Editorial

This supplement to the *International Journal of Obesity* is based on the proceedings of the symposium, 'Integrated Obesity Management: Bridging the Gap Between Primary and Secondary Care'. The symposium, held on 29 August 1998 and sponsored by Knoll Pharmaceuticals, was an official satellite of the 8th International Congress on Obesity in Paris, France.

The title of the symposium highlights the importance of bringing together hospital specialists and general practitioners in the management of obesity. During the last few years it has become obvious that obesity, with all its complications, is rapidly becoming a new epidemic of enormous proportions.¹ Traditionally, obesity was considered a self-inflicted condition affecting a small proportion of the population in affluent societies. Recent data have clearly demonstrated that obesity is increasing at an alarming rate in these countries. In less affluent countries, such as those of Eastern Europe, accumulating data are now demonstrating the paramount role of obesity as a threat to health in these societies, while in other parts of the world, where lifestyle and dietary habits would traditionally have helped control body weight, the incidence of obesity is increasing at an alarming rate.²

It is also important to note that the problems related to obesity are becoming more widely recognised. Over the last few years several new scientific associations have joined the International Association for the Study of Obesity (IASO). IASO now has members from about 30 countries, with members from ten new countries since the last international congress held in Toronto in 1994.

The establishment of the International Obesity Task Force has been an important development. It has been a driving force behind several initiatives aimed at identifying the problem and promoting practical ways to manage obesity at every level, from national recommendations regarding prevention and treatment down to straightforward suggestions for the development of structured programmes to treat obesity at the primary healthcare level.

Obviously, the scale of the obesity problem is such that treatment cannot just be the responsibility of a few specialists. Treatment will have to involve numerous doctors and other paramedical team members in many different sectors of each national healthcare system. The term 'specialist' may also need clarification. The term has often been used to differentiate the hospital physician from the general practitioner. However, in reality, very few hospital physicians are specialists in caring for obese patients. Many specialists are experts in endocrinology, diabetes, internal medicine, paediatrics, psychiatry etc. and have focused on obesity as one of their main interests. However, speciality units providing a comprehensive service to obese patients are very rare. Similarly,

training programmes in which obesity experts can assist the general practitioner in developing comprehensive management strategies for obese patients have been developed in very few countries.

Traditionally, the attitude of the medical profession towards obesity has been largely negative. Frank stated in one of his articles that 'The most common metabolic disease in the United States was treated with scorn, contempt and indifference.'³ Likewise, Hakala⁴ in describing the transition of a programme from an obesity speciality unit to general practice found that this was not possible, since most general practitioners asked did not want to continue the care of obese patients initially treated in a specialist unit: '...individual counselling by a physician interested in the management of obesity resulted in good results in long term weight reduction. Encouraged by this success, we designed a support programme in which every slimming subject has his or her own GP for follow up of weight and health status. This plan, however, did not work out in practice. Many GPs stated that they were not interested in or motivated by follow up of weight reduction in obese subjects.'⁴

An analysis of the letters of referral from physicians in the Stockholm region to our obesity unit found that basic information such as weight and height was often missing and that details of comorbidities, clearly of major importance for evaluating the referral letter, were generally inadequate.⁵ Only 7% of the referral letters contained the basic information which could reasonably be expected according to International Obesity Task Force (IOTF) standards.⁶ We carried out a survey of the registered physical activity programmes at the primary healthcare level, identified using the most commonly available Swedish database on healthcare delivery systems. Of the 151 programmes reported in the database, only 51 were in operation. The quality of these programmes was generally low, objectives were unclear and evaluation was rarely undertaken. Therefore, the obese patient in Sweden advised by his or her general practitioner to take up physical activity through a community-run programme will clearly have difficulty in finding a worthwhile programme.⁷ These examples suggest that the attitude to obesity among many specialists and most general practitioners results from frustration, as well as a lack of knowledge and interest.

It is important to develop future strategies for bridging the gap between those who are specialists in managing obesity (which may be different to 'specialists' in another metabolic field) and general practitioners. Unless specialists give priority to obesity management and convey the message to general practitioners that obesity management is important, relevant and worthwhile, the wrong signals will be

sent to the entire healthcare system and the outlook for patients is unlikely to improve.

In almost every society nobody wants to be obese. Today even in developing societies it has been realised that obesity carries negative health risks. We must learn to understand why a condition nobody strives for has become increasingly frequent and why so few comprehensive strategies have been developed to combat obesity.

The objective of the symposium was to illustrate the scope of the problem of obesity, to identify interesting pilot projects and to suggest constructive programmes which could be developed in future in collaboration between specialists and general practitioners. A particularly interesting component was the use of interactive keypads, enabling immediate audience reaction to questions asked during the symposium. The audience responses were screened seconds after the questions were asked, giving immediate feedback on the issues being addressed. Audience response data are included in this supplement to give a full flavour of the symposium.

I would like to conclude by thanking my co-chairman, Vojtěch Hainer, for his help and support. Thanks are also due to Knoll Pharmaceuticals for making the symposium and this supplement possible.

Stephan Rössner

Symposium Co-Chairman

References

- 1 Björntorp P. Obesity. *Lancet* 1997; **350**: 423–426.
- 2 James WPT. The International Obesity Task Force: obesity at the World Health Organisation. *Nutr Metab Cardiovasc Dis* 1996; **6** (Suppl): S12–S13.
- 3 Frank A. Futility and avoidance. Medical professions in the treatment of obesity. *JAMA* 1993; **269**: 2132–2133.
- 4 Hakala P. Weight reduction programmes at a rehabilitation centre and a health centre based on group counselling and individual support: short- and long-term follow-up study. *Int J Obes* 1994; **18**: 483–489.
- 5 Linné Y, Rössner S. The quality of referral letters to an obesity unit. *Int J Obes* 1998; **22**: 1231–1233.
- 6 World Health Organisation. Obesity – preventing and managing the global epidemic. Report of a WHO consultation on obesity, Geneva, 3–5 June 1997. WHO/NUT/NCD, 1998.
- 7 Hjalmarson A, Rössner S, Östenson CG. Supervised physical activity in Sweden – theory and practice. *Patient Education and Counseling* 1999.

Audience questions and answers relating to Professor Rössner's Introduction to the Symposium (see Editorial)

Q1. Which region of the world do you come from?

Selection	Percent (%)
Europe	61.9
The Americas	24.7
Asia/Australasia	8.1
Africa	4.5
Middle East	0.9

Rössner: So we have a majority of Europeans, quite a lot from the Americas and a few people from other parts of the world.

Q2. How would you best describe your professional role?

Selection	Percent (%)
Community based	33.1
Hospital based	66.9

Rössner: So while the majority are hospital based, there are quite a number who are community based. This is clearly important, given that we are looking at bridging the gap between primary and secondary healthcare.

Q3. How important do you feel the following options are in helping to bridge the gap between primary and secondary care in obesity management? (Please rank)

Audience ranking	
1st	Multidisciplinary teams
2nd	Educational programmes
3rd	Management guidelines
4th	Management centres
5th	Additional resources

Rössner: In this global evaluation, 'Multidisciplinary teams' are viewed as the most important. It's interesting to note that 'Additional resources' come at the bottom. Now let's see the results separated according to hospital or community based:

Community based		Audience ranking Hospital based	
1st	Educational programmes	1st	Multidisciplinary teams
2nd	Multidisciplinary teams	2nd	Educational programmes
3rd	Management guidelines	3rd	Management guidelines
4th	Management centres	4th	Additional resources
5th	Additional resources	5th	Management centres

Rössner: The first and second alternatives have swapped, but education and a multidisciplinary approach are still the most important things.

Audience questions and answers before Dr Evans' presentation

Q1. Which of the following arguments are likely to be the most influential in changing patients' attitudes?

Selection	Percent (%)
Health consequences	27.1
Moderate weight loss	26.6
Personal impact	46.4

Rössner: So, the global response here is to think of the 'Personal impact' as the most important argument.