

Managing Pediatric Obesity: The Lived Experience of the Pediatric Primary Care Provider

Ihuoma Eneli, MD, MS, University of Colorado; **Claudia Wies, FNP**, University of Colorado; **Gina Thompson, DO**, Nationwide Children's Hospital; and **Susan J. Woolford, MD, MPH**, University of Michigan

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Introduction

Childhood obesity is a highly prevalent chronic condition that often persists in adulthood and is associated with both short- and long-term morbidity (Hampl et al., 2023). Effective treatment remains challenging, particularly in the primary care setting. A key reason is that the etiology of childhood obesity is complex, driven by an inter-related and multifactorial set of socioecological, environmental, behavioral, and genetic factors (Hampl et al., 2023). In addition, treatment success hinges on how well the clinician can build engagement, empower families, and foster collaboration. However, current health care infrastructure can feel less supportive of clinicians trying to implement treatment guidelines and challenging for families to navigate. Hence, pediatric primary care providers (PCPs) who are strong advocates for children and committed to providing the best care possible often express frustration and report a sense of inadequacy in treating obesity (Rhee et al., 2018).

The 2023 American Academy of Pediatrics (AAP) clinical practice guideline on childhood obesity, while offering valuable clarity, has inadvertently increased the burden on PCPs (Hampl et al., 2023). The guideline advocates for lifestyle behavioral interventions and more intensive treatments, including anti-obesity medications (*Table 1*)—aspects of care for which

PCPs often lack training, experience, and time. These concerns are further exacerbated by limited access to allied health professionals, such as dietitians, activity specialists, and behavioral health providers, creating a challenging environment for providers to deliver optimal care, with implications for patient outcomes and clinician well-being. In this commentary, the authors examine the lived experience of PCPs attempting to address excess weight in pediatric patients and highlight key themes and actions.

Challenges of Managing Childhood Obesity in the Primary Care Setting

Pediatric PCPs report encountering the following challenges when addressing excess weight.

Sensitive Nature of the Topic

Discussing obesity is often uncomfortable due to the sensitivity of the condition, its association with child or parental guilt, and lingering beliefs about personal responsibility. The child or parent may not wish to raise or address the topic during the visit for these reasons. Even when they are receptive to exploring the issue, providers' time constraints due to competing demands, concerns about effectiveness, and reimbursement limitations make it difficult to adequately discuss the topic and engage the family in behavior change (Rhee et al., 2018). This problem is further aggravated by

TABLE 1 | Brief Summary of Interventions Suggested in the 2023 American Academy of Pediatrics Practice Guideline on Pediatric Obesity

Treatment Option	Interventions
Intensive Health Lifestyle Behavior Therapy (IHBLT) [a]	≥ 2 years old: use of motivational interviewing techniques
Obesity Medications	≥ 12 years old: phentermine/topiramate, glucagon-like peptide-1 receptor agonists (e.g., liraglutide, semaglutide), orlistat, <i>metformin</i> , <i>topiramate only</i> [b] *8–11 years: consensus statement and not recommendations; may be considered in select circumstances (e.g., severe obesity, serious comorbidities) ≥ 6 years old: setmelanotide (rare genetic disorders such as leptin deficiency)
Bariatric Surgery	≥ 13 years old with severe obesity defined as a body mass index (BMI) with BMI percentile 120 percent or greater than the 95th percentile: sleeve gastrectomy and Roux-en-Y surgery (gastric bypass)

SOURCE: Hampl, S. E., S. G. Hassink, A. C. Skinner, S. C. Armstrong, S. E. Barlow, C. F. Bolling, K. C. Avila Edwards, I. Eneli, R. Hamre, M. M. Joseph, D. Lunsford, E. Mendonca, M. P. Michalsky, N. Mirza, E. R. Ochoa, Jr., M. Sharifi, A. E. Staiano, A. E. Weedn, S. K. Flinn, J. Lindros, and K. Okechukwu. 2023. Clinical practice guideline for the evaluation and treatment of children and adolescents with obesity. *Pediatrics* 151(2):e2022060640. <https://doi.org/10.1542/peds.2022-060640>.

NOTES: [a] IHBLT suggested as an adjunct therapy for all treatment options. [b] Italicized text indicates off-label use.

the need for multiple follow-up visits to support weight loss and maintain successful outcomes over time.

Bias and Stigma

Beyond individual unconscious bias, systemic stigma exists in care settings—manifesting in infrastructure (e.g., inadequate equipment, gowns), processes (e.g., lack of privacy during weigh-ins), and staff attitudes (Hampl et al., 2023). PCPs often fear exacerbating negative experiences for patients, while families may anticipate or perceive judgment or doubt the effectiveness of interventions, leading to disappointment and strained interactions on both sides. In these situations, families may adopt an acrimonious approach toward the PCP, even when the PCP has been nonjudgmental and provided appropriate care. In addition, PCPs can be unfairly

criticized or perceived as biased if they do not prescribe the patient’s desired treatment (e.g., anti-obesity medications).

Family Dynamics

A difference of opinion between the parent and child regarding concerns about weight or treatment options, or even the need for treatment at all, is another unique nuance of pediatric obesity management. As obesity is often a charged topic for families, one that can be fraught with layers of guilt, recrimination, and differing perceptions of health risk, it is not unusual for the clinic encounter to devolve into finger-pointing and assigning blame. Yet, the PCP must figure out a way to engage the whole family for care to be successful (Hampl et al., 2023). They must mediate the discord regarding the best way to treat the patient while seeking consensus about the intervention; this is a

difficult situation that PCPs may feel ill-equipped to navigate, especially given the limited time of an office visit.

Provider Confidence and Training Gaps

Studies report varied levels of self-efficacy among PCPs in treating obesity. Long-standing gaps in training in nutrition, physical activity, and behavioral counseling remain. The introduction of new pharmacologic options, such as glucagon-like peptide-1 receptor agonists, adds another layer of complexity, as providers may lack experience or be reticent about using these medications (Hampl et al., 2023). Even approaches that have been deemed the standard of care, such as the use of motivational interviewing (MI), present some uncertainty. Recent studies have called into question the effectiveness of MI in the treatment of obesity, further diminishing the provider's sense of self-efficacy in delivering treatment (Resnicow et al., 2024).

Resource Limitations and Systemic Challenges

Efforts to integrate allied health professionals—such as dietitians, exercise specialists, and behavioral health providers—are frequently hampered by workforce shortages and inadequate insurance reimbursement or lack of coverage for lifestyle interventions, anti-obesity medications, and bariatric surgery. Community resources, including school-based programs and local healthy lifestyle initiatives, can support care, but availability is often inconsistent due to high turnover and precarious funding. To link these community resources with care provided in the primary care setting, the PCP or their office team must be intentional in identifying resources within the child's neighborhood (Eneli et al., 2025). Finally, tertiary care multidisciplinary programs proposed as a resource by AAP guidelines remain scarce, particularly outside of urban academic centers, leaving the PCP to expend time and resources trying to coordinate specialty care for their patients.

Considerations to Support the Primary Care Provider

A good starting point for the PCP is to assess their own bias against individuals with excess weight using Harvard University's Implicit Association Test, as provider bias can contribute to existing challenges in adequately managing obesity in the primary care setting (Project Implicit, n.d.). If bias is present, then learning about the pathophysiology of obesity and how to provide empathic care is imperative.

As patients and families often experience guilt over unsuccessful attempts to change their behaviors or to adhere to treatment plans, PCPs must highlight that weight management is not solely a matter of personal responsibility and will take time to achieve. Framing obesity within the context of genetics, biology, and environmental and social determinants of health can empower families and foster collaboration in developing the appropriate treatment plan. This viewpoint can also help the PCP avoid self-blame or self-judgment driven by their own frustration when the patient's outcome or behaviors are discordant with their expectations. Setting realistic goals and maintaining transparency about expected outcomes with a treatment plan is essential. For example, behavioral therapy typically results in approximately 2–4 percent body weight reduction, while pharmacologic options, such as phentermine combined with topiramate, may achieve 5–7 percent weight loss (Hampl et al., 2023; Skinner et al., 2023). Establishing shared expectations early in treatment can mitigate disappointment and discontinuation of care.

The benefit of having a clinician who is knowledgeable about different treatment options and understands the importance of health outcomes beyond anthropometrics (e.g., body mass index) cannot be overstated. Important indicators of health (e.g., hemoglobin A1c, lipids, metabolic dysfunction-associated steatotic liver disease, blood pressure), exercise tolerance, body image, and mental health can all improve with treatment,

even without significant weight loss (Skinner et al., 2023). Focusing only on anthropometrics can devalue other treatment outcomes that are important to the child or family based on their lived experience; such outcomes include increased self-confidence, improved family dynamics, and better peer relationships.

Most PCPs will benefit from assistance navigating the myriad insurance criteria that hamper access to obesity management medications. Having a tertiary care obesity program or obesity medicine clinician as a referral resource for consultation, especially for children with severe obesity or complex health needs, is also beneficial. Tertiary care programs are often multidisciplinary and capable of delivering the range and intensity of obesity treatment (e.g., intensive health behavior and lifestyle therapy, anti-obesity medications, and bariatric surgery) suggested in the AAP guideline (Hampl et al., 2023). Digital technology can also help extend care by delivering motivational messages, transmitting data collected via remote monitoring (e.g., Bluetooth-enabled scales and activity monitors), and gamifying applications that promote healthy lifestyle changes. Artificial intelligence applications integrated into the electronic medical record can support documentation and workflow, allowing PCPs time to engage with the family during visits.

In summary, a critical first step in supporting PCPs in managing pediatric obesity is acknowledging and validating their lived experience. This recognition clarifies areas where PCPs need additional support to provide care as proposed in the AAP guideline (Hampl et al., 2023). It also improves the probability of successful outcomes for the child and family, minimizes the PCP's frustration, and enhances their well-being.

References

Eneli, I. U., A. Tindall, A. Amponsah, R. Orozco, B. E. Fuller, M. M. Brown, A. Segna, H. Bradberry, and C. Smathers. 2025. Childhood obesity

as a pediatric vital sign: A population health initiative. *Pediatrics* 155(S1):e2024069159D. <https://doi.org/10.1542/peds.2024-069159D>.

Hampl, S. E., S. G. Hassink, A. C. Skinner, S. C. Armstrong, S. E. Barlow, C. F. Bolling, K. C. Avila Edwards, I. Eneli, R. Hamre, M. M. Joseph, D. Lunsford, E. Mendonca, M. P. Michalsky, N. Mirza, E. R. Ochoa, Jr., M. Sharifi, A. E. Staiano, A. E. Weedn, S. K. Flinn, J. Lindros, and K. Okechukwu. 2023. Clinical practice guideline for the evaluation and treatment of children and adolescents with obesity. *Pediatrics* 151(2):e2022060640. <https://doi.org/10.1542/peds.2022-060640>.

Project Implicit. n.d. *Project Implicit*. Available at: <https://implicit.harvard.edu/> (accessed April 20, 2026).

Resnicow, K., E. Delacroix, K. R. Sonnevile, S. Considine, R. W. Grundmeier, D. Shu, J. A. Faerber, A. G. Fiks, J. Steffes, D. Harris, H. Woo, T. Proctor, M. E. Wright, L. P. Shone, S. E. Barlow, R. C. Wasserman, R. Siegel, and M. S. Stockwell. 2024. Outcome of BMI2+: Motivational interviewing to reduce BMI through primary care AAP PROS practices. *Pediatrics* 153(2):e2023062462. <https://doi.org/10.1542/peds.2023-062462>.

Rhee, K. E., S. Kessler, S. Lindback, M. Littman, and R. E. El-Kareh. 2018. Provider views on childhood obesity management in primary care settings: A mixed methods analysis. *BMC Health Services Research* 18(1):55. <https://doi.org/10.1186/s12913-018-2870-y>.

Skinner, A. C., A. E. Staiano, S. C. Armstrong, S. L. Barkin, S. G. Hassink, J. E. Moore, J. S. Savage, H. Vilme, A. E. Weedn, J. Liebhart, J. Lindros, and E. M. Reilly. 2023. Appraisal of clinical care practices for child obesity treatment. Part I: Interventions. *Pediatrics* 151(2):e2022060642. <https://doi.org/10.1542/peds.2022-060642>.

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Author Information

Ihuoma Eneli, MD, MS, is Professor and Section Head of Nutrition, Department of Pediatrics, University of Colorado. She was the Vice-Chair of the National Academies of Sciences, Engineering, and Medicine's Roundtable on Obesity Solutions from 2019–2025. **Claudia Wies, FNP**, is a nurse practitioner in lifestyle medicine, Children's Hospital Colorado, and Instructor, Section of Nutrition, Department of Pediatrics, University of Colorado. **Gina Thompson, DO**, is a pediatric primary care physician, Nationwide Children's Hospital. **Susan J. Woolford, MD, MPH**, is Associate Professor, Department of Pediatrics, University of Michigan.

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Correspondence

Questions or comments should be directed to Ihuoma Eneli at Ihuoma.Eneli@CUanschutz.edu.

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