

GET TO GRIPS WITH OBESITY

(4) HOW PHARMACISTS CAN CONTRIBUTE TO OBESITY MANAGEMENT

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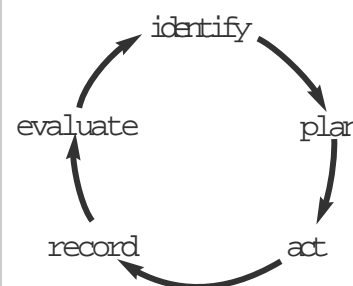
This last article in our series on obesity looks at ways in which pharmacists working in different sectors of health care can make a difference to obesity management



identify gaps in your knowledge

1. Can you list three drug groups that can cause weight gain?
2. Can you name a Government document that calls for obesity to be targeted?
3. If you had to write a protocol for the use of anti-obesity drugs, what guidance should it be based on?

This article relates to the Royal Pharmaceutical Society's core competencies of "common disease states" and "health promotion" (see "Medicines, ethics and practice — a guide for pharmacists", number 25, July 2001, p104). You should consider how it will be of value to your practice.



Unfortunately, despite the growing numbers of obese and overweight people, many health care professionals receive little formal education about obesity. The aim of this series is to provide enough information to support pharmacists who wish to be able to advise competently on this condition. Pharmacists are well aware of the dangers of obesity. But how can they have an impact on this challenging condition?

Obesity can be tackled in three ways. First, a whole community can be targeted. For example, promoting activities such as "walk to school week" will help instill a positive lifestyle change in children and their parents. This is called primary prevention and aims to prevent people from becoming obese. Secondary prevention means to target people who are already obese but have not yet developed any complications. These are people that many general practitioners do not see until they have become ill but pharmacists do see. The third way to tackle obesity is to cater for those who are obese and suffer from an associated medical problem. For example, you could offer waist-to-hip ratio measurements and advice to all patients for whom you dispense anti-hypertensive drugs.

THE COMMUNITY PHARMACIST

Community pharmacists are unique in that they get to know many of their patients well. Also, no other sector of pharmacy sees so many obese and overweight people daily. Obesity management requires support, follow-up and feedback and community pharmacists are in a good position to do this.

What services could you offer? Community pharmacists could offer different levels of intervention to overweight and obese patients (see

Panel 1 on p721). The most comprehensive service would be contractual in nature, sold to primary care trusts as a local pharmaceutical service and as part of a multidisciplinary weight management service. The level of intervention offered may depend on your interest, ability, knowledge, other services available, PCT interest, time and financial issues. Whatever you choose to offer, psychology is important so make sure your support is always friendly and well informed, and you can offer a private area for consultation. As a starting point, community pharmacists could buy a set of scales and tape measure and offer simple weight and waist measurements. As you gain patients, your service could develop beyond this. There may well be prescribing opportunities in the future.

Offer a personal service. Get to know your patients, their reasons for wanting to lose weight, and bear these in mind. The reasons why health care professionals tell patients to follow a certain course of action (eg, reduced cardiovascular events) may not influence patients (eg, "I want to be able to walk my children to school without them being embarrassed", "I want to be able to go out with my partner for dinner in a nice dress", "I don't want to have to wear a mask at night to help me breathe properly"). If we understand what motivates the patient, we can give better support.

Even if you decide not to offer any of the interventions shown in Panel 1, you should still be prepared to advise your patients on the weight gain side effects of the drugs you dispense, such as steroids, hormone replacement therapy, oral contraceptives, some antidepressants and sulphonylureas.

How will you be paid for offering services? There are two options here, but both can be exercised simultaneously. Many individuals currently pay over £10 to register with commercial weight loss organisations and over £5 per visit to what is essentially a social meeting around a set of weighing scales. These organisations are successful because of their ease of access, the availability of time for consultation and peer support.

So you might choose to charge patients a nominal fee per consultation but with the extra benefits of cholesterol and blood pressure screening and tailored advice on weight management. Take

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PANEL 1: LEVELS OF INTERVENTION IN OBESITY MANAGEMENT

I: OPPORTUNISTIC HEALTH PROMOTION

- 1 Passive leaflets available on healthy eating, lifestyle and exercise

II: ACTIVE HEALTH PROMOTION

- 1 Obese and overweight patients are actively selected and directed to health promotion material
- 1 Leaflets and advice are about losing weight and BMI risks

III: SIMPLE BMI MEASUREMENTS

- 1 In addition to active health promotion (II), individuals are invited to have BMI, waist or lean body mass and fat (using impedance monitors) measured
- 1 BMI chart supplied
- 1 Information on the benefits of weight loss are supplied (eg, coronary heart disease risk chart)

IV: OBESITY SCREENING SERVICE

- 1 In addition to simple BMI measurements (III), the individual is invited to have blood pressure, cholesterol and/or blood glucose measured.
- 1 Simple explanations on the meaning of each, and its relationship with obesity and morbidity should be given

V: WEIGHT MANAGEMENT SERVICE

In addition to an obesity screening service (IV), the consultation encourages an action plan with:

- 1 Realistic targets and discussion of expectations, failures and successes
- 1 Selective advice on diet, exercise and lifestyle
- 1 Information on a variety of nutritional and meal replacement products
- 1 The supply of a patient diary
- 1 A patient diary
- 1 Maintenance of records of patient parameters

VI: PHARMACIST PRESCRIBING

- 1 Pharmacist prescribing of anti-obesity agents within a weight management service (V), under a patient group direction or supplementary prescribing.
- 1 This would require an organised template for diet, drug and family history, and is likely to involve a contractual service to the PCT with referrals, GP faxback, monthly prescribing consultations and audit.

advantage of being qualified to advise on the results of tests and their implications on other diseases where appropriate. Many pharmacists are already offering simple testing with supportive advice and may choose to build on this.

The second option is to approach your primary care trust. Although PCT funds may already be allocated to various national service framework (NSF) incentives, obesity management falls within many targeted areas, for example, it is included in the NSF for coronary heart disease. PCTs will need to manage obesity and will be on the look out for support, but do not expect your PCT to part with monies for a plan or idea that you might be able to implement. It will give priority to those who already have their plan in action. Get your service running and develop it step-by-step. Be there at the right time, in the right place, with the right activity and in a position to prove your value. The following are tips for gaining access to funds:

- 1 Familiarise yourself with local priorities (eg, most health authorities have identified obesity as an issue in their health improvement plans) as well as with obesity management essentials.
- 1 Make the initial investment, be this time or money or both. The incidence of obesity is increasing and the obese individual is the

customer of the future, so this is an area worth investing in. Smaller pharmacies could join forces and share investment.

- 1 Make noise about your service and market yourself and colleagues. Speak to other health care professionals. Establish contact with local dietitians and diabetes nurses with a view to developing co-ordinated local management.
- 1 Some measure of activity and outcome will be asked for by those holding the purse strings. It should not matter if your numbers are small, as long as your methodology is efficient and robust.
- 1 Create simple patient questionnaires to provide evidence of patient satisfaction with your service.
- 1 Liaise with public health, your local pharmaceutical committee, local pharmacy groups and pharmacy advisers. These are a good source of support.
- 1 For those providing smoking cessation services it is worth pointing out that many patients who notice weight gain when they stop smoking will be prompted to start smoking again. Although priority must be given to smoking cessation, it would be worth offering smoking cessation and weight management services together.

As put by Graham Phillips in his excellent feature in *Pharmacy Magazine*,¹ "Have the facts (of obesity) on your fingertips and be ready to demonstrate, with examples, how this service development will work, what audit mechanism will be, and how you propose to measure what you have achieved. Then, and only then talk money."

I recognise that many community pharmacies, particularly smaller independents are finding business tough. Issues such as clawback and resale price maintenance have left morale low. Some may feel that development of new services will be difficult when they are finding it hard to maintain the services they currently supply. But unless new ways of generating revenue are explored, nothing will improve. The "sit and wait to be paid" attitude is no longer viable. If you do not set up and offer services as an individual or a group, then others will. The supplementary prescribing potential applies as much to dietitians and nurses as it does to pharmacists and we cannot leave our fate to others.

HOSPITAL AND FORMULARY DEVELOPMENT PHARMACISTS

Although obesity should be managed in primary care, many obese or overweight patients end up in hospital beds and on outpatient waiting lists because of problems associated with this condition (eg, type 2 diabetes, coronary heart disease, gallbladder disease, osteoarthritis, respiratory disorders, infertility and cancer). By the time this happens, we are forced to manage these diseases and at high cost.

It is usually unnecessary for hospital pharmacists to manage obesity because dietitians are available for this purpose. However, it is possible for hospital pharmacists to contribute. Hospital pharmacies can certainly participate in opportunistic health promotion by putting up posters and providing healthy lifestyle leaflets. But also, next time you are asked to work out a dose of a drug for an overweight patient, perhaps you could check whether he or she has been referred to the dietitian. Advice from hospital pharmacists can also be given to primary care patients even if a drug is not on formulary. Increasingly, drugs are recommended by a consultant's letter after an episode in outpatients. This letter could be supplemented with a "Guidance on the use of . . ." sheet which could be easily devised. With some 50 drugs being developed for the management of obesity over the next decade, hospital pharmacists should also be in a position to advise on the use of these future agents.

Formulary pharmacists can make a difference by formulating guidelines and protocols for obesity. The National Institute for Clinical Excellence has provided guidance on the two drugs currently available (orlistat and sibutramine), but some work is required to combine both sets of guidance with the summaries of product characteristics (SPC) and meaningful data on obesity management in order to make valid decisions.

Many secondary care trusts will not have evaluated these agents and anti-obesity drugs may not even be approved for use. But chances are, your diabetes consultants are already prescribing orlistat and sibutramine. Are they prescribing with your guidance? Even if they are only used in a small proportion of patients, multidisciplinary

action : practice points

1. The British Dietetic Association launches its three-year "Weight Wise" campaign in June. Plan an activity in line with this campaign. Resources such as posters, stickers and leaflets can be ordered via the website www.bda.uk.com
2. Do you know a dietitian? State registered dietitians can be contacted via your local hospital or GP practice. Contact your local dietitian and discuss the possibilities for obesity management in the context of your practice.
3. Look at Panel 1 and write down the pros and cons of each level of intervention.

evaluate

How could your learning have been more effective?
What will you do now and how will this be achieved?

nary teams should be aware of the nature of these drugs. In my experience, many non-pharmacists are involved in giving drug information and advice to patients, particularly in areas which have specialist multidisciplinary input. For example, nurses and dietitians will be the ones in contact with patients with diabetes, so pharmacy support on the use of drugs is essential.

If your formulary does not contain anti-obesity drugs, you could rectify this and create guidelines for their use to ensure that NICE and SPC criteria are met. You do not have to reinvent the wheel; obesity guidelines are found within organisations such as the National Obesity Forum (www.nationalobesityforum.org.uk) and the Association for the Study of Obesity (www.aso.org.uk). Support your guidance with the clinical benefits of weight loss, for example, serum cholesterol falls by 1 per cent for each kg lost. However, because cost is always an issue, also express the benefits of how improved metabolic markers will reduce the need for antidiabetic, antihypertensive, cholesterol lowering and other therapies in terms of money.

Sharing information is important. Your PCT counterpart, prescribing leads, diabetes consultants and PCT diabetes leads are essential points of contact. Hospital and primary care pharmacists do not get much opportunity to communicate so break this rule. Be active at hospital-primary care interface meetings. Joint guidelines and shared care protocols can be created to allow first prescribing in hospital with continuation in primary care. For example, the statins were once considered the domain of primary care. This is not so today because it was realised that if secondary care did not start prescribing, primary care would miss certain patients. The NSF for coronary heart disease has helped to encourage shared protocols for statins, but the same is not true for anti-obesity drugs.

PHARMACISTS WORKING FOR PCTs

The hub for planning and implementing obesity management is the PCT. The NSFs for coronary heart disease and diabetes both have standards for reducing the incidence of these diseases, and obesity is implicated as a major modifiable risk factor, with PCTs being called to take the lead. PCT pharmacists are linked to both hospital and community counterparts and should have already considered issues regarding obesity and its management. Under standard 1 of the NSF for heart disease, PCTs should have agreed and contributed to the delivery of local programmes and policies on reducing smoking, promoting healthy eating, increasing physical activity and reducing overweight and obesity by April 2001 (milestone 2) and in April this year, should have had quantitative data on the implementation of these policies (milestone 3). Part two of the diabetes NSF is due this summer and is likely to present more milestones for obesity management. The report "Tackling obesity: a toolbox for local partnership action" provides a framework for developing local action plans.²

PCT pharmacists should be able to influence and support the provision of obesity management services. We know that community based groups set up in primary care to stop people smoking have been successful and similar models for weight management are up

and running. Health action zones that have been working on weight loss projects (eg, exercise initiatives and healthy eating promotion) have reported positive outcomes. However, although primary care professionals appear keen to participate in weight loss programmes, some PCTs have only recently decided that this is an area worth investing in and so have a problem because funds have already been prioritised. Most weight management programmes set up by PCTs will probably be arranged to complement programmes within existing nurse-led clinics (eg, diabetes care and smoking cessation), but by the nature of these clinics, people who are obese but do not yet have health problems may not be seen. Given that prevention is better than cure, these people need to be catered for. What better place than the local pharmacy?

The average practice with 2,000 patients will have about 250 adults patients who are obese (similar in number to those who have hypertension and approximately twice the incidence of depression) and half of these will be motivated to begin weight loss programmes. Simple strategies are best and should target weight maintenance as well as weight loss. Programmes should aim at improving diet, increasing activity and motivating lifestyle changes. A small number of patients may benefit from drug therapy and given that there are only two agents recommended, guidelines can be relatively simple.

Currently, there are few clinics offering obesity management services in primary or secondary care (in 1998, the NHS Clinical Obesity Group counted only 12 in England) so activities tend to be carried out by a variety of health care professionals in an unco-ordinated fashion. Commercial weight loss programmes may be useful to some, but not all patients (particularly men) respond to the peer pressure format. The creation of champion practices in weight management supported by the PCT pharmacist will prompt PCTs to see the value of treating obesity.

ACTION IN OBESITY

Obesity prevention and management requires proactive action from all sectors: health care; the sports and food industry; schools; and Government. At last, the Government seems to be doing something about obesity. The NHS Plan states the intention to tackle obesity by improving the nation's diet (eg, the "five a day" pilots) and national service frameworks contain more exacting targets for local action. Schemes such as "exercise on prescription" which involved an agreement between a group of surgeries and health centres have had positive results. In one particular scheme, GPs and nurses in North West Lancashire were able to assess patients and refer them to a lifestyle fitness officer. Patient commitment was obtained by asking patients to sign a contract. Of the 779 patients who provided follow-up data, 58 per cent had lost weight and 94 per cent had a decrease in body fat. Simpler schemes have been successful. Researchers at Glasgow University and Glasgow Health Board found that displaying posters with the slogan "Stay healthy, save time, use the stairs" in a station increased stair use from 8 per cent to 15-17 per cent. This led to the Scottish Health Board distributing motivational posters to encourage the use of stairs in Scottish workplaces.

Recently, the report of the National Audit Office (Tackling obesity in England) along with the work of groups such as the National Obesity Forum appear to have culminated in the launch of an all party parliamentary group on obesity. For pharmacists, with the existence of patient group directions and the advent of near patient services, the climate for developing new skills in obesity management is good. Obese patients should have easy access to evidence based interventions and receive a directed flow of care. Our contribution will show that pharmacists can make a difference.

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