Roadmaps for Clinical Practice
Case Studies in Disease Prevention and Health Promotion

Assessment and Management of Adult Obesity:
A Primer for Physicians

Evaluating Your Patients for Overweight or Obesity
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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.

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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.
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.
How do I diagnose overweight and obesity?

The first step to diagnosing overweight and obesity is to determine your patients' BMI using weight and height measurements. BMI provides a measure of total body fat based on height and weight that applies to both adult men and women. The BMI can either be calculated using the simple equations shown in Figure 2.1 or determined using a BMI chart. For your convenience, a BMI chart is provided here as Figure 2.2; a laminated BMI chart is also included with this primer.

BMI replaces the previous height–weight terminology (such as percent ideal or desirable body weight) and is a more reliable method for assessment. This method is recommended because it provides an estimate of total body fat and is related to risk of disease.

**Figure 2.1 Determining BMI**

There are two easy ways to determine your patients' BMI:

1. BMI is calculated as weight in kilograms (kg) divided by the square of height in meters (m²).

   \[
   \text{BMI} = \frac{\text{weight (kg)}}{\text{height squared (m}^2)}
   \]

   Using pounds (lb) and inches (in), divide weight in pounds by the square of height in inches. Then multiply the resulting number by 703.

   \[
   \text{BMI} = \frac{\text{weight (lbs) \times 703}}{\text{height squared (in}^2)}
   \]

   or

2. Use a BMI chart (see Figure 2.2 or laminated card).

  * Although BMI can be used to estimate total body fat, it does not distinguish the composition of lean versus fat tissue. For example, a non-obese bodybuilder may have an elevated BMI due to unusual muscularity. By contrast, an older adult may have a normal BMI but may be obese due to an unusually low lean body mass. Other techniques, including skinfold anthropometry and bioelectrical impedance analysis, are available for assessing patients' proportions of lean and fat mass. However, these techniques are not currently recommended for office use.
# Body Mass Index Chart

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Body weight (pounds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>91 96 100 105 110 115</td>
</tr>
<tr>
<td>59</td>
<td>119 124 129 134 138</td>
</tr>
<tr>
<td>60</td>
<td>143 148 153 158 162 167 172 177 181 186</td>
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<tr>
<td>61</td>
<td>191 196 201 205 210 215</td>
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<tr>
<td>62</td>
<td>220 224 229 233 239 244 248 253 258</td>
</tr>
<tr>
<td>63</td>
<td>262 266 271 276 281 286 290 295</td>
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<tr>
<td>64</td>
<td>299 303 308 313 318 323</td>
</tr>
<tr>
<td>65</td>
<td>328 332 337 342 347 352</td>
</tr>
<tr>
<td>66</td>
<td>357 362 367 372 377 382</td>
</tr>
<tr>
<td>67</td>
<td>387 392 397</td>
</tr>
<tr>
<td>68</td>
<td>18.5 – 24.9</td>
</tr>
<tr>
<td>69</td>
<td>25.0 – 30.4</td>
</tr>
<tr>
<td>70</td>
<td>25.0 – 30.4</td>
</tr>
<tr>
<td>71</td>
<td>30.5 – 34.9</td>
</tr>
<tr>
<td>72</td>
<td>30.5 – 34.9</td>
</tr>
<tr>
<td>73</td>
<td>35.0 – 39.9</td>
</tr>
<tr>
<td>74</td>
<td>35.0 – 39.9</td>
</tr>
<tr>
<td>75</td>
<td>40.0 – 44.9</td>
</tr>
<tr>
<td>76</td>
<td>40.0 – 44.9</td>
</tr>
</tbody>
</table>


**Figure 2.2 Body Mass Index Chart**

*Note: BMI values for adults are calculated as weight in pounds divided by height in inches squared.*

---

**Figure 2.3 Classification of Overweight and Obesity by BMI, Waist Circumference, and Associated Disease Risks**

<table>
<thead>
<tr>
<th>Disease risk for Type 2 diabetes, hypertension, and cardiovascular disease</th>
<th>Disease risk for other conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity (mild) 30.0 – 34.9</td>
<td>Increased</td>
</tr>
<tr>
<td>Obesity (moderate) 35.0 – 39.9</td>
<td>Very high</td>
</tr>
<tr>
<td>Obesity (severe) ≥ 40</td>
<td>Extremely high</td>
</tr>
</tbody>
</table>


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**Booklet 2 • Evaluating Your Patients for Overweight or Obesity**

- **BMI (kg/m²)**
- **Waist Circumference, and Associated Disease Risks**
compared to those with normal waist circumferences. In addition, recent data from the National Health and Nutrition Examination Survey, a nationally representative cross-sectional survey of US adults, indicated that within the categories of healthy weight (BMI 18.5–24.9), overweight (BMI 25.0–29.9), and Class I (mild) obesity (BMI 30.0–34.9), adults with high waist circumference values were increasingly likely to have hypertension, diabetes, dyslipidemia, and the metabolic syndrome (see Figure 2.5) compared with those with normal waist circumference values.7

Although the mechanisms by which abdominal and/or visceral obesity lead to increased morbidity and mortality are not fully understood (see Figure 2.5), identification of excess abdominal fat is paramount because it categorically increases disease risk for each BMI class.8

### Why is it important to measure waist circumference?

After determining the BMI of your patients, the next step in evaluation is to measure waist circumference. Instructions for measuring waist circumference can be found in Figure 2.4. It is important to note that waist circumference is not measured at the level of the umbilicus (the “natural” waist), but at the level of the iliac crest.

**Figure 2.4 Measuring Waist Circumference**

Because most practices do not routinely measure waist circumference, it may be helpful for you or your intake nurse to explain why it is being done. A simple explanation, such as the following, usually suffices:

“A waist measurement is an important clue to your current and future health. I’d like you to breathe normally while I take your measurement.”

To measure your patients’ waist circumference:

1. Locate the upper hip bone and the top of the right iliac crest.
2. Place a measuring tape in a horizontal plane around the abdomen at the level of the iliac crest.
3. Ensure that the tape is snug, but does not compress the skin, and is parallel to the floor.
4. Read the measurement at the end of a normal expiration of breath.

It is important to know your patients’ waist circumference because the health risks of overweight and obesity are independently associated with excess abdominal fat.4, 6 Excess abdominal fat is clinically defined as a waist circumference >40 inches (>102 cm) in men and >35 inches (>88 cm) in women (see Figure 2.3). Population studies have shown that people with excess abdominal fat have an excess burden of impaired health and increased cardiovascular risk compared to those with normal waist circumferences. In addition, recent data from the National Health and Nutrition Examination Survey, a nationally representative cross-sectional survey of US adults, indicated that within the categories of healthy weight (BMI 18.5–24.9), overweight (BMI 25.0–29.9), and Class I (mild) obesity (BMI 30.0–34.9), adults with high waist circumference values were increasingly likely to have hypertension, diabetes, dyslipidemia, and the metabolic syndrome (see Figure 2.5) compared with those with normal waist circumference values.7

Although the mechanisms by which abdominal and/or visceral obesity lead to increased morbidity and mortality are not fully understood (see Figure 2.5), identification of excess abdominal fat is paramount because it categorically increases disease risk for each BMI class.

**Figure 2.5 The Metabolic Syndrome**

Excess abdominal fat is one of the clinical features of the metabolic syndrome, also known as insulin resistance syndrome, (metabolic) Syndrome X, dysmetabolic syndrome, and multiple metabolic syndrome.8 In the metabolic syndrome, abdominal obesity presents with concurrent features such as insulin resistance, dyslipidemia (hypertriglyceridemia or low high-density lipoprotein cholesterol levels), hypertension, and impaired glucose tolerance, which together amplify risk for cardiovascular disease beyond the risk for each individual feature.9

According to the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), the metabolic syndrome is defined as having three or more of the features listed in Figure 2.6.8 Under this definition, it is estimated that approximately 24% of US adults have the metabolic syndrome, with a higher prevalence rate among older individuals and Mexican Americans.10

The identification of the metabolic syndrome lends even greater urgency for the management of patient overweight or obesity. Even modest weight reduction and increase in physical activity can significantly decrease the risk of cardiovascular disease through control of the metabolic syndrome.
What health risks are associated with obesity?

The next step in assessing overweight and obesity is to review your patients’ medical, social, and family history for current and potential obesity-related symptoms and diseases. Figure 2.7, which contains a list of obesity-related conditions, can be used as a checklist.

As described in Booklet I, obesity is linked with some of the most prevalent and costly medical problems seen in daily practice. Obesity alone is a risk factor for Type 2 diabetes, hypertension, coronary artery disease, gallbladder disease, osteoarthritis, cancer, and early death. In combination with the metabolic syndrome, it further increases the risk of cardiovascular disease. In sum, obesity affects at least nine organ systems of the body.11

Note that the psychosocial complications of obesity may be as significant as the physical health concerns. Obese people, particularly those with extreme obesity, may experience discrimination and other difficulties in the workplace or in personal relationships, leading to poor self-esteem, social withdrawal, depression, and other mental health problems. In addition, obesity may lower the individual’s perception of general health, while comorbid disorders and their effect on physical function may lower morale.

Both psychosocial and other medical factors contribute to a decline in general health and quality of life. A continuum has been observed between mildly, moderately, and severely obese individuals, with quality of life worsening with increasing body weight and the number of acquired comorbid illnesses.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Defining level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal obesity</td>
<td>Waist circumference</td>
</tr>
<tr>
<td>Men</td>
<td>&gt;40 in (&gt;102 cm)</td>
</tr>
<tr>
<td>Women</td>
<td>&gt;35 in (&gt;88 cm)</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>≥150 mg/dL</td>
</tr>
<tr>
<td>High-density lipoprotein (HDL) cholesterol</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>&lt;40 mg/dL</td>
</tr>
<tr>
<td>Women</td>
<td>&lt;50 mg/dL</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>≥130/≥85 mmHg</td>
</tr>
<tr>
<td>Fasting glucose</td>
<td>110-125 mg/dL (ATP III defines as ≥110)</td>
</tr>
</tbody>
</table>


The American Association of Clinical Endocrinologists and the American College of Endocrinology suggest two additional factors be considered: overweight/obesity (BMI >25) and high 2-hour post-glucose challenge (>140 mg/dL). ACE Guidelines for Glycemic Control. Endocr Pract. 2003;9 (Suppl.):7–13.

Mary’s waist circumference is 36 inches. This, in addition to her triglycerides of 225 mg/dL, fasting glucose of 118 mg/dL, HDL cholesterol of 42 mg/dL, and blood pressure of 134/90, shows that she has the metabolic syndrome. This places her at increased risk of cardiovascular disease.

In reviewing Mary’s history, you identify five obesity-related conditions:

- hypertension
- gastroesophageal reflux disease (GERD)
- impaired glucose tolerance (possible diabetes)
- hypertriglyceridemia
- arthralgia

In addition, specific questions that you ask during the review of systems reveal the following symptoms:

- low self-esteem
- excessive daytime sleepiness
What additional testing is needed?

Based on your patients’ presenting signs and symptoms, perform tests to identify conditions associated with obesity and conditions that may contribute to your patients’ obesity. No single laboratory test or diagnostic evaluation is indicated for all patients with obesity. The specific evaluations performed should be based on presentation of symptoms, risk factors, and index of suspicion.\(^{11}\)

Nonetheless, based on other screening guideline recommendations, most, if not all, patients should have a fasting lipid panel and fasting blood glucose determination at presentation. The physician should also be alert to hypertension, obstructive sleep apnea, and gall-bladder disease, which are commonly associated with obesity. Although rarely a cause of obesity, hypothyroidism and Cushing’s syndrome should be considered in the differential diagnosis for obesity when indicated by patient history. Recommended tests for these and other conditions are outlined in Figure 2.8.

You decide to order additional tests to evaluate Mary’s hypertension and diabetes. When you ask Mary about her excessive daytime sleepiness, she feels that it is due to the fact that she stays up too late every night. She denies snoring, gasping, and choking episodes during sleep and denies awakening with headaches. She admits to decreased energy levels, decreased interest in her recreational activities, and negative feelings about her weight, but states that her mood, overall, is “good.” She feels that her quality of life would improve if she lost weight.
If suspicion of Hypertension (Chobanian et al. 2002)

- Measurement of neck circumference (>17 inches in men, >16 inches in women)
- Polysomnography for oxygen desaturation, apnea, and evidence of complete or near-complete upper airway obstruction
- Ear/nose/throat (ENT) examination for upper airway obstruction
- Blood pressure measurement
- Serum thyroid-stimulating hormone (>5 µU/mL)
- Thyroid uptake test
- TSH receptor antibodies
- Urine free thyroxine index or serum free thyroxine
- T3 resin uptake
- Free T3
- T4
- Ultrasonography with evidence of fat desaturation, apneic and hypopneic events
- Repeatedly elevated measurements of cortisol secretion (urine free cortisol [upper normal 110–138 nmol/d] or late-night salivary cortisol levels) may be needed

Sources

When should treatment for overweight and obesity be pursued?

In selecting the appropriate intervention for your patients, it is helpful to consult the NHLBI’s algorithm for treating overweight and obesity, which is adapted in Figure 2.9. According to the algorithm, patients should pursue weight loss and control of risk factors if:

- BMI is 30 or greater or
- BMI is 25 to 29.9 and they have two or more risk factors or
- Waist circumference is greater than 35 in women or 40 in men and they have two or more risk factors.

For those patients for whom treatment is not indicated, the algorithm recommends strategies for preventing overweight and obesity. In practice, all patients, especially those with a strong family history of risk factors, should be counseled on weight management.

What are the possible causes of obesity?

If treatment is indicated for your patients, begin by determining the most likely cause of your patients’ overweight or obesity. In many cases, overweight and obesity can be attributed to a mismatch between your patients’ lifestyle pattern of diet and physical activity and your patients’ calorie (energy) needs. Societal pressures that expose individuals to high-calorie convenience foods, along with technical advances that promote sedentary behavior, are a common cause of involuntary obesity.

Nonetheless, your patients’ history may suggest other causes of weight gain that warrant further investigation. For example, life events such as marriage, pregnancy, illness, relationship problems, quitting smoking/drinking, starting a new job, or a death in the
family can influence your patients' diet and physical activity patterns or impact weight directly. By completing the Graphing Your Weight Gain chart (see Figure 2.10), you can help your patients identify underlying causes of weight gain.

Although genetic factors may influence eating and physical activity behaviors and therefore susceptibility to weight gain, rarely do they account entirely for a person becoming overweight or obese. Nonetheless, a familial predisposition should be considered if at least one first-degree relative is obese. Reviewing family history is also important because it may provide an opportunity to implement preventive care for other at-risk family members.

Certain medications are known to contribute to overweight and obesity (see Figure 2.11). Drug-induced effects should be suspected when the weight gain coincides with the initiation or dosage increase of a particular medication. If medication is identified as the underlying cause or contributor to overweight or obesity, a medication substitution or change in dosage should be considered whenever possible.

Endocrine disorders are rarely the cause of overweight and obesity. Nonetheless, hypothyroidism, Cushing's syndrome, hypothalamic tumors, and damage to the hypothalamus as a consequence of radiation, infection, or trauma have all been associated with weight gain. Figure 2.8 lists these conditions along with their presentation and diagnostic criteria.

You suggest that Mary complete the chronological history of weight gain chart (Figure 2.10) at home and bring it to her next appointment. In reviewing this chart with her, Mary notes that she maintained a healthy weight as a child, gained 10 pounds in college, and gained an additional 15 pounds during her two pregnancies. Over the past 2 years, she has gained an additional 30 pounds. She attributes this weight gain to poor eating habits and minimal physical activity due to long hours and increased stress at work.

What is the next step in managing overweight or obesity in my patients?

After ruling out medical causes of overweight and obesity, the next step is to talk to your patients about weight loss. The next booklet in this series (Booklet 3: Assessing Readiness and Making Treatment Decisions) will help you get started. Before reading Booklet 3, you may wish to familiarize yourself with patient reimbursement options for obesity treatment (see Figure 2.12), in the event that your patients cite cost as a barrier to weight management.
Patients should be aware that certain weight loss expenses can now be claimed as tax-deductible medical expenses. Some insurance companies have begun to include these expenses in their coverage, as well.

The Internal Revenue Service (IRS) ruling 202-19, passed in April 2002, states that “obesity is medically accepted to be a disease in its own right.” For taxpayers, this means that treatment specifically for obesity — including many commercial weight loss programs — can now be claimed as a medical deduction if prescribed by a physician. Weight loss to improve appearance, general health, or sense of well being is not tax deductible. The IRS also states that health club dues, exercise equipment, nutritional supplements, and diet foods are not deductible.

To be eligible for this deduction, patients must be defined as obese, with a BMI of 30 or more. Individuals who are overweight but not obese can claim weight loss expenses as a deduction if their physician prescribes it as part of their treatment for a weight-related health problem such as heart disease, hypertension, or diabetes.

In addition to IRS benefits, certain employee benefits (e.g., medical savings accounts, flexible spending accounts, and health reimbursement arrangements) that follow IRS guidelines allow patients to seek reimbursement for costs if they meet the weight or medical qualifications to claim weight loss as a deductible expense.

Unfortunately, most managed care and additional insurance companies do not cover expenses related to weight loss. A recent study found that most plans currently promote fitness through Web sites, newsletters, programs related to specific weight-related health problems, and discounts or other financial incentives for fitness center memberships. However, companies have been reluctant to cover obesity treatment because it involves lifestyle changes that require extensive follow-up. With increasing evidence of the high medical costs of obesity, many companies are now beginning to regard obesity coverage as good business practice and may soon begin to adjust their policies accordingly.


If you only have 15 minutes....

- Tell your patient that you are concerned about his/her weight.
  You can initiate this discussion by saying, “I’m concerned about your weight because I think it is causing (or will cause) health problems for you. Do you think that your weight is causing problems for you?”
- Advise your patient to lose weight.
  First ask, “Have you ever tried to lose weight?” Praise your patient’s efforts, and reinforce that weight management through increasing physical activity and watching what one eats is good for health.
- If your patient is interested in weight management, share handouts for him/her to read at home.
  Some handouts that you can share are the Graphing Your Weight Gain chart, the Eating Pattern Questionnaire, and the Weight Loss Questionnaire.
- Remember to follow up: If you give your patient handouts to read at home, be sure to ask him/her about them at the next visit.
- Ask if your patient would like help developing a plan for weight management.
- If your patient is currently not interested in losing weight, continue to educate him/her on the impact of weight on health.
References


Suggested additional reading


People gain weight in different ways — some gain in a progressive upward fashion, others gain in an up and down cyclical fashion, and others after a long period of controlled weight see their weight climb steadily after one inciting event. Commonly, though, most people can relate their changes in weight to different life events. See the examples below.

Please graph your own weight gain. Fill in the life events that you relate to your weight. Take note of your pattern so you can better understand your weight gain, that is, how you got to where you are at today. Thank you for taking the time to complete this chart.
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