



Roadmaps for Clinical Practice

Case Studies in Disease Prevention and Health Promotion

Assessment and Management of Adult Obesity:

A Primer for Physicians

Setting Up the Office Environment

9

The American Medical Association (AMA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education (CME) for physicians. The AMA takes responsibility for the content, quality, and scientific integrity of this CME activity.

The AMA designates this educational activity for a maximum of 4.5 Category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those hours that are actually spent on the educational activity.

For additional copies, please contact:

Order Department
American Medical Association
PO Box 930876
Atlanta, GA 31193-0876
800 262-3211 (AMA members)
800 621-8335 (nonmembers)

You can fax your request to the AMA at 312 464-5600.

Please refer to product code NC 426203

For more information, please visit the Medicine and Public Health Web site at: www.ama-assn.org/go/medicineandpublichealth

This project was funded by the AMA and The Robert Wood Johnson Foundation.

November 2003



Citation

Kushner RF. *Roadmaps for Clinical Practice: Case Studies in Disease Prevention and Health Promotion—Assessment and Management of Adult Obesity: A Primer for Physicians*. Chicago, Ill: American Medical Association; 2003.

© 2003, The Robert Wood Johnson Foundation

This manual may be reproduced and distributed for charitable and educational purposes within the meaning of Section 170(c) of the Internal Revenue Code and may not be sold or distributed commercially.

Assessment and Management of Adult Obesity: A Primer for Physicians is not intended to function as a clinical guideline, standard of medical care, or definitive resource for the assessment and management of obesity. The instruments included in this publication are clinical tools, not research tools. Consequently, they have not been evaluated to establish reliability and validity. The American Medical Association neither endorses nor encourages use of the programs and resources listed in this document. They are meant to be a starting point and are not intended to be an exhaustive list of educational resources for physicians or patients seeking medical information.

Medical care is determined on the basis of all the facts and circumstances involved in an individual case and is subject to change as scientific knowledge and technology advance and patterns of practice evolve. This publication reflects the view of the experts and reports in the scientific literature as of 2003.

Acknowledgments

Primary Author

Robert F. Kushner, MD, Professor, Department of Medicine, Northwestern University Feinberg School of Medicine; Medical Director, Wellness Institute, Northwestern Memorial Hospital, Chicago, Illinois

Contributing Writers

Dawn Jackson, RD, LD, Registered Dietitian, Wellness Institute, Northwestern Memorial Hospital, Chicago, Illinois (Booklet 4: *Dietary Management*)

Jim Lyznicki, MS, MPH, Senior Scientist, Unit on Science Policy, American Medical Association, Chicago, Illinois (Booklet 1: *Introduction and Clinical Considerations*)

Brad Saks, PsyD, Clinical Psychologist, Wellness Institute, Northwestern Memorial Hospital, Chicago, Illinois (Booklet 3: *Assessing Readiness and Making Treatment Decisions*; Booklet 8: *Communication and Counseling Strategies*)

William J. Wilkinson, MD, Cooper Institute, Dallas, Texas (Booklet 5: *Physical Activity Management*)

Medical Editor

Claire Wang, MD, Scientist, Unit on Medicine and Public Health, American Medical Association, Chicago, Illinois

American Medical Association Project Staff

Arthur Elster, MD, Director, Medicine and Public Health
Missy Fleming, PhD, Project Director
Valerie Foster, Marketing Communications
Stephen Perez, Design
Sharmila Rao Thakkar, MPH, MPA, Project Manager
Meme Wang, MPH, Project Consultant

Reviewers

Caroline M. Apovian, MD
Boston University School of Medicine;
Center for Nutrition and Weight Management, Boston Medical Center

Daniel H. Bessesen, MD
University of Colorado Health Sciences Center;
Denver Health Medical Center

George A. Bray, MD, MACP
Division of Obesity and Metabolic Diseases, Pennington Center

William H. Dietz, MD, PhD
Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention

Karen A. Donato, SM, RD
Obesity Education Initiative, National Heart, Lung, and Blood Institute

J. Michael Gonzalez-Campoy, MD, PhD
Minnesota Center for Obesity, Metabolism and Endocrinology

Donald D. Hensrud, MD, MPH
Preventive Medicine and Nutrition, Mayo Medical School;
Executive Health Program, Mayo Clinic

James O. Hill, PhD
Center for Human Nutrition, University of Colorado Health Sciences Center

Van S. Hubbard, MD, PhD
Division of Nutrition Research Coordination, National Institutes of Health, Department of Health and Human Services

Wendy L. Johnson-Taylor, PhD, MPH, RD
Division of Nutrition Research Coordination, National Institutes of Health, Department of Health and Human Services

Faculty disclosures

Robert F. Kushner, MD, discloses that he is a consultant to Abbott Pharmaceuticals, maker of Meredia®, a medication discussed in this publication.

William J. Wilkinson, MD, discloses that the Cooper Institute receives revenue from the sale of *Active Living Every Day*, which is discussed and referenced in this publication.

Reviewers continued

Evelyn L. Lewis, MD, MA, FAAFP
Department of Family Medicine,
Uniformed Services University

F. Xavier Pi-Sunyer, MD, MPH
New York Obesity Research Center,
St. Luke's Roosevelt Hospital Center;
Columbia University

Thomas A. Wadden, PhD
Department of Psychiatry, University of
Pennsylvania School of Medicine

Holly Wyatt, MD
Department of Medicine, Division of
Endocrinology, University of Colorado Health
Sciences Center

*American Association of Clinical
Endocrinologists*

Om P. Ganda, MD, FACE
Yehuda Handelsman, MD, FACP, FACE
John S. Kukora, MD, FACS, FACE
Bill Law, Jr., MD, FACP, FACE
John A. Seibel, MD, MACE

*American Association of Public
Health Physicians*

Nancy Hiner
John Poundstone, MD, MPH
Jennifer Wyatt

American College of Physicians

Patrick C. Alguire, MD, FACP
Vincenza Snow, MD, FACP

American College of Preventive Medicine

Cynthia Ball, DO
Carolyn V. Brown, MD, MPH
Gary Bucher, MD, FAAFP, FACN
Ellen Remenchik, MD, MPH

American Gastroenterological Association

Samuel Klein, MD
Jeannette Newton Keith, MD

American Geriatrics Society

Suzanne Fields, MD

American Osteopathic Association

Martin S. Levine, DO
Karen J. Nichols, DO
William M. Silverman, DO

American Society for Bariatric Surgery

George S. M. Cowan, Jr., MD

American Society of Bariatric Physicians

George Bartels, MD, FAAFP
Michael Brennan, MD
Denise E. Bruner, MD, FASBP
David Bryman, DO
Ed J. Hendricks, MD
Charles R. Mabray, MD
Eneida O. Roldan, MD, MPH
Harold C. Seim, MD, MPH, FASBP
G. Michael Steelman, MD, FASBP

*Council on Scientific Affairs, American
Medical Association*

John F. Schneider, MD, PhD

Preface

In the United States, increasing trends in morbidity and mortality related to chronic diseases and injuries have led the American Medical Association (AMA) and others to address strategies for promoting health and preventing disease and disability. Over the past decade, the AMA has launched national campaigns against violence, alcohol abuse, and tobacco use. Recently, the AMA launched national programs to address low health literacy, patient safety, and disparities in health services and outcomes.

To further address the health challenges facing our nation, the AMA is developing a series of case-based publications for physicians as part of a new program titled *Roadmaps for Clinical Practice: Case Studies in Disease Prevention and Health Promotion*. The Roadmaps project fulfills an AMA and US Department of Health and Human Services (DHHS) partnership established through a Memorandum of Understanding (MOU) signed by both organizations in the year 2000. The series concentrates on the *Healthy People 2010* objectives, which were developed by the US Public Health Service to help professionals address the leading causes of morbidity and mortality in this country. The series also supports the goals of the DHHS *HealthierUS* initiative which was established in 2003 to help Americans lead longer, better, and healthier lives. This primer, produced with support from The Robert Wood Johnson Foundation, is part of the Roadmaps series.

The Roadmaps series aims to help physicians prevent or reduce injury and chronic disease through early detection and disease management in addition to promoting healthier lifestyles through their medical practices and communities. Emphasis is directed at promoting personal behaviors that have both immediate and long-term health benefits and at modifying behaviors that cause the greatest burden of suffering. According to the US Preventive Services Task Force, counseling patients about personal health practices (smoking, diet, physical activity, drinking, injury prevention, and sexual behavior) remains one of the most underused but important parts of the health visit.

This primer focuses on the rising prevalence of a serious, chronic health condition—obesity. Two weight-linked behaviors—physical inactivity and unhealthy eating—are given important consideration. It is estimated that 300,000 preventable deaths occur each year in the United States due to diet and physical inactivity, both of which contribute to obesity—only tobacco use causes more preventable deaths in this country. Growing scientific consensus on the health risks of physical inactivity and improper diet mandates that physicians become informed and prepared to assist patients in leading more active and healthy lives. Physicians have an important opportunity to encourage improvements in health behaviors and outcomes, including influencing motivation and success with weight loss treatment. **It is never too late to start and have a favorable impact on health. Patients of all ages can and will benefit.**

We encourage you to review this primer and to participate in the accompanying continuing medical education (CME) program. Please also take some time to complete and return the evaluation form that accompanies this primer. Your feedback is valuable for updating this publication and for planning future physician education programs. We invite you to use these resources and take action—in your practice and community—to promote healthier lifestyles among your patients, colleagues, and neighbors.

Contents

Assessment and Management of Adult Obesity: A Primer for Physicians **Booklet 9 • Setting Up the Office Environment**

-
- iii Preface
 - 1 Objectives
 - 2 Case presentation
 - 2 Does my office need to be specially equipped to provide care to my overweight and obese patients?
 - 3 How can my waiting room be improved?
 - 4 Why can weighing patients be a sensitive issue?
 - 5 Are there additional equipment needs in my office?
 - 7 How can I involve office staff in a team approach?
 - 8 What questionnaires, patient education handouts, and resources should I have available to provide obesity care?
 - 8 Putting it all together
 - 10 References
 - 10 Suggested additional reading

Objectives

This primer is designed to educate primary care physicians about providing medical care to overweight and obese adults. It is presented in a modular format to facilitate its use as an educational and teaching tool. Patient scenarios are included for self-evaluation and to reinforce information presented. A continuing medical education (CME) component worth 4.5 credit hours is also offered. After completing this program, physician participants should be able to:

- identify overweight and obesity in their patients
- describe the medical and public health implications of adult overweight and obesity and identify opportunities for patient, family, and community intervention
- incorporate assessment and management of adult overweight and obesity into their clinical practices
- identify specific patient comorbidities and health risks that are caused and/or exacerbated by overweight and obesity that may interfere or even contraindicate treatment
- understand the appropriate application of diet, physical activity, behavior changes, pharmacotherapy, and surgery in obesity treatment
- locate information about culturally and linguistically appropriate strategies and resources to prevent and treat adult overweight and obesity
- enhance personal and office practices to optimize sensitivity to the needs and concerns of overweight and obese patients

This primer is not intended to function as a clinical guideline, standard of care, or definitive resource for the assessment and management of obesity. However, more detailed information is available in the references and resources listed in each booklet of this primer.

Case presentation

Dr. Smith has noticed a change in his adult patient population over the past several years. More and more patients cannot be weighed because they exceed the 300-pound maximum weight that his scale can accommodate. Many patients are also embarrassed to find that they do not fit into the paper gowns that he has been using for years. Several patients are asking for help with losing weight, but he does not have any special intake forms or other patient handouts readily available. Dr. Smith wants to provide quality care and a supportive environment to his overweight and obese patients, but he does not know where to begin.

T

he 1999–2000 National Health and Nutrition Examination Survey (NHANES) from the Centers for Disease Control and Prevention (CDC) shows that more than 60% of adults and 15% of adolescents are overweight or obese.

This condition is now one of the most common medical problems seen in primary care. Attention to the needs

of overweight and obese patients promotes their comfort and confidence in the medical care they receive. This in turn strengthens the patient–physician relationship and leads to improved therapeutic outcomes.

This booklet focuses on changes that can be made in the medical office environment to enhance care for overweight and obese patients.

Does my office need to be specially equipped to provide care to my overweight and obese patients?

Physicians typically are sensitive to patients with disabilities — eg, visually impaired patients or patients who use wheelchairs or walkers — but they do not always realize that overweight and obese patients have special needs, too. Many industries now address the needs of overweight and obese persons, eg, by offering stylish larger size clothing and wider airline seats; comfort and accessibility are equally important in the physician’s office.

The National Association to Advance Fat Acceptance (NAAFA), an advocate group for overweight persons, outlines guidelines for health care providers who interact with obese patients.¹ (The recommendations contained in this booklet are generally consistent with their guidelines.) According to NAAFA, quality care begins with adopting a serious attitude and treating patients with gentleness, tact, and concern. Office-based systems can be optimized for patient care and comfort by using specific equipment, office tools, procedures, protocols, and joint efforts of office staff, all of which are described in greater detail in the remainder of this booklet.

How can my waiting room be improved?

After the initial call to make an appointment, patients base their first impression of a medical practice on the accessibility of the office and the waiting room. Many facility limitations, such as difficult access from the parking lot, stairs, narrow doors and hallways, and cramped restrooms, cannot be easily changed. However, a waiting room can be refurbished to significantly enhance the comfort of overweight and obese patients.

Recommendations for waiting room modifications include:

- sturdy armless chairs with at least 6 to 8 inches of space between them
- firm high sofas
- artwork and magazines that do not promote thin bodies as the ideal
- magazines and other reading material that encourage healthy living, nutrition, physical activity, and healthy aging
- health promotion posters that display inspirational messages or physical activity tips

Why can weighing my patients be a sensitive issue?

Unlike measuring blood pressure, heart rate, or temperature, body weight measurements can be an emotional experience. Many patients base their self-worth and attractiveness on the shape and weight of their body. Excessive preoccupation with body weight drives many individuals to weigh themselves daily or even several times a day. For some, their morning weight determines their mood for the day and dictates how much they will (or will not) eat over the course of the day. For overweight patients, the scale is either an enemy or a friend, depending on whether it has gone up or down since their last measurement.

The internal strife and critical self-value judgment that many overweight patients experience in relation to their body weight is compounded by the need to be weighed in the physician's office. Just being asked by the office nurse, physician assistant, or physician to "Please step on the scale so I can get your weight" can be a stressful experience. Emotions, whether or not they are openly displayed, commonly range from embarrassment, shame, or frustration to encouragement and elation. The nonverbal response or remarks that health care providers make regarding their patients' weight may influence patients' feelings about themselves. Being sensitive to this issue sets the tone for establishing a caring and empathic patient-physician relationship.

In consideration of patients' feelings, follow these recommendations:

- Weigh patients in a private setting, away from other patients and staff. This can be accomplished by placing a scale in the examination room or in a separate area of the office.
- Have office staff ask patients' permission to be weighed, rather than automatically requiring it.
- Have office staff record patient weight silently and free of commentary. Conduct discussions and counseling in the examination room.

Are there additional equipment needs in my office?

Screening and assessing for overweight and obesity must include obtaining accurate height and weight measurements. Unfortunately, the primary care physician often has a scale that does not measure more than 300 pounds, and the foot platform is too narrow to securely balance an overweight individual. If possible, have at least **one scale that measures in excess of 350 pounds, with a wide base and a nearby handle bar for support, if necessary.** For height, a wall-mounted sliding stadiometer takes the most accurate measurement, but a firm height meter attached to the scale will suffice.

Examination rooms should include:

- large-size gowns for patients to wear
- a sturdy step stool for mounting the examination tables
- a cloth or metal tape measure for measurement of waist circumference
- large adult arm and thigh blood pressure cuffs

Blood pressure cuffs are important because a bladder cuff that is too narrow will falsely increase the blood pressure measurement. To avoid errors, the bladder width should be 40% of the circumference of the upper arm at the midpoint and the length of the bladder should be 80% of the circumference of the arm.² Therefore, choose a large adult cuff (16 cm wide) for patients with mild to moderate obesity (or arm circumference 14 to 17 inches), and choose a thigh cuff (20 cm wide) for patients whose arm circumferences are greater than 17 inches.

For additional discussion of equipment needs, refer to Figure 9.1.

Figure 9.1 Checklist for Office-based Obesity Care**Equipment for waiting area**

- Open-arm chairs that can support more than 300 pounds
- Firm sofas that can support more than 300 pounds
- Weight-sensitive reading materials

Equipment for exam room

- Body weight scales with a capacity of more than 300 pounds
- Height meter
- Large gowns
- Step stools with handle bars
- Large adult and thigh blood pressure cuffs
- Tape measure
- Wide examination tables, preferably bolted to the floor.
Consider a hydraulic tilt, if possible.

Tools

- Body mass index (BMI) chart
- Self-administered medical questionnaire
- Eating Pattern Questionnaire
- Physical Activity Pattern Questionnaire
- Graphing Your Weight Gain Chart
- Food and activity diaries
- Pedometers

Procedures

- Treatment protocols
- Medication use
- Referrals to other health care professionals

See Booklet 10: *Resources for Physicians and Patients* for ordering information and copies of tools.

How can I involve office staff in a team approach?

The day-to-day operation of an office practice is extremely important for the delivery of effective obesity care. An integrative team approach can enhance patient care by ensuring that each element of care is competently performed by the appropriate team member and communicated to others on the team.

When enlisting the support of office staff, address the defined role of staff members, as well as the attitudes, beliefs, and biases they may have about obesity. Prejudice and discrimination toward obese patients are common, even among health care professionals. These attitudes and behaviors must be openly discussed and resolved. Periodically review key concepts on obesity screening, evaluation, treatment, and health guidance with your staff to provide up-to-date clinical performance.

The optimal team composition and management structure varies among practices. The following descriptions outline appropriate activities:

- Receptionists provide useful information about the practice, including general philosophy, staffing, fee schedules, and written materials.
- Registered nurses obtain vital measurements, including height, weight (for body mass index), and waist circumference; and provide instruction on and review of food and activity journals and other educational materials.
- Physician assistants/nurse practitioners monitor the progress of treatment and assume many other responsibilities of care.
- Physicians coordinate and manage integrating their patients' medical care.
- Frequent staff meetings are held to discuss and revise office practices, as needed.

It is critical that physicians take a systems approach in coordinating the health care of their patients. By using multidisciplinary teams and multi-organizational referral arrangements, physicians can participate in promoting a population-based perspective in medicine.

As clinicians, physicians have the ability to integrate individual, diagnostic, and management strategies within the context of family, cultural, and community factors to identify groups of overweight and obese patients in which to focus a concentrated set of preventive interventions.³

What questionnaires, patient education handouts, and resources should I have available to provide obesity care?

Obese patients can be evaluated using a medical questionnaire that can be mailed to them and completed prior to the initial visit, completed in the waiting room, or completed with the physician or other staff in the examination room. Sections of the form include queries about past participation in obesity treatment programs, a body weight history, current diet and physical activity levels, social support, and goals and expectations.

Assess patient questionnaires for reading level; some patients may have to work with a physician or nurse to answer the questions. Health education audiotapes and informational materials in patients' primary languages can facilitate assessment of past dieting behaviors. Be sure to consider the language and communication needs of patients from different cultures for whom US medicine and the use of questionnaires may seem invasive.³

Several questionnaires and handouts that address weight loss, diet, nutrition, physical activity, and medication management are included in Booklet 10: *Resources for Physicians and Patients*.

Putting it all together

Put Prevention Into Practice (PPIP), a national campaign coordinated by the Agency for Health Care Research and Quality (AHRQ) to improve the delivery of clinical preventive services, provides a useful framework for analyzing the office systems designed to deliver patient care.⁴ This framework has been adapted into an office audit that can be used to assess current obesity care (see Figure 9.2). After reviewing this booklet, you should be able to use this framework to change or enhance your office practices.

Figure 9.2 Audit for Delivery of Office-based Obesity Care

Do you routinely assess and evaluate patients for overweight and obesity?

For example, measure height, weight, waist circumference, body mass index (BMI); take a focused obesity history; assess readiness and barriers for weight loss.

What kinds of services or programs do you routinely provide to your overweight patients?

For example, dietary and physical activity counseling, group support, referral to a registered dietitian, email correspondence, use of anti-obesity medications or formula diets.

Are the services or programs recorded in patient charts?

For example, recommended dietary and physical activity behavioral changes; percent weight loss goal; correspondence to a registered dietitian, health psychologist, or exercise specialist; use and risks of anti-obesity medication.

What policies and procedures do you have in place for providing obesity care?

For example, all patients have height, weight, waist circumference, and BMI measured and recorded in their chart; patient readiness is assessed before initiating treatment; weight loss goals are established and tracked in the progress notes; patients with a BMI of ≥ 30 are assessed for anti-obesity medications; those with a BMI of ≥ 40 are assessed for bariatric surgery.

What forms, patient handouts, and educational materials are you using?

For example, focused obesity history form, diet and physical activity history forms, healthy snacks, strategies to increase physical activity during daily living, food and activity diaries, educational sheets on anti-obesity medications.

How does your office environment support or inhibit delivery of obesity care?

For example, sturdy armless chairs, large arm and thigh blood pressure cuffs, large gowns, measuring body weight in a private setting, a sensitive and informed office staff.

What functions do staff currently serve in the provision of obesity care?

For example, office nurse obtains weight, height, and BMI; physician's assistant reviews food and activity diaries and medication side effects; receptionist schedules referral appointments with dietitian and clinical psychologist.

What can you do differently?

Adapted from *A Step by Step Guide to Delivering Clinical Preventive Services: a systems approach*. Agency for Healthcare Research and Quality, Rockville, Md. Available at: www.ahrq.gov/ppip/manual.

References

1. National Association to Advance Fat Acceptance. Guidelines for health care providers in dealing with fat patients. Available at: <http://www.naafa.org>.
2. Perloff D, Grimm C, Flack J, Frohlich ED, Hill M, McDonald M, Morgenstern BZ. Human blood pressure determination by sphygmomanometry. *Circulation*. 1993;88:2460–2470.
3. Peters KE, Elster AB. *Roadmaps for Clinical Practice: A Primer on Population-Based Medicine*. Chicago, Ill: American Medical Association; 2002.
4. Agency for Healthcare Research and Quality. 10 steps: implementation guide: put prevention into practice. Adapted from *The Clinicians' Handbook of Preventive Services*. 2nd Edition. Rockville, Md: Agency for Healthcare Research and Quality; 1998. Publication No. 98-0025. Available at: www.ahrq.gov/ppip/impsteps.htm.

Suggested additional reading

Agency for Healthcare Research and Quality. A step-by-step guide to delivering clinical preventive services: A systems approach. Publ No APPIPO1-0001. Available at: www.ahrq.gov/ppip/manual/.

Crabtree BF, Miller WL, Aita VA, Flocke SA, Stange KC. Primary care practice organization and preventive services delivery: a qualitative analysis. *J Fam Pract*. 1998;46:404-409.

Kushner, RF. The office approach to the obese patient. *Prim Care Clin Pract*. 2003;30:327-340.

National Heart, Lung, and Blood Institute (NHLBI) and North American Association for the Study of Obesity (NAASO). *The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*. Bethesda, Md: National Institutes of Health; 2000. Publication No. 00-4084. Available at: <http://nhlbi.nih.gov/guidelines/obesity/practgde.htm>.

Starfield B. Primary care concepts, evaluation, and policy. New York, NY: Oxford University Press; 1992.

Woolf SH, Jonas S, Lawrence RS. *Health Promotion and Disease Prevention in Clinical Practice*. Baltimore, Md: Williams & Wilkins; 1996. Chapters 7, 8, 9.

Strategy for treatment of overweight and obesity

Evaluate your patients for current and potential health risks related to weight (Booklet 2)

- Measure body mass index (BMI)
- Measure waist circumference
- Assess for presence/extent of suspected comorbid diseases

Talk to your patients about weight loss (Booklet 3)

- Explain the importance of weight loss
- Assess your patients' readiness to make behavior changes
- Work with your patients to establish realistic treatment goals

Help your patients manage weight through dietary management (Booklet 4)

- Collaborate on strategies for reducing calories and balancing the diet
- Recommend weight loss programs and resources as needed
- Follow up with your patients to monitor progress and provide support

Help your patients manage weight through physical activity (Booklet 5)

- Collaborate on strategies for increasing physical activity in the daily lifestyle
- Recommend physical activity programs and resources as needed
- Follow up with your patients to monitor progress and provide support

If indicated, help your patients manage weight through pharmacotherapy (Booklet 6)

- Determine whether your patients are candidates for pharmacotherapy at this time
- If pharmacotherapy is an option, help your patients make and carry out treatment decisions
- Monitor your patients for weight loss and medication side effects

If indicated, help your patients manage weight through surgery (Booklet 7)

- Determine whether your patients are candidates for bariatric surgery at this time
- If surgery is an option, help your patients and their bariatric team make and carry out treatment decisions
- Manage your patients post-operatively

Optimize your communication and counseling style (Booklet 8)

- Establish an effective patient–physician partnership
- Help your patients obtain skills for self-management
- Be sensitive to anti-fat bias and approach the topic of weight sensitively

Optimize your office environment (Booklet 9)

- Be more sensitive to your patients' needs by adapting office practices and the waiting room configuration
- Set up your office with the equipment needed to assess and manage your patients
- Facilitate patient care through a team approach

Adapted from Serdula MK, Khan LK, Dietz WH. Weight loss counseling revisited. *JAMA*. 289;1747-1750:2003.