Managing obesity in primary care

The causes of obesity and benefits of weight loss

Why a holistic approach to obesity is needed

How to improve quality of life

**5 key points**

1. Obesity is complex and diseases related to it place a large burden on the NHS.
2. Its causes include genetic, social and environmental factors.
3. A weight loss of 5-10% can have important health benefits.
4. A flexible, structured, person-centred, holistic approach can result in good outcomes.
5. Weight management should be a mandatory aspect of primary care services managing long-term conditions such as diabetes and heart disease.

**Impact of obesity**

Obesity rates are predicted to rise to 47% for men and 36% for women by 2025 (McPherson et al, 2007). In Scotland, they rose from 15.9% to 26.8% for men and 17.3% to 26.4% for women between 1995 and 2009 (Scottish Government, 2011); this data also showed that those who were already obese were becoming more so.

In 2003, the number of people with obesity globally was estimated at 300 million; the figure is expected to continue to rise (World Health Organization, 2003).

**Causes of obesity**

The causes of obesity are multifactorial. They can be genetic, neuroendocrine and drug induced, but the most important influences are emotional, social and environmental and, underpinning all those, is genetic inheritance. The genetic contribution to obesity is estimated to be 25-40%, a small fraction of which is linked to specific obesity syndromes (Maffeis, 2000). More commonly, several hormones are implicated by their effect on appetite or the way in which the body deals with nutrients. Familial susceptibility occasionally occurs where there is an underlying low metabolic rate; this is more likely when one or both parents are overweight or obese.

Weight gain can occur at any time but there are certain circumstances in which this is more likely. People need to choose to be active.
which the risk is higher:

» Pre-birth, where undernutrition can lead to obesity later in life (increased by economic deprivation);
» Puberty, when fat cells can increase in number due to poor lifestyle, making weight loss later in life difficult;
» During pregnancy;
» Menopause;
» In men in their late 30s;
» After or during a change in social circumstances (for example marriage, changing jobs or retirement).

Depression is not only a cause of obesity but may also be a consequence of it. Anti-depressant drugs and other psychiatric drugs may lead to further weight gain. Some other treatments, for example those used in diabetes and asthma, also influence weight gain.

Changes in working and eating patterns and the 24-hour availability of convenient, energy-laden foods has increased food consumption. At the same time, advances in home and workplace technology mean people need to expend less energy, so they have to make a deliberate choice to be active.

Obesity intervention needs to reflect the multifactorial nature of its development with a holistic, person-centred approach.

**Benefits of weight loss**

Weight loss is an important aspect of the prevention and treatment of comorbid conditions. Even a 5-10% weight loss has health benefits (Scottish Intercollegiate Guidelines Network, 2010). Some of the benefits for those with long-term conditions are shown in Table 1.

The risk of developing type 2 diabetes can be reduced by 58% with a weight loss of 5-7% (Diabetes Prevention Program Research Group, 2002; Tuomilehto et al, 2001). In addition, Williamson et al (2000) showed that a 25% reduction in early mortality could be achieved by those with type 2 diabetes who maintained weight loss.

**Primary care setting**

Primary care is the ideal setting in which to address obesity. It is readily accessible to the general population and patients are often familiar with the primary care team. The team is also likely to know the patient’s family and social circumstances, which creates a bond of trust between professional and patient.

Practice nurses, who are involved in the care of those with long-term conditions, see their patients on a regular basis, which gives them an ideal opportunity to incorporate obesity management into practice.

However, there are only eight Quality and Outcome Framework points to be gained for identifying a patient for weight management. This lack of incentive does little to generate interest or support within the multidisciplinary team in making a difference to these patients, yet obesity is often the root cause of serious cardiometabolic diseases and a physical sign of the likelihood of long-term illness.

### Managing obesity

Many factors can reduce the effectiveness of interventions for obesity in primary care, including: time pressures during consultations; a lack of appropriately trained staff; a shortage of community dieticians; the potentially enormous caseload; language or cultural barriers; and the sheer intractability of patients’ eating habits, exercise behaviour and clinical condition. These all conspire to make GPs, other team members and, often, patients themselves lose heart and stop trying.

SIGN (2011) recommends that all practitioners providing obesity management be appropriately trained. Cost-effective strategies are required (Harvey et al, 2008). It is also recommended that any intervention is multifactorial (Avenell et al, 2004) but there is a lack of practical approaches available to practitioners (Mulvihill and Quigley, 2003), in particular those that incorporate all the required elements.

### Pilot scheme

An obesity clinic was piloted between October 2008 and October 2009 at a primary care practice in the north east of Scotland. The aim was to achieve cardiovascular risk reduction through obesity management by addressing the emotional and behavioural wellbeing of patients, as well as their diet and exercise. The ultimate goal was sustainable weight loss and improved quality of life.

The practice nurse involved in the pilot scheme was introduced to weight management by visiting a secondary care obesity clinic. Follow-up support was provided by a nurse specialist in obesity management, who visited the practice every one to two months and maintained email and telephone contact.

### Tools

A set of scales suitable for measuring high weights was purchased as well as an accurate stadiometer for measuring height and calculating body mass index (BMI). Wide blood-pressure cuffs were needed to avoid falsely high blood-pressure readings. Tape measures, as well as conversion weight and height charts also provided patients with appropriate information.

Patients were given a booklet, My Personal Approach to Weight Management, to allow them to work in partnership with the nurse. Its contents reflected good practice guidelines (SIGN, 2010).

Helping individuals to identify barriers, including behaviour-change strategies, and providing written goals and actions is recommended by NICE (2006). Self-care is increasingly being advocated for long-term conditions and it is important to put patients at the centre of a working partnership to improve confidence and a sense of control (Department of Health, 2006).

All these aspects are incorporated into this evidence-based, theoretically underpinned, holistic, person-centred approach to obesity management; this is a structured and practical intervention known as the Holistic Approach Towards Self-care in Obesity Management, or HATSM (Brown and Wimpenny, 2011a; 2011b).

### Setting up the clinic

With space at a premium, it was difficult to find a room for the clinic but, after some rescheduling of GPs’ surgeries, a room within the health centre was allocated for one day a week. This provided a waiting area with seating suitable for patients who were overweight.

GP computer records were searched to compile an obesity register including:

» Patients with a BMI of 30;
» Patients with a BMI of >28 with comorbidities;
» Those presenting with metabolic syndrome;
» Those already attending clinics for coronary heart disease, diabetes and hypertension.

Appointment times were set, initially...

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**Table 1. Benefits of Weight Loss for Long-term Conditions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Result of weight loss</th>
</tr>
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<tbody>
<tr>
<td>Total cholesterol</td>
<td><strong>Reduced</strong></td>
</tr>
<tr>
<td>Low density lipoprotein</td>
<td><strong>Decreased</strong></td>
</tr>
<tr>
<td>High density lipoprotein</td>
<td><strong>Increased</strong></td>
</tr>
<tr>
<td>Blood pressure</td>
<td><strong>Reduced</strong></td>
</tr>
<tr>
<td>Glycaemic control</td>
<td><strong>Improved</strong></td>
</tr>
<tr>
<td>Type 2 diabetes risk</td>
<td><strong>Reduced</strong></td>
</tr>
<tr>
<td>Lung function in asthma</td>
<td><strong>Improved</strong></td>
</tr>
</tbody>
</table>

Source: Scottish Intercollegiate Guideline Network (2010)
for 30 minutes with 15 minutes for follow-up. Patients were invited opportunistically at consultation by nurses or GPs, or when they came for review of their long-term conditions.

A spreadsheet was created to monitor progress.

### Assessment

Patients had their BMI calculated and fasting blood-glucose, cholesterol and thyroid functions checked. This was to rule out hypothyroidism, diabetes and impaired glucose tolerance, and to calculate their cardiovascular risk.

It was important to establish patients’ understanding of the risks associated with obesity. While people are becoming increasingly aware of its links with diabetes and heart disease, links with conditions such as cancer, osteoarthritis and sleep apnoea are less well known.

Before presenting for advice on weight loss, most patients had already unsuccessfully tried to lose weight through low-fat diets, calorie counting, a commercial slimming club or joining a gym. Often, their first visit was quite emotional due to their low self-esteem, but listening to their account of the factors that contribute to weight gain in a non-judgemental way put patients at ease and encouraged them to open up and reveal more about their weight problems.

It was important to make patients aware that they would only lose weight if they reduced their food intake and increased activity levels. Once this “less in, more out” approach is achieved, weight loss has to follow. With the ultimate aim being weight maintenance following weight loss, it was vital that underlying issues and difficulties in making changes were identified and tackled. Eating habits and appetite are the result of complex physical and emotional behaviours.

It was important to assess readiness to change. Patients who are not ready to commit to change should be reassured that help will be available when the time is right for them. Review appointments for long-term conditions also provide the opportunity to discuss the topic again.

If patients have additional medical conditions – such as hypertension, dyslipidaemia or diabetes, or a high cardiovascular risk – they should automatically be offered support in weight management.

The increasing awareness that obesity is multifactorial has intensified the need for a holistic approach to its management. Patients need to take responsibility for their own health issues but there also needs to be a fundamental attitude change within the multidisciplinary team to ensure that patients receive the support, advice and guidance they need in order to be able to improve their health.

Using the flexible, structured HATSOM approach facilitated person-centred, holistic care that resulted in good outcomes. This was recognised by the National Obesity Forum in 2009, when this development won the Best Practice Award.

It provides a new approach to addressing weight management in primary care and may prove to be a useful tool in this ongoing challenge.

### References


