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The patient experience in bariatric surgery: a narrative inquiry and qualitative analysis

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Keywords:	Bariatric Surgery, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Patient-Centered Care

The patient experience in bariatric surgery: a narrative inquiry and qualitative analysis

Abstract

Background 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, use of questionnaires such as the Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) 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 quality queries or indicators defined in advance by healthcare providers and health authorities. A biopsychosocial model may permit a better understanding of the patient experience, to truly improve care pathways.

Objectives This study seeks to construct a narrative of the bariatric surgical care journey with instruments of 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 To achieve these aims, 16 bariatric surgical patients at the intermunicipal teaching hospital of Créteil (CHIC), France, will be included and interviewed once before and twice after surgery. 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.

Key Messages

- **What is already known on this topic** The integration of patient experience into the development of care pathways and treatments is essential for quality healthcare. Currently, Patient-Reported Experience Measures or Patient-Reported Outcome Measures only partially reflect personal experience and are limited to particular aspects, e.g., satisfaction, pain management, and wait times.
- **What this study adds:** This research will collect the narratives of patients enrolled in a bariatric surgery pathway using a rigorous narrative inquiry methodology, with the aim of creating a metanarrative of this care journey.
- **How this study might affect research, practice or policy:** Such an inquiry can facilitate the development of better quality indicators based on patient experience, rather than criteria defined by healthcare providers or authorities.

Keywords

Quality of Health Care, Narrative inquiry, Patient-Centered Outcomes Research, Feelings,

Bariatric Surgery

INTRODUCTION

Along with overweight, obesity is defined by the World Health Organization 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, having medical, psychological, and social dimensions. This argues in favour of a biopsychosocial model.[2] Access to bariatric surgery is highly regulated in France. Bariatric patients undergo major surgery that will impact their future lifestyle and quality of life. To be eligible, patients 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. Preparation for the operation is long, and patients may receive psychological, nutritional, and exercise support before and after surgery.[3 4] 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, permitting 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 their new lifestyle.

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.[5,6] Major drivers of bariatric surgery program attrition include patients’ environmental context and resources, their social roles and identities, their emotions, and their beliefs about the impact of the operation.[7] 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.,[8] patients sought to lose 85% of their excess weight and deemed a <51.8% reduction of excess weight disappointing. This contrasts with definitions of surgical success in the medical literature, which set the bar as low as ≥25% excess weight loss.[9]

Several other common goals have emerged from studies examining the motivations of patients undergoing bariatric surgery. These include improved health and quality of life, improved body appearance, improved psychological well-being, and improved interpersonal relationships.[10–14]

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.[15–18] Between June 2019 and February 2020, Dijkhorst et al.[19] recruited 333 American, Danish, and Dutch patients, who were administered the BODY-Q Expectations: Weight Loss scale to evaluate their future expectations (i.e., 2 y 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 y old).

Hospital care performance—especially in surgery—is ordinarily evaluated by indicators from healthcare databases and safety guidelines.[20] With the growing importance of patient-centred healthcare, surveys such as the Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) have become widespread in recent years.[21] However, these tools only partially reflect personal experience and are limited to particular aspects, e.g., satisfaction, pain management, and wait times. Other approaches include using tracer patients[22] and interviewing patients or relatives about the care pathway, e.g., information received or invitations extended to participate in support workshops.[23] 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, collaborative approaches. Narrative inquiry[24] is a qualitative methodology for understanding the unique experiences of individual while also considering social and cultural aspects. It offers a less reductive perspective of healthcare.

We hypothesize 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 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 (SRQR).[25]

Study Population and Sample Size

The study is to include obese individuals enrolled in a first-line bariatric surgery program at CHIC. When a surgery date is scheduled, a patient has a preoperative appointment with the surgeon and anaesthesiologist. At that time, the investigating surgeon informs the patient about the study if the latter is eligible to participate. Patients who agree to take part are contacted by a clinical research nurse, who again explains the study and schedules the first study interview.

The ideal sample size of patients in narrative inquiry studies is not well defined;[26] however, it is typically recommended that 10–20 narratives be collected to construct a metanarrative. We will include 16 adult patients (4 men, 12 women) with a good knowledge of French and full possession of their mental faculties. Assuming a 25% loss to follow-up due to postponement of surgery or patient attrition, we plan on ultimately analysing interviews for 12 patients.

The following clinical and socioeconomic data about subjects will also be collected: sex, age, BMI, type of employment, marital and familial status, medical history, interview dates and settings, dates and types of surgery, days of hospitalization, 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 mo after initial surgery, and the number of new hospital admissions ≤3 mo after initial surgery.

Study design

Interviews

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

Through questions posed by 2 interviewers during these interviews, subjects will be invited to tell their stories of obesity, illness, and medical care, whose biological, psychological, and social dimensions will be considered.[27]

The interviewers will devote the first minutes of the first interview to introducing themselves. Then they provide an overview of the research process, the preservation of confidentiality, and the pseudonymization of stories. They will take pains to emphasize 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.’[28] 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 the course of 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—e.g., ‘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 followed by a prompt for more details, as above, e.g., ‘Do you want to tell us more?’

To ensure consistency of study conditions, the interviewers will ensure that each patient interview lasts no longer than 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;[29] and the ‘parallel chart’ invented by Charon.[28] It has been termed ‘parallel notes’.[30 31]

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 h. 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 e-mail 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 co-construction of illness narratives about obesity and bariatric surgery.

Analysis

The interview transcripts (3 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 (i.e., the extension of the narrative over the 3 interviews conducted with each patient before and after surgery) and the transversal or synchronic aspects (i.e., comparing narratives between patients at the same point of the 3-interview sequence). The literary method of close reading, as adopted and adapted by Rita Charon in the field of narrative medicine,[28 32] will be used to conduct a careful analysis of frame, form (genre, style, repetition, metaphor, voice), space, temporality, plot, and desire.

The qualitative analysis is conducted by 2 independent researchers who have not interviewed the patients. It will be based on Gioia methodology and include three coding phases:[33] the first phase adheres as closely as possible to the words spoken by the interviewees, the second develops an initial level of abstraction and synthesis, and the third yields a set of themes and subthemes.

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 anonymized to preserve confidentiality.

Ethics

Before their inclusion, patients received oral and written information about the research. Their oral consent was then obtained for participation in the study, including interviews and anonymized recording.

This study was approved by the SUD-EST VI Clermont-Ferrand Comité de Protection des Personnes (biomedical research ethics committee).

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 metamethodological 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 permit the construction of a metanarrative representative of the full 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 co-constructed by study participants and interviewers. Questionnaires focused on recurrent themes emerging from our analysis can also be designed.

CONCLUSION

Our narrative and qualitative study of the experiences of bariatric surgery patients demonstrates replicable methods, models, and tools for innovating in public health through the design of new indicators rooted in people’s needs and stories.

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The 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, use of questionnaires such as the Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) have 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 quality queries or indicators defined in advance by healthcare providers and health authorities. A biopsychosocial model may permit a better understanding of the patient experience, to truly improve care pathways. This study seeks to construct a narrative of the bariatric surgical care journey with instruments of 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 anlysis: To achieve these aims, 16 bariatric surgical patients at the intermunicipal teaching hospital of Créteil (CHIC), France, will be included and interviewed once before and twice after surgery, at month 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
- Patient-Centred Outcomes Research
- Monocentric study in bariatric surgery

Keywords

Quality of Health Care, Narrative inquiry, Patient-Centred Outcomes Research, Feelings, Bariatric Surgery

INTRODUCTION

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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 program 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.

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

We hypothesize 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 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 (SRQR).[27]

Study Population and Sample Size

The study is to include individuals living with obesity enrolled in a first-line bariatric surgery program at CHIC (Créteil, France). When a surgery date is scheduled, a patient has a preoperative appointment with the surgeon and 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 again explains the study and schedules the first study interview. Each patient will be interviewed three times: before bariatric surgery and at 3 mo and 6 mo. 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, 12 women) 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.

The following clinical and socioeconomic data about patients will also be collected: sex, age, BMI, type of employment, marital and familial status, medical history, interview dates and settings, dates and types of surgery, days of hospitalization, 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 mo after initial surgery, and the number of new hospital admissions ≤3 mo after 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 participating patient in the CHIC Department of General Surgery: the first, 10–17 d before surgery, when the patient comes in for the presurgical appointment with the surgeon and anaesthesiologist; the second, 3 mo after surgery; and the third, 6 mo after surgery.

Through questions posed by 2 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 pseudonymization of stories. They will take pains to emphasize 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 the course of 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—e.g., '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 follow by a prompt for more details, as above, e.g., 'Do you want to tell us more?'

To ensure consistency of study conditions, the interviewers will ensure 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 h. 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 e-mail 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 co-construction of illness narratives about obesity and bariatric surgery.

Analysis

The interviews will be recorded and then transcribed. The interview transcripts (3 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 (i.e., the extension of the narrative over the 3 interviews conducted with each patient before and after surgery) and the transversal or synchronic aspects (i.e., comparing narratives between patients at the same point of the 3-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, voice), space, temporality, plot, and desire. We will ask, for example: 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 anonymized 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 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 in order to understand 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, which will support the back and forth between the data and their conceptualisation.

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Ethics and dissemination

This study was approved by the SUD-EST VI Clermont-Ferrand Comité de Protection des Personnes (biomedical research ethics committee). Before their inclusion and before each interview, patients will receive oral and written information about the research. Their oral consent will then obtain for participation in the study, including interviews and anonymized recording. 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 metamethodological 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 permit the construction of a metanarrative representative of the full 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 co-constructed by study participants and interviewers. Questionnaires focused on recurrent themes emerging from our analysis can also be designed.

CONCLUSION

Our narrative and qualitative study of the experiences of bariatric surgery patients demonstrates replicable methods, models, and tools for innovating in public health through the design of new indicators rooted in people’s needs and stories.

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Competing interests: The authors declare no competing interests in relation this study.

Authors’ contributions: M.Vignot, C.Jung, S Bathaei, A Lazzati, V Gateau, F Angeli and C Delorenzo designed the study. S Bathaei and A Lazzati include the patients. M.Vignot, C.Jung conduct the interviews. C Delorenzo conducts the narrative supervision. V Gateau, F Angeli and C Delorenzo validate the methodology. M.Vignot, C.Jung, C Delorenzo and V Gateau will analyze the data. M.Vignot, C.Jung, S Bathaei, A Lazzati, V Gateau, F Angeli and C Delorenzo will interpret the data. M.Vignot, C.Jung, S Bathaei, A Lazzati, V Gateau, F Angeli and C Delorenzo drafted, revised and approved the manuscript.

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Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Page/line no(s).

Title and abstract

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Title. First page
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Abstract section

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Introduction Pages 3-4
Purpose or research question - Purpose of the study and specific objectives or questions	Study objectives (methods section) page 5

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Methods section Page 5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Methods section Interviews (p6-7) Parallel notes (p7) Narrative supervision (p8)
Context - Setting/site and salient contextual factors; rationale**	Study population (p5)
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Study population (p5)
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Ethics and dissemination section, p8
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Study design (p6) Study population and sample size (p5) Analysis section, (p8)

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Analysis section, p8
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Study population and sample size (p5)
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 8
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 8
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 8

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Page 9 (discussion part) To be done upon publication of the results
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Page 9 (discussion part) To be done upon publication of the results

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	To be done upon publication of the results
Limitations - Trustworthiness and limitations of findings	To be done upon publication of the results

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 10
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 10

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014 DOI: 10.1097/ACM.0000000000000388

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

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The 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 (PREMs) and Patient-Reported Outcome Measures (PROMs) 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, CHIC), 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 study onpatient experiences of bariatric surgery demonstrates 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 personalize outcomes.
- Monocentric study in bariatric surgery
- Patient follow-up limited to 6 months after bariatric surgery

Keywords

Quality of Health Care, Narrative inquiry, Patient-Centred Outcomes Research, Feelings, Bariatric Surgery

INTRODUCTION

Along with overweight, obesity is defined by the World Health Organization 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/m^2, or a BMI of ≥35 kg/m^2 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 (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO).[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 program 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 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: Weight Loss scale to evaluate their 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 (PREMs) and Patient-Reported Outcome Measures (PROMs) 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, collaborative approaches. Narrative inquiry[26] is a qualitative methodology for understanding the unique experiences of individual while also considering social and cultural aspects. It offers a less reductive perspective of healthcare.

We hypothesize 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 (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 (SRQR).[27]

Study Population and Sample Size

The study is to include individuals living with obesity enrolled in a first-line bariatric surgery program 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, 12 women) 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 hospitalization, 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 initial surgery, and the number of new hospital admissions ≤3 months after 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-minutes 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 2 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 pseudonymization of stories. They will take pains to emphasize 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 follow 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 minutes. 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 e-mail 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 co-construction of illness narratives about obesity and bariatric surgery.

Analysis

The interviews will be recorded and then transcribed. The interview transcripts (3 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 3 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 3-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, voice), space, temporality, plot, and desire. We will ask, for example: 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 anonymized 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 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). Before their inclusion and before each interview, patients will receive oral and written information about research. Their oral consent will then obtain for participation in the study, including interviews and anonymized recording. 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 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 co-constructed by study participants and interviewers. Questionnaires focused on recurrent themes emerging from our analysis can also be designed.

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Competing interests: The authors declare no competing interests in relation this study.

Authors' contributions: M.Vignot, C.Jung, S Bathaei, A Lazzati, V Gateau, F Angeli and C Delorenzo designed the study. S Bathaei and A Lazzati include the patients. M.Vignot, C.Jung conduct the interviews. C Delorenzo conducts the narrative supervision. V Gateau, F Angeli and C Delorenzo validate the methodology. M.Vignot, C.Jung, C Delorenzo and V Gateau will analyze the data. M.Vignot, C.Jung, S Bathaei, A Lazzati, V Gateau, F Angeli and C Delorenzo will interpret the data. M.Vignot, C.Jung, S Bathaei, A Lazzati, V Gateau, F Angeli and C Delorenzo drafted, revised and approved the manuscript.

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Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Page/line no(s).

Title and abstract

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Title. First page
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Abstract section

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Introduction Pages 3-4
Purpose or research question - Purpose of the study and specific objectives or questions	Study objectives (methods section) page 5

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Methods section Page 5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Methods section Interviews (p6-7) Parallel notes (p7) Narrative supervision (p8)
Context - Setting/site and salient contextual factors; rationale**	Study population (p5)
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Study population (p5)
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Ethics and dissemination section, p8
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Study design (p6) Study population and sample size (p5) Analysis section, (p8)

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Analysis section, p8
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Study population and sample size (p5)
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 8
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 8
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 8

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Page 9 (discussion part) To be done upon publication of the results
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Page 9 (discussion part) To be done upon publication of the results

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	To be done upon publication of the results
Limitations - Trustworthiness and limitations of findings	To be done upon publication of the results

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 10
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 10

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
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The patient experience in bariatric surgery: protocol of a French narrative inquiry and qualitative analysis

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Primary Subject Heading:	Qualitative research
Secondary Subject Heading:	Patient-centred medicine, Surgery, Health services research
Keywords:	Bariatric Surgery, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Patient-Centered Care

The 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 (PREMs) and Patient-Reported Outcome Measures (PROMs) 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, CHIC), 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 study onpatient experiences of bariatric surgery demonstrates 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 personalize outcomes.
- Monocentric study in bariatric surgery
- Patient follow-up limited to 6 months after bariatric surgery

Keywords

Quality of Health Care, Narrative inquiry, Patient-Centred Outcomes Research, Feelings, Bariatric Surgery

INTRODUCTION

Along with overweight, obesity is defined by the World Health Organization 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 (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO).[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 program 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 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: Weight Loss scale to evaluate their 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 (PREMs) and Patient-Reported Outcome Measures (PROMs) 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, collaborative approaches. Narrative inquiry[26] is a qualitative methodology for understanding the unique experiences of individual while also considering social and cultural aspects. It offers a less reductive perspective of healthcare.

We hypothesize 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 (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 (SRQR).[27]

Study Population and Sample Size

The study is to include individuals living with obesity enrolled in a first-line bariatric surgery program 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, 12 women) 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 hospitalization, 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 initial surgery, and the number of new hospital admissions ≤3 months after 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-minutes 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 2 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 pseudonymization of stories. They will take pains to emphasize 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 follow 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 minutes. 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 e-mail 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 co-construction of illness narratives about obesity and bariatric surgery.

Analysis

The interviews will be recorded and then transcribed. The interview transcripts (3 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 3 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 3-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, voice), space, temporality, plot, and desire. We will ask, for example: 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 anonymized 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 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 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 co-constructed by study participants and interviewers. Questionnaires focused on recurrent themes emerging from our analysis can also be designed.

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Competing interests: The authors declare no competing interests in relation this study.

Authors' contributions:

Marina Vignot/MV, Camille Jung/CJ, Sarah Bathaei/SB, Andrea Lazzati/AL, Valerie Gateau/VG, Frederica Angeli/FA and Christian Delorenzo/CD designed the study. Sarah Bathaei/SB and Andrea Lazzati/AL include the patients. Marina Vignot/MV Camille Jung/CJ, conduct the interviews. Christian Delorenzo/CD conducts the narrative supervision. Valerie Gateau/VG, Frederica Angeli/FA and Christian Delorenzo/CD validate the methodology. Marina Vignot/MV, Camille Jung/CJ, Christian Delorenzo/CD, Frederica Angeli/FA and Valerie Gateau/VG will analyze the data. Marina Vignot/MV, Camille Jung/CJ, Sarah Bathaei/SB, Andrea Lazzati/AL, Valerie Gateau/VG, Frederica Angeli/FA and Christian Delorenzo/CD will interpret the data. Marina Vignot/MV, Camille Jung/CJ, Sarah Bathaei/SB, Andrea Lazzati/AL, Valerie Gateau/VG, Frederica Angeli/FA and Christian Delorenzo/CD drafted, revised and approved the manuscript. Marina Vignot/MV, as guarantor, is responsible of the overall content. The guarantor accepts full responsibility for the finished work and/or the conduct of the study, had access to the data, and controlled the decision to publish.

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Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Page/line no(s).

Title and abstract

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Title. First page
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Abstract section

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Introduction Pages 3-4
Purpose or research question - Purpose of the study and specific objectives or questions	Study objectives (methods section) page 5

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Methods section Page 5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Methods section Interviews (p6-7) Parallel notes (p7) Narrative supervision (p8)
Context - Setting/site and salient contextual factors; rationale**	Study population (p5)
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Study population (p5)
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Ethics and dissemination section, p8
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Study design (p6) Study population and sample size (p5) Analysis section, (p8)

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Analysis section, p8
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Study population and sample size (p5)
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 8
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 8
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 8

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Page 9 (discussion part) To be done upon publication of the results
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Page 9 (discussion part) To be done upon publication of the results

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	To be done upon publication of the results
Limitations - Trustworthiness and limitations of findings	To be done upon publication of the results

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 10
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 10

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
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