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Perceptions of anti-obesity medications among people with obesity and healthcare providers in the US: Findings from the OBSERVE Study

Lee M. Kaplan[1] | Kimberly Gudzune[2] | Jamy Ard[3] | Rekha Kumar[4] | Nadia N. Ahmad[5] | Hong Kan[5] | Tracy J. Sims[5] | Jiat Ling Poon[5] | Kristen King-Concialdi[6] | Kathleen Beusterien[6] | Sheila Drakeley[6] | Julia P. Dunn[5] | Scott Kahan[7] | on behalf of the OBSERVE Study

[1]Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA

[2]Johns Hopkins University School of Medicine, Baltimore, Maryland, USA

[3]Wake Forest School of Medicine, Winston-Salem, North Carolina, USA

[4]Weill Cornell Medical College, New York, New York, USA

[5]Eli Lilly and Company, Indianapolis, Indiana, USA

[6]Oracle Life Sciences, Austin, Texas, USA

[7]George Washington University School of Medicine, Washington, District of Columbia, USA

Correspondence

Julia P. Dunn, Cardiometabolic Health Global Medical Affairs, Eli Lilly and Company, Lilly Corporate Center, 893 S Delaware St, Indianapolis, IN 46285, USA.
Email: dunn_julia@lilly.com

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Eli Lilly and Company

Abstract

Objective: The objective of this study was to understand the perceptions of and drivers/barriers to antiobesity medication (AOM) use among people with obesity (PwO) and health care providers (HCPs) in the United States.

Methods: In 2022, PwO and HCPs completed cross-sectional surveys that included questions on perceptions of obesity management and AOMs. Data were analyzed using descriptive statistics.

Results: Survey participants (1007 PwO and 474 HCPs) emphasized the effectiveness of lifestyle change and the patient's responsibility to address obesity. PwO reported a willingness to take newly approved AOMs long term. HCPs believed that their patients would adhere to AOMs long term if they experienced success. Both PwO and HCPs perceived an increased effectiveness of a multimodal approach to combining AOMs with HCP-guided lifestyle intervention. Potential barriers to long-term use of AOMs for both groups included concerns regarding long-term side effects and outcomes, costs and insurance coverage, and perception of AOMs that do not align with treatment of a chronic disease.

Conclusions: PwO and HCPs are interested in new AOM options, but educational gaps remain as a barrier to recommended multimodal chronic care. Ongoing education that includes the known effectiveness and safety data of newer AOMs and pending outcome trials could improve shared decision-making in obesity care.

INTRODUCTION

The established negative health impact of the US obesity endemic [1, 2] necessitates the implementation of effective, scalable treatments. Guideline-recommended treatment options for obesity include a combination of lifestyle interventions, pharmacotherapy, and/or metabolic and bariatric surgery [3]. However, previous research has found that less than 1% of people with obesity (PwO) in the United States used antiobesity medications (AOMs) between 2015 and 2018 [4]. Recently, there have been

considerable advances in pharmacotherapy for obesity, with multiple new AOMs approved by the Food and Drug Administration (FDA) for long-term treatment of this chronic disease [5]. Advancements in the understanding of the pathophysiology of obesity and the effectiveness of new and emerging AOMs are ushering in a modern era of obesity care [6]. Despite guideline recommendations for multimodal obesity care, the low use of AOMs remains a significant barrier for patients. Poor insurance coverage and high costs are major factors limiting access to these treatments [7, 8]. Additionally, some health care providers (HCPs) may be reluctant to prescribe AOMs due to limited clinical experience and knowledge gaps [9, 10]. When HCPs are hesitant to prescribe AOMs, PwO may remain unaware of pharmacotherapy options, further hindering their access to appropriate care [10].

Given the substantial health care and societal burden of obesity and rapidly evolving treatment landscape, there is an increasing need to adopt pharmacotherapy as a scalable component of evidence-based multimodal obesity management [11]. However, existing perceptions regarding obesity and its treatment among PwO and HCPs may continue to impede optimal management of the disease. Therefore, the present study aimed to elucidate current perceptions of obesity and obesity treatment, including AOMs and potential drivers and barriers to AOM use, among PwO and HCPs in the United States.

Study Importance

What is already known?

- Advances in the understanding of the pathophysiology of obesity and development of new antiobesity medications (AOMs) are fostering a new era in obesity treatment.
- Shared decision-making has historically been underused in obesity care.

What does this study add?

- Discordant responses between people with obesity (PwO) and health care providers (HCPs) to patient–provider interactions appeared to stem from the perception that the patient's responsibility to implement lifestyle changes is central to treating obesity.
- Both PwO and HCPs were interested in new AOM options and believed that AOMs are most effective when combined with lifestyle changes guided by HCPs.

How might these results change the direction of research or the focus of clinical practice?

- Education on the known effectiveness and safety data with further research on the long-term effects of new AOMs could improve obesity care by elevating shared decision-making between HCPs and PwO.

METHODS

As part of the US OBSERVE (i.e., PerceptiOns, Barriers, and OpportunitieS for Anti-obEsity Medications in Obesity CaRe: A SurVEy of Patients, Providers, and Employers) study, PwO and HCPs who managed care for PwO completed separate but complementary online surveys. Data collection spanned from May to June 2022 for PwO and from May to December 2022 for HCPs.

Study participants, i.e., both PwO and HCPs, were recruited from the general population and HCP survey panels managed by All Global Circle, respectively. HCP recruitment materials indicated that the survey focused on "obesity treatments" or "prescription antiobesity medicines," whereas PwO invitations simply stated that a new survey was available. Eligible participants provided their informed consent electronically and received a fair market value incentive for their time. Survey content was based on current literature at the time of research design and came from exploratory qualitative interviews with PwO and HCPs to understand drivers and barriers to AOM use using the Sense-Think-ACT-Relate (STAR) framework [12]. AOMs were referred to as "prescription medications for weight loss" in the PwO survey and as "antiobesity medications" in the HCP survey. Weight reduction was referred to as "weight loss" in both the PwO and HCP surveys. The study received an "Exemption" determination from Sterling institutional review board (identifier #9434).

Eligibility criteria

PwO

US adults (aged ≥18 years) with overweight (27 ≤ body mass index [BMI] < 30 kg/m^2) and at least one obesity-related complications (e.g., type 2 diabetes, cardiovascular disease, hyperlipidemia) or obesity (BMI ≥ 30 kg/m^2) were invited to participate. For Asian participants, overweight was defined as BMI of 23 to 27.4 kg/m^2 and obesity as BMI ≥ 27.5 kg/m^2 [1]. Quotas (i.e., for age, sex, race and ethnicity, and region) were set to assemble a broad sample of US adults with overweight and obesity [13]. Individuals employed as HCPs were excluded.

HCPs

Physicians, physician associates (PAs), and nurse practitioners (NPs) were invited to participate if they had at least 3 years of clinical experience or post-training practice, spent at least 60% of their time in direct outpatient care, and saw at least 100 patients in a typical month (pre-pandemic), with at least 10% of their patients having obesity. Physicians were required to be board-certified or board-eligible and

TABLE 1 Characteristics of participating PwO.

	PwO ($N = 1007$)
Age, median (IQR)	47 (35.0–60.0)
Gender, *n* (%)	
Male	357 (35.5)
Female	640 (63.6)
Other (nonbinary, gender-fluid, genderqueer, etc., or prefer not to answer)	10 (1.0)
Race, *n* (%)	
White	547 (54.3)
Black or African American	333 (33.1)
Asian	79 (7.8)
Native Hawaiian or other Pacific Islander	8 (0.8)
American Indian or Alaskan Native	51 (5.1)
Other race or origin	64 (6.4)
Prefer not to answer	6 (0.6)
Hispanic or Latino/a/x, *n* (%)	154 (15.3)
BMI, mean (SD), kg/m^2	35.9 (7.2)
Obesity classification, *n* (%)[a]	
Overweight: BMI 25.0–<30.0	140 (13.9)
Obesity class I: BMI 30.0–<35.0	349 (34.7)
Obesity class II: BMI 35.0–<40.0	216 (21.4)
Obesity class III: BMI 40.0+	234 (23.2)
Asian, overweight	16 (1.6)
Asian, obesity	52 (5.2)
Education, *n* (%)	
Some high school or less, high school graduate or equivalent	238 (23.7)
Associate degree or technical school graduate or less	456 (45.3)
Undergraduate 4-y degree	211 (21.0)
Graduate school	100 (9.9)
Prefer not to answer	2 (0.2)
Primary health insurance, *n* (%)	
Commercial (including plans purchased through the State Health Exchange)	445 (44.2)
Medicaid	173 (17.2)
Medicare (with or without additional coverage)	254 (25.2)
VA/CHAMPVA/TRICARE/other	37 (3.7)
No insurance/not sure	98 (9.7)
Socioeconomic status[b], *n* (%)	
Low socioeconomic status	407 (40.4)
Mid-high socioeconomic status/other	600 (59.6)
Experience using any prescription medications to manage weight, *n* (%)	
Never	801 (79.5)
Not now but in the past	156 (15.5)
Currently taking	42 (4.2)
I do not remember	8 (0.8)
Number of weight-reduction methods ever used, median (IQR)	6 (3.0–8.0)

Abbreviations: CHAMPVA, Civilian Health and Medical Program of the Department of Veterans Affairs; PwO, people with obesity; VA, Veterans Affairs.

[a]Estimated from self-reported weight and height.

[b]Low socioeconomic status: Total annual household income before taxes less than $29,999 or Medicaid insurance coverage; Mid-high socioeconomic status/other: total annual household income before taxes $30,000 and above or not Medicare Advantage insurance coverage.

specializing in general practice or family medicine, internal medicine, obstetrics and gynecology, obesity or bariatric medicine or weight management, bariatric surgery, endocrinology, cardiology, gastroenterology or hepatology, or psychiatry. PAs and NPs were eligible if they practiced in general practice or family medicine, internal medicine, obesity medicine, or bariatric surgery.

Measures

For PwO, clinical interactions with HCPs regarding weight were examined. Participants' understanding of obesity as a disease and their perception of how it should be treated were included in the survey. Various weight-reduction methods and treatment experience factors, including their thoughts on maintaining the weight reduction long term, were investigated. Additionally, participants' knowledge and attitudes toward prescription AOMs and their experience and discussion with HCPs regarding AOMs were examined by the survey.

For HCPs, their clinical approach to obesity and beliefs on obesity were investigated. Similar to PwO, their interactions with PwO focusing on obesity and weight management were examined. HCPs' perspectives on AOMs, as well as their experience with prescription weight management or AOMs, were also evaluated by the survey.

Statistical analyses

Study variables were summarized using descriptive statistics. Categorical variables were presented as frequencies and percentages and continuous variables as means (SD) or medians (IQR). Results for Likert-type five-point scales were reported after combining either the first two or last two scale responses. For example, "Strongly agree" and "Agree" were combined to represent the percentage of participants who agreed with questionnaire items, and "Quite a bit" and "Very much" were combined to represent the degree to which participants believed questionnaire items. Statistical analyses were conducted using R version 4.2.0 or newer (R Project for Statistical Computing).

RESULTS

Overall, 1007 PwO were included in the analyses (Table 1). The mean-BMI of PwO was 35.9 (SD 7.2) kg/m^2, and the mean age was 47.3 (SD 15.2) years. PwO were represented across all four US regions, with 41.9% living in the South. A median of six different weight-reduction methods, mostly related to lifestyle changes, were reported by PwO, with about one-third of PwO (29.5%) having tried eight or more methods (Supplemental Table S4).

TABLE 2 Characteristics of participating HCPs.

	HCPs ($N = 474$)
Age, *n* (%)	
<35 y	33 (7.0)
35–44 y	106 (22.4)
45–54 y	138 (29.1)
55–64 y	126 (26.6)
>65 y	62 (13.1)
Prefer not to answer	9 (1.9)
Gender, *n* (%)	
Male	323 (68.1)
Female	131 (27.6)
Other (nonbinary, gender-fluid, genderqueer, etc.)	2 (0.4)
Prefer not to answer	18 (3.8)
Race (select all that apply), *n* (%)	
White	331 (69.8)
Black or African American	8 (1.7)
Asian	92 (19.4)
Native Hawaiian or other Pacific Islander	3 (0.6)
American Indian or Alaskan Native	1 (0.2)
Some other race or origin	12 (2.5)
Prefer not to answer	35 (7.4)
Ethnicity, *n* (%)	
Hispanic or Latino/a/x	25 (5.3)
Not Hispanic or Latino/a/x	399 (84.2)
Prefer not to answer	50 (10.5)
Among total HCPs ($N = 474$), *n* (%)	
Physician	424 (89.5)
PA	40 (8.4)
NP	10 (2.1)
Primary medical specialty of HCPs ($n = 474$)[a], *n* (%)	
General practice/family medicine	90 (19.0)
Internal medicine	81 (17.1)
Obesity medicine bariatric medicine/weight management	70 (14.8)
Cardiology	47 (9.9)
Bariatric surgery	50 (10.5)
Endocrinology	45 (9.5)
Psychiatry	31 (6.5)
Obstetrics/gynecology	30 (6.3)
Gastroenterology/hepatology	30 (6.3)
Experience prescribing any prescription medications to manage weight, *n* (%)	
Never prescribed	23 (4.9)
Previously prescribed	17 (3.6)
Occasionally prescribe	113 (23.8)
Regularly prescribe	321 (67.7)

Abbreviations: HCP, health care provider; PA, physician associate; NP, nurse practitioner.
[a]PA/NP specialty: General practice/family medicine ($n = 14$), internal medicine ($n = 11$), obesity medicine/bariatric medicine/weight management ($n = 22$), bariatric surgery ($n = 3$).

Overall, 474 HCPs were included in the analyses (Table 2). The HCP sample consisted of physicians (89.5%) and NPs/PAs (10.5%). Physicians and NPs/PAs had a mean (SD) of 19.1 (9.0) and 10.8 (6.1) years in practice, respectively. On average, HCPs spent 89.4% of their clinical time in direct outpatient care. Notably, 42.9% of physicians considered themselves "obesity medicine specialists"; 9.2% were certified by the American Board of Obesity Medicine (ABOM), and 24.1% planned for ABOM certification in the future.

Patient–provider interactions regarding obesity

Both PwO and HCPs rated the individual with obesity as having the greatest responsibility for managing obesity (mean [SD], 62.1 [27.3] and 50.1 [22.5] points, respectively) when allocating 100 points across five different stakeholder groups (Figure 1). Both groups ranked HCPs as second most responsible, with HCPs allocating themselves more responsibility than PwO (mean [SD], 21.1 [13.8] vs. 13.7 [12.6] points, respectively). Most PwO (70.2%) reported that it would be helpful to have their HCPs involved in their weight management. In contrast, only one-half of HCPs (49.6%) believed that their patients with obesity wanted to receive their advice regarding obesity or weight management.

Discord occurred between PwO and HCP responses to questions on patient–provider interactions regarding obesity and its treatment. Although most HCPs (87.3%) responded that they regularly initiate conversations with patients regarding weight, 43.0% preferred to discuss obesity-related complications rather than obesity directly to avoid making their patients feel uncomfortable. Whereas HCPs reported that they "often" or "always" (69.2%) set goals for their patients with obesity, almost one-half of HCPs (45.8%) reported that PwO do not adhere to the recommended weight-management treatment plan. In contrast, three-quarters

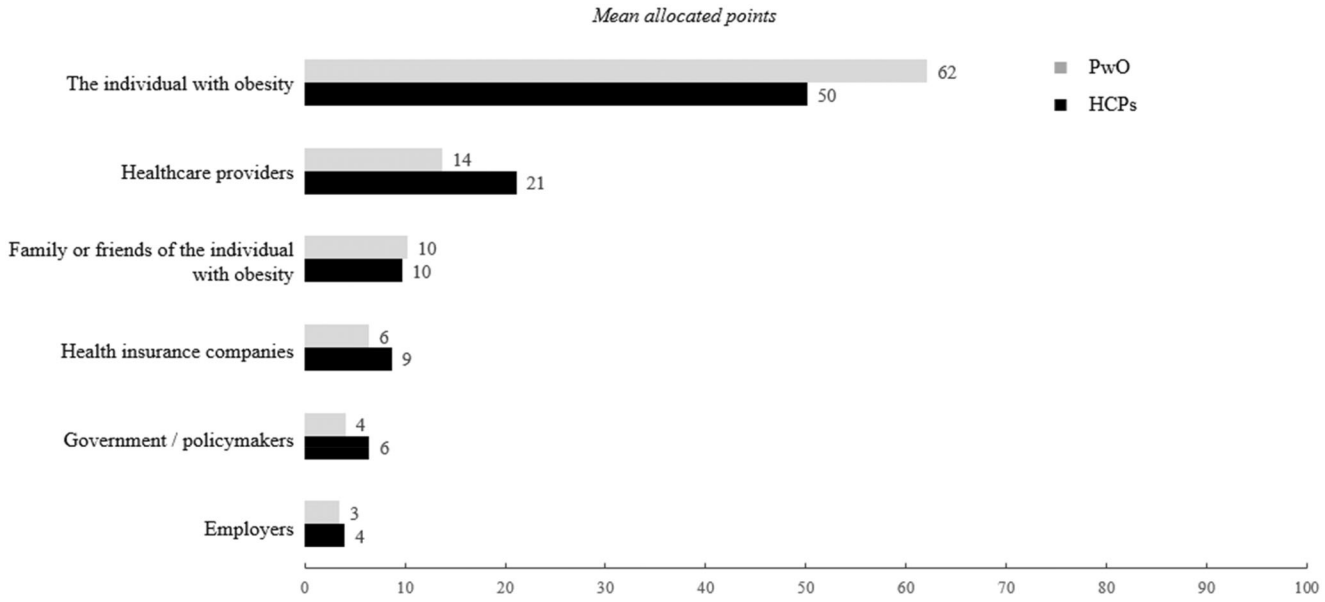

FIGURE 1 Perceived level of responsibility for managing obesity across people with obesity (PwO) and health care providers (HCPs). Question: Please allocate 100 points across each group below to indicate the relative level of responsibility you believe each group below has in managing obesity for an individual with obesity. The more points you assign means more responsibility. Your total should equal 100.

(74.3%) of PwO indicated that their HCPs do not discuss weight management or do not set goals. Furthermore, less than one-quarter of PwO (22.9%) reported that their HCPs set achievable weight-reduction goals.

Although more than one-half of HCPs (58.9%) reported that they enjoy treating patients with obesity, a similar proportion reported that obesity is more complex than treating other chronic conditions (61.0%) and that treating obesity is frustrating (56.9%). Notably, 45.1% of HCPs reported not having enough time to counsel patients with obesity, and more than one-half (58.6%) saw prior authorizations as a barrier. Almost one-half (48.5%) of HCPs also reported difficulty being reimbursed for the visit when treating patients for obesity. More than one-half of HCPs (63.5%) agreed that obesity often requires treatment with prescription medications for effective management, in contrast to 90.9% of HCPs agreeing to that same statement for type 2 diabetes and 92.9% for hypertension.

Perceptions of obesity management

Greater proportions of HCPs than PwO agreed that factors including genetics, psychological, behavioral, cultural, and aspects related to social determinants of health may prevent PwO from maintaining long-term weight reduction, indicating a greater understanding of the multifactorial etiology of obesity among HCPs (Figure 2). Despite this, the majority of HCPs (68.1%) agreed that AOMs, surgery, or other adjunct medical treatment should only be initiated after PwO fail to lose weight via lifestyle changes.

Prior AOM experience

About one in five PwO (19.7%) had experience with prescription AOMs, with 4.2% currently taking AOMs. Among these AOM-experienced PwO, 37.9% used AOMs approved for short-term use, 22.2% used AOMs approved for chronic weight management, 33.3% used AOMs withdrawn from the US market owing to safety concerns, and 6.1% used other prescriptions. Among the ~80% AOM-naïve PwO, 65.8% were unaware of any FDA-approved prescription medications for weight reduction. With respect to HCPs, nearly two-thirds (63.7%) reported prescribing currently available short-term AOMs, most (85.4%) had prescribed AOMs approved for chronic weight management, and about one-half (54.9%) had prescribed AOMs that have been withdrawn from the US market.

Primary reasons for AOM discontinuation were similar among PwO and HCPs: side effects (13.5% and 26.6%, respectively) and costs/lack insurance coverage (11.6% and 11.2%, respectively). About one-tenth (10.5%) of PwO who discontinued AOMs noted that it was because their HCPs recommended discontinuation. Additional reasons reported by HCPs were patient requests to stop (13.5%) and medication interactions (12.0%).

Perceptions of AOMs

Regarding long-term outcomes, more than one-half of PwO (56.9%) agreed that AOMs could improve or prevent "weight-related health conditions"; about one-half (51.8%) agreed that AOMs could play an important role in supporting long-term weight management (≥2 years). More than one-half of HCPs (58.0%) agreed that AOMs

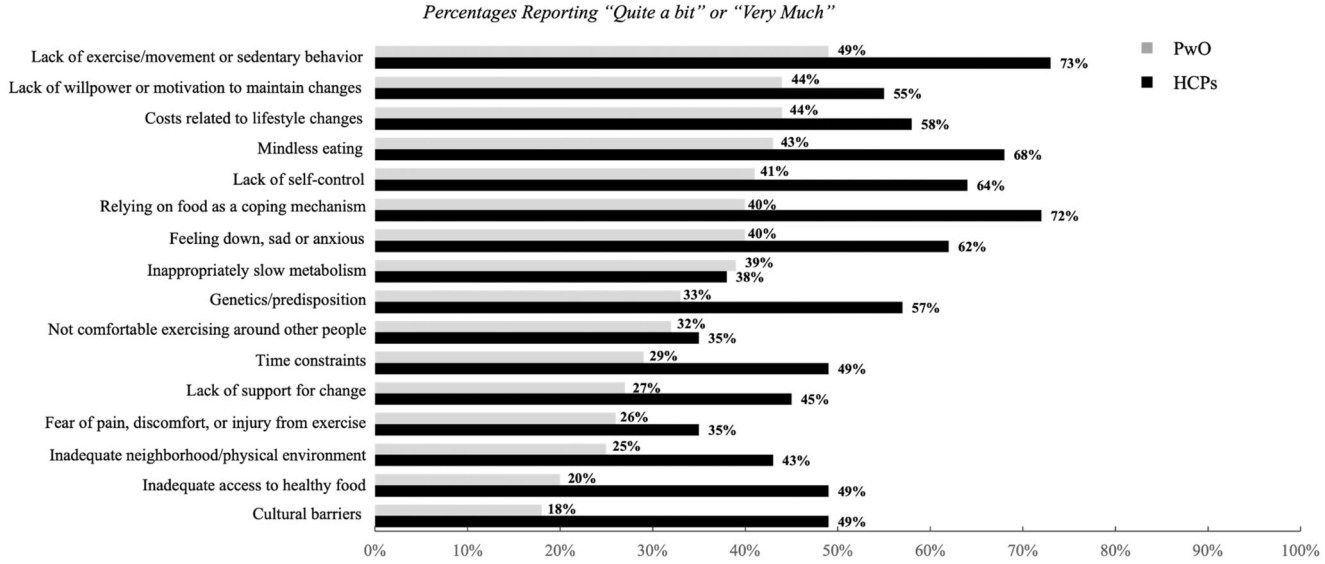

FIGURE 2 Perceived factors that prevent people with obesity (PwO) from successfully maintaining weight reduction long term: PwO and health care provider (HCP) ratings. Question for PwO: To what extent does each of the following items prevent you from successfully keeping weight off over the long term (at least 2 years)? Question for HCPs: To what extent do the following contribute to the inability to maintain weight loss among your patients with obesity? Answer Key: Not at all, A little bit, Moderately, Quite a bit, or Very much. Quite a bit and Very much data are reported together.

are effective in helping a patient maintain weight reduction over time. In contrast, many HCPs and PwO held perceptions that AOMs are for short-term use. Specifically, 63.1% of PwO and 73.2% of HCPs agreed that AOMs can help "kick-start" weight-reduction efforts. Almost one-half of both PwO (43.7%) and HCPs (42.8%) agreed that AOMs are only a short-term solution. In accordance with the perception that AOMs are preferred for short-term weight management, 60.1% of PwO held the perception that it may be possible for AOMs to help them make long-term lifestyle changes that continue to last even after they discontinue the medication.

When ranking effectiveness of the five modalities (i.e., AOMs, bariatric surgery, lifestyle counseling, behavior counseling, diet or change in eating habits, and over-the-counter medications or supplements) on long-term (≥2 years) weight reduction, HCPs ranked AOMs (36.3%) similar to bariatric surgery (38.4%), and PwO ranked AOMs higher (23.3%) than bariatric surgery (17.5%; Figure 3). A substantially higher proportion of HCPs, compared to PwO, ranked over-the-counter medications or supplements as the least-effective option (82.5% vs. 51.2%). Both groups perceived effectiveness of maintaining weight reduction long term (≥2 years) to be more than doubled when comparing AOMs alone versus AOMs combined with self-directed lifestyle changes (from 25.2% to 53.9% for PwO and from 25.5% to 58.6% for HCPs) or with HCP-guided lifestyle changes (from 25.2% to 60.6% for PwO and from 25.5% to 68.1% for HCPs).

Willingness to use newly approved AOMs

Most HCPs (78.3%) were willing to recommend a new FDA-approved AOM, and almost one-half of PwO (49.9%) reported being likely to try a new FDA-approved prescription to manage their weight. Moreover, almost one-half of PwO (47.0%) were willing to use a new AOM intended to be taken long term (≥2 years), and most HCPs (76.8%) agreed that their patients with obesity would adhere to taking a new AOM long term (≥2 years) if they were satisfied with the weight reduction achieved.

Over three-quarters of HCPs reported that the following factors would increase their willingness to recommend a hypothetical newly approved AOM: insurance coverage (86.1%), potential to address other obesity-related complications (83.8%), ability to reduce appetite (77.8%), wide prescription by other HCPs (77.4%), and recommendation from an obesity medicine specialist (77.0%). Similar trends were observed among PwO, but fewer PwO were positively influenced by these factors compared to HCPs. The most influential factors for PwO were as follows: AOMs being recommended by an obesity medicine specialist (74.8%) or by their primary care provider (71.8%), insurance coverage of costs (68.3%), and the potential to address obesity-related complications (68.0%; Figure 4). More than double the proportion of HCPs considered AOMs that increased metabolic rate without being a stimulant as favorable (74.3%) compared with AOMs that are a stimulant (35.2%). PwO responded with less distinction between these two AOM options (67.7% vs. 54.4%, respectively).

When questioned regarding concerns with new FDA-approved prescription AOMs, medication cost was the predominant concern for both groups (63.1% of PwO and 67.7% of HCPs). Both groups also had similar levels of concern for long-term side effects (57.5% of PwO and 56.8% of HCPs), negative impact on health and health conditions (56.3% of PwO and 58.8% of HCPs), and possible

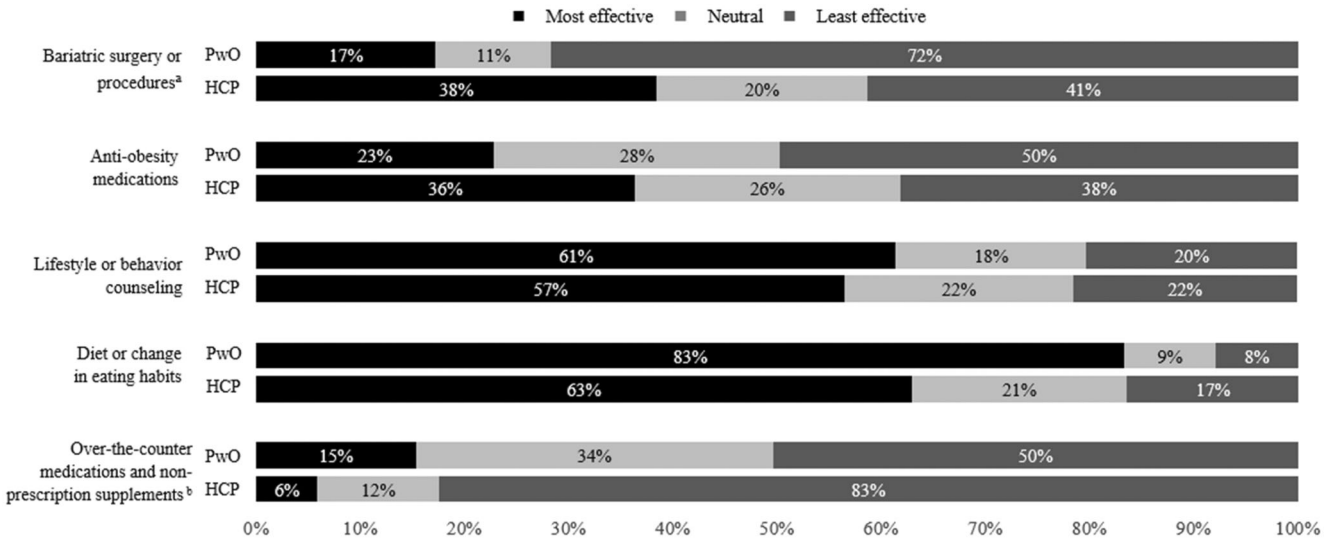

FIGURE 3 Perceived effectiveness rankings of single modality long-term weight-reduction methods among people with obesity (PwO) and health care providers (HCPs). [a]For example, sleeve gastrectomy, gastric balloon, gastric band or bypass. [b]For example, herbals, vitamins. Question: Considering weight loss and maintaining weight loss long term (at least 2 years), please rank the following obesity treatments in order from most effective (1) to least effective (5). Categorization of responses: Most effective (Rank 1–2), Neutral (Rank 3), or Least effective (Rank 4–5).

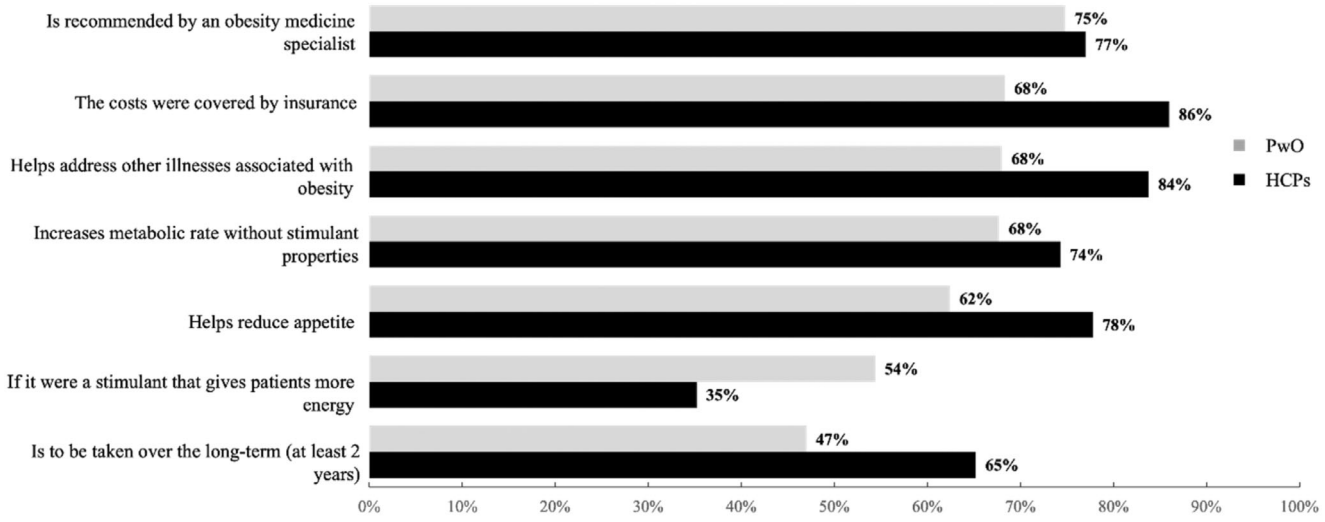

FIGURE 4 Percentage of people with obesity (PwO) and health care providers (HCPs) reporting factors that would increase the likelihood of using a new antiobesity medication (AOM). Question for PwO: To what extent would each of the following increase or decrease the likelihood that you would try a new Food and Drug Administration (FDA)-approved prescription weight-loss medication to manage your weight? Question for HCPs: To what extent do each of the following increase or decrease the likelihood that you would recommend a new generation FDA-approved AOM to manage a patient's weight? Answer Key: Strongly decreases likelihood, Decreases likelihood, Neither increases nor decreases likelihood, Increases likelihood, or Strongly increases likelihood. Increase and Strongly increase data are reported together.

interactions with other medications (54.4% of PwO and 49.4% of HCPs). Additional concerns with a potential new FDA-approved AOM included building tolerance (54.5% of PwO and 46.6% of HCPs), becoming dependent on AOMs to control weight (41.7% of PwO and 36.3% of HCPs), and short-term side effects (50.0% of PwO and 39.2% of HCPs), to which PwO had higher levels of concern than HCPs.

DISCUSSION

The current research found that, although PwO and HCPs have interest in new AOMs, various perceptions regarding chronic disease management of obesity remain as barriers to evidence-based care. Both groups had responses supporting misperceptions that obesity is largely attributable to an individual's motivation and behavior rather

than being a multifactorial disease of gene–environmental interactions driving susceptibility to the modern obesogenic environment [3, 14]. Conversely, certain HCP responses suggested a shift to a more current evidence-based understanding of the disease. Other responses that were aligned between PwO and HCPs may provide an opportunity to support patient–provider interactions.

A prevailing perception observed for both PwO and HCPs was that lifestyle changes are a highly effective intervention for weight reduction. Both groups identified dietary changes and lifestyle/behavior counseling as more effective than AOMs or bariatric surgery for long-term weight reduction, which conflicts with evidence indicating that long-term effectiveness of lifestyle intervention alone is less meaningful than surgery or AOMs [15]. This misperception of the effectiveness of lifestyle changes alone observed in the current study may stem from traditional views and approaches to obesity management in older guidelines that have focused heavily on lifestyle intervention due to limited additional options at the time [16].

Most HCPs believed that patients should only have access to adjunct treatment options after failing to reduce weight using lifestyle changes alone. Despite reporting previously being unable to achieve or maintain a meaningful treatment effect with lifestyle changes alone, many PwO still receive recommendations from HCPs to repeat such efforts prior to evidence-based adjunct therapies [17]. The ongoing emphasis on lifestyle changes and belief in their effectiveness conflict with the understanding of obesity as a multifactorial chronic disease in which physiology causes variable responses to lifestyle interventions [14]. The inflated perception of the effectiveness of lifestyle changes to cause long-term weight reduction may explain why PwO and HCPs allocated most responsibility for disease management to the individual with obesity, with much less responsibility assigned to HCPs. In the current study, the reported magnitude of responsibility for the PwO to manage their disease was less than that reported in a survey completed in 2015 of US adults [18]. However, respondents in a Canadian survey [19] conducted in a time frame overlapping with the current study found results very similar to those of the study from 2015 [18] This emphasizes the need for ongoing patient education on the notion that obesity is a disease and not a result of lifestyle choices.

Findings from the current study highlight the HCP perception that obesity clinical care is challenging. A similar portion of HCPs responded that they enjoy treating patients with obesity and that obesity care is frustrating; almost two-thirds of HCPs reported that obesity is more complex than treating other chronic conditions. Reported challenges included reimbursement for obesity care, time constraints to counseling, and prior authorizations.

Beyond practice-based burdens, a theme was found supporting discord between PwO and HCPs that may strain the patient–provider relationship and limit the ability for effective shared decision-making. Approximately one-half of HCPs preferred discussing obesity-related complications opposed to obesity directly. Although about one-half of HCPs did not believe that their patients wanted to receive advice from them regarding weight management, most PwO reported that it would be helpful to have their HCPs involved in their weight management. This discrepancy supports prior research that found that shared decision-making is generally underused in obesity management [20]. Furthermore, inconsistencies between the two groups were also observed for goal setting. These clinical challenges are a barrier to effective clinical engagement between PwO and HCPs, which could be improved by implementing available tools [21, 22] and resources into patient–provider interactions [23].

The goal of treating obesity is to improve long-term health and quality of life by achieving chronic maintenance of weight reduction based on individualized health needs. HCPs and PwO had different perceptions regarding barriers to success for maintenance of weight reduction. From one perspective, HCPs' responses supported a potential appreciation for a multifactorial etiology, including genetics, social determinants of health, and cultural barriers. Alternatively, a theme also emerged that put the onus on the patient, as the four barriers that HCPs perceived to have the most impact focused on patient behaviors, including lack of exercise/movement or sedentary behavior, relying on food as a coping mechanism, mindless eating, and lack of self-control. These perceptions align with the response from nearly one-half of HCPs that their patients with obesity do not adhere to the recommended treatment plan. However, this demonstrates a gap in the appreciation of neurobiological processes that can burden patients attempting to adhere to certain recommendations, especially for extended time periods, as well as a gap in the appreciation of guidelines for AOMs that support patients in adhering to nutritional recommendations [24].

Alternatively, less than one-half of PwO perceived that any of the factors was a substantial barrier. This suggests that the study survey did not include barriers that PwO found highly relevant, indicating that there is a need for additional research to better understand the whole spectrum of barriers at the patient level. Subsequent education for HCPs on patient-reported barriers could support patient-centered approaches and increase success rates of weight-reduction maintenance.

Study findings are consistent with previous research showing low awareness of AOMs and lack of understanding on the long-term effect of AOMs for maintaining weight reduction [25]. At the time of the survey in 2022, nearly two-thirds of PwO who did not report a current or previous prescription for AOMs were not aware of any FDA-approved AOMs. In February 2024, the Pew Research Center surveyed more than 10,000 US adults on perceptions regarding obesity and obesity treatment with glucagon-like peptide-1 (GLP-1) agonists. Of respondents, 75.0% had some knowledge of the medications, and, of those, 53.0% considered them a good treatment option for PwO or those with obesity-related complications. Potentially a contributor to agreeing that newer AOMs are a good option is that 65% responded that willpower alone is insufficient for long-term weight reduction [26]. Comparing this recent research with the current findings suggests an ongoing dynamic shift likely influenced by the frequent lay and social media references to newer AOMs and their role in obesity care.

Although HCPs detailed AOMs as more effective as a single modality than PwO did, both groups more than doubled in their

perceived effectiveness for long-term weight reduction from AOMs when combined with lifestyle changes. This view is consistent with previous research on older AOMs in combination with intensive lifestyle intervention [27]; however, an additive effect of an intensive lifestyle intervention to new highly effective AOMs is less apparent [28–30].

The majority of PwO and HCPs agreed that AOMs are an important part of multimodal obesity care supporting weight reduction and long-term maintenance. In contrast, about two-thirds of both groups held the perception that prescription AOMs can "kick-start" weight reduction, indicating that both groups envision a short-term treatment role for AOMs. Of importance, using AOMs to implement a short-term intervention for obesity treatment is expected to decrease the likelihood of successful long-term maintenance of weight reduction, as multiple clinical trials have demonstrated significant weight regain after discontinuing AOMs [31, 32]. Our findings support that both PwO and HCPs would benefit from more education on obesity as a chronic disease that, for most patients, will require chronic medical treatment.

In the current study, PwO expressed willingness to try new AOMs if recommended by HCPs. HCPs reported favorable insurance coverage as a leading factor related to their prescribing of AOMs, and PwO reported the same factor among their top four for taking AOMs. Relatedly, both HCPs and PwO reported cost as their predominant concern regarding AOMs. Achieving insurance coverage parity for obesity care compared with that of other chronic diseases may contribute to apparent willingness for both HCPs and PwO to use modern approaches to obesity care. For long-term maintenance of weight reduction, HCPs and PwO had an aligned perception to increased effectiveness of an approach that combines AOMs with HCP-guided lifestyle intervention opposed to AOM alone. As guidelines recommend a model of chronic care with a multimodal approach to obesity [3], this alignment among HCPs, PwO, and guidelines could be expected to support both the therapeutic relationship and improved health outcomes. The OBSERVE study also identified that PwO prefer magnitudes of weight reduction [33] that are unrealistic with lifestyle intervention alone or older AOMs but that newer AOMs could be better incorporated into shared decision-making [34, 35]. Long-term side effects of new AOMs were a shared concern between PwO and HCPs. This is understandable, as 55.0% of HCPs reported previously prescribing AOMs that have been withdrawn from the US market owing to safety issues. The recent publication of the 3-year follow-up of a cardiovascular outcomes trial for an AOM demonstrated a 20.0% risk reduction of major adverse cardiovascular events with semaglutide treatment compared to placebo in PwO or people with overweight and established that cardiovascular disease is a major advancement for obesity care [36]. Additional long-term outcome trials with highly effective AOMs are ongoing [37, 38] and will further advance informed clinical decision-making. Equipping HCPs with relevant clinical evidence regarding AOMs, including long-term outcomes and safety data, would enable them to have more informative discussions with their patients regarding obesity as a chronic disease that requires long-term management. Ultimately, this can elevate the HCP as the patient's trusted source of authority in an era with many nonmedical influences.

Strengths of the study include the large sample size and the demographic diversity of the participants, which is reflective of the US population living with excess weight [39]. The study also ensured representation across a wide range of physician specialties, including PAs and NPs, allowing the results to provide greater granularity of the experiences and perceptions of clinicians who provide care for PwO. Another strength of this study is the rigorous research design, which integrated quantitative methods with learnings from qualitative research.

This study also has limitations. First, the cross-sectional survey design only captured data at a specific point in time, and the self-reported data may be subject to recall bias. Additionally, the HCP recruitment likely does not represent the general HCP population, as HCPs were invited via survey panels that advertised the study as being focused on "obesity treatments" or "prescription antiobesity medicines," likely resulting in a larger cohort of HCPs who have greater awareness of AOMs and more willingness to prescribe AOMs compared to what is observed in the current literature [20]. In line with this, the study sample included a high proportion of HCPs who considered themselves to be obesity specialists and HCPs planning to expand their obesity expertise. As such, although the current HCP findings may not represent the general HCP population, the study included HCPs who are likely on the forefront of the ongoing dynamic shift in perceptions occurring with the transition into a modern era of obesity care.

CONCLUSION

The OBSERVE study provides insights into the multifaceted perceptions and attitudes surrounding obesity and AOMs among US PwO and HCPs. Perceptions that patients are most responsible for managing their obesity and that patients must fail lifestyle changes prior to receiving additional obesity treatment may strain the patient–provider relationship. Findings also underscore the need for broader efforts to address misperceptions that prevent treating obesity in parity with other chronic diseases, including the misperception that AOMs have a limited role in long-term disease management. In favor of such efforts, PwO indicated an openness to advice and recommendations from their HCPs, including receptiveness to newer AOMs. Many of the identified barriers to obesity care and evidence-based use of AOMs can be potentially addressed with education regarding current and pending clinical trial data on long-term outcomes, safety with newer AOMs, application of available clinical tools, and education on obesity as a chronic disease. Ultimately, supporting the evidence-based application of advancements in obesity care would be expected to elevate shared decision-making and the clinical relationship between HCPs and PwO.O

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ORCID

Lee M. Kaplan https://orcid.org/0000-0002-6301-2696
Kimberly Gudzune https://orcid.org/0000-0002-7782-1769
Jamy Ard https://orcid.org/0000-0002-1643-6795
Julia P. Dunn https://orcid.org/0000-0001-9561-0183

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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