

HEALTH ADVOCACY

Obesity: A Barrier to Adequate Healthcare

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ABSTRACT

In the setting of increasing global obesity rates, the obesity epidemic is at the forefront of today's highly publicized medical issues. Some of the most alarming data is that of increasing rates of obesity in children. With this knowledge, it is easy to forget about the individual patient's plight for non-judgmental care. It can therefore be argued, that before population health approaches, initiatives and the subsequent interplay of health policy are effective, the individual must still be addressed regarding access to care. The following discussion will attempt to outline the unique barriers to health care that obese individuals face and how we as medical students, residents and practicing clinicians can adapt to their needs to ensure the most sensitive and effective care possible. Although new funding in Ontario has been provided for bariatric surgery and outpatient clinics, the onus inevitably falls on primary care physicians to fill the gap in primary obesity prevention and continuity of care.

INTRODUCTION

In the McMaster University Medical Journal's 2004 edition, we were educated about the implications of obesity to Canada's health care system, society, and the economics thereof.¹ Since then, the obesity epidemic has continued on its rapidly growing trajectory.^{2,3} As of the most recent estimates from the 2004 Canadian Community Health Survey, 59% of the adult population is overweight (BMI \geq 25 kg/m²) and 23% is obese (BMI \geq 30 kg/m²), compared to 32.5% and 14.9% in 2000-2001 respectively.^{2,3} As for children, in 2004 26% of Canadian children aged 2-17 were overweight.² The obesity rate in children has also increased over the past 15 years: from 2% to 10% in boys and from 2% to 9% in girls.² Furthermore, this alarming rate of adiposity shows no signs of stopping soon.²

As a concerted effort to provide evidence-based recommendations to help streamline efforts on the management and prevention of obesity, the members of the Obesity Canada Clinical Practice Guidelines Expert Panel have just released the 2006 Clinical Practice Guidelines, the summary of which was published in April 2007's edition of the CMAJ.² As stipulated in the guidelines, population health approaches, initiatives and the subsequent interplay of

health policy will probably be more effective than individualized interventions in preventing and reducing the prevalence of obesity.⁴ However, what is often overlooked are the unique needs of the obese patient in obtaining adequate care and seeking out interventions.^{5,6,7,8} This applies to both issues with weight-loss and maintenance as well as other primary and preventative health concerns.^{5,6,7,8} With this in mind, the following discussion paper will outline some of the barriers to health care that obese individuals face and how we as medical students, residents and practicing clinicians can adapt to these needs to ensure the best possible care.

OBESITY AND BARRIERS TO HEALTHCARE

Obesity confers higher morbidity and mortality to patients' health and should therefore be considered an independent health risk.⁶ Obesity is associated with the development of heart disease, dyslipidemia, hypertension, Type 2 diabetes, obstructive sleep apnea, osteoarthritis and various gynecologic cancers.^{5,6,7,8} The significant morbidity obese individuals suffer due to these obesity-related diseases are thought to be compounded by issues relating to inadequate access to healthcare, especially that of prevention.⁶ With

Table 1. An outline of patient and physician barriers to healthcare in the obese**Patient Barriers to Adequate Medical Care and Preventative Services**

- Self-consciousness about weight
- Fears of disparaging, negative or inappropriate comments from physicians and medical staff
- Weight gain or failure to lose weight since last appointment
- Past negative experiences with, or disrespectful treatment from, physicians and medical staff

Health care provider barriers to adequate medical care and preventative services

- Lack of appropriate medical equipment to accurately assess and treat patients who are obese
- Lack of training in accommodating the physical and emotional needs of persons who are obese
- Difficulty performing examinations, such as pelvic exams, due to the patient's size
- Focus on treating ongoing medical conditions, to the exclusion of preventative care services

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Table 2. Recommendations for sensitive care of obese individuals**1. Create an accessible and comfortable office environment**

- Provide sturdy, armless chairs and high, firm sofas in waiting rooms.
- Provide sturdy, wide examination tables that are bolted to the floor to prevent tipping.
- Provide a sturdy stool or step with handles to help patients get on the examination table.
- Provide extra large examination gowns.
- Install a split lavatory seat and provide a specimen collector with a handle.

2. Use medical equipment that can accurately assess patients who are obese

- Use large adult blood pressure cuffs or thigh cuffs on patients with an upper-arm circumference greater than 34 cm.
- Have on hand extra long phlebotomy needles, tourniquets, and large vaginal speculae.
- Have a weight scale with adequate capacity (greater than 350 pounds) for obese patients.

3. Reduce patient fears about weight

- Weigh patients only when medically appropriate.
- Weigh patients in a private area.
- Record weight without comments.
- Ask patients if they wish to discuss their weight or health.
- Avoid using the term obesity. Your patients may be more comfortable with terms such as "difficulties with weight" or "being overweight." You may wish to ask your patients what terms they prefer when discussing their weight.

4. Monitor obesity-related medical conditions and risk factors

- Conduct tests to assess type 2 diabetes, dyslipidemia, hypertension, sleep apnea, ischemic heart disease, thyroid disease, and nonalcoholic steatohepatitis as medically indicated.
- Consider concerns of the extremely obese patient that may be overlooked such as lower extremity edema, thromboembolic disease, respiratory insufficiency (Pickwickian syndrome), skin compression (ulcers), and fungal infections.

5. Offer preventive care services

- Allow adequate time during office visits for preventive care services.
- Recommend or provide preventive care services such as Pap smears, breast examinations, mammography, prostate examinations, and stool testing.

6. Encourage healthy behaviors

- Discuss weight loss—as little as 5 to 10 percent of body weight—as a treatment for weight-related medical conditions. Work with your patient to establish realistic treatment goals.
- Emphasize healthy behaviours to prevent further weight gain, whether or not the patient is able or willing to lose weight.
- Encourage physical activity to improve cardiovascular health.
- Seek professional resources to assist your patients and provide referrals to registered dietitians, certified diabetes educators, exercise physiologists, weight management programs, and support groups, as appropriate.
- Provide printed educational materials and lists of resources to patients. Offering this information may be especially helpful if your time with the patient is limited. Be sure that reading materials appropriately emphasize health rather than thinness.
- Promote self-acceptance and encourage patients to lead a full and active life.

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respect to barriers to care, the concept is that of a two-way street, with patients and physicians alike increasing barriers to adequate, non-judgmental patient-centred care (Table 1).^{5,6}

In recent American survey-based studies, it was found that obese females are less likely to receive certain preventative care services such as pelvic exams, Pap smears, clinical breast exams and mammograms.^{6,7,8} At this time, no comparable Canadian studies could be found, but it is not a far stretch of the imagination that the same may be true in Canada, especially in those morbidly obese (BMI \geq 40kg/m²). These results are alarming, as overweight and obese women have higher mortality rates for cervical and breast cancer.^{6,7,8} In follow up to these studies, Amy et al. conducted a survey administered to both a sample of 498 American women and 129 health care professionals.⁸ What they found was that obese women perceived their weight as a barrier to obtaining appropriate health care and would often delay cancer screening tests.⁸ The frequency of such statements increased as a function of BMI.⁸ The women's perceived barriers revolved around past disrespectful treatment, embarrassment at being weighed, negative attitudes of providers, unsolicited advice to lose weight, and medical equipment that was too small to be functional.⁸ As for the healthcare providers, they reported inadequate training in caring for obese females and found examining obese women more difficult.⁸ In an American survey distributed to family physicians, 38.5% attributed lack of willpower as one of the most important factors to their patients' obesity.⁶ It is therefore likely that medical professionals have a role to play in exacerbating obese individuals' barriers to care. In this respect, it is commendable that the 2006 Canadian obesity guidelines have addressed this issue in their statement encouraging primary health care professionals to create a nonjudgmental atmosphere when discussing weight management.² Although such recommendations are a step forward for sensitive care, its successful implementation is yet to be determined.

CREATING AN OBESE-SENSITIVE PRACTICE: RECOGNIZING SPECIAL NEEDS

Since obese patients have a disproportionately higher need for preventative healthcare, an effort must be made by medical students, residents, practicing physicians and allied health professionals to create a safe, accepting and non-judgmental environment in which to service this unique population of individuals.^{5,6,7,8} Table 2 outlines the suggestions made by the Weight-control Information Network of the American National Institute of Health to better service the obese patient population.⁵

With respect to the periodic health exam, it is understood that the physical exam, especially that of the abdominal, respiratory and cardiac systems, is often difficult to perform

accurately in obese individuals due to the expanded soft tissue barrier.⁶ Additionally, certain physical findings, such as peripheral edema and signs of thromboembolism, may be more subtle and easily overlooked.⁶ It has therefore been suggested that other evidence-based investigation modalities (such as echocardiography) be validated as alternatives.⁶ That being said, pap smears, breast exams, mammography, prostate exams and stool testing are not impeded by size and should be conducted on all patients.⁵ With respect to blood pressure measurement it is important to use the larger cuff in those individuals whose upper arm circumference is greater than 34 cm, otherwise, a falsely elevated blood pressure would result, leading to inaccurate treatment targets.⁶

CURRENT INITIATIVES

In discussing efforts to provide superior, sensitive care to obese individuals, our discussion directs us to the Hamilton General Hospital and the efforts of the bariatric outpatient clinic. The clinic was founded in 2004 by Dr. Arya Sharma, an internationally-renowned obesity specialist trained in nephrology.⁹ Although his original interest was hypertension and its relationship to diabetes, Dr. Sharma soon focused his research on obesity and its relationship to cardiovascular disease.⁹ The clinic treats obesity as a disease. It is designed for the morbidly obese and is served by a multidisciplinary team of physicians, registered nurses, registered dietitians, a certified kinesiologist, social workers and ward clerks to best meet the unique needs of the obese.⁹ Patients are both psychologically and medically supported through physician-supervised weight loss and management.⁹ Most patients are on partial meal replacements (e.g. Optifast®) and/or medications (e.g. Sibutramine, Orlistat), while others in the process of being referred to surgery (not available in Hamilton). Having spent some time in the clinic myself, I have witnessed first hand the dedication of such individuals to providing sensitive care on a formidably small budget.

In August 2007, the Hamilton Health Sciences (HHS) became Canada's second Obesity Centre of Excellence, the first having been established at the Toronto Humber River Regional hospital (HRRH).^{11,12} Hamilton's funding details for 2007/2008 include \$510,000 in base funding to increase treatment capacity to 500 additional patients per year in addition to the 200 outpatient cases already followed.¹² A further \$180,000 in capital funding will be provided to upgrade HHS facilities in anticipation of accommodating more patients.¹² Furthermore, the plan is to create a complimentary care model between the two sites, utilizing the medical and bariatric surgical expertise at HHS and HRRH respectively.¹² Plans for implementation of the new funding are still in their infancy; it is anticipated that many changes to clinic structure and function are yet to come.

CONCLUSION

In light of the unique needs of obese individuals outlined, it is our responsibility as healthcare professionals to be non-judgmental and sensitive in their care. This includes being sensitive to both their psychosocial as well as biological needs. Before we can truly get a grip on the epidemic itself, obesity needs to be treated as a disease and no longer as a cosmetic issue: the health-related perils of obesity have been clearly outlined.^{2,9} As suggested by Dr. Sharma himself, the need exists for obesity centres of excellence to be disseminated across Canada. With the addition of Hamilton as the second Obesity Centre of Excellence, there is hope that the issue is finally reaching government attention and we are making progress in providing complex obesity care. The proposed care model is, however, still in its infancy. Furthermore, bariatric surgery is still not a readily available resource, and does not address the needs of the overweight and less extremely obese. In the meantime, while current expansion plans are being implemented and gaps in care exist, the onus inevitably falls on primary care physicians to provide primary obesity care and prevention.¹³ Furthermore, primary care physicians will require support in this role; the 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children have only begun to address such issues, but not without promise.

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Edmonton. We wish him the best of luck and much success in his new role as he continues the national battle against obesity. †

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Author Biography

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