

Letter to the Editors

Comment on the Paper by Uerlich et al: Obesity Management in Europe: Current Status and Objectives for the Future. Obes Facts 2016;9:273–283

Vojtech Hainer^a Constantine Tsigos^b Hermann Toplak^c Dragan Micic^d

^aObesity Management Center, Institute of Endocrinology, Prague, Czech Republic;

^bDepartment of Nutrition and Dietetics, Harokopio University, Athens, Greece; ^cDepartment of Internal Medicine, Medical University of Graz, Graz, Austria; ^dMedical Faculty, University of Belgrade, Belgrade, Serbia

Surveys on Obesity Management in Europe

The recently published paper entitled ‘Obesity management in Europe: current status and objectives for the future’ (Obes Facts 2016;9:273–283) summarizes the results of a survey on obesity management conducted in 23 member countries of the European Association for the Study of Obesity (EASO) [1]. The team of authors includes experts both in obesity management and in obesity prevention and emphasizes the important role of preventive measures in changing the obesogenic environment to a leptogenic one and thus contributing to the improvement of obesity management across Europe.

This is the third survey on obesity management in EASO member countries. The two previous surveys prepared by the Obesity Management Task Force (OMTF) of the EASO were conducted in 2003 [2] and 2007 (unpublished results). All surveys showed insufficient care of obese patients across Europe although the questions addressed to obesity experts differed between them. Moreover, in the previous surveys representatives of the national obesity associations (presidents or vice-presidents) filled the questionnaire after consultation with members of the National Executive Committees, while the survey by Uerlich et al. [1] included a broad spectrum of participants (e.g. researchers, general or specialized physicians, dietitians, psychologists, exercise physiologists, and social workers) who were invited to participate by the presidents of the national obesity associations.

Failure in the Implementation of Guidelines on Obesity Management

Uerlich et al. [1] stressed the role of guidelines in the implementation of effective measures in obesity management. The first comprehensive guidelines on obesity management appeared in the 1990s. In 2003, the first European survey among EASO members established that national guidelines were available in 18 of 24 member countries [2], but all representatives of the national obesity associations recommended to prepare European guidelines. In response to this call, the first European guidelines on obesity management were published in 2004 [3]. These guidelines, developed by the EASO OMTF and based on 13 existing national obesity guidelines, addressed in particular primary care physicians and emphasized mainly the role of common rules in obesity management. A recently published EASO position statement on multidisciplinary obesity management in adults briefly summarizes the main principles in the care of obese adults [4]. All above mentioned recommendations provide just essential information on principles of obesity management. However, several more comprehensive guidelines on both obesity management and on bariatric surgery have been published and frequently translated to national languages of the EASO member countries [5–7]. In addition, more extensive guidelines on obesity management have recently been published both in Europe [8] and the USA [9]. Uerlich et al. [1] consider currently available guidelines too long and elaborate for daily use and report several reasons for the failure in implementing these guidelines [1]. The absence of efficient multidisciplinary teams and multi-level networks in obesity management may certainly play a crucial role. Thus, specialized obesity management centers should have a unique position in coordination of obesity management and guideline implementation. In 2007, such specialized centers existed in 15 out of 18 EASO member countries, as reported by national obesity associations, and their number highly varied across Europe. Some of them which fulfilled the EASO criteria joined later a network of EASO-Collaborating Centers for Obesity Management (COMs) [10], together with many others over time to reach by now the number of 70 from 32 professional membership associations across Europe.

Involvement of Physicians in the Care of Obese Patients

According to the first EASO OMTF survey carried out in 18 EASO member countries in 2003 [2], different physicians were involved in the care of obese patients:

- obesity specialists in 94% of countries,
- general practitioners (GPs) in 89% of countries,
- other physicians in 44% of countries.

GPs were mainly engaged in obesity management in 50% countries, obesity specialists in 32% countries and other physicians in 18% countries. The second EASO OMTF survey conducted in 2007 in 24 EASO member associations confirmed that in most countries, obesity management is in the hands of GPs or other physicians (e.g. internists, endocrinologists/diabetologists, cardiologists, gynecologists) with no specialized expertise in obesity management. Moreover, funding for GP's care of obese patients in European countries widely differed. It was provided either by health insurance (36%) or government (36%) or paid privately by the individual (28%). None of the responders to the survey rated the quality of care of obese patients provided by GPs as appropriate and gave several reasons: unsatisfactory treatment outcomes, inadequate reimbursement for the time demanding care, poor knowledge about obesity, and underestimation of obesity as a disease by both public and health care providers. In the same survey, 96% of responders supported engagement of obesity specialists in the care of obese patients as well as the need for specialized obesity

training. In some countries, however, there are many individuals and institutions that declare themselves as obesity specialists, obesity centers or clinics, but frequently without appropriate expertise. Moreover, some of them use ineffective or potentially harmful treatment procedures.

A recent survey conducted among 2,022 US primary care physicians revealed that almost two-thirds felt that they lack effective strategies to help obese patients although they felt a responsibility to promote weight-related care [11]. A similar national survey from the USA reported that primary care physicians perceive the lack of patient motivation as the greatest barrier in the successful obesity management, while they feel that better knowledge of obesity management and positive attitudes towards it among physicians may contribute to a better outcome [12]. Another study conducted among family physicians described a general sense of frustration in managing obesity – resulting from poor reimbursement for the time-demanding treatment, a lack of self-efficacy, and many factors that were perceived as beyond the physician's control [13]. Finally, a recent international study [14] addressed 335 clinicians who cared for obese patients in order to investigate their attitudes and practices in obesity management. Approximately half of the participants were based in Europe, most of them were nutritionists (26.0%), obesity specialists (19.1%), and endocrinologists/diabetologists (17.0%). It is not surprising that these experts were confident in their ability to manage obesity effectively. However, they reported that most of their patients were unable to achieve their weight loss goals. Although participants emphasized a need for comprehensive multidisciplinary obesity management, only 72% had access to a dietitian, and most of them had limited access to services by psychologists/psychiatrists, exercise physiologists, specialist nurses etc. Rather low was also the access to a bariatric surgeon (32%), pharmacotherapy (37%) and meal replacement (26%). Surprisingly, the lowest access to pharmacotherapy was in Europe (28%) and North America (14%). As expected, the access to most services was much higher among obesity specialists.

Who Are Obesity Specialists?

Multiple surveys and obesity management strategies included obesity specialists or physicians with special training in obesity management in the care of obese patients [3, 5, 8, 10]. As reported by Uerlich et al. [1], 'specialists are often not specifically specialized in obesity'. Moreover, no concrete definition of obesity specialists has been provided nor the conditions required for their practice. Notably, obesity specialists engaged in EASO COMs were required to be physicians with special training in obesity management, e.g., SCOPE fellows or other physicians with comparable knowledge, skills, and competence as documented by a structured CV; specific clinical research experience and training were also expected [10].

No doubt, an obesity specialist should be a physician with expertise in the sub-specialty of obesity medicine (obesitology). He/she should be a partner of health authorities including the health insurance companies in the implementation of the obesity management program in daily medical practice. Nowadays it is not popular to create new medical sub-specialties which usually lead to further splitting of the current medicine. Nevertheless, obesity medicine is not about splitting but about connecting not only medical but also other related disciplines.

In the USA, a country with one of the highest prevalences of obesity, a sub-specialization in obesity medicine was initiated 4 years ago when The American Board of Obesity Medicine was established with American Society of Bariatric Physicians, The Obesity Society, Columbia University Institute of Human Nutrition, and Harvard Medical School Blackburn Course in Obesity Medicine as primary continuing medical education partners [15]. Nowadays, over

1,600 American doctors obtained a certificate for obesity specialist [15]. However, whether or not to follow Americans and to establish obesity medicine ('obesitology') as a novel medical discipline in Europe should be seriously considered. Both experts and health authorities in each particular country should take into account the locally available educational system in postgraduate medicine as well as specific human and financial resources. Specialist weight management for severe and complex obesity is now accepted in the UK health system [16]. However, it is emphasized that there is no single stakeholder willing to take overall responsibility for obesity care. Perhaps, obesity management centers together with certified obesity specialists could play this role in the future.

Voluntary and Commercial Weight Management Groups

It is obvious that no health care system can afford to take care of all overweight and obese individuals. Many overweight individuals and subjects with uncomplicated obesity can obtain appropriate care in voluntary or commercial weight loss groups. Even in 2003, most EASO member countries (90%) had both voluntary and commercial weight management groups, whereas work-site groups were reported only in 4 countries [2]. It can be assumed that nowadays an accessibility of weight loss groups has substantially increased across Europe. Cognitive behavioral therapy applied in groups may significantly increase motivation of obese patients to be actively involved in obesity management. In addition, more information for changing lifestyle could be provided for obese patients through educational materials, books, TV, and other media, but only delivered by competent experts

Conclusion

Uerlich et al. [1] appeal in their paper for more emphasis on the long-term multidisciplinary approaches and on the collaboration between health care providers in obesity management. This demand is in agreement with other reported experiences in obesity management. Recently, a need for introducing certified obesity specialists in the care of obese patients has been raised. Obesity specialists together with obesity management centers should ensure evidence-based approach across the obesity management networks and should communicate, as acknowledged partners, with health care authorities and insurance companies about obesity prevention and treatment.

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