Managing obesity in primary care: do our patients deserve better?

Persons who are naturally very fat are apt to die earlier than those who are slender.

Hippocrates, *Aphorisms*, II.44

THE recent release of a new weight management drug onto the market in the United Kingdom has created a great deal of discussion, within both the lay and professional press, about the problem of obesity and its management within the health care system. However, instead of considered discussion about the merits of this drug within a sensible weight management plan, the response to its release has been reactionary, indicative of a poor understanding of the principles of effective weight management and highlighting the absence of any structured approach within the National Health Service (NHS) to tackling this serious health problem.

There is often hype and misinformation in lay publications surrounding the release of new drugs, and those that hold the promise of assisted weight reduction are likely to be of even greater interest to the general public. Orlistat is a lipase inhibitor that prevents the absorption of up to 30% of dietary fat, resulting in a lowered calorie intake and creating unpleasant reminders for those patients who fail to adhere to a low fat diet.[1] Its mode of action alone was enough to create intense interest. The stories in the daily newspapers about the new 'wonder slimming drug' were predictable, even though the available data showed that the average weight loss was modest (5%–10% of body weight) and is dependent upon adherence to a low fat diet and exercise plan.[2] In fact, the major benefits of the drug come from its ability to help prevent weight regain and produce meaningful improvements in blood lipids and blood glucose control.[2]

However, without some vision about how such drugs could and should contribute to effective weight management in appropriate patients, the current debate about Orlistat has lacked focus and allowed the old prejudgements about obesity to resurface. Health professionals found themselves dragged into discussions about whether the NHS should pay for 'lifestyle drugs', with the underlying assumption that obesity is not a serious health condition but rather a self-inflicted product of gluttony and sloth. Some general practitioners (GPs), keen to investigate this new therapeutic dimension that could help in the management of their obese patients, began prescribing immediately. Health authorities reacted by banning the prescription of Orlistat within their districts, reinforcing the notion that pharmacological treatment of obesity is not warranted. The end result is a great deal of confusion about what are acceptable and appropriate strategies for the management of obese patients within the NHS.

General practitioners and other primary health care professionals are — after obese patients themselves — the most directly affected by this lack of coherence in the management of overweight and obese patients within the NHS. Given the current situation, it is not surprising that many doctors consider obesity management to be frustrating, time-consuming, and pointless.[3] They are reluctant to take on the management of a condition that they feel ill-equipped to deal with and where there is little agreement on effective intervention. However, despite their reluctance, GPs are already investing considerable time in the management of the consequences of being overweight and obesity. The serious co-morbidities, such as coronary heart disease, diabetes, and certain cancers, actually account for only a small amount of weight-related ill-health dealt with in primary care. Of much greater consequence is the management of the non-fatal but debilitating health problems associated with obesity, such as respiratory problems, back pain, osteoarthritis, and fertility problems.[4]

Until recently, there has been little direct evidence to support the benefits of systematic management of overweight and obese patients within primary care. The potential for effective intervention in general practice was shown by Craddock in the 1970s, where he was able to significantly reduce the number of children who became obese within his practice by targeting pregnant women and new mothers with healthy eating advice and continued support. [5] A recent report from the NHS Centre for Reviews and Dissemination concluded that there is sufficient evidence from short-term studies to support the value of treating adult obese patients with a range of therapies, including diet, behaviour modification, exercise, drugs, and surgery where appropriate. The long-term benefits of such interventions remain to be proven but the report concluded that comprehensive care, which included regular follow-up and strategies for weight maintenance, should be integral to all weight loss programmes.[6] It also suggested that primary health care teams should be more actively involved in identifying overweight patients, helping them to reduce weight, and monitoring treatment. The value of such an approach was shown in a recent trial of a non-pharmacological intervention to control cardiovascular disease risk in Danish general practices.[7] Patents whose BMI was 30 kg/m^2 on entry to the trial had lost an average of 6% of body weight (together with a marked reduction in blood pressure and blood cholesterol) after one year of comprehensive care.

The Scottish Intercollegiate Guidelines Network (SIGN) was the first organization to build upon the recent trials demonstrating the benefits of moderate weight loss with the release of a comprehensive set of evidence-based guidelines on the management of obesity for Scotland in November 1996.[8] The SIGN guidelines were quickly followed by similar documents from the American Obesity Association,[9] the World Health Organization,[4] and the US National Institutes of Health.[10] Each organization produced similar algorithms for the clinical management of overweight and obese patients that focused on the role of primary care and were based on a structured process of care based on five key elements: recruitment and referral, comprehensive health assessment, goal-setting, selection and implementation of an appropriate management scheme, and monitoring and evaluation. In June 1997, the Royal College of Physicians of London released a report that provided additional guidance about the use of drugs in the management of obesity.[11] This report was substantially revised following the withdrawal of fenfluramine and dexfenfluramine from the market, and was then re-released in December 1998.

It has now been over two years since the SIGN guidelines were released, but the ambivalence towards obesity intervention within the NHS remains. There has been no concerted attempt to implement the guidelines in general practice or to effectively question their basis and provide alternative solutions.[12] Instead, inaction and uncertainty remain. Surveys of current practice in the management of overweight and obese patients reveal a situa-

tion in general practice where patients are often inadequately assessed, are set inappropriate weight loss goals, are offered limited therapeutic intervention, and are poorly supported and reviewed. Very few practices have an agreed protocol. It is not surprising that there is confusion concerning the role of drugs in such a management scheme.

Developing a coherent strategy for dealing with the issues of obesity in primary care must be a priority. Retreating from active intervention in obesity management is not in the best interests of patients and will only exacerbate the problem and create enormous pressures on the resources of primary care in the near future.

TIMOTHY P GILL

Scientific secretary, International Obesity Task Force

YVONNE H CARTER

RCGP chairman of research

Editorial submitted on behalf of the RCGP Steering Group on Obesity Management in Primary Care

References

1. Drent ML, Larsson I, William-Olsson T, *et al*. Orlistat (RO 18-0647), a lipase inhibitor, in the treatment of human obesity: a multiple dose study. *Int J Obesity* 1995; **19:** 221-226.
2. Sjostrom L, Rissanen A, Andersen T, *et al*. Randomised placebo-controlled trial of Orlistat for weight loss and the prevention of weight regain in obese patients. *Lancet* 1998; **352:** 167-172.
3. Cade J, O'Connell S. Management of weight problems and obesity: knowledge, attitudes and current practice of general practitioners. *Br J Gen Pract* 1991; **41:** 147-150.
4. World Health Organization. *Preventing and Managing the Global Epidemic*. [Report of the WHO Consultation on Obesity, Geneva, 3-5 June 1997.] Geneva: WHO, 1998.
5. Craddock D. *Obesity and its management*. 3rd edn. London: Churchill Livingstone, 1978; 160-173.
6. NHS Centre for Reviews and Dissemination. The prevention and treatment of obesity. *Effective Health Care* 1997; **3(2):** 1-12.
7. Traeden Ul, Holm L, Sandstrom B, *et al*. Effectiveness of a dietary intervention strategy in general practice: effect on blood lipids, health and well-being. *Public Health Nutr* 1998; **1:** 273-281.
8. Scottish Intercollegiate Guidelines Network (SIGN). *Obesity in Scotland. Integrating prevention with weight management. A national clinical guideline recommended for use in Scotland*. Edinburgh: SIGN, 1996.
9. Shape Up America. American Obesity Association (AOA). *Guidance for treatment of adult obesity*. Bethesda: Shape up America, 1997.
10. National Institutes of Health. C*linical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults: the evidence report*. Washington DC: US Department of Health and Human Services, 1998.
11. Royal College of Physicians Working Party of Obesity Management. *Overweight and obese patients: principles of management with particular reference to the use of drugs*. London: RCP, 1997.
12. Little P. GP documentation of obesity: what does it achieve? *Br J Gen Pract* 1998; **48:** 890-894.

Address for correspondence

Professor Yvonne H Carter, Department of General Practice and Primary Care, Medical Sciences Building, Queen Mary and Westfield College, Mile End Road, London E1 4NS. E-mail: y.h.carter@mds.qmw.ac.uk

Changing times for disinfection and sterilization procedures in general practice

LONG gone are the days when surgical and other clinical instruments boiled away in the corner of the treatment room. Current practice may soon change too as a result of a new European Commission directive 93/42/EEC,[1] which came into force on 14 June 1998. This directive has widespread implications. It is about the 'comprehensive regulation of medical devices' — anything from the vaginal speculum to the most complex of equipment such as an endoscope — and it determines how we should clean, prepare, and sterilize instruments for use in every aspect of clinical practice.[2]

Sterilization and disinfection are, of course, two very different processes. Disinfection is a process used to reduce the number of viable micro-organisms but which may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores. It does not achieve the same reduction in microbial contamination levels as sterilization. Sterilization, however, renders an object free from viable micro-organisms, including viruses and bacterial spores.

Most general practices now perform minor surgery and almost all undertake some minor invasive procedures. How and where our equipment is disinfected and sterilized, including even auroscopes and thermometers, are now governed by the new directive. Surgical instruments, and their preparation and sterilization, are of particular importance. Some practices possess bench-top sterilizers and may already be familiar with this directive. Others, that depend on their local hospital sterile supplies department (SSD), may not yet be aware of how it will affect them. Hospital SSDs that supply general practice surgeries may now find that they are unable to do so. The directive indicates that if a device or its labelling is altered by a hospital — for example, through its SSD — that provider then becomes responsible for it when used by a separate hospital or a general practice, in the same way as if it had just been manufactured. Hospitals or SSDs that clean, sterilize, and then pack devices for surrounding practices will have to show that they conform to these newer, more stringent recommendations. This, of course, has major financial implications, especially if new sterilizing equipment needs to be purchased in order for supplies to continue.[2]

Equipment or devices made available to clinics or practices, even on loan, also fall within the remit of this new directive. One may anticipate that some hospital departments may be unwilling to carry this responsibility. Paradoxically, if used by the same provider unit, or within the same set of hospitals, then there is no such issue. Failure to abide by these new regulations means that such health care providers in the United Kingdom would be liable to criminal proceedings.

Manufacturers of sterilizers also have a responsibility to inform clinicians about restrictions on re-using medical devices and how to sterilize them. Failure to do this can result in the repeated re-sterilization of equipment intended for only limited re-use, rendering the supplier (in other words, the hospital or SSD) liable to medical negligence. The balance between re-using equipment, in the light of environmental concerns, must be weighed against an economic assessment whereby purchasing single-use devices may be better in the long run.

So how exactly will this new directive impact on general practitioners (GPs)? These changes may mean that GPs will decide to purchase their own bench-top sterilizers resulting in

more on-site decontamination. This is where there are potential problems. Recent research has revealed a worrying lack of knowledge of these matters among GPs and their staff. In 1997, a study of over 8000 GPs in the Trent Region (response rate 49%) found that less than a half of GPs fully understood what was meant by sterilization.[3] In addition, over 90% of the GPs had a bench-top sterilizer, but only one-quarter possessed and used a log-book, and at least one-third of these users inadequately serviced the sterilizer at intervals of one year or even longer. In a more recent study in Northern Ireland of over 360 practices (response rate 30%), the vast majority undertook at least one of a range of surgical procedures.[4] However, only one-quarter and one-third of responders were familiar with the Medical Devices Agency (MDA) definitions of sterilization and disinfection respectively. In this latter study, almost 90% of the GPs were actively interested in a workshop on sterilization and disinfection.

In the context of an expanding interest in GPs carrying out minor surgical procedures in their practices, directive 93/42/EEC will undoubtedly impact on general practice, and soon. Furthermore, at least one medical protection agency has recently emphasized the medicolegal importance of infection control procedures in general practice.[5]

What sources of help can GPs access in order for them to remain free of criminal and medical negligence claims? First, the oft-quoted but still useful infection-control nurse for the locality may well have a part to play in some of these issues, often in collaboration with the medical microbiologist responsible for the local community. This is of particular relevance where practice nurses find themselves responsible for disinfecting and sterilizing procedures. Secondly, it is prudent to ensure that more than one person is familiar with the workings of the practice sterilizer, including the recommended procedures for servicing and maintenance. Thirdly, the MDA can provide advice and guidance on choosing the most apropriate sterilizer for your practice (see contact details below). Finally, the MDA produces excellent written material about a range of subjects; for example, general guidance on decontamination,[6] or the purchase and maintenance of bench-top sterilizers,[7] which are easily obtainable. There are also plans to hold a tripartite conference involving the MDA, the General Practice Committee (GPC) of the British Medical Association, and the Royal College of General Practitioners to explore and examine some of these critical issues.

Procedures for disinfection, sterilization, and the use and reuse of medical instruments are certain to change. This directive will alter the working practice of many treatment rooms. GPs, practice nurses, and management need to anticipate such changes before supplies of sterile equipment are withdrawn precipitously and without warning.

SURINDER SINGH

Lecturer and principal in general practice, Department of Primary Care and Population Sciences, Royal Free and University College Medical Schools, University College London, Royal Free Campus, London

DOMHNALL MACAULEY

Professor of primary care research and principal in general practice, University of Ulster, County Antrim, Northern Ireland

BILL REITH

Honorary secretary of Council, Royal College of General Practitioners, London

Technical enquiries: Medical Devices Agency, tel: 0207 972 8100; Internet: www.medical-devices.gov.uk

References

1. Council Directive 93/42/EEC. *Official Journal of European Communities* 1993; **36(L169, July 12):** 1-12.
2. Ridgway GL, Hodges CJS, Kreuzer MH. Implications of European directive on medical devices. *Lancet* 1998; **351:** 1831-1832.
3. Allen KW, Humphreys H, Sims-Williams RF. Sterilization of instruments in general practice: what does it entail? *Public Health* 1997; **111:** 115-117.
4. Smyth ETM, McIlvenny G, Thompson IM, *et al*. *A survey of sterilizing and disinfection in general practice in Northern Ireland.* [Abstract.] International Conference of the Hospital Infection Society, 13-17 September 1998.
5. The Medical Defence Union, UK. *Problems in general practice – minor surgery*. London: MDU Publications, 1997.
6. Medical Devices Agency. *Sterilization, disinfection and cleaning of medical equipment. Guidance on decontamination from the Microbiology Advisory Committee to the Department of Health Medical Services Directorate*. London: MDA, 1996.
7. Medical Devices Agency. *The purchase, operation and maintenance of benchtop steam sterilizers*. London: MDA, 1997.

Acknowledgement

We would like to thank Dr G L Ridway for commenting on an earlier draft of this editorial.

Address for correspondence

Dr Surinder Singh, Department of Primary Care and Population Sciences, Royal Free and University College Medical Schools, University College London, Royal Free Campus, Rowland Hill Street, London NW3 2PF.