

The diagnosis and treatment of eating disorders requires a high level of competence from doctors. Who should possess this competence, and what patients should be in focus?

Eating disorders in general practice

Eating disorders are mental illnesses, the somatic symptoms of which are included in the diagnostic criteria. Patients may also have somatic complications that can affect their mental state. Such a combination of psychiatry and somatic symptoms can be challenging for the treatment provider in the primary as well as the specialist health service, and may contribute to a perception that this is a difficult patient group that requires special competence.

The prevalence of anorexia and bulimia nervosa in young women is estimated to be 0.2–0.4 % and 1.0–1.5 %, respectively (1). Eating disorders not otherwise specified, including binge eating disorders, are even more common and occur in 2.5–3.5 % of individuals (1). This means that most GPs will have patients with one type of eating disorder or another. In this issue of the *Journal of the Norwegian Medical Association*, two articles are published that deal with how patients with eating disorders experience their treatment and follow-up in general practice (2, 3). The results may give the impression that monitoring of this patient group in general practice is perhaps deficient, and that there is too little focus on eating disorders and the serious complications of these.

This then invites the question of whether the GP has the necessary competence and sufficient time to identify eating disorders and follow up those who have to be referred to the specialist health service. On the other hand, the question also arises of whether an apparent lack of competence may be indicative of the fact that the GP is assigned tasks that should fall within the remit of the specialist health service.

The Department of Health's strategic plan for eating disorders was published in 2000 (4), as well as guidelines for the treatment of serious eating disorders in the specialist health service (5). The purpose of both these documents was to raise the level of competence and improve the treatment options for this patient group. Whereas the strategic plan's recommendation of a professional network to provide peer supervision and enhance competence was also intended to encompass the primary health service, the guidelines for treatment were limited to serious eating disorders in the specialist health service. Work on new national guidelines for assessment and treatment is underway, and it is hoped that it will be completed in 2015. These guidelines also encompass assessment and treatment in the primary health service. The working group emphasises that the recommendations should clarify what the GP is expected to be able to do, depending on the degree of severity of the condition, as well as what criteria should form the basis for further referral.

The GP will generally be the first to encounter the patient and has a unique opportunity to identify eating disorders at an early stage. In addition, the GP should provide treatment options and make referrals for those who need more specialised treatment. This requires both diagnostic and therapeutic competence in the field of eating disorders and an insight into which patients should be treated where. Competence-enhancing measures are therefore important for GPs, and should include more teaching on eating disorders as part of medical studies, courses linked to specialisation, and introducing the problem as a topic in the peer supervision groups. Posi-

tive feedback from the specialist health service, including a peer supervision service, but also support in assessment and treatment, are measures that will help the general practitioner to obtain more experience.

Not all GPs can be expected to have an equal interest in this area of medicine, and the specialist health service must provide support when the general practitioner requests it. Little research has been conducted on the effect of early intervention, but clinical research indicates that early and appropriate intervention may reduce the duration of the illness, and result in fewer admissions and shorter treatment time. The absence of criteria for the level at which the patient should be treated represents a challenge, and it has been difficult to arrive at a basis on which such criteria should be established. With the introduction of DSM-5, a grading of the degree of severity of eating disorders has been introduced for the first time (6). The degree of severity of anorexia nervosa should primarily be assessed on the basis of BMI, whereas the degree of severity of bulimia and binge-eating disorder is defined based on the frequency of vomiting or binge-eating, respectively. A clearer distribution of responsibility and tasks is needed between the primary and specialist health services, linked to the degree of severity of the illness. This will reduce the probability of the GP being assigned tasks that require a competence beyond that which can be expected of a generalist.

Resources in terms of doctors, and competence in eating disorders, also vary in psychiatric healthcare, particularly with regard to somatic symptoms and complications. This results in more GPs being left with the responsibility for assessment of the patient's somatic condition. Such tasks and responsibilities belong in the specialist health service. It will sometimes be necessary for the GP to be able to perform examinations and take blood tests; nevertheless it is important that the responsibility for the treatment of the condition as a whole, not only the mental component, lies with the specialist health service.

The two articles in this issue of the *Journal of the Norwegian Medical Association* may also paint a different picture of patients' experience of follow-up by their GP (2, 3). Many are happy with the manner in which they are received, and patients state that specific questions about various symptoms help them to open up on topics that are initially difficult to talk about. There is therefore no risk in questioning the patient. When eating disorders are suspected, it is important that the GP elicits the relevant symptoms and undertakes the necessary clinical examinations. The GP should have competence in treating the less serious conditions, and the specialist health service should help provide guidance where necessary, accept those patients for whom the GP requests an assessment, and have competence with regard to the more serious conditions. Clearly defined requirements for competence and clear distribution of responsibilities can contribute to improved care for a vulnerable patient group.

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