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Communication Between the Obese Patient and Bariatric Surgeon☆

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ABSTRACT

Communication between the bariatric surgeon and the obese patient is very important as it influences the expectations of patients with regard to surgery, aim of the surgery and the understanding of the mechanisms of failure of surgery. Furthermore, the incidence of certain psychopathology in these patients makes it necessary for the surgeon to have the ability to communicate to the patient the need for motivation and the maintenance of healthy life habits. Although the topic is subjective, in this article we review several useful recommendations to optimise communication before and after surgery. Finally, we emphasise the need to create workshops to train the bariatric surgeon in these issues that we consider so important.

La comunicación entre el paciente obeso y el cirujano bariátrico

Palabras clave:
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Cirugía bariátrica
Habilidades de comunicación
Expectativas

RESUMEN

La comunicación entre el cirujano bariátrico y el paciente obeso es muy importante, ya que influye en las expectativas de los pacientes respecto a la cirugía, sus objetivos y la comprensión de los mecanismos por los que esta puede fallar. Además, la incidencia de determinadas condiciones psicopatológicas en este grupo de población exige a los cirujanos poseer unas habilidades psicológicas que les permitan una comunicación destinada a conseguir el compromiso del paciente y el mantenimiento de unos hábitos de vida saludables. A pesar de la subjetividad del tema, en este artículo se exponen ciertas recomendaciones útiles para optimizar dicha comunicación antes y después de la intervención quirúrgica. Por último, destacamos la necesidad de crear talleres destinados a la formación del cirujano bariátrico en esta faceta que consideramos tan importante.

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Introduction

Doctor–patient communication plays a very important role in patient care,[1] influencing their health as much as their quality of life.[2] There is an additional aspect to this when a patient is referred for surgical intervention.[3] In the same way that the relationship between the surgeon and an oncological patient has its own characterisitcs,[4] interaction with an obese person requires not just the proper explanation and meticulous performance of the surgery itself, but also requires social and psychological skills to obtain good results.

No other area of general practice requires as much collaboration and motivation from the patient to achieve the expected results as this. So much so that several authors[5,6] have described how the maintenance or increase of weight loss during the first year after surgery depends primarily on the information that patients receive, their expectations, the acquisition of good nutritional habits, and regular physical activity.

Because of this, Lanyon et al.[5] emphasise the need to continue reinforcing all these factors after surgery. In addition to this, the prevalence of diverse pre-surgery psychopathological conditions in this patient group is relatively high,[7] and this should be taken into account when communicating with patients. In fact, it has been confirmed that bariatric post-surgery outcomes are poorer in patients with psychological conditions; and, for this reason, they will need more active psycho-social intervention.[8]

Although establishing guidelines or rules for communication between surgeons and obese patients is rather complicated due to the subjectivity of the topic, this article proposes several useful recommendations for improving this relationship. We cover two different scenarios, before and after surgery, and present some final remarks on training the surgeon in this respect.

First Interview

Wording

Obesity continues to be a socially-stigmatised disease, frequently associated with feelings of guilt. Terms such as ''obesity'', ''fat'' or ''obese person'' convey a negative message to the greater percentage of patients, who prefer to speak of their condition using words such as ''overweight'', ''excess weight'', ''weight problems'', ''unhealthy body weight'', or ''unhealthy body mass index''.[9,10] Therefore, the terms that we use to refer to obesity during a medical interview do matter.

Expectations and Objectives

Often, the expectations of patients regarding weight loss after surgery are greater than the results expected by the surgeons.[11,12] This creates disappointment in the medium to long term, significantly reducing the adherence to dietary and behavioural programmes. For this reason, it is easier to indicate achievable, realistic objectives from the beginning, based on the surgeon's experience, the patient's individual characteristics, and on existing research. Many patients ask how many kilograms they should lose within a specific period of time. We point out the fact that there is a weight-loss range, which is dependent on certain factors, and that for this reason the patient should not focus all their hopes on weight loss. In accordance with this, we also challenge the popular conception of obese people that surgery will work miracles. We aim to make them understand, at this point, that surgical intervention is merely a starting point to help them to lose weight and address any associated diseases, as long as they are able to maintain certain specific behaviour over time. Patients must know that surgical intervention alone is not enough to reach an ideal body weight.

Following this approach of actively involving patients in the process of addressing their own disease, we emphasise the requirement for pre-operative weight loss, which, through a low-calorie diet, will, in addition to reducing hepatic volume and making surgery easier for the surgeon,[13] test the patient's capacity for making sacrifices and a genuine effort to change their behaviour when needed. We believe that this is how the issue should be explained to the patient. Moreover, Livhits et al. find that pre-operative weight loss may be positively associated with weight loss after surgery,[14] although the relationship is not entirely clear.

Surgical Intervention

As the patient's commitment is a high-priority, we describe the intervention and the mechanisms by which it works (restriction, poor absorption, a mix of both). Whilst the informed consent form gives details of some of the characteristics of the intervention, some terminology may be complex. The use of images, drawings and plans may be useful strategies for improving surgeon–patient communication and may also increase patient understanding and satisfaction.[15] It is suggested that explanatory booklets using simple language are provided, repeating the information discussed during the consultation. Some patients are anxious and do not assimilate all the information from the outset; therefore also having the information in a paper format will help them to remember the details and should also clarify any doubts.

The reversibility or irreversibility of the surgery, the possible post-operative complications, as well as their severity and how to address them will also be clarified. We challenge the concept that bariatric surgery is a minor intervention; it is a major procedure with elevated risks, particularly in patients with certain comorbidities.[16] Once all this information has been explained, we then describe the normal post-operative process that occurs in most cases, involving a short hospital stay and low analgesic requirements. This will help the patients to internalise the challenge that they are about to face.

Quality of Life

Some patients ask about symptoms following surgical intervention, or if they will need chronic treatment as a consequence of the change in their gastrointestinal anatomy, or question what they will or will not be able to do afterwards. In other words, they are concerned about decreased post-operative well-being. In most cases an ''expected'' improve-