The Patient Journey to Gastric Band Surgery: A Qualitative Exploration

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Aims: This study explored the views and experiences of obese people preparing to undergo laparoscopic gastric banding (LAGB) leading up to the time of surgery.

Background: Weight loss surgery (WLS) is the most successful intervention available for the treatment of morbid obesity, and LAGB is among the most commonly used procedures in bariatric surgery. So far, the patient experience of deciding to undergo LAGB has been explored rarely and predominantly retrospectively.

Design: Semi-structured interviews took place with 23 patients about to undergo LAGB between June 2011 and March 2012. Data were analyzed using thematic analysis. Demographic and quality of life data situated the sample within the LAGB patient population.

Results: Three overarching themes were described. Participants were “living with obesity,” including the physical, social, and psychological challenges and consequences of being obese. These created in them a “desire to change,” expressed in multiple unsuccessful attempts to lose weight, and a quest for information, finally focusing on WLS. Eventually, “expectations toward LAGB” were formed, mainly to hand back a measure of control that enabled them to achieve, as well as ultimately to maintain, weight loss. This active process resulted in the patients’ decision to undergo LAGB. When combined, these themes outline a distinct patient journey toward gastric banding.

Conclusion: Knowledge of the patient journey can inform both selection and care of patients awaiting gastric band surgery and is required by all health professionals working with this patient group.

Introduction

WITH THE WORLDWIDE and unrelenting increase in obesity amongst all age groups, bariatric (weight loss) surgery (WLS) is firmly established as an effective and safe treatment for severe obesity.¹ However, in order to achieve a successful outcome from surgery, the technical intervention and the human contribution by both patients and health professionals must combine their equally important input. Knowledge about the experience of bariatric surgery, including the challenges it represents as seen from the patient’s view, is therefore essential to aid patient selection, preparation, and care, as well as to provide the best possible support for this patient group.

Background

Weight loss surgery (WLS) is by far the most successful intervention available for the treatment of morbid obesity.² Laparoscopic adjustable gastric banding (LAGB) is among

the most commonly used interventions in bariatric surgery.³ A very small gastric pouch is created by placing an adjustable band around the proximal stomach, just below the gastro-oesophageal junction. Normal saline solution is injected into a subcutaneous port placed on the abdominal wall to regulate the tightness of the band. The purely restrictive procedure does not affect the absorption of micronutrients but reduces the amount of food that can be eaten in any given meal, and, of equal importance, a sensation of early satiety is created when eating.

LAGB is reversible and widely recognized as a low risk weight loss procedure.⁴ Nevertheless, complications do occur. Most problems are device related, for example slippage of the band and port-related complications such as leaking. Other complications remain rare, but poor adherence to dietary advice can lead to problems, including esophagitis as well as nausea, vomiting, and, more severely, pouch dilation.³ In addition, the development of excess skin after substantial weight loss can also require further surgery.⁵

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Weight loss surgery results in more marked and sustained weight loss than conservative treatment.¹ Overall weight loss is greatest at around 12 and 18 months,⁶ and a mean reduction of 20–30 kg is maintained for up to 10 years.¹ However, some weight regain following bariatric surgery is to be expected. It generally occurs approximately 2 years postoperatively and is estimated at about 15% of the maximum weight loss.⁷ Failure to lose weight is usually attributed to poor adherence to the postoperative diet.⁸ As time progresses, patients may be able to eat more, may start experimenting, and grazing can become common behaviour.⁹

Obese adults who undergo WLS live longer than those who do not.¹⁰ The weight loss is also associated with significant improvements in obesity-related comorbidities, including type II diabetes, dyslipidaemia, hypertension, and obstructive sleep apnea. These conditions are either resolved or their symptoms significantly reduced. The psychological benefits may become apparent within several weeks of surgery.¹¹ They include improvements in body esteem¹² and perceived attractiveness,¹³ quality of life,⁸ and levels of reported depression.¹⁴ The improvements occur most noticeably over the first 6 postoperative months and are maintained thereafter,¹⁴ resulting in observable improvements in educational achievements and occupational status.¹⁵ Even if a patient's weight remains in the obese bracket, the psychological benefits are still present.¹⁶

Publications concerning the patient experience of WLS remain few in number. These studies were undertaken with participants following a variety of procedures, often without distinguishing them, and across all levels of severity. However, among the variety of studies, a number of common themes arise, including surgery being seen as a last resort, that is to be approached actively, and that enforces a need to limit eating.

Weight loss surgery represents a "last resort"¹⁷ in an array of escalating interventions, as well as a "renewed hope."¹⁸ Once made, the decision to undergo WLS has been described as being far from opting out of the work of losing weight. Instead, the decision is seen as an active, decisive step toward a higher grade intervention that is, in its severity, proportionate to the problem.¹⁹ By restricting how much and which foods can be eaten, WLS acts by enforcing a need to limit eating, taking the decision away from the participants. Whether this is described as "providing structure,"¹⁷ "finding a balance,"¹⁸ or "imposed control,"²⁰ all authors point toward the liberating experience of reducing choice.

In order to succeed, WLS requires substantial changes in lifestyle. The moment when this change and the difficulties these adjustments create are acknowledged has been described as "reality setting in."^{17,21} However, WLS is seen only as a first step, helping a move "back to normal," and once that is achieved, patients have to maintain that weight level "like a normal person,"¹⁹ making the input required by them very clear.

A Swedish study,²² the first to examine qualitatively the period prior to WLS, describes the preoperative experiences of 23 Swedish WLS patients. It reports a perceived addiction to food, as well as feeling hopeless regarding weight loss. Fears described include fears of future illness and death and fears of living a restricted life hoping for "control and opportunities." The patients also reported feeling ignored by health professionals. These themes are reported as stand-alone themes and a relationship between them is not established.

A need to take our understanding of these issues further and make them directly applicable to the nursing care of WLS

patients remains. Therefore, a prospective study of WLS patients prior to surgery is needed.

Study aims

This study aimed to explore the views and experiences of obese people preparing to undergo LAGB leading up to the time of surgery.

Materials and Methods

Design

Following a realist approach, which acknowledges individual, subjective perceptions of an otherwise factual, mind-independent reality,²³ this research sought to account for participants' experiences and realities. Thematic analysis²⁴ was employed to examine participants' perceptions and experiences prior to LAGB. This approach is widely used in healthcare research and also widely seen as able to address realist methodological concerns.²⁵ It was chosen because of its flexibility and its ability to aid the creation of theory based on data and to find solutions for real world problems.²⁴

Sample

Twenty-three patients (19 women, 4 men) due to undergo LAGB were recruited on two sites in England between June 2011 and March 2012. Participants were recruited using an information sheet given to all eligible patients at both sites; the information sheet included an invitation to return an "Expression of interest to participate" form to the research team. All participants had been accepted to undergo gastric banding in either of the two participating sites, which included a body mass index (BMI) of ≥ 40 or of >35 with comorbidities. They had also successfully completed a preparatory program to demonstrate their readiness for surgery and commitment to succeed (inclusion criteria). As different interventions in bariatric surgery are used for patients with different health problems and needs, it was decided that those undergoing types of bariatric surgery other than gastric banding could not participate (exclusion criterion). During the recruitment period, all eligible patients from both study sites were introduced to the study by the bariatric specialist nurse. Those interested also received a comprehensive information leaflet and, following a 72-hour waiting period, gave informed consent. Seventeen potential participants declined to take part in the study.

Data collection

Data were collected using in-depth interviews lasting up to 60 minutes at a time and place agreed with the individual participant, normally the participant's home. The semi-structured nature of the interviews ensured that all known areas of interest were covered, but left ample opportunities for the participants to raise and pursue any issues of concern to them. The interviews took place during the final 2 weeks before the date set for surgery.

Apart from demographic information, quality of life data were collected using the obesity-specific 31-item Impact of Weight on Quality of Life (IWQOL)-Lite questionnaire.²⁶ This is a psychometrically sound instrument that has demonstrated clinically sensitivity²⁷ and good content validity.²⁸

Data analysis

Following transcription, the data were analyzed using applied thematic analysis to identify, validate, and report patterns (themes) within the data. Coding was inductive, meaning that codes were established directly from the data, allowing the participants' views to be established. Initial codes were merged into themes and summarized into three overarching categories (see Results). By linking back to the original data, the categories were reconnected to outline the patient journey to gastric band surgery.

To maximize the reliability and rigor of the results, the following trustworthiness measures were employed:²⁹

1. All direct quotations are attributable to the individual participant by adding the individual participant identifier (in brackets). This demonstrates the inclusion of data from all participants.
2. The analytical results were peer debriefed. Discussing the emerging themes and categories initially as well as the patient journey later on within the research team exposed the analyst to searching questions by an experienced protagonist playing devil's advocate.
3. Negative case analysis: "outliers" to emerging themes were openly considered and could all be explained from the data. No adjustment of themes was required to accommodate these.

The numerical data were of a purely descriptive and supportive nature, placing the participants within the wider group of bariatric surgery patients and aiding transferability of the overall results. Statistical analysis was restricted to mean and standard deviation.

Ethical issues

Obesity is a highly controversial issue, with both society and individuals attributing blame for being obese. The research was approved by the South West Research Ethics Committee, Bristol, England. To ensure strict anonymity, all participants were allocated numeric codes. Only one researcher was able to link data to the individual participant. Some of the quotations used were adjusted (e.g., by neutralizing gender) to ensure that anonymity was maintained.

Although there could be no "right" or "wrong" in the participants' replies, the interviews could potentially be very stressful for the participants. Had any participant shown any sign of distress, the interview would have been discontinued

immediately. Furthermore, the specialist bariatric nurses were aware of the interview dates and were available to provide support if required.

Results

The participants were between 29 and 65 years of age, and included 4 men and 19 women. All participants were of a white British background; no patients due to undergo bariatric surgery at the two sites were of any other ethnic origin. Most participants had been obese since childhood; only a few became obese later life, which was typically the case for women during or following pregnancies. In terms of professional and educational achievements, the participants ranged from those holding university degrees to untrained blue collar workers.

In terms of quality of life, the participants were shown, with the exception of the indicators for self-esteem, to be slightly better than would be expected for the overall population of WLS patients, especially in terms of physical functioning (see Table 1). This slight deviation can be explained by the sample including only LAGB patients, a procedure that appears more appealing to patients with a lower BMI and less severe comorbidities.³⁰

The initial qualitative analysis resulted in three broad themes: "living with obesity," "desire to change," and "expectations toward surgery." A second, deeper analysis uncovered the existence of a patient journey toward gastric banding that was actively pursued by the patient.

Living with obesity

The experience of being obese can be summarized as encompassing physical changes in terms of increased body size and health-related issues as well as psychological problems, including feeling disempowered and suffering from low self-esteem.

The physical changes related to obesity stretch far beyond "generally being very unfit" [22] and were the first to manifest. All participants reported "doing things" as difficult [24] because of physical problems, such as "grinding knees" [18], "constantly being hot and sweaty and feeling tired" [12] as well as difficulties in daily life, such as being unable to "tie my shoelaces" [14], having problems "getting my socks on" [24], or "getting in and out of little doorways and chairs" [7]. At times, these experiences were recognized as a turning point in

TABLE 1. QUALITY OF LIFE AMONG THE PARTICIPANTS

	<i>Impact of Weight on Quality of Life Questionnaire-Lite (IWQOL)</i>					
	<i>Overall</i>	<i>Physical function</i>	<i>Self-esteem</i>	<i>Sexual life</i>	<i>Public distress</i>	<i>Work</i>
<i>Means and standard deviations to be expected³⁹</i>						
General community	91.8 [12]	90 [14.9]	87.5 [19.4]	95.1 [13]	96.5 [10.9]	95.4 [11.5]
Severely obese	54.6 [19.5]	48.4 [21.2]	45.9 [25.9]	65.9 [29.9]	62 [24.7]	68.1 [23.7]
Bariatric surgery	36.9 [19]	31.7 [21.7]	30.4 [25.3]	45.8 [31.8]	40.8 [25.4]	49.7 [27.5]
<i>Results</i>						
Mean [standard deviation]	47.9 [22.1]	53.7 [19.6]	25.6 [25.4]	51.8 [34.8]	42 [28.7]	58.6 [30.6]

The maximum score for each of the six criteria is 100; the lowest possible score is 0. The upper rows show the values (mean and standard deviation) to be expected by different patient groups; the lower row is lists of data obtained from the participants in this study.

the process, leading to a realization that they needed to change.

We went to a place that has those play things and slides. My son was crying at the top and I couldn't get there. Another mother had to go up and get my son, who was crying because I couldn't get up there. I don't want that, that's not right. [5]

As life with obesity became more difficult, the awareness of health issues related to obesity and the reduction in life expectancy grew. The health problems described included arthritis, diabetes, depression, plantar fasciitis, reflux, sciatica, breathing and heart problems, and high blood pressure. These either already existed or were felt to loom on the horizon.

All [my family] had heart problems. My mum's gone, nephew's gone at 35, my sister and my brothers had bypasses, and they are all big people, so I do worry about things like that, I definitely need to change. [24]

The health problems and shortened life expectancy were felt to be important not just for the participant, but also for what this meant for their dependents.

I'm going to shorten my own life and that's going to have a desperate effect on my partner because who is looking after my partner after I am gone? [17]

I've got a daughter of two and I need to be around a lot longer and be well enough to take care of her. [4]

Obesity and its consequences "affect day-to-day life every day" [21] because it "takes away everything [and] affects every aspect of life," and it is the "first thing when I wake up and it is there until I go to sleep" [10]. The problems were recognized to have arisen due to a loss of control over their eating habits and weight development.

I never feel as though I've conquered or been able to completely control that. [9]

The persistence of the problems made the participants feel disempowered, having never felt they had been "in control of it" [9], having battled with it all their lives [19, 21], with constant hunger and most of all an inability to control their eating being mentioned by many participants [2, 4, 5, 7, 9, 13, 22]. Self-esteem was also low, with participants reporting feeling self-conscious [12, 13, 21], unhappy to socialize [15], feeling embarrassed [8, 16], self-loathing [5], with low self-esteem [2, 5, 6, 10, 12, 13, 15, 16, 20, 24], and fearing that people will look at them [2, 17].

Desire to change

For the participants, being obese meant that because of having lost control over their eating (i.e., caloric intake), they encountered major psychological and social problems, as well as health threats and activities-of-living restrictions. The increasingly desperate situation in which they found themselves resulted in a decision process that normally took a long time to complete. It was spurred on by reaching a specific clothing size, age, or BMI landmark, as well as by health problems, reaching a point where life was made increasingly difficult. Also, concerns for others, such as young children [2, 4, 5, 13, 15] or spouses [4, 17, 18, 19], played a major role for many by reinforcing the need to lose weight. An alternative motivation for two participants for desiring this change and initiating the journey toward surgery was an improvement of

other, unrelated health problems that left them re-energized and ready to contemplate tackling their weight problem [15, 23]. In any case, this was seen as a "life change" [5] that was the "most important thing in my life" [13] and "the only option" [6] left because participants could not "live my life like this anymore" [2] and did not "want to think about my weight every day" [5].

The desire to change was first expressed by attempts to lose weight. "None succeeded" [4], or rather led only to temporary weight loss, with the lost pounds and stones coming "back in 1 to 2 years" [8]. These "yo-yo dieter[s]" [14] felt trapped in a "diet roundabout" [9] that left them giving up, feeling that they had "tried all else, all other options" [1] with the exception of WLS.

The decision to opt for WLS "took a very long time" [12], always several months, normally a number of years. The aims of the surgery were twofold. The participants wished to reverse the manifold health problems or threats listed above by losing weight. How much weight they wanted to lose was expressed in terms of either weight, health benefit, self-esteem, quality of life, or clothing size. At times, single aims were expressed, but most comments represented combinations of these goals.

I just want to be within normal weight, not skinny, not very thin. I want my blood pressure to lower so I don't have to take medication, I don't want to develop diabetes, arthritis in my knees, cancer, all these things. I want to wear nice clothes. I want to feel comfortable in my body and I've got grandchildren, I'd like to do more things with them. [1]

A second, equally important goal was expressed indirectly: the most pressing problem related to obesity was often not just to lose the excess weight, but to maintain the weight loss achieved. This was made clear when the participants expressed their expectations toward the gastric band (see Expectations toward surgery).

The aims that gastric banding was meant to help the participants achieve reflected the concerns they had about their obesity. The specific expectations toward the intervention were formed during an intensive search for, and consideration of, extensive information. Gathering and understanding information was considered of great importance, as "you need to know it all" [4].

Beyond television, newspapers, and journals, two main sources of information dominated. First, the participants talked to people. This included health professionals, such as their general practitioners, dieticians, surgeons, and especially specialist nurses, all of whom provided extensive factual information about all aspects of weight management and WLS. The nurses in particular represented a major source of support beyond the provision of information and throughout this process.

She gave me lots of information and texts me on a regular basis. I've asked her questions and she's answered them. She'll be there as long as it takes. [7]

This was supported by talking to other WLS patients. Here, "other," including potentially embarrassing and "silly," questions than those directed at health professionals could be asked [13]. Beyond being factual, their contribution was important, as it brought "it into real life to listen to people, their successes and problems" [9]. Meetings with other patients were arranged by health staff as part of the preparation process for surgery, while on a private level, contact with friends

or relatives who had undergone WLS was actively sought by many.

There's nothing better than speaking to someone who's already gone through what you're thinking of going through. [15]

The Internet was a second, equally prominent source of information, via Internet groups of WLS patients and candidates, continuing the theme of face-to-face communication above.

There was a Web site for people who have had the same or similar operations, so I have found a lot of information there. [21]

Conventional Internet sites were also used and perceived to be "very good" because there the participants could learn all they "needed to know, the good and bad" [9]. All participants were perfectly aware of the ambiguous nature of the Internet where content is not necessarily reliable and where "you can find some scary things" [4].

It was helpful, but you have to be careful what sites you look at, some have very misleading information. If you go to the health service Web site, they give you more accurate information. [23]

The importance of this critical use of Internet sites is brought into focus when considering that the Internet was often used "as a first step, before getting information from the professionals" [19]. A fairly recent addition to the Internet also potentially added to the depth of the information that can be retrieved. Actually "watching the operation on YouTube" [18] added further insights for those who wished to do so. As a result of this information-gathering exercise, the participants were very well informed about bariatric surgery overall and specifically gastric banding.

I've done lots of reading, I have talked to lots. I know what's involved. [3]

Expectations toward surgery

Throughout all interviews, the gastric band was described as an aid [1], help [4, 14, 15, 19, 21, 22], back-up [2], or tool [13, 21, 22] that would help them "stop the habit of eating" [7] by

giving them "something to work with" [13], a "stop mechanism" [5], making them "feeling fuller quicker" [8] and "preventing [them] from overeating" [10]. However, it was never described as "a solution to the problem, it's not a quick fix" [21], and it is "not a miracle cure" [3] because "it's a help, it's a tool" [22]. And this attitude toward the band as assisting the participant rather than solving the problem for them "makes me responsible" [13]. It is therefore "the harder option, you have to work with it" [14], and it rewards the participants by making them feel "that I can have a little bit of control over what I eat" [16].

By signaling satiation much earlier than before, and by the limited volume of the gastric pouch, the band was hoped to signal to the participants that they had eaten enough. This was perceived as a sensation that they had lost, and thus lost control over their eating.

I seem to have lost the switch that tells me, "Stop eating, you are full, you can't eat any more." So I'm hoping that it will flick the switch to tell me, "No, that's it. That's enough. You can't have any more." It will force me to eat less, more often. [15]

The band was therefore seen as "a back-up to reinforce change" [2], leading to weight loss, which, in contrast to earlier experiences, could be maintained and would bring the desired health benefits and extended lease of a happier life with increased confidence. The limitations to the band's ability to enforce change were widely acknowledged and the potential to "outwit" the band by indulging in liquidized high-calorie food was no secret, but no participant anticipated following this route.

Despite the well-founded knowledge about the surgery and the general expectation that the surgery would be a success, fears remained. These related to "the unknown" [9] because, in the words of the participants, "I have read about other people" [16] and "you don't really know what it entails until you go through with it" [9].

A patient journey toward gastric banding surgery

Once the initial analysis was complete and the results were related back to the original data, a distinct and actively pursued patient journey toward gastric banding (see Fig. 1)

FIG. 1. The patient journey to gastric band surgery.

became discernible with the three categories. The themes they incorporate present as interlinked stages, forced by their very nature into a set sequence.

Without acknowledging the existence of and experiencing the consequences of obesity, including the perception of a loss of control with an ever-increasing weight and without accepting the fact of being obese, a longing for change cannot develop. The desire and determination to change is first expressed in multiple unsuccessful attempts to lose weight and is fed by the yearning to regain control and to reverse the problems arising from the large body size. A process of information gathering ensues that eventually leads the obese person toward information about WLS. At times, this occurs by chance, but most often it is the result of actively searching for help beyond the traditional approaches to weight loss. While learning about surgery, including what it can and cannot do, expectations are formed, relating directly to the areas in which change is desired: the re-establishment of an element of control, as well as the maintained loss of weight, leading to the reversal of the everyday and long-term consequences of obesity.

Despite their interdependence, the steps in this journey are not inevitable. Instead, they represent an active process that is driven by the patient. Acknowledging that their difficulties in life are due to their obesity and accepting the fact of being obese is only the beginning. All participants had to choose and pursue WLS actively as a treatment option. They also had undergone a selection process to filter out unsuitable or unready candidates, which entailed demonstrating their knowledge of and commitment to the band, as well as the preoperative loss of some weight.

Discussion

The results of this study validate the findings from existing literature. The content of the three categories "living with obesity," "desire to change," and "expectations toward surgery" does resemble data previously published. Most notably an interview study²² of 23 Swedish patients admitted to hospital "awaiting" bariatric surgery, following selection by a multidisciplinary team. Many themes noted by the Swedish researchers mirror the findings of this study. These included the patients' feelings of powerlessness to control their food intake, their hopelessness to achieve weight loss in any other way, their negative body image, and their fear of ill health, as well as the restrictions they suffered in their daily lives. Most importantly, however, for the Swedish patients was that the prospect of surgery was perceived as negative. For these patients, being scheduled for WLS did symbolize how complete their dependency on surgery was, and being in the hospital for surgery was seen as "a state of suffering." They endured bariatric surgery because they depended on the surgery for their future survival and health.²² For the participants in this study, the situation was dramatically different. They had not only accepted the facts and consequences of their situation prior to their decision to turn to surgery, but they had also decided to do something about it, and had taken steps of their own accord. They had secured having surgery as part of an active process by undergoing a rigorous selection process that required the demonstration of knowledge, concordance, and determination. For all of them, WLS represented not hopelessness but renewed hope^{17,18} based on their own effort.

This study also, for the first time, merges the individual strands of patient experiences and desires into a compelling model of an active patient journey toward gastric banding. This advances existing knowledge and makes it more directly applicable to the provision of high-quality nursing care to WLS patients. By providing a window into patient perceptions and motivations, it assists professionals preparing and caring for individuals undergoing WLS.

The journey can also be anchored in Prochaska and DiClemente's model of change³¹ (Table 2). When viewed within this model, previously applied to weight management and smoking cessation, the initial experience and acknowledgement of obesity with its negative experiences and the resulting desire of change represents the "contemplation stage" with its self-evaluation, ambivalences about the need to change and evaluation of pros and cons, as well as the identification of positive outcome expectations. All participants had demonstrated a readiness for change (i.e., the "preparation stage") due to multiple failed weight loss attempts in the past, and eventually entered the "action stage," moving actively toward their desired behavioral change and toward modifying their food-related environment. They worked together with health professionals, and especially the bariatric nurses, on reorganizing their eating behavior and on enhancing their food-related self-efficacy. Within this set-up, the gastric band does not represent the center of the journey. Instead, it is reduced to the "aid" or "tool" that most participants referenced. This becomes important when confronting the common perception of WLS being "seen as a quick fix."³² Rather than opting out of the effort of losing weight, the decision to have surgery was an active, decisive step within a wider cluster of activity¹⁹. With the band representing an aid rather than the solution, the participants in this study asserted that the principal effort remained firmly with the obese person.

All participants in this study had recently successfully completed a selection process to determine their suitability for surgery. This could potentially result in presenting the views they thought were expected of them. However, the participants were aware that this study was independent of the selection and treatment process. The interviews also presented the themes within intricately interwoven personal experiences and motivations, often enhanced by testing the participants' determination with the required preoperative diet and weight loss. This makes it unlikely that the participants viewed the interviews as yet another part of the selection process.

Finally, the journey outlined here represents the participants' views prior to surgery, and all data were collected before surgery had taken place. Therefore, patients were consciously unaware of what exactly they personally would experience after surgery. Nevertheless, they were well informed about the surgery and did demonstrate considerable self-awareness. All participants also knew that maintaining

TABLE 2. PROCHASKA AND DICLEMENTE'S
MODEL OF CHANGE (1984)

Stage 1: Precontemplation (not ready)
Stage 2: Contemplation (getting ready)
Stage 3: Preparation (ready)
Stage 4: Action
Stage 5: Maintenance

weight loss after surgery would require major life-style changes of them, although not all can be expected to turn this awareness into the required action.³³

Study limitations

Several limitations are of note in this study. The sample consisted exclusively of white British participants, as no patients of another ethnicity underwent LAGB on either research site throughout the study period. Including the experiences of participants from other ethnicities would result in a valuable extension of the study results.

The sample was also restricted to patients undergoing LAGB, an intervention primarily used for those with a lower BMI and less severe comorbidities than patients scheduled for other types of bariatric surgery, especially gastric bypass.³⁰ Inquiring into the experiences of these more severely obese patient groups, with their more severe health issues and the different nature of the surgical intervention, would potentially have led to different findings. However, within the restricted sample size, this less focused approach could not be taken without sacrificing depth and breadth of the intervention-specific data.

Implications for practice

This study provides valuable insights into the gradual decision process of WLS patients. Knowing about the components and active nature of this journey toward surgery will inform nursing care and facilitate improvements in its practice. Nurses play a significant role in bariatric care, from first contact to discharge and follow-up.³⁴ Patient safety is best served when they are specifically trained to deal with the medical, physiological, and especially psychological needs of severely obese patients.³⁵ Nursing guidelines in bariatric surgery often focus on the physical assessment and technical preparation of patients,^{36,37} although a comprehensive preoperative nursing assessment should include the identification of support systems and patient and family education needs. This requires nurses to have a solid understanding of the issues that are relevant for a particular patient.³⁴ Knowledge of the patient journey to gastric banding will therefore assist in providing knowledge and understanding of these crucial needs. Beyond mere understanding, the need for helping relationships during the action and subsequent maintenance stage of change³¹ highlights the enhanced need for high-quality nursing care.

Eligibility for bariatric surgery is based on the severity of the obesity, the individual's fitness to undergo surgery, and the individual's readiness for surgery.³⁸ The latter does not just signify the patient's physical need and desire to undergo surgery, but also an acceptance of obesity and full comprehension of the intended surgery with its demands and risks. It must include a strong determination to adhere to the post-operative diet and exercise regimen, as well as consideration of the overall psychological state. These aspects of readiness are of great importance, as a lack of understanding about the risks and postop requirements of surgery results in 30% of patients being denied bariatric surgery or having it delayed.³⁸

The need to know about the patient journey is further emphasized by the persistence of prejudices and misinformation about obesity and bariatric surgery among the public and also healthcare staff.³⁵ It is of note that WLS patients have reported feeling ignored by health professionals, which compounded their disempowering experience of anticipating

WLS.²² This contrasts strongly with the participants in this study, who perceived health professionals and especially bariatric nurses as close allies and a major source of support. Being aware of the patient journey to gastric banding will play a key part in combating these prejudices and in helping nurses to provide the best possible care to these patients.

Conclusion

Patients undergoing WLS must be able to expect the same high quality care as all other patients. This requires nurses and healthcare professionals to be knowledgeable in this specialist area, and understanding the patient journey to gastric banding described in this paper will help to inform patient care further.

A second round of interviews, 1 year after surgery, will consider the continued progress of the participants. It will examine whether their renewed hope gained during an active, patient-driven, preoperative journey, and their expectation that the gastric band would assist them in controlling their eating, were realistic. Confirming that this link exists could help to enhance further any preoperative preparation programs for gastric banding patients.

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