

Original Article

General Practitioners' Attitudes and Practices toward Managing Obesity

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ABSTRACT

Objective: To assess the general practitioners (GPs) attitudes and practices toward obesity management and their recommendations for improvements, if any

Design: Self administered questionnaire having three main dimensions: socio-demographic characteristics of GPs, GPs difficulties in dealing with obese patients and attitudes of GPs toward managing obesity

Setting: Twenty nine primary care centers chosen randomly out of 87 in Kuwait

Subjects: Data elicited from two hundred general practitioners working in 29 primary care centers in Kuwait

Main Outcome Measures: To determine reasons for difficulties facing GPs in managing obese patients in primary care settings and their solutions

Results: The majority of the GPs (85%) reported that management of obesity must be part of their job. However, one fifth were facing difficulties in dealing with obese patients all the time. The unavailability of either dietitians or nutritionist in clinics was the most common cause for their difficulty in tackling obesity. Most GPs reported that they advise their obese patients to increase their physical activities. The same GPs rarely preferred to prescribe medications, or surgery or behavioral therapy.

Conclusion: GPs have proposed some suggestions that would improve obesity management at primary care level. They include involvement of the media, presence or easy access to a dietitian and creating separate

KEYWORDS: attitudes, barriers, obesity management, practices, primary care

INTRODUCTION

Obesity is increasing at an alarming rate throughout the world. Today it is estimated that there are more than 300 million obese individuals in the world^[1,2]. In white populations living in the west and north of Europe, Australia, and the United States, the prevalence of obesity is similarly high in men and women. Obesity represent a rapidly growing threat to health^[3].

Obesity co-morbidities include coronary heart disease, hypertension and stroke, certain types of cancer, non-insulin-dependent diabetes mellitus and other diseases. In addition, the obese suffer from social bias; prejudice and discrimination, not only on the part of the general public but also of health professionals and this may make them reluctant to seek medical assistance^[4]. Obesity is defined as Body Mass Index (BMI) equal to or greater than 30 kg/m² according to WHO in 1998^[5].

The occurrence of obesity is influenced by a complex interaction of genetic, environmental and behavioral factors. Therefore, a multidisciplinary treatment program that enables the physician to draw on the resources of specialists in nutrition,

exercise, and behavior modification that works with the obese patient as an actively involved member of the team is needed^[5]. Physician's involvement is necessary for medical assessment, management, counseling and coordination of multidisciplinary obesity treatment^[6].

The prevalence of obesity seems to be increasing in most parts of the world, even where it used to be rare. Obesity represents a major threat to health and quality of life in the Arabian population^[7-10]. In Bahrain the prevalence of obesity was significantly higher among female subjects (32%) than male (25%) throughout all the age groups^[11]. Similar trend was seen in Saudi Arabia where the prevalence of obesity was 24% and 16% respectively^[12].

In Kuwait the prevalence of overweight and obesity (BMI > 25 and > 30 kg/m²) increased by 20.6 and 15.4% and by 13.7 and 8.4% among men and women, respectively, according to the data collected during two time periods: 1980 - 1981 and 1993 - 1994^[13]. Primary care physicians play a central role in the systematic assessment and management of obesity^[14]. Guidelines for the management of obesity have been developed in

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Table 1: Socio demographic characteristics of GPs who participated in the survey

Variable	n	Percent
Sex		
Female	111	55.5
Male	89	44.5
Employment		
General practitioner	105	52.5
Family physician	95	47.5
Nationality		
Kuwaiti	104	52.0
Non Kuwaiti	96	48.0
Age (Years)		
20 - <35	69	34.5
35 - <45	74	37.0
45 & above	57	28.5
Years of experience in primary care		
< 5 years	60	30.0
5 - 10 years	46	23.0
11 - 15 years	35	17.5
> 15 years	59	29.5
Health area		
Capital	59	29.5
Hawalli	33	16.5
Farwaniya	45	22.5
Ahmadi	25	12.5
Al Jahra	38	19.0

several countries^[15].

Primary care physicians have excellent opportunities to help obese patients understand the health risks of obesity and encourage them for health promoting behaviour^[16-18]. Family practitioners' awareness and diagnosis of the obesity and overweight status is low and may contribute to its under-management^[19]. There is also a reluctance to treat patients without co-morbidities^[20] as there is to treat the overweight, as opposed to the obese patient^[21]. Although GPs consider themselves well prepared to treat obese patients, they believe their intervention is probably less than desirable^[22]. The aim of this study was to assess attitudes and practices of primary care physicians toward managing obesity.

SUBJECTS AND METHODS

Kuwait has 700 primary care physicians working in 87 clinics in its five governorates. A random sample of 200 physicians was subjected to a cross-sectional study survey. Every fourth clinic in alphabetical order was selected for the survey. The survey is based on self-administered questionnaire related to literature in the field. The questionnaire had three main sections. The first dealt with socio-demographic characteristics such as age, sex, work status, years of experience, work area and nationality of GPs. The second part focused on the GPs' difficulties in dealing with obese patients. The third section dealt with the GPs

Table 2: GP's opinion about obesity and related health problems in Kuwait

Variable	n	Percent
Opinion about prevalence of obesity in Kuwait		
<10%	03	1.5
10 - 25%	37	18.5
26 - 50%	105	52.5
> 50%	43	21.5
Don't know	12	6.0
Management of obesity is role of GP		
Yes	171	85.5
No	29	14.5
Frequency of obese people attending general practice		
Always	122	61.0
Sometimes	75	37.5
Rarely	03	1.5
Management of obesity if present with other risk factors		
Yes	195	97.5
No	05	2.5
If obesity related to patient complaint		
Yes	182	91.0
No	18	9.0
If obesity alone		
Yes	116	58.0
No	84	42.0
How frequently GP face difficulties in dealing with obese patients		
Always	40	20.0
Sometimes	135	67.5
Never	25	12.5

experience and different attitudes toward various obesity management options. In addition, GPs were asked about their suggestions to improve obesity management in primary care.

To ensure survey's legitimacy for clarity and scope, 20 GPs were pilot-tested and the format finalized. 250 questionnaires were sent with official letters to the head of each primary care clinic and only 200 were returned. Prior to data entry and analysis questionnaires were hand-checked for completeness and coded using appropriate statistical tests. The analysis was based on SPSS (Statistical Package for Social Sciences, version 13.0). The descriptive statistics, frequencies and percentages are used to describe socio-demographic characteristics, difficulties in dealing with obese patients and obesity management options. Pearson Chi-square test of independence was used to test the association between the years of experience and the difficulties in dealing with obese patients. A p value of < 0.05 was taken as significant.

RESULTS

Table 1 highlights the socio-demographic details of the GPs who participated in the study. Out of 200 respondents 111 (55.5%) were female and 89 (44.5%)

Table 3: Reasons for difficulty in dealing with obese patients

Reasons	n	To great extent	To some extent	To little extent
Lack of confidence	101 (57.7)	3 (1.7)	39 (22.3)	32 (18.3)
Lack of training	66 (37.7)	17 (9.7)	44 (25.1)	48 (27.5)
Lack of time	10 (5.7)	99 (56.6)	51 (29.1)	15 (8.6)
High failure rate	4 (2.3)	82 (45.8)	74 (42.3)	15 (8.6)
No guidelines	21 (12.0)	77 (44.0)	47 (26.9)	30 (17.1)
No resources, eg. Dietitians	11 (6.3)	110 (62.8)	35 (20.0)	19 (10.9)

Table 5: Association between GP's years of experience and difficulties faced while counseling obese patients

Difficulties	<5 Years	5 - 10 Years	11 - 15 Years	>15 Years	p value
Counseling					<0.01
Always	16 (27.1)	7 (15.2)	5 (14.3)	10 (17.5)	
Sometimes	41 (69.5)	36 (78.3)	25 (71.4)	33 (57.9)	
Never	2 (3.4)	3 (6.5)	5 (14.3)	14 (24.6)	
Lack of confidence					<0.05
To great extent	1 (33.3)	1 (33.3)	0 (0.0)	1 (33.3)	
To some extent	20 (51.3)	8 (20.5)	6 (15.4)	5 (12.8)	
To little extent	15 (46.9)	6 (18.8)	4 (12.5)	7 (21.9)	
No	21 (21.0)	29 (29.0)	20 (20.0)	30 (30.0)	

were male. Among these categories, 52% were Kuwaitis and similar percent were employed as GPs. 47.5% were family physicians. More than one third (37%) of GPs were aged between 35 and 45 years and 28.5% were above 45 years of age. As regards experience in the field, 30% had less than five years and 30% had more than 15 years.

Table 2 describes the prevalence of adult obesity in Kuwait and its relation to health problems. More than 50% GPs reported that prevalence of obesity was between 26 - 50% and only 21.5% stated it to be more than 50%. The majority of GPs (85.5%) believed that it is part of their role to counsel obese patients in primary care. About 61% GPs reported that their primary care clinics always have obese patients seeking medical help. Almost all GPs agreed that they can manage obesity if associated with other risk factors like hypertension and type 2 diabetes mellitus. Simultaneously, 91% GPs perceived low back pain and knee pain as other risk factors in order to counsel obese populations. About 58% GPs discussed obesity in asymptomatic obese population.

Table 2 also indicates that 20% GPs faced difficulties in managing obese patients as compared to 12.5% who never faced any difficulty.

Table 3 shows that 60% GPs think difficulties can be due to the absence of dietitians and health professionals. About 56.6% think that lack of time is a main reason for difficulty. Moreover, obese patients had difficulty in maintaining ideal weight. The least reported reason by GPs was their lack of

Table 4: GP's frequency of using management options to treat obese patients

Options	Never	Rarely	Sometimes	Usually	Always
Increase physical activity	-	5 (2.5)	34 (17.0)	58 (29.0)	103 (51.5)
Reduce calorie intake	-	24 (12.0)	37 (18.7)	60 (30.3)	77 (38.9)
Eat less in general	-	17 (8.5)	52 (26.3)	57 (28.8)	72 (36.4)
Discuss health consequences	-	20 (10.0)	52 (26.0)	64 (32.0)	64 (32.0)
Refer to dietitian	-	64 (32.7)	63 (32.1)	46 (23.5)	23 (11.7)
Start anti-obesity treatment	5 (2.7)	168 (85.7)	17 (8.5)	3 (1.5)	3 (1.5)
Refer for surgery	6 (3.1)	185 (94.4)	4 (2.0)	1 (0.5)	-
Behaviour therapy	4 (2.1)	168 (87.0)	11 (5.7)	6 (3.1)	4 (2.1)
Active counseling	1 (0.5)	130 (67.0)	33 (17.0)	19 (9.8)	11 (5.7)

confidence and training.

GPs were asked as indicated by Table 4 about the recommended management options for obesity. As a result, this survey discovered that more than 50% always recommended increase in physical activities and 33% recommended reduction in calorie intake. Other management options like surgery, anti-obesity treatment and active counseling were rarely recommended.

In Table 5 Pearson Chi-square testing technique was used to compare GPs years of experience and the amount of difficulty faced in counseling obese patients. There was a highly significant association between them. As evidenced, the test results designate 24.6% to doctors with more than 15 years of experience who never had any difficulties with obese patients as compared to a 3.4% to doctors with five year experience ($p < 0.01$). In addition, the study showed that there is a directly proportional relationship between experience and confidence ($p < 0.05$). This means that GPs with more years of experience were more confident and faced less difficulty in counseling obese patients.

DISCUSSION

Nowadays, obesity is a major public health problem across the world. Easy solutions are not straightforward because there are complex interactions between three facts. First, there is an abundant availability of calories dense food. Second, there is little demand for calorie burn in the modern world especially in this region. Third, there is an impact of our genetic make up. Several systematic reviews in recent years have shown that diets, exercises and behavioral approaches if combined could lead to effective management strategies at least for short terms^[23].

This study examined the GPs attitudes and current practices in obesity management. It found that almost all GPs had strong positive views about their roles and responsibilities. They thought that physicians and health professionals must play an important role in promoting preventive measures,

encouraging positive behavior and identifying treatments. The GPs role includes treating obesity and its emotional and medical consequences^[24]. More than 50% of the physicians were convinced that obese patients were treated in the asymptomatic population. A study in Texas^[25] confirmed that family physicians usually address issues of nutrition and physical activity in asymptomatic obese adult residents. Then again, this study showed that 61% GPs had regular visits by obese patients and more than 75% of those visits were difficult to handle. This was confirmed by another study, where GPs thought that obesity was difficult to be handled in primary care practice^[26].

The reasons for the alleged difficulties can be identified in more depth. Firstly, there was high failure rate in maintaining ideal weight. Several studies showed that success rates in reaching and maintaining an ideal weight were low^[27]. In the same field, GPs rated that treatments of obesity were less effective than other chronic diseases^[28]. Secondly, there were time constraints. Different opinion revealed that physicians although they faced 'busy clinical practice settings' at the primary care clinics nevertheless they succeeded in providing their patients with a variety of practice strategies to combat obesity. The key to their success was based on enlightening each patient with his or her risk factors. Furthermore, they recommended certain diets and encouraged patients to become active participants in weight loss programs^[29].

In reality, the most commonly recommended treatments for obesity are the increase of physical activities and the reduction in caloric intake. A study conducted in the U.S.A. showed that two thirds of physicians provided dietary advice and three quarters of doctors found that dietary advice was the responsibility of physicians^[30]. In another study, 99% of doctors recommended aerobic exercises and 97% provided dietary counseling^[31]. To concur, obesity experts viewed that medications prescribed to obesity patients were less effective and could not replace diets and exercises^[32]. Similarly, this study showed that most of GPs preferred not to prescribe anti-obesity medications. Also, this can be due to poor safety profiles of these medications^[33].

On the contrary, another study in Korea indicated that 68.8% of their physicians prescribed anti-obesity medication without allowing sufficient time for non-pharmacological therapy to take its effect. This was due to their lack of training on obesity treatments and management^[34].

This study also declared that GPs frequently referred their obese patients to dietitian. This can be due to lack of time or because patients had been under the impression that dietitians provide more

help than GPs. On the contrary, another study finding confirmed that GPs rarely referred obese patients to health professionals like dieticians for follow-up or treatment^[35]. At the same time, GPs in a different study referred obese individuals who were in greater need of losing weight or were less motivated or were less likely to accept treatments but equally likely to profit from them^[36].

As regards to surgical intervention, 94% of the GPs had rarely chosen this as a management option. Several studies agreed that surgical procedures were underutilized^[37] while others reserved surgical intervention for those with more serious clinical risks^[38].

In Kuwait 86% of doctors did not recommend behavioral therapy. This could have been due to different reasons. First, such therapy option was not widely available in Kuwait. Second, there was a lack of interest in gaining experience in this field. Third, the therapy was not in agreement with cultural standards. Despite all these reasons, behavioral therapy has proven positive results. It employed long term behavior modifications to control improper eating habits and behaviors (like eating too rapidly or eating while watching TV). This study confirmed such favorable results and strongly recommended this kind of reaction to obesity^[39].

Only 33% GPs performed active counseling on obese patients. This low percentage could have been due to lack of experience or lack of training in this field. Also, it could be due to the absence of clear and specific primary care guidelines. Those guidelines were available in certain countries. The researchers in those countries suggested expanding them to counsel obese patients. To elaborate, the guidelines must involve weight loss techniques and the different ways of improving patient's compliance and motivation^[40]. Others have agreed that some GPs did not provide enough guidelines on weight management strategies due to inadequate counseling skills and confidence^[41].

At any rate, as shown clearly in this study, experience was ranked as the most important contributor to knowledge concerning managing obesity^[42].

In general, several studies^[33] suggested that there was a need for appropriate approaches and practices toward obesity. In addition, more information and training must be available to doctors and health professionals. This can be accomplished by keeping up-to-date with related information. Additionally, seeking skills improvement and getting social support are highly recommended to make management programs more effective^[43]. Another study concluded that new strategies must be

considered and implemented like employing obesity specialists at the primary care clinics^[44].

CONCLUSION

In conclusion, this study demonstrated that many GPs believed in their essential role in managing obesity although 67% of them have faced some difficulty from time to time. In order to overcome that and promote professional fulfillment, several recommendations were suggested by the GPs. First, the media must be involved to educate people about risk factors and unwanted consequences associated with obesity. Second, about 28.5% of the GPs think that there is an urgent need for more practical training for them and their nurses. Third, primary care clinics must have professional dietitians in order to assist and provide on-job-training. Fourth, some suggest establishing a specialized obesity clinic at the level of primary care centers thus minimizing the number of patients visiting GPs. As a result, GPs will be able to provide more time and better quality of care to their patients.

Finally, there is no doubt that early implementation of proposed recommendations could help GPs to improve the quality of obesity management and overcome any unexpected difficulties. Consequently, GPs will be considered as essential in managing obesity and in providing better long term outcome.

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