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Patient experience in bariatric surgery: protocol of a French narrative inquiry and qualitative analysis

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ABSTRACT

Introduction The quality of hospital care, especially surgery, is traditionally assessed using indicators derived from healthcare databases or safety indicators. Given the growing importance of placing the patient at the heart of care evaluation, the use of questionnaires such as the Patient-Reported Experience Measures and Patient-Reported Outcome Measures has become widespread in recent years. However, these tools—addressing factors such as satisfaction, pain management or wait times—only imperfectly reflect the patient's experience, and all such attempts at patient-centred care quality assessment rely on questions or indicators defined in advance by healthcare providers and health authorities. A biopsychosocial model may allow to better understand the patient experience and to improve care pathways. This study seeks to construct a narrative of the bariatric surgical care journey with instruments from narrative inquiry, propose a metanarrative that can serve as a basis for more sophisticated and reliable patient-focused care quality models and define indicators linked to patients' feelings and stories.

Methods and analysis To achieve these aims, 16 bariatric surgical patients at the hospital of Créteil, France (Centre Hospitalier Intercommunal de Créteil), will be included and interviewed once before and twice after surgery, at months 3 and 6. Narratives collected will be used to construct a metanarrative intended to encompass all possible narratives. This metanarrative may ultimately inform new patient care quality indicators, furthering care focused on patients and tailored to their needs and predispositions.

Ethics and dissemination The study is funded by the Group of Clinical Research and Innovation in Île-de-France and was approved by CPP SUD-EST VI Clermont-Ferrand (France) Research Ethics Committee. The results will be submitted for publication in peer-reviewed journals. The patient associations will be approached for the dissemination of the study results.

Trial registration number NCT05092659.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Rigorous narrative inquiry methodology: our narrative and qualitative studies on patient experiences of bariatric surgery demonstrate replicable methods, models and tools for innovating in public health and designing new indicators rooted in people's needs and stories.
⇒ Patient-centred outcomes research: gathering information directly from patients about their experiences to improve the quality of care and personalise outcomes.
⇒ Monocentric study in bariatric surgery.
⇒ Patient follow-up limited to 6 months after bariatric surgery.

INTRODUCTION

Along with overweight, obesity is defined by the WHO as 'abnormal or excessive fat accumulation that presents a risk to health' and is a risk factor for chronic diseases.[1] Body mass index (BMI) estimates the degree of obesity and helps gauge the level of associated health risk.

Management of obesity is multidisciplinary. It has medical, nutritional, psychological and social dimensions. This argues in favour of a biopsychosocial model.[2] Access to bariatric surgery is highly regulated in France. Indeed, patients living with obesity undergoing bariatric surgery will experience significant changes in their lifestyle and quality of life. To be eligible, patients in France must have a BMI of ≥40 kg/m² or a BMI of ≥35 kg/m² associated with at least one comorbidity that the surgery might counter.[3] These criteria are similar to those issued by the American Society of Metabolic and Bariatric Surgery and the International Federation for the Surgery of Obesity and Metabolic Disorders.[4] Preparation for the operation is long, and patients may receive psychological, nutritional and counselling exercise support before and after surgery.[4–6] In the short term, such multidisciplinary support enhances the likelihood of success in bariatric surgery. It provides patients with a better understanding of the benefits, risks and expectations associated with it, contributing to informed decisions; reduces associated risks, such as diabetes or high blood pressure; improves short-term

weight loss and long-term weight stability after the operation and provides nutritional and psychological assistance needed for a new lifestyle. The long-term effect of this preparation on lifestyle habit modification is less clear.[5 7]

While obesity and associated comorbidities affect men and women equally, 60%–80% of patients who undergo bariatric surgery are women, indicating that psychosocial or other external factors exert an influence.[3 8] Major drivers of bariatric surgery programme attrition include patients' environmental context and resources, their social roles and identities, their emotions and their beliefs about the impact of the operation.[9] Hence it is essential to determine the feelings and wishes of patients to provide better support and prevent dropout.

Patients consider bariatric surgery for various reasons. Weight loss is often the main one, and many patients have ambitious weight loss goals. In the study by Karmali *et al*,[10] patients sought to lose 85% of their excess weight and deemed a <51.8% reduction of excess weight disappointing. This differs from the definitions of surgical success in the medical literature, where the target is a 25% reduction in total body weight for sleeve gastrectomy and a 33% reduction for Roux-en-Y gastric bypass surgeries.[11]

Several other common goals have emerged from studies examining the motivations of patients undergoing bariatric surgery. These include the improvement of health and quality of life, body appearance, psychological well-being and interpersonal relationships.[12–16]

Moreover, some studies have highlighted the desire among these patients for a return to 'normality'—in terms of physical health, body image, social interactions and everyday activities—often stemming from the impact of obesity on various aspects of their lives.[17–20] Between June 2019 and February 2020, Dijkhorst *et al*[21] recruited 333 American, Danish and Dutch patients who were administered the BODY-Q Expectations, a weight loss questionnaire to evaluate patient's future expectations, that is 2 years after bariatric surgery. Mean expectations were high (73.1±20 on the 100-point scale) and even higher for the subset of younger patients (<40 years old).

Hospital care performance—especially in surgery—is ordinarily evaluated by indicators from healthcare databases and safety guidelines.[22] With the growing importance of patient-centred healthcare, surveys such as Patient-Reported Experience Measures and Patient-Reported Outcome Measures have become widespread in recent years.[23] However, these tools only partially reflect personal experience and are limited to particular aspects, for instance, satisfaction, pain management and wait times. Other approaches include using tracer patients[24] and interviewing patients or relatives about the care pathway, for example, information received or invitations extended to participate in support workshops.[25] Nevertheless, these attempts at patient-centric healthcare assessment rely on questions or indicators preliminarily defined by caregivers and health authorities.

Narrative methods and analyses are critical for making changes and developing interprofessional, multidimensional, integrated and collaborative approaches. Narrative inquiry[26] is a qualitative methodology for understanding the unique experiences of individuals while also considering social and cultural aspects. It offers a less reductive perspective of healthcare.

We hypothesise that the collection of patient narratives through interviews, per the methods of narrative inquiry, will enable the construction of a metanarrative for the bariatric surgery patient journey. From that metanarrative, we may extract themes, key ideas and patterns common to all individual narratives, thereby affording a broader perspective and a deeper understanding of the patient experience.

METHODS

Study objectives

This prospective study is based on narrative interviews conducted at the hospital of Créteil, France (Centre Hospitalier Intercommunal de Créteil (CHIC)) with a population of consenting patients enrolled in first-line bariatric surgery. Its goals are to assemble patients' narratives from their experiences along bariatric surgery care pathways; to propose a metanarrative that can serve as a foundation for a more sophisticated and more reliable approach to healthcare, based on patients' experiences and to construct indicators linked to the feelings and stories of patients. The study will adhere to the 21 items of the Standards for Reporting Qualitative Research.[27]

Study population and sample size

The study is to include individuals living with obesity enrolled in a first-line bariatric surgery programme at CHIC (Créteil, France). When a surgery date is scheduled, a patient has a preoperative appointment with the surgeon and with the anaesthesiologist. At that time, the investigating surgeon informs the patient about the study if the latter is eligible to participate. This information is provided orally and in writing, with an information sheet validated by the ethics committee. Patients who agree to take part are contacted by a clinical research nurse, who explains again the study and schedules the first study interview. Each patient will be interviewed three times: before bariatric surgery and at 3 months and 6 months after surgery. Before each interview, the patient is informed again of the study's objectives, the interview process and its recording. The interview only starts after explicit oral agreement from the patient.

The ideal sample size of patients in narrative inquiry studies is not well defined[28]; however, it is typically recommended that 10–20 narratives be collected to construct a metanarrative. We will include 16 adult patients (4 men and 12women) with a good knowledge of French and no treated for a severe psychiatric illness. Assuming a 25% loss to follow-up due to postponement of surgery or patient attrition, we plan on ultimately analysing interviews for 12 patients.

We will also collect the following clinical and socioeconomic data about patients: sex, age, BMI, type of employment, marital and familial status, medical history, interview dates and settings, dates and types of surgery, days of hospitalisation and potential complications.

Outcomes

The primary outcome measure will be the metanarrative constructed from the separate experiences of study participants on their care journeys. Secondary outcome measures will be the questionnaire developed from the common metanarrative, the number of patient experiences completely documented, the number of surgical revisions ≤3 months after the initial surgery and the number of new hospital admissions ≤3 months after the initial surgery.

Study design

Inclusions started in March 2023. The last inclusions are planned for October 2024. Study results will be available for October 2025.

Interviews

Three 45-min interviews will be conducted with each participant in the CHIC Department of General Surgery: the first, 10 to 17 days before surgery, when the patient comes in for the presurgical appointment with the surgeon and with the anaesthesiologist; the second, 3 months after surgery and the third, 6 months after surgery.

Through questions posed by two interviewers during these interviews, patients will be invited to tell their stories of obesity, illness and medical care, whose biological, psychological and social dimensions will be considered.[29]

The interviewers will devote the first minutes of the first interview to introducing themselves. Then they will provide an overview of the research process, the preservation of confidentiality and the pseudonymisation of stories. They will take pains to emphasise the ethical value of the study, highlighting that each experience collected may improve the journeys of future patients following similar care pathways. Next, the interviewers will describe the collection of stories and address any doubts or questions the patient may have. Then they will ask for the patient's final agreement and, if granted, begin recording the interview.

The interviews will always begin with a predetermined narrative question modelled after the introduction that is used and suggested by Rita Charon: 'I will be your doctor, and so I have to learn a great deal about your body and your health and your life. Please tell me what you think I should know about your situation'.[30] The adapted version to be used in this study is as follows: 'We will be your interviewers on three occasions; so we need to learn a great deal not only about what led you to consult a CHIC doctor and follow this care pathway towards bariatric surgery, but also about your experience and story of illness. Can you please tell us what you think we should know?'

During an interview, interviewers may prompt a subject to continue or further develop the story. Thus, to a subject who has stopped speaking, they may ask, 'Do you want to tell us more?' or 'Would you like to explain further?' Alternatively, the interviewers may return to one or more of the subject's previous statements using an introduction—for instance, 'You mentioned …', 'You told us that … ', 'You talked about…' or 'You broached the subject of … '—followed by repetition or rephrasing of those statements. This will then be followed by a prompt for more details, as above, for example, 'Do you want to tell us more?'

To ensure consistency of study conditions, the interviewers will guarantee that each patient interview lasts approximately 45 min. Before ending they will say: 'We are almost at the end of our interview. Would you like to add anything?' Then they will schedule the following interview.

At the beginning of the second and third interviews, the interviewers will review what was told by the interviewee during the previous interview and offer the latter the chance to provide further information.

Parallel notes

Each interviewer will write a first-person account of an interview immediately after it has ended. This reflective, autobiographical practice blends the genres of field notes in the traditions of ethnography and autoethnography; the memos of the researcher, within the framework of grounded theory[31] and the 'parallel chart' invented by Charon.[30] It has been termed 'parallel notes'.[32 33]

The objective is to engage the interviewers in a process of emotional exploration, reflection and self-assessment. The interviewers may share some or all of their parallel notes during supervisory meetings with the narrative methodologist.

Narrative supervision

From the start, the interviewers will meet with a narrative methodologist monthly for 2 hours. These meetings can begin by reading the parallel notes. The interviewers will discuss their experiences, allowing for adjustments to the research and interviewing process, and they will begin to develop their theoretical and metanarrative reflections. At the end of each meeting, the methodologist will prepare a summary of the session and email it to the interviewers.

Although they will not be included in the analysis of interviews, the parallel notes and methodologist's summaries shall be considered study documents. They contribute to the coconstruction of illness narratives about obesity and bariatric surgery.

Analysis

The interviews will be recorded and then transcribed. The interview transcripts (three per patients) will be the focus of a narrative analysis of form and plot and a qualitative analysis of themes.

For the narrative analysis, we will consider the longitudinal or diachronic aspects (the extension of the narrative over the three interviews conducted with each patient before and after surgery) and the transversal or synchronic aspects (comparing narratives between patients at the same point of the three-interview sequence). The literary method of close reading, as adopted and adapted by Rita Charon in the field of narrative medicine,[30 34] will be used to conduct a careful analysis of frame, form (genre, style, repetition, metaphor and voice), space, temporality, plot and desire. For example, we will ask: does a narrative seem to belong to a precise genre? What about its style, its voice, its language, its mood? Why are some words repeated? Are there any meaningful metaphors and images? Are there many characters/people? Are they well described or just mentioned? Which is the spatiotemporal structure of the story? And what about the main events? Is the plot well-ordered, linear, or chaotic? And so on.

We will use automated lexicometric analysis of patient discourse to identify the most frequent terms employed. Where necessary, the methodologist's summaries may also be analysed in this way. Quotes from patients' stories will be anonymised to preserve confidentiality.

The qualitative analysis will cover both the interviews and the parallel notes, in order to analyse the participants' experiences using two different sources. It will use classic grounded theory methodologies:[35 36] detailed analysis of the interviews with respect for the interviewees' language and expressions; back and forth between empirical data and progressive theorisation with the aim of understanding the lived experience, etc. The data will be analysed inductively, with the aim of progressively conceptualising them and understanding what the interviewees feel and experience around bariatric surgery.

The qualitative analysis will be carried out by two researchers who will be backed up by a scientific committee, that will support the back and forth between the data and their conceptualisation.

ETHICS AND DISSEMINATION

This study was approved by the SUD-EST VI Clermont-Ferrand Comité de Protection des Personnes (Biomedical Research Ethics Committee). All participants will be informed both orally and in writing. To be included, patients must have consented orally to participate in the study. The results of this study will be presented in congresses on bariatric surgery and will be submitted to a peer-reviewed journal. The patient associations will be approached for the dissemination of the study results. The study has been registered on ClinicalTrials.gov (NCT05092659).

Patient and public involvement

Patients and/or the public were not involved in the study. The patient associations will be approached for the dissemination of the study results, as requested by several associations.

DISCUSSION

This study stands out as the first to apply the described methodology within the field of bariatric surgery. We will devote part of our research efforts to a meta-methodological reflection aimed at refining the methodological instruments and planning similar studies with larger cohorts in oncology and other medical fields.

Analysis of all stories collected will allow to construct a metanarrative that is able to represent a spectrum of potential patient narratives. This metanarrative can assist in going beyond the assumptions of healthcare professionals and institutions to develop patient-centred care quality indicators consistent with the unique experiences coconstructed by study participants and interviewers. Questionnaires focused on recurrent themes emerging from our analysis can also be designed.

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Contributors MV, CJ, SB, AL, VG, FA and CD designed the study. SB and AL included the patients. MV and CJ conducted the interviews. CD conducts the narrative supervision. VG, FA and CD validate the methodology. MV, CJ, CD, FA and VG will analyse the data. MV, CJ, SB, AL, VG, FA and CD will interpret the data. MV, CJ, SB, AL, VG, FA and CD drafted, revised and approved the manuscript. MV, as guarantor, is responsible for the overall content. The guarantor accepts full responsibility for the finished work and/or the conduct of the study, has access to the data, and controls the decision to publish.

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Competing interests None declared.

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