Eating disorders in primary care: A survey of provider perspectives

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Abstract

Objective: Eating disorders are complex illnesses resulting in impaired psychological and physiological functioning which can become life-threatening(1). These disorders commonly develop in adolescence or young adulthood, and it is often the primary care office where affected patients first encounter the healthcare system (2). The main goal of this study was to identify whether gaps exist in provider training on how to identify and treat eating disorders, and to assess for barriers to providing treatment in the primary care office.
Methods: A brief online survey was distributed to primary care providers (PCPs) in Manitoba to gain an understanding of their confidence and preparedness with identifying and treating eating disorders. The survey also included an open-ended response for participants to provide additional comments or perspectives pertaining to their interactions with eating disorders in their practice.
Results: Participants (n = 48) reported treating an average of 4.36 patients with eating disorders over the last 12 months and 4.2% reported utilizing screening tools to assist with identifying eating disorders. Participants further identified a moderate confidence level in evaluating a patient for an eating disorder and low confidence level in their ability to medically manage eating disorders in their practice.
Conclusion: This study highlights the current education and training involving eating disorders in family medicine residents and physician assistants working in primary care as being inadequate. The results also suggest PCPs find navigating the current system in Manitoba to access specialized eating disorder treatment difficult and inefficient. There remains a need for increased treatment access. With increased training and resources, the primary care office could assist in filling part of this need.

Introduction

Eating disorders are characterized as highly complex illnesses with severe impacts on one's psychological, behavioural, and physiological well-being (3). Individuals regardless of age, gender, ethnic or racial identity, or socioeconomic status can develop an eating disorder with most cases having an onset prior to age 30 (1,4). Despite being treatable, these disorders have an overall mortality rate of 10-15% which is greater than any other mental illness (5). Early diagnosis and treatment of eating disorders has shown to not only increase the likelihood of full recovery, but also decrease the risk of development of prolonged and potentially life-threatening medical complications (2). It is often primary care providers (PCPs) who are the initial point of contact with the healthcare system for patients with eating disorders (2). Consequently, gaining more understanding of how PCPs can assist with early identification of patients with eating disorders and, where appropriate, initiate evidence-based treatment is of high importance.

Over the last decades, there has been an estimated 25% increase in the global prevalence of eating disorders with over 1.7 million Canadians suffering from these disorders at any given time (4,6). Similarly, the number of hospitalizations for eating disorders in adolescent and young adult women in Canada has increased by nearly 30% since the 1980s (7). One known contributing factor to the rise in prevalence over recent years is the COVID-19 pandemic (8). The various social restrictions put in place to mitigate the spread of the virus have resulted in disruption to daily routine, increased isolation, and decreased access to social supports. For some, these restrictions have exacerbated previous eating disorder behaviours or contributed to the development of new behaviours in vulnerable individuals (8). This increase in prevalence has been directly observed at the Health Sciences Centre in Winnipeg, Manitoba as the centre reported a tripling of referral rates in adolescents seeking eating disorder treatment since the

onset of the pandemic (9). This increase in referrals has resulted in additional stress on an already overburdened system as patients are added to a waiting list as long as two years to receive treatment (9). The ongoing escalation in wait times for specialized treatment highlights the need for more consideration on how to ensure patients on these waiting lists receive adequate and timely support in the interim.

Diagnostics

While there are more than seven different types of eating disorders, three of the most prevalent in Canada are anorexia nervosa, bulimia nervosa, and binge-eating disorder (10). The following descriptions are simplified definitions and characteristics of these disorders. In addition to an extreme fear of gaining weight, anorexia nervosa is characterized by a restrictive caloric intake and persistent distorted perception of one’s body despite being at a lower-than-average weight (11). Depending on the presentation of various symptoms, anorexia nervosa can be further specified as either restrictive or binge/purging type. Diagnostic criteria for bulimia nervosa include repeated binge eating episodes during which a larger than average amount of food is consumed within a given time accompanied with a feeling of loss of control (11). Binging episodes are followed by behaviours of purging such as excessive exercise, laxative abuse, or self-induced vomiting. Relapse rates have been reported to be as high as 65% and 85% for anorexia nervosa and bulimia nervosa, respectively (12,13). Lastly, binge-eating disorder is characterized by eating an amount of food larger than what most people would consume within a given time frame accompanied with a feeling of lack of control over the amount being consumed (11). The binge episodes are enmeshed with feelings of distress, guilt, and embarrassment (11). These episodes are also not followed by compensatory behaviours and, as a result, binge eating disorder is often associated with obesity (7).

Treatment

In Canada, access to and availability of eating disorder treatment varies based on each province. Most publicly funded treatment centres are found in large urban areas in addition to limited community treatment networks to provide support to patients after hospitalization (4). Ultimately, the fragmented treatment system contributes to difficulty accessing care, especially in cases where patients may be geographically isolated or experiencing complex comorbidities, such as substance use, that result in additional barriers for receiving treatment (4). In response to the COVID-19 pandemic, health care professionals have been attempting to adjust to providing eating disorder treatment, whether it be through virtual and telehealth interventions or increasing the education for caregivers to provide at-home interventions. What remains to be determined is whether these changes made in attempt to overcome the barriers brought on by the pandemic will result in innovative ways which can be further utilized to improve access to care after the pandemic (14).

When it comes to accessing specialized eating disorder treatment of any kind, the greatest initial barrier is receiving a timely diagnosis (10). The need for effective and timely intervention in patients with eating disorders is highlighted by the significantly elevated rates of mortality compared to other psychiatric conditions and the general population, especially in patients with anorexia nervosa (5). It is important to acknowledge how unlikely it is that patients will present to their PCP with “eating disorder” being the primary complaint. Instead, patients will often present with symptoms that arise from engaging in eating disorder behaviours such as amenorrhea, extreme fatigue, or gastrointestinal discomfort (2). Because of this, ensuring PCPs are competent in providing routine assessment for eating disorders, body image, and mood is essential for identifying which patients may need additional assessments and intervention (see

Figure 1) (1). Such assessments could include utilizing non-judgmental motivational interviewing to assess a patient's motivation to change pathological eating habits and patterns, followed by a thorough assessment to determine which method of treatment would be most appropriate and beneficial (1,4).

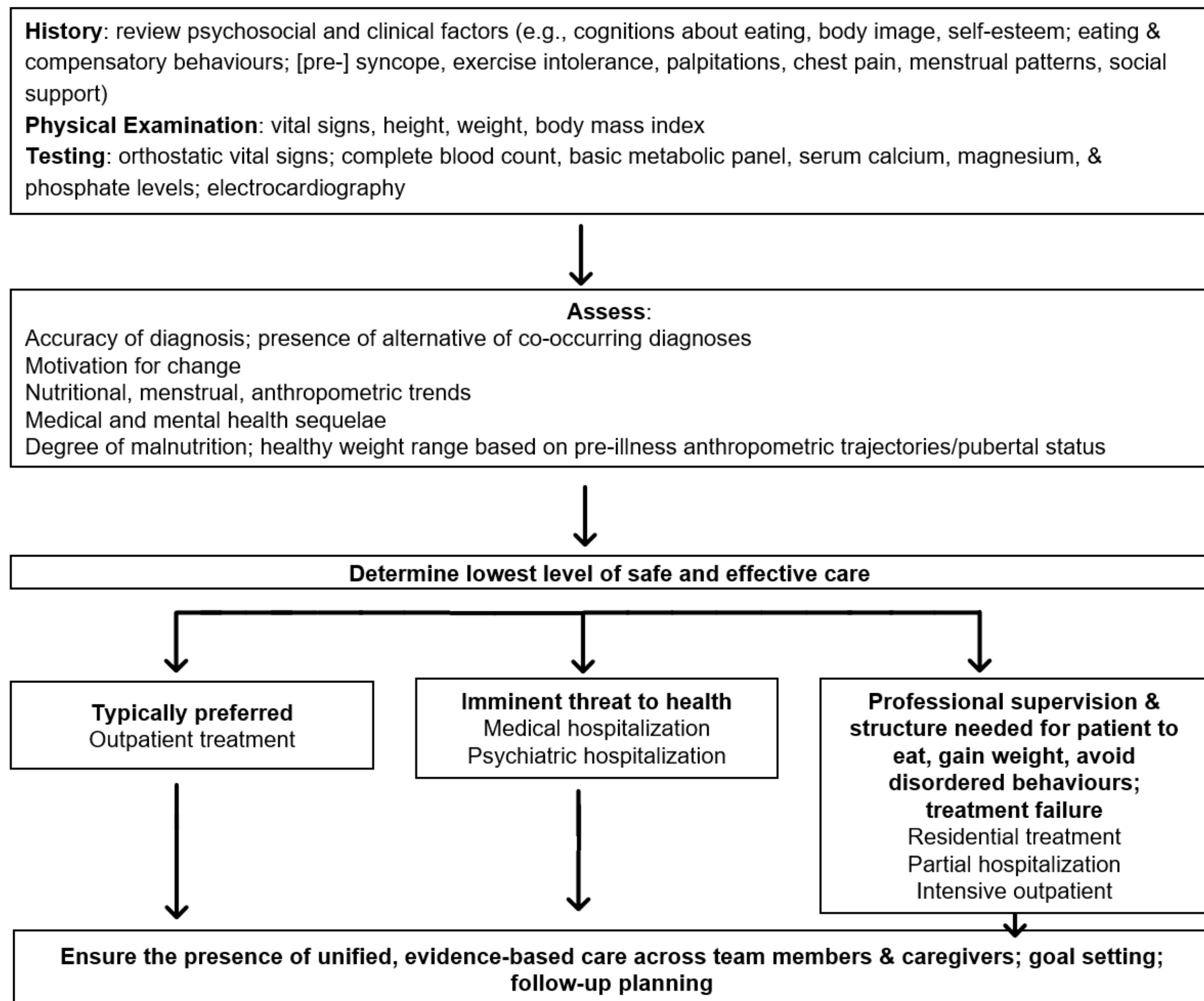

Figure 1 Algorithm for eating disorder management in the primary care setting (3)

Once it has been established that a patient would benefit from eating disorder treatment, the initial step is to determine whether the patient is medically stable or if emergency medical attention is required (4). Following medical stabilization, the purpose of treatment becomes

providing ongoing nutritional support and re-introduction of normalized eating patterns in a supportive environment (4). Ideally, a comprehensive treatment plan is developed for each patient which could include ongoing monitoring of physical symptoms, cognitive behavioural therapy, body image therapy, medication, and education about eating disorders (7). Multiple treatment settings exist, including residential, inpatient, day treatment, and outpatient programs with various factors contributing to which setting a patient may receive care from. In addition to the patient's medical status, these factors also include suicidal ideation, motivation to engage in treatment, self-sufficiency in controlling urges to excessive exercise and other purging behaviours, and whether there are additional social supports in place (2).

Many patients can be adequately treated in an outpatient setting which ideally consists of a team-based approach involving a clinical dietician, therapist, and clinician aware of the associated medical concerns with eating disorders (1). As part of their role in managing a patient with an eating disorder, PCPs ideally can identify the early signs and symptoms of medical complications and determine when referral for specialized treatment is needed. Due to the complex nature of these disorders and the often slow and non-linear recovery process, any PCP providing care for a patient with an eating disorder should consider the following: 1) their comfort level in treating long-term mental health disorders, 2) the capacity of the physical office setting in managing eating disorder treatment, including whether there are mental health professionals and dieticians available, and 3) comfort level in treating underweight patients (5).

Screening Tools

Routine assessment for eating disorders, body image, and mood by health care providers of young adults and adolescents are essential for identifying which patients may need additional assessments and intervention (1). One widely known screening tool for identifying eating

disorders is the SCOFF questionnaire (see Appendix A), which was developed as a short, concise tool making it an ideal for PCPs to identify core features of anorexia nervosa and bulimia nervosa in their patients (15). The tool consists of five “yes-or-no” response questions with each “yes” response equaling one point; a total score of two or greater indicates the patient is likely to have a diagnosis of anorexia nervosa or bulimia nervosa (15). Due to its sensitivity of only 53.7%, it is recommended that PCPs utilize the SCOFF questionnaire in addition to asking patients about family history of eating disorders, history of affective disorders, and whether they engage in activities considered to be high-risk for eating disorder development such as modeling or athletics (2).

As previously mentioned, early detection of eating disorders is important in preventing future complications, improving prognosis, and ensuring the appropriate treatment implementation (16). When assessing the confidence and interest in delivering eating disorder treatment, it has been found that primary care providers report lacking awareness regarding how to initiate eating disorder interventions in their practice (17). It has also been found that, despite up to 91% of family practitioners and pediatricians stating they agree their roles should involve assessing for and identifying eating disorders, these conditions often fail to be diagnosed (17). With the increase in referrals for eating disorder treatment occurring in Canada, the typical path of care previously utilized may not be sufficient for meeting the needs of these high volumes of patients. As a result, looking at ways to ensure care and treatment is provided to patients in need through other possible mechanisms, such as through their PCP, may be one such solution.

Objectives

The primary objective of this study is to gain an understanding of the perspectives of PCPs in Manitoba regarding identification and treatment of patients aged 18 years or older with

eating disorders in their daily practice. Secondary objectives include determining whether Manitoban PCPs currently utilize any screening tools to assist with identifying eating disorders in their patients. An additional secondary objective includes identifying the greatest barriers faced by Manitoban PCPs to providing care for their patients with eating disorders. This was achieved by administering a short survey to Manitoban PCPs which asked for self-reported confidence in their abilities, level of preparedness, and interest in receiving new tools/strategies when addressing disordered eating. Additionally, this study asked which screening tool(s), if any, were being used by primary care providers to assess patients for eating disorders.

Methods

The Department of Family Medicine and the Master of Physician Assistant Studies at the University of Manitoba were asked to distribute an invitation to participate in a concise online survey to former graduates of their programs and current residents working in the primary care setting in Manitoba. An advertisement including a link to the survey was also included in an edition of the Manitoba College of Family Physicians' online newsletter. The survey used in the present study was a modified version of the 8-item quantitative survey developed for a similar study conducted in the United States (17). Responses to the survey were gathered using the online platform Survey Monkey.

Participation in the study was voluntary and consisted of completing seven questions (see Appendix B), five of which involved responding to questions on a 10-point Likert scale. Prior to accessing the survey, participants provided informed consent through an online consent form and were able to withdraw their participation by exiting out of the survey at any time. Eligibility for the survey was confirmed by requiring all participants to respond to the following question: "Are

you currently practicing in the field of primary care medicine in Manitoba?" All participants that responded "yes" were directed to the brief survey.

Prior to activating the survey, approval was obtained by the University of Manitoba Health Research Ethics Review Board. As part of the survey, participants were asked to identify whether they were practicing as physicians or physician assistants. The term "disordered eating" was used to refer to all levels of eating issues including picky eating, restricting, binging, purging, anorexia nervosa, bulimia nervosa, other specified feeding and eating disorders, and other eating issues that may not meet diagnostic criteria provided by the DSM-V.

Results

Throughout approximately four weeks, a total of 48 participants completed the survey, 38 (79.2%) of which were physicians and 10 (20.8%) were physician assistants. Forty-seven out of 48 participants reported encountering an average of 4.36 patients with eating disorders in the last 12 months, including patients for whom they had provided ongoing medical management for the disordered eating, referred for specialty eating treatment, provided feedback about eating to, or continued to see as part of their routine practice while they received additional treatment. Furthermore, one participant was considered to be an outlier after reporting they had seen more than 100 patients with disordered eating in the last 12 months. This participant further clarified these patients had concerns relating to obesity, overeating, and comorbid mental health conditions.

The scores for the Likert-style questions were categorized as follows: less than 5 was considered low, between 5 and 8 was considered moderate, and greater than 8 was considered high. Overall, participants reported a moderate level of confidence in their ability to evaluate a patient for an eating disorder (mean 5.90, standard deviation (SD) 1.92), a low level of

confidence in their ability to medically manage an eating disorder in their practice (mean 4.71, SD 1.99), and a moderate level of confidence in their ability to advise and support a patient in making eating disorder treatment decisions (mean 5.04, SD 2.07). A moderate level of interest was reported by participants in learning new tools or strategies for addressing eating disorders in their practice (mean 7.77, SD 2.13) (see Table 1).

Table 1 PCP confidence in evaluating and treating eating disorders and interest in learning new strategies for eating disorder treatment in their practice (n = 48)

Currently…	Mean (SD)
How confident are you in your ability to evaluate a patient for the presence of disordered eating in your daily practice?	5.90 (1.92)
How confident are you in your ability to manage disordered eating medically in your daily practice?	4.71 (1.99)
How confident are you in your ability to advise and support a patient in making decisions about their eating disorder treatment?	5.04 (2.07)
How interested would you be in learning new tools or strategies for addressing disordered eating in your practice?	7.77 (2.13)

In response to whether screening tools were currently being used to screen for eating disorders, 2 (4.2%) responded "yes" and 46 (95.8%) reported "no" (see Table 2). Both participants that endorsed using screening tools reported using the SCOFF tool.

Table 2 Use of eating disorder screening tools by PCPs in daily practice (n = 48)

	Yes	No
Do you currently utilize any screening tools to screen for eating disorders in your practice?	2 (4.2%)	46 (95.8%)

Sixteen participants responded to the final question of the survey which was an open-ended response to leave additional comments or perspectives on encountering eating disorders in their practice. One participant mentioned the scarcity of resources available in remote, northern communities which contributes to concern for patients not having access to adequate treatment.

Another participant mentioned they found a non-pathological approach to eating disorders is preferred and contributes to patients being more engaged in the treatment process. The most prominent themes noted throughout the responses were that there is difficulty in patients accessing treatment due to lack of resources, lack of understanding on how to navigate the system, and lack of overall training on how to manage eating disorders.

A conflicting view between participants was whether routine screening for eating disorders should be utilized in primary care. One participant expressed that screening for eating disorders should be routine, while another suggested that it is impractical to make use of multiple screening tools for various conditions during one visit. This participant further suggested that time and resources should instead be directed toward educating patients on when to present to their PCP for specific concerns. Another participant commented that it is difficult to approach screening for eating disorders in patients who present with a history of complex trauma, homelessness, food scarcity, and other social determinants of health.

Discussion

The present study is the first to examine the perspectives of PCPs in Manitoba regarding their confidence in identifying and treating eating disorders in their daily practice. The results highlight some of the barriers reported by PCPs to treating eating disorders, including inadequate training and lack of resources. Further, this study reinforces the need to expand eating disorder treatment in the province of Manitoba, as numerous participants mentioned the challenges associated with long wait times and difficulty accessing specialized care for their patients. Due to the lack of overall data on prevalence of eating disorders in Manitoba, there are no previous statistics to compare to the reported mean of 4.36 patients being treated for disordered eating

over the last 12 months. Therefore, it is unknown as to whether this number is greater or less than what was experienced in previous years.

Overall, there are multiple implications which can be drawn from the results of this study, including the following three themes which will be further addressed: 1) there remains a lack of adequate training for PCPs regarding eating disorders, 2) PCPs feel there is inadequate treatment and resources available to meet the needs of their patients with eating disorders, and 3) the present specialized eating disorder treatment system in Manitoba is difficult for PCPs to navigate.

Lack of Adequate Training

With participants reporting an average moderate confidence level (mean = 5.9) in their ability to evaluate a patient for disordered eating and low confidence level (mean = 4.71) in their ability to manage disordered eating medically, this suggests the present medical education and training in this area is inadequate. Previous studies provide additional support for this claim, one of which noted that over 75% of family medicine residents in Canada reported receiving five hours or less of training in the assessment and treatment of child and adolescent eating disorders throughout their entire residency (18). The same study reported that nearly 60% of medical residents recognized early identification and screening for child/adolescent eating disorders as an area in which they required additional training (18). A similar pattern of training exists for Canadian physician assistants. For example, the University of Manitoba Master of Physician Assistant Studies has a single 90-minute lecture to cover the topic of eating disorders including a brief introduction to their typical presentation, pathophysiology, and treatment.

When recalling the education and training on eating disorders received in medical school, one participant noted that, not only did they feel there to be a gap in their knowledge of how to

manage eating disorders medically, but also in how to educate caregivers and family members on how to best provide support for their ill loved ones. As previously mentioned, another participant expressed difficulty knowing how to incorporate eating disorder screening and management in patients with complex social concerns, such as homelessness and/or food insecurity. Together, these responses suggest that not only is there a need for continued generalized education on eating disorders for PCPs, but also specific training on how to approach eating disorders in patients of various socioeconomic status or cultural backgrounds.

These results regarding lack of education are also consistent with those of a recent study which looked at the engagement of PCPs in providing care to adolescent patients with eating disorders (17). A total of sixty PCPs who treated children and adolescents responded to an 8-item survey with questions about their experiences managing eating disorders in their practice. Most participants responded that they felt moderate and low confidence in their abilities to evaluate and manage patients with eating disorders in their practice, respectively. The participants were highly interested in receiving new strategies from eating disorder specialists on how to integrate eating disorder treatment into their own practice.

When considering how this continued education and training could be carried out in Manitoba, multiple recommendations have been made by the Canadian Eating Disorders Strategy. The report includes numerous recommendations to help improve outcomes for individuals who are currently living with or are recovered from eating disorders in Canada. One such recommendation involves developing a continuing medical education series by eating disorder specialists for which providers can receive credit for attending (4). This series could ensure up-to-date, evidence-based treatments are communicated to practitioners effectively and efficiently. Additionally, establishing a task force to establish a minimum standard curriculum

for eating disorders to be taught within medical education programs across the country would ensure a consistent minimum level of training for all healthcare providers (4).

Lack of Treatment & Resources

When it comes to barriers to treatment access in Canada, the most prominent concern remains there being an unequal distribution of treatment programs across provinces and territories (10). Even if patients are referred by their PCP in a timely manner, they may wait months after seeing their PCP for a specialized assessment, followed by months of waiting for admission to a day-program or hospital if they meet admission criteria (10). In Manitoba, publicly funded eating disorder treatment for patients over age 18 is limited to the Provincial Eating Disorder Prevention and Recovery Program at the Women's Health Clinic or the treatment program at the Health Sciences Centre. With wait times to receive treatment at the Women's Health Clinic being up to 24 months, additional provincial funding is paramount in expanding treatment services (9).

Another example of a lack of resources pertains to screening for eating disorders in primary care. Since disordered eating behaviours are often hidden by affected patients, screening for eating disorders contributes to understanding the extent of a patient's pathological eating behaviours or patterns and can expose cases that may be otherwise missed (19). Despite this, and the fact that various eating disorder screening tools are available, no guidelines exist in Canada to recommend which screening tool is the most effective in identifying eating disorders in the primary care setting. Barriers to using screening tools in PCP settings include the time available per appointment, varying levels of familiarity with the different screening tools, and limited sensitivity levels available for the various tools being used (2).

Having one or two screening tool recommendations for all PCPs to utilize, and specific guidelines for when to implement these tools, would allow for more consistent and uniform screening across Manitoba. Of note, the importance of public education on the warning signs of eating disorders and when to encourage a loved-one to present to a PCP if there are concerns for disordered eating would also be of benefit in ensuring that those seeking treatment do not go unnoticed.

Difficulty Navigating the System

This study highlights the difficulty experienced by many PCPs in Manitoba when it comes to navigating the present treatment system for specialized eating disorder care. Whether it be a lack of knowledge on who to refer to, the available treatment options not being accessible for patients, or difficulty in understanding which of the available treatment options would be most suitable for their patient, participants reported a low to moderate level of confidence in their ability to advise and support a patient in making decisions about their eating disorder treatment. With there existing both private and public options for treatment, there remains a need for a centralized database for both patients and providers to improve both knowledge of and access to treatment options. The COVID-19 pandemic has likely contributed to increased confusion with navigating the treatment system, as many medical appointments have transitioned to a virtual format or have been cancelled altogether.

My Health Teams, an initiative in Manitoba which provides an accessible and comprehensive team-based approach to primary care, was described by a participant as an alleviating factor against the difficulty with navigating the treatment system. The participant further described having access to a dietician through My Health Teams was a valuable resource to have available when caring for patients with disordered eating. As such, My Health Teams has

the potential to serve as a valuable resource when encountering eating disorders in the primary care setting. With members of the My Health Team consisting of a variety of providers including nurses, dieticians, pharmacists, mental health workers, and occupational therapists, this is in accordance with the recommended team-based approach to outpatient eating disorder care (1).

Limitations & Future Directions

One limitation of this study is its small sample size which limits the generalizability of these results to PCPs across Manitoba. An additional limitation is that participants were not asked to identify which healthcare region they were employed in or whether they work primarily in an urban versus rural setting. Including these questions as part of the survey could have contributed to understanding the basic demographics of patients presenting to their PCP with eating disorder symptoms. While there remains no research into the demographics of eating disorder patients in Manitoba, it would be beneficial to gain an understanding into which, if any, patterns exist. Specifically, it would be helpful to understand patients of which age group(s) are most frequently presenting to their PCP with disordered eating. Knowing at which age patients are most likely to first present with disordered eating would help determine the most appropriate age providers should begin screening. Overall, there is much work to be done when it comes to understanding eating disorders in the Manitoban population. Having high-quality data on patient demographics would allow for more relevant and focused training to be directed towards PCPs that are most likely to encounter these patients.

An additional limitation of this study is that participants were asked to report on their experiences with eating disorders in patients aged 18 years or older. A useful future direction would be to repeat this study while asking participants to report on their encounters with patients below 18 years of age. Having such information could assist with advocating for which age

group is most in need of increased government funding and resources as there are separate treatment programs for adolescents and adults.

Lastly, while the survey distributed in this study was intentionally brief, many additional questions can be raised based on the limited answers provided by participants. Future research into investigating reasons most providers are not using screening tools would be of benefit when it comes to addressing this gap. Additionally, future research could investigate specific reasons that providers felt low confidence in medically managing eating disorders in their practice. With this being the first study investigating eating disorders in primary care in Manitoba, there remains many opportunities for further understanding on how to optimize treatment for these disorders by PCPs.

Conclusion

Despite its limitations, the present study provides valuable data on the self-reported level of preparedness and confidence of PCPs in Manitoba when it comes to treating and identifying eating disorders in their practice. While this study demonstrates that Manitoban PCPs acknowledge the importance of early identification and treatment of eating disorders, there is an obvious knowledge and training gap that needs to be addressed. With adequate training, resources, and utilization of My Health Teams, the primary care setting in Manitoba has the potential to play an effective role in providing treatment to medically stable patients with eating disorders and further mitigate the long wait times for specialized treatment.

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Appendix A

SCOFF Questionnaire

1. Do you make yourself **S**ick because you feel uncomfortably full?
2. Do you worry you have lost **C**ontrol over how much you eat?
3. Have you recently lost more than **O**ne stone (14 lb or 7.7 kg) in a three month period?
4. Do you believe yourself to be **F**at when others say you are thin?
5. Would you say that **F**ood dominates your life?

Appendix B

Brief Provider Survey

Please specify your current level of practice:
MD Nurse Practitioner Physician Assistant

For the purposes of this survey, when we say "disordered eating" we are referring to all levels of eating issues, including (but not limited to): picky eating, dieting behavior, restrictive eating, binge eating, purging, anorexia nervosa, bulimia nervosa, other specified feeding and eating disorders, and subclinical eating issues.

We are specifically asking about your experience at this time with disordered eating in patients, ages 18 years old and older.

1. How many patients would you estimate you have treated in the past 12 months and are currently treating with disordered eating (this includes patients for whom you've provided ongoing medical management for the disordered eating, referred for specialty eating treatment, provided feedback about eating to, or continued to see as part of your routine practice while they receive other treatment)?

2. Currently, how confident are you in your ability to evaluate a patient for the presence of disordered eating in your daily practice?

1 2 3 4 5 6 7 8 9 10

Not at All Confident — Very Confident

3. Currently, how confident are you in your ability to manage disordered eating medically in your daily practice?

1 2 3 4 5 6 7 8 9 10

Not at All Confident — Very Confident

4. Currently, how confident are you in your ability to advise and support a patient in making decisions about their eating disorder treatment?

1	2	3	4	5	6	7	8	9	10
Not at All Confident									Very Confident

5. At this time, how interested would you be in learning new tools or strategies for addressing disordered eating in your practice?

1	2	3	4	5	6	7	8	9	10
Not At All Interested									Very Interested

6. Do you currently utilize any screening tools to screen for eating disorders in your practice?

   Yes No

   If yes, please list which tool(s).

7. If you have any additional comments or perspectives regarding your interactions with patients presenting with an eating disorder, please leave them below.

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