African Americans' Perceptions of Physician Attempts to Address Obesity in the Primary Care Setting

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BACKGROUND: Obesity disproportionately affects African Americans and leads to several major co-morbidities. While guidelines recommend physicians identify obese patients and counsel them on weight management, little is known about how these efforts are received by patients.

OBJECTIVE: To elucidate how obese, urban African American patients perceive the physician role in the treatment of obesity and to identify specific provider behaviors that may motivate or hinder attempts at weight loss.

DESIGN: Qualitative study involving eight focus groups.

PARTICIPANTS: Forty-three obese African-American patients recruited from academic internal medicine practices participated in focus groups between September 2007 and February 2008.

MEASUREMENTS AND MAIN RESULTS: Four broad themes emerged: (1) dislike of the word obese, (2) importance of the physician manner and timing when discussing weight, (3) necessity of a personalized approach in discussing weight management issues, and (4) variable response to scare tactics. Within each theme participants identified specific physician behaviors that were perceived as either motivating or hindering attempts at weight loss.

CONCLUSIONS: Physicians must be cognizant of the potential unintended consequences of the techniques they use to educate and counsel African-American men and women on obesity, particulary those that may be perceived as negative and act to further alienate obese patients from seeking the care they need.

KEY WORDS: obesity; African American; perception; counseling.
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INTRODUCTION

African Americans are disproportionately affected by obesity, with a prevalence among adults of approximately 45% as compared to 30% of Caucasian adults.[1] The disparity in estimates of extreme obesity is even greater, with an estimated prevalence among African Americans more than twice that of Caucasians.[1] Further, across multiple treatment modalities, including behavioral therapy and surgery, African Americans lose less weight than Caucasians.[2–5]

Currently the United States Preventive Services Task Force (USPSTF) recommends that clinicians screen all patients for obesity, defined as BMI $\geq$30 kg/m^2, and provide intensive counseling on lifestyle and behavior modification to promote weight loss to overweight and obese patients.[6] Despite these recommendations, most data suggest that such counseling occurs in less than 20% of primary care visits.[7–9] Reasons cited for physician inaction have included time constraints, limited training on behavioral counseling, and beliefs that medical management of obesity may be futile.[10,11] Not only are primary care providers not routinely offering counseling, many obese patients do not seek advice regarding weight management from their physicians or believe that weight problems should be managed on one's own.[12,13]

To date, little research has been done exploring how patients in general perceive current physician attempts at obesity management,[11] and to our knowledge no study has focused specifically on obese African Americans. A survey of women participating in obesity trials revealed that obese women were significantly less satisfied with their physicians' expertise in the area of obesity and with their care for weight management.[12] More recently, discrepancies between patient and provider perceptions regarding obesity have been identified. Survey data collected from obese patients immediately following an office visit found that providers more frequently reported a discussion on weight management than did patients.[14] Finally, a study of VA patients, comprised of 35% African-American participants, found patients were more likely than providers to believe sufficient time exists in an office visit to address weight.[13]

To improve physician efforts at counseling patients about obesity during clinical encounters, experts have called for the development of interventions targeted at increasing physicians' knowledge of obesity treatment with a focus on behavioral modification counseling.[7,11,15] An improved understanding of African-American patients' perceptions of the role of their physicians in weight management will enhance the development of interventions that are culturally relevant and have a higher likelihood of success. The purpose of this qualitative study was to elucidate how obese African Americans currently perceive the physician role in the treatment of obesity and to identify specific provider behaviors that are motivating versus those that may be counterproductive.

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METHODS

Study Setting and Participants

Obese African-American men and women age 18–65 were recruited from two general internal medicine practices at an urban, academic medical center. Consecutive obese patients were recruited in person by a study investigator (SHW, AMG) at the time of a routine medical visit or by referral to a study investigator by their primary provider after a routine visit. Inclusion criterion was a calculated BMI (in kg/m^2) greater than 30 by self-reported height and weight. While overweight patients are recognized to be at increased risk of continued weight gain, they were excluded from this study as their perception of and experiences with primary care providers likely differs from obese patients. We also excluded individuals who reported a medical contraindication to physical activity, or lacked the ability to give informed consent or participate in a group discussion as determined by their primary provider or the principal investigator (SHW). No direct advertising to patients in the form of flyers or posters was utilized, and no incentive was provided for referral of potential participants. Participants received a $20 gift card and two tokens for public transportation at the conclusion of each focus group as compensation for their time and contribution to this study. No non-monetary incentives were provided. The Temple University Institutional Review Board approved the study protocol and methods for maintaining anonymity.

Data Collection

Eligible participants were contacted by phone by the principal investigator (SHW) to confirm their interest in the study and to schedule a focus group time. As many participants were referred to a study investigator by their primary providers, an accurate number of patients initially screened cannot be provided. A total of 94 patients were scheduled to attend a focus group, and of these 43 participated, for a participation rate of approximately 46%. Focus groups were comprised of either all men or all women to allow for assessment of gender differences and similarities. An African-American study investigator (AMG) with prior qualitative research experience facilitated all groups.

Prior to the beginning of each focus group, all participants were informed that discussions would be audio-taped and responses would be kept confidential, shared with only the research team. The informed consent document and consent to audio-tape were read aloud by the group moderator and signed by each participant at the beginning of all groups. In order to direct the discussions, a focus group guide was developed by the study team (see Appendix 1). Decisions about the wording of questions and which to include were made by consensus. All questions were initially open ended. Consistent with qualitative methodology, analysis of transcripts began while data collection was ongoing. Based on early dominant themes, follow-up probes for questions 1 and 3 were added after the second focus group with both genders in order to refine the group discussions and achieve thematic saturation.

All focus groups were audiotaped and transcribed. Participants were informed that the principal investigator (SHW) would sit in on the discussions in order to collect the informed consent documents, run the tape recorder and note observations about group interactions. Each focus group lasted approximately 75–90 min.

Analysis

Analysis of the transcripts was an iterative process based on grounded theory, a method of analyzing data that focuses on hypothesis and theory generation from the collection of data. The process involves first collecting data and then reviewing it to generate codes. Codes that refer to similar content are grouped into concepts and then more broadly into categories. These categories then provide the basis for theory or hypothesis generation, a reverse from more traditional research methodology where the process begins with hypothesis generation and then moves to data collection. With grounded theory, both induction and deduction are used throughout the analysis with a focus on constant comparison methods.

Two study physicians (SHW and AP) independently coded all transcripts at the completion of each focus group. Atlas.ti version 5.2 was used to assist with data management and analysis. Based on initial coding conference discussions, focus group questions were further refined and follow-up probes added to verify and elucidate early emerging themes. Coding disagreements were settled by discussion and consensus among the study team, with audiotapes reviewed as necessary. Transcripts from all focus groups were then re-coded independently by the two investigators and systematically discussed to refine the code list, checking for exclusivity and completeness of the codes. A master code list was generated and used to review transcripts with identification of dominant emerging themes.

RESULTS

Participant Characteristics

Eight focus groups ranging in size from 2 to 12 participants were conducted over 5 months. There were a total of 43 participants [37% men (n=16) and 63% women (n=27)], ranging in age from 30 to 64 years (median 50 years). BMI, as calculated from self-reported height and weight, ranged from 30.2 to 57.7 kg/m^2 (median 38.6 kg/m^2). All participants reported weight loss attempts in the past, and some were continuing with these efforts at the time of the focus group. There were no differences in responses between participants actively trying to lose weight versus those not currently trying, or in participants were who more successful at achieving weight loss versus who were unsuccessful. All of the dominant themes emerged in the first two groups with both men and women, and there were no gender differences regarding perceptions of physician behavior.

Findings

Participants' perceptions of the physician role can be grouped in the following broad themes: (1) dislike of the word obese, (2) importance of the physician manner and timing when discussing weight, (3) role of a personalized approach in discussing weight management issues, and (4) acceptability of scare tactics. Within each of these constructs, participants identified behaviors that were perceived as positive and would motivate further attempts at weight loss. Participants also identified negative physician behaviors within each construct that could be counterproductive toward encouraging weight loss attempts.

Theme 1: Dislike of the Word Obese. Participants expressed a strong disdain for the term 'obese' and preferred that it not be used by physicians when discussing their health or weight management. While many participants perceived themselves as 'fat,' a similar number self-reported as 'obese.' No differences were identified in the perceptions of physicians' actions when counseling for weight loss by those who identified themselves as fat versus those who self identified as obese. The majority of participants reported that the word obese carried negative connotations and was associated with some form of discrimination. As two participants explained: *"There are all kinds of negative pictures of being obese."* *"When I hear the word 'obesity' I feel discriminated against. The first thing they think is that you eat all day. The second thing they think is that you're lazy, you smell."* Additionally, several women stated that they did not believe the word obese should apply to a human being and that it should be used only in reference in large animals. *"When I hear the word 'obese' I think of an elephant…We are not animals."* Participants offered several alternatives for the term obese, which included 'thick,' 'heavy,' 'big boned,' 'well endowed,' and, as expressed by one participant: *"You can even say we're fat and I'm okay with that."* Few participants recognized the use of the word 'obese' as medical terminology in the context of counseling for weight management, and many expressed a lack of understanding of how obesity is defined in clinical practice. *"I don't feel like I'm obese, but she looked up on this chart and said 'you are obese.' I just don't understand that."* In fact, none of the participants discussed potential methods of assessing body fat mass, including BMI, waist circumference, waist-to-hip ratio, or body fat composition. Both men and women expressed feeling less motivated to attempt to lose weight and more frustrated and hopeless when physicians used the terms 'obese' or 'obesity.'

Theme 2: Importance of Physician Manner and Timing When Discussing Weight. Participants passionately discussed the importance of the physician's manner and communication skills, including how the physician's approach to the topic of weight could impact them as patients (Table 1). First, it was felt that the way something is said is just as important as the content of what is being discussed. Significant emphasis was placed on the need for the physician to demonstrate respect, remain non-judgmental, and sincerely express concern for a patients' well-being. Further, participants reported an appreciation of verbal recognition from their providers regarding small amounts of weight lost (even 2 to 3 pounds) and that this recognition served as a potent motivator to continue with their weight loss efforts. By the same token, it was widely recognized among men and women that physicians who were perceived as disrespectful, insincere, or emotionless were less likely to inspire behavior change, and that these actions may actually be counterproductive, leading to increased feelings of hopelessness and futility. Physicians that were perceived to be threatening or scolding were also reported to be less effective.

Next, many focus group participants expressed frustration and anger with a physician who attributed all of their complaints to their weight without actually addressing the specific complaint. While they recognized that weight could contribute to poor health, they desired treatment targeted toward their complaint rather than a suggestion that weight loss is the only possible treatment.

Table 1. Importance of Physician Manner and Timing

Communication skills/message	*"It is in the way that you say it sometimes and not what you say. In how you talk to a person."*
	"I want them to tell me the truth but I don't want them to throw it out there like it has no meaning. I want them to say it just right."
	"Sometimes you want to punch them in the head because sometimes it is not the things you say but maybe the way you say it."
	"Don't be condescending and certainly don't be bossy."
Expression of concern for patient well-being	*"And if he showed some concern and passion…at least he's caring about my health."*
Verbal recognition of small losses	*"He said 'I see you lost 3 pounds.' It made me feel kind of good because it seemed like he was concerned about me and proud of me."*
	"One of my doctors said 'You're losing weight, aren't you?' I said 'Thanks for noticing because my primary didn't say a word to me about it."
Attributing complaints to weight	*"You go to the doctors and the first thing they say…you tell them you have an ingrown toenail—lose weight."*
	"Don't blame everything I talk about on my weight. My headache may not be because I'm fat."
	"Don't scold me and tell me everything is due to the weight."
Timing	*"Don't tell me to lose some weight while they are going out the door."*
	"I think you need to ask a person first—'How do you fell about your weight? Do you want to lose weight?'—before they just jump in."

Finally, a significant portion of each discussion centered on the importance of the timing of weight management discussions. The primary concern was that physicians take enough time to counsel patients in detail. Some participants also believed that their doctors should first assess if patients want to discuss their weight and if they are at a point where they feel ready to and have a desire to make changes in order to lose weight. Repeated attempts by physicians to counsel and educate made over time were reported to be motivating if done from a "positive" perspective. However, constant "hounding" of patients and "harping" about their weight was perceived to have a negative impact on both confidence and willingness to change.

Theme 3: Role of a Personalized Approach in Discussing Weight Management Issues. The discussion about how physicians could best help patients begin to control their weight often focused on the importance of a personalized approach (Table 2). Participants recognized that individuals differ with respect to motivators and barriers to losing weight. They expressed a desire for their physicians to take time to explore these needs with their patients in order to offer the most appropriate advice, including specific strategies to overcome previously identified obstacles. In addition, participants stated that their physicians should set and discuss individual weight loss goals with them. Several participants openly stated they were unsure how much weight their doctors expected them to lose or how much weight loss was necessary to improve their health.

Table 2. Role of a Personalized Approach

Individual counseling	*"I would like to think that the responses are not programmed, that is not a cookie cutter and everybody who comes in, I'm going to give you the same spiel."*
	"They should look at everybody as individuals and not just look at my medical records but get to know me as a person…and take care of me."
Goal setting	*"I need you to lose this amount of weight in this amount of time."*
	"I don't know what my weight goal to help the diabetes is."
	"As far as a doctor goes, that (weight loss goal) would be another 100–150 pounds. They live in fantasy land."
Health consequences	*"If you know what this person is predisposed to then you can try to steer them away from the things that will complicate the situations that they already have."*
	"Make you see exactly, even if it's in the test results, what I've been trying to tell you has finally come, and this is what you need to do."
	"All the time she's been telling me this, but until the lab work actually confirmed it, that's what scared me. It wasn't her scaring, but it was in black and white and I could actually see it."
	"He could list all the risk factors involved and 'we could reduce the medications that you are on."
Specific suggestions	*"Suggest different ways of doing things. Suggest a way to exercise or…better nutrition."*
	"If they could put some information in our hands—put a chart of this where you are and this is where you need to be. Put some information or resources or places, just put something."
	"Give me a menu or something…a real chart I can follow, recipes for comfort food to make it lower calories, less cholesterol, lower sodium."
Recognition of effort	*"That you are making an effort and they act like they don't believe it."*
	"When it looks like a person is not losing weight or they're not doing anything, the worst thing you could do is stop being supportive to that person."
	"Even if we say we're doing it and you came back a month later and you didn't lose any weight, then it's sad if they say 'you're not trying."

In terms of the content of the weight management discussion, in addition to addressing specific goals and challenges, participants felt that physicians should focus on the health consequences of obesity most pertinent to the individual patient. They believed it is the physicians' responsibility to initiate this discussion and to educate patients in a straightforward fashion about the impact of weight reduction on health. Participants repeatedly stated that "ignoring it" was one of the worst things their doctors could do. While most participants expressed an understanding of some of the health risks associate with obesity and a desire to be healthier and live longer, they wanted their providers to clearly explain which risks were most pertinent to them as individuals. Some participants reported that it was only after they developed a condition such as diabetes or heart disease and their physician discussed the connection to their weight that they finally understood what their personal health risks were. Others agreed that seeing the abnormalities in the laboratory studies "made it real" for them.

Participants also commonly reported a need for more specific advice on how to achieve weight loss rather than broad statements on the need to lose weight. They suggested a daily meal planner, a referral to a specified weight loss program, advice on what look for in food labels and strategies to address individual barriers as key elements of a weight management discussion. They also hoped to receive this information directly from their doctors, repeatedly stating their beliefs that their primary care providers posses the knowledge and skills necessary to manage obesity.

Finally, participants expressed a desire for their physicians to recognize their efforts even when they were unsuccessful. Physicians who were interpreted as making the assumption that their patients were not trying or didn't care about themselves were perceived to be acting as another barrier to weight loss attempts. Conversely, patients felt encouraged to continue lifestyle changes when their doctors acknowledged their efforts and offered assistance to help succeed with weight loss.

Theme 4: Acceptability of Scare Tactics. Both men and women had mixed reactions to the use of scare tactics by physicians for the purpose of encouraging weight loss. Some perceived this technique as motivating and even necessary to promote behavior change: *"I like to be scared. Scare me with all the bad things that can happen if I don't lose weight."* Others felt that this was a form of intimidating patients that was both unnecessary and potentially counter-productive: *"I look at it as a threat. The only thing the doctor should do is encourage."* All participants agreed that the success of using scare tactics to effect behavior change for the purpose of weight loss depended almost entirely on the reaction of the individual patient: *"It all depends. Sometimes people respond the wrong way from that tactic…"* Further, they felt that their physicians should be able to identify which patients might respond well to this tactic versus those who would respond negatively.

DISCUSSION

We found that obese patients' perceptions of physician behavior varied and could serve either to further motivate African Americans to attempt weight loss or act as a barrier, driving them away from seeking the assistance they need. Most notably, participants disliked the word 'obese,' viewing it as an emotionally charged term and lacking understanding of its clinically definition. Prior studies have reported similar objections to the use of certain descriptors of excess weigh including both 'obesity' and 'fatness,' with more neutral terms, such as 'weight' or 'excess weight' being preferred.[16] Much of the opposition to the use of these terms likely stems from the stigmatization of obesity, which has been reported even in the medical community.[17–20] While feelings of discrimination, intolerance, and disrespectful behaviors are still reported, a study by Anderson and Wadden suggests that interactions with physicians concerning weight may be improving in more recent years, with fewer individuals reporting negative interactions with health-care professionals, and an increase in the sense of satisfaction with medical care received.[21] Despite these findings, more improvement is needed, as evidenced by data that suggest many obese patients still do not routinely seek weight management advice from their physicians.[12]

The manner in which physicians communicate with patients about obesity plays an important role in how patients

process weight-related messages and could affect the efficacy of physician attempts at weight managment. In this study, obese urban African Americans perceived a direct, respectful approach focused on the positives of weight reduction as an effective motivator for weight loss. Prior studies have similarly shown that health counseling that uses positive framing, such as emphasizing the health benefits of weight loss, can increase patient receptivity compared to counseling that is negatively framed, such as focusing on the health risks of remaining obese.[15,22] While it remains unknown if this contextual framing has an impact on the rates of patient implemention of behavioral change for weight loss, it is recognized that physicians' manners in discussing weight appear to affect patient receptiveness to obesity counseling and education, a critical first step in motivating lifestyle change.[23] Moreover, participants in our study expressed a desire for physicians to fully assess patient readiness to address their weight and review prior experiences with weight loss attempts in order to deal with potential obstacles. This finding suggests that increased training and education of physicians to properly assess readiness to change and self-efficacy as suggested by Motivational Interviewing techniques[24,25] may be an effective way to improve patient-provider communication regarding obesity.

In addition to addressing how counseling is delivered, the content of weight management discussions must also be examined. Consistent with prior research, participants in our study focused heavily on the need for physicians to provide more specific and personalized advice. Potter et al. also reported patients prefer explicit instruction on nutrition and diet, weight loss goals, and exercise recommendations rather than a discussion of the health consequences of obesity.[26] While particiants in our study had mixed reactions to the use of scare tactics, no prior studies have exmained patient response to or effectiveness of scare tactics for weight management. The use of scare tactics in public health campaigns remains controversial and generally unaccepted; however, it has been shown to be effective in decreasing smoking rates.[27]

One of the major challenges in improving the management of obesity by primary care providers remains bridging the gap between patient and physician expectations. While patients desire more assistance and specific information from their physicians, physicians have been reported to have low self-perceived confidence in treating obesity and a belief that patients are not motivated enough to lose a significant amount of weight.[10,28,29] Limited reimbursement and time constraints present further barriers to physician counseling.[10,11] Our study findings reinforce the patients' perception that physicians have the knowledge, skills, and time to provide the necessary weight management counseling. It is imperative for physicians to recognize this discrepancy between patient and provider perceptions and expectations regarding weight management as a first step towards addressing it.

The findings from this study have limited generalizabilty. The results presented here are based on focus group data from urban obese African Americans receiving primary care services at an academic health center. The views expressed may not be generalizable to other racial or ethnic groups, or to African Americans residing in or receiving health care in other settings. In addition, all group participants reported prior attempts at weight loss; thus, our findings may differ from African Americans who have not yet attempted to lose weight. Further, no data on educational and income levels were collected. Importantly, approximately 20% of the focus group participants were known to the nurse pracitioner who moderated the discussions; however, only about 10% would identify her as their primary provider. While we acknowlege this may have hindered frank discussion regarding physician behaviors and participant perceptions, it should be noted that the majority of these participants participated in the last focus groups with both genders. No new themes emerged in these groups, and, more importantly, the discussions encompassed a similar range of themes as earlier groups, and participants expressed similar emotional levels during the discussions. Since participant recruitment consisted primarily of physician referral rather than patient self-referral, the potential for selection bias exists. Although physicians may have been more likely to refer patients with whom they have good relationships or those they have counseled on weight management, participants did identify several physician behaviors that were either lacking entirely or not well received. Finally, a substantial body of existing research in this area with which to triangulate the qualitative data is lacking. More research is needed to extend our findings to diverse patient populations and should include the perspectives of patients residing in many geographic areas and receiving care in varying settings, including private and community practices.

In conclusion, the results of our study highlight the need for physicians to be cognizant of the potential unintended consequences of the current techniques they use to counsel African Americans about obesity. Physicians must be aware that their patients may respond unexpectedly if approached in a manner they percieve as disrepectful, condescending, emotionless, or non-supportive. Physicians should minimize if not completely avoid using the word 'obese' in the clinical setting with African Americans and provide more information on clinical measures of excess of weight, including BMI. Further, physicians should discuss the significance of excess weight as it relates to individual health risks. Providers must be cautious when employing scare tactics as a means to promote lifestyle change to achieve weight reduction as not all patients respond well to this technique. Since many of the African-American participants in our study reported prior negative experiences during clincial encounters, physicians should consider counseling approaches that let them remain accessible to patients, offering concrete advice on weight loss goals, diet, excercise, and potential ways to address individual barriers.

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REFERENCES

1. **Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM.** Prevalence of overweight and obesity in the United States, 1999–2004. JAMA. 2006;295(13):1549–55.
2. **Kumanyika SK, Obarzanek E, Stevens VJ, Hebert PR, Whelton PK.** Weight-loss experience of Black and White participants in NHLBI-sponsored clinical trials. Am J Clin Nutr. 1991;53(6 Suppl):1631S–8S.
3. **Wing RR, Anglin K.** Effectiveness of a behavioral weight control program for Blacks and Whites with NIDDM. Diabetes Care. 1996;19(5):409–13.
4. **Parikh M, Lo H, Chang C, Collings D, Fielding G, Ren C.** Comparison of outcomes after laparoscopic adjustable gastric banding in African Americans and Whites. Surg Obes Relat Dis. 2006;2(6):607–10. discussion 610–2.
5. **Anderson WA, Greene GW, Forse RA, Apovian CM, Istfan NW.** Weight loss and health outcomes in African Americans and Whites after gastric bypass surgery. Obesity. 2007;15(6):1455–63.
6. U.S. Preventive Services Task Force. Screening for obesity in adults: Recommendations and rationale. Rockville, MD: Agency for Healthcare Research and Quality;2003.
7. **Sciamanna CN, Tate DF, Lang W, Wing RR.** Who reports receiving advice to lose weight? Results from a multi-state survey. Arch Intern Med. 2000;160(15):2334–9.
8. **Ruser CB, Sanders L, Brescia GR, et al.** Identification and management of overweight and obesity by internal medicine residents. J Gen Intern Med. 2005;20(12):1139–41.
9. **Anis NA, Lee RE, Ellerbeck EF, Nazir N, Greiner KA, Ahluwalia JS.** Direct observation of physician counseling on dietary habits and exercise: Patient, physician, and office correlates. Prev Med. 2004;38 (2):198–202.
10. **Foster GD, Wadden TA, Makris AP, et al.** Primary care physicians' attitudes about obesity and its treatment. Obes Res. 2003;11(10):1168–77.
11. **Alexander SC, Ostbye T, Pollak KI, Gradison M, Bastian LA, Brouwer RJ.** Physicians' beliefs about discussing obesity: Results from focus groups. Am J Health Promot. 2007;21(6):498–500.
12. **Wadden TA, Anderson DA, Foster GD, Bennett A, Steinberg C, Sarwer DB.** Obese women's perceptions of their physicians' weight management attitudes and practices. Arch Fam Med. 2000;9:854–60.
13. **Ruelaz AR, Diefenbach P, Simon B, Lanto A, Arterburn D, Shekelle PG.** Perceived barriers to weight management in primary care: Perspectives of patients and providers. J Gen Intern Med. 2007;22(4):518–22.
14. **Greiner KA, Born W, Hall S, Hou Q, Kimminau KS, Ahluwalia JS.** Discussing weight with obese primary care patients: Physician and patient perceptions. J Gen Intern Med. 2008;23(5):581–7.
15. **Forman-Hoffman V, Little A, Wahls T.** Barriers to obesity management: A pilot study of primary care clinicians. BMC Fam Pract. 2006;7:35.
16. **Wadden TA, Didie E.** What's in a name? Patients' preferred terms for describing obesity. Obes Res. 2003;11(9):1140–6.
17. **Rand CSW, MacGregor AMC.** Morbidly obese patients' perceptions of social discrimination before and after surgery for obesity. South Med J. 1990;83:1390–5.
18. **McAffe L.** Discrimination in medical care. Healthy Weight J. 1997;11:96–7.
19. **Kaminsky J, Gadaleta D.** A study of discrimination within the medical community as viewed by obese patients. Obes Surg. 2002;12:14–18.
20. **Cossrow NHF, Jeffery RW, McGuire MT.** Understanding weight stigmatization: A focus group study. J Nutr Educ. 2001;33(4):208–14.
21. **Anderson DA, Wadden TA.** Bariatric surgery patients' views of their physicians' weight-related attitudes and practices. Obes Res. 2004;12:1587–95.
22. **Rothman AJ, Salovey P.** Shaping perceptions to motivate healthy behavior: the role of message framing. Psychol Bull. 1997;121(1):3–19.
23. **Anderson DA, Wadden TA.** Treating the obese patient. Suggestions for primary care practice. Arch Fam Med. 1999;8(2):156–67.
24. **Emmons KM, Rollnick S.** Motivational interviewing in health care settings: Opportunities and limitations. Am J Prev Med. 2001;20(1):68–74.
25. **Waldrop J.** Behavior change in overweight patients. Motivational interviewing as a primary care intervention. Adv Nurse Pract. 2006;14(8):23–7.
26. **Potter MB, Vu JD, Croughan-Minihane M.** Weight management: what patients want from their primary care physicians. J Fam Pract. 2001;50 (6):513–8.
27. **Hill D, Chapman S, Donovan R.** The return of scare tactics. Tob Control. 1998;7(1):5–8.
28. **Mercer S, Tessier S.** A qualitative study of general practitioners' and practice nurses' attitudes to obesity management in primary care. Health Bull. 2001;59:248–53.
29. **Befort CA, Greiner KA, Hall S, et al.** Weight-related perceptions among patients and physicians. How well do physicians judge patients' motivation to lose weight? J Gen Intern Med. 2006;21:1086–90.

APPENDIX 1

Table 3. Focus Group Guide

How can doctors and health-care providers help encourage you to try to lose weight?
Be supportive (how?)
Tell me two or three specific things to do or not to do
Scare me with all the bad things that can happen if I don't lose weight
Point out all the ways that I hurt or have physical trouble because of my weight
What would you tell your doctor or health-care provider is the best thing he or she could do or say to help you lose weight?
What would you tell your doctor or health-care provider is the worst thing he or she could do or say regarding your weight?
Try to scare you
Not understand your point of view
Not understand how hard it is to lose weight