

Letters

Conversations about obesity need to be realistic and informed

In response to the Ewald et al article 'Quantifying the benefits and harms of various preventive health activities' (*AJGP* December 2018),¹ we would like to comment on the benefits and harms attributed to weight loss. Tools to aid discussion about preventive health activities are welcome. But while the article provides useful information for health service prioritisation, it is of limited assistance for discussing individual risk with patients as risk is presented as a population-based statistic.

It is always important to set realistic goals with patients. While 40.9% of the eligible population participated in bowel screening in 2015–2016,² the annual probability of 5% weight loss (approximately 2 kg/m²) is 12.5% for people with a body mass index (BMI) 35–39.9 kg/m².³ This weight loss is far less than the five-point BMI reduction that is mentioned in Table 1. The article is potentially advocating for unrealistic weight outcomes for patients living with obesity.

The article also does not discuss the differences in treatment burden for the proposed preventive activities. For example, attending to bowel cancer screening is much less burdensome for patients than weight loss treatments.

Table 1 does not provide any examples of harm from weight loss despite a large body of literature describing the experience of harm in family interventions, workplace interventions,⁴ and post-bariatric surgery.⁵ Harms can be related to stigmatisation,⁴ side effects from

medications,⁶ through to life-threatening harms including suicidality and self-harm.⁵ No treatment is without potential side effects or adverse events and patients must be informed of these when making decisions about care. And these harms are likely to be mediated in positive and negative ways as a consequence of the patient's particular life circumstances.

We advocate for obesity risk to be kept in perspective with other harms, for realistic and context-orientated goals to be set with patients,⁷ and for potential harms from weight loss management to be always visible.

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Reply

The correspondents point out some interesting aspects of the problem we set out to explore, but may have misread some aspects. If a patient asks, 'How much health benefit will I get if I do X?', the answer has to be based on observations made on a sample of people. This is necessarily a probabilistic process. All discussion of risk is based on prior observation of a population sample. We do not know whether the individual in question will benefit at all, but we can derive an estimate of change in risk from the best available evidence collected from a population of other people.

When risk reduction is pursued by changing a risk factor that is a continuous variable, the question arises of how much risk reduction for how much risk factor

change. We chose 5 body mass index (BMI) points as the quantum of risk factor change, but were not advocating that this should be a target for weight reduction. We could have equally calculated the result per 1 unit of BMI, or 0.1 units of BMI. For the record, for 1 BMI unit the reduction in deaths per 1000 per decade would be 4.5 for men and 2.7 for women, and for 0.1 BMI unit the numbers would be 0.46 for men and 0.27 for women.

The correspondents seem overly concerned with potential harms of weight loss. In the table we present some potential harms, but have labelled this as an incomplete list. Harms and treatment burden are quite individual, but at least our approach quantifies the benefits side of the equation (at least the mortality risk). This may be of assistance to clinicians engaged in discussion of preventive activities to help patients set realistic goals consistent with their values.

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Cloud storage system for patient data would contribute to better healthcare in general practice

The Astana Declaration has identified the crisis facing delivery of future primary healthcare.¹ Likewise, the Royal Australian College of General Practitioners (RACGP), Royal College of General Practitioners (RCGP), The Royal New Zealand College of General Practitioners (RNZCGP) and Jackson and Ball highlight the need for quality care through promotion of continuity of care in general practice.²

The question is how do we measure and promote continuity of care in general practice? This needs to be examined within the broader context of holistic healthcare of patients, in many of whom multimorbidity is the norm. Holistic care in general practice also includes continuation of multidisciplinary specialist care, especially in the aged. Here, general practice plays a central and pivotal role.

Access to medical data on care delivered by every healthcare provider is vital to better understand patient status, and provide more optimal care to the patient by current or new healthcare provider(s) of the patient's choice.

In many countries access to such data is currently limited, inadequate, delayed or non-existent, often relying on the patients' recall and ability to produce discharge letters provided years earlier that are more often misplaced by the elderly. Lack of patient data is unsatisfactory for the promotion of optimal continuity of care.

In this digital age, cloud storage – unified data storage in which data can be stored and retrieved instantly from secure and durable storage systems – is a reality. There is additional backup archival storage to prevent data loss. The use of such a cloud storage system enables rapid access to healthcare details across disciplines to healthcare providers of the patient's choice.

Use of such a system in general practice would contribute to promotion of optimal care through better record keeping, and access to data through a system that can be easily audited (measured) for effectiveness and efficiency.

This proposed cloud storage system is already in use in some parts of Australia. Queensland Health has used a Health Provider Portal (HPP) for general practices and hospital clinicians for several years. HPP users need a QGov login account. Expected benefits include a reduction in duplicate tests and improved patient outcomes.³

The use of cloud storage systems needs to be expanded, especially in countries like Malaysia, to optimise healthcare outcomes.

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