

OBSERVATIONS: BRIEF RESEARCH REPORTS

Barriers to Subspecialty Care Among Patients With Extremely Severe Obesity

Background: Rates of extremely severe obesity (body mass index [BMI] ≥ 60 kg/m²) are disproportionately increasing (1). One in 270 Americans now have a BMI of 60 kg/m² or greater, which was once thought to be exceptionally rare (1). Patients in this BMI category have 2 to 3 times greater incidence of major comorbid conditions (2), but they face accessibility issues obtaining necessary medical care (3). We set out to describe access to subspecialty care among patients weighing more than 450 lb.

Methods: We used a deceptive “secret shopper” technique to attempt to schedule an appointment for a hypothetical patient weighing 465 lb. We sampled 15 practices in each of 5 subspecialties (dermatology, endocrinology, obstetrics and gynecology, orthopedic surgery, and otolaryngology) located in 4 metropolitan areas (Boston, Massachusetts; Cleveland, Ohio; Houston, Texas; and Portland, Oregon) (Table). We obtained a list of practicing physicians from each state’s medical licensing board and used a random-number generator to create call lists for each specialty. We excluded practices requiring medical records or insurance verification, resulting in 441 practices being called, to reach a sample size of 300. Weight-related comments were recorded. The funding source had no role in the design or conduct of the study.

Results: Of the 300 practices, 123 (41%) declined to schedule an appointment for the patient (Figure). A total of 52% lacked “basic standards of care,” which we defined as a clinic space that could accommodate the patient and an examination table and waiting room chair with a sufficient weight limit to hold the patient. An additional 16% of practices had a substandard plan of care that involved workarounds for accessibility limitations. In total, only 117 practices (39%) were fully accessible. The Table presents characteristics of the practices surveyed.

Endocrinology practices were the most willing to schedule the patient (75%) and the most likely to meet basic standards of care (57%). Otolaryngology practices were the least willing to schedule the patient (48%), and

dermatology practices were the least likely to meet basic standards of care (37%).

Weight-related comments included, “We have reached our capacity for bariatric patients at our site.” A staff member at an orthopedic surgery practice stated, “You might have better luck calling a bariatric surgeon first.”

Discussion: Our study found that patients weighting more than 450 lb face substantial limitations when attempting to access specialty care, with fewer than half of the practices surveyed meeting basic standards of care. Furthermore, information on accessibility was difficult to obtain, which may pose an additional barrier for patients who call in advance to determine if they will actually be seen for their appointment. These findings are consistent with previous studies showing that patients in a wheelchair are denied subspecialty care 22% of the time, even though the Americans with Disabilities Act mandates their accommodation (4).

Practices may be limited by the cost of accessible medical equipment, given that the most common reason for declining to schedule the patient was the lack of an adequate examination table. However, tables with weight limits of 800 lb or more are available for under \$700, which is less expensive than most standard examination tables. Procedural subspecialties may additionally have deemed the patient a poor surgical candidate for an elective procedure, although this would not explain those that declined to schedule a patient whose chief concern strongly suggested a malignant condition (for example, otolaryngology: new hoarseness with a mass on imaging).

Numerous studies have documented pervasive weight stigma within the health care system (5). In line with these findings, many staff members made potentially insensitive weight-related comments.

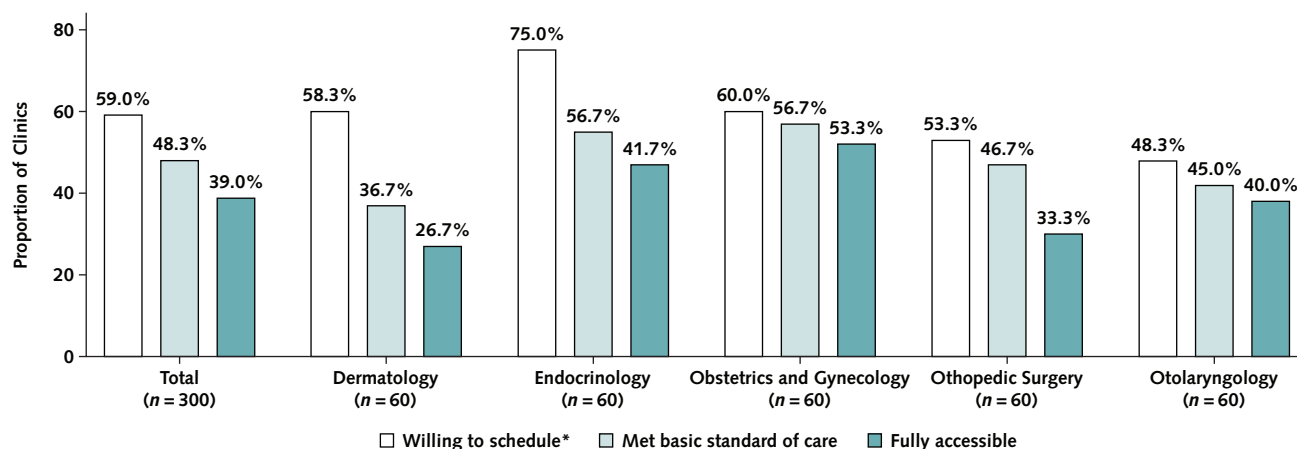
We have identified a clear need for clinic managers and staff members to be familiar with the accommodations required to safely care for patients with higher weights and to be able to answer basic accessibility questions, including the weight limits of examination room tables and waiting room chairs. Smaller practices that cannot accommodate such patients should be prepared to refer them to specific clinics. Practices should implement staff training in weight-inclusive care to minimize stigmatizing comments. Existing tools to assess and improve clinic spaces should be used, such as the clinical environment checklist (3).

Table. Characteristics of Practices Sampled

Characteristic	Overall (n = 300)	Dermatology (n = 60)	Endocrinology (n = 60)	Obstetrics and Gynecology (n = 60)	Orthopedic Surgery (n = 60)	Otolaryngology (n = 60)
Academic	95	13	24	22	16	20
Academic-affiliated	52	7	12	10	11	12
Community	153	40	24	28	33	28
Multidisciplinary	65	2	16	19	14	14
With bariatric center	46	1	14	11	11	9
Without bariatric center	19	1	2	8	3	5
Single specialty	88	38	8	9	19	14
Practice size*						
<5	66	14	8	20	17	7
5–15	137	23	26	29	30	29
>15	95	23	26	10	13	23

* Practice size by number of physicians and advanced practice providers (nurse practitioners/physician assistants) practicing in that specialty at that location. Note: Unable to find practice size at 2 of the 300 total practices sampled.

Figure. Proportion of surveyed practices ($n = 300$) willing to schedule and meeting accessibility and basic standards of care for a patient weighing more than 450 lb.



Hypothetical patient's chief concern: changing mole (dermatology); type 2 diabetes (endocrinology); postmenopausal uterine bleeding (obstetrics and gynecology); joint replacement consultation (orthopedic surgery); and new hoarseness with mass on imaging (otolaryngology).

* Reported reasons for declining to schedule the patient: examination table weight limit was insufficient ($n = 88$); multiple impediments ($n = 15$); examination rooms, hallways, or doorways were too narrow ($n = 5$); hung up on the caller >2 times after hearing the patient's weight ($n = 4$); and no reason provided or other ($n = 11$).

The high weight of the hypothetical patient limits the generalizability of our results. Practice sampling was not targeted. We did not sample rural practices to preserve anonymity. Differences between specialties may be partially attributable to the differing urgencies of the patient's chief concern.

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