Who should prescribe obesity management medications? An IFSO position statement

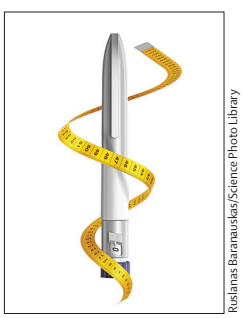
Eligibility to prescribe obesity management medications (OMMs), including GLP-1 receptor agonists and dual incretin agonists, should rest on demonstrated training and the capacity to deliver comprehensive obesity care, not on specialty title alone. Many current rules tie prescribing rights to a specialty rather than to competence in managing the chronic disease of obesity. This principle applies to every specialty, including primary care.

Obesity is a chronic, relapsing disease. Optimal treatment requires careful assessment, continuous lifestyle support, and selection among pharmacological, endoscopic, and surgical options, all with long-term follow-up. Physicians who meet defined competency standards should be eligible to prescribe OMMs regardless of their specialty. Metabolic bariatric surgeons working within multidisciplinary metabolic bariatric surgery (MBS) programmes can meet these standards, and many already use OMMs across the treatment pathway. Excluding bariatric surgeons on specialty grounds alone risks delaying treatment and fragmenting care, potentially creating major barriers to comprehensive obesity care.

In some health systems, eligibility to prescribe or be reimbursed for OMMs is defined by specialty or care setting, not assessed competence (appendix pp 1–2). In practice, prescribing and reimbursement are linked in some countries: a prescription from outside the authorised group is often not reimbursed. For example, in India, GLP-1 receptor agonists are approved only if prescribed by endocrinologists, internal medicine specialists, and, for some indications, cardiologists.[1] Japan and Malaysia restrict insurance-covered or public-sector prescribing to listed specialties. France opened OMM prescribing to all physicians in 2025 because specialist-only initiation caused long waits and unequal geographical access (appendix pp 1–2). France has also moved closest to a competence-based standard: since June 2026, reimbursed initiation includes metabolic bariatric surgeons who hold an inter-university diploma in obesity surgery and practise in designated centres.[2]

The International Federation for the Surgery and Other Therapies for Obesity (IFSO) proposes that any physician prescribing OMMs should demonstrate competence in five domains, verified by structured training and assessment where available: (1) understanding of obesity as a disease (eg, pathophysiology; biological, nutritional, psychological, and social determinants; secondary causes; and the distinction between preclinical and clinical obesity with diagnosis beyond BMI),[3] (2) pharmacology (eg, mechanisms, titration, and contraindications; gastrointestinal, biliary, pancreatic, and aspiration risks; adjustment of glucose-lowering treatment; pregnancy and contraception; and preservation of lean body mass), (3) treatment selection (eg, indications and limits of lifestyle therapy, OMMs, endoscopic therapies, and MBS; when to escalate, combine, or sequence; and realistic expectations, including recurrent weight gain and relapse of complications such as type 2 diabetes after discontinuation), (4) long-term follow-up (eg, monitoring of response, adverse effects, nutritional status, and muscle function; management of suboptimal clinical response; and a documented plan for maintenance and referral), and (5) team-based, person-centred care (eg, access to dietitians, mental health professionals, exercise specialists, and nurses; non-stigmatising communication; and shared decision making).

Where systems exist, evidence of competence includes recognised certification, a fellowship or structured obesity-specific training with assessment, plus continuing medical education. The American Board of Obesity Medicine (ABOM) certifies physicians across base specialties by qualifying continuing medical education or a recognised fellowship, followed by an examination, showing that obesity competence can be defined, taught, and examined across specialties.[4] ABOM certification is restricted to physicians in the USA and Canada, and ABOM lists 428 diplomates in surgery, without reporting how many are bariatric surgeons.[5] Elsewhere, the World Obesity Federation's SCOPE certification is open to all health professionals, including surgeons, with at least 6 months of practical experience in obesity management.[6] Many countries have no such system and, until one exists, documented obesity-



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specific training should be accepted, and the absence of formal credentialing should not by itself prevent trained physicians from prescribing.

Metabolic bariatric surgeons are the clearest test case for competence-based eligibility: those with appropriate training already prescribe OMMs within the MBS pathway, guided by IFSO consensus.[7] For prescribing before MBS, the IFSO consensus found insufficient high-level evidence for routine preoperative OMMs but supports personalised use,[7] which in practice could include people with very high BMI, high anaesthetic risk, or poorly controlled type 2 diabetes. Perioperative management should be agreed with anaesthesia teams: IFSO advised discontinuation before MBS, whereas multi-society guidance supports continuation in many patients after risk assessment.[7,8]

For prescribing OMMs after MBS, the consensus supports adding OMMs for suboptimal clinical response or recurrent weight gain and considering them before conversion or revision surgery. Emerging evidence suggests similar OMM-induced weight loss with and without previous MBS, without an apparent increase in adverse effects.[7] Reimbursement rules can block this pathway—eg, Switzerland excludes people with previous or planned MBS from reimbursed semaglutide and liraglutide for weight management.[9]

For MBS after pharmacotherapy, IFSO has stated that eligibility for MBS after OMM-induced weight loss should be judged on baseline (pre-treatment) measures and the burden of obesity-related complications, not on current weight alone.[10] Choosing between continuing, combining, or switching treatments requires knowledge of all treatment alternatives.

For continuity and breadth of practice, people treated in MBS programmes attend follow-up for years. Mandating a separate endocrinology referral solely to start or adjust an OMM might delay treatment and add cost when the surgeon is competent to prescribe; specialist referral remains appropriate when additional expertise is needed. Many metabolic bariatric surgeons work across OMMs, endoscopy, and MBS, placing them well to discuss the least invasive effective option. Metabolic bariatric surgeons should therefore be able to prescribe OMMs as part of a multimodal pathway of care, meeting the same competency standard as physicians in any other specialty.

Many specialised obesity services, including MBS programmes, already have a multidisciplinary team that long-term pharmacotherapy needs: dietitians for protein, micronutrient, and gastrointestinal support; mental health professionals for eating behaviour and adherence; exercise specialists for resistance training to preserve lean mass, as IFSO recommends;[7] and specialist nurses for titration and adverse-effect triage. These teams could expand access to active treatment using existing infrastructure.

IFSO recommends competence-based prescribing eligibility for OMMs, with payer coverage aligned accordingly: (1) base eligibility on obesity-specific training and competence, assessed where available, not by specialty title; (2) recognise existing credentials, such as ABOM and SCOPE certification, obesity medicine fellowships, and equivalent national or society programmes; (3) include trained metabolic bariatric surgeons in accredited MBS programmes or specialised obesity centres as eligible prescribers; (4) require access to multidisciplinary care, evidence-based lifestyle support, and documented follow-up, directly or via referral; (5) establish a joint IFSO and World Obesity Federation task force to develop a cross-specialty curriculum, for endorsement by endocrinology, surgical, and obesity societies; and (6) strongly encourage services prescribing OMMs across specialties to monitor and report safety, effectiveness, and continuity of care using available data collection systems.

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