Bariatric Surgery Competence in the Spotlight

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KAILUA KONA, HAWAII — In the last 5 years, the annual number of bariatric procedures has increased 10-fold, from 30,000 to 300,000 worldwide, Dr. Louis F. Martin said at a meeting on medical negligence and risk management.

With that increase has come debate about whether new mechanisms are needed to credential bariatric surgeons and how best to minimize risks for patients and physicians alike. "There's just a frontier atmosphere right now," said Dr. Martin, professor of surgery at Louisiana State University, New Orleans.

Kimberly D. Baker, a Seattle-based defense lawyer who also holds a BS degree in nursing, agreed.

Contributing to this problem is the public's fascination with "makeover" television shows, which have stoked interest

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MS. BAKER

in bariatric surgery not just among persons who weigh 400-500 pounds but also among much smaller people, she said in a commentary session at the meeting, sponsored by Boston University.

In response to the demand, some surgeons are taking advantage of hospital privileges that allow them to do general abdominal surgery by claiming that hospital liability insurance covers them to perform much more complex bariatric procedures without having to prove their competence, she said.

"Hospitals are really not being put on notice about the extent or scope" of practice by some surgeons doing these procedures, Ms. Baker said.

She predicts future lawsuits against bariatric surgery programs that overrepresent their attributes. "If your surgical center or hospital is going to tout itself as the biggest and the best for bariatric surgery patients, you better have the right credentialed individuals, a quality improvement program in place, and the data to back it up," she advised.

Dr. Martin noted that the guidelines of several surgical organizations state that bariatric surgery programs should have a multidisciplinary team approach, specialized equipment, and a high level of expertise. The multidisciplinary approach should encompass support from dietary, psychological, medical, and exercise or physical therapy professionals to effect behavior modification in the patient.

"The operation is a blend of surgery and behavior modification and does require a different model," Dr. Martin said. In 2005, fewer than half of academic general surgical residency training programs had a multidisciplinary bariatric surgical program, he noted.

Bariatric surgeons hope to establish a data collection system through insurance companies to follow outcomes, he added. This could help provide continuous quality improvement in the field.

Knowledgeable bariatric surgeons take extensive preoperative steps to decrease the risks of the surgery to patients, Dr. Martin said. For example, his program only accepts morbidly obese patients who can walk for at least 10 minutes on a treadmill, because if they are unable to do so, their cardiovascular system might not withstand surgery.

Patients are required to lose at least 10% of their initial weight before surgery, show acceptable pulmonary function on a spirometer, agree not to smoke, and undergo regular testing for nicotine if they have a history of smoking. Sleep studies, pulmonary exercises to improve blood gas levels, and other steps to improve pulmonary function pay off, he said.

"If you don't do that, and they have the trauma of surgery, they get very short of breath," Dr. Martin explained.

He gives large doses of Lovenox and takes other measures to prevent deep vein thromboses and pulmonary emboli.

All patients undergo an extensive psychological evaluation and must participate in behavior modification groups. They are asked to prove they can change their behavior before surgery by increasing the distance they can walk in 10 minutes or by walking a mile. ■