

Barriers to Obesity Management in Primary Health-Care

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ABSTRACT

Objective: Obesity management is a complex issue that requires a multifaceted approach, encompassing medical, social, and psychological aspects. The objective of the study was to determine the barriers to obesity management in Turkey.

Methods: This is a descriptive study. The survey of European General Practitioners for their perception, knowledge about obesity, and its treatment was administered randomly to 254 family physicians (FP). The survey consisted of 33 questions, 3 of which were open-ended.

Results: Most of the FPs recognize obesity as a chronic disease (94.9%). Hundred forty-one of them (55.5%) record weight and perform regular follow-up. Fifty-four out of 231 (23.3%) think they need more education in obesity and 159 (62.6%) stated they were not confident and knowledgeable to offer the best obesity care. Considering communication of weight, 194 (75.3%) do not hold discussions on weight with people living with obesity (PwO). Regarding the stigmatization, 66 (26.0%) believe weight management is solely the responsibility of PwO, 115 (45.3%) think PwO lack the will power to lose weight and 89 (35.0%) think their colleagues are biased against PwO. Hundred sixty-two of them (63.8%) believe that prejudice, misunderstanding, and bias in health care hinder obesity diagnosis and treatment.

Conclusion: While the majority of FPs in Turkey recognize obesity as a chronic disease, they still require additional education regarding obesity care. Furthermore, they consider weight bias among FPs to be a substantial obstacle to the diagnosis and treatment of obesity.

Keywords: Obesity, primary care, family physicians, stigma, diagnosis

Introduction

Obesity has become a global pandemic, putting substantial strain on health-care systems around the world.

In many countries, primary care is regarded as the primary health-care component for people living with obesity (PwO).¹ Because primary care systems are already burdened with the burden of multiple health conditions other than obesity, integrating PwO surveillance into the system has long been a challenge.² There are numerous obstacles impeding obesity care, in addition to the primary health-care system's limited capacity. Previous research has highlighted concerns connected to health-care professionals (HCPs), such as their unfamiliarity with obesity care, lack of confidence in managing obesity, fear of offending PwO, and perception of obesity as a personal fault rather than a sickness. Furthermore, factors related to PwO include a lack of trust in health-care options, a lack of motivation, a lack of belief in the success of available treatments, a lack of time HCPs share,³ and a lack of confidence in HCPs for managing obesity.⁴ The issue of self-confidence is closely related to the stigma associated with weight, concerns about disrupting the patient-physician relationship, insufficient training and resources, and skepticism about treatment efficacies.

It has been observed in several studies that HCPs, including primary care physicians, hold negative attitudes toward people with obesity, stigmatizing them with being indolent, lacking motivation and being noncompliant.⁵⁻⁷

Although obesity has been defined as a disease by World Health Organization and many countries have recognized it as a chronic relapsing disease, there is still a huge tendency to consider it as a risk factor.⁸ Global acceptance of obesity as a chronic relapsing disease has been advocated, emphasizing its role in facilitating diagnosis and management. Even a brief

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intervention by a FP has been acceptable to PwO and has resulted in behavior change and weight loss.⁹⁻¹²

Documentation and monitorization of weight, height, body mass index (BMI) and weight circumference (WC) are crucial for diagnosis and management of obesity. European Association for the Study of Obesity (EASO) guidelines recommend determination of BMI to identify people with obesity and perform WC measurement as a surrogate marker for abdominal obesity.¹³ Unfortunately, widespread implementation of this documentation is hindered among most HCPs, including family physicians (FPs).¹⁴

In addition to the inertia in documenting BMI and WC, discussions among FPs and patients about overweight and obesity seem to be considerably rare across the board.^{14,15} A crucial aspect to consider in this regard is the apparent hesitancy among physicians to initiate discussions regarding weight concerns with their patients.^{16,17}

The aim of our study was to define the level of awareness and knowledge about obesity among Turkish FPs, with a focus on identifying major obstacles perceived during patient visits. To achieve this, we planned to implement the survey that EASO developed to determine the perception, knowledge about obesity, and its treatment in European FPs.¹⁸

Materials and Methods

A descriptive study was conducted using a questionnaire to assess the perception and knowledge of Turkish FPs about obesity. The inclusion criteria were limited to currently practicing FPs in Turkey. The questionnaire was delivered to FPs during a National Family Physician Congress in Antalya, Turkey. Participants were randomly selected from FPs working in various cities and institutions using simple random sampling. A total of 275 FPs were asked to complete the questionnaire. Nine of them did not want to participate. The remaining 10 of the questionnaires had missing data and thus were excluded. A total of 254 FPs were included. They were coming from different regions of Turkey. It took around 5-10 minutes for participants to complete the survey. Instructions were provided in the questionnaire and consent form was also provided along with it.

The survey of European General Practitioners for their perception, knowledge about obesity, and its treatment was translated to Turkish with the permission of EASO.¹⁸ The survey consists of 33 questions, 3 of which were open-ended (Supplementary Material 1).

The survey is about the following issues regarding the perceptions of physicians on:

MAIN POINTS

- The majority of Turkish family physicians classify obesity as a chronic condition.
- The majority of Turkish family physicians claim they lack the knowledge and confidence to provide optimal obesity care due to their lack of education in the subject.
- Turkish family physicians appear hesitant to initiate conversations about weight during patient encounters.
- Approximately half of them believe that obese individuals lack the motivation to lose weight.

- a) The FPs' views on their own training and confidence about providing treatment for obesity
- b) Their view of prevention and treatment of obesity and the role of the HCPs in preventing obesity
- c) Their view about obesity being a chronic disease
- d) Their habits in the follow-up of patients with obesity, their tendency to monitor their patient's weight
- e) Their knowledge about the etiology, complications and management options for obesity
- f) Their own therapeutical approach
- g) Their propensity in terms of initiating discussion of weight with PwO
- h) The perceptions of FPs' about stigma toward patients with obesity

The study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of Koç University (approval number 2020.302.IRB3.109), and written informed consent was obtained from all participants.

Statistical Analysis

Statistical analysis was conducted using the Statistical Package for the Social Sciences Statistics software (version 25.0, IBM Copr., Armonk, NY, USA) program. Mainly descriptive analyses were performed using frequency and percentage.

Results

All the participants were native Turkish speakers. Response rates were 100% for all questions. Regarding the questions related to the FPs' views on their own training and confidence about providing treatment for obesity, about 90% (208) of the FPs needed more training and would like more training to be available about obesity. Their views about their care for PwO are as follows: 62.6% (159) of FPs state they are not confident enough to offer the best support to patients due to a lack of knowledge; 58.7% (149) think that FPs generally provide effective advice on losing weight; 92.9% (236) believe all HCPs, including FPs, should play a role in obesity prevention; and only 3.5% (9) stated that they particularly should be playing a major role in preventive measures. The FPs' responses to questions about their perceptions regarding the prevention and treatment of obesity and the role of the HCP in preventing obesity are shown in Table 1.

Of the FPs questioned, 94.9% (241) considered obesity a disease, and 70.9% (180) of them were advised by their relevant health authorities that obesity is a disease. Moreover, 92.1% (234) of Turkish GP's agreed that if obesity was more widely recognized as a disease, it would result in better patient care.

In general, 65.4% (166) of Turkish FPs' spent less than 10 minutes with their patient. Of the total, 29.1% (74) of Turkish FPs have patients with obesity; 55.5% (141) of Turkish FPs keep records of at least some of their patients' weight; and 25.2% (64) never keep records of their patients weight. Among FPs, 61.8% (157) proactively follow-up with their patients who suffer from obesity to monitor their progress in losing weight at every visit, and 0.8% (2) never monitor their patients progress in losing weight.

The most common causes of obesity stated by the FPs were lack of exercise, eating high-fat or high-sugar foods, and eating too much. The stated causes are shown in Figure 1.

Table 1. Responses to the Questions About the Perceptions of Family Physicians' About the Prevention and Treatment of Obesity

Comments	Neither				
	Strongly Disagree	Somewhat Disagree	Agree Nor Disagree	Somewhat Agree	Strongly Agree
More needs to be done to educate the public on the causes and consequences of obesity	182 (71.7%)	41 (16.1%)	4 (16)	4 (16)	23 (%9.0)
More effective treatment of obesity would significantly reduce the burden on healthcare systems	187 (73.6%)	31 (12.2%)	7 (2.8%)	6 (2.4%)	23
More needs to be done to effectively treat people with obesity	168 (66.1%)	52 (20.5%)	5 (2.0%)	7 (2.8%)	22 (8.7%)
More needs to be done to prevent obesity in the first place	184 (72.4%)	34 (13.4%)	6 (2.4%)	7 (2.8%)	23 (9.0%)
The health-care profession needs to play a bigger role in preventing obesity	101 (39.8%)	96 (37.8%)	27 (10.6%)	17 (6.7%)	13 (5.1%)

Of the FPs, 94.5% (240) indicate type 2 diabetes mellitus (DM) as the most serious complication of obesity, followed by cardiac disease 93.3% (237), hypertension 91.3% (232), and sleep apnea 87.0% (221). Considering the role of surgery in alleviating the complications of obesity, 63.0% (160) thought it was effective for obstructive sleep apnea, 55.1% (140) for dyslipidemia, 53.3% (135) for type 2 DM, 46.1% (117) for heart disease, and 26.3% (67) for cancer.

The most commonly available treatments for obesity stated by the FPs were help in planning diets and food intake 92.9% (236), bariatric surgery 70.9% (180), and help in planning physical activity and exercise 66.5% (169). Of the total FPs, 49.6% (126) considered medication availability sufficient in Turkey, and 16.1% (41) stated that herbal medications were used in obesity management in Turkey. For 37% (94) of FPs, diet is the first therapy they suggest to their patients;

for 25.6% (65) diet and exercise should go together; and for 10.6% (27) exercise is enough. Of all the FPs, 80.3% (204) say they only refer patients with obesity to a specialist after they have first tried an exercise or dietary regimen. On average, they referred 31.0% (71) of their patients to specialists.

Of all FPs, 33% (84) occasionally or rarely initiate discussions on weight with PwO, while 75.3% (194) regularly or occasionally do not hold discussions on weight with PwO. The reasons why some Turkish FPs rarely or never discuss weight with their patients are shown in Figure 2.

Of the total, 54.7% (139) say that they give patients with obesity more time for consultation compared with other patients, and 37.8% (96) state that a patient's weight does not affect the amount of time they give people for consultation. Perceptions of FPs about stigma toward patients with obesity are shown in Table 2.

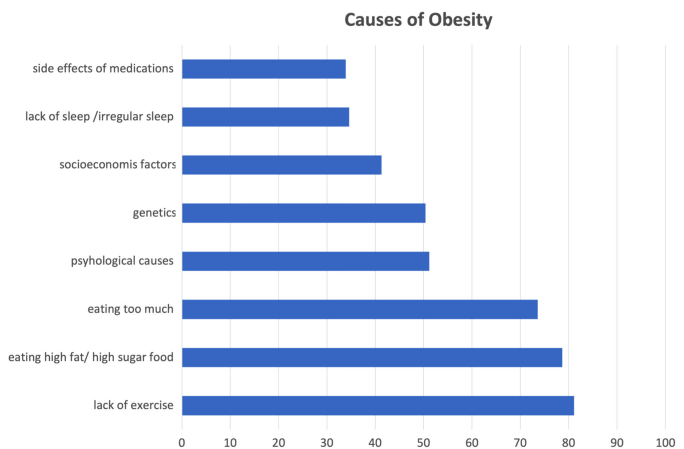


Figure 1. Suggested causes of obesity by Turkish family physicians.

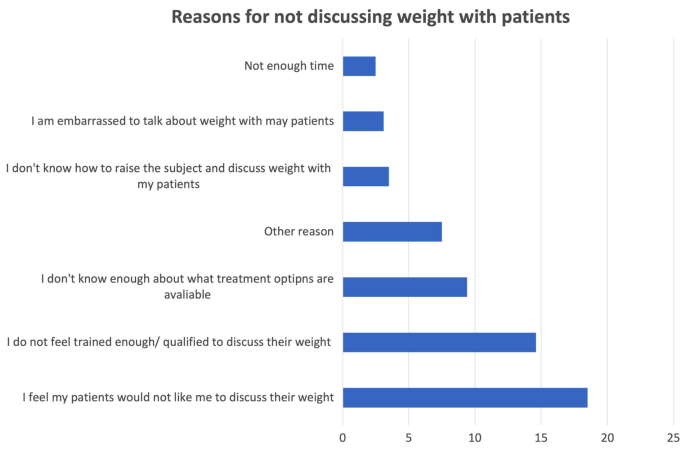


Figure 2. The reason why some Turkish family physicians who rarely or never discuss weight with their patients.

Table 2. Perceptions of Family Physicians About Stigma Toward Patients with Obesity

Comment	Agreeing Response % (n)
Weight management is entirely the responsibility of the patient	26.0% (66)
Their colleagues and peers show a bias against patients with obesity	35.0% (89)
Biases and misconceptions around obesity are common amongst health-care practitioners	48.0% (122)
Biases and misconceptions in health care impede how patients with obesity are diagnosed and cared for	63.8% (162)
People with obesity lack the willpower to lose weight	45.3% (115)
People with obesity don't understand the information that family physicians provide to them	36.6% (93)
People with obesity regain weight because they are lazy and have stopped trying to manage it.	51.2% (130)

Discussion

This study offers a comprehensive exploration of FPs' perspectives on obesity in Turkey, shedding light on their awareness, knowledge levels, and attitudes toward PwO. Since the prevalence of overweight and obesity have increased dramatically, all HCP's, including FPs will be encountering more patients with weight-related issues.¹⁹ Most FPs attending our survey, similar to their European counterparts, believed that it is the role of the health-care profession in preventing obesity.¹⁸ Most thought it was the responsibility of all HCPs, but only a very small percentage indicated that it was the responsibility of only the FP. Notably, around 28% of general practitioners (GPs) in Europe considered GPs to play a role in obesity prevention, reflecting a consistent perspective.¹⁸

The lack of confidency about the complexities of obesity was observed in more than half the FP's. This was far more than that observed in Europe (30%).¹⁸ The need for additional training was a prevalent sentiment among Turkish FPs, aligning with a comparable but smaller percentage in Europe (83%), where the greatest numbers came from the UK and Poland (86%).¹⁸ Most of the Turkish FPs stated they would like more training to be available, as in Europe.¹⁸ Training programs have shown promise in enhancing the self-efficacy and confidence of the FPs in the management of obesity and can result in weight loss in patients.^{9,20}

Turkish FPs overwhelmingly regarded obesity as a disease, surpassing the European average (83%), close to levels in Italy (92%), Spain (95%), and Poland where all the participant FPs considered obesity as a disease.¹⁸

The identified causes of obesity were largely consistent with those reported in Europe, with noteworthy variations, such as a higher consideration of genetics and psychological causes by Turkish FPs.¹⁸ Physicians previously have described obesity a behavioral problem due to physical inactivity and overeating.^{21,22}

In terms of patient management, a significant percentage of Turkish FPs maintained records of patients' weight and proactively monitored their progress, although a quarter did not record patient weight—a higher proportion than observed in Europe.¹⁸ Actually this recording seems to be more than the documentation exercised elsewhere.^{14,23}

There was consensus on the need for more effective treatment of obesity, especially in order to decrease the complications of obesity. The results in the European survey were similar.¹⁸ Most Turkish FPs agreed that type 2 DM, cardiac disease, hypertension, and sleep apnea were the most serious complications of obesity, similar to the responses that European GPs gave.¹⁸

Treatment options and referral practices reflected nuanced variations between Turkey and Europe.¹⁸ Interestingly medication availability was considered more in Turkey (49.6%) compared to Europe (35%).¹⁸ Most of the Turkish FPs state they only refer patients with obesity to a specialist after they have first tried an exercise or dietary regimen. This percentage is 73% in Europe.¹⁸ This was similar to previous findings where physicians chose to give advice on particularly diet and exercise more frequently than just referring the patient to specialty care.²⁴ It has previously been shown that even very brief

interventions in the primary care can result in weight loss, also particularly if referrals to special weight management services can be made as needed.^{9,11,25}

About a third of Turkish FPs occasionally or rarely initiate discussions on weight with patients with obesity. This figure is 82% in Europe.¹⁸ The reasons beyond the reluctance for discussions were the belief that their patients would not like to discuss this issue, lack in self confidence, and belief that they were not trained or qualified enough about the treatment options available. The top 3 reasons in this aspect in the European survey were again the belief that the patients would not like to talk about their weight, second, the belief that it is the responsibility of the patient to talk about weight, and third, lack of time.¹⁸ These barriers are very similar to the ones that have been raised with previous research.^{3,15,26} Accessibility to and regulations of obesity drugs may have impacted the responses related to therapies and the way FPs initiate discussions with their patients indeed, since having treatment options would have increased willingness to discuss about the weight problem and offer treatment options.

The study highlighted potential biases among Turkish FPs, with findings mirroring those in Europe. Approximately, half believed they allocated more time to patients with obesity. About a quarter Turkish FPs considered weight management the sole responsibility of the patient. This percentage 43% in Europe and up to 67% in Germany.¹⁸ About a third believe their colleagues and peers show a bias against patients with obesity, similar to their counterparts in Europe (37%).¹⁸ Additionally, a notable portion acknowledged biases and misconceptions within health care affecting the diagnosis and management of obesity, with similar results (60%) being evident in Europe.¹⁸ A little less than half consider people with obesity as they lack willpower to lose weight, about half believe that they regain weight because they are lazy, and about a third believe these patients do not understand the information FPs give them. These seem to be evident in Europe as well with percentages as 56%, 32%, and 40% in Europe respectively.¹⁸ Our findings and the European findings are consistent with many of the previous research about stigmatized behaviors of the HCPs, like physicians, nurses, psychologists, and medical students against PwO. Previously physicians have been shown to have beliefs like that the people with obesity are lazy, noncompliant, awkward, unattractive and ugly, undisciplined, and have low willpower.^{5,6,22,26}

The limitations of the study is that the demographic data of the participants are missing. Experience level of the FPs, region they work in, and information about the medical school they trained in could not be obtained. Their level of experience, where they work, or whether they have obesity themselves would have affected their responses. Moreover since the surveys were conducted during a meeting, there is the bias that FPs who were more eager about training were the participants of the study.

In conclusion, this study offers valuable insights into the perceptions of Turkish FPs regarding obesity, revealing both shared perspectives with their European counterparts and distinctive nuances. The findings underscore the importance of tailored educational interventions to enhance FPs' knowledge and reduce biases, ultimately contributing to more effective obesity management in Turkey. With this knowledge in hand, as the Turkish Society for the Study of Obesity, we have

planned educational programs about obesity and obesity stigma for FPs and have implemented more effort into establishing more lectures about obesity into the undergraduate medical school programs.

Ethics Committee Approval: This study was approved by Ethics Committee of Koç University (approval no: 2020.302.IRB3.109).

Informed Consent: Written informed consent was obtained from the patients who agreed to take part in the study.

Peer-review: Externally peer-reviewed.

Declaration of Interests: The authors have no conflict of interest to declare.

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Supplementary Material 1. The survey in Turkish.

Obezite Anketi Lütfen aşağıdaki soruları dikkatlice okuyunuz ve size en uygun cevabı işaretleyiniz.

- Obezite sebepleri, sonuçları ve tedavisi hakkında ne kadar eğitime ihtiyacınız olduğunu düşünüyorsunuz?
 - Çok daha fazla eğitim
 - Biraz daha fazla eğitim
 - Aldığım eğitim yeterli
 - Biraz daha az eğitim
 - Çok daha az eğitim
- Şu anda verilen eğitimden daha fazlasının sağlanmasını ister misiniz?
 - Kesinlikle evet
 - Belki
 - Muhtemelen hayır
 - Kesinlikle hayır
- Obezitenin karmaşıklığı hakkında hastanıza en iyi desteği verebilecek kadar yeterli bilgi sahibi olduğunuzdan ne kadar emin misiniz?
- Aşağıdaki ifadelere katılıp katılmadığınızı belirtiniz.
- Sizce pratisyen hekimler kilo vermek ve obeziteyle mücadele konusunda hastalarına ne kadar etkili bilgi veriyor?
 - Çok etkili
 - Kısmen etkili
 - Ne etkili ne etkisiz
 - Kısmen etkisiz
 - Hiç etkili değil
- Tıp fakültesi boyunca obezitenin sebepleri, sonuçları ve tedavisi hakkında eğitime yaklaşık kaç saat ayrılmıştır?
 - Hiç zaman ayrılmadı
 - 4 saatten daha az
 - 4-8 saat arası
 - 9-12 saat arası
 - 13-48 saat arası
 - 48 saatten daha fazla

SORU NO	SORULAR	Kesinlikle Katılmıyorum	Katılmıyorum	Ne katılıyorum ne katılmıyorum	Katılıyorum	Kesinlikle Katılıyorum
1.	Obezitenin sebepleri ve sonuçları hakkında toplumun bilinçlendirilmesi için daha fazla şey yapılmalıdır.					
2.	Obezitenin daha etkili tedavi edilmesi, ilgili komorbiditelerin sağlık sisteminde oluşturduğu yükü önemli ölçüde azaltacaktır.					
3.	Obezite tedavisinin daha etkili olması için daha fazla şey yapılmalıdır.					
4.	Öncelikli olarak obezitenin önlenmesi için daha çok şey yapılmalıdır.					
5.	Kilosunu kontrol etmek hastanın kendi sorumluluğudur.					
6.	Sağlık çalışanı obeziteyi önlemede daha fazla rol almalıdır.					

- Aşağıdakilerden hangisi obeziteyi önlemede daha fazla rol oynamalıdır?
 - Pratisyen hekimler
 - Diğer sağlık çalışanları
 - Pratisyen hekimler dahil tüm sağlık çalışanları
- Bir hastanıza ortalama ne kadar süre ayırıyorsunuz?
 - 15 dakikadan fazla
 - 10-15 dakika arası
 - 10 dakikadan az
- Hastalarla kilo problemini konuşmak için,
 - Konuyu genellikle ilk hastanın açmasını beklerim
 - Konuyu genellikle ilk ben açarım
- Obez hastalarla kilo problemini tartışmak için konuyu ne sıklıkla siz açarsınız?
 - Her zaman
 - Sıklıkla
 - Zaman zaman
 - Nadiren
 - Hiçbir zaman
- Hasta obez olmasına rağmen hastayla kilo problem konusunu açmadığınız zamanlar oluyor mu?
 - Evet, sıklıkla
 - Evet, zaman zaman
 - Hayır, hiçbir zaman
- Hangi hasta grubuyla kilo problemini düzenli olarak tartışırsınız? (Birden fazla şık işaretleyebilirsiniz.)
 - Obez hastalar
 - Fazla kilolu hastalar
 - Obez ya da kilolu olmayan hastalar
- Eğer hastalarınızla kilo problemini nadiren tartışıyorsanız ya da hiçbir zaman tartışmıyorsanız sebebini belirtiniz. (Birden fazla şık işaretleyebilirsiniz.)
 - Bu konuda tartışıp tartışmamak hastanın kendi sorumluluğudur
 - Yeterli zaman yok
 - Var olan tedavi seçenekleri hakkında yeterli bilgim yok
 - Var olan tedavi seçeneklerinin etkili olduğunu gösteren yeterli kanıt yok

- e. Bu konuyu tartışmak için yeterli eğitim almadığımı düşünüyorum
- f. Konuyu nasıl açacağımı bilmiyorum
- g. Hastaların bu konuyu benimle tartışmak istemediğini düşünüyorum
- h. Bu konuyu hastalarım ile tartışmaktan çekiniyorum
- i. Diğer sebepler
14. Hastalarınızın kilo takibinin kaydını tutuyor musunuz?
- a. Evet, tüm hastalarımın
- b. Evet, bazı hastalarımın
- c. Hayır
15. Hastalarınızın yüzde kaçının obez olduğunu düşünüyorsunuz?
16. Obezite bir hastalık mıdır?
- a. Evet
- b. Hayır
- c. Emin değilim
17. Obezitenin tedavi edilebilir bir hastalık olduğu hakkında ilgili bir sağlık otoritesi tarafından bilgilendirildiniz mi?
- a. Evet
- b. Hayır
- c. Emin değilim
- d. Obezite hakkında hiç bilgilendirilmedim
18. Obezitenin daha çok hekim tarafından hastalık olarak kabul edilmesi sağlık çalışanlarının hastalara daha iyi bir tedavi sunmalarını sağlayabilir mi?
- a. Evet
- b. Hayır
19. Kilolu olmak günümüzde normal olarak kabul edildiği için hastalarım obez oldukları için endişe duymuyor.
- a. Katılıyorum
- b. Katılmıyorum
20. Obez hastalarımın büyük çoğunluğu hasta olduklarını düşünmüyor.
- a. Katılıyorum
- b. Katılmıyorum
21. Ülkenizdeki sağlık sorunları arasında obezite ilk beş içerisinde kaçınıcı sırada yer almaktadır?
22. Aşağıdakilerden hangisi/hangileri obezitenin en ciddi komplikasyonlarından? (Birden fazla şık işaretleyebilirsiniz.)
23. Aşağıdakilerden hangisi/hangileri obezitenin en yaygın sebeplerindendir?
- a. Genetik
- b. Çok sık yemek yemek
- c. Çok fazla yemek yemek
- d. Çok yağlı/şekerli yemek
- e. Yeterli egzersiz yapmamak
- f. Sosyo-ekonomik sebepler
- g. Psikolojik sebepler
- h. Uykusuzluk/düzensiz uyku
- i. İlaçların yan etkisi
24. Aşağıdaki obezite tedavilerinden hangileri çalıştığınız bölgede mevcuttur?
- a. Bariatrik cerrahi (ör. sleeve gastrektomi, gastrik bypass)
- b. Diyet ve beslenme planlamasında destek
- c. Fiziksel aktivite ve egzersiz planlamasında destek
- d. Bilişsel davranış terapisi
- e. İlaç (ör. sibutramine)
- f. Bitkisel ilaç
25. Obez hastalarınız aşağıdaki tedavilerden hangilerini almaktadır?
- a. Bariatrik cerrahi
- b. Diyet ve beslenme planlamasında destek
- c. Fiziksel aktivite ve egzersiz planlamasında destek
- d. Bilişsel davranış terapisi
- e. İlaç (ör. sibutramine, phentermine)
- f. Bitkisel ilaç
- g. Diğer
26. Aşağıdaki obezite tedavi seçeneklerini etkinlikleri konusunda değerlendiriniz.

SORULAR	Çok etkili	Etkili	Az Etkili	Etkisiz	Bilmiyorum
1. Bariatrik cerrahi (ör. Sleeve gastrektomi, gastrik bypass)					
2. Diyet ve beslenme planlamasında destek					
3. Fiziksel aktivite ve egzersiz planlamasında destek					
4. Bilişsel davranış terapisi					
5. İlaç (ör. sibutramine, phentermine)					
6. Bitkisel ilaç					

27. Obezitenin cerrahi tedavisinin, aşağıdaki komplikasyonları düzeltmede yüzde kaç başarılı olduğunu düşünüyorsunuz. Tek tek değerlendiriniz.
- a. Tip 2 diyabet _____
- b. Kalp hastalığı _____
- c. Dislipidemi _____
- d. Obstrüktif uyku apnesi _____
- e. Kanser _____

28. Obezite tedavisinde ilk olarak neyi önerirsiniz?
- Egzersiz
 - Diyet
 - Bilişsel davranış terapisi
 - İlaç
 - Cerrahi
 - Kilo vermelerini öneririm ama yöntemini çoğunlukla hastaya bırakırım
29. Obez hastaları hangi aşamada bir uzmana yönlendirirsiniz?
- Obezitenin ilk belirtisinde
 - Diyet ve egzersiz denedikten sonra
 - İlaç tedavisini denedikten sonra
 - Bir uzmana yönlendirmem
30. Obez hastalarınızın yüzde kaçını bir uzmana yönlendirirsiniz?
31. Obez hastalarınızın kilo verme sürecini ne sıklıkla takip edersiniz?
- Her randevuda
 - Bazen
 - Sadece hasta konusunu açarsa
 - Hiçbir zaman
32. Obez hastalarınıza diğer hastalarınızdan daha fazla mı daha az mı süre ayırırsınız?
- Daha fazla zaman ayırım
 - Daha az zaman ayırım
 - Hastanın kilosu ona ayırdığım zamanı etkilemez

33. Lütfen aşağıdaki ifadelere katılıp katılmadığınızı belirtiniz.

SORU NO	SORULAR	Katılıyorum	Katılmıyorum
1.	Kilo kontrolünün tamamiyle hastanın kişisel sorumluluğu olduğunu düşünüyorum.		
2.	Meslektaşlarımdan obez hastalara karşı önyargılı olduğunu düşünüyorum.		
3.	Sağlık çalışanları arasında obezite hakkında önyargının ve yanlış bilgilendirilmenin yaygın olduğunu düşünüyorum.		
4.	Obezite hakkındaki önyargıların ve yanlış bilgilerin obezitenin tanısını ve tedavisini engellediğini düşünüyorum.		
5.	Obez hastaların kilo verme iradesinden yoksun olduklarını düşünüyorum.		
6.	Obez hastaların verdiğimiz bilgileri anlamadığını düşünüyorum.		
7.	Obez hastaların tembel olduklarını ve çabalamayı bıraktıkları için verdikleri kiloları geri aldıklarını düşünüyorum.		