How can primary care rise to the challenge of obesity?

Jonathan Pinkney

Obesity is a fast-growing challenge in primary care, yet in the past many practices – along with much of the NHS – have been very poorly trained and equipped to offer patients much support. An increasing evidence base for treatment, along with care models based on prospective studies, have established potential frameworks for the development and staffing of such services in primary care. This article argues that General Practitioners and Nurses with a Special Interest in obesity could perform a vitally important role in enabling primary care to rise to this difficult challenge.

There is little room for doubt, from a medical-economic perspective, that increasingly common and serious lifestyle-related diseases – coronary heart disease (CHD) and type 2 diabetes (T2D) – are spiralling out of control (*Table 1*). While prevention would be the ideal solution to this growing problem, the British Heart Foundation has estimated that <1% of the costs of treating cardiovascular disease (CVD) are spent currently on prevention (BHF, 2003), and this is almost certainly true also for T2D.

The backdrop to the high prevalence of T2D and CVD is the metabolic syndrome. It is well established that the metabolic syndrome – the main precursor of CVD and T2D – is strongly associated with obesity, and there has been a rapid rise in the prevalence of obesity. The proportion of UK adults with body mass index (BMI) >25 kg/m^2 is now about 70% (National Centre for Social Research, 2004), and the risks of CVD and T2D begin to rise as BMI exceeds 25 kg/m^2 (Colditz et al, 1990; Chan et al, 1994). If greater emphasis is to be given to the primary prevention of T2D and CVD, the metabolic syndrome must be identified earlier in its natural history, and this requires the recognition of obesity as a significant and potentially modifiable risk factor. The NHS, therefore, as it strives to preserve the concept of care that is free to all at the point of delivery, faces a daunting challenge to adapt to the rise of lifestyle-related disease where personal choice also plays a significant role.

At this point, sceptics should note that obese people already take up much more of their GPs' and practice nurses' time than their lean neighbours (Frost et al, 2005), and that obesity more than doubles the prescribing costs for most major classes of drugs (Cervoni, 2005). But can primary care really take on yet another role, and, if so, how can it do so in a way that is effective?

The answer is, obviously, that it can and increasingly does do this, but this can only be achieved with some adaptation and with appropriate training. Most healthcare professionals, particularly medical graduates, learn very little of practical use about obesity in their undergraduate or postgraduate careers, emphasising the need for improved postgraduate

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Article points

1. Primary care now finds itself at the forefront of the battle against obesity.
2. The challenge for primary care is not so much to take on yet another role but, rather, to adopt a new approach to an existing patient group.
3. Obesity is not specifically one of the areas of medicine identified for the General Practitioner with a Special Interest role.
4. However, given that the principal importance of obesity is as a major risk factor for metabolic disease, a special interest in obesity would fit very appropriately alongside special interests in diabetes and coronary heart disease.

Key words

- GPwSIs
- Obesity
- Coronary heart disease

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Table 1. The costs of diabetes and coronary heart disease.

- The costs of diabetes in the UK are huge and growing still further: there are already around 1.8 million people with diabetes, and this is set to rise to some 3 million by the year 2010 (Diabetes UK, 2004), as a result of increased screening and diagnosis, and demographic changes in the population.
- Diabetes now consumes about 5 % of the NHS budget and this is expected to rise to 10 % by the year 2010 (Diabetes UK, 2004).
- Coronary heart disease, in its various guises, already affects around 10 % of the population and causes around 245 000 deaths per year (Tillin et al, 2005).
- This costs the UK some £1.7 billion per year and another £5.3 billion in lost productivity (British Heart Foundation, 2003).

Page points

1. The prevention and successful treatment of obesity is, in the author's opinion, one of the most challenging but worthwhile goals in medical practice.
2. Selection of the most appropriate obesity treatments is an individualised decision agreed between the patient and a trained and experienced team of professionals.

training in this area. Enter the General Practitioner with a Special Interest (GPwSI) in obesity!

Obesity management is worthwhile

Although it might seem superfluous to make this point, the prevention and successful treatment of obesity is one of the most challenging but worthwhile goals in medical practice. While the ill effects of obesity can be palliated by expensive polypharmacy and long-term medical care, until the usual outcome – a premature death (Peeters et al, 2003) – we should try to not miss opportunities to prevent and treat obesity before the ill effects arise.

It is fair to say that many obese patients will not be sufficiently interested in, or motivated to, accept treatment, let alone respond to it; however, for those who are motivated, the potential benefits are important (Jung, 1997). A variety of intervention studies using lifestyle, diet or other behaviour modifications alone or with antiobesity drugs or bariatric surgery clearly point to the significant benefits for treatment responders, in terms of sustained weight loss, reductions in medical comorbidities and improvements in quality of life (Pinkney, 2002; Pinkney and Wilding, 2004; Sjostrom et al, 2004; Torgerson et al, 2004). While health economics are undoubtedly important, and the cost-effectiveness of treating obesity is only now becoming generally accepted for bariatric surgery, in the author's opinion it would be as wrong to deny the possible utility of treating obesity as it would be to argue against the treatment of a range of common cancers which curtail life expectancy by similar amounts to obesity.

Need to individualise obesity management

In an age that has witnessed a proliferation of protocols and pathways, it is important to appreciate the limitations of these in the context of obesity. People become obese for a wide variety of reasons, including: strong genetic factors; sometimes subtle but equally strong environmental and familial factors, over which they (or we as healthcare professionals) may have little control; and personal choices. The individual nature of obesity is highlighted frequently when a detailed weight history is recorded for the patient. Without understanding the causes, how can we help people to find the potential solutions? For one patient, the emphasis of treatment might need to be increased physical activity or a change of job; for others, it might be reduced portion sizes or reduced intake of alcohol, fat or carbohydrate; and for others still, it might be the treatment of depression, reduced isolation and increased socialising. When all other hopes are bleak, bariatric surgery, if the risks are viewed as acceptable, can be life saving for many.

All of these conundrums are repeated and magnified further in the particularly difficult area of childhood obesity. The need to individualise treatment was also emphasised in a report on the appropriate use of antiobesity drugs by the Nutrition Committee of the Royal College of Physicians (2003). Thus, while protocols can act as general guides to the available treatment options, the selection of the most appropriate treatments is an individualised decision agreed between the patient and a trained and experienced team of professionals.

Possible care models

Obviously, primary care is the main gateway into health care, and as the recent Government White Paper on health (Department of Health [DoH], 2006) sets out, whenever possible health care should be provided as near to the patient as possible. For the great majority of overweight or obese patients, there is little, in principle, that requires secondary care interventions (either diagnostic or therapeutic), unless they: require a specialist medical second opinion on grounds of disease complications or atypical features (such as suspicion of unusual syndromes, including genetic and endocrine diseases); have particularly severe or morbid (grade 3) obesity; or need assessment for, or delivery of, special dietetic, drug-based or surgical interventions. However, a recent detailed survey of UK general practices that reported an interest in treating obesity found that the interventions on offer were extremely limited indeed (Laws et al, 2004b), and one might infer from this that knowledge of obesity, relevant training, or time and resources allocated to this problem remain widely deficient.

General practice, though, is learning from the experiences of the Counterweight Programme, which was an attempt to establish a primary care model for the treatment of obesity. In this programme, which has been led mainly by practice nurses and supported by dietitians, GPs and other physicians as appropriate, a long-term behaviour-based intervention has been offered (Laws et al, 2004a). Important preliminary phases of this project have included local needs assessments and a period of specific training for the professionals leading the interventions. This programme has been shown to be effective in assisting around one-third of patients to lose at least 5% of body weight within 12 months (Laws et al, 2004a), and provides an important potential care model.

Obviously it will be seen that some two-thirds of patients achieved a very limited response, as might have been predicted; this illustrates the point that successful weight control is achieved currently by a minority of obese patients. While it is hoped that new treatments will help to improve these response rates, it makes sense to concentrate valuable resources on the most motivated individuals who are showing good responses, and not to dissipate them on poorly motivated people who are not responding well.

A primary care framework to treat obesity

Obesity is caused by an interplay of different factors, and the solutions to obesity are dependent upon the reversal of these factors, and – where this is not possible – upon bariatric surgery. Therefore, a framework of individualised options is required to treat obesity. Primary care and those who work in it are an important link in the chain, but other support will be found from the commercial sector, and secondary care can provide several further management options for selected patients.

The National Obesity Forum has recently suggested a pathway for the assessment and management of obesity in primary care, and has developed a set of useful learning tools available on its website (http://www.nationalobesityforum.org.uk/apps/content/html/ViewContent.aspx?id=6548 [accessed 13.03.2006]). Important attributes of this pathway are the input of dietitians (a *sine qua non* of weight management), the central role of primary care, and, occasionally, the necessary involvement of secondary care.

A full range of options requires an adequately developed secondary care obesity service. However, all the knowledge and skills necessary for the majority of assessments, management decisions and provision of interventions for weight management can be acquired by GPs and nurses in primary care. Nurse practitioners who diagnose and prescribe, and who are frequently very well versed in the management of T2D and CVD, will also find themselves well placed to take on a special interest role in this field. Thus, a GPwSI or a Nurse with a Special Interest (NwSI) in obesity could play a pivotal role in developing and providing high-quality local obesity management in primary care, either at individual practice level or for consortia of practices.

GPwSIs and NwSIs

The NHS Plan (DoH, 2000) set primary care at the centre of the modern NHS. Subsequently, the Royal College of General Practitioners (RCGP) has set out several possible roles for GPwSIs, including acting as local service leads and offering specific opinions for colleagues (RCGP, 2004). It has also been emphasised that GPwSIs should not be seen as a way to provide a second-class service, and clearly it will not be possible to develop the GPwSI obesity role without some training in this area. Unlike diabetes and CHD, obesity is not specifically one of the areas of medicine identified for the GPwSI role (*Table 2*), but given that the principal importance of obesity is as a major risk factor for metabolic disease, a special interest in obesity would fit very appropriately alongside special interests in diabetes and CHD.

Many of the same comments can be made regarding the potential role for NwSIs in obesity. The DoH (2003), in conjunction with the Royal College of Nursing, has set out the need for the further development of NwSIs. While obesity has not yet received much attention as an area of medicine suitable for such a nurse role, the experience of the Counterweight Programme suggests that nurses could also develop a pivotal role in weight management. As with the GPwSI

Table 2. Areas of care identified for the General Practitioner with a Special Interest role (Royal College of General Practitioners, 2004).

- Care for older people
- Child protection
- Coronary heart disease
- Dermatology
- Diabetes
- Drug misuse
- Ear, nose and throat
- Echocardiography
- Emergency care
- Epilepsy
- Headaches
- Mental health
- Musculoskeletal conditions
- Palliative care
- Respiratory medicine
- Sexual health

Page points

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Table 3. Some of the skills required by an obesity team.

Tasks
- history taking and interpretation
- physical examination
- dietary and lifestyle analysis
- identifying eating disorders and making appropriate specialist referrals
- dietary and exercise assessment and goal planning.

Knowledge areas
- detailed understanding of the aetiology and complications of obesity
- awareness of the indications for specific types of investigations
- knowledge and practical experience of antiobesity drugs
- awareness of the possible roles of alternative dietary strategies
- a broad understanding of the different surgical interventions available together with their main indications and contraindications and other pros and cons
- knowledge of the controversies and common potential pitfalls that are present in all of these areas.

role, it would be inappropriate for nurses to be expected to take on a special interest role in obesity management without being provided with appropriate training.

Training

There is a common misapprehension that obesity is managed adequately by people without any formal training or detailed knowledge. Like any other area of medicine, if treatments are to be employed and referrals made appropriately, and if good results are required, then the need for training in obesity cannot be dismissed in this way. The needs for training and continuing education were emphasised in a recent report by the Nutrition Committee of the Royal College of Physicians (2003). There are several training courses available in the UK that can meet these educational needs (http://www.leicestershirediabetes.org.uk/documents/Obesity%20Training%20Directory.pdf [accessed 13.03.2006]).

Any clinical service requires an informed, up-to-date lead specialist, whether this is a GP, a nurse practitioner or a practice nurse, but this person alone cannot take on the whole problem. There are many skills required by an obesity team (*Table 3*), regardless of how it is configured. In the author's view, an experienced dietitian and a suitably trained GP or nurse practitioner can readily provide an obesity service, with appropriate support from secondary care in specific circumstances.

Conclusions

Primary care now finds itself at the forefront of the battle against obesity. Opportunities to identify and treat obesity arise every day in the management of patients with T2D and CHD risk factors. In this respect, the challenge for primary care is not so much to take on yet another role but, rather, to adopt a new approach to an existing patient group, drawing on available knowledge and care models. Obesity is one of the most challenging yet rewarding areas of medicine, but the price of success is appropriate training, careful patient selection and enthusiasm. The GPwSI in obesity could have a lot to offer his or her patients. ■

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