Title of Thesis: "Modern-Day Lepers": The Role of Patient Race/Ethnicity in Provider Processes for Treating Obese Adults

Name of Candidate: Mabel Allison Hyde
Master of Applied Sociology, 2015

Thesis and Abstract Approved: Brandi Harris-Wallace
Assistant Professor
Department of Sociology and Anthropology

Date Approved: April 14, 2015
Mabel Hyde
a.hyde619@gmail.com

EDUCATION
University of Maryland Baltimore County  May 2015
Master of Arts in Applied Sociology, GPA: 4.0

College of Southern Maryland  Spring 2011
Certificate in Grant Proposal Writing

University of North Carolina Wilmington  December 2010
Bachelor of Arts in Communication Studies, GPA: 3.8
Minor in Journalism

Roehampton University London  Spring 2010
Study Abroad, Media, Culture & Communication

AWARDS/INDUCTIONS
Chancellor’s List for Distinguished Academic Performance  Spring 2008, Fall 2010
UNCW Leadership Excellence Award  Spring 2009
Lambda Pi Eta (Communication Studies National Honor Society)  Fall 2009-Fall 2010
Phi Kappa Phi (National Collegiate Honor Society)  Fall 2010

WORK EXPERIENCE
Agora Inc. Legal Marketing Editor/Manager, Baltimore, MD  (June 2011-Present, Manager since July 2013)
• Evaluate and revise financial newsletter advertising for compliance with commercial speech, copyright, trademark and defamation laws, and for exemption from SEC and CFTC regulation
• Work with general counsel to respond to cease and desist letters and agency inquiries
• Manage 6 legal editors and marketing review for 6 publishing companies
• Hire and train new legal editors on relevant case law

Holiday Inn Express Sales Manager, Prince Frederick, MD (January 2011-June 2011)
• Arranged and oversaw group room blocks banquet room reservations
• Managed and trained front desk employees
• Oversaw and reported weekly and monthly sales

National Diabetes Education Program Intern (Hager Sharp), Washington, D.C.  (Summer 2010)
• Analyzed social media efforts and prepared report for National Institutes of Health client
• Wrote feature articles and press releases on diabetes to be used by 200 program partners
• Used CisionPoint to assist in production of quarterly media report

MTV Networks VH1 Digital Intern, New York, NY  (Summer 2009)
• Composed, edited, and updated promotional material on the VH1 website
• Transcribed celebrity interviews

Star News Editorial Intern, Wilmington, NC  (Spring 2009)
• Covered local news and events to write two stories per week
• Maintained community events calendar on website
As talk of the “obesity epidemic” in the US persists, research has found that blacks and Hispanics are more likely than whites to be considered obese according to standard body mass index (BMI) measurements. At the same time, research shows the US healthcare system continues to provide lower quality care to patients of racial/ethnic minorities, by exhibiting lower levels of patient-centeredness and providing less effective treatments. This raises the question of whether providers consider how racial/ethnic or cultural differences might play a role in a person’s ability to lose weight, and whether providers tailor their communication and advice to patients with respect to these factors. This qualitative project was designed to explore these issues. Convenience and snowball sampling were used to recruit eight health care providers (both general practice physicians (n=4) and general nurse practitioners (n=4)) in the mid-Atlantic for semi-structured interviews on their views and experiences of communication with overweight and obese patients. Providers reported that patient race/ethnicity does not influence their weight loss recommendations; however, most report they do consider patient socioeconomic status (SES) and associated factors such as insurance status and health literacy. Providers believe their most effective practices for facilitating weight loss in patients are setting small, attainable goals and using positive reinforcement. Patient motivation is also highlighted as a strategy for successful health outcomes. Although providers report being sensitive to the stigma obese patients face, they also explain patients’ inability to lose weight as the result of a lack of will power and commitment.
"Modern-Day Lepers": The Role of Patient Race/Ethnicity in Provider Processes for Treating Obese Adults

Mabel Hyde

Thesis submitted to the Faculty of the Graduate School of the University of Maryland, Baltimore County in partial fulfillment of the requirements for the degree of Master of Applied Sociology 2015
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Introduction

In 2010, the CDC reported that blacks and Hispanics had 51% and 21% higher obesity rates than whites\(^1\), likely due to three differences among ethnic/cultural groups: behavioral aspects such as cultural cooking and eating habits, cultural norms of ideal body image, and access to healthy foods and safe locations for physical activity. Not only do these race/ethnic groups likely face environmental factors that contribute to excess weight, but they may also receive less effective care than whites from the health care system. It has been widely established that the U.S. health care system is not culturally sensitive, and the lack of equality in communication and treatment has been detrimental to minorities. In 2004, the Institute of Medicine (IOM) released a groundbreaking report stating that racial disparities in health care exist due to health care systems, providers and utilization managers and their biases and uncertainty about minority patients (Betancourt & Maina, 2004). The report called for increased data collection and reporting of health care access and utilization by race/ethnicity, an increase in underrepresented minorities in the health care workforce and cross-cultural training for health care professionals, and further research for interventions that might eliminate such disparities.

Given the CDC’s proposed explanations for the large discrepancy in obesity rates between race/ethnic groups, and the IOM’s call to action for finding ways to make the health care system more accommodating and effective for treating minorities, this qualitative study was conducted to explore health care providers’ perspectives on how patient race/ethnicity influences their treatment of obese adults. The findings from this research suggest it is possible that only few providers view patient race/ethnicity as

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\(^{1}\) As measured by body mass index (BMI). BMI is calculated by weight (kg) divided by height (m\(^2\)), with a BMI between 25 to 29 being “overweight” and a BMI of 30 or greater being “obese”, (“About BMI for Adults,” 2015)
having an isolated effect on their treatment of obese patients. Instead, providers may be more likely to report patient socioeconomic status as a factor that guides their treatment approach.

**Literature Review**

In reviewing the existing literature surrounding this research topic, four distinct areas of prior study became apparent. This literature review is organized around them into sections on doctor-patient communication about obesity, the effects of race/ethnic group and cultural differences on health care experience, perceptions of weight by race/ethnicity, and the social construction of obesity and stigma.

*Doctor-Patient Communication about Obesity*

The literature suggests that communication between primary care doctors and their patients about being overweight/obesity currently leaves much to be desired for patients. Various studies of physicians in the U.S., Britain and France show that physicians view obesity as being caused primarily by lack of physical activity and overeating (Puhl & Heuer, 2009), rather than factors outside of a patient’s control, such as genetics. In fact, research has shown that health care providers are as likely as the rest of society to describe overweight individuals as “repulsive, disgusting, weak, and lacking self-discipline,” (Rogge, Greenwald & Golden, 2004), and “awkward, unattractive, ugly, and noncompliant,” (Puhl & Heuer, 2009). Physicians spend less time, are less engaged in discussions, and enact fewer interventions with obese patients than with non-obese patients (Forhan & Salas, 2013).

These prejudices from those in power manifest themselves through what Harvey (1999) calls *civilized oppression*: “a systematic and inappropriate control of people by
those with more power.” For civilized oppression to exist, there must be non-peer, power-laden relationships, in which individuals in the relationship hold unequal amounts of personal or organizational power based on wealth, education, attraction, and athleticism. Overweight and obese individuals are typically subordinate in these relationships as they are deemed less attractive and athletic, and often have less education and income than those who are not overweight. And, as research shows that it is commonplace for healthcare providers to criticize patients for their weight (Puhl & Heuer, 2009; Rogge, Greenwald & Golden, 2004), it is likely that they are contributors to the civilized oppression faced by overweight and obese individuals.

The literature evidences this lack of physician engagement with overweight patients. Beran, Fowler, Kind and Craft (2008) found that, through separate focus groups of obese patients and generalist physicians, patients generally perceive that their physicians do not initiate conversations about weight, while physicians feel that they do initiate these discussions. Also, while patients desire personalized advice about weight loss, physicians reported to use only one or two general messages with all of their overweight patients, and felt that more individualized advice was outside the scope of their role as a primary care physician. This lack of effective doctor-patient communication has likely led to a negative view of the health care industry for many obese individuals. In fact, in a survey study of 2,340 patients, obese patients reported lower levels of satisfaction with most aspects of their most recent health care visit, as compared to normal-weight patients (Puhl & Heuer, 2009).

Unfortunately, these experiences only reinforce the health disadvantages obese individuals face. Good doctor-patient communication is associated with higher levels of
patient satisfaction, compliance with physician orders (Waitzkin, 1984), and more effective behavioral interventions including increased physical activity and dietary change (Devoe, Wallace, & Fryer, 2009). Similarly, patient trust is linked to patient satisfaction, compliance with treatment regimens, continuity of the doctor-patient relationship, and health outcomes (Stepanikova, Mollborn, Cook, Thom, & Kramer, 2006). With unsatisfactory doctor-patient communication and low levels of patient trust for obese individuals, unfavorable health outcomes are likely to only continue.

In an analysis of recorded conversations on physical activity between physicians and patients, Caroll, Antognoli and Flocke (2011) found that physicians rarely assess patients’ readiness to change behavior and almost never reference recommended guidelines for exercise. Additionally, patient “ambivalence” was frequent; that is, when a patient acknowledges the importance of physical activity yet shows reluctance or uncertainty about increasing his or her own levels of physical activity. When patient ambivalence occurred, 51% of physicians offered limited support, such as briefly acknowledging barriers to physical activity and making suggestions for working around them, while the remaining 49% of physicians gave no response at all.

Greiner et al. (2008) found that only 61% of primary care physician-obese patient pairs agreed upon having discussed the patient’s weight, diet and exercise. Those lacking physician-patient discussions about weight and physical activity, discrepancies in physician/patient perceptions of the medical encounter, and gaps between patients’ desires and physician practices, signal a significant need for a more specialized approach for primary care physicians to treat their overweight patients.
One such approach – the “5A framework” – was evaluated in a study by Jay et al. (2010). Researchers found that when doctors used this approach, which consists of assessing patients’ risk, current behavior and readiness to change, advising for change of certain behaviors, agreeing on specific goals, assisting in addressing barriers and securing support, and arranging for follow-up, patients were more likely to be motivated to lose weight. The Centers for Medicare and Medicaid have taken notice, as they now offer incentive payments for providers who demonstrate documented use of the Five A’s (Elrod, 2014).

Similarly, Leske, Strodi and Hou (2012) found that when patients trusted their doctor and were engaged in a more collaborative relationship, they felt empowered and were more likely to accept and monitor their weight-loss goals. Greiner et al. (2008) found that those obese patients who did report having discussed weight, diet and exercise with their physicians also reported having higher motivation and confidence in losing weight than patients who did not report having such discussions.

In regard to factors that hinder patient empowerment, a study by Forhan, Risdon and Solomon (2013) found that barriers to obese patients’ engagement in their health care were availability of resources, importance of doctor-patient relationship, meaningfulness of doctor-patient communication, the patient’s feeling judged and lacking privacy, and limited provider knowledge about obesity.

Even specific language used by physicians has been shown to affect patients’ impression of their unhealthy weight. A study by Tailor and Ogden (2009) found that doctors often used euphemisms instead of the actual word “obesity” for fear of upsetting
patients. Their findings suggested that use of the word “obesity” made patients feel more upset and anxious, while also interpreting the issue as being more serious.

*The Effects of Race/Ethnic Group and Cultural Differences on Health Care Experience*

In determining whether physicians may communicate differently with patients of different race/ethnic groups, in regard to weight, it is useful to first examine the ways in which patient race/ethnicity affects doctor-patient communication and patients’ overall health care experience.

Dovidio and Fiske (2012) provide an overview of disparities faced by minorities in health care, and possible explanations for why health care providers treat patients from certain race/ethnic groups with less compassion and attentiveness than others. They report that blacks, Latinos and American Indians in the U.S. face more health problems and suffer higher mortality for many conditions than do whites, and propose that even when health care providers do not hold explicit racial biases (that is, they will not state that they hold any type of prejudice), they often exhibit implicit bias by unknowingly adjusting their treatment and communication approach based on their perception of patients’ warmth (how willing they seem to cooperate) and competence. Health care providers are found to associate varying levels of each of these traits with certain races and socioeconomic statuses. For example, poor blacks, undocumented immigrants, Latinos and poor whites are often seen as low in warmth and competence, and black professionals, Asian immigrants, Jewish Americans, professional women, lesbian and gay professionals, are stereotypically seen as high in competence and low in warmth. Health care research suggests that the former group is often met with inferior treatment and passive neglect from doctors, and the latter group is often met with obligatory
contact, but active harm (e.g., less active behavioral interventions or unnecessary procedures) from health care providers. According to Dovidio and Fiske (2012), physicians generally recommend more advanced and effective treatments and procedures for whites than blacks due to their assumptions that blacks are less educated and less active. Indeed, research shows that minority patients often pick up on cues of implicit racial bias from health care providers, which leads to their distrust of physicians (Dovidio & Fiske, 2012).

Chapman, Kaatz and Carnes (2013) provide further explanation of implicit biases held by physicians. They found that simply knowing about a stereotype affects an individual’s processing of information, and that while individuals’ levels of explicit bias – the degree to which they will say they hold certain prejudices – level off with age, implicit bias remains unchanged. Because implicit bias remains so constant and is often at odds with an individual’s personal beliefs, targeting and attempting to overcome implicit biases is an extremely challenging feat. It can be even more difficult for physicians than other professionals, since the uncertainty and time sensitivity of the diagnostic and treatment process may further increase reliance on stereotypes for decision-making. Indeed, physicians are trained to be aware of and rely on group-level information like population risk factors, which may further increase stereotypes. At the same time, physicians may believe in their own objectivity based on their vast knowledge of scientific data (Chapman et al., 2013), making it even more unlikely for them to realize their own implicit biases and the ways in which they might be harmful. Similar to findings from Dovidio and Fiske, Chapman et al. cited that physicians have been found to implicitly associate blacks with being uncooperative and to implicitly prefer white
patients (with the exception of black physicians, who are more neutral to patient race). These implicit biases have been linked to disparate treatment decisions, such as black patients receiving less analgesia than white patients in emergency departments, and black patients being less likely than white patients to receive the appropriate therapies for acute coronary syndrome (Chapman et al., 2013).

The literature is filled with research that substantiates the existence of such racial/ethnic biases in health care, as well as minority patients’ perceptions and resulting distrust of providers. For example, survey data from the 2000-2001 Community Tracking Study found that compared to whites, minorities tend to have lower scores on indirect trust measures that use their levels of agreement with statements about physicians’ likely behaviors, such as providing referrals, performing unnecessary tests, or being influenced by insurance rules in making medical decisions. Interestingly, when trust was measured directly by asking patients whether they trust their doctors to put their medical concerns above all others, white and non-white patients did not differ (Stepanikova et al., 2006). This finding suggests that distrust in physicians may still be present for racial/ethnic minority patients, even when they do not recognize or explicitly report it. It is possible that by not acknowledging their distrust for physicians, they are not actively seeking out other physicians who may be more attentive to their needs and therefore able to provider them with better care.

Similarly, a telephone survey of multiethnic patients who had seen doctors who had previously completed tests of explicit and implicit ethnic/racial bias, found that doctors who exhibited greater implicit bias were rated lower in patient-centered care by black patients than by white patients. Latino patients gave providers lower ratings than
other groups regardless of providers’ implicit bias (Blair et al., 2013). First, these
findings suggest that even when doctors do not realize or openly acknowledge their racial
biases, such attitudes are perceptible to marginalized patients. Second, these findings
suggest that Latinos may generally receive lower quality health care from physicians due
to cultural barriers, rather than providers’ racial biases, and/or that Latinos exhibit greater
distrust for physicians regardless of whether a physician holds racial/ethnic biases.

This discrimination may be lessened when patients are paired with a doctor of the
same race/ethnic group. Data from the 1994 Commonwealth Fund Minority Health
Survey showed that respondents who had the ability to choose their own doctor were
significantly more likely to be race concordant compared to patients who did not have the
choice, consistent for all racial groups. With the exception of Asian Americans, all other
racial/ethnic groups represented in the survey were more likely to have white physicians.
Respondents of each group reported highest level of satisfaction if race concordant
(Laveist & Nuru-Jeter, 2002). These findings are important in that they show that
although the majority of patients in the U.S. see white physicians, patients tend to feel
most comfortable with physicians of the same race/ethnicity. The researchers suggest this
preference for same-race physicians may exist due to a host of phenomena, including a
sense of connection with same-race providers, exceptionally positive past experiences
with same-race providers, or past experiences of discrimination from providers of a
different-race, either personally experienced by the participant or by someone they know.
Each of these explanations points to the cultural sensitivity that is necessary when
treating a patient, and that physicians appear to be lacking when it comes to treating
patients of different race/ethnic groups.
Perceptions of Weight by Race/Ethnicity

A study by Chithambo and Huey (2013) found that among overweight black and white women (as measured by BMI), black women reported lower perceived weight and higher feelings of attractiveness overall. In fact, where BMI was negatively associated with feelings of attractiveness for white women – that is, the higher a white woman’s BMI was, the less attractive she reported feeling – there was no relationship between BMI and feelings of attractiveness for black women.

Dorsey, Eberhardt and Ogden (2010) conducted a study on weight perceptions of a sample of overweight and obese white, black, and Mexican-American adults (as determined by BMI). Prior to being weighed, all participants (including those not overweight, who were excluded from the study after BMI was determined to be under 25) were asked to describe their weight status as either overweight, about the right weight, or under weight. When overweight and obese participants reported that they were overweight, a “correct perception” was counted, and when they reported they were underweight or about the right weight, a “misperception” was counted. Researchers found that for overweight participants of all races, having a “correct perception” of weight was positively associated with weight management behaviors (having tried either to lose weight or to not gain weight) over the last year. However, among overweight participants with “misperception,” blacks were less likely than whites to have exhibited weight management behaviors, and among obese patients with “misperceptions,” black patients were also less likely to desire to weigh less.

Durant et al. (2008) conducted a study on the relationship between adults’ BMI, race/ethnicity, perceptions of the health dangers caused by their weight, and whether they
had ever been told by a physician that they were overweight or obese (‘physician advice’). Researchers found that after controlling for physician advice received, overweight blacks and Hispanics were half as likely as whites to believe that their weight was damaging to their health.

Durant et al. also found that among those who had been told they were overweight by physicians, Hispanics were significantly more likely than whites to believe that their weight was damaging to their health. However, for overweight and obese patients among each race/ethnic group, patients who were told by physicians that they were overweight were more likely than those not told to believe their weight was damaging to their health.

As a whole, these studies demonstrate that blacks and Hispanics are less likely than whites to feel that they weigh more than they should in order to be healthy and to feel attractive. One explanation for this may be that with the use of standard BMI as the measurement, more blacks than whites are determined to be “overweight,” even though they are of healthy sizes for their body composition. A second explanation may be that black and Latino cultures attribute more feminine attractiveness to “curves” for women, while white culture attributes feminine attractiveness to being very thin. Finally, in contrast to the previous two explanations, it may be the case that physicians do not communicate as effectively with racial/ethnic minority patients that they are at unhealthy weights, and therefore, these patients do not realize the seriousness of the need to lose weight. Research is clearly needed to determine which, if any, of these explanations may be valid, to determine to what degree healthy weight/standard BMI differs for individuals of different cultures, and to determine whether physicians are communicating equally
effectively with overweight patients of all races on the need to reach and maintain a healthy weight.

Theory: Social Construction of Obesity and Stigma

Not only is doctor-patient communication in regard to weight confounded by the various ways to determine what defines healthy weight, but it can be both influenced by and an influencer of the stereotypes that western society associates with being overweight. Interestingly, the social construction of obesity that largely dictates these stereotypes has come full circle since some of man’s earliest writings and works of art. According to Eknoyan (2006), for much of mankind’s history being, colloquially termed “fat” had a positive connotation. This is because those bodies that would store more fat per calorie ingested and would burn fewer calories for energy expended, were rewarded most in terms of survival during the chronic food shortages that marked the majority of man’s early days. Especially during the Middle Ages, being rotund was associated with affluence, power and influence. It was in the 1700s when western society first documented some of the health consequences of being overweight, and although by the 1800s, being significantly overweight was regarded as morally reprehensible and detrimental to health, common medical opinion still held that carrying 20 to 50 pounds of “excess flesh” was healthy in order to have a reserve in case an individual fell ill. However, in the 1900s, when platform scales became accessible and body weight data became available for analysis, the insurance industry began performing and releasing studies that linked excess weight to increased mortality. Based on these findings, the industry also began reporting ideal weights by age and height based on BMI (at the time, known as the “Quetelet Index”). These significant moves officially changed the course of
the medical community’s opinion on carrying excess weight. Psychiatrists were the first to comment on this and quickly linked being overweight with subconscious conflicts born out of Freudian psychology (Eknoyan, 2006). This led to the stigmatization of being fat as a condition resulting from abnormal mental state.

As Western Society’s medical community continued to research the health effects of being overweight, nutrition evolved as a legitimate scientific pursuit, in which food values were expressed in calories and treatment for obesity shifted toward appetite control, dieting and exercise. The National Obesity Society was created in 1950, which is now known as the American Society of Bariatrics – “bariatrics” being a newer medical term focusing on appetite control, dieting and exercise. As more studies are completed in the field of nutrition and obesity, more and more diseases are added to the list of illnesses caused by obesity, further medicalizing it (Eknovan, 2006). And while this might seem to be a step toward combatting stigma as obesity is recognized as a health condition, the studies linking poor nutrition and lack of physical activity with excessive weight only further stigmatize obesity as a condition resulting from lack of self-control.

To understand this stigma, we can look to Erving Goffman’s work, which suggests stigma is assigned to a group of people who have been discredited by society due to some type of “rule-breaking” behavior. Goffman (1986) describes three types of stigma: various physical deformities, blemishes of individual character, and tribal stigma of race, nation and religion. In the case of this research, those who are overweight are in an especially compromised position as they face two of these categories of stigma. First, they are seen as having a “physical deformity” in that they are larger in size than is considered normal and acceptable to society. Second, their character is stigmatized due to
the rule-breaking behaviors society associates with being overweight, such as being lazy, and lacking willpower and intelligence (Chapman et al., 2013; Forhan & Salas, 2013; Wang, Brownell, & Wadden 2004; Puhl & Heuer, 2009).

In this way, Rogge, Greenwald and Golden (2004) argue that groups such as the National Institutes of Health (NIH), the U.S. Public Health Service (USPHS), the Centers for Disease Control and Prevention (CDC), the American Heart Association, and the American Diabetes Association play a significant role in the social construction of obesity. These groups emphasize obesity’s link to disease and mortality and the steps those who are obese can take to return to a normal weight. This results in our understanding of obesity as abnormal, unhealthy and undesirable, and the fault of those who suffer from the condition. As a society we are conditioned to believe that they (the stigmatized) can “fix their condition” if they will just make the personal effort to eat better and exercise. Because of this construction, those who are obese are condemned for being irresponsible in the same way as those who suffer from sexually transmitted diseases or lung cancer, as opposed to other illnesses such as breast cancer or leukemia, which are not considered to be the fault of the individual.

Hermiston (2010) even argues that today’s definition of obesity has been socially – and inaccurately – constructed as an “epidemic,” since the term is traditionally reserved for infectious diseases that may suddenly wipe out a large population. Hermiston argues that society’s construction of obesity as an “epidemic” is not due to an increase in the availability and types of processed foods and increasingly sedentary lifestyle, but instead a calculated movement to strong-arm society into what experts consider to be a healthier lifestyle. With such intense focus on standard measurements to determine whether one is
overweight, and even tests for predispositions to be overweight, everyone in society becomes “at risk” for obesity, rather than just being classified only as a spectator. With obesity’s depiction as being “morally reprehensible” (Hermiston, 2010), being overweight is further stigmatized as a condition to be fought off at all costs.

And while society’s institutions may believe that such harsh treatment and disregard for obese individuals might give them the strongest incentive to lose weight, research by Wott and Carles (2010) has found exactly the opposite. Perceived weight stigma was associated with higher levels of binge eating and poorer weight loss during a behavioral weight loss program, suggesting that negative comments and attitudes towards an individual’s weight may actually impede rather than promote weight loss. A study by Major, Hunger, Bunyan and Miller (2014) yielded similar results. Researchers presented women with one of two similar, fictitious news articles; the first article described an employer policy of firing overweight employees, and the second article described an employer policy of firing employees who smoke. The first article was considered to be the weight stigma “threat” condition, and the article on smoking was the control. Among women who read the “threat” article, their own perceived weight was positively correlated to calories consumed afterward, with no relationship appearing between perceived weight and caloric consumption for women who read the smoking article. Additionally, among women who perceived themselves to be overweight, caloric consumption was greater for women who read the “threat” article than for women who read the control article. These findings further suggest that the presence of weight stigma may promote additional weight gain among those who already consider themselves to be overweight.
Even more troubling is that overweight individuals tend to accept this negative social construction of obesity in believing that their being overweight is their own fault and that all overweight individuals are lazy and lack will power (Rogge, Greenwald & Golden, 2004). This is also the reason obese individuals have access to even fewer/smaller social support networks than individuals of other stigmatized groups. In a study that measured biases overweight individuals held about overweight people in general, researchers found that participants did not hold more favorable attitudes toward “in-group” members as other minority group members do (Wang et al., 2004). With a lack of understanding and support even between overweight individuals, the stigma placed on them by society is cemented even further since not even group members contest it. With so much discrediting of overweight people and the obvious harm the presence of stigma inflicts, it seems unlikely that individuals would even want to seek treatment for fear of more shaming.

Hence, Goffman’s discussion of the ways in which discredited individuals may respond to stigma is also relevant to this research. The most pertinent response described is that individuals suffering from physical deformities may undergo plastic surgery, although they still may be stigmatized as someone who formerly belonged to the discredited group (1986). This phenomenon has been supported in the literature on weight stigma in that those who undergo surgeries to reduce weight such as gastric bypass or liposuction, are often still regarded as “lazy and sloppy, less competent and sociable, less attractive, and having less healthy eating habits” after surgery, and more so than individuals who lost weight through diet and exercise (Vartanian, 2013). This is even reflected in the health policies and initiatives that are enacted and supported by the
public, such as First Lady Michelle Obama’s “Let’s Move!” campaign to get children and adults to exercise 60 and 30 minutes (respectively) each day and to adopt healthier diets (“Let’s Move!,” n.d.) and the proposed Stop Subsidizing Childhood Obesity Act, which would eliminate tax deductions for companies that advertise unhealthy foods to children (“Stop Subsidizing,” 2014). Meanwhile, the only public support overweight individuals can seek for obtaining weight loss surgery is a grant from the Weight Loss Surgery Foundation of America (WLSFA). And in order to receive this support, individuals must be willing to help raise 10% of the funds they request (“Free Weight Loss Surgery,” n.d.).

And yet there is also research that indicates residual stigma is still present for individuals who lose weight through diet and exercise as well (Latner, Ebneter, & O’Brien, 2012). For many obese individuals, significant amounts of weight lost are still not enough to make the person appear to be “thin” or “normal size.” Even when an individual loses 5-10% of body weight as recommended to prevent chronic illness, they are still denied the respect and “moral advantage” that their weight loss should afford them, because they are still considered overweight (Rogge, Greenwald & Golden, 2004). Based on this research, it appears that once an individual has been stigmatized as being overweight or obese, it is unlikely he or she will ever fully shed the stigma that is attached to those statuses.

Relevance to and Implications for the Current Study

The findings above on doctor-patient communication and trust in relation to race/ethnicity are important in that a patient’s trust in a health care provider is associated with his or her satisfaction with health care received, compliance with prescribed treatment regimens, continuity of the doctor-patient relationship, and health outcomes
Whether it is due to physicians’ lack of cultural awareness, racial/ethnic biases, or both, racial/ethnic minority patients are receiving lower quality communication and care, which adversely affects health outcomes.

When it comes to health care discussions about being overweight, and how best to manage weight, it is more likely than not that patients from minority race/ethnic groups are receiving lower quality communication from physicians in several ways. First, as is evidenced by several studies mentioned, standard BMI is the measurement used most frequently by the medical community to determine whether a person is overweight or obese. However, as research by Affuso, Bray, Fernandez and Casazza (2010) has shown, blacks have significantly lower body fat percentages than whites and Mexican-Americans of the same relative BMI. This suggests that if standard BMI is the method also used by physicians to determine whether a patient is overweight or obese, at a minimum, there are likely black patients whose weight is not unhealthy, or is not as dangerously unhealthy as their standard BMI measurement would suggest. This would mean that these patients are being told they need to lose weight or lose more weight than is medically necessary.

Also, as the CDC (2010) recognized, there are significant cultural differences in eating habits, and access to healthy foods and safe locations for exercise. Such differences mandate that physicians offer overweight patients recommendations that take into account a patients’ culture and access to resources. The abundance of research that shows that patients of minority race/ethnic groups report significantly lower levels of satisfaction and trust in physicians, and greater levels of discrimination, would suggest that physicians overwhelmingly practice health care with approaches that are only sensitive to the dominant group’s culture.
Finally, with such harsh stigmatization of the overweight population, it is all the more important to study how generalist providers identify and interact with these individuals in medical encounters. Their approaches to communicating with patients may determine whether patients continue to utilize health care services and whether they adhere to provider recommendations. The extent to which providers are able to deliver the most appropriate assessments and recommendations may encourage the patient’s chances for achieving and maintaining a healthy weight. And the chances of a provider delivering such useful information and advice will likely rely upon their ability to make sure their communicative approach and proposed weight loss solutions are sensitive to both the patient’s culture and possible feelings of stigmatization about his or her weight. As suggested by the literature on effective approaches to doctor-patient communication in regards to weight, providers should be focused on empowering patients rather than further isolating them from the rest of society. Even with all of this said, much of the research on overweight/obese patients and their health care experiences is based on patient’s self-reported experiences, leading Puhl and Heuer (2009) to call for research that examines health care practices among providers.

These issues are relevant to this research because it aimed to identify the different ways (if any) in which providers account for cultural differences when treating overweight and obese patients of different races/ethnicities. While the current study did not involve direct observation of patient-physician encounters, it explored one side of this interaction by gathering the viewpoints of providers. This study’s exploration of providers’ perspectives was guided by four main research aims.
Research Aims

Aim 1: Identify the processes through which providers determine that a patient is overweight to the extent that weight loss needs to be discussed. For instance, processes may include the use of measurements such as basic weight, standard measures of BMI, waist measurements to estimate abdominal fat thickness and fat thickness at other points of the body, or direct measures of fat using technology such as advanced scales or hand-held devices, (Moffat, 2010), or non-medicalized approaches such as general physical appearance.

Aim 2a: Describe the different communication models providers use to tell patients of different races that they are overweight.

Aim 2b: Describe the different communication models providers use to explain the associated risks and possible weight loss strategies to patients of different races.

Aim 3: Explore provider perspectives on which communication models may be effective for discussing unhealthy weight and weight loss strategies with patients of different racial/ethnic backgrounds.

Methods

Study Design & Participants

I performed a qualitative study in which I conducted eight semi-structured, tape-recorded interviews with generalist physicians and general nurse practitioners (NPs) that provide primary care to patients. Physicians and NPs were recruited from various geographic locations throughout the Mid-Atlantic area, including urban, rural and suburban locations. Moreover, I attempted to draw my sample of healthcare providers from categories such as ‘Family Medicine,’ ‘Internal Medicine,’ ‘General Practice,’ and...
I chose to interview generalist physicians, as opposed to bariatric specialists, for several reasons. First, generalist physicians are the primary point of entry to the healthcare system, as well as the gatekeepers to more specialized services (Forhan & Salas, 2013). Because of this, it is more likely that generalist physicians see a more diverse patient base, in terms of patients’ insurance status (which may limit some patients from seeing a bariatric specialist altogether), awareness of being overweight, knowledge of negative health consequences associated with being overweight, and level of motivation for losing weight. Because bariatric physicians specialize in weight loss, patients who already see these physicians are likely more aware of their overweight or obese status and their need to lose weight to improve health. As this research sought to explore how physicians interact with overweight patients of all types, including those who may be less aware that their weight is unhealthy, less aware of the consequences of being overweight, and less motivated to lose weight, interviews with only bariatric specialists might have shed light on a more limited type of physician-patient dynamic. Finally, it would be much more challenging to secure bariatric specialists for interviews, as there are approximately 2,000 bariatric physicians in the U.S. (“American Society of Bariatric Physicians,” n.d.), compared to approximately 216,000 physicians practicing internal medicine, family practice, or general medicine specialties (Physician Specialty Data Book, 2012).

I interviewed physicians and NPs who have patient bases that include obese adults. I recruited these healthcare professionals first by convenience sampling of those who showed interest in the study and were willing to participate. I established contact

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2 “Gynecology” was also included in the search for general practitioners as studies have shown that as much as 44 percent of women’s general preventive care visits are with OB/GYNs (“Preventive Services,” 2014).
with these providers by calling their offices and briefly describing my study to the person who answered the call (See Appendix A for the initial contact call script), and asking who the best person would be to speak to about having a recruitment letter passed on the physician(s) in the office. The recruitment letter included details on the study, my contact information, and my plans for following-up so that the provider can review that information (See Appendix B for recruitment letter). I also sent – along with the recruitment letter – an informed consent information sheet, which detailed the purpose, procedures, benefits, and possible risks of the study, as well as what will be done to maintain physician confidentiality, an explanation of the voluntary nature of participation, and my contact information if the provider has further questions (See Appendix C for informed consent information sheet). In most cases, upon calling the offices, the receptionist provided a fax number and said s/he would pass the forms on to the provider. In other cases, the receptionist put me in touch with an office manager who either stated at the onset that the provider(s) would not be able to participate, or that I could send the information to him/her to share with potential participants.

As part of my convenience sampling I included nurse practitioners that are part of my extended social network. Some of the reasons for including nurse practitioners are similar to those for interviewing generalist physicians: Nurse practitioners likely see more diverse patient bases than specialist physicians, and including them in the study made for a larger pool of possible participants, as there are nearly 150,000 nurse practitioners in the U.S. (“NP Facts & Figures,” 2009). Also, in terms of consistency in the sample, there is little argument against including nurse practitioners, since according to Cassidy (2012), studies have largely found that treatment practices, prescribing
behavior and clinical outcomes are similar for physicians and nurse practitioners. Finally, nurse practitioners in the state where this research was conducted have the ability to diagnose, treat and prescribe without physician involvement, so any nurse practitioners included in this study would likely have much the same abilities in treating obese patients as a generalist physician would (Cassidy, 2012).

I also recruited providers listed under these specialties on the websites of two major medical centers in the Mid-Atlantic, which included physicians and nurse practitioners practicing in twelve different cities. I casted a wide net in this search in order to get a diverse group of providers with diverse patient bases.

After reaching out to the first round of providers through convenience sampling, I began to use snowball sampling by asking those providers who had participated at the conclusion of their interviews if they would recommend other providers for the study. I asked those referring providers if I could include their names in the subsequent recruitment letters. Although all participants agreed to pass on the study information to their colleagues, snowball sampling was ultimately successful with only one participant in the study: One nurse practitioner shared the study information with the entire staff of providers in her practice’s two offices, and I was able to secure interviews with two physicians who reached out to me from the practice’s other office.

The greatest challenge in this study was securing providers to participate. From September through mid-December 2014, I reached out to approximately 45 providers/offices, 35 of which were providers/offices that I had no connection to, and secured eight participants. In order to make participation as convenient as possible, I informed providers the interviews would take no longer than 30 to 45 minutes, and I gave
them the option of scheduling either a phone or in-person interview, at a time and place that was convenient for them. I also followed up by phone with each person whom I sent a recruitment letter (whether it was an office manager or a provider), one week after sending the letter. Although I had initially planned to attempt to speak with the provider (or schedule a more convenient time to do so) to offer more details on the study and ask for their participation (See Appendix D for provider follow-up call script) on the follow up calls, I most often spoke with the office contact to see if any providers had expressed interest in participating in the study. I was often encouraged by the office representatives to resend the documents. In those cases, I called their offices once more, one week after making the first follow-up call. In sum, the recruitment process took up to three weeks for each provider (although I recruited many providers simultaneously).

Upon a provider’s agreement to participate, we (either the office manager or the provider and myself) scheduled the time and place for the interview. The first interview took place on September 30th and the final interview took place on December 10th, 2014.

Prior to the start of all interviews participants gave verbal consent on the recording, acknowledging both that they read and understood the informed consent information sheet, and that they understood the interview was being tape-recorded. I began transcribing provider interviews as soon as they were completed. To protect the identities of participants, the recordings were kept in a password-protected file, which were only accessible by my thesis advisor and me. Pseudonyms are also used and names of practices and practice locations have been removed to protect confidentiality of participants.
Data Collection

As stated earlier, the interviews with providers were tape-recorded, and their lengths ranged from 18 minutes to one hour, with the mean length being 35 minutes. Four interviews were phone interviews and four were in person interviews, with three taking place at the providers’ offices and one at the home of the provider. Providers also either filled out a demographics form (or provided their responses on the recording), that asked for their birth year, sex, race/ethnicity, languages spoken, medical specialty, and year licensed (see Appendix E for provider demographic survey).

I took a phenomenological approach to data collection and analysis, as this methodology aims to essentially “borrow other people’s experiences in order to understand the deeper meaning of it in the context of the whole human experience” (Baker, Wuest, & Stern, 1992, pp.1357). And although theory development is not the ultimate goal as in a grounded theory approach, a phenomenological approach “may lend itself to theorizing by revealing the phenomena’s previously hidden meanings, essential structures, and relationships,” (Rogge & Greenwald, 2004). This was appropriate given my research aimed to identify and explore the effectiveness of different communication models used by physicians, which are likely influenced by various patient characteristics as well as experiences and beliefs of providers themselves.

In taking a phenomenological approach to interviewing, I engaged in “phenomenological bracketing” – the process of suspending one’s beliefs and preconceptions so that the “true” phenomenon may come to light (Wimpenny & Gass, 2000).
I conducted the semi-structured interviews following a list of eight general questions that served only as a guide for the interview (see Appendix F for complete interview guide). The questions and follow-up probes were broad and open-ended, in order to leave room for participants to elaborate on discussion topics, potentially addressing multiple questions in one response. I began by asking the very general questions: “What proportion of your patients would you say are overweight? What proportion would you say are obese?” My second intended question was “How do you determine if a patient is obese?”, although most providers asked how I was defining “obese” before answering the first questions. In response to that, I would say “however you define ‘obese,’ if you distinguish overweight from obese at all.” Their response to this would give me the answer to my second question. If not addressed in the provider’s response, I would pose follow-up questions such as “Are there any patients for whom you decide that process of determining obesity isn’t accurate? If so, can you describe these patients?” As the interviews progressed, I continued posing questions that were very broad, following them up with probes as needed to get providers to elaborate on the processes they use and to explain the impact (if any) that a patient’s race/ethnicity or culture has on these processes.

I found that no providers brought up on their own how patient race/ethnicity or culture affects their decision-making processes in communicating with patients and prescribing treatment/advice. In order to obtain this information, I probed with more general questions as the interview progressed, but if still not mentioned, I would eventually ask them how such traits might affect their decision making processes. For instance, later in the interview, I often asked: “What are some pieces of advice/strategies
you give a patient who you’ve determined is obese?” I would follow up that question by asking “Is the advice you give the same for all obese patients? If not, what factors would lead you to deviate from what you normally suggest?” If providers did not bring up race/ethnicity or culture, I would eventually ask questions such as “Does a patient’s race, ethnicity or culture affect that advice you give in any way?” I also asked providers “Would you say your patients tend to adhere to the weight loss regimens you suggest?” If the provider said they do not, or some do not, I would often follow up by asking the provider to describe the patients who generally do not adhere to their recommendations. If providers still do not address patient race/ethnicity or culture, I would use a probe such as “Some of what I’ve read in the literature suggests that patients of certain ethnicities or cultures are less trusting of doctors, or show lower levels of compliance with prescribed regimens. Can you comment on the extent to which you’ve found that to be true, or on the ways you may have noticed this?”

Finally, in performing the interviews I had to be aware of how my own statuses (white, female, and graduate student) could affect each provider’s willingness to respond with open and honest answers. In terms of being a graduate student, while providers might have respected me for seeking higher education, it was also possible that they would assume I was not able to understand the complexities of the medical profession since I do not belong to the field. They may have been hesitant to give me complete answers for fear of my misunderstanding, or even due to their own position of authority and lack of willingness to openly converse with someone of lower social and educational standing. I did not sense this was an issue, since a few providers willingly explained certain terms and phrases to me (e.g., “insulin resistance”). Being a white female, I
anticipated that both male providers and providers of other race/ethnic groups would feel less comfortable or willing to be completely open with me, in that we do not share an “in-group” connection. In order to overcome these potential barriers, I began each interview by building rapport with the provider to show that I could be trusted to maintain the privacy of the information they share, that I would suspend all personal judgment about what they told me, and that I was capable of engaging in dialogue about the profession. I did this in many interviews by first asking general biographical questions such as: what made the provider decide to practice in their specialty, what made them choose to practice in this location, how long they have been practicing, and what does s/he see as the most prevalent health issues of today. I was not able to spend as much time on these questions in all interviews however, since a few providers had blocked only thirty minutes of their time in between appointments and meetings, and I did not want to take up more time than necessary. In those interviews, I began with just one or two rapport-building questions and then dove into my first planned question. Finally, I still expected a significant barrier in the research to be eliciting honest communication about how patient race/ethnic group affiliation affects providers’ decision-making. Because I am white, I expected white providers would be more candid than any other providers in the responses they give me about race/ethnicity. As it turned out, no providers brought up the effects of race/ethnicity on their treatment recommendations without probing. While I cannot be certain that this was not the result of my own statuses, I believe that providers did not bring race/ethnicity up on their own because they do not feel it affects their approach to providing treatment. I did not sense that any of the providers who were of different races/ethnicities than me felt any discomfort in discussing them. Of course, I must
acknowledge that this is the one barrier that I had the least ability to overcome. I acknowledge this limitation in collecting my data.

Research Ethics/IRB

This research was subject to Institutional Review Board (IRB) approval, as it fell under the definition of “research with human subjects” (Social/Behavioral Research Course, 2014), as I obtained information about living individuals (physicians and nurse practitioners) through interaction with them (in-person and phone interviews). It qualified for expedited review by one or more members of the IRB, in that the research posed no more than minimal risk to subjects.

One of the most important conditions in gaining IRB approval was maintaining the confidentiality of the study participants. As mentioned earlier, interview recordings and transcription were kept in a secure location, and identifiers such as name and location of practice were completely removed in the reporting of findings and replaced with pseudonyms.

Although physicians were describing their approaches to patient interaction, The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule was not an issue in the case of this research. The Privacy Rule protects individual health information that can reasonably be used to identify an individual (Summary of the HIPAA Privacy Rule, 2003). Concerns over this rule were not relevant to this research since I was not attempting in any way to get identifiable information about specific patients; the study was successfully performed obtaining only general, de-identified, non-patient specific information from physicians. The consent form that participants acknowledged having
read also required that they agree to disclose only general, de-identified, non-patient specific information in the interview.

Data Analysis

In analyzing my data I performed a thematic analysis, which “focuses on identifiable themes and patterns of living and behavior,” (Aronson, 1994). In the first step of this analysis, I examined each transcribed interview separately, identifying and listing patterns of experience through both direct quotes and summaries of common ideas. According to Aronson (1994), patterns of experience can include processes and attitudes toward processes. In the second step of performing a thematic analysis, I identified all data within an interview that described the patterns of experience listed in the first step.

In the third step of performing the thematic analysis, I used the patterns of experience and corresponding data to develop sub-themes intended to “form a comprehensive picture of the collective experience,” (Aronson, 1994). After I performed the first three steps of analysis on each interview separately, I reviewed the analyses of all interviews collectively, in order to highlight the most common sub-themes. I also highlighted the most striking differences in physician responses. I then reviewed all the themes and organized them under each research aim (if any) that they addressed. For those that did not fall under any research aim, I made note of them as directions for future research. Finally, I theorized in what ways these themes described providers’ perspectives and how they could affect health outcomes for patients.

As the final step of the thematic analysis, I referred back to the literature to build valid arguments for identifying certain themes and their connections to provider perspectives and patients’ health outcomes. I then formulated my final theses explaining
how the most common patient traits and elements of physician approaches for treating obese adults affect health outcomes for patients of different race/ethnic groups.

Figure 1. Conceptual Model for Thematic Analysis
Results

Participant Characteristics

Participants ($n = 8$) ranged in age from 30 to 88 years (mean = 51.5 years). Most were female (87.5%, $n = 7$) and Caucasian (75%, $n = 6$) with the remainder (25%) including one African American and one Latina participant. Most participants were doctors of medicine (MDs) (62.5%, $n = 5$), with the remaining 3 participants being nurse practitioners (CRNPs). Family Medicine was the most common specialty (87.5%, $n = 7$), with one provider specializing in Internal Medicine. Years practicing ranged from one to 64, with a median of 20.5 years. Most participants spoke only English fluently (62.5%, $n = 5$), with the remaining three participants also speaking fluent (1) Arabic, (2) Spanish, and (3) German and Canadian French. Most practice in what the US Census Bureau (2010) defines as “urban clusters” (62.5%, $n = 5$), areas with a population of 2,500 to 49,999. The remaining three providers practice in “urbanized” locations, areas with populations of at least 50,000.
### Table 1. Participant Characteristics Chart

<table>
<thead>
<tr>
<th></th>
<th>Dan</th>
<th>Pam</th>
<th>Diane</th>
<th>Jane</th>
<th>Kim</th>
<th>Gina</th>
<th>Isabel</th>
<th>Mandy</th>
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<td>F</td>
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<td>Caucasian</td>
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<td>Latina</td>
<td>Caucasian</td>
</tr>
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<td>Urban cluster</td>
<td>Urban cluster</td>
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<td>Urbanized</td>
<td>Urban cluster</td>
<td>Urbanized</td>
<td>Urban cluster</td>
</tr>
<tr>
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<td>German &amp; Canadian French</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Spanish</td>
<td>None</td>
</tr>
</tbody>
</table>

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<sup>3</sup> Based on 2010 US Census populations: [http://www.census.gov/quickfacts/](http://www.census.gov/quickfacts/); [http://www.usacityfacts.com/](http://www.usacityfacts.com/); and Census definitions of “Urbanized Areas,” “Urban Clusters,” and “Rural” from [http://www.census.gov/geo/reference/ua/uafaq.html](http://www.census.gov/geo/reference/ua/uafaq.html): Urbanized Areas = 50,000 or more people; Urban Clusters = at least 2,500 and less than 50,000 people; Rural = all population, housing, and territory not included within an urban area.
Findings

Research Aim 1: Identify the processes through which providers determine that a patient is overweight to the extent that weight loss needs to be discussed

Research Aim 1 was addressed with one of the first questions posed to all providers, which asked how they determine which patients they will speak to about being overweight or obese. All providers except for one nurse practitioner said they use body mass index, and the standard categories outlined by the CDC for defining “overweight” and “obese.” Except for one physician, all of those using BMI mentioned some caveats to relying on the measurement for determining whether a patient’s size is unhealthy. For instance Jane, a white 35 year-old female CRNP who practices in an urbanized area, said:

Well so I use the BMI category. Just because that’s still sort of how we’re trained….um, but I feel like I’ve heard something about – well I know there’s nuances with it, but I’m not sure if any of the nuances, muscle or height, have made it to guidelines. So anyway, I’m still using the BMI… And it’s like, I have a few [exceptions] – for one, it’s a tall, really muscular male, you know, who works out a lot and has a lot of muscle mass. I mean, there’s no differentiation, there’s no BMI [measure] where you can tell that person’s muscle. So that’s one case and then the other case, I have a few, like, overweight, um, Caucasian women – anyway, it doesn’t really matter what their race is, but they do triathalons and they do you know, 45 mile bike rides, but they still have some excess fat tissue which puts their BMI in the overweight category, and I know that they’re healthier than the majority of my skinny patients who don’t exercise at all [LAUGHS].

Diane, a white 54-year-old female CRNP whose practice is in an urban cluster area, also referenced using BMI and acknowledged it is affected by excessive muscle. However, she did not feel that was an excuse to forego a conversation about healthy weight:

“I have a number of patients that are bodybuilders that have a very increased muscle mass. But as a friend of mine who is a PhD in nutrition and sports nutrition said, your heart doesn’t care about what its pumping blood through whether it’s fat or muscle. It needs to come down. So if I get one of these really heavy body builders that come in, it’s like yeah, you’re way overweight. Let’s look at what we’re doing here. What are they trying to do, what’s their goal.”
Kim, a white 55-year-old female physician whose practice is an urbanized area, discussed using a combination of BMI and just looking at the patient due to time constraints, even though she knows other methods might be more accurate.

“I know that we’re all supposed to use waist circumference. But you know, I’ve got a fifteen minute visit, I’m always way late anyway, and the waist circumference thing, it’s not going to change what I do. I can do their BMI and I can look from across the room and see that they have a big belly. So I know that we’re supposed to do it, I even teach that we’re supposed to do it, but no, I never do it. I think I’ve done it once in my whole career... You’ve got a triage. That’s just not anywhere near the top of my priorities list.”

Similarly, Gina, a 47-year-old African-American female physician who practices in an urban cluster area, mentioned using BMI and a “common sense” approach of looking at the patient, but was the only provider in the study who suggested that BMI definitions of “overweight” and “obese” could probably be more accurately broken down by race or ethnicity:

“I’ve also read that some people are actually thinking that maybe there needs to be sort of a, breaking it down by race. Because you have Asians whose BMI, because they’re smaller people, you know. Maybe a BMI of 26, 27 for an Asian person – it’s like why are you diabetic? Because they’re just not supposed to be that big. As opposed to African Americans, like I said, you see these people ‘oh yeah, according to this your BMI is 28.’ Man, you know if you did a, like a body percent fat, you know this man’s probably got 8 percent body fat. So some of this, is like, you know, ‘alright, yea it says you’re technically overweight,’ but you look at the person, and there’s not an ounce [of fat] ...I’ve heard some people say for African Americans there should be, like you know, maybe overweight is above 29 or we come up with other ways to measure you know, if we looked at measuring percentage body fat, or something like that. That’d be a different, because it’s like a good sort of average...They say waists, measuring waist size, that’s possibly something that’s 40 for a man that sort of is, ‘OK, you have a lot of abdominal obesity,’ so maybe if they start saying ‘well maybe we need do that,’ because that may give us more information about health than you know, that ratio.”

Finally, there was only one provider – Mandy, a white 46-year-old female CRNP practicing in an urban cluster area - who did not mention using BMI, but referenced using weight instead, with those patients at 300 pounds or over being what she considers the most severely overweight.

While most providers in this study rely heavily on BMI, they are aware that the measurement is not fool proof on its own. However, only one referenced the idea that race or
ethnicity could skew what a healthy BMI is, based on different body compositions. Most others who spoke of caveats referred to patients who are tall, or who have a lot of visible muscle.

Research Aim 2a: Describe different communication models providers use to tell patients of different races that they are overweight

All eight providers reported that a patient’s race/ethnicity does not affect the way they tell them they are overweight. Even so, the providers’ responses revealed several themes around how they bring up overweight and obesity with patients.

Teachable Moments

One physician aptly referred to one of these concepts as “teachable moments,” or moments that provide an “in” to discussing weight with the patient in a way that is relevant to the ongoing conversation. Most physicians who referenced these moments did so in response to being asked how they initiate discussion on a patient’s unhealthy excessive weight.

Kim used the term ‘teachable moments’ and explained why they are necessary in terms of weight loss discussion for her as a general practitioner:

“Well in medicine, you don’t have anywhere near enough time to do all the things you need to do. So a big part of it is what else is on the agenda. And then, you also try to get your teachable moments in. So if the complaint – say they have an acute complaint. I see a lot of people with chronic things. But my people bring all sorts of acute complaints. So one, if it’s preventable, two if I have time, three is if the complaint they’re coming with can in any way be tied up with the weight. You’re looking for a teachable moment. So three things: preventive, time, and teachable moment.”

Indeed, for most providers this “in” often comes after it has been established that a patient has a condition that excess weight could be contributing to. As Jane explained, mentioning the condition on its own can even prompt the patient to bring up weight him/herself:

“I’m like ‘Ok, well we’re reviewing some numbers, your blood pressure is a little heavier or higher, your cholesterol is a lot higher than last year.’ And then they go ‘Yea, I put on some weight and I’m really upset about it.’ Or, they just come in and they’re just like ‘God I keep trying to lose weight and I can’t do it.’ So that’s kinda, they just, yea. That’s
kind of how they bring it up to me. It’s either just right out of the blue or it’s sort of peripherally related to the section that I’m driving.”

Isabel, a 57-year old Latina medical doctor practicing in an urbanized area, described a similar ‘teachable moment’ in motivating patients to lose weight:

“And one thing that I’ve found that has been a little helpful to get people motivated is that, now that we’re using that test called hemoglobin AIC... You can predict if a person is at risk for type 2 diabetes. So when they see that, and people are so scared of diabetes, that “Whoa. What can I do not to get the diabetes?” So I say ‘Good question! Move more, eat less!’ [LAUGHS]. Or eat the right kind of food, you know.”

Diane, however, described bringing up weight in a very straight-to-the-point manner that contrasts with the method brought up by most other providers in the study:

“We have an electronic medical records system so once those are entered in the BMI is automatically recorded. If that BMI is 25 to 30, a little yellow box shows up. If its 30 and over a red box shows up. Just like I would address a high blood pressure at a patient appointment I would also address that weight problem and issue. Patients know when they’re overweight. It doesn’t come as a surprise to them. Ill just say an open-ended statement such as ‘Hey you’re overweight. What are you doing about that?”

Other physicians, including Gina and Pam, a 30-year old white female practicing in an urban cluster area), specified that the purpose of the appointment is important in determining whether they will bring up weight. For instance, if the patient they are seeing is not their personal patient, or the patient is there for a sinus infection or a cut, they will not bring up weight.

Research Aim 2b: Describe the different communication models providers use to explain associated risks and possible weight loss strategies to patients of different races

Once initiated, several factors appear to influence provider-patient discussion on overweight and obesity. In reference to Research Aim 2b, most providers did not state outright that they varied their approaches for discussing risks and weight loss based on patient race/ethnicity. This was not surprising, as seven of the eight providers did not feel that the process of losing weight was biologically different for people of different races/ethnicities. Dan,
an eighty-eight year old male practicing in an urban cluster area, expressed this perspective most explicitly:

“The human body is the same. It’s all, have you made up your mind to lose weight? Do you they accept the fact that you are overweight and really need to look better or feel better or move faster? Once you get that concept in your head, everybody is the same.”

Only Diane stated that patient ethnicity has a biological effect on weight, and explained it in terms of insulin resistance:

“If you’re northern European or whatever, you have a normal amount of insulin resistance. In other words, a normal amount of your metabolism is not going to use that insulin. And then therefore put it in storage, that extra insulin. Where the body usually stores extra insulin is in abdominal fat. So therefore, if I have no family history of diabetes, I’m northern European or whatever I probably have very little insulin resistance. If I have more insulin resistance because of genetics, Asians, Hispanics, I can tell you about one woman in this practice who is Asian Pacific Islander, and she has tremendous insulin resistance and it causes her to carry a lot of abdominal fat.”

Even so, she – like almost all other providers – reported that patient race/ethnicity has no bearing on her discussions of health risks or weight loss recommendations. According to Diane:

“As far as ethnicity, not really. I mean, it used to be that you’d always think well somebody who’s Hispanic, rice and beans, Chinese is going to be more Asian food. Not so much anymore. In the states everything’s gotten to be such a melting pot. I mean, my nice Asian Pacific Islander patients are eating the same garbage that everybody else here in [the area] is eating.”

Cultural Eating Habits

One of the providers, Isabel, did explain that she acknowledges cultural eating habits when talking to patients about weight loss strategies. Her suggestion is to watch portion sizes rather than give up traditional food altogether:

“So Latino countries, I know that they’re very carb heavy. So I always bring that up, you know. The rice and the tortillas, you know, so I always make that emphasis in using the plate, either drawing it for them or I have those plates [POINTS TO PLASTIC PLATES SHE HAS WITH PORTION SIZES MAPPED OUT] until I run out.”
Other providers like Pam described scenarios where a patient’s cultural traditions made it hard for them to lose weight, but did not report making any type of additional recommendation for those patients:

“I only had one patient [whose culture affected her weight] she was Nigerian, and they usually eat one huge meal a day and everyone eats together, like in a huge sitting. And she told me it was difficult for her to kind of change that habit, but she was trying to eat more, smaller meals throughout the day... So she told me it’s kind of the way her culture is, not so much the food they eat, but just the way they go about doing things.”

Pam explained that she did not need to make any further recommendations to the patient since the patient said she was already “trying to eat more American.”

*Racial/Ethnic and Socioeconomic Perspectives on Body Image*

While maintaining that they give the same type of weight loss recommendations to patients of all races/ethnicities, several providers did comment on how a patient’s race/ethnicity and/or socioeconomic status (SES) can influence other parts of conversation, in that their perspective of weight and body image can lead a patient to be more comfortable with being overweight or obese, and more reluctant to lose weight. Kim described the situations where she had encountered this and her typical response:

“There are some socioeconomic groups and some racial groups that kinda like, African-American women, I think African-American women sometimes really don’t want to lose weight, they’ll say things like ‘If I do that I’ll lose my booty.’ or they’ll point to their butt, and they don’t want to lose their butt. And you know, that’s well known. That’s been out there in the literature and I’ve seen that for years. And uh, so you can’t, you really have to distinguish between how it looks because sometimes, actually, you know, I mean in white culture they say skinny looks better anyway. Not necessarily in everybody’s culture. This is not about – I often say, ‘This is not about how you look, you look great. This is about protecting you from diabetes that runs in your family, that sort of thing’... I guess African American women need their butt [LAUGHS]. They don’t wanna look like skinny – you know, sometimes skinny people don’t want to look skinny, you look like you have HIV or you’re on drugs, stuff like that. And you know, in terms of how you look at things as adults, kids, people don’t want their kid to look skinny. Especially poor people or people from other countries. Skinny is not healthy, they want them to be a chubby baby, that’s a healthy baby.”
Jane also commented on how Caucasian culture promotes skinniness, while weight is seen as a positive thing for African Americans and Hispanics. She reported giving the same type of response as Kim, when faced with patients who may not want to lose weight for body image reasons:

“With every person I come at it from – I have the ability to just say “it’s all about health.” So I don’t ever say it’s about image…It only comes up when they say to me ‘Oh but my husband,’ or ‘my boyfriend’ or ‘my partner really like me the way I am.’ You know, and then I kind of have to say, ‘Well that’s really great that you have such positive self-esteem for what you look like, and that’s awesome, but we still have to kind of think about the fact that some of these, just the health aspects of it.’ So I don’t bring up that unless they say it to me.”

Gina explained her observation of how race/ethnicity and SES can intermingle to affect a patient’s “threshold” for considering themselves overweight:

*I have patients, and it’s usually, I think African Americans might not think of themselves as being overweight until they’re like, 100 pounds overweight. Where I think white patients might be kind of ‘ok, 30, 40 pounds, oh my god. Get the lap band.’ So I know that there’s a cultural [aspect]. And I think if an African American woman…and there also may be some socioeconomic [aspects], African Americans who are more middle class, they may have more of a…they might be a little more conscience about weight or whatever, at a lower weight…Where I think what’s considered big, small, it definitely is, there is a racial difference.*

She described her typical responses to both types of patients:

*Maybe for someone who believes that they’re really overweight, I might say ‘Look. Your BMI is 25, your numbers look good. If you want to lose weight it’s all cosmetic, it’s not going to change health, anything like that. So I wouldn’t be so upset about it, because everybody else is looking at you thinking you look great. Whereas see I might try to approach it that way. Sometimes it works, sometimes it doesn’t. If it’s someone who’s like ‘No I’m not interested in that.’ It’s like ‘Ok, well let’s try to increase your exercise. What are you eating? Can you do more vegetables, more fruit? What about sodas? Can you stop, ya know? Maybe they’re not necessarily wanting to go ‘yea, let’s start going to Weight Watchers, let’s get bariatric surgery,’ from the get go, but they might say ‘well, ok. Let me try to cut out sodas.’ They might be more receptive to ‘these things might be healthier for me. My blood pressure is up a little bit, these things might get it down.’*
All of the providers who commented on factors such as race/ethnicity, culture, and SES affecting a patient’s perspective on weight reported stressing to patients that losing weight is not about image, but about health.

**Patient Access to Resources**

Rather than race/ethnicity or culture – the factors this research sought to explore – SES was the most commonly mentioned factor providers felt influenced weight, their weight loss strategy recommendations, and their overall communication with patients. Providers discussed healthy food being more expensive than unhealthy options like fast food, resources like gyms costing money, and lack of transportation making it difficult to get to grocery stores to purchase fresh food. Kim discussed why she feels SES and associated factors such as class and education are more influential than race or ethnicity:

“I see low-income folks…everybody’s fat [LAUGHS]. Everybody’s fat. I know that the statistics are Hispanics and African Americans are worse, that might be true, it might have other factors. But you know, probably the white folks that I see are just as bad, I’d like to see the statistics on that too. I think there are statistics – I think poverty will make you more likely to be overweight and obese. That feels true. You know, trailer-park folks, they’re big… I think class is probably even more important than race… money, health literacy, because sometimes people make big changes that don’t help at all. You know, they switch to fruit juice because I screwed up and I didn’t mention it.”

Gina explained that even with some of the free alternative resources available for losing weight, a person’s neighborhood and education level can still impede their ability to lose weight:

[LOW-INCOME URBAN NEIGHBORHOOD] where [I once worked]… the social workers gave us these little like calendar things and they had all these ideas of you know, things to do for enrichment with the kids and you know, like basically cooking for WIC, and all that stuff. And you know, health foods and here’s a menu and all this stuff, it was like ‘Oh these are good ideas.’ And the nurse practitioner student who was working with me said ‘Yea, of course this means you have at least a sixth grade reading level to do this, and most health things you should have it written at a second grade reading level.’ So basically what you’re saying is none of the people we give this to is going to follow this. ‘Yea.’ Oh, because they had great stuff – little recipes and all this kinda stuff, but I guess it was too high literacy [LAUGHS]. But it was like they had tried – like, here’s a way you can go to the farmers market and the kinds of foods and then you could use this
and then you have your WIC thing and the extra subsidies from using the farmers market, so they would try to do these things. But, you have to spend the time to cook, and it’s one of those things that you have to like, you had a whole generation of people who didn’t. Grandmothers did, but then you had a generation or two where you know, nobody grew gardens in their little city houses and nobody went to the market and nobody cooked and now everybody’s having to do that [LAUGHS].”

Jane brought up how the stress associated with lower SES can lead to unhealthy eating habits and weight gain:

“A lot of it is poverty, socioeconomic status, access to healthy foods, access to places to exercise safely outside. Kids going through a great deal of stress can raise cortisol or just set out bad habits when they’re young, because a lot of time they’re just trying to survive…food period is their goal, it’s not what type of food.”

Accordingly, almost all providers commented on how they adjust their recommended strategies for weight loss based on patient SES, or how they only make recommendations that they feel are in the reach of all patients, regardless of SES. For instance, Mandy explained the types of recommendations she would and wouldn’t make to a patient of low SES:

“[I recommend] things that are achievable for them for where they are. I mean, you can’t tell them to go get organic food. They can’t afford it. But they can afford water. I tell them to put Crystal Light in it if they can’t stand the taste of water. Just cutting out soda alone might just be enough.”

Jane explained her strategy for making recommendations that are in the reach of her low-income patients:

“We have a nutritionist but I feel like that may not always be successful. With nutritionists – because again, a lot of our patients are low-resource, and you know, are in this neighborhood, so it’s food desert neighborhoods; they don’t have adequate healthy choices to pick from… I mean I always tell them about farmer’s markets and you know, using their food stamps and stuff. But yeah, I mean I think if you have transportation difficulties, or you know, can’t pay your rent or you’re, you know, just all that stuff, the food can often be just a low priority in terms of quality or choices. And then also we have this flyer going around that the nutritionist printed out, which was like if you’re going to go to fast food restaurants, these are the healthier choices. So we have that which is something that I can pass out that was like, you know, somewhat helpful…And then, most of my patients have phones, and so I kind of say like ‘hey did you know that this app is free on your phone to help you kind of track your diet and make some better choices?’ So I do bring that up.”
Pam explained how she responds when patients say they cannot afford healthy food:

“I told this particular patient that she should look at the serving sizes, knowing that her goal for weight loss would be 1,500 calories, and if she can only get things that aren’t right, she should make sure she looks at those serving sizes, um, you know, and the calories and maybe look at different labels and see what she can afford that might be a little bit healthier. You know, this instead of this, getting low fat of something instead of the regular, because there’s not too much of a price difference there, if she can’t afford the fresh produce and things. But, you know. And I told her if she doesn’t buy chips and cookies, then she can’t eat them.”

And although not specific to treating obese patients, two providers described a significant overall impact that patient SES has on their interactions with patients. Kim explained how her normal communication style has been shaped by having always treated lower SES patients:

“It’s all about style and rapport, and being patient-centered and sort of being authentic and approached as opposed to sitting on your high horse and all that…speaking in a language that, you know, when I talk to people who aren’t too fancy, I’m not talking about ‘stool’ and ‘defecation,’ I’m talking about ‘poop,’ you know what I mean? [LAUGHS]… I’m probably not so good, because I’ve spent my whole career taking care of the bottom of the socioeconomic class, I’m actually not so good in, uh, coming up with more formal language. Which maybe is a disadvantage for some fancier patients.”

Mandy explained how factors like insurance status and access to transportation has long affected the way she provides care:

“Like I said, I’ve always worked pretty much with people who need help, versus the high-falutin. I haven’t worked in the big cardiologies and all that to know when they see a much different clientele. So, I have to be more aware of who I’m dealing with because everybody has issues. You know, if you work in an area where everyone has insurance, you don’t have to think very much. You’re like ‘OK, here’s the medicine you take, this is it, this is it, go.’ Me, I would have to look at them and go ‘If I write for this prescription, can you afford it?’ That’s the first question, and ten to one, it’s a ‘no.’ Then I have to look in my samples and see if I have free samples, then I’d have to say ‘This is the sample they have, it may not be the best one but it’s free. See if this works.’ So we spend a lot more time dealing with a lot of things, so getting a little rash may not be as easy in some places because I may have the rash, I may know what it needs to be treated, but they can’t afford it. Or they don’t have a car! They don’t have anyone who can drive them to get the medicine. We have to come up with plans.”
Patient Unique Life Circumstances

Three providers brought up how certain unique life circumstances not related to race/ethnicity or SES can affect a person’s weight and ability to lose weight. Gina described a few of these situations:

*I think sometimes if situations, if they have like a stable home situation, that kinda helps. It’s kind of hard to do it if your job is scary, or you know, you have a difficult relationship, or there’s a lot of stress in your family. I guess it’s kind of like trying to motivate somebody to stop smoking. Sometimes when someone has that heart attack, it’s enough to say ‘OK, I’m not smoking,’ and then they stop. Because they’ve got something that says ‘yea, now I know why I need to stop smoking.’ And they’ve done it enough, they stop, and then they finally do it. But if they want to stop smoking but they just broke up with their boyfriend, and they’re having some financial difficulties and they’re trying to move, and this, it’s hard.”*

Isabel described her interaction with a patient whose role as a caretaker made losing weight difficult:

*“I think of one patient now, she is a black lady and she is the caretaker of her mom and her sister who are both disabled. So she is the one that has to do the grocery shopping and the cooking and the stuff like that. But they like to eat junk. But my patient is the one that has to provide the junk. So I told her, I said ‘Don’t buy the junk and you blame me. You say ‘my doctor said I can’t eat that,’ so you’re gonna put them on a diet too. You’re gonna make them all eat healthier so you won’t be tempted to eat the junk.’ You know, because it’s more than just them. If it was just them I think it would be easier. But it’s what’s around them.”*

Finally, Mandy noted that “flexibility” is important, in that the people she sees lose a lot of weight are typically those who do not have to care and cook for several younger children and a spouse. Instead, they can easily change their eating habits without disrupting the lives of others.

These findings show that patient SES influences these providers’ initial recommendations for weight loss in that they make sure their recommendations are straightforward and have low or no cost to implement in order to be in the reach of all patients. Additionally, at least some providers recognize how a patient’s unique life circumstances can impede weight loss. If a provider is aware of these circumstances, they might make recommendations for working around
them. Finally, it appears that for providers in this study, patient race/ethnicity does not affect their recommendations at the onset of the conversation on weight loss. Patient race/ethnicity or culture does appear to play a role in the discussion when it leads to the patient’s preference to stay at a heavier weight. Providers respond to patients’ reluctance to lose weight in these instances by reminding them that getting to a lower weight is about being healthy, not about image. Although rare, patient race/ethnicity or culture also enters the conversation when patients discuss cultural eating habits that inhibit healthy eating. Only one provider reported making additional suggestions for those patients: to watch portion sizes of the unhealthy food.

*Research Aim 3: Explore provider perspectives on which communication models may be effective for discussing unhealthy weight and weight loss strategies with patients of different racial/ethnic backgrounds.*

Five providers in this study discussed how only a small proportion of their patients achieve lasting weight loss. Even so, there was significant overlap in the providers’ recommendations that they felt were most effective with all patients. They did not state that any recommendations were more effective for patients of certain races/ethnicities than others.

*Advice Effective for All Patients*

Six providers stated that one of the easiest and most immediately effective recommendations they make for all overweight and obese patients is cutting out sweet beverages such as soda. Four providers discussed setting small, realistic weight loss goals for patients and being sure to follow up with patients on their progress at each visit. Three of these providers emphasized the positive feedback they give patients who have lost even as little as half a pound, sometimes parading the patient around the office to tell office staff how much weight s/he has lost. Four providers mentioned specifically avoiding recommending a “diet” to patients and instead recommending “lifestyle changes” to eating habits.
Meeting the Patient Halfway

Another strategy providers described as being more likely to lead to patient weight loss – sometimes with respect to a patient’s race/ethnicity or culture-related perspective on weight – was an approach that can be described as “meeting the patient halfway,” or allowing for patient input in planning the weight loss process. The providers presented this notion in various ways.

Gina explained the story of how one patient’s initial resistance to losing weight lead her to suggest a low-end weight loss goal – one that would be just enough to improve some aspects of the patient’s health:

“I remember when I was working in [West Urban Area], I guess she was like a girl who’s about 25, 27 and she was like five four, 280 pounds, real pretty girl. Blood pressure to the roof… I mean 20…it’s like you know you’re going to be on blood pressure [meds], maybe we need to lose some weight. And she looked at me and said “[Dr. Gina], I don’t wanna be all skinny like you. I mean my boyfriend, he’s not gonna find me…” And I’m like ‘Stop, I didn’t say you had to be a size four. I didn’t say you had to look like me,’ because I mean she probably never will be that. ‘I’m just talking maybe 20 pounds just to see if we can keep you from getting on blood pressure [meds].”

Similarly, Dan said that although he sets a medical goal for his patients, he is willing to let the patient stop sooner in certain situations:

“I will stop if you look at yourself and you say you’re comfortable with the way you are…I set a medical goal. However, I also tell them to be comfortable with their bodies. If they reach my medical goal and they feel good about themselves, they feel fine, that’s fine with me.”

Isabel explained how she approaches the same scenario with her patients:

“I try to say ‘well what I want you to be is healthier.’ Have a healthier lifestyle. So if you don’t lose weight, but you are being physically active, and your numbers are looking good… because I do have patients that are like that. They’re big and they’re obese, but they’re physically active, they’re able to do stuff without getting short of breath, and they just like to eat. And they don’t wanna make an effort.”

Dan, Diane, and Kim shared similar responses.
Patient Personal Motivation

The commonality that almost all providers mentioned among patients they see successfully lose weight was personal motivation. The providers’ responses suggest they feel differently about just how much they are able to influence this motivation. Mandy said of these patients who successfully lose weight:

“They’re motivated. They’re really motivated. And yea, you have to be able to change your entire lifestyle, is what they usually have done. And that’s how they did it. My sister-in-law went on the Trim Fit Mom, I’ve got the book over there. And really, completely changed the way she’s eaten. One lady I know lost a lot of weight started going to the gym like five days a week, which she’d never done, and changed how she ate because of that. I mean huge lifestyle changes. For the people to lose subsequent weight, they have done major overalls. It’s not easy. It’s not…[It’s a] personal [decision]. Yea, I usually find that the doctor that seems to be the pushiest, gets the least results. I don’t find they’re very successful at all.”

Diane responded similarly, although emphasized her role a bit more:

“They were fed up and they were finally ready to change their life. These are my folks that go for gastric bypass surgery or lap band surgery or successfully go through a diet program. These are folks that are like, they’re done. They’re ready to make that big change. These are in the same category as people who quit smoking, quit alcohol, or quit drugs. They’re quitting eating bad and taking better care of themselves… I can lead them to where they need to be, but they have to be willing to follow it. They have to be willing to go along with it. That’s my job to motivate them to do it.”

Pam explained that a health condition is often the primary force behind patient motivation:

“I feel like, well I wouldn’t really say any demographics stand out for people who’ve made changes, but they usually have a chronic medical condition. So maybe they have diabetes or worsening diabetes or worsening back pain. Or you know, something is giving them a little push to you know, maybe make the lifestyle changes. Not like someone who just comes in and is pretty healthy but obese, you know. These people usually have a secondary reason.”

Kim explained that in some drastic cases, the personal motivation to lose weight can even come from the way a weight-related condition threatens a patient’s career:

“I don’t know whether you could say this across the board. You know, sometimes you get somebody who has a real important reason. You know, like I have two pilots, who have to lose weight in order to get their diabetes under control so that they’re not on insulin so
they don’t lose their pilots license. And I’ve had a couple of truck drivers like that, too. And you know if your job depends on it, getting off insulin, because you can’t have your license, that, you know there’s a few times where you see something – boy is that a motivator. But I only have a handful of stories like that. But that’s dramatic. Or sometimes a relative has diabetes or something like that.”

“Modern Day Lepers:” Recognizing Stigma and Avoiding Blaming Obese Patients

Although exploring stigma was not one of this study’s explicit research aims, many providers alluded to the stigma overweight and obese patients face, and explained how their respectful approach to interacting with patients was ultimately far more important than either the patient or provider’s race in securing patient trust. The providers who mentioned their strong relationships with patients also reported that these relationships have a positive effect on a patient’s likelihood of achieving weight loss. As such, the concepts of stigma and patient trust tie in with Research Aim 3. For instance, Pam explained:

“I noticed that the ones that did [lose weight], we clicked better. Like personality-wise. Like I felt like, they liked me, not just as a doctor, but we kinda like, clicked in the room, we had something to talk about, felt more comfortable, felt more like a friendly relationship. Those were the patients that actually came in with losing weight.”

Dan explained the way he builds trust with patients who are overweight:

“I respect the people who are overweight. It’s an ailment. It’s a disease. It’s not a joke or ‘she is fat’ or ‘he is fat.’ No, I treat them with respect. I treat them with dignity.”

In some cases, providers described exactly how their realization of stigma is key to earning the trust and respect of their overweight and obese patients. It was clear that Jane was receptive of the uncomfortable situation discussing weight can put obese patients in:

“But it can be very tricky [to bring up weight] when you have morbidly obese patients, because they’re almost expecting you to say something. And, you know, it just creates a tension in the room, but I can do that in a very diplomatic way. But I kind of take the social cues.”

Mandy described how she takes on the role of “supporter” when she interacts with overweight or obese patients who feel stigmatized:
“I mean a lot of times, they’re breaking down in tears, they’re crying. Because they’re so aware of how overweight they are, they’re so aware of what can happen, and they’re so hopeless, and they’re so hurt by how they’ve been treated by the medical profession, and a lot of them don’t go back. A lot of them don’t go back. Because all they think people see is that they’re fat and that’s their problem. They don’t feel that people see them as a hypertensive that needs to be treated. They feel that they’re the fat woman that has hypertension because she’s fat. And that’s how they see it. And so they don’t get care all the time and that’s another problem why they’re so bad, because they really feel like they’re lepers. They’re like the modern day lepers, I think. I really do think that’s how they’re feeling. Because you can’t hide obesity. You couldn’t hide leprosy. And that’s how I think they feel. They feel shunned by most medical people so they find it very refreshing to find somebody who doesn’t see them as the ‘fat woman,’ but sees them as a person that, ‘well you’ve got diabetes, let’s see what we can do to help you with it.’ And make their weight in it, but not the forerunner. If that makes any sense.”

Her thoughtful assessment of how obesity is like the modern day version of leprosy was the most serious and expressive statement any participant made in terms of recognizing stigma, and she was one of only two participants who acknowledged that stigma can prevent obese individuals from seeking care.

Isabel explained what she believes makes patients feel stigmatized and how she works around it:

“There are people that are very sensitive and I think it has to do with the words that are used to describe their obesity. You know, I like to try to stick to medical terms. You know, but even the term ‘obesity’ to some people can be offensive. Uh, you know, so I try to then just say you know, overweight, or healthy weight. When we used to have paper charts when I was with the other practice, I remember having this patient who, huge BMI, 50 plus, and it listed morbid obesity and she got to see that and she said ‘What does morbid mean?’ And I said, ‘Well, that’s, your weight fits that criteria,’ so that, you know, I felt very uncomfortable because the word is horrible… It’s like ‘you’re gonna die.’ So anyway, so it’s hard for some patients, it’s very hard. And you know I don’t like to use the term ‘fat.’ Like sometimes they refer to themselves, or they beat themselves down, like ‘I’m so fat,” and I try to discourage them to use that word or to look at themselves in that way.”

Gina acknowledged that many in the medical field contribute to the stigma around obesity and, even described how the practice she belongs to had contributed to that stigma at one point:

“I had this poor woman who I think, she hadn’t had a physical or PAP in forever, because I mean, she was overweight…I mean I’ve had patients who are bigger, but it didn’t help that – at least now we’re getting better with getting some gowns that actually fit because we were getting these gowns and they only fit like six patients, because you
have to – I mean, they're finally getting some that are bigger, but the poor woman had this pink gown [MAKING HAND MOTIONS SHOWING STRUGGLING TO COVER HERSELF UP], and it wasn’t quite covering and she’s trying to cover for a physical and she’s all sweating and she was all like [CONTINUES HAND GESTURES], and she just felt so uncomfortable, you just felt so bad. You’re just kinda like, ‘Look, these gowns don’t fit anybody.’ [LAUGHS].

Finally, Diane reflected the opposite view: that overweight or obese patients who say they’ve been stigmatized are likely just very sensitive:

“Well where I usually see this is when I have a new patient come in. Let’s say they’re five foot five and 225 pounds, and they come in and they sit down and they say ‘I just got rid of my last doctor because she told me I was fat. She just would tell me I was fat all the time.’ Yea, I hear this a lot. And you know, it’s probably that this person is very sensitive about their weight. What they’re telling me is I’m really sensitive about my weight and I don’t want you to capitalize on it. I may have to wait until there’s more of a level of trust. So maybe the third or fourth visit though, you know, we need to address this. And just drop the ball right there, we need to address this weight issue. And then they can never say ‘oh my gosh, all you ever talk about was that I was fat.’ You need to have some trust because this is telling somebody something they already know.”

Three providers discussed how society plays a large role in the prevalence of obesity. This perspective may have contributed to their sensitivity toward the stigma of obesity. Dan cited the way advertising for unhealthy food is largely to blame:

“You have to really understand the psychology of people, and the advertisement of the TV. They make McDonalds very attractive to eat. By the way, French fries – McDonald’s – are terrific [GRINS]. And all other foods when they advertise for food; it’s a food channel. There is Burger King, there is Wendy’s, there is – they all make it so attractive. They don’t tell you about the value in the calorie, they don’t tell you about the cholesterol in it or this and that, but make it very attractive. It’s an art. The advertising art of making people go out and buy a whole chicken, and so you know, it’s abundance. The pizzas, the other things, they’re all quick, quick meals, loaded with fat, loaded with good tasting medicine, good tasting material, and uh, people buy it. And next thing you know, weight is on.”

And although this research was not about childhood obesity, the life course significance of obesity as producing subsequent health problems was mentioned. Isabel spoke about how obesity is such a problem in the US because it’s showing up in increasingly younger people, due to several societal changes:
This country has an obesity problem. Big time obesity problem. I guess maybe that's why
you chose this topic, but you know, and the sad part is now that it trickles down to the
children. And the new habits, technology, you know, kids are sedentary. So it starts now
even earlier, we're starting to see Type 2 diabetes in children when that used to be a
disease of adults. It's sad. We try to...it's a difficult problem to tackle. And it takes a
village to tackle a problem. Because it's not just us. It has to do with the school system,
with home, the community, making the communities more, you know, like, this community
is great because it has a lot of paths that people can walk, but it's a community that
public transportation is very bad. So people have to be in the car to get to places. And uh,
so, in that sense city living is a lot better because people can walk to places. But um,
here, you know it's school systems have cut back on their PE, um, high school kids get
half of a semester of PE in the entire four years of high school. You know, if a student
doesn't do sports, that's it. You know, and that to me, is a sin.”

Gina shared her thoughts about how the government could do more to make healthy eating easier
and more affordable for people, such as making fruits and vegetables cheaper, putting in more
sidewalks, and subsidizing memberships to workout facilities.

Despite so many physicians reporting their sensitivity to the stigma around obesity and
their recognition that several factors outside a patient's control are at play, some of the providers
still made comments that showed they see the patient as having some responsibility for not
losing weight. For example, Gina spoke about how people are always looking for a quick-fix and
ways around fully committing to healthy changes:

“Patients want the easy pill. I mean believe me if there was a pill that could make you
drop 50 pounds, don't you think I would give that to you? And we would all be taking it?
If there was an easy way, you know, this is what to eat and I said eat these twelve foods in
this portion for the rest of your life and you would stay the weight you want. Would you
even do it? You probably wouldn't, you'd go 'Well, how about if four days a week I do
this, then three days a week, I have, ya know, some cake, and I'm good except for when
I'm on vacation.' I mean, how about if I do these eleven foods and then I switch one for
this...’ You know, it's hard.”

While acknowledging that losing weight may be harder for some patients than others, Diane
described a type of patient that may not be willing to put in the work to lose weight:

“Oh I have entire families that are very comfortable with being morbidly obese. It's just,
they were raised this way – 'the clean plate,' fill your plate, it's healthy to eat this much,
and that's, you know, their family is this way. They love to say ‘I look like my mom,' ‘I
‘I don’t have any choice but to look this way.’ And they’re not in a lot of cases willing to do the work it would take to get down to a normal body mass and it may take them a lot more work depending on where the metabolism is at, where their insulin resistance is, a number of things factor into that weight.’”

Finally, Pam cited some of the reason other providers had mentioned as contributing to weight problems, but instead described them as “excuses”:

“Most of the ones that make the excuses are morbidly obese, and it’s because ‘oh my back hurts so I can’t walk,’ or ‘my knees hurt so I can’t walk or go to the gym,’ or ‘I don’t have money to eat right because I’m on food stamps and healthy food is expensive,’ or ‘I can’t pay for Weight Watchers,’ or you know, ‘I’m too busy to exercise, I have six kids at home.”

Clearly the providers in this study hold complex views on obesity and its causes. Even those providers who whole-heartedly reported that they were sensitive to the stigma around obesity made other comments suggesting they view obese patients as not being willing to put in the work necessary to lose weight.

**Discussion**

Understanding the general practitioner’s perspective on treating overweight and obese patients and the effects of patient race/ethnicity on that interaction makes an important contribution to the existing literature. This study further informs research on provider-patient interaction and on the experiences of groups often stigmatized by the health care industry: obese individuals and people of minority races/ethnicities. Many studies have been conducted on general doctor-patient communication, doctor-patient communication on obesity, doctor-patient communication as related to race/ethnicity, and different racial/ethnic perceptions of weight, but to my knowledge, there are none that have examined provider-patient communication on obesity with a focus on patient race/ethnicity.


Patient Race/Ethnicity

One of the most resounding findings in this research was that providers did not feel that patient race/ethnicity influences (nor that it needs to influence) their approaches to treating overweight and obese patients. This held true for the majority of providers when asked about their strategies for determining whether a patient’s weight was healthy, and when asked whether their discussion of health risks and weight loss recommendations were influenced by patient race/ethnicity. Race/ethnicity likely did not influence these things because all but one provider felt that the process of losing weight is not different for people of different races/ethnicities once environmental factors are removed.

In determining whether a patient’s weight is healthy using BMI – the primary method of seven providers in the study – the main caveats cited were patients being tall or having a lot of muscle mass, rather than a patient’s race/ethnicity-related build making them heavier. This practice of using BMI, and citing muscularity as the main (if not only) caveat, is accepted as the standard in health care. As Elrod wrote in the July/August 2014 issue of Nurse Practitioner Perspective:

“BMI is a widely accepted method because it is age-independent and the same for both sexes…While BMI is the standard for diagnosing overweight or obesity, clinical judgment should be exercised for muscular patients. In these patients, the height-to-weight index will be appropriate, yet will classify them as having an elevated BMI.” (pp. 46)

When connected back to findings from Affuso et al., (2010) that show non-Hispanic blacks have a significantly lower percentage of body fat compared to non-Hispanic whites and Mexican-Americans at the same BMI percentile, this finding means that non-Hispanic black patients who are not visibly muscular might be told they are overweight or obese when their
weight is not particularly unhealthy for their build. This may have contributed to the CDC’s (2010) findings that blacks had significantly higher obesity rates than Hispanics and whites.

The two areas where providers did acknowledge the influence of patient race/ethnicity on weight and on provider-patient interaction was in relation to cultural eating habits and ideal body sizes. The providers’ observations on body size preferences reflect the literature that posits that African American and Hispanic adults are less likely to view themselves as overweight at the same BMI as their white counterparts (Durant et al. 2008), and that African American women report feeling more comfortable with their bodies at higher BMIs than do white women (Chithambo & Huey, 2013).

Notably, all of the providers who mentioned the effects of culture on eating habits and ideal body size practice in urbanized areas with the exception of Gina, who began her career in an urbanized area (the time of her career on which many of her stories on the subject were based). This is significant, as it shows that providers in less urban areas likely encounter less culturally diverse patient bases with a limited number of perspectives on body image, thus making these providers less sensitive to any preferences for a body image other than “thin.” Kim’s comments on body image were particularly noteworthy when considering that she practices in an urbanized location and states seeing low-income patients. She reported that “African American women need their butt,” and “skinny people don’t want to look skinny,” because it can “look like you have HIV or you’re on drugs.” When viewed in the context of where she practices, this suggests that she is regularly confronted with various culturally influenced perspectives on body image, as well as perspectives associated with lower-income urban populations, and that she must work around these perspectives in motivating patients to lose weight. She, and the other providers who spoke of facing similar situations (Isabel, Jane and
Gina), explained that because of these varying cultural perspectives on body image, described making the conversation not about image but about ‘below-the-surface-level’ aspects of health, such as blood pressure and hemoglobin A1C levels, in motivating patients to lose weight.

The effects of practice location become even more apparent when juxtaposed with comments from both Diane and Dan, who practice in the same less-diverse, urbanized cluster area. Diane stated that things have gotten to be such a “melting pot” in the US that her Asian Pacific Islander patients eat the “same junk” as everyone else; it’s not that Hispanics eat all rice and beans and Chinese eat all Asian food as you might expect. Dan reported “everyone wants to look thin, trim and beautiful.” It is likely that practicing in a less urbanized, less diverse town means that providers like Diane and Dan rarely encounter patients who have diverse cultural eating habits, or who are concerned that looking too thin might give others the impression they have HIV or a drug addiction. Rather, their patient populations likely share the same ideal body image as being small, so image can often successfully be used as motivator for patients to lose weight, just as Diane reported doing herself. And if the patients who successfully lose weight are those that commit to structured programs like Weight Watchers as Diane also explained of her patient base, being thin may even be associated with having the financial resources necessary for maintaining a small figure – the opposite of possible associations in diverse, low-income urban areas such as where Kim practices. In the case of providers who practice in these less urban locations, it may take less effort to convince most patients to lose weight, but those patients who do not share in the “standard” ideal body image may not receive the attention or recommendations needed in order to lose weight. And in addition to those overweight and obese patients who are not successfully motivated or properly advised on how to lose weight, these providers in less diverse areas using image as a weight loss motivator may be neglecting the fact
that being thin does not necessarily equal healthy. As some of the providers in more urban areas noted, there are patients who are overweight but are more physically active and therefore healthier than their less active, “skinny” patients.

However, even among those providers who mentioned the significance of cultural eating habits and cultural perspectives on body image, all but one reported that these topics only come up in conversation if the patient brings them up. The providers who mentioned these situations in their interviews mentioned them only upon probing, and spoke of them as a less than frequent occurrence. This suggests that if a patient wants a provider to give them advice for incorporating their cultural eating habits into a healthy diet, they will generally need to bring it up themselves. And even if a patient does bring thing up, it’s not clear if many providers (even those who practice in more diverse, urbanized areas) will have specific recommendations for working around those eating habits, aside from suggesting that the patient practices moderation with any traditional foods that are unhealthy.

On their face, these findings contradict those from Dovidio and Fiske (2012) that suggest physicians recommend more advanced and effective treatments for whites than blacks, since these providers report giving the same advice regardless of patient race/ethnicity. It may be the case however that such discrepancies in treatments prescribed by physicians are not as apparent at the primary care level, since the main recommendations discussed by providers in this study were lifestyle changes rather than surgery or medication. It may be that white patients are approved more often for bariatric surgery than minority patients, but that topic was not investigated in this research.

It also may be the case that although providers give the same one or two general messages about losing weight to all patients – the consensus of this study as well as research by
Puhl and Heuer (2009) – those recommendations might be more effective for patients of certain races/ethnicities than others. In this way, giving identical recommendations to all patients could prove to be another form of racial/ethnic bias that the 2004 IOM report on racial disparities in healthcare sought to discourage. Indeed, the report stated that inequalities in health care exist due to the biases and uncertainties providers hold about minority patients. In the case of treating obese patients, providers may hold ill-conceived notions that patients of different races/ethnicities all eat the same food, or would all prefer to be thin. This lack of cultural awareness could leave some patients unmotivated to lose weight, or without receiving the proper advice for eating a healthier diet.

However, the providers in the current study would likely argue that if any group-level information like population risk factors should guide their treatment, it is a patient’s socioeconomic status and associated traits such as health literacy and education levels.

*Patient Socioeconomic Status*

Although beyond the immediate scope of this research, it is clear that if the providers in this study are mindful of any group-level patient characteristics when making their weight loss recommendations, they are thinking of SES. The providers reported considering patients’ access to resources – such as having insurance to pay for medications or a nutritionist, and having transportation and money to get to a grocery store and buy fresh, healthy food. Providers also cited health literacy as affecting the way they discuss health risks and weight loss strategies, since patients of lower education levels may not have an understanding of the way certain chronic conditions are related to weight, or an understanding of calories and the importance of proper portion sizes. Providers mentioned how patients of certain SES may have to overcome additional hurdles to lose weight, such as increased daily stressors that increase cortisol.
production and make eating healthy a low priority. With the exception of a few providers like Diane and Jane who said they might recommend a program like Weight Watchers to patients whom they thought could afford it, most providers reported sharing the same free or affordable and easy to implement recommendations with all patients, rather than suggesting distinct weight loss plans to patients of different SES.

While only one provider’s comment alluded to the intermingling of race/ethnicity and SES in the case of African-American patients, the majority of providers held that SES is more responsible for overweight and obesity than race/ethnicity. The literature, however, paints a more complex picture of that relationship. A recent study by Jones-Smith, Dieckmann, Gottlieb, Chow and Fernald (2014) found that for whites, Hispanics and Asians, children with the highest SES were significantly less likely to be overweight or obese, whereas SES was not significantly related to odds of being overweight/obese for African American and American Indian children. This may be the case because, as two of the providers in the current study mentioned, being impoverished can also be associated with being skinny, so it could be the effects of poverty manifest as excess weight in children of certain races/ethnicities, but for others, such as African Americans and American Indians, it has mixed effects. This contradicts what many of the providers said in the current study, in that they made no distinction between the races/ethnicities for which they felt SES was a determinant of weight.

A study that examined the relationship between SES and obesity in adults in the US found that African American and Mexican-American men with high income are more likely to be obese than those with lower income, but that there is no trend between education level and obesity in men (Ogden, C.L., Lamb, M.M., Carroll, M.D. & Flegal, K.M., 2010). The study also found that women with higher incomes are less likely to be obese than low income women, and
that women with college degrees are less likely to be obese than women with less education. These findings on women are more reflective of what the providers in the current study said. Given that seven of the eight were female providers, it could be that the majority of their patients are women, which is why they noted such a distinct relationship between lower SES, lower education levels, and being overweight or obese.

This could have implications for all general practitioners in that it may be helpful for them to spend extra time getting to understand the particular situations of low income women and even high income men, to understand what factors make it difficult for them to maintain a healthy weight. They could then use this information to make recommendations for weight loss that are more sensitive to these patients’ unique situations. Providers may also want to pay particular attention to educating low-income women on ways to maintain a healthy weight, and on being more thorough with higher income men about the risks of being overweight or obese.

Patient Unique Life Circumstances

The providers’ acknowledgements of patients’ unique life circumstances and how they affect weight loss may explain why providers did not report basing weight loss recommendations on race/ethnicity alone. Providers may recognize that for any overweight or obese patient, there is an amalgam of factors that has led to their unhealthy weight and creates obstacles for losing weight. It is notable however, that only three providers in this study described such life circumstances as affecting weight. Interestingly, these providers each gave in-person interviews and happened to have had the three longest interviews (59 minutes, 50 minutes and 48 minutes) in the sample. It is possible that other providers might have mentioned encountering these situations if their interviews were longer. It is also possible that the candidness displayed by each of these three providers in their interviews was reflective of how candid they are with patients,
making them more in tune with such personal situations their patients are facing. Since becoming aware of a patient’s unique life circumstances, such as having a difficult relationship, a stressful job, or caretaking responsibilities – as opposed to patient socioeconomic status or race/ethnicity – would often require that the patient disclose them to the provider, it may be that only providers who have very open communication with patients and who have attained high levels of patient trust are made aware of these circumstances and are able to advise around them.

**Patients Traits & Provider Methods Associated with Successful Weight Loss**

The strategies for encouraging weight loss that providers cited most commonly as being effective were recommending cutting out sweet beverages like sodas, setting small weight loss goals for patients, giving an abundance of positive feedback for even the smallest amounts of progress, and suggesting “lifestyle changes” rather than temporary changes like “going on a diet.” If implemented, these strategies could be useful in helping patients regardless of race/ethnicity or SES, which is likely why they are some of the most commonly reported as being successful. Although five providers mentioned structured programs such as Weight Watchers as having worked for some patients, it was not mentioned by all of them as one of their most effective recommendations probably because it is not in the financial reach of all patients. It might also not fit into the lifestyles of patients who are dealing with increased amounts of daily stress and don’t have the time to make the commitment. Finally, it may be outside the scope of certain patients’ education levels due to the work involved in tracking food intake and exercise and adding up points. This could mean that structured programs like Weight Watchers are helpful for patients who can afford them and have such stable and independent living situations that they can completely alter their eating habits without disrupting others. Outside of those types
of patients, simple, concrete, “do it yourself” recommendations that have low or no cost of entry, coupled with tangible health goals, are likely more effective.

Ultimately, the trait the most providers noted among patients who had successfully lost weight was personal motivation, often due to an existing chronic condition caused by weight, or a family history of such conditions. While most providers who cited personal motivation as key explained that it has to come from the patient, two providers did state that it was their job to motivate the patient. But even with only two explicitly stating they saw this as their responsibility, five providers described embracing a practice of “meeting the patient halfway” when encountering patient resistance on the subject of losing weight.

This was another strategy the providers mentioned as being helping to successfully motivate patients to lose weight. As touched upon earlier, if an overweight or obese patient expressed that they liked the way they looked, some of the providers in this study would allow that to influence their weight loss recommendations. They might set a lower end weight loss goal that would be enough to get the patient off blood pressure medication, to lower their blood sugar, or to make it easier for them to be physically active. They might also suggest smaller, more easily implemented goals if patients showed little interest in making large changes immediately. The providers felt that by setting smaller goals that are focused on improving very specific parts of the patient’s wellbeing, patients would be more willing to try making changes. Providers acknowledged that it can be overwhelming and not particularly motivating for a patient to hear that s/he needs to lose 100 pounds just to “be healthier.”

This theme of “meeting the patient halfway” could be used to inform prior research that has focused specifically on the way providers respond when patients show reluctance or uncertainty about increasing physical activity. One particular study found that when faced with
patient reluctance or ambivalence to being more active, just barely half of physicians offered further but limited guidance such as briefly acknowledging the patient’s barriers to physical activity and making suggestions for working around them (Caroll, Antognoli & Flocke, 2011). The remaining half did not respond at all to these patient reactions. That study and this current one call into focus the question of how far the general practitioner’s role extends in making sure his or her overweight and obese patients lose weight, as opposed to just telling them they need to lose weight. Elrod expressed her view of the former in the July/August 2014 issue of *Nurse Practitioner Perspective*:

> “Remember, no matter how extensive or clinically sound the program, outcomes depend on patient behavior. NPs should engage patients in behavioral counseling using the Five A’s to identify both barriers and the strategies to overcome them.”

Interestingly, while the first part of Elrod’s statement may sound as though blame is being ultimately placed on patients who do not lose weight, the second sentence clarified that Elrod feels that it is the provider’s job to encourage patient behavior that is conducive to weight loss.

The providers’ responses in the current study, especially when compared to those limited responses reported by Caroll, Antognoli & Flocke (2011), show that they are sensitive to patients’ different goals and comfort levels, rather than requiring patients meet a non-negotiable weight loss goal. Their stories suggest that they realize in order for the patient to be willing to lose weight at all, there has to be a compromise, and that at least these five providers – like Elrod (2014) – view their roles as extending further than just delivering information to patients but in seeing to it that healthy changes are made.

Part of the process for the provider of ensuring that changes are implemented is building patient trust. Providers in this study mentioned that they saw weight loss more commonly among patients with whom they had stronger relationships. The strategy of meeting the patient halfway
is likely helpful in building up that relationship with patients and even combatting some of the stigma overweight and obese patients sense from the medical profession, because they feel that they have a provider who is willing to consider their situation a unique medical problem. This reflects the literature referenced earlier, in that good doctor-patient communication is associated with greater compliance with physician orders (Waitzkin, 1984), and can facilitate more effective behavioral interventions such as smoking cessation, increased physical activity, dietary change and willingness to undergo cancer-screening tests (Devoe, Wallace, & Fryer, 2009).

Some providers’ use of “teachable moments” to bring up weight could also be seen as another means of combatting stigma. This is because the providers described these discussion topics as a way to avoid making the patient feel as though their weight is the “forerunner” in every conversation and the only thing the provider notices about them. This shows that most of the providers in this study recognize the importance of first being able to establish a relationship and trust with the patient before discussing weight.

The providers’ focuses on building patient trust appear to be born out of their recognition of the stigma overweight and obese individuals face and how the health care industry contributes to that stigma. The most striking comment on this subject came from Mandy, who stated that obese individuals probably feel like modern-day lepers, because they cannot hide their obesity so they are constantly stigmatized by it. She explained that her history of working with underserved populations both in third-world countries and in the states was responsible for her empathy for all patients, and that she believed doctors who do not have this type of experience tend to have less empathy and are the providers ultimately responsible for obese patients not seeking care. In fact, Mandy was one of only two providers who acknowledged that stigmatization from the healthcare industry often stops overweight and obese individuals from seeking the care they
need, with the other physician who mentioned it, Gina, having referenced beginning her career practicing in an urban, underserved area. This concept is supported by existing literature that holds that a patient’s trust in his or her doctor is linked to the continuity of the doctor-patient relationship (Stepanikova et al., 2006). In the case of obese patients, this trust likely depends on the provider’s level of empathy and his or her strategies (if any) to avoid making patients feel any more stigmatized.

Gina described situations of obese patients not seeking out care they need in terms of women who choose to forego getting women’s wellness exams because they believe they are too heavy, and even mentioned how her practice used to carry exam gowns that were not large enough for many patients. Similarly, Mandy commented on how offices where she had previously practiced did not have exam equipment large enough for patients over 300 pounds. These stories show that in addition to the provider’s interpersonal communication with the patient, institutional bias in the health care industry is also responsible for the stigmatization of obese patients. Thus, even if a provider is especially patient-centered, institutional biases may still discourage obese patients from seeking care.

Because of this, provider-patient relationships in the case of overweight and obese patients should be an area of study in itself. The provider has to attain the patient’s trust while also fulfilling their duties of letting the patient know his or her weight is unhealthy and making recommendations for losing weight. The provider is at a disadvantage before s/he even meets the patient, because as some providers in this study noted, the patient is expecting the provider to bring up their weight immediately because they’ve already been stigmatized by others for their weight and feel that it is the only thing anyone notices. Additionally, the provider may have to focus extra attention on making the patient feel comfortable when confronted by industry bias.
present in his or her own practice, such as smaller exam gowns and equipment with limited or no ability to accommodate obese patients. This is why some providers mentioned not bringing up weight at the first visit or as the first topic of discussion, or with patients who are not their personal patients. Some providers also discussed being mindful of the specific language they use with patients, making sure to not use the word “fat,” or even “obese” or “morbid.” This approach confirms research from a 2009 study by Tailor and Ogden that found that some doctors choose to use euphemisms for the word “obesity” in an effort to not upset patients.

In this way, it is clear that the majority of providers in this study were very aware of the stigma overweight and obese patients face and make efforts to not contribute to it, even though only two mentioned that lack of these efforts can cause these patients to stop seeking care. It appears the providers who mentioned being mindful of stigma and being careful not to contribute to it view this as an important strategy for gaining patient trust.

This is not to say that all providers in the study were especially sensitive to stigma. As noted earlier, one nurse practitioner expressed her feelings that overweight or obese patients who talk about feeling stigmatized are likely just extra sensitive about their weight and do not like when doctors bring it up. Seven providers – including most of those who described always treating patients with respect and acknowledging stigma – still made comments that alluded to the patient’s personal responsibility for being overweight. Clearly the type of area these providers practice in has no bearing on this particular perspective; it was shared amongst participants almost unanimously. This reflects the existing literature, at least in part, which holds that health care providers see obesity more as the result of behavioral problems than genetics or environmental factors (Puhl & Heuer, 2009; Rogge, Greenwald & Golden, 2004).
Interestingly, when these providers made these statements, they were not in response to questions that asked whether they felt obese patients were to blame for their weight. These responses came in passing as providers were responding to other topics, whereas when they were asked explicitly about what they felt contributed to obesity, they responded by naming a number of environmental factors that did not place blame on the patients. This suggests that even those providers who are sensitive to obesity stigma may still hold implicit biases toward obese patients. This is hardly surprising, or legitimate cause to blame providers, as they are trained to deal with heavy patient loads and time constraints by relying on group-level information to treat patients (Chapman et al., 2013). It also makes sense that providers would not realize their own biases, as physicians tend to believe in their own objectivity due to their vast knowledge of scientific data (Chapman et al., 2013). These implicit biases toward obesity would also parallel findings from past studies on physicians and patient race, which have shown that even those providers who state they do not hold racial biases sometimes still exhibit them unknowingly (Dovidio and Fiske, 2012). The patients who are on the receiving end of these biases notice them, even if the provider does not, and it leads to distrust of the provider, which can lead to lower levels of compliance with treatment (Stepanikova et al., 2006). This phenomenon is likely already happening in relationships between providers and their obese patients.

Fortunately, this larger trend of provider biases and the suffering of physician-patient communication that follows has not gone unnoticed by the health care industry and medical schools. Since the early 2000s, after realizing that over the course of schooling, medical students often transform from being patient-centered to more rigid and less able to communicate medical issues with a lay person, several schools have incorporated courses into their curricula that focus on clinical communication skills, cultural competency, and humanism in medicine (Lewis,
The University of Missouri-Columbia School of Medicine, for instance, has developed a “Patient-Centered Care Objective Clinical Exam,” in which students are critiqued by patients in terms of communicating effectively, avoiding jargon, listening actively, displaying empathy, and leading critical conversations (Hoffman, Griggs, Donaldson, Rentfro & Lu, 2014). One of the most recent and striking developments around this subject is the addition of questions to the 2015 medical college admission test (MCAT) that focus on the importance of sociocultural and behavioral determinants of health (Ananth, 2013).

Even with all of these changes and the increased attention on patient-centered care, Epstein and Street (2011) argue that there is still a long road ahead for the health care industry to fully understand what the concept means and to assess whether it is being practiced. They explain that where being patient-centered care was once considered the physician quickly asking the patient “any questions?” at the close of an appointment, it should go much further in inviting the patient to participate in the discussion, which “should be tailored to patients’ needs to permit meaningful deliberation and shared mind’ (pp. 101). This call for more personalized patient communication supports the findings from the current study, in which many providers acknowledged the need to be aware of a patient’s particular circumstances in order to effectively discuss weight loss with them. Nonetheless, with many providers in the study reporting that they share the same one or two weight loss messages with all patients, the need remains for more efforts to teach and remind providers how to deliver patient-centered care and personalized medicine, and for better tools for assessing it. Indeed, Epstein and Street (2011) call for a number of new efforts to measure patient-centered care, including tools that incorporate detailed feedback from patients and their families and even direct observation of providers.
Conclusion

In summary, based on this study’s findings, as well as the existing literature on racial biases in the health care industry and population statistics on obesity, patient race/ethnicity may not affect most general practitioners’ approaches to diagnosing and treating obese patients. If this is the case, one explanation may be that providers do not believe the processes of gaining and losing weight are different for people of different races/ethnicities once environmental factors are removed. And while providers in more diverse, urban areas acknowledge that race/ethnicity can affect eating habits and body size preferences, providers in less diverse, less urban locations may feel that culture does not even affect environmental factors that would cause a patient to be heavier or to make weight loss more burdensome. Because of these discrepancies in beliefs around the effects of culture, and the limited suggestions providers have for accommodating cultural eating habits and body images, the cross-cultural training the IOM report suggested (2004) could be helpful for general practitioners in terms of treating overweight and obese patients of different races/ethnicities.

It may be that patient socioeconomic status, and associated factors such as education level, are more influential to a general practitioner’s approach to treating obese patients, both in terms of what they recommend for weight loss and how they explain the issues surrounding obesity. A patient’s unique life circumstances that are not necessarily tied to race/ethnicity or SES may also affect a provider’s weight loss recommendations, if the patient discloses those circumstances to them.

Ultimately, providers may not report that patient race/ethnicity affects their weight loss recommendations because they recognize that even within one race/ethnic group, SES and life circumstances such as stress from work, family and relationships will make each patient’s
situation uniquely different. This realization might lead providers to deliver very personalized recommendations to patients, or on the opposite end of the spectrum, it may be what leads them to craft and deliver one or two general static messages about weight loss to all patients - messages that are likely so broad that patients are left without any specific actionable advice.

When it comes to successful weight loss, medical practitioners likely feel that the patient’s personal motivation is the most important factor, although not all general practitioners may feel that motivating the patient is their responsibility. When patients are personally motivated, providers feel it is often the result of a health condition the patient has that is caused by excess weight. And although two providers in the current study described body image as an appropriate weight loss motivator, it was not named as one of the most effective motivators. Among other reasons, this could be because “thin” is not the ideal body image for patients of certain races/ethnicities and SES, as was found by some providers practicing in more diverse, urban areas. These findings suggest that especially when dealing with more diverse patient bases, providers likely cannot rely on using image as a weight loss motivator.

Finally, at least some general practitioners likely recognize the stigma obese patients face, and therefore make an effort to build patient trust before addressing weight, and to not use words like “fat” and sometimes even “obese” in an effort to not upset them. Another strategy of building trust with the patient and not further stigmatizing them is to allow the patient to have input in their weight loss goals.

Perhaps most importantly however, is that according to this study, even those providers who acknowledge stigma and make compromises with their patients likely still see the patient as being largely responsible for their weight, even if subconsciously. Fortunately for patients, at least some of those providers who feel this way still believe they are responsible for motivating
patients to lose weight. Nonetheless, the literature shows that patients are able to perceive and internalize even implicit biases from physicians.

Limitations

The main limitation of this study was the small, non-randomized sample. With only eight providers from five different cities, and only one being male, the results are not generalizable. Also, the convenience and snowball sampling methods likely led to a biased sample in that some of the providers who chose to participate were more mindful of or even passionate about the topic of obesity than the general population of general practitioners. For example, Isabel described her involvement with several national programs that encourage physical activity and better nutrition for adolescents, and Mandy stated how “glad” she was that obesity was the focus of this research. Kim, in addition to her schooling to become an MD, mentioned having a separate advanced degree that called for knowledge of the literature on obesity as well as delivering patient-centered care. With at least three providers showing a prior interest in obesity research and the care of obese patients, it is likely that they were more sensitive than the general population of providers to obesity stigma and the notion of providing patient-centered care to obese patients.

The second limitation of this research is that it relied on providers’ reports of their attitudes toward obese patients and patients of minority races/ethnicities. It is possible that social desirability bias was a factor, in that providers may have censored their responses since they did not want to appear insensitive or prejudiced against any type of patient. My own status of being a white female may also have led providers to not want to share certain perspectives with me on white patients or female patients.
Another limitation stems from the various locations and time constraints among the interviews. They varied in length from 18 minutes to one hour, so I was able to delve into certain topics more thoroughly with some providers than others. Additionally, the location of the interview – whether it was over the phone, at the provider’s office, or in one case, at the provider’s home – affected the depth of the conversation. The in-person interviews – especially the one held at a nurse practitioner’s home – tended to allow for more time to build rapport since those providers typically had more time to speak and kept the interview going longer. For the other four who set aside time to speak on the phone, the interviews were more structured and were kept closer to 30 minutes or less, so not as much time was spent building up rapport with “ice-breaker” questions, in order to keep to the time frame the provider had blocked off in their workday. Because of this, some providers seemed to maintain a “matter of fact” approach to the interview, not being as candid in responses or sharing as many stories. Another result of the varying time frames and levels of openness in the interviews was that not all providers were asked the exact same set of questions, making it impossible in certain instances to make fully informed comparisons between providers.

Future Directions for Research

With the predominant finding in this study that providers may consider patient SES more than race/ethnicity as one of the main determinants for how they will interact with and advise patients, future research should investigate whether a larger, more representative sample of providers takes SES into account to the same degree.

Future research should also explore how a larger, more representative sample of providers considers patients’ unique personal circumstances not related to SES or race/ethnicity in their treatment processes. This research should also explore which patient personal
circumstances are most salient to providers as those that call for personalized weight loss recommendations. Based on the current study, some of these circumstances might be having more dependents to care for (children, spouses, older parents, etc.), having a stressful job, and being in a turbulent relationship.

Another area for future research is the effect of patient sex on body image perspective and on provider-patient communication on obesity. When providers in this study brought up how patients of certain races/ethnicities have different perspectives on body image, their examples were always related to women. For instance, providers cited responses such as female patients saying their boyfriends liked them being larger, and they described African American women wanting to keep their “booty.” Future research should investigate whether cultural perspectives on body image are confounded by sex. For instance, do white men and African American men view size and weight differently, or is the distinction between cultural views only applicable to women? This research should also investigate whether providers speak to men and women differently about weight, since the providers in this study seemed to mostly refer to their discussions with female patients.

Additionally, the way in which providers view their own master status as affecting patient perceptions – rather than just how patients view providers – is an area that calls for further research. This concept appeared when Jane, was asked if she noticed that any difference in levels of patient trust based on patient race/ethnicity. While she had never had a patient come out and disagree with her assessments of their weight, she admitted to fearing that her own master status as a white female (as well as her being of normal weight) might lead patients of other races to doubt her:

“If I do [feel that patients don’t trust me], it’s subconscious – like that I feel that an African American woman is not going to trust me, this like young Caucasian female,
who's not obese. Um, so you know, but so I try and remain – I try and give them some positive feedback before I tell them negative feedback. I’ll, I’ve never verbally been told, ‘that’s BS’ or whatever. I’m sure that behind closed doors they might think that, um, but it’s never been like out in the open, in terms of like, ‘I don’t trust you or believe what you’re saying.’ No.”

As mentioned earlier, in the case of speaking with overweight or obese patients, physicians face a dilemma in trying to gain patient trust while also convincing and motivating them to lose weight. As Jane’s comment shows, this could be the case for general provider-patient communication based on a provider’s sex, age, race/ethnicity, and more. Future research should examine whether other providers are as conscious of their own master statuses, and if that affects the way they interact with patients.

Future research should investigate general practitioners’ perspectives on prescribing weight loss medications. Although outside the scope of this study, several providers commented on the use of weight loss medications and whether they felt they were helpful. Some mentioned prescribing them as routine, while others expressed feeling they were not helpful or appropriate for most people. For instance, Dan mentioned matter-of-factly including some medications as part of his recommended weight loss regimen:

“So uh, all of them get the diet and then the exercise, depending on how much weight and can you, can your heart tolerate the exercise. And then uh, the medicine, which may be if you retain a lot of fluid, then it’s a fluid pill once, twice a week. And then a depressant, a good, I mean appetite depressant medication. So you don’t feel like eating, and that’s the idea.”

Jane appeared less confident in prescribing medications, but did acknowledge she was doing more of it than she had in the past:

“And then some of [the patients], depending on how much they’ve tried before, I’m starting to delve a little bit into the prescribing of medications, because I feel like before I was like ‘I’m never going to do that, they’re really dangerous,’ but now I think I’m realizing that, um, I can get more comfortable with them because, you know, it really should be tried before you’re referring to bariatric surgery, which I also do. Um, and that, you know, the risks of remaining obese are probably going to outweigh the risks of the medication. So I’m trying to get better, more comfortable, at proposing medication when it’s safe.”
Isabel however, stated that she does not like any of the weight loss medications that are currently available and that they are not to be viewed as a one-stop-shop solution:

“I often have patients that come in wanting me to give them a magic pill to lose weight. And I’m not a fan of that because I don’t think what’s available right now is useful. I’m not familiar with the newer ones that have been approved, uh, but what we have had in the past is not something that I have found helpful, because it’s not a long-term solution. And even the surgical approaches are not necessarily long term either. You know, there are patients that are going to be helped by that type of approach, but it always has to be looked at as a tool. It’s not what’s going to lose the weight for you, you have to lose the weight. So it’s going to require effort.”

With such contrasting opinions on medications, and a clear desire for them from patients, it would be useful to collect and analyze more providers’ perspectives.

Finally, this study’s findings demonstrate the importance of tailoring communication and advice to a patient’s unique circumstances, as well as the need to learn how to do it more effectively. Therefore, research should continue to examine the different ways in which providers can be taught to deliver patient-centered care and personalized medicine. Ongoing research should be conducted to assess whether any change is present in the health care workforce after the inclusion of social and behavioral questions to the MCAT and the increasing amount of coursework on patient-centered care being incorporated to medical school curricula.
Appendix A

Initial Contact Call Script

To Person Answering the Phone:

“Hello. My name is Allison Hyde and I’m calling from the University of Maryland, Baltimore County. I’m calling because I’m doing some research as part of my master’s thesis and I’d like to see if [INSERT PHYSICIAN’S NAME, OR IF MULTIPLE, SAY ‘PHYSICIANS IN YOUR OFFICE’] would be interested in participating. Would it be possible for me to speak with him/her now?”

If physician is not available or if person answering the phone asks to take a message, say:

“I’d be very happy to leave a message, but I also have an information sheet on my study that I can send for Dr.[_____] to review. What would be the best way for me to deliver this so that Dr. [___] can review it? [TAKE INFORMATION, EMAIL, FAX NUMBER, ETC.] And is there a good time for me to call and reach Dr. [_____] to follow-up with him/her after sending the information on my study, either by phone or e-mail?” [TAKE INFORMATION, THANK THEM FOR THEIR TIME AND END THE CALL].

If passed on to Physician:

“Hello Dr. _____________. My name is Allison Hyde. I’m calling from the University of Maryland, Baltimore County about a research study I am conducting for my Master’s thesis. I’m interviewing physicians on their experiences treating obese adult patients. I am not asking to hold an interview now, but I would like to discuss whether you would

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4 If I visit the office in person, I will follow this same script, except in places of saying “I’m calling,” I will say “I am here today,” and will bring recruitment letter and information sheet with me to leave for physicians.
be willing to participate at a time in the future that is convenient for you. Do you have a few minutes to talk now?

IF NO: Thank you for your time. Is there a more suitable time for me to call you to discuss the project and your participation?

If no: “I would really like to get your perspective in this study. I can provide you with additional information on the project, both right now and by sending you an information sheet” – [allow them to answer – yes: give them details re: the study, including that I’m looking for physicians with diverse patient bases, and stress the significance of their input; ask them if they would now like to participate – schedule mutually convenient time, and thank them for their willingness to participate. No: thank them for their time and end the call – note reason for refusal if possible.]

If yes: Set up a mutually convenient time. Thank them for their willingness to participate and end call.

IF YES: Great, thank you. I am conducting a research study to better understand the processes physicians use when providing care to obese adult patients, and their perspectives on providing such care. I am interested in learning more about how you determine a patient is obese, the topics you cover when discussing a patient’s weight with them, and the advice you give for reaching a healthier weight. My study will include interviews with five to ten physicians in the Baltimore–Washington area who provide primary care to a culturally diverse patient base that includes obese adults. I have
identified you as a potential interviewee based on your professional profile on [INSERT WHERE PROFILE WAS FOUND: AMA WEBSITE, ETC.]

I would like to interview you by telephone or in-person. The interview will be relatively short and should only take about 30 minutes. I should stress that I am not interviewing any patients, nor will I ask you to provide any specific patient health information.

Instead, the focus of this study is to learn about the physician’s perspective in treating obese patients. The study has been approved by UMBC’s Institutional Review Board and I can send you an information sheet that will lay out all of the details for you.

**Would you be willing to participate in this project?**

*IF YES:* Great! What does your schedule look like over the next week? Is there any chance you could squeeze me in for 30 minutes? We could even split up the interview if it’s more convenient for you, and speak twice for about 15 minutes each time. [Schedule interview. Then tell them about the informed consent information sheet that you will send to them, find out how they would like to receive it (fax, email, etc.).] I’ll also go over the sheet before the interview so that I can get consent before we begin. I know you have agreed to participate, but I would just like to stress that I won’t be asking any questions about specific patients or their health information, so HIPPA laws are not a concern for this study.

*IF NO or UNSURE OF PARTICIPATION:* Would it be alright if I sent you the information sheet so that you can review the details of the study before deciding?

*[Probe and address any concerns he/she has and barriers to participation.*]

*Examples: HIPPA, little availability for interview. Emphasize the importance of*
the project, how brief it is, the need for this research, my willingness to work with
them, and their ability to end their participation at any time during the interview.
If still a refusal, thank him/her for his/her time.]
Appendix B

Provider Recruitment Letter

Physician Name
Practice
Street
City State Zip

September 10, 2014

Dear Dr. <Physician Last Name>:

I write to ask you to participate in a 30-minute telephone or in-person interview, to share your experiences providing medical care to obese adult patients from different cultural backgrounds. You have been identified as a physician practicing [INSERT LISTED SPECIALTY] in the Baltimore –Washington area, and I am interested in hearing your perspective. I will ask you about your processes for communicating health risks and advice to obese patients, but I will not ask about specific patients. The interview will be scheduled at your convenience, and conducted by myself, a master’s student completing my thesis in the field of sociology.

The project has been endorsed by the University of Maryland, Baltimore County’s Institutional Review Board.

I will call you within the next week to follow up on this invitation. If you do not wish to be called, please contact me (410-610-3538 or mahyde1@umbc.edu).

Thank you for considering this invitation.

Sincerely,

M. Allison Hyde
Master’s Student
Department of Sociology
University of Maryland, Baltimore County
Appendix C

Information Sheet for Participation in a Research Project

Whom to Contact about this study:
Principal Investigator: Allison Hyde
Department: Sociology
Telephone number: 410-610-3538
Email: mahyde1@umbc.edu

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Physician Care of Obese Patients

I. INTRODUCTION/PURPOSE:
   I am being asked to participate in a research study. The purpose of this study is to examine physicians' perspectives and processes for communicating with and treating obese adult patients. I am being asked to volunteer because I have been identified as an expert in this area as a physician with a culturally diverse patient base that includes obese adults. My involvement in this study will begin when I agree to participate and will continue until I have been interviewed by the Principal Investigator. About 30 persons will be invited to participate.

II. PROCEDURES:
   As a participant in this study, I will take part in an interview in which I will be asked about my processes for treating obese adult patients. Based on my preference, the interview will be conducted over the phone or in-person at a time and location of my choosing. My participation in this study will last for approximately 30 minutes. The interview will be recorded, and later transcribed. All personally identifying information will be removed from the transcriptions.

III. RISKS AND BENEFITS:
   My participation in this study does not involve any significant risks and I have been informed that my participation in this research will not benefit me personally.

IV. CONFIDENTIALITY:
   Any information learned and collected from this study in which I might be identified will remain confidential and will be disclosed ONLY if I give permission. All information collected in this study will be stored in a locked file cabinet in a locked room. Only the investigator and members of the research team will have access to these records. If information learned from this study is published, I will not be identified by name. By signing this form, however, I allow the research study investigator to make my records available
Consenting to participate in this research also indicates my agreement that all information collected from me individually may be used by current and future researchers in such a fashion that my personal identity will be protected. Such use will include sharing anonymous information with other researchers for checking the accuracy of study findings and for future approved research that has the potential for improving human knowledge.

Check if recording instruments are used during the research study:

☐ I give permission to record my voice or image

☐ I do not give permission to record use my voice or image

V. COMPENSATION/COSTS:
My participation in this study will involve no cost to me. I will receive course credit for my Master’s thesis.

VI. CONTACTS AND QUESTIONS:
The principal investigator, Allison Hyde, has offered to and has answered any and all questions regarding my participation in this research study. If I have any further questions, I can contact Dr. Brandy Harris-Wallace at (410) 455-5815 or bhwalla@umbc.edu.

If I have any questions about my rights as a participant in this research study, contact the Office for Research Protections and Compliance at (410) 455-2737 or compliance@umbc.edu.

VII. VOLUNTARY PARTICIPATION
I have been informed that my participation in this research study is voluntary and that I am free to withdraw or discontinue participation at any time. I have been informed that data collected for this study will be retained by the investigator and analyzed even if I choose to withdraw from the research. If I do choose to withdraw, the investigator and I have discussed my withdrawal and the investigator may use my information up to the time I decide to withdraw.

I will be given a copy of this consent form to keep.
Appendix D

**Provider Follow-up Call Script**

To Person Answering the Phone:

“Hello. My name is Allison Hyde. I’m calling from the University of Maryland, Baltimore County. May I please speak with Dr. ____________?”

If physician is not available or if person answering the phone asks what this is in reference to, say:

“I am following up with him/her regarding information I sent him/her on a study I am conducting for my Master’s thesis. Is there a good time for me to call and reach Dr. ____________?”

To Physician:

“Hello Dr. _____________. My name is Allison Hyde. I’m calling from the University of Maryland, Baltimore County about the research study I am conducting for my Master’s thesis on physicians’ perspectives on and processes for treating obese adult patients. I am calling to follow-up on an information package that I sent to you a week ago about my project. Do you have a few minutes to talk now?

**IF NO:** Thank you for your time. Is there a more suitable time for me to call you to discuss the project and your participation?

**If no:** “I would really like to get your perspective in this study. I can provide you with additional information on the project” – [allow them to answer – yes: give them details re: the study and the significance of their input; ask them if they would now like to participate – schedule mutually convenient time, etc.]
and thank them for their willingness to participate. No: thank them for their time and end the call – note reason for refusal if possible.

If yes: Set up a mutually convenient time. Thank them for their willingness to participate and end call.

**IF YES:** Great, thank you. I am conducting a research study to better understand the processes physicians use when providing care to obese adult patients, and their perspectives on providing such care. I am interested in learning more about how you determine a patient is obese, the topics you cover when discussing a patient’s weight with them, and the advice you give for reaching a healthier weight. My study will include interviews with five to ten physicians in the Baltimore–Washington area who provide primary care to a culturally diverse patient base that includes obese adults. I have identified you as a potential interviewee based on your professional profile on [INSERT WHERE PROFILE WAS FOUND: AMA WEBSITE, ETC.]

I would like to interview you by telephone or in-person. The interview will be relatively short and should only take about 30 minutes. I should stress that I am not interviewing any patients, nor will I ask you to provide any specific patient health information. Instead, the focus of this study is to learn about the physician’s perspective in treating obese patients.

**Would you be willing to participate in this project?**

**IF YES:** Great! What does your schedule look like over the next week? Is there any chance you could squeeze me in for 30 minutes? We could even split up the interview if it’s more convenient for you, and speak twice for about 15 minutes...
each time. [Schedule interview. Then remind them of the informed consent information sheet that was faxed to them a week ago.] Did you have a chance to review the consent sheet I sent a week ago? Should I send you another copy of the so that you can review it before the interview? Or, if it’s more convenient, I can go over the sheet before the interview so that I can get consent before we begin. I know you have agreed to participate, but I would just like to stress that I won’t be asking any questions about specific patients or their health information, so HIPPA laws are not a concern for this study.

**IF NO or UNSURE OF PARTICIPATION: Probe and address any concerns he/she has and barriers to participation. Examples: HIPPA, little availability for interview. Emphasize the importance of the project, how brief it is, the need for this research, my willingness to work with them, and their ability to end their participation at any time during the interview. If still a refusal, thank him/her for his/her time.**
Appendix E

Provider Demographics Survey

I would like to get some basic information about you so I can describe the people who are participating in this project.

1. In what year were you born? 19 __ __

2. Are you male or female?
   □ 1 Male
   □ 2 Female

3. What is your race/ethnicity?
   □ 1 American Indian / Alaska Native
   □ 2 Asian
   □ 3 Black / African American
   □ 4 Native Hawaiian or Other Pacific Islander
   □ 5 White
   □ 6 Other (specify) _________________________

4. What languages do you speak other than English? _____________________________
   ________________________________________________________________________

4. In what year were you first licensed to practice medicine? ___ ___ ___ ___

5. What is your medical specialty?
   □ 1 Internal Medicine
   □ 2 Family Medicine
   □ 3 Other (specify)
Appendix F

Interview Guide

Initial questions for building rapport:

a. What made you decide to go into [INSERT SPECIALTY, i.e., PRIMARY CARE, INTERAL MEDICINE, etc.]?

b. What made you decide to practice in [INSERT GEOGRAPHICAL AREA]? 

c. How long have you been practicing?

d. What is your greatest health concern for people today? (i.e., What is the most destructive, unhealthy habit you see from your patients/people in general? What illnesses or conditions do you feel pose the greatest threat to society?)
   • Follow-up (if obesity not mentioned): Where does obesity fall for you on the list of health conditions threatening the population?

Questions to achieve research aims:

a. How do you determine if a patient is obese (what is your process)? [RA1]
   • Follow up: Why do you use this process?
   • Follow up: Are there any patients for whom another process of determining obesity might be better? If so, can you describe them?

b. How do you decide whom you will talk to about their weight? [RA2a]

c. How do you go about telling a patient he or she is obese? [RA2a]
   • Follow up: How do certain patient characteristics affect your approach to telling a patient that s/he is obese (if at all)?

b. When you talk to patients about weight what are some areas you cover? [RA2b]

e. What are some pieces of advice/strategies you give a patient who you’ve determined is clinically obese? [RA2b]
   • Follow up: Is the advice you give the same for all obese patients?
   • Follow up (if no): What factors would lead you to deviate from what you would normally suggest?

f. Would you say your patients tend to adhere to the weight loss regimens you suggest? [RA3]
   • Follow up (if indicates some do not): Can you describe the patients who generally do not adhere to your recommendations?
   • Follow up (if no mention of patient race/ethnicity or culture): Some of what I’ve read in the literature suggests that patients of certain ethnicities or cultures are less
trusting of doctors, or show lower levels of compliance. Can you comment on the extent to which you’ve found that to be true?

g. Have you found that certain approaches to discussing weight are more effective depending on the patient’s cultural background? [RA3]
   • Please give me some examples.

h. Are there certain patient characteristics you feel are most often associated with successful weight loss? With failure to lose weight? [RA3]
   • Follow up: Please give me some examples.
   Follow up: Please tell me what, if any, strategies you use to encourage those patients who are not successful.
References


Lewis, B. (2014). Medical Schools Putting Focus on the Patient Experience. Retrieved from


