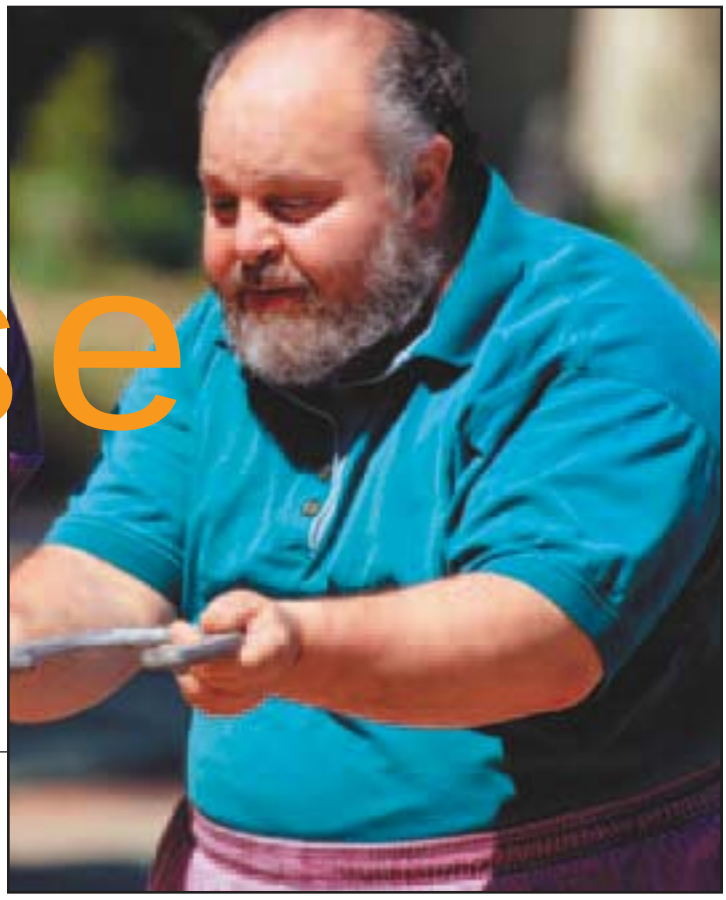
Myths About the Obese Patient



By Maurice Larocque, MD

A comment I hear regularly from doctors I meet at continuing medical education sessions on obesity is "I hate treating fat people." Since I've constantly enjoyed treating overweight people for the past 30 years, I have wondered what factors motivate such an attitude. Here are a few misconceptions that some doctors have about obese patients. My own comments follow each quote.

"Obese people just aren't motivated and they don't listen. I tell them to lose weight, but they come back a month later and haven't lost a pound. They're always full of excuses and they have no willpower."

False. A patient who consults a physician is seeking help. Treating obesity is, above all, treating the person behind the problem — just like treating someone who has an alcohol or drug dependency.

When physicians wish to bring about a change in a patient's behaviour, they must realize that they are merely a tool in the patient's hands. It is the patient who is solely responsible for his/her success or failure. The physician must endeavor to be the best tool possible, yet must not feel guilty should the patient fail. Doctors are often confronted with failure in trying to help obese patients and, therefore, often ridden with guilt.

Motivation is a complex emotion that is different from willingness or desire. All patients who see a doctor because of excess weight want to slim down, yet they do not necessarily have the motivation to do so. It is up to the physician to help the patient determine where the motivation problem lies.

"Obesity is not an illness. Most of my women patients want to lose weight for esthetic and fashion reasons. It's much more a matter of vanity than an illness."

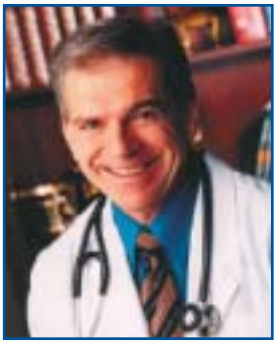
False. Obesity is the result of an imbalance between energy intake and expenditure. Is it an illness? Are alcoholism and drug dependency illnesses?

For more than a decade, experts have considered obesity as an illness and a major risk factor for numerous diseases, such as Type II diabetes, hypertension, dyslipidemia, coronary disease, stroke, cystolithiasis, osteoarthrosis, sleep apnea and cancer of the endometrium, breast, prostate and colon. Along with smoking, obesity is the most widespread medical problem in our society.[1]

The World Health Organization now refers to obesity as a worldwide epidemic. More than 50% of the North American population suffers from excess weight and obesity. Obesity in children has increased radically, affecting almost one in three children, and experts are predicting an imminent epidemic of Type II diabetes.[2]

The body mass index (BMI) is used to simplify the measurement of excess body weight and the related health risks (BMI = weight [kg]/height [m2]) (see Table 1). Waist measurements are also a good indicator of an individual's visceral fat and can serve as an independent predictor of health risks.

"Dieting doesn't work. All my patients who have lost weight have quickly regained the weight."



Dr. Larocque is a general practitioner at Cliniques médicales MLA in Montreal and Verdun, Quebec, and is the President of the Association des médecins traitant l'obésité (AMTO). He is particularly interested in the treatment of overweight patients.

False. All diets that involve a reduction in normal calorie intake result in weight loss.

Choosing the right low-calorie diet (LCD) is important, however, in order to avoid nutritional deficiencies that could be harmful to the patient's health. The most important nutrients are proteins — the increase of which should be inversely proportional to the recommended calorie intake so as to maintain muscle mass and prevent a slowing down of basal metabolism. The standard protein requirement of 0.8

Table 1

Classification of Obesity According to Body Mass Index, Waist Measurements and Health Risks

Weight	BMI	Category	Health Risk	
			Male < 100 cm waist	Female < 90 cm waist
< Normal	< 18.5	–	–	–
Normal	18.5 to 24.9	–	–	–
Overweight	25 to 29.9	–	Increased	High
Obese	30 to 34.9	I	High	Very high
	35 to 39.9	II	Very high	Very high
Extremely obese	> 40	III	Extremely high	Extremely high

BMI = body mass index
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g/kg ideal body weight (IBW) at maintenance weight increases to 1.0 g/kg IBW when the individual follows a LCD (1,200 calories), and to 1.5 g /kg IBW in a very low-calorie diet (VLCD) (less than 800 calories).

The recommended daily intake is at least 1,200 calories for adult females and 1500 calories for adult males. Weight loss must not exceed 1% of total body weight per week. Diets of under 800 calories per day are intended (1) for individuals with a BMI of more than 30; (2) for those who have a BMI of 27 and present with comorbidity factors; and (3) for people who have experienced repeated failure with conventional LCDs or who have an urgent medical or psychological need to lose weight. Diets of less than 800 calories per day foster quicker weight loss while preserving body mass. It is important to ensure that the diet contains sufficient proteins and other nutrients that are essential to the patient's health. Moreover, patients require the supervision of a physician who is equipped to deal with the psychological factors that are inherent in such diets.

The results of a comparative study presented at the 8th International Congress on Obesity, held in Paris in 1998, demonstrated that both types of diets (i.e., LCDs and VLCDs) result in the same rate of weight maintenance (82%) once four years have elapsed, if patient follow-up occurred after the weight loss. Without follow-up, however, the weight-maintenance rate after four years is less than 10% with both types of diets.[3]

Dieting's bad reputation stems from the low rate of weight maintenance after four years. Weight gain subsequent to a diet that preserves muscle mass is not

caused by a metabolic imbalance, but rather by a resumption of excessive calorie intake.[4,5] It is, therefore, important that long-term monthly follow-up be provided in order to maintain the patient's motivation and newly acquired behaviour patterns.[3, 6]

The choice of diet should, as much as possible, suit the patient, as he/she will adhere to it more easily. Other factors that should be taken into account are the patient's personality, the state of his/her health, the amount of weight to be lost and how medically urgent the weight loss is.

It is also important to note that successful weight maintenance increases proportionately to the number of past failures, as self-knowledge is gained with each attempt at weight loss.

"It's genetic. You can't do anything about it."

False. In the past decade, much research has been done on the topic. To date, more than 300 genes have been identified that may be linked to obesity. Experts estimate that heredity plays a 25% role in obesity, which means that the individual's environment is three times more significant.[7]

Thus, a person from an obese family could nevertheless gain mastery over his/her weight by taking in fewer calories or by increasing his/her expenditure of energy. If a correlation is drawn between weight and basal metabolism, it can be asserted that a half-hour of walking per day could counter any genetic tendencies.

"Yo-yo dieting is dangerous. If you keep trying different diets, you won't be able to lose weight anymore and, in fact, you'll get fatter and fatter."

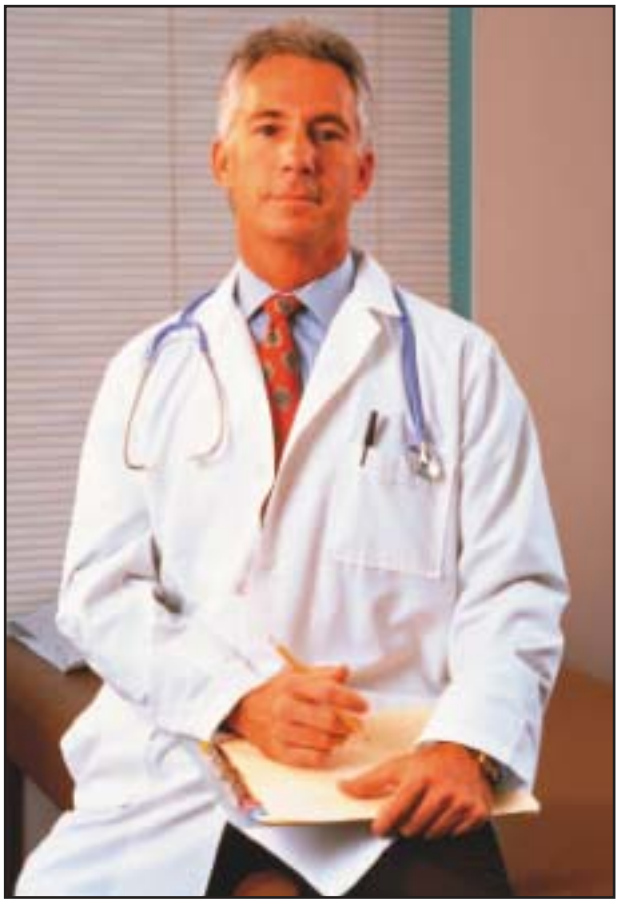
False. This is a widespread myth. Studies have clearly demonstrated that basal metabolism slows down by 5% to 20% during the weight-loss period and goes back to normal four to six weeks after a weight-maintenance diet is begun.[4] This temporary slowdown, which equates to approximately 300 calories per day, can be compensated for by a daily 30- to 40-minute walk.

An important literature review on the "yo-yo" phenomenon concluded that remaining obese is more dangerous than making repeated attempts to lose weight.[8] Alarmist studies on weight cycles have not taken into account voluntary weight loss. Such studies have primarily measured involuntary weight variation caused by different diseases.[8]

It is interesting to note that an alcoholic's success rate in an initial attempt at detoxification is virtually nil. Success is proportionate to the number of attempts. The same applies to patients who suffer from obesity. A survey of 100 patients who

had reached their ideal weight and subsequently gained weight showed that only 12% gained back more weight than they had lost.

To help identify the habits, behaviours and attitudes that contribute to weight problems, we use a computerized questionnaire made available to patients in the waiting room.[9] The questionnaire has enabled us to determine that, for many patients who consult a physician, an attempt at weight loss is, in fact, only a temporary step in a gradual process of weight gain.

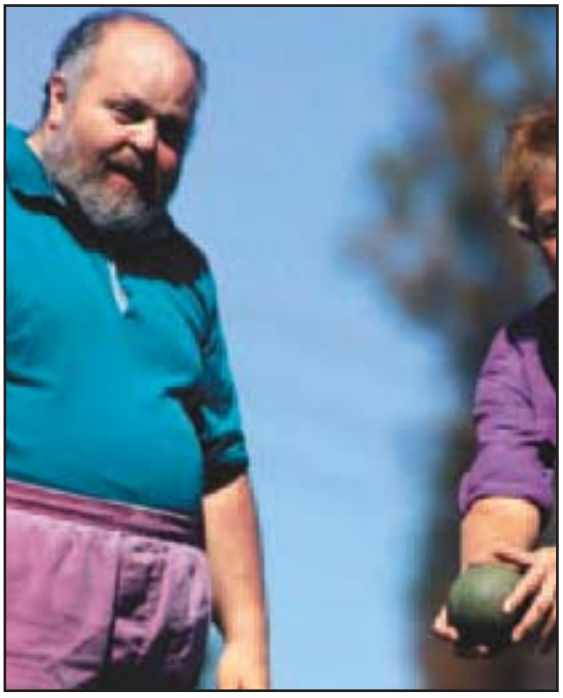


"I don't feel like playing psychologist. They're not motivated. They're passive and have no willpower. I don't have any time for that."

False. There is much suffering — both physical and psychological — behind the problem of obesity. That is why an obese person is ready to try anything and even fall for gimmicks in order to lose weight.

Physicians are the health-care professionals in the best position to help patients and ease their suffering. Our experience has shown that physicians underestimate their capacity for helping patients through their psychological distress. Yet shrugging off the psychological dimension of a human being is sidestepping the Hippocratic oath.

A patient who goes to see a doctor is a person seeking help. Empathic listening should be a primary skill for a physician. A recent study reported that doctors interrupt their patients after only 23 seconds.[10] All respondents nevertheless deemed themselves highly attentive to their patients. There is also an immense difference between sympathy and empathy. Sympathy is to be avoided.



Physicians are not there to comfort their patients in times of trial or suffering. Empathy, however, is rooted in an understanding of the behaviour that needs changing and in a realistic and optimistic attitude that can motivate the patient to change.

Another requisite quality of a physician is being non-judgmental, regardless of the patient's behaviour. Your body language often says more than your words. Your overweight patients are, for the most part, perfectionists who will be guilt-ridden about the slightest slip in their diet or seeing no change on the scales.

A physician must also be able to suggest therapeutic measures without imposing them. Because of the way we have been trained, doctors are used to imposing treatment. However, if we wish to foster changes in behaviour, it is the patient who must take responsibility and, in collaboration with the physician, choose the therapy that is best suited to these individual needs.

Lastly, we must help our patients by giving them hope, being optimistic and providing them with useful tools. Past failures, as well as slips and hurdles along the way, are learning experiences. Success depends on perseverance, not perfection. We must show our patients how to benefit from their mistakes in order to progress.

"I'm waiting for effective drugs to come along. ... There's nothing to be done, short of surgery."

False. There are currently two categories of drugs: One is anorectics and the second is agents that reduce calorie absorption. Medication is indicated in the following cases:

- Failure of conventional weight-loss diets in conjunction with behavioural therapy;
- A BMI of 27 or more with at least one concomitant illness; or
- A BMI of 30 or more.

Some of the anorectics that have been on the market for a number of years are distant cousins of amphetamines (noradrenergic receptors) and act as stimulants. Usage should be limited to short periods of time (approximately six weeks).

Sibutramine is a new anorectic that affects serotonin and noradrenaline neuroreceptors. With this molecule, weight loss is modest — approximately 6 kg per year — occurring primarily in the first six months of treatment.[11] No resulting cases of valvulopathy or primary pulmonary hypertension have been identified to date. The most frequent side effects are dry mouth and constipation.[12]

A new category of drugs has just been introduced: pancreatic lipase inhibitors. They reduce fat absorption from food intake by 30%. Weight loss is comparable to that induced by sibutramine. The most common side effects are steatorrhea, abdominal cramps and, occasionally, fecal incontinence.[13]

The treatment of persons who face a problem of obesity should not focus primarily on medication, but rather on behavioural changes and the motivation needed to bring about such changes. Drugs can be used as a tool to initiate the weight-loss process, but should only be used for short periods, during which patients should be given additional psychological or emotional support to face a challenging situation. We are of the opinion that prescribing medication without behavioural support is unjustified in the treatment of obesity.

Bariatric surgery, which results in weight loss, is still at the experimental stage and must only be used as a last resort in patients presenting with morbid obesity (50 kg or more of excess weight) who have repeatedly failed to respond to conventional weight-loss methods (LCDs and VLCDs) in conjunction with behaviour modification.

Following surgery, stringent follow-up measures are essential, as well as nutritional support, to prevent nutritional deficiencies, and psychological support to deal with the depression and emotional distress that may come about as a result of a loss of a defence mechanism.

Conclusion

Obesity is increasingly being considered as a behavioural problem, on the same level as alcohol or drug dependency. Given their concern for people and their close contact with their patients, physicians are the health-care professionals best suited to treat this disorder, which has all the markings of an epidemic. Each case constitutes a challenge and each success is a source of great satisfaction for the attending physician. Dx

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