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MEDICAL EDUCATION

Applying the Principles of Professionalism to Preventing, Treating, and Identifying Obesity

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In response to the burgeoning obesity epidemic, a number of studies over the past decade have assessed residents' training needs to determine how best to improve the care of patients who are obese. The studies have described obesity-related training and curricula offered in residency programs and assessed residents' perceived skills and competence. Studies have also reported on residents' attitudes toward obesity treatment in general and the patients who need it. Here, we seek to summarize the results of these needs assessments and, in so doing, find that many of the identified needs can be constructively viewed through the broader lens of the core skills and competencies of professionalism.

The literature and our own work in this area support the view that residents need further training to obtain basic, obesity-specific medical knowledge and counseling skills. We believe, however, that full integration and sustained implementation of best practices in preventing, assessing, and treating obesity may require a shift from defining obesity topics narrowly to exploring professionalism in general and the professional challenges of treating obesity. While it has not been easy to come to agreement about the definition of professionalism, recent work has gone a long way in clarifying its domains or categories [1-3]. On the basis of this work, we focus on the following aspects of professionalism: commitment to carrying out professional responsibilities; sensitivity to a diverse patient population; commitment to self-awareness, life-long learning, self-improvement, and excellence; and ability to work effectively in multidisciplinary and coordinated practice teams and settings [1, 4, 5]. It is our view that training efforts should apply these aspects of professionalism to the effective prevention, identification, and treatment of obesity.

Carrying Out Professional Responsibilities

A number of studies have shown that physicians, including residents, do not provide obesity counseling as often as they should [6-9]. One reason for this may be physicians' attitudes about the value of obesity interventions and treatment. Residents, faculty, and practicing physicians appear to be pessimistic about patients' prospects for responding effectively to the complex challenges of obesity. In one survey, close to a third of internal medicine residents felt that treating obesity was futile [10]. In another, half or more residents and faculty agreed that their patients would not lose a significant amount of weight and reported that treating patients who are obese is very frustrating and that they have not been successful in doing so [11]. These beliefs about the potential effectiveness of obesity prevention and treatment

options—called "treatment expectations"—may shape physicians' willingness to broach the topic with patients, encourage the development of "blame-the-victim" attitudes toward patients, and undermine physicians' motivation to learn and put into practice the kinds of skills that have been shown to work.

Review of the outcome evidence for obesity interventions directly challenges these negative treatment expectancies. True, when outcomes are measured as mean weight loss, they often do not appear to achieve clinical significance and may discourage providers from investing time in treating patients. But when data are re-analyzed to show clinically meaningful weight loss—5 percent or more of body weight—they start to seem more worthwhile, with 29 to 54 percent of participants, depending on the intensity of the interventions, achieving clinically meaningful weight loss [12]. Other approaches change or expand the definition of success by shifting to a more patient-centered perspective. Many studies reveal, for example, that patients ask for physician help in tackling the subject of obesity and strongly advocate for physicians to take a primary role in counseling, treatment, and referral [13-15].

More immediate, observable, and measurable indicators, such as patient motivation and intention to lose weight, appear to be sensitive to the quality of counseling [16] and have been associated with long-term behavior change and weight loss. Patient activation [17], the degree to which patients are knowledgeable, active, responsible partners in managing their health and care, offers promise as an intermediate outcome and has been shown to be associated with improvements in management of diabetes, asthma, and hypertension [18, 19]. Physicians (and residency programs) could set their sights on activating patients and use that to assess effectiveness in educating and counseling [20]. Using this alternative goal could contribute to physicians' overall sense of making a difference in the fight against obesity. Helping residents to view obesity interventions as a more prevention-focused, long-term process [21] and from a population, rather than an individual, perspective may go a long way toward encouraging them to take on the challenge. Recent developments in our understanding of smoking cessation and the relapse-prone process of recovery from substance abuse teach us that ongoing efforts should be acknowledged, and residents should be helped to transfer this new understanding to the treatment of obesity.

Another possible reason for physicians' failure to take on obesity counseling may have to do with the stigma of obesity, which can cause them to be reluctant to broach the sensitive and loaded topic of weight or to lack faith that patients can and will lose weight. Such challenges call for enhancement of residents' ability to respond sensitively to the diversity of patients they encounter.

Sensitivity to Patients

Sensitivity to patients requires, perhaps, equal measures of respect, compassion, concern, and collaboration. A number of studies that have explored residents' attitudes toward patients who are obese suggest that stigma and bias are still problems [22-25]. And, not surprisingly, we found that faculty attitudes are similar to

those of residents: 45 percent of internal medicine, pediatrics, and psychiatry faculty in our institution reported agreeing with the statement "I have negative reactions towards the appearance of obese patients" [11]. Bias like this has been shown to affect clinical care [26, 27], and patients who are obese have consistently reported that stigma and perceived bias and discrimination are major barriers to receiving high-quality, effective care [28, 29]. In fact, after our study on attitudes of faculty was published, we received many e-mails from patients attesting to the impact of physicians' negative attitudes on their struggles with and commitment to losing weight. While exploring the sources for these views is beyond the scope of this paper, it is clear that they conflict directly with one of the essential aspects of professionalism: demonstrating sensitivity to a diverse patient population through respect, courtesy, empathy, compassion and concern [1]. As one person wrote us, "*Nothing* will help the obese patient until the physician really *hears* them. Not until they really *see* them. Not until they finally take *care* of them."

Beliefs about the causes of obesity may also reflect negative attitudes about personal versus physician versus specialty responsibility for continued obesity. The complexity of these beliefs is illustrated by findings that between one-third [10] and one-half [30] of surveyed physicians agreed that "most obese patients could reach a normal weight if motivated to do so." This belief may put too much emphasis on willpower and fails to acknowledge real environmental, genetic, and metabolic influences on weight gain. At the same time, roughly equivalent majorities of residents simultaneously endorsed each of the following attribution beliefs: obesity is primarily caused by genetic factors, by environmental factors, and by behavioral factors [10]. While this acknowledges the multidimensional nature of obesity, it may reflect an attitude that the causes of obesity are too complex for them too address. Curricula could address these negative attitudes through efforts to help residents understand patient perspectives and experiences of stigma as well as through exposure to new understandings of the metabolic underpinnings of obesity. Some have recommended promoting empathy by encouraging residents to take stock of their own health behavior and wellness orientation, and we have found some preliminary evidence that suggests that residents' self-efficacy in their own weight management may influence the impact of an obesity curriculum [21].

Self-Awareness, Lifelong Learning, and Self-Improvement

Residents' ability to recognize that attitudes about obesity can influence quality of care and decision making are essential elements of professionalism. Physicians should constantly strive to improve their competence, and, if negative attitudes interfere with their ability to provide the highest quality of care, they have a responsibility to explore those attitudes, recognize when they are operating, and work to counter them. Attitudes do appear to be related to competence: we found that faculty with greater perceived competence in assessment held less-biased attitudes toward and felt less uncomfortable treating patients who were obese [11]. Others have found that residents who felt less qualified to treat obesity were more likely to agree that behavioral factors were the primary cause of obesity [10].

Efforts to improve residents' ability to treat obesity, therefore, must begin with a focus on identifying negative attitudes—either because these attitudes hinder the development of competence or because they are the product of inadequate competence. If the former, attempts should be made to change attitudes through role modeling and mentoring and through faculty development [21], if necessary, and also by assisting residents in recognizing and investigating (debunking) those attitudes. If inadequate competency is the problem, residency programs should seek to foster and evaluate competence in managing obesity-related conditions and also to single out the least-competent residents for remediation and attitude change interventions. Evidence that attitudes may worsen as residents progress through their residency training and that 3rd-year residents feel no more qualified than 1st- or 2nd-year residents [30] supports this need for early and ongoing intervention.

Commitment to self-improvement and excellence pays off when physicians know of and are able to implement best, evidence-based, practices. In the arena of obesity prevention and treatment, evidence is mounting that comprehensive behavior change approaches are effective when they build motivation and self-efficacy in managing weight and being healthy and then set and monitor individualized, specific goals [31-33]. These approaches include motivational interviewing and the 5As model of counseling [34, 35]. Recent work has adapted these interventions so that they can be carried out in a primary care visit and integrated into decision-support, electronic health record systems. It appears, however, that residents do not currently feel qualified to make good use of these counseling strategies: 40 percent report feeling inadequate in assisting patients in setting goals; 59 percent, in using motivational interviewing to change behavior; and 39 percent, in providing brief counseling interventions [36]. Such findings led a working group at the National Heart, Lung and Blood Institute to point to gaps in training in the areas of behavioral medicine and motivational interviewing skills [37]. More generally, physicians report receiving inadequate training in obesity counseling and treatment [10, 38, 39] despite evidence that training in this area can be effective [40, 41].

To be considered professionals, residents are expected to demonstrate a commitment to improvement and excellence that requires that they strive to assess their skills, ensure awareness of best practices, seek out and use feedback data and opportunities, and take action to improve their competence. Residency programs could support this principle of professionalism by teaching residents how to review the evidence to identify best practices and then how to secure the kinds of data (e.g., through patient surveys, electronic health records, chart review, faculty supervision and feedback, and academic detailing) that would give them information on their effectiveness in identifying and treating obesity within their practice settings (e.g., academic detailing and use of electronic information systems [37]. Of course, faculty role modeling and mentoring can facilitate this commitment or can serve as a barrier—in the latter case, faculty development is called for, using some of the strategies identified above for residents to change faculty attitudes and treatment expectancies.

Multidisciplinary and Coordinated Practice Teams and Settings

Lastly, we are experiencing a clear paradigm shift from the model of the physician-as-solo-professional to a much more multidisciplinary, coordinated approach to care. Guidelines call for residents to be trained in team-based (consisting of clinicians, nutritionists, and physical activity specialists) obesity management and to be educated about facilitating evidence-based obesity management within the system of care [37]. The limited time available to physicians to counsel patients calls for maximum use of allied health professionals and health system and community resources and supports.

Residents report not feeling competent in these areas: 37 percent report feeling unable to effectively collaborate with registered dieticians and refer to community nutrition resources when appropriate [36]. Residents also report difficulty collaborating with health care professionals from other disciplines [2]. To close this gap, residency programs will have to ensure that disciplines train together and that educational efforts be directed toward transferring individual competencies into the team context and building collaboration skills. Residents must also learn to understand and improve the system through quality improvement projects that create and sustain change.

Conclusion

While needs assessments clearly suggest that residency programs must better prepare physicians to address the obesity epidemic, we believe that much of that work can be situated within the context of professionalism, building obesity prevention, assessment, and treatment into programs' existing goals of producing effective, competent, continuously learning physicians. Viewing training needs for obesity care through this professionalism lens serves to focus efforts on core principles of responsibility, self-monitoring and -regulation, patient-centered care, and teamwork and on ensuring that physicians take on an active and effective role in preventing, identifying, and treating obesity.

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