

GLP-1 Persistence in Obesity: Why Patients Stop and What Helps

Responses from endocrinology and diabetes clinicians on GLP-1 and dual GIP/GLP-1 treatment for weight management, where first-year persistence breaks down, why cost outweighs tolerability as the leading stop reason, how clinicians respond to side effects and plateaus, and what may make long-term obesity pharmacotherapy more sustainable.

Context – Signal – Judgement – Action

30 Survey records	6 Countries represented USA, UK, Canada, Italy, France, Germany	90% Completion rate	8933360 Survey ID
-----------------------------	--	-------------------------------	-----------------------------

WHY THIS REPORT

The prescription is only the beginning of the persistence problem.

GLP-1 and dual GIP/GLP-1 therapies have changed the expectations around pharmacological obesity treatment. For endocrinologists, however, the real-world question does not end with efficacy. It continues through insurance coverage, monthly cost, dose escalation, nausea or constipation, a slowing weight-loss curve, patient expectations, and the decision to keep going when the treatment experience is harder than the persistence question suggested.

The MDForLives data captures that downstream work. Clinicians were asked how much of their GLP-1/GIP prescribing is now devoted to weight management, how often patients discontinue in the first year, what most commonly causes premature stopping, how gastrointestinal adverse effects influence persistence, what clinicians do when tolerability or a plateau becomes difficult, which strategies appear to help, and what future change could matter most.

The pattern is not simply “patients stop because of side effects.” Cost and reimbursement dominate the stop-reason question. Tolerability still matters, but dose repair is the most common response. Expectations are fragmented across speed, lifestyle effort, durability after stopping, and adverse effects. And when clinicians look ahead, affordability and coverage outrank new formulations as the change most likely to improve long-term adherence.

Survey lens: MDForLives survey ID#2 8933360 captured 30 survey records with a 90% completion rate across 6 countries: USA, UK, Canada, Italy, France, and Germany. Core clinical questions Q4–Q12 use n=27. The report excludes internal operational fields, required-visit validation fields, after-survey fields, and honeypot fields from analysis.

CLINICAL CONTEXT

Obesity pharmacotherapy is being framed as chronic care, which makes persistence clinically central.

The 2026 American Diabetes Association Standards of Care expect that obesity pharmacotherapy indicated for chronic therapy should be continued beyond reaching weight-loss goals to maintain health benefits, and that dose and titration should be individualized to balance effectiveness, health benefits, and tolerability. The ADA also notes that gastrointestinal side effects can be addressed with counseling and, where needed, slower titration. WHO’s 2025 global GLP-1 guideline similarly treats obesity as a chronic, relapsing disease and conditionally recommends GLP-1 therapies for long-term treatment within comprehensive care, while explicitly identifying cost, system readiness, and equity as implementation constraints.

That external context matters because it changes the meaning of discontinuation. If obesity pharmacotherapy is intended to function as long-term disease management, then a stop driven by cost, expectations, or early tolerability is not only a medication event. It is a break in the care pathway. The survey therefore offers a useful clinical lens on what happens between treatment initiation and long-term continuation.

External clinical context is provided for interpretation. MDForLives survey findings remain the source for all respondent percentages in this report.

EXECUTIVE SUMMARY

Six findings that separate efficacy from real-world persistence.

INSIGHT 01 Cost leads premature stopping 63.0% High out-of-pocket cost or lack of reimbursement is the single most frequent stop reason, well ahead of GI adverse effects.	INSIGHT 02 Dose repair is the preferred next step 51.9% When side effects or a plateau become intolerable, the most common response is to return to the last tolerated dose and pause titration.
INSIGHT 03 Personalized titration supports persistence 40.7% Slower, individualized dose escalation ties to the most effective one-year persistence strategy.	INSIGHT 04 Expectation-setting matters just as much 49.7% Comprehensive pre-treatment counseling ties personalized titration as the leading persistence strategy.
INSIGHT 05 Multidisciplinary support is often seen as critical 40.7% Another 37.0% call it helpful for selected high-risk patients rather than necessary for everyone.	INSIGHT 06 Affordability is the expected future lever 59.3% Lower drug costs and expanded insurance coverage for out-of-pocket options, greater tolerability, or less frequent dosing.

Obesity is already a material part of GLP-1/GIP prescribing

33.3% say 25–50% of their GLP-1/GIP prescriptions are primarily for weight management.

CONTEXT
For endocrinology and diabetes practices, GLP-1 and dual GIP/GLP-1 prescribing now spans dynamic management and obesity treatment. The same class can therefore sit inside different clinical goals, reimbursement rules, follow-up needs, and patient expectations.

WHAT THE DATA SHOWS
The largest group, 33.3% (9/27), estimates that 25–50% of their total GLP-1/GIP receptor agonist prescriptions are written primarily for weight management or obesity rather than type 2 diabetes. Another 29.6% (8/27) place the share below 25%, 14.8% (4/27) place it at 51–75%, and 22.2% (6/27) say more than 75% of their prescribing is primarily for weight management.

THE INSIGHT
Obesity care is not a marginal use case in this respondent group. The spread suggests heterogeneous practices, but it also shows that weight-management prescribing is substantial enough to create a distinct persistence workload. Clinicians are managing not only dose and response, but also a treatment journey in which insurance, patient expectations, and chronic-use conversations can differ from diabetes care.

WHY IT MATTERS
As obesity prescribing becomes a larger share of practice, persistence needs a deliberate workflow. Coverage verification, side-effect preparation, dose-escalation flexibility, and long-term expectation-setting cannot be treated as optional aftercare if the therapy is to work as intended for chronic disease management.

Q4 • Share of GLP-1/GIP prescriptions primarily for weight management • n=27



First-year discontinuation is common enough to be part of routine obesity care planning

40.7% estimate that 10–25% of patients discontinue within the first 12 months.

CONTEXT
A chronic medication can be highly effective in trials and still underperform in practice if patients do not remain on treatment. For GLP-1-based obesity therapy, persistence can be challenged by cost, tolerability, early expectations, perceived plateaus, and the need to keep paying for treatment over time.

WHAT THE DATA SHOWS
The largest response group, 40.7% (17/27), estimates that 10–25% of patients prescribed GLP-1/GIP therapy primarily for weight management or obesity during the first 12 months. A further 22.2% (6/27) estimate 26–40%, 14.8% (4/27) estimate 41–55%, and 7.4% (3/27) estimate more than 55%. Only 11.1% (5/27) place discontinuation below 10%, while 3.7% (2/27) are unsure or do not track it.

THE INSIGHT
The survey does not provide a single real-world discontinuation rate; it captures clinician estimates. Even so, the distribution signals that attrition is a normal clinical issue rather than a rare exception. That makes the first year a series of persistence checkpoints: can the patient obtain treatment, tolerate escalation, interpret the pace of weight loss realistically, and maintain the financial and behavioral demands of therapy?

WHY IT MATTERS
If persistence is assessed only when a trial is closed, the intervention arrives late. A more proactive pathway would identify risk before initiation and then revisit cost, tolerability, expectations, and support during dose escalation and maintenance.

Q5 • Approximate share discontinuing within 12 months • n=27



GI side effects are a persistence challenge, but clinicians usually try to manage through them

51.9% say GI side effects only occasionally cause discontinuation before the target maintenance dose.

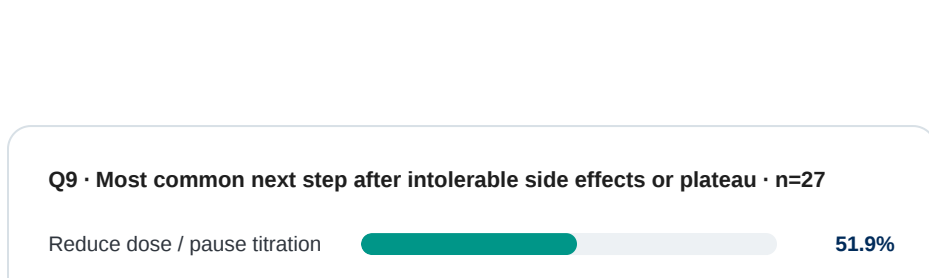
CONTEXT
Nausea, vomiting, constipation, diarrhea, and related GI symptoms are familiar treatment issues with GLP-1-based therapy. The key persistence question is not whether symptoms occur, but whether they become severe or persistent enough to force treatment abandonment before the patient reaches a maintenance dose.

WHAT THE DATA SHOWS
51.9% (14/27) say GI side effects occasionally account for 10–24% of discontinuations. Another 29.6% (8/27) say they frequently account for 25–50%, 11.1% (3/27) say very frequently for more than half of discontinuations, and 11.1% (3/27) report a rare level. In the separate stop-reason question, only 25.9% select persistent GI adverse effects as the single most frequent cause of premature stopping.

THE INSIGHT
GI symptoms are clinically consequential, but the pattern does not look like automatic treatment failure. They appear more often as a management burden that can be navigated. That interpretation is strengthened by Q9, where clinicians prefer dose reduction and a pause in titration over switching or abandoning medication.

WHY IT MATTERS
Current KOL guidance aligns with this practical response: recommending individualized dose titration and noting that slower escalation may help people experiencing GI challenges. The real-world skill is knowing when to slow down, when to remain at a lower effective dose, when to switch, and when symptoms make continuation inappropriate.

Q7 • GI side effects as a direct cause of discontinuation • n=27



When tolerability or a plateau becomes difficult, the first move is usually to step back rather than switch

51.9% reduce the dose to the last tolerated level and pause titration.

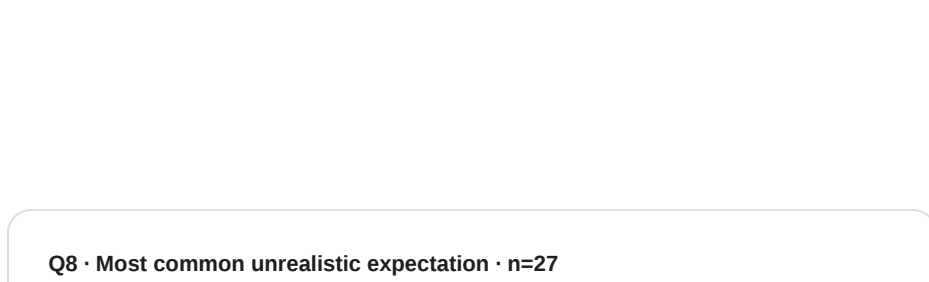
CONTEXT
The decision after intolerable side effects or an apparent weight plateau can reveal how much clinicians trust dose adjustment versus medication substitution. It also shows whether the clinical response is predominantly pharmacological, behavioral, or discontinuation-based.

WHAT THE DATA SHOWS
A majority, 51.9% (14/27), reduce the dose back to the last tolerated level and pause titration. Switching to another GLP-1/GIP therapy primarily for weight management or obesity during the first 12 months, 22.2% (6/27), adding adjunct behavioral or nutritional counseling by 18.5% (5/27), and discontinuing medical therapy to focus solely on lifestyle modification by 7.4% (2/27).

THE INSIGHT
The dominant behavior is preservation. Clinicians appear to distinguish a difficult dose from a failed treatment. That creates a stepped decision pathway: first recover tolerability, then reassess response, and only then decide whether switching or discontinuation is necessary.

WHY IT MATTERS
This approach may help prevent premature escalation to a new agent simply because the first titration path was too aggressive. It also creates a clearer patient message: needing to slow down is not the same as treatment failure, but ongoing symptoms still require active clinical review.

Q8 • Most common next step after intolerable side effects or plateau • n=27



Expectation-setting is not one conversation because patients can misunderstand four different parts of treatment

Rapid early loss, no need for lifestyle change, and permanent loss after stopping each attract 29.6%.

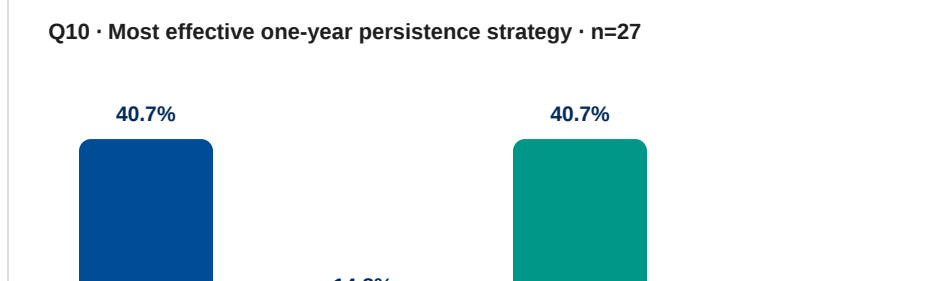
CONTEXT
Unrealistic expectations can surface as disappointment, nonadherence, unsupervised dose changes, or a belief that a treatment has failed. In obesity care, expectations are multidimensional: how fast weight should change, how much lifestyle effort is still needed, whether side effects will occur, and what happens if medication is discontinued.

WHAT THE DATA SHOWS
The survey produces an unusual three-way tie. 29.6% (8/27) say the most common unrealistic expectation is rapid, dramatic weight loss in the first few weeks. Another 29.6% say patients believe medication eliminates the need for diet and exercise modifications. A further 29.6% say patients expect weight loss to remain permanent after stopping medication. The remaining 11.1% (3/27) identify the assumption of zero adverse effects.

THE INSIGHT
There is no single education gap to fix. A useful pre-treatment conversation has to cover pace, participation, persistence, and tolerability. The connection to Q10 is direct: comprehensive counseling about realistic weight-loss expectations lies as the leading strategy for one-year persistence.

WHY IT MATTERS
Expectation-setting can reduce avoidable discontinuation without promising a specific outcome. It can also protect the clinician-patient relationship when weight loss slows, dose escalation takes longer than expected, or treatment needs to continue beyond the point the patient originally imagined.

Q9 • Most common unrealistic expectation • n=27



Persistence is built through two equal levers: personalized titration and pre-treatment counseling

40.7% select slower titration and 40.7% select comprehensive pre-treatment counseling.

CONTEXT
When clinicians are asked which strategy has proven most effective for one-year persistence, they have to prioritize among dose design, side-effect management, counseling, and digital follow-up. The response therefore reveals which parts of the care pathway they believe do the most preventive work.

WHAT THE DATA SHOWS
Slower, personalized dose titration schedules are selected by 40.7% (17/27). Comprehensive pre-treatment counseling regarding realistic weight-loss expectations is also selected by 40.7% (17/27). Proactive management of GI side effects, including antiemetics or dietary adjustments, is chosen by 14.8% (4/27), while digital health tools, reminders, or habit tracking are chosen by 3.7% (1/27).

THE INSIGHT
The top two strategies address different failure modes but share the same principle: reduce avoidable surprise. Personalized titration reduces the shock of treatment intolerance. Counseling reduces the shock of normal clinical reality not matching expectations. Both happen before the patient reaches a stop decision.

WHY IT MATTERS
Persistence programs focused only on reminders may miss the larger problem. A patient rarely needs an app to remind them that therapy is unavoidable, too difficult to tolerate, or not producing the result they expected. Digital tools may support care, but the survey gives greater weight to clinical pacing and expectation-setting.

Q10 • Most effective one-year persistence strategy • n=27



Multidisciplinary support is valued, but clinicians do not see one universal model for every patient

40.7% call structured multidisciplinary support critical; 37.0% call it helpful for selected high-risk patients.

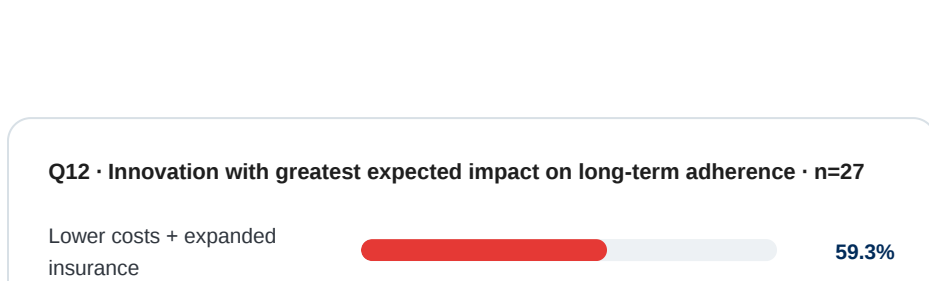
CONTEXT
Obesity pharmacotherapy can sit across endocrinology, primary care, nutrition, behavioral health, pharmacy, nursing, and sometimes bariatric or other specialist services. The question is whether every patient needs structured multidisciplinary support or whether additional support should be targeted to those at greatest risk of discontinuation.

WHAT THE DATA SHOWS
40.7% (12/27) say patients without multidisciplinary support have significantly higher drop-out rates and therefore view it as critical. 37.0% (10/27) call it helpful for specific high-risk patients but not required for everyone. 22.2% (6/27) say medication management and physician follow-up are sufficient for most patients.

THE INSIGHT
The respondent group is more aligned on the value of support than on how broadly it should be deployed. That points to a risk-stratified model: some patients may need intensive nutrition and behavioral support, while others may remain persistent with focused clinician follow-up and a clear medication plan.

WHY IT MATTERS
A universal high-touch program may be resource-heavy, but a low-touch model can miss patients facing cost, expectations, or complex adverse effects. The practical question becomes who should receive which layer of support and when that support should escalate.

Q11 • Importance of structured multidisciplinary support • n=27



The innovation clinicians want most is not a new formulation. It is affordability.

59.3% say lower drug costs and expanded insurance coverage would have the greatest impact on long-term adherence.

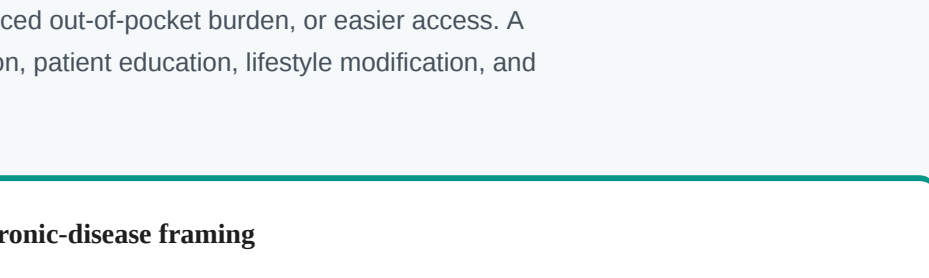
CONTEXT
The survey asks respondents to look three to five years ahead and choose one innovation most likely to improve long-term GLP-1 adherence. The choices include oral alternatives, more tolerable formulations, lower costs and broader coverage, long-acting depot injections, and next-generation multi-agonist efficacy.

WHAT THE DATA SHOWS
Lower drug costs and expanded health insurance coverage lead at 59.3% (16/27). Oral alternatives replacing injectables are next at 18.5% (5/27), followed by more tolerable formulations with fewer GI side effects at 14.8% (4/27). Monthly or longer-acting depot injections and higher-efficacy dual or triple agonists each receive 3.7% (1/27).

THE INSIGHT
The future priority echoes the current stop reason. Respondents are not saying innovation is unimportant; they are saying the biggest persistence gain may come from making existing effective therapy financially sustainable. This is a striking counterweight to a product-development narrative focused primarily on route, dosing frequency, or efficacy.

WHY IT MATTERS
For clinicians, it suggests that persistence may remain constrained even as new molecules improve. For health systems and manufacturers, it points to affordability, reimbursement, and benefit design as adherence infrastructure. The strongest next-generation treatment cannot improve long-term persistence for a patient who cannot keep accessing it.

Q12 • Innovation with greatest expected impact on long-term adherence • n=27



When clinicians describe the one change they want, coverage and affordability dominate the language.

The open-ended question asked: “In your opinion, what is the twenty most critical change needed in healthcare policy or medical practice to support long-term GLP-1 adherence for potential weight-loss and durability? It is not clinical pathway, treatment choice, or a solution to patient-specific barriers in English, Italian, German, and French.

The comments should not be converted into prevalence percentages without formal coding. Qualitatively, however, they reinforce the closed-question pattern. Most comments center on insurance coverage, reimbursement, lower cost, reduced out-of-pocket burden, or easier access. A smaller set expands the problem beyond price to prescribing access, long-term disease recognition, patient education, lifestyle modification, and treatment trade-offs such as skeletal-muscle preservation.

Coverage & reimbursement Repeated calls for insurance coverage, reimbursement, lower out-of-pocket cost, and partial or full coverage for chronic obesity treatment.	Chronic-disease framing Some respondents explicitly argue that obesity and GLP-1 treatment should be recognized as chronic care rather than a short intervention.
Prescribing access Comments include easier prescribing and, in one case, specialist-limited prescribing with reimbursement, showing different views on how access should be governed.	Education & counseling Respondents mention medical education and counseling about the pros and cons of treatment as adherence-supporting practices.
Lifestyle support One response identifies lifestyle modification, echoing the view that medication should sit inside broader chronic obesity care.	Body-composition concerns One response highlights reducing skeletal-muscle loss, adding a minority clinical concern not captured by the closed questions.

What the open responses add: The quantitative data identifies affordability as the leading stop reason and future lever. The qualitative comments show what “affordability” means in practice: reimbursement, lower patient cost, simpler access, and recognition that long-term obesity treatment needs long-term financing.

PEOPLE ALSO ASK • TOPIC FAQ

Frequently asked questions about GLP-1 persistence in obesity care.

How long are GLP-1 medicines used for obesity? GLP-1 and dual agonist therapies are generally used as long-term treatment when they remain effective, tolerable, and clinically appropriate. Current WHO and ADA guidance treats obesity as a chronic disease and emphasizes ongoing, individualized management rather than a short fixed course.	Why do GLP-1 medicines cause gastrointestinal side effects? Nausea, vomiting, diarrhea, constipation, and related gastrointestinal symptoms are recognized effects of GLP-1-based therapy. Symptoms often occur during treatment initiation or dose escalation, so clinicians commonly adjust titration and provide practical dietary guidance based on tolerability.
Can slower GLP-1 dose titration improve tolerability? Yes. Current ADA guidance recommends individualized dose titration to balance effectiveness and tolerability and notes that some patients may need a slower escalation or smaller dose steps when gastrointestinal symptoms are difficult.	What happens to weight after stopping GLP-1 treatment? Weight regain can occur after GLP-1-based obesity treatment is stopped. Because obesity is chronic and relapsing, treatment discontinuation should be planned with clinical follow-up, lifestyle support, and discussion of alternative or maintenance strategies when appropriate.
Does GLP-1 treatment replace diet and physical activity? No. GLP-1 medicines are part of a broader obesity-care plan. WHO guidance specifically states that they should be used within comprehensive care that includes healthy eating, physical activity, and professional support when needed.	What role can multidisciplinary support play in GLP-1 obesity care? Clinicians, behavioral health professionals, pharmacists, nurses, and other care-team members can help with nutrition, expectations, side-effect management, medication access, and long-term behavior change. The amount of support needed varies by patient and clinical context.

ENDOCRINOLOGY PERSISTENCE LENS

What this means at four points in the GLP-1 care pathway.

The survey suggests that persistence can be strengthened by designing the treatment journey around predictable failure points rather than waiting for discontinuation to occur.

Before prescribing Access lens. Clarify coverage, prior authorization, expected recurring cost, and what options exist if reimbursement changes. Cost is the leading stop reason in this respondent group.	During titration Tolerability lens. Give patients permission to slow down. The most common next step after intolerable symptoms or a plateau is returning to the last tolerated dose and pausing titration.
At expectation-setting Communication lens. Cover pace, lifestyle participation, side effects, and the chronic treatment horizon. There is no single expectation prescription to correct.	During long-term follow-up Support lens. Decide who needs multidisciplinary escalation and who can remain stable with clinician follow-up. The survey supports a layered rather than one-size-fits-all model.

CLOSING PERSPECTIVE

The next GLP-1 persistence gain may come less from stronger efficacy and more from removing preventable friction.

The survey captures a mature clinical tension. GLP-1 and dual GIP/GLP-1 therapies can be powerful tools in obesity care, but long-term effectiveness depends on whether patients can remain on a plan that is financially reachable, tolerable enough to continue, understood well enough to trust, and supported appropriately over time.

Cost is the clearest signal. It is the leading single reason clinicians see patients stop, the dominant theme in the open-ended policy question, and the future innovation most respondents believe would improve adherence. That consistency suggests the persistence problem cannot be solved entirely inside the prescription.

Tolerability creates a different kind of friction. GI side effects matter, but respondents commonly manage around them by stepping back to the last tolerated dose and pausing titration. Current ADA guidance supports individualized titration, including slower escalation for patients experiencing gastrointestinal challenges. This convergence between survey behavior and guideline content suggests that a flexible dose pathway is not a workaround; it is part of good long-term treatment design.

Expectation-setting is equally important. Clinicians see three equally common misconceptions: fast dramatic loss, no need for diet and exercise, and permanence after stopping. That explains why pre-treatment counseling ranks alongside personalized titration as the leading persistence strategy. The patient needs to know not only what the medicine can do, but how long it may need to be used, what lifestyle still contributes, what side effects may occur, and what a plateau does or does not mean.

The remaining question is how much support each patient needs. Some respondents view multidisciplinary care as critical, while others reserve it for high-risk patients or believe physician follow-up is enough for most. The likely solution is not one universal program. It is a risk-based pathway that escalates nutrition, behavioral, pharmacy, or other support when access, expectations, side effects, or adherence risk become harder to manage.

1 • Build affordability into the treatment plan Confirm coverage and recurring cost early, then document the fallback if reimbursement changes.	2 • Make titration adaptable Use tolerability as explicitly as response to decide pace rather than treating the maximum schedule as the only successful path.
3 • Prepare patients for the full treatment horizon Discuss pace, lifestyle, side effects, maintenance, and what stopping may mean before expectations harden.	4 • Risk-stratify support Identify who needs nutrition, behavioral, pharmacy, or other multidisciplinary involvement rather than relying on the same follow-up intensity to everyone.
5 • Track why patients discontinue Separate access-related discontinuation from intolerance, inadequate response, preference, and expectation mismatch to interventions within the active follow-up plan.	6 • Treat persistence as a clinical outcome If obesity pharmacotherapy is chronic care, staying on an appropriate plan becomes part of the quality of the pathway, not merely patient compliance.

Help future obesity-treatment insights reflect what happens after the prescription.

Join MDForLives to share clinical perspectives on access, tolerability, expectations, and long-term GLP-1 care.

Join the Panel

REFERENCES AND DATA SOURCE

Sources used for this report

1. MDForLives internal survey report. All Markets Report by SCID 8933360. Project: Engagement Campaign | Ends: January Survey, Aug. 30 total survey records, 90% completion rate, across 6 countries: USA, UK, Canada, Italy, France, and Germany. Clinical context: Diabetes care (n=27).

2. American Diabetes Association. “S. Obesity and Weight Management for the Prevention and Treatment of Diabetes: Standards of Care in Diabetes – 2026.” Diabetes Care, 2026.

3. American Diabetes Association Professional Practice Committee for Obesity. “Pharmacologic Treatment of Obesity in Adults: Standards of Care in Overweight and Obesity.” Diabetes, Obesity, and CardioMetabolic CARE, 2024.

4. World Health Organization. “WHO issues global guidance on the use of GLP-1 medicines in treating obesity.” 1 December 2025. WHO.