

**SURGEONS
ON THE MOVE**

THE POWER OF ORGANIZATION:



*A report on the experience
of the Indiana Obesity Coalition*

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Early in September 2005, I received a letter from the Indiana Department of Health requesting bariatric surgeons to review draft rules to implement the provisions of Senate Enrolled Act (SEA) 360, which had been passed by the Indiana General Assembly during the last legislative session. Enclosed with the letter were a copy of SEA 360 and a set of draft rules.

Essentially, SEA 360 required surgeons to monitor bariatric patients for five years and to report to the state any deaths or serious complications. The law also mandated that coverage for bariatric surgery be offered by all private payors and health maintenance organizations and to be offered to all state employees. But also included in this law was the requirement for all patients to first undergo a physician-supervised, nonsurgical weight loss period of at least 18 months before becoming eligible for bariatric surgery. Clearly, the rules attached to this legislation represented a dramatic deviation from current standards and would result in severe limitation of patient access to weight loss surgery. Furthermore, the mandated reporting of deaths and complications would be a strong disincentive for surgeons to take on challenging cases for fear of penalization by state government and by public opinion, thereby compounding the plight of obese patients to appropriate therapy. The author of the bill was Sen. Patricia Miller (R-Indianapolis), a seasoned legislator with extensive experience in health affairs and the Chair of the Senate Health Affairs Committee.

This letter was the first I had heard of this situation. I had just moved to Indiana and was unaware that this legislation had been passed. However, it became evident over the next few days that no bariatric surgeon had been consulted in the course of passing this legislation, and indeed its existence was a surprise to all physicians and most administrators. Those administrators who were familiar with the law had erroneously presumed that it was a positive and beneficial act; yet, unfortunately, no surgeon was consulted.

First response to the legislation

Upon reading the law, its provisions, and the proposed draft rules, I was convinced that urgent action was necessary. My first reaction was to inform Neil Hutcher, MD, FACS, president of the

American Society for Bariatric Surgery (ASBS), to whom I faxed the letter and its enclosures. Dr. Hutcher immediately called me to express his indignation at the restrictive and punitive nature of the law. He advised me that only by forming an organization of surgeons at the state level would we be able to make a political impact and amend this serious development. He also declared his strong support for our efforts at reversing this law.

My first endeavor was to arrange an introductory meeting with Senator Miller. The purpose of this meeting was to understand her intentions behind the creation and passage of the bill into law and to create an opportunity to present opinions on behalf of bariatric surgeons and patients. We conducted this meeting at the State Department of Health; accompanying me were Margaret Inman, MD, FACS, a reputable and busy Indianapolis bariatric surgeon, and Marilyn York, RN, an experienced former director of two successful bariatric programs.

The meeting, which lasted almost an hour, was held in a congenial atmosphere. The senator informed us that the main impetus for the legislation was her concern about the widespread commercialization of bariatric surgery, coupled with complications that had occurred in some high-profile cases. She was worried that the benefits of bariatric surgery were being touted without consideration being given to the potential risks involved in this surgery. She did listen attentively to our opinions and indeed admitted that she was unaware of the sheer magnitude of the obesity epidemic, nor of the numerous medical benefits of surgical therapy. We also described the rigorous evaluation process for eligibility of surgical candidates and the lifelong commitment to follow-up.

We described at length the restrictive repercussions of her bill and the unrealistic requirements in tracking and reporting. We presented to the senator a letter written by a bariatric patient, who described the rigors of completing 18 months of medically supervised dieting at a personal cost of \$3,000 in copayments, losing no weight in the process, and indeed succumbing to renal complications of progressive diabetes and hypertension. Finally, we submitted to the senator and the officials from the Department of

Health copies of numerous landmark articles that represented overwhelming scientific evidence on the benefits of bariatric surgery. At the end of the meeting, the senator indicated that she would consider introducing a new bill that would take into account our objections in the matter.

Organizing bariatric surgeons

My next step was to make a call to action by contacting all Indiana bariatric surgeons, identified from the ASBS members Web site. I also had discussions with US Surgical, Ethicon, and Inamed, informing them of the potential repercussions of this law. The representatives of all three corporations expediently released funds and agreed to support a meeting of all the surgeons at a local hall. They also provided me with unlimited access to legislative and reimbursement consultants who extended to me valuable advice both by telephone and in person. Some of these consultants were dispatched to counsel me and attend our first meeting of bariatric surgeons.

At that initial meeting—convened in Indianapolis and attended by more than 20 surgeons and their associates—we discussed at length the details of the law and the predictable negative repercussions on patient access and on our profession. We made a decision to form a coalition to be named the Indiana Obesity Coalition (IOC). We intentionally did not call it a surgical coalition so as to be inclusive of all specialists and did not call it a medical coalition so that we could include obese individuals—including patients and their families—the real stakeholders in this process. At that meeting, we also agreed that we would seek the services of a legislative consultant to guide and advise us on how to proceed.

I think the most rewarding aspect of this meeting is that we were able to congregate all the physicians in one room and quickly arrived at a consensus on how to proceed. In addition to a pervasive sense of indignation, there was also disappointment with the Indiana State Medical Association (ISMA), an organization charged with protecting the interests of practicing physicians and ensuring quality health care for the community. My communications with the ISMA revealed that they had been monitoring the progress of the bill but believed it consisted of only

positive aspects and did not seek the opinions of any bariatric surgeons. Furthermore, the government liaisons of all the major hospitals in Indiana were also following the bill and also took no steps to inform their own bariatric surgeons. Clearly, this is an example of the widespread unfamiliarity of nonsurgical professionals with the main pillars of the management of morbid obesity.

Patient involvement

We also took every opportunity to inform both our prospective patients and postoperative patients of the impending restrictions to care that they would all face if the law were left unmodified. We attended support groups, public education seminars, and all possible patient-related activities. We encouraged patients to write to their representatives in the legislature, providing them with contact information for these individuals. After the initial general sense of doom and frustration, there rapidly developed a feeling of impending triumph and euphoria, as we all recognized the strengths that we possessed as a rich and diverse group. Some of our patients were closely acquainted with legislative representatives and were able to expound, on a personal level, the benefits of bariatric surgery. These representatives had witnessed dramatic improvements in their friends and constituents and pledged to support our cause. Other patients worked in the press media and other outlets, and by virtue of their positions, were ideally situated to promote our cause to the lay public and decision-makers alike. The obesity-related Web sites and chat rooms were buzzing with discourse and animated discussion. There was a true mobilization of the masses, and it was clearly an invigorating experience.

Calling for extra support

We now had the enthusiasm, and the “people power,” but we needed an expert to harness and prudently focus and direct this energy. There is a fine line between applying steady pressure on legislators and creating an atmosphere of animosity and contempt. Furthermore, none of us had an intimate understanding of the intricacies and machinations of the legislative process, which I

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rapidly learned is very complicated and liable to sudden and irreversible setbacks. And, most importantly, there were always other parties whose interests may be opposite to ours and whose resources and experience were quite capable of arresting our progress through the convolutions of the general assembly. All of our good work could be easily eliminated or repeatedly postponed if our cause was not presented to key legislators in the persuasive manner it deserved. For these reasons, it was imperative that we identify a legislative consultant to champion our cause.

The selection of an appropriate lobbyist proved to be an interesting exercise. Recognizing the critical role that this resource would play in our task, I decided to expend maximum effort in this selection process. Obviously, having recently relocated to the area, and void of any previous experience in legislative affairs, I was fairly ignorant on how to proceed. A search of the Internet revealed a long list of firms that appeared to be potentially suitable. Realistically, I could not interview every firm. In order to arrive at a short list, we contacted the ISMA, who narrowed the list down to five firms. I interviewed each one and reviewed their proposals. In order to gain input from other members of the coalition, I called for a follow-up meeting and presented to the membership the various characteristics, strengths, and credentials of each group. To finally really narrow it down, I contacted legislators' offices and directly asked their staff which of our short-listed lobbyists were they most comfortable with. We ultimately selected Mark Scherer because of

his extensive experience in governmental health affairs, considerable knowledge and past success in health legislation, and his close and positive relationship with Senator Miller built on many years of complicated legal conversations and negotiations. We created a fund to pay for his services from an account that was established by the IOC. This account was funded by the members of the coalition and by a matching fund generously provided by the ASBS. Thomas R. Russell, MD, FACS, Executive Director of the College, also supported our efforts by listening patiently and attentively and providing invaluable advice and encouragement.

After securing the services of Mr. Scherer, we set out a plan of action. We decided that the most effective strategy would be to approach Senator Miller and maintain the momentum for a new bill that would protect the mandated offer of coverage of bariatric surgery but modify the tracking and reporting rules to allow for more acceptable terms. Of importance, also, was the dire need to reduce the presurgical dieting period from 18 months to a more reasonable six-month period. There was precious little time, since it was already October and the next session was scheduled to be held in February 2006. Because the February session is typically brief, there was intense competition in introducing new bills. In addition, there was always the possibility of the bill meeting resistance from other parties whose interests rested in preventing the passage of a bill that improved patient access to bariatric surgery.

Mr. Scherer worked closely with Senator Miller and Rep. Tim Brown (R) in the House to produce a bill that addressed all our concerns. In the course of these events, Mr. Scherer did detect some waning enthusiasm from the senator. So, in an attempt to strengthen our position and further provide the senator with unbiased information about the merits (and risks) of bariatric surgery, we arranged for her to have a telephone conversation with a nonsurgical expert in the field: Samuel Klein, MD, professor of medicine and nutritional science at Washington University School of Medicine. This event had a positive effect on the senator, and to that end we are in profound gratitude for Professor Klein's assistance. There was renewed vigor in the process and we

felt a definite uplift in our expectations.

The next few weeks were characterized by a flurry of e-mails, conversations, meetings, numerous drafts, and the expenditure of substantial intellectual energy over the definitions of complications and reporting mechanisms. Finally, a bill that was agreeable to all parties was drafted. It was submitted to legislative committee and subtle changes in language were modified and approved.

The hearing and what followed

On the day it was to be considered on the Senate floor, testimonials were presented by bariatric surgeons, other health care providers, and several patients who dramatically described the extensive benefits they enjoyed as a result of weight loss surgery. Incredibly, the bill passed unanimously at the Senate and the House. We then followed this up with a letter to Gov. Mitchell E. Daniels, Jr. (R), in which we again highlighted the importance of this bill, and it was signed into law on March 22, becoming effective July 1.

The revised law, known as SEA 266, maintains the widespread mandate to offer coverage for bariatric surgery. It also stipulates that patients would be monitored for five years, but within reasonable efforts; that physicians would *anonymously* report major complications and nutritional deficiencies that result in hospitalization or invasive therapy to the state; that physicians will report the positive and beneficial outcomes of weight loss surgery; and that the onus will be on physicians to preoperatively educate their patients on the requirements to qualify for surgery, the details of the operation, the possible complications, and the side effects, including the expected lifestyle changes after surgery. Very importantly, we were able to reduce the waiting dietary period for patients from 18 months to only six months.

We have already begun to see the positive repercussions of this new law. Numerous payors are informing their patients that, as of July 1, patients on 18 months of preoperative dieting will be released early and authorized to receive consultations from bariatric surgeons.

The IOC met recently to discuss the future of this organization. We have every intention to con-

tinue to mature and evolve. Dana Lindsey, MD, devised a comprehensive organizational scheme that includes leadership positions, a secretary, and several committees that will be responsible for increasing membership, increasing public awareness and education, advancing scientific progress, and maintaining a collective database for free sharing of all our outcomes. We have also admitted representatives from our partners in industry to serve as nonvoting members. We are currently in the process of constructing a Web site for the coalition, which will be found at www.indianaobesitycoalition.org.

Conclusion

As this report illustrates, there is an enormous amount of power that can be gained by physicians organizing at a local level. Obviously, as in our case, there needs to be a central issue to act as the initial impetus for the creation of such a group, but once this power is recognized, it becomes clear that such a worthy movement must be sustained. This is certainly not the last challenge that we will face, but I am confident that in Indiana we now have a living, vibrant body that will have the ability to protect the interests of its health care providers and their deserving patients. □

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