



Patient perspectives of the Bariatric Care Pathway on the Wirral

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Executive summary

This study involved interviews which described the views of patients and their significant others who had been on the bariatric care pathway in the last three and a half years.

Twenty four interviews were carried out with: 15 patients who had had bariatric surgery, 5 who had not and 4 who were significant others of the patients.

Six main themes emerged from analysis of the resulting data:

- Overweight; the chronic struggle with associated health problems and co-morbidities.
- Experiences of the lifestyle and weight management services.
- The complexity of bariatric surgery and physical problems that have resulted from undergoing this type of operation.
- The experience of being an NHS patient in a private healthcare system, problems of follow-up care.
- Post surgical physical and psychological changes.
- Being obese affects how you are treated by other people.

Not all patients found bariatric surgery to be the 'magic bullet' they perhaps envisaged it would be.

Post surgery patients had difficulties adapting to a limited nutritional intake both physically and psychologically.

Psychological issues were found to present themselves in both patients who had and those who did not have surgery.

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1. Introduction

Obesity is one of the biggest public health issues affecting England. In England in 2006 the prevalence of overweight in people aged 16 and over was 38% (approximately 15.4 million people), with 24% obese (approximately 9.8 million people). Furthermore, this prevalence is increasing; the Health Survey England (HSE) 2008 Adult Trend tables show that in England there was a marked increase in the proportion of adults that were obese, from 13% in 1993 to 24% in 2008 for men; and from 16% to 25% for women (HSCIC 2010).

The incidence of obesity has both severe financial and health implications; the cost of obesity in the UK is now estimated to be over £1billion per year (Shan 2008). Additionally, obesity is related to several chronic health diseases, in particular diabetes and cardiovascular disease. In total there are 18 co-morbidities which are commonly associated with obesity, including type II diabetes, cancers, asthma, osteoarthritis and chronic back pain (Guh et al 2009).

The Department of Health recommend that obese patients should be advised on and attempt interventions on healthy eating, physical activity and behaviour change. Drug therapy, such as Orlistat should only be considered as an addition to lifestyle intervention not as an alternative. Furthermore bariatric surgery should only be considered once all other interventions have been exhausted and patients must show commitment to being able to make lifestyle changes.

NICE (2006) recommends structured weight loss programs delivered by health care professionals which aim to reduce calories, usually at around 600 kcal/day deficit. Whilst popular commercial weight loss programs, e.g. Weight Watchers have been found to reduce users' weight at a moderate level, success rates are often significantly impacted by adherence and commitment to the diet (Dansinger et al 2005). Structured weight management strategies which work with patients not only by providing dietary advice but also helping in understanding the reasons behind overeating and emotional eating can have much more long term positive benefits to the patients (McDonald 2009). Furthermore by addressing patients' common misconceptions about meals, these strategies can further

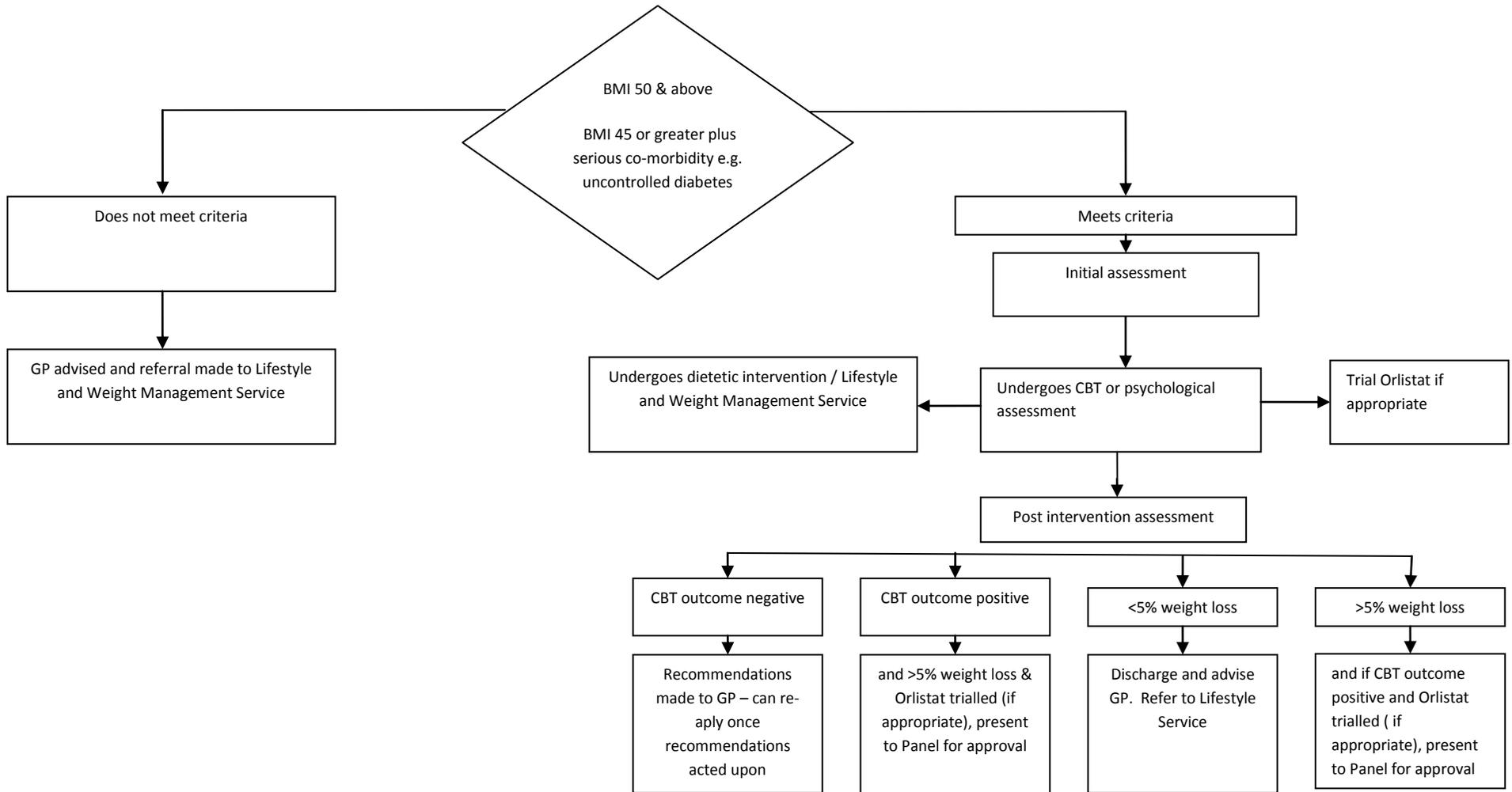
assist in producing a lifestyle change rather than a quick fix diet which is not achievable in the long term (Cook 2009). Patients are all different and a one size fits all approach should not be used, often underlying issues need patience and understanding from health care professionals and patients often have different needs in terms of how much support they require (McDonald 2009).

NICE (2006) recommends that everyone should take part in some form of physical activity, for those who are obese this is particularly significant. An increase in body weight cannot be solely attributed to diet; exercise is also a key component in reducing obesity. Furthermore physical activity is associated with improved motivation and therefore a more compliant diet, an improved metabolism and improved body shape, (Stear 2004). Only 35% of men and 24% of women report achieving the recommended physical activity levels, (30 minutes of moderate activity 5 times a week). Evidence has shown that physical activity coupled with healthy eating has a bigger effect on weight loss than interventions that focus only on healthy eating (Goodpaster 2010) supporting the need for a multicomponent approach to weight loss interventions.

For patients whom healthy eating, physical activity and drug therapy are not sufficient, bariatric surgery is recommended (NICE 2006). There are many different surgical procedures including the gastric band, gastric bypass and duodenal switch. Surgery can cause complications including respiratory disorders and psychological disorders (Colquitt et al 2009). However surgery results in greater weight loss than conventional weight loss methods (e.g. healthy eating and exercise) in moderate (body mass index greater than 30) and severe obesity. Furthermore reductions in co morbidities, such as diabetes and hypertension, have also been demonstrated post surgery. Two years post surgery, patients' quality of life was also found to have significantly improved (Colquitt et al 2009).

NHS Wirral's Bariatric Care Pathway (BCP) is a weight management programme (see figure 1) which includes lifestyle and weight management education, drug therapy and potentially bariatric surgery. NHS Wirral commissioned an independent study of the BCP from Liverpool John Moores University to evaluate the effectiveness of the project.

Figure 1: NHS Wirral's Bariatric Care Pathway (BCP)



1.1 Aims

The main aim of this report, which forms one part of the overall evaluation of the Bariatric Care Pathway (BCP), is to explore the patient experience of the BCP. In the first instance the BCP is a 12 week weight loss programme; the pathway can also include cognitive behavioural therapy, drug therapy and bariatric surgery. In order to be considered for bariatric surgery, two specific criteria should be met: namely achieving a 5% reduction in bodyweight and being considered psychologically suitable for this type of surgery. If these criteria are met, the final step on the pathway is case review and selection by a panel of health professionals. A secondary aim of this evaluation is to consider whether those patients who took part in the study interviews (both those who did and did not have surgery) have benefited (based on self reported outcomes available from interview data only) and what the impact of the bariatric care pathway has been on both the individual and their family.

2. Method

A qualitative approach to data collection and analysis was taken, the aim of which was to describe the views of patients and significant others who had been on the bariatric care pathway in the last three and a half years.

2.1. Data collection

Twenty two participants took part, fifteen of those had had surgery, three had not had surgery and four were significant others of the patients. There were sixteen female patients and four male patients, three of the significant others were male and one was female. The interviews were carried out in the patients' own homes between March and June 2011. Interviews were semi-structured and focused on patient's experiences of the BCP and the impact of the BCP upon them. (for interview schedule see Table 1).

Table 1. Retrospective Interview Schedule

1. Please can you tell me about your experience of the Bariatric Care Pathway (BCP)?	
2. Please can you tell me about the weight you lost at each stage of the BCP?	
3. Can you tell me about how long you were on the BCP and what sped up or slowed down your progress at each stage of the pathway?	
4. In what ways did the BCP affect your health and health care?	
5. Can you tell me about how you were involved in decisions about the treatment options you received whilst on the BCP?	
6. Can you tell me what do you think was good about the BCP?	
7. Can you tell me what do you think was NOT so good about the BCP?	
8. What do you think could be done to make the BCP better for patients?	
9. Can you tell me whether you think the BCP represents good value for money?	
<i>For those who <u>did not</u> have surgery additional questions are:</i>	
10. Can you tell me the reasons why surgery was not pursued?	
11. Can you tell me about any alternative measures you have taken to lose weight?	

2.2. Data analysis

Data were analysed using a framework analysis approach to identify emergent patterns and themes (Ritchie and Spencer 1994). This five stage process involved familiarisation with the data; the generation of a thematic framework; indexing of all transcripts; charting data and mapping data extracts to the framework; followed by a process of interpretation.

Two researchers undertook the initial framework generation during which a selection of transcripts were scrutinised independently and an index of the key issues, concepts and themes was devised. These drew on *a priori* issues linked to the aims and objectives of the study and on issues expressed by the participants. Findings were compared and a final framework agreed; indexing, charting and mapping processes were then completed and an audit trail was completed by a third researcher to ensure that all relevant data featured in the framework and that the final map represents the data that were derived from each of the individual transcripts.

2.3. Ethical approval

Ethical approval for this research was granted by Liverpool John Moores University Research Ethics Committee. The protocol was also presented to Northwest 12 Lancaster Ethics Committee (NHS REC) who deemed the work a service review and advised that NHS REC approval was not required in this case.

Confidentiality

To preserve confidentiality, a code was allocated to each participant and was used on all recordings and ensuing documentation. The list of master codes is known only to the research team. The master codes and corresponding names are kept in a locked filing cabinet and on a password protected university PC, accessible only by the research team. Interview recordings were available and listened to only by the researchers and when not in use stored in a password protected PC and destroyed after transcription. All interview transcripts are securely stored in locked filing cabinets and in University password protected computers. According to Liverpool John Moores University guidelines, research data will be stored for ten years and personal data will be destroyed on completion of the study.

3. Results:

Analysis extracted a number of core themes:

1. Overweight; the chronic struggle with associated health problems and co-morbidities
2. Experiences of the lifestyle and weight management services.
3. The complexity of bariatric surgery and physical problems that have resulted from undergoing this type of operation.
4. The experience of being an NHS patient in a private healthcare system, problems of follow-up care.
5. Post surgical physical and psychological changes.
6. Attitudes towards obese people

3.1 Theme 1: Overweight; the chronic struggle with associated health problems and co-morbidities

All those interviewed had experienced problems with their weight for most of their lives or at least over many years and had tried many different ways to lose weight. Most have attended diet clubs such as Weight Watchers and been prescribed weight loss drugs such as Orlistat (or in some cases Reductil, now withdrawn due to increased risk of heart problems – (Burns et al 2010)). In some cases participants had managed to lose a certain amount of weight for a short period of time but were unable to maintain the loss, becoming increasingly heavier over time.

“I’ve done all the stuff like going to slimming clubs, I’ve tried tablets, I’ve done this and that...”

“I’ve lost a considerable amount of weight with Weight Watchers on two occasions, but I always put it back on...”

“I lost about 3½ stone with Slimming World, but then over about 18 months it started going back on again.”

“Been there, done that, got the T-shirt.”

“I was a fat toddler, a fat child...I’ve done everything you could possibly imagine.”

“I don't think there is anything I haven't been on, I've tried everything.”

“I was always overweight from a child, I can never remember being thin, I remember being called fatty at school”

“I’ve been big all my life”

Prior to undergoing bariatric surgery those interviewed reported experiencing a whole range of problems associated with their weight such as reduced mobility due to knee problems, other joint problems, having difficulty walking, gastric reflux, high blood pressure,

diabetes (Type 2), sleep apnoea. Many of these problems have improved or gone into remission as participants reduced their weight after surgery. Table 2 shows the average weight loss for each participant in this study (self reported data).

“My weight was hindering me...two replacement knees...neck and shoulder injuries...lack of mobility”

“I also have, or did have, high blood pressure, diabetes Type 2 and arthritis...I am now not taking any medication for the diabetes...the blood pressure tablets I have been off since Christmas”

“I had gastric reflux...I was admitted quite a few times with the reflux... the reflux has gone now”

“I did have high blood pressure for which I was on tablets. I had acid reflux, depression, back ache, aching joints, everything that comes with being so morbidly overweight...my blood pressure has gone back to normal...back ache has totally gone.”

Table 2. Self reported weight loss and surgery type by patient

Patient	Approx timescale since surgery (months)	Approx weight loss (stones)	Type of surgery
A	17	14	duodenal switch
B	16	8	gastric bypass
C	27	10	gastric bypass
D	24	8	gastric bypass
E	35	9	gastric bypass
F	36	6	gastric band
G	24	8.5	gastric bypass
H	36	8.5	gastric bypass
I	16	6	gastric bypass
J	38	10	gastric bypass
K	8	6	gastric band
L	26	8	gastric bypass
M	39	10	duodenal switch
N	36	7	gastric band
O	9	6	duodenal switch

"...Those health problems that have improved (are) diabetes (off metformin), high blood pressure (slightly lower, but level) and sleep apnoea..."

"I'm much healthier, I mean I walk everywhere now, I've got a bike, I do things that I could never do before... my blood pressure has gone down I used to be on about 6 blood pressure tablets, I've just been reduced now to ½ tablet a day, my cholesterol - I've been taken off all cholesterol tablets now it's perfect."

"X is much better in herself, she is a lot more mobile, and she is not tired when she walks. Just walking around town was too tiring. Now we can go on days out, and she doesn't have to sit down anymore."

"(Mobility) has improved. My quality of life is a lot better"

3.2 Theme 2. Experiences of the lifestyle and weight management services.

Referral to the lifestyle and weight management service (LWMS) had in most cases been made via the patient's general practitioner or practice nurse. Individual experiences of the service appeared to differ somewhat in terms of location and programme delivery. A number of patients reported attending courses where they routinely underwent weekly (for 12 weeks) one-to-one sessions with a dietician, others reported attending group sessions (with privacy whilst being weighed) and one-to-one sessions with a dietician only if needed. In the case of group sessions, one patient found the lack of privacy upsetting and managed to be transferred to a LWMS location where one-to-one sessions and privacy were available. Only a few patients reported positive outcomes from attending LWMS courses and two participants reported particularly negative experiences.

"Absolutely awful...horrendous, it needs an overhaul. You can't ask me how fit I am or how do I get on in work in a room full of people...they were taking my blood pressure whilst people were sat here...everyone could hear you..."

"They made me do a lifestyle course, it was no good..."

"The weight management for me was the worst thing ever. And I told my GP and she just laughed and said you're not the first one to come in. It was just awful and they didn't know what they were doing."

"I went to the lifestyle and weight management group, but I didn't think that would be very helpful. The reason being, I'm in a wheelchair and to follow the diet and everything you have got to exercise, and I just can't do that."

"The lifestyle part of it I would recommend to anybody...It was really good"

"Yes, absolutely fine and educational"

Almost all those interviewed who had completed the BCP prior to being put forward for surgery reported a positive experience. A one-to-one session with the dietician and having a diet tailored to individual needs was reported as being particularly helpful. Being held accountable to the same person each week for individual weight loss was added encouragement in losing weight, as was the incentive of the surgery if the 5% weight loss was achieved. One participant found the programme beneficial but struggled to fit it around work commitments as her employers did not allow time off during working hours. Other participants mentioned they enjoyed the assessment sessions with the clinical psychologist.

Sessions with the dietician

“Yes, excellent. She never stopped and she didn't give you false hope...when I saw X definitely, really good guidance.”

“It was about re-educating, like not looking at a packet of something thinking ‘oh that's got no salt or sugar, but understanding, that was very beneficial.”

“I think when you go to the likes of those groups (Slimming World)...you are competitive, but when you are on your own the competition has gone. Whereas with X it was like sitting in front of a teacher, and you have got to explain why you have done it.”

“I did enjoy it. It gave you an incentive each week...you knew you were going with the same group of people each week, so I didn't want to let myself down, I didn't want to let X down.”

“When I saw X definitely (good value for money), really good guidance.”

“... you go for 12 weeks and you keep a diary, they give you handouts, they give you recipes, you have the talks and so on and so forth...very useful, especially for people who go there and have no idea.”

“...absolutely fine and educational. The only thing was it didn't fit in with my being in work...it was during the day and I had to juggle things around...I had to take time off, they didn't give me time.”

Sessions with the clinical psychologist

“...we were there for a couple of hours. It was one of those things that usually take about 40 minutes. X was very thorough and very nice.”

“It was fine. X was really nice...concerned that we had the right support and that we were in the right frame of mind and everything. I found that good.”

“I was in for one and a half hours with X, he went right back to my childhood.”

3.3 Theme 3. The complexity of bariatric surgery and physical problems that have resulted from undergoing this type of operation.

Of the three types of bariatric surgery undergone by those who took part in this study, nine patients underwent the gastric by-pass, three had the duodenal switch and three had a gastric band fitted. Some of those interviewed reported extreme pain and complications post-surgery, with half being re-admitted for further operations (at least two patients had two further corrective operations). Most patients spent very little time in hospital post surgery, although one patient spent five weeks in an NHS hospital post operatively.

Experiences post-surgery

“I was in first of all for 4 days...I came home with the staples and everything in, but I was extremely unwell at home. I was due to go back on day 10 to get my staples out and when I got there I passed out with the pain... I was in for another 3 days...that took me about 6-8 weeks to get over.”

“When I had the surgery I really was quite unwell after, I was just out of it really.”

"Initially I was fine for the first 2-3 hours. After that I was in agony. They had given me the maximum of morphine and I was still in pain. I could have done really with being put out."

"Initially great. The only problem I had was 2 days after I came home...I started feeling ill and kept throwing up... and I ended up back in hospital for a week."

"...it was really painful. Even the painkillers weren't helping...that first day was terrible" PLp4
"I was being sick all the time, I wasn't able to keep the food down all the time, so I was really worried about that. Every time I ate anything I was sick, so I had to go back in for stretching..."

Patient involvement in the choice of surgery

Whilst most of those interviewed felt they had been involved in the choice of surgical procedure, others felt they had been denied this choice.

"X gave me the options, the band, the bypass and the duodenal which was quite bad really – it scared me: I didn't want anyone pushing me towards that one...so I decided on the bypass."

"I didn't want the bypass originally – I originally wanted the gastric band. The guy recommended the bypass. So I thought I'll go along with that."

"...I was having the gastric band and then all of a sudden my GP and the specialist decided the band wouldn't be good enough, it's got to be the bypass. I wasn't even asked. I was told I was having it."

"X said he was going to do the by-pass. I asked about the other one...and after he spent five minutes explaining he said he was going to do the by-pass. Be told, that was me."

3.4. Theme 4. The experience of being an NHS patient in a private healthcare system and problems of follow-up care.

Participants reported undergoing their surgery and follow up care in one of two hospitals which will be referred to as hospital A and hospital B.

Immediately post-surgery

There were mixed views regarding treatment by staff at Hospital A in the days following their surgery.

“It was marvellous...staff were wonderful”

“Fantastic...everyone was absolutely lovely.”

“I was glad to get home, I felt my after care was atrocious...I felt they didn't listen to me...I didn't want to be in the bed all the time, I was so uncomfortable, and when I asked for help to get out they wouldn't give me help, because they were not insured or whatever excuse they want to use, which I thought was absolutely appalling.”

“...they didn't listen to my history...the weighing nurses, and one was totally rude, and you don't do that to me...”

“...when I had gone in for the pre-op I had said that I didn't want to have a blood transfusion. So the day of the surgery X came in and he sort of gave me a lecture about it's not a supermarket, people think they can come in and say 'can I have one of them and one of them' and I thought Ugh!...he was quite abrupt and rude...”

There were no negative reports regarding the post operative after care at Hospital B, although one patient said that she would have preferred more information about how to cope once she went home.

“Brilliant...I couldn't fault them at all”

“Excellent...they were there when I wanted them, and they would do what I asked. I couldn't ask any more.”

“They were wonderful...the staff and nurses at X were really, really good.”

“They were ok. I felt like it was a bit of a production line though. I don't think they gave enough information out.”

Post-surgery follow up and after care

Hospital A

Participants who had undergone surgery at Hospital A felt let down by the lack of after-care. One patient reported no communication at all from the hospital post surgery. Another telephoned the emergency number he had been given because he was feeling very unwell two days after his surgery and the only advice he was given on this occasion was to attend his local Accident and Emergency Department. Another patient felt let down by the apparent lack of communication between the hospital and her local district nurse who she expected would visit her to remove her surgical staples; the district nurse did not attend and the staple site became infected. A further complaint concerned the administration department because the patient was receiving notice of her appointments the day after they were due.

“I've never heard from them since (the operation). I've not been signed off...the minute you've had the operation it all fell apart...there was no aftercare.”

“The only problem I had was 2 days after I came home...I started feeling ill and kept throwing up. I phoned them and tried to get through to the department... I told her how I felt. She said that if I felt that bad why didn't I go to the A&E? I went “pardon?” She repeated herself. I said “fine”. So I went to my local hospital, Arrowe Park, and I ended up back in hospital for a week.”

“I was given a kit to bring home with me from Hospital A...I had 3 different sized scars and one of the scars was quite sore, so they had given me the proper staple removal kit. They had contacted our district nurse in my surgery to say you need to come out and remove

these, and no-one turned up to remove them. Then the scar started to have pus and was getting quite sore.”

“...Sometimes I might get a letter a day late for an appointment which was the day before...”

“I just knew that if I had been paying privately the service that I got would have been a whole lot better...I was an NHS patient in a private hospital.”

Hospital B

There were no complaints about the aftercare at Hospital B. One patient reported follow up appointments every 3 months for a while and then every 6 months over a period of two years, she also felt there was someone she could phone if she needed to.

“ [Information given] as and when you needed it...I couldn't fault them at all”

“Smashing...brilliant...great.”

3.5 Theme 5. Physical and psychological changes experienced post bariatric surgery.

The majority of those interviewed were glad they had been given the opportunity to have bariatric surgery and, despite the problems, most felt it had made a big difference to their lives. However, one or two patients expressed regret at having undergone the operation and felt they hadn't been given enough information regarding the long term effects such as vitamin and mineral deficiencies leading to hair loss, crumbling teeth and losing toenails. Lazy bowel leading to constipation was another side-effect that one participant found difficult to cope with whilst at the other end of the spectrum another individual has suffered from constant diarrhoea for more than two years.

“No regrets. Even if I had the pain again I would still go down that route”

“It's made a huge difference: it's given me my life back”

“If you are asking me whether I would have it again, no I wouldn’t...they don’t tell you what can happen in the future.”

“When I had it done and I came home and my hair started falling out in big clumps, my nails snapped off, my toenails came off, I wasn’t prepared for any of that.”

“My hair has gone very thin...I am having trouble with my nails snapping off...”

“There’s a thing I never knew, which I have only found out in the last 6-8 weeks, is that because of the size of my stomach...you can get a lazy bowel and you get constipated a lot. My GP gave me micro-enemas so if I get that bad I can do it myself, but you don’t know about that side of things.”

“...a lot of things have happened to me since the operation, it seems like one thing after another...the food passes through my system so quick that it doesn’t solidify it just comes out...”

Excess skin

In the longer term as participants shed excess weight the problem of loose skin emerged, causing distress in some cases.

“...it’s so ugly, I can’t go swimming it’s just horrible the way it looks and it seems to take the shine off the whole thing, it’s like you’ve made this swan but it’s got a big boil on its bum...”

“My only problem is the skin now, and we have applied [For funding for surgery to remove excess skin], but they said no. They said I had to wait another year to stabilise, but then it’s the psychological thing, and that is a big thing. So we are trying to save up now. People don’t know that you’d lost weight, where they looked at me when I was fat, now they look at me because I have layers of skin; I’m like a walking jelly. People stare.”

Psychological effects

Some participants reported feeling depressed since their operations and thought they might have benefited from counselling. Others stated that although the operation might have improved their physical health, their underlying problems had not been addressed. Yet others are having problems in eating 'normally' because of the perception of the physical changes the operation has made.

"X said she can't understand why I haven't been offered some sort of counselling since the operation and why it's not included in the post operative assessment because I really do feel down and I haven't slept for months and months...I could be suffering from anxiety"

"...it's after the operations that the problems hit home...the operation has changed him, not the same happy person he was before..."

"Fat people aren't daft...I know I shouldn't have a cake, but do you know I'm sad inside and that cake makes me happy.. I know what I am putting in my mouth, I know what I am doing – but do you know what? They give me that comfort..."

"Us fat people know where we are going wrong but we all have issues - that isn't addressed."

"No matter how I think about myself, that operation has fixed my stomach but it hasn't fixed my head"

"...I still can't eat. They said to me it was psychological...I say I will have a little piece of meat today, but I have to go and be sick because I just know it's going nowhere."

3.6. Theme 6. Attitudes towards obese people.

A sub-theme emerged which cut across the core themes which was how being obese affected the way people treated you.

“(at a LWMS meeting)...the girl stood up in front of me and said ‘you know why you’re here don't you, because you are obviously grossly overweight’... Now if I was an alcoholic she couldn't stand up in front of me and say well you know why you are all here it's because you all drink too much, because she wouldn't get away with it.”

3.7. Patients who did not have bariatric surgery

Three participants were interviewed who had been referred onto the BCP but who did not go on to have bariatric surgery. One participant (1) was not obese as a child but started to gain weight post-pregnancies and was referred onto the BCP by her GP when her BMI became excessive. The other participants (2&3) had experienced problems with their weight throughout their lives and had been referred onto the BCP by their GPs because of increasing ill-health due to obesity-related conditions.

Participant 1

Participant 1 found the dietary advice and monitoring by the dietician most useful and had achieved the 5% weight loss during the 12 week period of the programme but decided against surgery for a number of reasons. First of all she found that with encouragement and support from the dietetics team she had been able to lose a considerable amount of weight without resorting to surgery and the associated risks. Second, her decision was influenced by the experiences of a close friend who had previously undergone bariatric surgery and was unhappy with some of the aspects of the surgery. The friend had lost a considerable amount of weight but was nevertheless unhappy for reasons ranging from being unable to eat the type of foods she was previously able to consume such as meat or bread, to the fact she would have to take medication and vitamin supplements for the rest of her life. The

combination of seeing the (apparently negative) effect of bariatric surgery on her friend and assessing the physical risks associated with any surgery was key to this patient deciding not to go forward to be assessed for the operation.

“I could see she wasn’t happy...she said ‘I have more bad days than I have good’... She couldn’t eat meat, she couldn’t eat pasta, rice, bread, she said she would have to take tablets for the rest of her life, vitamins etc. I could see she wasn’t the same person, she was a bit withdrawn.”

As a result this interviewee felt that those who were candidates for surgery would benefit from being given more information regarding the effects or side-effects of bariatric surgery.

“I think people should be fully informed of the advantages and disadvantages as well.”

At the time of interview this participant had maintained the weight loss achieved on the BCP and was continuing to eat healthily.

“I do like to have an intake of fresh food daily. I like to go to the shop each day and get fresh food, like the meat and the vegetables, and I also give them to the children.”

Participant 2

This participant “...had been on every diet since my childhood” but it was a different story to Participant 1 about why she did not go on to have bariatric surgery. She related she had been attending LWMS for approximately six years and latterly been referred to the BCP, but during that time her weight had increased from 17 to 24 stones. After being referred onto the BCP she attended for a number of weeks but was struggling to lose the 5% and missed an appointment with the dietician due to family problems. As a consequence of the missed

appointment she received a letter through the post informing her she was no longer on the pathway and would need to attend LWMS before she could be put forward for the BCP once more. She felt unhappy with this decision as she has previously attended the LWMS on a number of occasions and each time had gained weight rather than lost it. In terms of the 5% qualifying weight loss (in order to be considered for surgery) this interviewee pointed out that if an individual could lose 5% of their body weight they wouldn't need to approach the NHS for support, but the fact that she was unable to lose weight meant she needed more support rather than less, which now appeared to be the case.

"...if I could lose weight I wouldn't have gone to those classes...they basically said 'we can't give you this and we are not going to help you...that's what upsets you the most."

At the time of interview the participant felt her weight would just continue to increase without bariatric surgery. It was also starting to cause problems with her health and her work which included some physical activity.

"(They) need exercise, and to do things and I'm struggling to keep up with that. I absolutely love my job but there will come a day when I say I can't do this anymore, that I can't keep up with them."

Participant 3

The third participant who was interviewed had started on the BCP but found the programme inflexible. Although she attended for six weeks she said she suffered from agoraphobia which prevented her from attending every session that she was required to, in

addition to which she was not losing much weight. It was not clear from this participant's responses whether she had voluntarily dropped out of the programme because she was required to attend on a regular basis or whether she had been informed by the dietetics team she was no longer on the pathway, either due to a failure to lose any weight or lack of attendance.

"It's hard to get to a certain place at a certain time...having that weekly was just too much at the time...home visiting and flexibility (would make it better for patients)"

At the time of interview this participant said she had managed to reduce her weight from 24 stones to 22 stones through her own effort since leaving the BCP.

4. Discussion

It was clear from the interviews that participants had experienced problems of excess weight for most of their lives, and having tried numerous approaches to losing that weight felt bariatric surgery was their last resort.

Some patients reported negative experiences of how the LWMS courses were run and how they felt they had been treated. It may be the case that as the purpose of the LWMS courses were to lose weight that some of those interviewed had failed to do this, and thus mentally consigned the experience to the list of other failed weight loss attempts. On the other hand however, most participants had clear memories of the BCP leading to their surgery. There were many positive comments regarding their experiences of one-to-one sessions with the dietician and the support and supervision they had received.

The participants in this study were successful in achieving their 5% weight loss within the twelve week BCP programme where, presumably, they had been unable to do this previously. Two reasons could be suggested for this difference in outcome. It may be that building a relationship with the dietician and reporting to the same individual on a regular

basis introduced a greater element of commitment from the patient. The quality of the relationship with the dietician may also be a key factor in their successful weight loss because one individual mentioned not wanting to 'let X (dietician) down'. Second, there was the added incentive of the possibility of bariatric surgery at the end of the course (the 'light at the end of the tunnel') if they were successful. Participants mentioned finding the programme beneficial because it re-educated them about nutrition in a way they could understand, advice which was also useful to them after their surgery.

Whilst most participants felt they had been involved in their choice of type of surgery, two reported they felt the decision had been made for them and they were not given a choice (they were given the by-pass rather than the band). Burns et al (2010) suggest that patients selected for gastric by-pass may have a higher body mass than those who are selected for banding, which may have been the case for these two patients. However, the fact that the patients felt they had been 'told' rather than being involved in the decision making suggests that there may have been inadequate explanation by their consultant regarding the type of surgery to be performed.

In terms of undergoing bariatric surgery, few participants had a problem-free experience either immediately post-surgery or in the months following their operation, reporting extreme post operative pain as well as continual vomiting. An apparent lack of communication between the private sector and the NHS also caused difficulties for one participant who was given conflicting advice on who was the most appropriate point of contact for post surgery issues.

There appears to have been differences between the two hospitals in how participants were treated by hospital staff at the time of their surgery. Some patients reported rudeness by both the nursing staff and the consultant at Hospital A, whilst others had no complaints. Those patients' who reported rudeness from staff argued it was because they were NHS patients in a private hospital and if they had been private patients paying for their own operation they felt they would have been treated more positively.

Patients attending Hospital B reported no negative comments about how they were treated. This pattern was repeated in terms of the two year follow-up package for patients following their bariatric surgery. There were no complaints from those who had attended Hospital B with one patient describing 3-monthly and then 6-monthly follow ups as well as explaining she felt there was someone she could telephone if she needed to. On the other hand patients described feeling 'let down' by the lack of follow up care at Hospital A, which for one patient had been 'non-existent'.

On the whole, most participants who had undergone bariatric surgery were thankful they had been given the opportunity, although two patients expressed regret and wished they had not had it done. Most were unprepared for the huge physical and emotional changes following their surgery and would have liked more information about what to expect and how to manage the problems that arose. Many experienced hair and nail loss which they found distressing. There was a huge change in what could be eaten and for some participants they are still encountering problems of not knowing what they can consume without it leading to nausea. Following weight loss the problem of excess skin was mentioned by most participants; two patients found it particularly distressing, one of whom felt she couldn't appear in public any more in a swimsuit (whereas she previously swam regularly, even when morbidly obese).

From a psychological perspective there were mixed reports of emotional health. Some participants felt they had 'got their lives back', feeling much healthier, relieved by the reduction in medication due to remission of co-morbidities, and able to resume activities such as 'walking the dogs' or 'walking to the shops'. Others have become depressed or anxious despite the fact their physical health has improved. One individual remarked that although her 'stomach had been fixed' the operation 'hadn't fixed her head' – in other words the physical aspect of overeating had been addressed but not the psychological issues underlying the problem. Another described the comfort that eating a piece of cake gave her, salving the sadness 'inside'.

A theme which cut across other themes was attitudes towards obese people. Some patients believed that they received a lack of respect from those health care professionals whose job it was to specifically work with obese people.

Three patients were interviewed who had been referred onto the BCP but not gone forwards for bariatric surgery. Whilst one patient had felt they could continue to lose weight without surgery and found the BCP a positive experience she also suggested that more information was needed on the physical and psychological effects that may result from bariatric surgery. However, in a previous report (Stuart, Brizell, Irvine and McVeigh 2011) the BCP team reported that patients receive adequate information regarding possible effects. It may be the case that patients are selective about the information they retain pre-surgery i.e. they only 'hear what they want to hear' and filter out any possible negative effects of surgery, as the idea of losing weight becomes so compelling they would go ahead anyway.

The remaining two patients would have accepted the offer of bariatric surgery had they been put forward for it, were very disappointed they had not been recommended for it and would still like to undergo this operation to help them lose weight. Whilst one patient has reported losing 2 stones through her own efforts (thus reducing her weight from 24 to 22 stones) she continues to be morbidly obese with increasing health problems. The outcome for the third patient is also poor in that her weight keeps increasing, and with it her health problems; there is also the possibility that she will soon be unable to work because of her excess weight.

Comparing the reported outcomes of patients who underwent surgery to those who did not suggests that psychological issues can persist in either case. In the case of physical health whilst co-morbid conditions (such as diabetes and high blood pressure) continue to be a problem for those who remain obese, they can go into remission after surgery if weight loss is maintained. On the other hand, surgery carried out on obese patients comes with increased risk and complications, and this was experienced by several patients interviewed who had undergone surgery. A point of interest regarding the positive outcome for the patient who did not undergo surgery but who has managed to lose weight (and maintain the

loss) is that she has not struggled with weight gain since childhood i.e. obesity was adult onset rather than a lifelong problem. Thus it may be of interest for future research to investigate whether there is any difference in weight loss success for those who have been overweight since childhood or become obese as adults.

5. Conclusions

Whilst for some participants in the present study bariatric surgery has had a very positive impact, allowing them to enjoy improved health and quality of life, for others it was not the 'magic bullet' they perhaps envisaged. The reasons for this have varied from physical problems developing post surgery (in some cases leading to two more lengthy and painful operations) to depression despite improved general health. Physically there are the difficulties involved in adapting to a limited nutritional intake often leading to hair and nail loss which patients find distressing; at a later stage of weight loss there is the problem of excess skin. More information pre-surgery about physical changes that may come about after the operation, plus dietary support and regular monitoring regarding vitamin deficiencies post surgery might alleviate some of these problems. The formation of a patient group meeting to discuss difficulties around eating (post-bariatric surgery) and shared solutions might also be of benefit. From a psychological perspective patients experience a seismic shift in their relationship with food which has for most of their life been a friend and an emotional crutch. In addition to dietary advice it might be useful to address the individual issues underlying obesity through counselling or CBT both before and after surgery. Finally, despite the problems described and the difficulties encountered along the journey, the majority of those interviewed were positive and enthusiastic about their surgery and the resulting weight loss which has allowed them a quality of life they wouldn't have otherwise enjoyed.

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