

Battling Obesity

BY CINDY MURPHY McMAHON

With costs to treat obesity-related illnesses soaring and the outlook grim for the nation's children, forward-looking physicians see a bright future for bariatrics.

SALLY WAS IN HER LATE 40s AND MOVED slowly as she walked into her physician's office. Her gait was more like a waddle as she shifted her weight back and forth with each step. She was tired beyond her years, and most of all, she was disgusted. She was disgusted with herself for weighing more than 300 pounds, and she was angry with the medical community. Taking several medications for hypertension, diabetes type 2, a lipid disorder, and osteoarthritis, Sally was bordering on desperation.

This visit to a physician was different, however. She was seeing a bariatrician, a physician who specializes in the treatment of obesity. Working with her doctor, Peter Vash, MD, of Los Angeles, within six weeks Sally

was able to reduce her hypertension medications by 50 percent, eliminate one of the diabetes meds, and reduce her osteoarthritis prescription, all the while sleeping better and walking easier.

"Her quality of life dramatically improved," Vash says of the woman he calls a typical bariatric medicine patient. "She began to have an outward look of optimism and hope."

A costly problem

Obese people like Sally are beginning to get the attention of the medical community, insurers, and the government. Although there has been some discrepancy over exactly how many deaths each year in the United States are caused by obesity, everyone involved agrees that obesity is a serious



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“Committed patients in the right hands of a physician who is trained in bariatric medicine can be successful,” says Peter Vash, MD, the secretary of the American Obesity Association and the executive medical director at the Lindora Medical Clinics in southern California.

Frequently Asked Questions

WHAT IS A BARIATRICIAN?

Bariatricians are licensed physicians who, as members of the American Society of Bariatric Physicians (ASBP), have received extensive continuing medical education in the treatment of overweight and obesity. They are not bariatric surgeons, who only treat obese patients through surgery.

WHAT DOES A BARIATRICIAN DO?

They offer patients comprehensive treatment using diet, nutrition, exercise, lifestyle changes, and sometimes medications.

WHAT KINDS OF PHYSICIANS BECOME BARIATRICIANS?

Bariatricians come from all medical fields, including family practice, internal medicine, endocrinology, ob/gyn, pediatrics, anesthesiology, and more. They often are looking for a fulfilling specialty that offers a good deal of patient contact.

ARE BARIATRICIANS MORE PREVALENT IN CERTAIN PARTS OF THE COUNTRY?

Bariatricians are practicing in all parts of the nation.

WHERE DO BARIATRICIANS GET THEIR TRAINING?

The ASBP offers continuing medical education programs, a peer-reviewed quarterly journal, and a bi-monthly journal. It also publishes “Bariatric Practice Guidelines” and “Anorectic Usage Guidelines.” Board certification is available through the American Board of Bariatric Medicine.

DOES INSURANCE PAY FOR BARIATRIC TREATMENT?

Currently, there is limited coverage. But experts in the field predict that will be changing as research shows the long-term benefits of bariatric treatment and as the nation seeks to ward off the staggering cost of obesity-related diseases. They consider Medicare’s 2004 decision to throw out its policy that stated obesity was not a disease an important first step.

WHERE CAN I GO FOR MORE INFORMATION ON BARIATRICS?

Contact the American Society of Bariatric Physicians in Aurora, Colorado, at (303) 770-2526, or on the Web at www.asbp.org. ■

health problem.

The Centers for Disease Control and Prevention last year issued an estimate of 400,000—then revised that to 365,000—deaths a year due to obesity, making the condition one of the leading causes of preventable death. Several months later, in April 2005, it put forth a new calculation of 25,814, dropping obesity to an unofficial seventh-place preventable-death ranking.

While the controversy and confusion over the number of deaths continues, there is no denying that obesity is a health hazard, as it increases the risk for many diseases and conditions, including type 2 diabetes, hypertension, cardiovascular and gallbladder disease, osteoarthritis, sleep apnea, and some cancers. The medical costs associated with obesity are staggering and the problem is growing. In addition, physical inactivity, junk food diets, and other factors in the Western lifestyle have led pediatric experts to call childhood obesity one of the major problems facing children.

According to the Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, the medical and related costs of obesity in the United States in 2000 were more than \$117 billion, and data suggest the emotional costs also are enormous. *The International Journal of Obesity* in 1991 published a study of former severely obese patients. It concluded:

- 100 percent preferred to be deaf, dyslexic or have heart disease
- 92 percent preferred to have a leg amputated

✓ According to the Surgeon General, the medical and related costs of obesity in the United States in 2000 were more than \$117 billion.

• 90 percent preferred to be blind rather than be obese again. Further, 100 percent of those polled preferred to be of normal weight than a severely obese multimillionaire.

All of these facts, plus Medicare's 2004 decision to discard its policy which stated that obesity was not a disease, may be reflected in physicians' growing interest in bariatric medicine as a practice opportunity.

The American Society of Bariatric Physicians (ASBP) has 1,100 members. Founded in 1950, in 2000 it achieved its longtime goal of being awarded a seat in the House of Delegates of the American Medical Association. About two-thirds of the society's members incorporate a bariatric program into their primary care practices, while the other one-third specialize in bariatric practices.

Factoids

✓ Obesity, by definition, is having a body mass index (BMI) of 30 or higher.

✓ The U.S. Census Bureau estimates that approximately 26 million men and 32 million women are obese.

✓ Obesity is now considered a chronic medical disease with serious health implications that is caused by a complex set of factors.

✓ Obesity is a proven risk factor for high blood pressure, type 2 diabetes, high blood cholesterol, coronary heart disease, gallbladder disease and some cancers. Co-morbid conditions include sleep apnea, osteoarthritis, infertility, idiopathic intracranial hypertension, lower extremity venous stasis disease, gastroesophageal reflux, and urinary stress incontinence.

✓ The percentage of young people who are overweight has more than tripled since 1980.

✓ Severely obese people—with a BMI of at least 35—are more than twice as likely as people of normal weight to be in fair or poor health. They suffer about twice as many chronic medical conditions.

✓ Adult onset diabetes, or type 2, accounts for nearly 90 percent of all cases of diabetes, and researchers estimate up to 97 percent of type 2 cases in overweight people are a direct result of obesity.

✓ Eighteen percent of the Medicare population is obese.

✓ Between 1991 and 1998, the prevalence of obesity among persons age 60 to 69 increased 45 percent.

✓ Five of the top 10 self-reported health conditions of Medicare beneficiaries are obesity-related: hypertension, diabetes, arthritis, stroke, and some cancers. ■

BATTLING OBESITY

Continued from previous page



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Craig Keebler, MD, the medical director of the Center for Medical Weight Management at Swedish Medical Center in Seattle and the chairman of the American Board of Bariatric Medicine, says self-insured corporations are more likely than HMOs to offer benefits for obesity treatment.

“Insurance companies in general need to hold down costs, so they’re less likely to look at obesity treatment, which is preventative, but corporations are paying out of their own pockets, and they see an expensive problem down the road that they want to avoid.”

“Our membership has increased,” says ASBP Executive Director Beth Little. “That’s because the government is paying attention to obesity. All the studies show not only the prevalence of obesity and overweight is increasing, but that it is increasing at a faster rate than ever before.”

The number of physicians seek-

ing to be certified by the society’s sister organization, the American Board of Bariatric Medicine (ABBM), is swelling, too.

“The number going through the exam process is increasing exponentially,” says Kelly Wettengel-Dycus, the executive director of the ABBM. “In 2002, 40 were tested. In 2003, 80, and in 2004, over 100

went through the exam process to become diplomates of the ABBM.”

Sameena Rasheed, MD, is one of the ABBM board members who oversees the academic side of bariatrics. She conducts the written and oral exams of those applying for certification and makes site visits to their practices.

“The site visit is very important,” Rasheed says. “You can pass exams, but if you’re not working with patients individually, counseling them, helping them change their attitudes and behaviors and maintain their weight loss—that’s what’s important.”

While physicians frequently come to bariatrics from family practice and internal medicine, they represent a variety of special-

BATTLING OBESITY

Continued from previous page

ties, including psychiatry, ob/gyn, and pediatrics. Rasheed, a former anesthesiologist, is an example of someone who made a major practice change. She has been a bariatric physician for a little more than eight years, ever since she was bedridden with cancer and decided to change her lifestyle.

“I was deteriorating physically, lying in bed and struggling through chemotherapy. I knew I needed better nutrition, and studying that led me to bariatric medicine.” She now has an independent practice in Longview, Texas.

“The patients are so vulnerable. You really have to listen to them,” she says. “On our site visits we make sure the physician is teaching about nutrition, doing behavior modification, and has a maintenance plan. The weight has to be kept off.”

She compares treating obesity to treating hypertension and other chronic conditions. “The patient needs to come back for checkups—one month, three months, six months. What really matters is if the patient has a change in attitude.”

Defining the players

A discussion of bariatric medicine wouldn't be complete without some background information and clarification of terms:

- ✓ A bariatric physician is different from a bariatric surgeon, who performs surgical procedures for the treatment of obesity.

- ✓ Bariatricians or bariatric physicians, on the other hand, treat the obese

patient with a comprehensive approach that includes diet and nutrition, exercise, lifestyle changes, and when appropriate, medications such as appetite suppressants.

- ✓ The word bariatric comes from the Greek word *barros*, which translates as heavy or large.

Changes in the way obesity is viewed by the medical community have paved the way for the practice of bariatric medicine. For example, obesity is no longer seen as the result of lack of willpower, but as the result of a complex interaction of genetic, behavioral, and environmental factors. The American Obesity Association says no human condition—not race, religion, gender, ethnicity, or disease state—compares to obesity in prevalence and prejudice, mortality and morbidity, sickness and stigma.

Obesity is defined using the now widely accepted body mass index (BMI) measurement tool. A BMI of 25 to 29.9 is considered overweight, while a BMI of 30 to 39.9 is considered obese. Extreme, or class III, obesity is a BMI greater than 40. According to the National Institutes of Health, a 20-percent rise above the desirable body weight is the point at which excess weight begins to be a health hazard.

Because the current generation of children, adolescents, and young adults is the most overweight in the nation's history, the CDC says reducing young people's obesity is one of its top priorities. At the other end of the age spectrum, Medicare's statements are key, also. In removing the language in Medicare policy that said obesity was not an illness,

Health and Human Services Secretary Tommy Thompson said in 2004 that the new policy would allow Medicare officials “to review scientific evidence to determine which interventions improve health outcomes for seniors and disabled Americans who are obese.”

Physicians have typically not been encouraged when treating their obese patients because they were not able to get reimbursed for it, except as part of other disease states, according to Vash, who is also the secretary of the American Obesity Association and an assistant clinical professor at UCLA School of Medicine. However, as the lead author on a research study for publication in the spring edition of the *American Journal of Bariatric Medicine: The Bariatrician*, he says he has great hope.

“The medical treatment of obesity has been pretty dismal and doctors have been pretty discouraged over their obese patients,” Vash says. “But we found that committed patients in the right hands of a physician who is trained in bariatric medicine can be successful.”

The study followed 2,000 obese patients at the Lindora Medical Clinics in southern California for one year. These 34 clinics, based in Costa Mesa, treat nearly 4,000 people a day. Vash is the executive medical director for the clinics.

“If patients committed to treatment after the first month, we followed them for a year and found an average weight loss of 25 pounds or 12 percent of body weight.” For comparison, Vash says a 10-percent loss maintained over a year is the “Gold Standard.”

“The key is the physician’s interactions,” he says. “It’s important to see the patient not just as a number. It’s rarely just about hunger and calories. People use food as a coping mechanism.”

The “iceberg under the surface”

A board-certified internist and endocrinologist, Vash says he realized during his fellowship at UCLA that diabetes was out of control in type 2 patients, largely because of a lack of exercise and maladaptive eating. He says research has shown that a diabetes type 2 patient’s symptoms could be dramatically reduced or resolved if the patient reduced weight and increased activity.

He says physicians need to look at treating obesity not as a hopeless experience, but a professional challenge with economic opportunities - for the patient as well as the physician.

“There’s a tremendous opportunity for physicians to seize upon and dramatically help patients reduce or eliminate their number of medications,” he says. “When you look at the care costs of obesity and the rising number of obese children, you see that there is the potential to bankrupt the health-care system as we know it,” he warns.

That dire outlook is shared by Craig Keebler, MD, the medical director of the Center for Medical Weight Management at Swedish Medical Center in Seattle and the chairman of the American Board of Bariatric Medicine.

“The traditional model of insurance not paying for obesity treatment is going to change,” Keebler says. “Everybody knows there’s this

iceberg under the surface. The number of obese kids means open heart surgery and kidney dialysis may be happening to people in their 30s. The nation is going to have to do something.”

But, at least right now, that message doesn’t seem to be resonating loud and clear with insurers. Currently, insurers are paying for bariatric treatment in “limited markets and in limited fashion,” according to the ASBP’s Little. “Right now, insurance companies are looking for balance,” she says. “It is a chronic disease and they need to see that patients have some accountability, some success.” She believes Medicare’s change in its long-standing policy in 2004 has opened the door for more coverage by insurers.

The American Obesity Association hailed the Medicare decision, saying it will encourage employers and managed care companies to cover appropriate treatments. “It marks a new chapter in the fight against obesity,” according to the association’s vice president, Judy Stern.

Keebler says self-insured corporations are more likely than HMOs to offer benefits for obesity treatment. “Insurance companies in general need to hold down costs, so they’re less likely to look at obesity treatment, which is preventative,” he says. “But corporations are paying out of their own pockets, and they see an expensive problem down the road that they want to avoid.”

LuAnn Heinen is the director of the Institute on the Costs and Health Effects of Obesity, part of the Washington, DC-based Business

Group on Health, a nonprofit coalition of large companies that provide health coverage to more than 45 million workers, retirees, and their families. Heinen says employers are interested in supporting evidence-based medicine, so where there is evidence of positive outcomes, employers will be more interested in providing coverage.

The Business Group on Health launched its obesity institute in 2003, calling obesity one of the nation’s most serious, yet most preventable, health problems. It is working to estimate the cost of obesity to employers, initiate employee communication on healthy weight, and design employer-sponsored wellness programs that meet HIPAA requirements.

Heinen says employers are doing a lot for the prevention of obesity with people who have BMIs of 25 and lower by promoting nutrition and exercise. For obese people with BMIs of 35 or greater, she says employers would like to learn about alternatives to bariatric surgery, which is very costly.

Bariatric surgery typically costs tens of thousands of dollars, most of which is paid by private insurance. It carries serious risks, such as bowel obstructions and malnutrition.

Vash sees great potential for bariatric physicians to lower health-care costs by reducing the need for bariatric surgery. “There are about 10 million Americans who have class III obesity—the most severe—with BMIs over 40,” he says. “As such, they qualify for bariatric surgery. Each bariatric surgery costs an average of \$20,000. If we can help people not become obese, we can reduce the

BATTLING OBESITY

Continued from previous page

need for bariatric surgeries.”

He says insurance companies are beginning to be more cooperative, noting that in a few states, Blue Cross/Blue Shield allows patients four visits a year to a bariatrician. “Insurance companies are beginning to see if patients go to doctors who know what they are doing, health-care costs for these patients are greatly reduced.”

The lack of universal coverage for bariatric treatment apparently hasn't been a huge obstacle for bariatricians, says Little, and some don't even want insurance reimbursement, “Because then they are told how to practice.”

Little says insurers sometimes will pay when a co-morbid condition, such as diabetes, is the primary reason for the patient's visit. Otherwise, she says, “Patients who come to a bariatrician understand that it is fee for service.” She says people have become used to paying for self-improvement services and “feel safer” under the care of a physician than with some other form of weight-loss program.

Keebler believes now is a “very exciting time” to go into bariatric medicine. He cites several reasons:

“Changes are happening in the whole science of understanding of what causes obesity, plus there are 140 obesity drugs currently in development—the first of which is to be out in about a year. And the insurance piece will ultimately turn around.”

Little, understandably, is equally enthused about bariatric medicine. “Bariatric physicians get an enormous amount of satisfaction,” she says. “They are in a position to join a patient on a journey and serve as a coach, as well as a medical adviser.”



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