The History of the American Society for Metabolic and Bariatric Surgery

4

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Chapter Objectives

1. Review the history and evolution of the American Society for Metabolic and Bariatric Surgery (ASMBS).
2. Provide an overview of current programs and initiatives undertaken by the society.
3. Demonstrate the vision and leadership that led to the current state of metabolic and bariatric surgery within the United States.

Introduction

The history of the American Society for Metabolic and Bariatric Surgery (ASMBS) parallels the development of metabolic and bariatric surgery (MBS) closely. In studying this history, three distinct periods emerge. The first, the Era of Inquiry (1967–1988), established the initial scientific foundation of MBS. The second is the Era of Rapid Growth (1989–2004) during which the society supervised rapid growth in the number of surgeons and programs and the growth of integrated multidisciplinary teams. The number of cases grew rapidly spurred on by laparoscopic access and with increasing diversity in procedures performed and use of devices. The third period, the Era of Quality and Engagement (2004 to present), established the society's focus on safety and increasing engagement with other stakeholders. These stakeholders include medical colleagues, international surgeons, the American College of Surgeons, medical societies dedicated to the management of obesity, and patient advocacy groups. Together we have focused on building an infrastructure for the population management of obesity in the United States and globally using a similar collaborative model that exits between surgery and medicine in other disciplines. Most patients with obesity are treated in a community hospital setting. The participation of surgeons and their integrated health partners in using high-quality data for ongoing quality improvement provides leadership to improve patient safety and experience of care within the community. The ASMBS has been successful in creating a high-value data-driven network of nationally accredited programs accepted as the foundation of quality by payers. Over the last interval, the network has been leveraged to address ongoing quality issues for underperforming centers focused on readmissions and enhanced recovery protocols. These efforts are transformational. MBS is conducted in the United States within a learning and continuously improving culture. It is the signal achievement of this era.

The Era of Inquiry 1967–1988

From the beginning, MBS developed through multidisciplinary collaboration with the focus located at the University of Iowa (UI). At UI, a unique environment was created by the collaboration of surgeons, physiologists, biochemists, and integrated health professionals at the National Institutes of Health (NIH) General Clinical Research Center (GCRC). This Center, led by Edward Mason, MD (Fig. 4.1), presented its multidisciplinary findings in collaborative discussions of each other's work. In 1967 in a symposium honoring Owen H. Wangensteen, MD, Dr. Mason's mentor, Dr. Mason, and Chikashi Ito, PhD, presented the first case of gastric bypass. These meetings became more formal and became known as the Mason Surgical Treatment of Obesity Symposium Workshop in 1976, attracting national and international scientists and surgeons interested in treating the disease of obesity. With NIH funding, the group continued to explore the physiological and metabolic effect of gastric bypass and presented their findings at the American Surgical Association Meeting in 1969.

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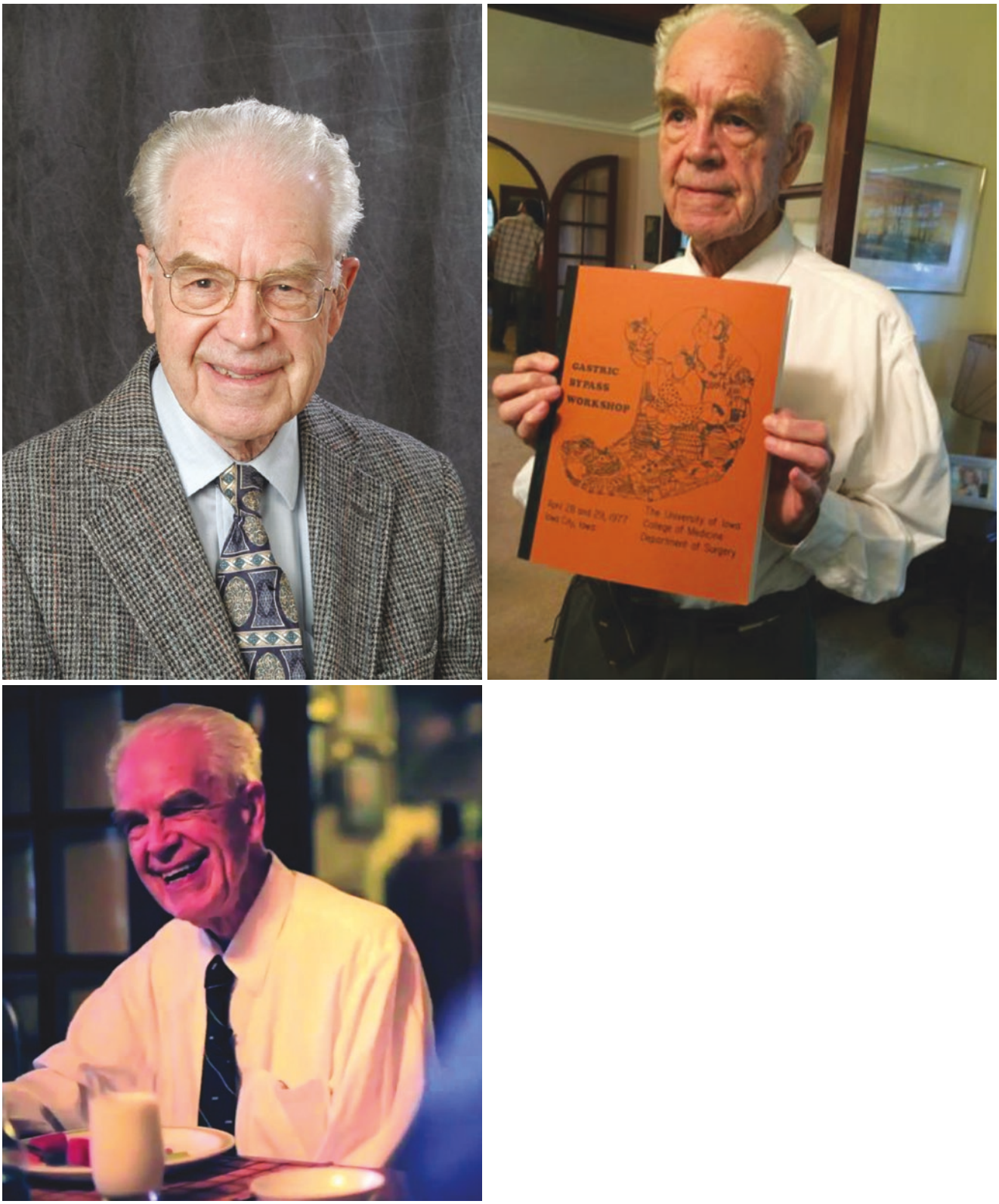

Fig. 4.1 Edward Mason, MD

Edward Mason writes about those days:

> The postgraduate course was started because of the increasing number of surgeons performing obesity surgery, who were communicating and sharing experiences and ideas by phone. Nicola Scopinaro, MD, from Genoa and surgeons from Sweden were early attendees. In 1977, there were 28 presentations and symposia listed for the meeting, which was held April 28 and 29 and called the Gastric Bypass Workshop. I found a copy of the bound paperback of 187 pages recording transcript of the 1977 meeting, which was distributed after the meeting. The last article is about plans for a Gastric Bypass Registry. The Workshop transcript was distributed a month after the meeting. It includes the presentations and discussion that were recorded and transcribed.

Long-term results and prospective and larger trials began to contribute to the knowledge base, culminating in the first NIH consensus conference on December 4, 1978. This conference was of pivotal importance. It was at this conference that the jejunal-ileal bypass was shown to have substantial problems, and restriction (gastric bypass and vertical banded gastroplasty) was established as a credible procedure. The society was formed on this strong scientific foundation.

John Kral writes:

> Having attended the Iowa City colloquia, the academic surgeons J D Halverson, J P O'Leary, H J Sugerman and myself, at the colloquia in 1983, met in a pub during the lunch break to propose expanding the colloquia to the format of scientific meetings with membership, program committees, minutes, abstract selection and "democratic" principles. That afternoon, June 3, 1983 at an impromptu business meeting of the attendees a proposal for the formation of a society for the study of obesity surgery was made and accepted.

The aims of the society were to "develop guidelines for patient care, promote research into the outcomes and quality of bariatric surgeries and encourage an exchange of ideas among researchers and surgeons" [1]. In deference to Mason, the term "bariatric"—a continuation of his tradition of the colloquia—was adopted. In 1984, the first annual meeting of the American Society for Bariatric Surgery (ASBS) was held in Iowa City. The meeting attracted more than 150 participants and 36 oral presentations. After meeting again in 1985 in Iowa City, the society chose to rotate annually between different venues.

The original officers were the following: Edward Mason, MD, *president*; Boyd Terry, MD, *secretary-treasurer*; and Patrick O'Leary, MD, *program committee chair*. Initially, terms of office were 2 years in duration. However, as the work of running the society increased, the term of office decreased to 1 year in 1989 for the term of Cornelius Doherty. In recognition of his leadership in bariatric surgery, the Edward E. Mason Founders Lecture was established and given for the first time on June 2, 1989, by H. William Scott Jr., MD, from Vanderbilt.

In the early days of the academic effort to define the science of the surgical treatment of obesity, there was support by the NIH in convening a consensus conference and presentations of critical data at the Society for Surgery of the Alimentary Tract, the American Surgical Association, and the Western Surgical Association meetings. Many of the early surgeon scientists were also active in the American College of Surgeons (Ward Griffen, MD, and Patrick O'Leary, MD).

The majority of surgeon leaders from this era commented on the serious barriers in trying to mainstream their research and surgical treatment of obesity into their departments and community hospitals. The formalization of the society served to promote the ability to provide a forum for exchange of ideas, research, and best practice and education of its members; however, it also established a political force within American surgery and served to promote access to care for the surgical treatment of obesity. The criticism and perception by the surgical establishment had a profound impact on the character of the society and drove some decisions (both good and bad) from a group that felt on the defensive. Perhaps, in many ways, this reflects the very real discrimination and prejudice that patients who suffer from obesity also feel. A fiercely independent and entrepreneurial character is firmly entrenched in the society's foundation. These echoes of the underdog reappear throughout the 30+ year history of the ASMBS and continue to contribute to the development of our specialty and the identity of the society that serves to forward its practice.

The nascent society continued to encounter a difficult environment full of opportunity. Cornelius Doherty, a private practice surgeon recruited to join Edward Mason in IU and president of ASBS from 1989 to 1990, writes:

> The early surgeons in our field operated at a time when the prejudice against surgical treatment of severe obesity was at its zenith. Organized medicine had abandoned them with indifference. Third-party payers were denying patient access to surgery arbitrarily. Professional liability carriers were stopping availability of coverage or charging exorbitant premiums. Plaintiff attorneys were predatory about filing cases. My agenda during my Presidency was to position the ASBS in the best possible way to plea the case for acceptance of surgical treatment of severe obesity at the National Consensus Development Conference of 1991. I had early notice that this conference would occur. I worked to that end tirelessly. I spearheaded the appointment of Lars Sjostrom as an Honorary Life Time Member of the ASBS. The team from ASBS effectively presented decisive data that advanced the recognition of the value of bariatric surgery.

Twelve of the 14 surgeon speakers at the 1991 NIH Consensus Development Conference, "Gastrointestinal Surgery for Severe Obesity," were ASBS members. In a breakfast meeting at Brennan's in New Orleans, Michael Sarr, MD; Edward Mason, MD; John Kral, MD; Patrick O'Leary, MD; Cornelius Doherty, MD; and Harvey Sugerman, MD, set the agenda for the conference. These surgeons were able to present compelling data that influenced

the panel of nonsurgical experts to express a positive overall position in the Consensus Conference Statement, which paved the way for improved acceptance of gastric restrictive or bypass procedures for patients affected by severe obesity and influencing third-party payers. Thus, in many ways, advocacy for access to care was involved in the original mandate of the society. The society was focused during this time on getting at least 200 surgeon members so that they could qualify as a registered society with the American College of Surgeons. There was significant growth in the specialty of MBS, especially with the broader knowledge by patients that there may be an effective treatment for this disease. The NIH consensus conference was the pivotal event of this time and has stood the test of time. The 1991 guidelines still provide the backdrop against which decisions are made about whether a patient has access to surgery both in the United States and around the world.

The society leadership reflects a strong commitment to both private practice and academic practice. Although there has never been a formal ratio established in the bylaws, traditionally one-half of the Executive Council has come from private practice with a rotation of the presidency from 1 year to the next between academic and private practice. As more surgeons in private practice have been publishing peer-reviewed literature, serve to teach and train residents and fellows, participate in the quality program, and serve on and lead committees—along with the requirement by many academic surgical departments for high-volume practice and the employment by major hospital systems of physicians—the lines delineating private practice from academic practice have blurred. There remains, however, a very strong belief that both aspects of practice should be represented in the decisions of the society. Surgeons drove some of the pivotal developments in the specialty in private practice (Table 4.1).

Table 4.1 Presidents of ASBS/ASMBS

1983–1985	Edward E. Mason, MD, PHD (A)
1985–1987	John D. Halverson, MD (A)
1987–1989	J. Patrick O'Leary, MD (A)
1989–1990	Cornelius Doherty, MD (PP/A)
1990–1991	George S. M. Cowan Jr., MD (A)
1991–1992	John H Linner, MD (PP)
1992–1993	Boyd E. Terry, MD (A)
1993–1994	Otto L. Willibanks, MD (PP)
1994–1995	Mervyn Deitel, MD (A)
1995–1996	Alex M. C. MacGregor, MD (PP)
1996–1997	Kenneth G. MacDonald (A)
1997–1998	S. Ross Fox, MD (PP)
1998–1999	Henry Buchwald, MD, PhD (A)
1999–2000	Latham Flanagan, Jr. MD (PP)
2000–2001	Robert E. Brolin, MD (A)
2001–2002	Kenneth B. Jones, MD (PP)
2002–2003	Walter J. Pories, MD (A)
2003–2004	Alan C. Wittgrove, MD (PP)
2004–2005	Harvey J. Sugerman, MD (A)
2005–2006	Neil Hutcher, MD (PP)
2006–2007	Philip R. Schauer, MD (A)
2007–2008	Kelvin Higa, MD (PP), first president of ASMBS
2008–2009	Scott Shikora, MD (A)
2009–2010	John Baker, MD (PP)
2010–2011	Bruce Wolfe, MD (A)
2011–2012	[a]Robin Blackstone, MD (PP)
2012–2013	Jaime Ponce, MD (PP)
2013–2014	Ninh T. Nguyen, MD (A)
2014–2015	John Morton, MD (A)
2015–2016	Raul Rosenthal, MD (A)
2016–2017	Stacy Brethauer, MD (A)
2017–2018	Samer Mattar, MD (A)
2018–2019	Eric DeMaria, MD (A)

A academic, *PP* private practice
[a]Only woman to serve as president in the history of the society

The Era of Rapid Growth 1989–2004

The original structure of the society was established in the bylaws and has evolved throughout time. Officers were nominated by a nominating committee, and except for two elections, the slate of officers was unanimously selected. The first occurred when Harvey Sugerman, MD, was nominated, but George S. M. Cowan, MD, was elected in 1989.

This period of the society saw tremendous growth in the numbers of procedures and diversity of procedures including the use of devices in large numbers of patients. Increasing numbers of surgeons operating without a knowledge base or programmatic structure led to an increase in complications with a rise in malpractice premiums. Many insurance companies dropped benefits due to the sharp upturn in cost. This was demonstrated starkly in 2005 when the State of Florida lost all access for bariatric surgery by any company. Scrutiny of the data in bariatric surgery showed a lack of rigor; there was a growing public awareness of the increase in the numbers of patients with obesity as well as the number of surgeries being done for obesity. These challenges foreshadowed the next era of the society's growth.

At the time Boyd Terry, MD, became president (1991–1992), the society had just struggled through a major schism of its membership because of problems regarding the use of dues for the journal and bylaw uncertainty. In addition, controversy between biliopancreatic diversion and duodenal switch lent itself to spirited debate. Through Dr. Boyd's leadership, the society emerged with more focus on representation from different regions of the country and an emphasis on communication and well-focused objectives for committee work. Surgeons within the society were concerned that their success with gastric bypass would be eroded by the adoption of untested "extreme" procedures that caused more harm than good. This theme, existing in 1991, has had an echo throughout the history of the society. Intense procedural controversy

erupted again when the Food and Drug Administration (FDA) approved the first device to be used in the treatment of obesity: the adjustable gastric band (AGB). With the increase in public scrutiny, surgeons who practiced unproven technology outside of Institutional Review Board (IRB) guidance came under increasing scrutiny and pressure not to offer unproven and untested procedure variations. The tendency to develop and use procedures without scientific support contributed to uncertainty by medical and surgical colleagues and patients. It hampers the advocacy by surgeons to garner support with payers who may believe that we are advocating surgery in order to line our own pockets. Even when we present valid and strong evidence, we have trouble convincing payers and others, in part because of this historical context. This tension between commercialism and scientifically based procedure indications continues to the modern era of the society including the omega-loop gastric bypass and one anastomosis duodenal switch. The society has taken a firm stand on these issues, discouraging the use of procedures that do not have sufficient evidence of safety and effectiveness from being performed outside IRB guidance. The society, led by data-driven analysis through the clinical issues committee and sanctioned by the Executive Council, developed and implemented a process for evaluating procedures and determining when the evidence is sufficient for the society to place them on the accepted procedures list. This encourages surgeons and industry who contribute to the creation of new procedures to work through an IRB process and establish an evidence basis prior to widespread implementation.

ASBS began to achieve its political goals of formal participation in American surgery when it was voted a membership in the American College of Surgeons Board of Governors 1998. Patrick O'Leary, MD, had just joined the Executive Council of the Board of Governors, and when the request by Henry Buchwald, MD, came through, he was pivotal in getting it approved. Still, there were substantial barriers in the academic world. Particularly harsh was some of the criticism coming out of the surgical leadership of the University of Louisville, Kentucky, where one prominent surgeon declared bariatric surgery "charlatanism." Within the academic establishment, surgeons who were involved in the surgical treatment of obesity were not well respected, their papers were not given credibility or even published, and their careers were at risk. Henry Buchwald, MD, recounts that when he became the president of ASBS, his chairman commented, "You have just killed your career."

Integrated Health

Early on, awareness of the critical input and support of a variety of professionals in addition to surgeons were recognized. This was followed by the formation of the Allied Health Sciences Committee (AHSC) in June 1990 with Georgeann Mallory, RD, as the first chair. The committee included registered dietitians, exercise physiologists, bariatric physicians, psychologists, nurse practitioners, and physician assistants. The membership of this committee, which elects its own president and council, has grown. Contributions both to the peer-reviewed literature and to clinical pathways of care as recognized in the accreditation standards have emerged to enhance the management of patients before, during, and after surgery. With the growing needs of the society, Georgeann Mallory, RD, who worked with Dr. Alex Macgregor, the 10th president of the ASBS, was appointed as executive director in 1993. She also served as the first chair of the AHSC.

Mary Lou Walen was appointed the second chair of the AHSC. She writes:

> As Chair of the AHSC, it was important to me that all those working with patients receive education and information about the operations; complications; all aspects of care including working with the hospital both clinical and administration; learning about how to get paid for treating the patients; involving the primary care physicians and the specialists in becoming members of the treatment team; keeping the patients motivated and fully informed.

During Walen's chairmanship, workshops were developed and included in the program on clinical issues, patient education, insurance challenges, nutrition, psychology, and other topics; an allied health keynote speaker was added to the program; the AHSC chair was invited to all ASMBS Executive Council meetings; the committee requested to become a section and the Allied Health Sciences Committee became the Allied Health Sciences Section; and the president of the section became an elected position serving a 2-year term (Table 4.2).

The AHSC chair became a voting member of the Executive Council of ASBS in 2004. The Allied Health Sciences Section became the Integrated Health Section in 2008. In the immediate perioperative period, the role of nursing in successful recovery and recognition of developing complications was recognized, and a formal test and certification in bariatric nursing for RNs working for two or more

Table 4.2 Integrated health presidents of ASBS/ASMBS

1991–1996	Georgeann Mallory, RD
1996–1999	Mary Lou Walen
1999–2004	Tracy Martinez, BSN, RN, CBN
2004–2006	Deborah Cox, RN
2006–2008	Bobbie Lou Price, BSN, RN, CBN
2008–2010	William Gourash, MSN, CRNP
2010–2012	Laura Boyer, RN, CBN
2012–2014	Karen Schultz, NP
2014–2016	Christine Bauer, MSN, RN, CBN
2016–2019	Karen Flanders, MSN, ARNP, CBN

years in the field was established through the leadership of Bill Gourash, PHD, MSN, CRNP, and a dedicated group of item writers. For this work Dr. Gourash received the inaugural ASMBS Integrated Health Distinguished Advanced Practice Provider Award.

The Allied Health Section also established the Circle of Excellence Award, given annually to recognize outstanding ASMBS members who made contributions to the Integrated Health Section.

The Integrated Health Section has been integral to incorporating the role of a multidisciplinary team into the requirements for accreditation in metabolic and bariatric surgery. The presidents of the Integrated Health and the integrated health council have played a significant role in developing an IH strategic plan. A focus over the last few years has been to update the nutrition guidelines and begin to share best practice by publishing tool kits for integrated health teams across the United States to use. They also have published a support group manual. They participate in every committee of ASMBS as well as having committees specifically for topics pertinent to the integrated health team members. Since the last publication of the history of ASBMS in the inaugural textbook, the Integrated Health Leadership has the following accomplishments:

- Micronutrient guidelines
- Support group manual
- Webinar offerings for IH members (to provide education for all, but for those who cannot or do not attend OW)
- Established an Integrated Health Facebook group and Twitter presence
- A new Certified Bariatric Nurse web-based platform for renewals to simplify the process
- CBN working toward accreditation as a certification program
- >1000 Certified Bariatric Nurses
- A task force exploring credentialing for advance practice providers
- Tool kit on the ASMBS website with documents geared toward helping new (and experienced) providers with program start-up and development
- YouTube videos on the value of integrated health individuals in ASMBS membership
- Developed new categories of awards for recognition: Distinguished Behavioral Health Provider, Distinguished Advanced Practice Provider, IH Committee of the Year
- Change in leadership (IH President, IH President-elect, and IH Secretary) terms from 2 to 1 year for each position, as well as change in process in which election is for IH Secretary who then rotates to IH President-elect who then rotates to IH President

Growth of the Society

The rapid growth in the society paralleled the growth in the numbers of procedures and programs. This phenomenon was promoted by an increase in the number of people experiencing obesity, a growing awareness of surgical treatment of obesity, including the effect on type 2 diabetes; multiple stories began to be published including testimonials by celebrities like Carnie Wilson. The most significant factors in the growth of MBS were the transition from open to laparoscopic access with a resulting marked decline of mortality and morbidity and coverage by Medicare. Coupled with the implementation of national accreditation in the field and a strong access to care effort by the society, the numbers of people accessing surgery began to number in the tens of thousands. As the numbers of cases started to grow, the strongest focus of the society during this era was in the education of the membership. Dr. Brolin, who was president during the beginning of the "golden age" of laparoscopic access to bariatric procedures, focused on the training of general surgeons including a preceptorship committee (formed in 1999), which has evolved into the Bariatric Training Committee.

The "golden age" of laparoscopic approach to bariatric surgery was born with controversy. By 2001–2002, during the presidency of Ken Jones, MD, the surgeons supporting open procedures and the surgeons who supported laparoscopic procedures were openly antagonistic to each other's approach. Surgeons who had been doing open procedures were going to weekend courses sponsored by industry to learn the laparoscopic approach and coming back to their hospitals to do very complex laparoscopic gastric bypass procedures (GBP) with serious complications. At this time the delineation of privileges at many hospitals did not include advanced vs. basic privileges in laparoscopy. Since that time this has been corrected in part through the leadership of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). This was a perfect storm for plaintiffs' attorneys and the media, who regarded the surgery as unnecessary to treat obesity, a condition that they believed was self-inflicted by an inability to control one's desire to eat. All of these aspects provided fertile ground for a malpractice crisis that almost brought down the society and the specialty. Once again, the society found itself on the defensive. This crisis was precipitated by a number of untrained general surgeons rushing into the then-fertile financial ground of providing bariatric procedures without appropriate training or structure. Led by Samar Mattar, MD, this evolved into a certification of fellows in MBS including a didactic study program and test. This program has provided a strong scientific and technical foundation for postgraduate practice of MBS.

Medical Liability

In the 1990s and into 2000, bariatric surgeons were making "news," not so much for the benefits in health and quality of life for many but with not-so-back-page stories of procedures and outcomes gone awry for the few—especially for those cases or patients with notoriety. For some liability insurers, bariatric surgery outcomes were so uncertain that risk stratification of bariatric procedures resulted in regions where malpractice insurance for surgeons who practiced MBS was unavailable (Florida) or, if so, at premium rates that were increasingly higher than general surgery coverage.

In 2005, with the support of our society, NOVUS Insurance Company, a risk retention group, was founded, with the expectation that with the guidance of a firm, expert in medical malpractice defense, bariatric surgery could be shown to be of actuarial risk similar almost to that of general surgery. It was clear to the Board, which was made up of regular members of the ASMBS that for any bariatric practice, careful attention to patient selection, education, evaluation, and operative preparation was critical. In addition, the consent process, with expanded face-to-face explanation and significantly improved documentation, was imperative.

However, the basis for most lawsuits had to be recognized to have resulted not from technical operative error but a breakdown in patient, sometimes family, and physician rapport and untimely or inappropriate response to indicators of patient deterioration. In short, it is not that a leak occurred that makes a claim likely, and perhaps difficult to defend, but it is the "aggravating circumstances" together with an unanticipated outcome that make a claim virtually certain. Such circumstances are many, including surgeon unavailability when needed, inadequate surgeon empathy in a time of crisis, inexperienced "coverage" or poor "hand-off," delay in or failure to respond to calls, lack of communication between all care providers, and inadequate initial risk disclosure paired with undocumented patient understanding. In addition, there is a well-established and documented weight bias among health-care providers and within the health-care industry toward not only the patient with obesity but also the surgeons or physicians who treat it. The society realized that a strategy to establish a quality standard as well as share best practice would be necessary and would be necessary to underlie the overall increase in case volume.

In 2011, NOVUS was merged into NORCAL Mutual Insurance Company. In 2011, the ASMBS "Professional Liability" Committee became the "Patient Safety" Committee. Increasingly, the committee recognized the importance of closed claims as a significant resource in our improving patient safety. In 2012, our monthly e-publication ("Top 5 on the 5th") vignettes, derived from closed claims, met with broad society support. They are anticipated to resume in a new format in the ASMBS new magazine *Connect*. Investigation is ongoing as to whether we may develop a closed claims database, similar to that of the American Society of Anesthesiologists, which for more than 30+ years has resulted in material improvements in anesthesia services and a 30% average decline in anesthesiologists' liability premiums. Over the past 5 years, more work has done on evaluating closed claims, which were collected in 2016 and 2017.

The Era of Quality and Engagement from 2004 to Present

Quality and Data Registries

One of the outgrowths of the period of crisis from 2001 to 2004 was an awareness that the image of the society needed to change. Rather than allowing any surgeon with minimal training, low volume, or no programmatic elements to participate, the society made a decision in its annual business meeting to establish a national center of excellence program. A minimum of 125 cases was required to qualify with the result that the number of operating surgeons and programs contracted sharply throughout the next few years. Surgeons and programs that did not participate lost their ability to offer MBS as the contraction in the market place occurred. As part of that effort, the Bariatric Outcomes Longitudinal Database (BOLD) was developed to support the accumulation of data for both outcomes' information and research. This was not, however, the society's first efforts at creating a registry.

Standardized data collection and analyses for surgical treatment for obesity began in 1985 under the direction of Edward Mason, Department of Surgery, University of Iowa Hospitals and Clinics (UIHC). The National Bariatric Surgery Registry's (NBSR) goal was to meet a growing need for quality control in reporting outcome results by assisting surgeons in continuing improvement for patient care through outcome analyses. The NBSR was run in the Department of Surgery at UI and received full financial support from one corporate sponsor during the first 2 years. Subsequent support came from surgeons who voluntarily participated through membership fees, satellite data collection, and submission.

The International Bariatric Surgery Registry (IBSR) provided software, training, and instruction manuals for collecting, storing, and preparing reports of local data for comparison with the total data reported. Management of the system was by Kathleen Rehnquist, BS, from 1986 to 2006. Dwight "Ike" Barnes; John Raab, RN; and Mark Crooks provided personal computer programming. Together they provided successful software throughout ten updates/revisions. Graduate students provided the integrated statistical analysis from the College

of Preventive Medicine, biostatistics division (Donald Jiang; Elizabeth Ludington, PhD; Wei Zhang, PhD; and Shunghui Tang, PhD). Professors mentoring the students included Robert Woolson, PhD; Miriam B. Zimmerman, PhD; and Michael P. Jones, PhD. The aggregate analyses were accomplished via SAS programming at the University Computer Center on IBM mainframes until aggregate analysis and computers evolved to use PC SAS on a personal computer housed in the IBSR office. In 2006, the final repository of the aggregate data represented 85 data collection sites for 45,294 subjects whose surgery was performed by 148 surgeons many of whom were members of ASBS.

Newsletters, manuals, papers, and data for lectures or publication could be prepared using the IBSR software or by special reports of the aggregate data with assistance from IBSR staff. Direct access to the registry data was never available, due to privacy policies of the UIHC, State of Iowa, and Federal Regulations (HIPPA). Quarterly reports were provided to each satellite surgical practices with de-identified results to help surgeons compare patient outcome with that of the total IBSR experience. More than 70 newsletters were published, with Dr. Mason soliciting a medical section for surgeons and other IBSR staff writing articles of interest regarding data collection and how data results were reported. The ultimate closure of the IBSR resulted from inadequate financing to support a Web-based data collection system and incomplete follow-up methods for complete data analysis and verification.

BOLD was the society's second effort at a registry. In 2004 the ASBS established an independent not-for-profit company, the Surgical Review Corporation (SRC), to oversee the ASMBS Centers of Excellence quality program. The BOLD registry was developed with input by ASMBS surgeons. A few years after the COE program was implemented, participation in the registry became a requirement for accreditation. Requiring data entry of all bariatric cases began the process of changing the surgical culture within community hospitals where the majority of patients received MBS. This second effort at a data registry was also problematic. These include data not available reliably for use in continuous quality improvement; individual surgeon office, rather than hospitals, often paid registry fees and collected; poor definitions and haphazard methods; and quality of data collection and poor long-term follow-up. In addition, the registry was not connected to the national data quality movement and began to fall behind other efforts like the National Surgical Quality Improvement Program (NSQIP). Despite the important efforts of Deborah Winegar, PhD, the final database director and surgeon members of the quality program who worked tirelessly to try and improve the registry, a point was reached which required a change in direction. A scientific project to compare three data registry options was conducted, and with input from the ASMBS Quality and Standards Committee, the society decided to move away from BOLD. The aggregate data from BOLD has not been lost; some publications have resulted from this data.

Under the leadership of Robin Blackstone, MD, President of the ASMBS, and David Hoyt, Executive Director of ACS, ASMBS joined the Centers of Excellence program with the American College of Surgeons Bariatric Surgery Network on April 1, 2012. This established one authority for national accreditation in the United States, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The program established a registry based on strong principles of data collection and integrity of the data, including collection of 100% of cases performed at the accredited center; defined data entry variables; and third-party data collection by certified of the clinical reviewers. Each program receives two semiannual reports (SAR) that allow comparison of their programs on key variables to national benchmarking providing the high-quality data necessary for the use of outcomes to improve practice at the local level with continuous quality improvement. In addition to local efforts, the data is examined by the MBSAQIP Quality Committee to identify areas where national improvement projects could take place. One project focused on programs with high emergency department readmission rates. In this project, led by John Morton, MD, programs that were high outliers in readmissions were identified and offered an opportunity to participate in the DROP process (Decreasing Readmissions through Opportunities Provided) [2]. The second project, led by Stacy Brethauer, MD, offered programs with higher length of stay the opportunity to participate in the use of a set of enhanced recovery protocols for metabolic and bariatric surgery. In addition to prospective projects that occur in the real-world setting of community practice as demonstrated by these two national quality improvement projects, the MBSAQIP registry accumulates high numbers of patients annually. The quality of data collected and the availability of public use files of the previous year's data allow retrospective review and study of even small effect size complications. The data registry provides high-quality data that offers a credible foundation for quality improvement and best practice at the community and university hospital level.

Strategic Plan Development

The society has successfully met many challenges during its history. However, the world of medicine changes constantly, and in order to respond, the society created a plan for its own evolution. A formal strategic plan for the society—led by Phil Schauer, MD, with input from the Executive Council—was developed and embraced at the business meeting in 2008. As part of the evolution of the specialty, the society

elected to change its name from the American Society for Bariatric Surgery (ASBS) to the American Society for Metabolic and Bariatric Surgery (ASMBS) at the annual business meeting on June 15, 2007.

The strategic plan was implemented fully during the presidency of Bruce Wolfe, MD, with a change in the structure of the committees to align with the established mission, vision, values, and goals of the society and direct alignment of the committee projects with the overall budget of the society. The strategic plan drove many of the expenditures of the society, and all budget items are considered in light of the overall mission and goals. The alignment of the committee structure enabled a much higher productivity in the committees and drove improved communications and work product of the committees. Every facet of the society from budget decisions to the overall work plan of the committees was aligned. Dr. Wolfe also created a Quality and Standards Committee to assess the accreditation program and propose an evolutionary process. These updates to the operating structure of the ASMBS would transform the society into one that had the engagement of a very large group of young leaders and members of the society from both academic and private practice. This current model has provided robust volunteerism and energized committees with emerging and diverse merit-based leadership. Implementing a culture of leadership development has been the ultimate guarantee of continuation of new ideas and strategy to meet future challenges. The current committees report evolving goals/objective and accomplishments each year in the ASMBS Annual Report (https://asmbs.org/about/annual-report).

The Journal

Obesity Surgery, the original journal of the ASBS, was founded in 1990, adopted by the society in 1991 and achieved Index Medicus status in 1995. Its birth was not without controversy. In 1989 at the annual meeting in Nashville, Tennessee, the Executive Council, at its statutory meeting, had prepared a nominating slate for consideration at the business meeting, including a proposal initiated by the president, Patrick O'Leary, MD, for joining the North American Association for the Study of Obesity (NAASO) and other International Association for the Study of Obesity (IASO) organizations in adopting the *International Journal of Obesity* as the ASBS journal. As a guest at the council meeting, Dr. Mervyn Deitel presented his own proposal for a journal. *The Executive* Council supported Dr. Deitel's proposal, pending his providing a business plan and other details. At the business meeting, however, following controversial presentations during the scientific meeting, which drew criticism for premature clinical use of novel operations without adequate patient follow-up, the membership rejected the nominating committee's slate of candidates. At that same meeting, the membership voted on, *and accepted*, the proposal to adopt *IJO* as its journal, affirming the possibility that, at some later time, Dr. Deitel might provide a separate proposal to be duly considered.

A few months later, Dr. Deitel (with support from some newly elected council members) mailed selected members requesting support for his journal. His rallying cry: "Pull out all your rejected manuscripts and we will publish them!" Through a closed ballot process, the leadership of ASBS nullified the 1989 business meetings' decision, adopting Dr. Deitel's journal with mandatory subscription in 1990. Dr. Deitel, who had sole ownership of the journal, later decided to sell the journal. It came as a surprise to younger members that the journal *Obesity Surgery* was actually privately owned; after considering the option to purchase it, the ASBS decided to establish its own journal. Eventually, *Obesity Surgery* was sold to a publisher and adopted as the official journal of the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO). It maintains the tradition of publishing articles from the international community and—under the direction of Dr. Henry Buchwald and Nicolas Scopinaro, MD, and the current editor, Scott Shikora, MD—has made significant progress in improving its impact factor.

In February 2004, the ASMBS established a new journal *Surgery for Obesity and Related Disease* (*SOARD*) owned by the society—with Harvey Sugerman, MD, as the first and current editor. Dr. Sugerman is largely credited with developing an outstanding editorial board and with the high quality that the journal has achieved. The initial journal was published in six issues during the year, increasing to monthly publication in 2017. During the course of the journals' history, the editorial board has made concerted efforts to standardize the reporting of key variable like total weight loss, in order to produce articles with less heterogeneity. The impact factor in 2017 was 4.5, placing it as number 11/165 surgical journals. In 2017, the journal published 396 original manuscripts. The journal represents the readership with 44% of manuscripts from North America, 34% from Europe, and 10% from Asia. A continuing medical education program was implemented and led by Samar Mattar, MD, awarding 3671 h of CME to 278 readers and 472 h of CME to reviewers in 2017. Dr. Sugerman continues to lead the journal effort. Raul Rosenthal, MD, was appointed coeditor. The 14-year history of the journal is a tribute to the men and women who design, execute, and write about their research and to those who guard the portals of good science in ensuring the journal reflects the highest values of inquiry. The journal allows us to bring the light of scientific inquiry to shine on our work in an environment without the bias that Dr. Sugerman and many others, who struggled for recognition of

their work during their careers, faced. The journal is the embodiment of how far the specialty has traveled.

Access to Care

Surgeons who treat other forms of disease have enjoyed wide access to their procedures through coverage by insurance. Patients who suffer from obesity, however, have long been victims of a misperception of their role in being affected by obesity (personal responsibility) and denied coverage based on the perception of the "cosmetic" nature of surgical treatment.

This quest to obtain wider access for patients has been one of the critical driving forces behind the society's growth. These efforts have been ongoing since the earliest days of the society but were formalized by the creation of the Access to Care Committee on November 11, 2008. During the next 5 years, the work of the committee included partnering with advocates outside ASMBS in the battle for access. This coincided with the vision the society had to create a population management approach to the management and treatment of obesity. Part of this strategy is to provide more balance in reporting around obesity and to train advocates at many levels of leadership with ASMBS. The society engaged Roger Kissin and Communications Partners in order to fulfill the strategic goal of making the society the public voice of authority in this field and add to the education of the media about this subject.

This strategy has been extremely successful in changing the dialogue. Currently, the president and senior leadership give more than 300 interviews to major media outlets per year with messaging that is developed and approved by the Executive Council; media training is provided to all committee chairs and chapter presidents so that when we respond to a query, we can do that with one consistent message. Another successful strategy was to field a rapid response team approach to changes in benefits. If any entity (company, government agency, state agency) tried to change or drop a benefit or began to consider implementing one, a group of experts—including the surgeons from that area, industry with lobbyists on the ground, and leadership from the ASMBS Access to Care Committee as well as the Obesity Action Coalition (OAC)—could convene to immediately address the problem. This has been a very successful strategy in maintaining and gaining new coverage. The most convincing argument, however, is the effectiveness of surgical therapy both on obesity itself and, perhaps even more profoundly, for the effect on obesity-related diseases such as diabetes. Even with all these efforts, which are intense and ongoing, far less than 1% of the patients who have significant disease that will limit their longevity have access to the most effective care. Although we often think of access as limited by coverage, in fact it is just as limited by the available surgical manpower, which at this time can provide only 1% of patients with surgical treatment. It is also limited by reimbursement. It takes many resources in structure, process, and personnel to support patients through the entire course of care, and reimbursement for all of this supportive care is lacking. In this environment, the tricky questions of who should have access to surgery and what the optimal procedure should be persist despite efforts to define indications. Meanwhile the scientific data on epigenetic transfer of obesity-promoting genes and the differences in physiology in regard to hunger, satiety, and metabolism of patients who suffer from obesity are now widely documented. Support by the government for treatment came with the announcement of the National Coverage Decision by the Centers for Medicare and Medicaid Services (CMS) providing access to surgical treatment for Medicare and Medicaid beneficiaries as of February 21, 2006. It was expanded for the treatment of diabetes in 2009. Although CMS continues to support access to surgery, they dropped the requirement for accreditation of the program providing the surgical care—a decision born in controversy and of great concern to the society about the safety of the decision. Currently the fight for access continues and has come down to a state-by-state battle to establish bariatric surgery as an essential benefit in the Affordable Care Act. Twenty-two states recognize bariatric surgery as an essential health benefit. All these politics are local, and a local political force is needed. To meet this need, the ASMBS state chapter program was established during the presidency of Neil Hutcher, MD. The goals for the state chapters are to advocate for increased access at the local level and to establish collaboration for best practice in the quality program. Each state chapter has an elected State Advocacy Representative. At the beginning of 2018, OMA and TOS announced that their respective groups would be establishing State Advocacy Representative (STAR) Programs—modeled after the ASMBS STAR Program. Both TOS and OMA are hopeful that they will have a STAR in every state by the end of 2019. OAC is also formulating plans for regional OACSTARs. At the time of this report, plans were underway to establish an Obesity Care Continuum STAR Program to link these programs across AND, TOS, OMA, OAC, and ASMBS.

Obesity Action Coalition

In addition, a need for advocacy on the policy level was identified. Experts on public policy from Kellogg School of Business at Northwestern were engaged to study the access problem. Led by Dr. Daniel Diermeier, it was determined the nature of the issues that led to the loss of insurance coverage required a public policy approach. The Obesity Action

Coalition (OAC) was founded in 2005 by Robin Blackstone, MD; Georgeann Mallory, RD; and Christopher D. Still, DO, FACN, FACP, to fill the patient-advocacy gap for the disease of obesity.

The Obesity Action Coalition (OAC) is a more than 60,000 member-strong 501(c) (3) national nonprofit organization dedicated to giving a voice to the individual affected by the disease of obesity and helping individuals along their journey toward better health through education, advocacy, and support. The OAC's core focuses are to raise awareness and improve access to the prevention and treatment of obesity, provide science-based education on obesity and its treatments, fight to eliminate weight bias and discrimination, elevate the conversation of weight and its impact on health, and offer a community of support for the individual affected.

The OAC is made up of a vibrant membership community where individuals can find valuable information to help them on their weight journey and connect with others who share similar experiences. The OAC is also the founder of the highly successful *Your Weight Matters* brand, which encompasses *Weight Matters Magazine*, the *Your Weight Matters* National Convention, and the *Your Weight Matters* National Campaign. The goal of the *Your Weight Matters* brand is to deliver one clear, concise message: "Your Weight Matters – For Your Health."

Obesity Care Advocacy Network

The leading obesity advocate groups founded the Obesity Care Continuum or "OCC" in 2010 to better influence the health-care reform debate and its impact on those affected by overweight and obesity. The OCC was composed of the Obesity Action Coalition (OAC), the Obesity Society (TOS), the Academy of Nutrition and Dietetics (AND), the American Society for Metabolic and Bariatric Surgery (ASMBS), and the American Society for Bariatric Physicians (ASBP). The American College of Surgeons, although not a member of the OCC, supports the work of the group by acting as an independent third-party advocate. The OCC evolved into the Obesity Care Advocacy Network (OCAN) with a mission to partner with medical societies and organizations to change how the nation perceives and approaches the US obesity epidemic by educating and advocating for public policies and increased funding for obesity education, research, treatment, and care. Now with a membership of 19 organizations including the American Academy of Physician Assistants; Academy of Nutrition and Dietetics; American Association of Clinical Endocrinologists; American Association of Nurse Practitioners; American Council on Exercise; American Society for Metabolic and Bariatric Surgery; AMGA; Black Women's Health Imperative; Healthcare Leadership Council; National Alliance for Healthcare Purchaser Coalitions; Novo Nordisk, Inc.; Obesity Action Coalition; Obesity Medicine Association; SECA; the American Gastroenterological Association; the Endocrine Society; The Obesity Society; Weight Watchers; and the YMCA of the United States. The group has sponsored three workgroups centered around implementing the provisions of TROA through the administrative mechanisms as well as address military readiness on the impact of obesity on the national armed forces.

The Treat and Reduce Obesity Act (TROA)

In June of 2013, the ASBMS, as part of the OCC network, endorsed the Treat and Reduce Obesity Act of 2013 (TROA)—a bipartisan, bicameral bill that has been introduced in the 113th Congress. The bill aims to effectively treat and reduce obesity in older Americans by increasing Medicare beneficiaries' access to qualified practitioners who can deliver intensive behavioral therapy for obesity and allowing Medicare Part D to cover FDA-approved obesity drugs. The initial efforts to enact the bill were not successful; however, it was reintroduced into congress in April of 2017 by Senators Bill Cassidy (R-LA) and Tom Carper (D-DE) and Representatives Erik Paulsen (R-MN) and Ron Kind (D-WI). TROA (Senate Bill 830/House of Representatives Bill 1953) is strongly supported by OCAN as well as the American College of Surgeons who joined the advocacy effort in 2018. Specifically, TROA will provide the Centers for Medicare and Medicaid Services (CMS) with the authority to expand the Medicare benefit for intensive behavioral counseling by allowing additional types of health-care providers to offer these services. The legislation would also allow CMS to expand Medicare Part D to provide coverage of FDA-approved prescription drugs for chronic weight management. The budget impact analysis paper developed by Wayne Su and IHS Markit has been useful in demonstrating the significant potential savings to the Medicare program ($19–21 billion) over 10 years should Congress pass TROA.

National Obesity Care Week (NOCW) 2018 (October 7–13)

The Obesity Action Coalition (OAC), The Obesity Society (TOS), the STOP Obesity Alliance, the Obesity Medicine Association (OMA), and the American Society for Metabolic and Bariatric Surgery (ASMBS) launched the first NOCW in 2018. The goal is to build within the public understanding of obesity and value of science-based care. The ASMBS

believes that NOCW elevate awareness of the disease of obesity, create an understanding of the challenges people affected by obesity endure, and promote the support of treatment.

International Affiliations

Obesity is an epidemic affecting many countries outside the United States. Our colleagues from around the world have made exceptional contributions to the science and art of MBS. In recognition of this, ASMBS became a founding member of the International Federation for the Surgery of Obesity (IFSO) formed in 1995 at a meeting in Stockholm. IFSO currently has more than 50 member societies. There are 3600 members of ASMBS that are also members of IFSO.

The international committee was organized in 2009, and Raul Rosenthal, MD, was the first chair. The first International Congress was at the 2011 Annual Meeting: Bariatric Surgery in Latin America. International interest and growth have been strong and increasing annually (Fig. 4.2).

The ASMBS Foundation

The ASMBS Foundation is a 501(c) (3) nonprofit organization developed to raise funds for conducting research and education, increasing public and scientific awareness and understanding, and improving access to quality care and treatment of obesity and severe obesity.

The ASMBS Foundation was established through the efforts of the ASMBS Executive Council in 1997 spearheaded by S. Ross Fox, MD. The ASMBS Executive Council and Dr. Fox recognized the need to provide fund-raising—through charitable gifts and public and private donations—to support their shared vision to improve public health and well-being by lessening the burden of the disease of obesity and related diseases throughout the world. The foundation has continued to support the activities of the society centered around access, education, and research. Currently the foundation is undergoing a strategic process to revitalize the board, building a stronger foundation of philanthropy with a new executive director, and continuing to build national presence to the Walk from Obesity.

Obesity Week

In fall 2013, the ASMBS and the Obesity Society (TOS) held their annual meetings in conjunction with one another. Surgeons, researchers, bariatric medicine specialists, and

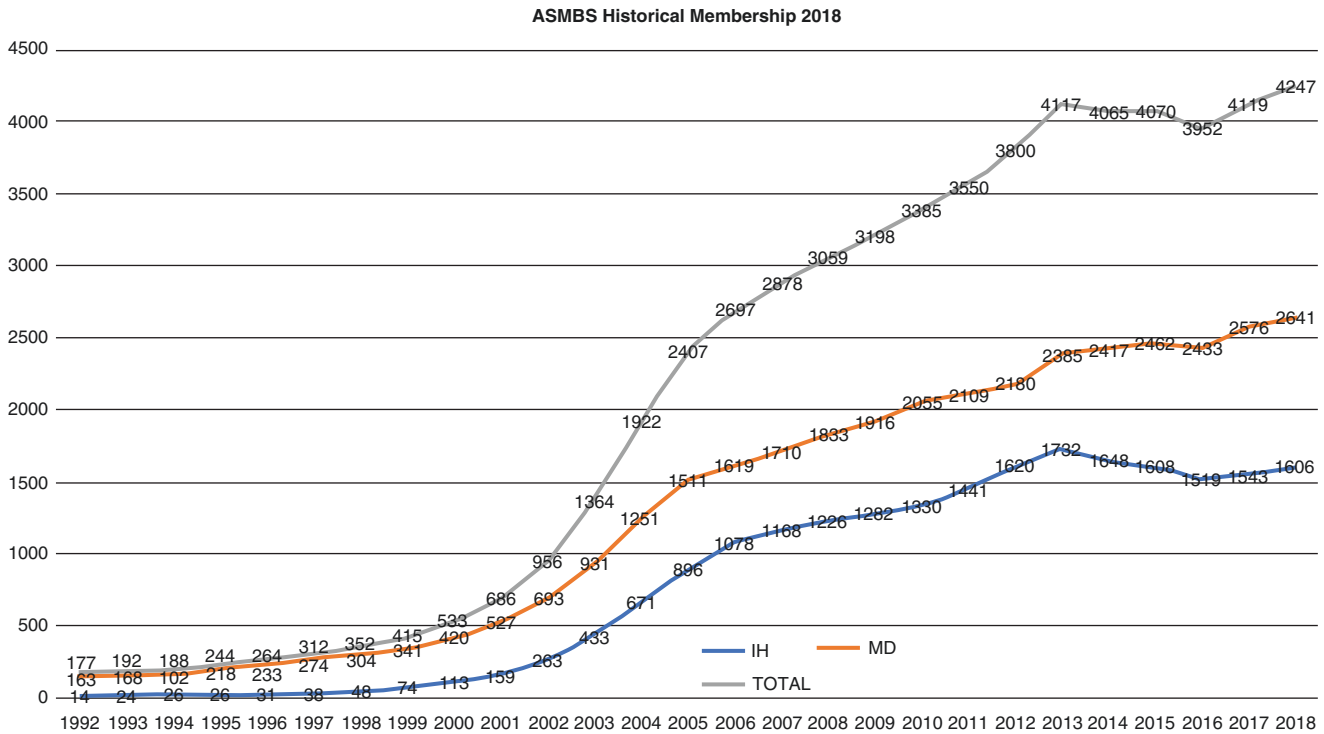

Fig. 4.2 Growth of the ASMBS

integrated health professionals came together for one action-packed week. Each society maintained its own traditions and meetings, but each member who attended was able to choose from among a wide variety of educational options. Phil Schauer, MD (ASMBS), and Gary Foster, MD (TOS), forged the path to the first conference supported by the ASMBS Executive Council and membership. The meeting is designed to foster the understanding of the pathophysiology of obesity, the application of science to the clinical management of patents, and the mechanism of action of surgery and pharmaceutical and behavioral management and to establish collaboration in research. Obesity week has blossomed into one of the most well-attended scientific meetings of the year with an expanded catalogue of course offerings and sharing of dialogue among its many diverse members. Attendance in 2018 included 5300 people, equally divided between surgery and medicine physicians and integrated health members.

Conclusion

The history of the ASMBS is one of the intense and focused efforts by visionary leaders, but it is also the story of engagement of the members in the development of the specialty. The foundation of the society is grounded in the efforts of critical thinkers, scientists, and visionaries, but with the transition to the national accreditation system, all members of the society have participated in one of the most important and successful quality initiatives in American surgery. The sense of having a special mission, of championing a group of patients who face daily discrimination and prejudice, and of being fierce advocates for a science that has delivered hope to millions of patients affected by diabetes and obesity defines members of the ASMBS. The surgeons and integrated health colleagues of ASMBS deliver on a daily basis *the most effective therapy in the history of medicine,* with a mortality that is less than a laparoscopic cholecystectomy.

The American Society for Metabolic and Bariatric Surgery has matured throughout the 30+ years of its existence. The society has shown visionary leadership in education, multidisciplinary care, access to care, accreditation, and quality improvement. The ASMBS has responded to the crises of its time with action and become part of the wider society of physicians managing obesity. The society has taken a leadership position in defining approved procedures, providing guidance to the FDA in the approval of new devices, providing guidance to members on a wide range of topics, and establishing an ethics committee to hear grievances about advertising and practice issues. The twin drivers of access to care and quality have driven engagement of the membership with their society. The strength of the society lies in the adherence to scientifically valid principles, fairness, and increasing transparency of governance and in the engagement of talented members who volunteer their time to serve on committees. The dedication of our members to provide high-quality safe care continues to be our most closely held goal. Although we may have been considered outsiders at one time, our experience in quality and collaboration, access to care issues, and managing change should propel us into the leadership of our hospitals and American surgery.

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