme. This cross-cutting theme has major implications for successful interactions between the patient and provider. One area of concern that was highlighted from the focus group discussion was a disconnect between physician perceptions of patient apathy and social and ecological challenges. For instance, on multiple occasions respondents faulted the patient for not being proactive in their own health and failing to take the necessary steps for weight management in a "blaming the victim" tone. Some patients may not be able to adhere to recommendations to eat healthily due to associated costs and poor access to affordable and healthier food options. Additionally, patients may live in neighborhoods where perceived crime precludes them from being physically active outdoors (eg, walking to the grocery store could be unsafe). Providers felt there was a delicate balance in broaching the topic and did not want to appear to be badgering or insensitive to the patient's lived experiences. Indeed, it is reasonable that the perception of a condescending tone could hinder healthy dialogue between the patient and provider. In a similar vein, patient-provider communication that is ambiguous can result in missed opportunities for addressing weight management. For example, in a study examining the degree of agreement in which weight was discussed between patients who were obese and providers, Greiner and colleagues observed that, compared to patients, providers were more likely to report discussing weight management.<sup>35</sup> This discrepancy highlights the importance of effective patient-provider communication and how patients and providers perceive their own and each other's communication.

Third, motivation was a key component that providers discussed. Even in the ecological context, self-perceived motivation remains crucial for initiating and sustaining behavior change.<sup>36</sup> Our findings identified how providers view their patients' degree of motivation and motivating factors. Some physicians described patients as being obese due to a lack of motivation. Others spoke about strategies to personalize communication with patients to identify important people and activities in their lives that could prompt behavior change. A study examining patient motivation suggests that physicians play an important role in motivating patients to lose weight.<sup>37</sup> Findings show that an acknowledgment by physicians of modest weight loss was a motivating factor.<sup>38-41</sup> Conversely, physicians who were perceived as disrespectful and insincere were perceived by patients as being less motivating, ineffective in encouraging behavior change, and left patients feeling hopeless.<sup>35,37</sup> This underscores the need for implementing the clinical strategy of "motivational interviewing" to address the Institute of Medicine's aim for improving the health care delivery system through patient-centered approaches.<sup>42</sup>

It can be inferred that physicians in the current study had similar interactions with patients. Physicians in the current study described frustration of repeatedly informing patients of their overweight or obese weight status and other comorbidities. Additionally, physicians described patients as shutting down during discussions of weight. It is reasonable that patients were equally frustrated and were aware that physicians perceived them as lacking motivation to address their weight. This frustration can inadvertently lead to detrimental interactions resulting from a poor patient-physician relationship, decreased willingness of the physician to discuss weight loss and weight management goals, and perceived discrimination by the patient. One of the worst-case scenarios is the reluctance of physicians to offer treatment for obesity.<sup>28</sup>

## CONCLUSIONS

There are multiple barriers to facilitating needed behavioral change in combating the rising tide of obesity. Successfully conquering these barriers requires structural and functional changes in health care delivery. Changes in health care need to occur from a local, system, and societal standpoint.

Weight management strategies that include social support mechanisms, including a positive provider-patient relationship, are imperative. Individualized interventions, particularly those including an ecological framework that incorporates individual, family, community, and policy levels, are warranted. Furthermore, these interventions must include support from allied professionals, including nutrition, kinesiology, behavioral psychology, and medicine, to name a few.

A multidisciplinary and coordinated approach may enable the target population to attain far better health and quality-of-life outcomes. Our findings can inform larger studies that compare and contrast perceptions of facilitators and barriers to weight management among physicians, patients, and community organizations that provide services and resources to overweight and obese patients. Additionally, future research studies incorporating a variety of medical specialties and allied health professionals involved in weight loss and weight management disciplines, and examining perceptions of these health professionals with respect to men, are warranted. Identifying the perspectives of the aforementioned groups of stakeholders can yield meaningful policy, health care, and public health recommendations and best practices to reduce the obesity epidemic.

### Patient-Friendly Recap

- Achieving weight loss in overweight and obese patients is an ongoing public health challenge, with higher burden in African American and Hispanic women.
- The authors examined physician perceptions when discussing weight management with their female patients.
- They found that although primary care visits provide a potentially amenable setting to address weight management, positive patient-provider communication and identifying individualized motivation are important.
- Some physicians feel they are unable to influence patient behaviors.

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### Author Contributions

Study design: Walker, Kusch, Fink, Nelson, Morris, Cisler. Data acquisition or analysis: all authors. Manuscript drafting: all authors. Critical revision: Walker.

### Conflicts of Interest

None.

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