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Exploring the Patient-Reported Impact of the Pharmacist on Pre-bariatric Surgical Assessment

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Abstract

Background

The effects of surgical procedures and the need for life-long nutrient supplementation may impact on medication regimes, requiring changes to dosage and formulation of medicines, which can be difficult for patients following surgery. Our pre-surgical assessment pathway involves a pharmacist with specialist knowledge of bariatric surgery, to help prepare patients for these changes.

Objective

To explore the patient-reported impact of the specialist bariatric pharmacist in pre-surgical assessment.

Setting

National Health Service Hospital, United Kingdom.

Methods

A two phased, retrospective study design using participants recruited from pre-surgical clinic lists. The first phase consisted of confidential, face to face semi-structured interviews. A constant comparative analytic framework informed the construction of the second phase, which consisted of a confidential survey to test the generalizability of the findings with a larger cohort of patients.

Results

A total of 40 participants (12 interviews, 28 surveys) were recruited to the study. The majority of participants were female ($n = 33$), mean age 50 years, mean pre-surgical weight 124 kg ($n = 38$). The most common comorbidity was type 2 diabetes. Participants on medication had at least one comorbidity, with the majority of conditions improved or eliminated after surgery.

Conclusions

The pre-surgical consultation with the pharmacist was highly valued by the participants, providing information and support which helped prepare for medication changes after bariatric surgery. Many felt that a post-surgical appointment with the pharmacist would provide support and improve compliance with vitamins and medications. Future research into the role of pharmacists in the bariatric multi-disciplinary team and patient support are recommended.

Keywords

Bariatric surgery
Patient experience
Pharmacist
Medication compliance
Multi-disciplinary team
Vitamins
Supplementation

Introduction

Many people with obesity who seek bariatric surgery have related comorbidities, necessitating polypharmacy. In the UK, 64% of patients undergoing bariatric procedures have three or more obesity-related health conditions [1]. The malabsorptive and restrictive effects of bariatric surgical procedures and resultant rapid weight loss necessitate life-long vitamin and mineral supplementation surgery [2]. This often means altered pharmacokinetics of medications, e.g. dose, formulation and timing [3, 4] which vary according to the individual health status of patients. Additionally, there is a need for lifelong follow-up and nutritional supplementation. Bariatric surgery is time of immense physical, social and personal change [5, 6] which requires a period of adjustment for patients.

To prepare for surgery, UK patients attend appointments with members of the bariatric multi-disciplinary team (MDT) to ensure that they meet individualised targets, e.g. weight loss or changes to health behaviours, demonstrating their ability to adapt to post-surgical lifestyle changes [7]. Once a patient is cleared for surgery, they attend our pre-surgical assessment clinic which has an embedded pharmacist as part of our MDT. During pre-surgical assessment, all patients have an appointment with the pharmacist, who carries out a medication review, integrating changes to current medication post-surgery, discusses compliance with nutritional supplementation after surgery, highlighting issues regarding the timing, duration and interaction with specific medication and vitamins. The pharmacist actively encourages patients to ask questions and discuss their concerns. At the end of the appointment, a written summary is given to the patient, with copies sent to their General Practitioner and incorporated into their hospital records to ensure that information is available to all parties involved in the patients' care.

There is an increasing drive to involve patients in clinical research to ensure that studies are carried out which are relevant to patients and provide opportunities for patients to be included in decisions about research from design to dissemination [8]. In the UK, as part of ethical approval process for research carried out in National Health Services (NHS) settings, applications must demonstrate patient involvement in the research as part of the approval process [9].

Our unit actively carries out patient-focused research, with and for patients. The idea for this study was based on findings from a previous study which explored how patients adjust to life after bariatric surgery [5]. Findings showed that patients reported issues around medication and supplementation compliance which warranted further investigation. Many participants discussed the importance of pre-surgical contact with the bariatric MDT in preparing for and

adjusting to life after surgery which we decided to explore further with this study.

The inclusion of a pharmacist in pre-surgical pre-assessment is unique to our service and is not standard practice within UK bariatric surgical units. In order to further engage with patients to co-create research studies which incorporate the views and needs of our patients, the aim of this study was to explore the patient-reported impact of the pharmacist in pre-bariatric surgical assessment.

Methods

A retrospective, two phased, study design with participants randomly recruited from pre-surgical assessment clinic lists by an independent researcher in a large National Health Service (NHS) hospital in the UK. As all patients in our service attend pre-surgical assessment, all patients on the pre-surgical clinic lists were eligible to participate. The first phase involved individual, face to face semi-structured interviews, assisted by a topic guide, which were audio-recorded and transcribed verbatim. Participants were asked to voluntarily take part by discussing their experiences of seeing the pharmacist during pre-surgical assessment. Each interview was carried out by the same independent researcher and took between 30 and 45 min. A constant comparative approach was used, which means that data collection and analysis were undertaken concurrently, with analysis guiding further sampling [10]. This approach allowed researchers to discover areas of interest and to identify concepts of importance to participants and explore these further. Data collection and analysis continued until no new concepts were identified, meaning data was saturated and recruitment to phase 1 ceased. The findings informed the construction of the second phase, which consisted of a confidential survey to test the generalizability of the findings with a larger cohort of patients. During the interviews and data analysis for phase 1, it was noted that participants preferred to discuss the impact of the pharmacist appointment in terms of preparation for surgery, dealing with changes to health status and medication after surgery. Participants did not routinely discuss amount of weight loss, despite collecting data on this as part of the participant demographics. In order to focus on the aim of the study and to reduce the number of questions to encourage responses, questions around weight loss were not included in the survey. Prior to distributing study information, the survey was pilot tested with a representative group of patients, who confirmed that the emphasis should be on patient experiences and not on clinical outcomes.

For phase 2, participants were also identified from clinic lists, with an information pack containing the study information and a link to an on-line

Participant (surveys)	Gender	Age	Time since surgery (months)	Type of procedure	Self-reported weight at time of surgery (kg)	Self-reported weight loss at time of interview (kg)	Self-reported weight at time of interview (kg)
A	F	46	8	Roux-en-Y Gastric bypass	140	44	96
B	F	61	13	Roux-en-Y Bypass (conversion from sleeve gastrectomy)	123	12	111
C	F	53	10	One Anastomosis gastric bypass	111	38	73
D	F	63	10	Roux-en-Y Gastric Bypass	138	42	96
E	F	60	10	Roux-en-Y Gastric Bypass	102	31	71
F	M	61	6	One Anastomosis Gastric Bypass	154	21	133
G	F	65	24	Roux-en-Y Gastric Bypass	126	57	69
H	F	56	18	Roux-en-Y Gastric Bypass	120	70	70
I	F	47	12	One Anastomosis Gastric Bypass	120	51	69
J	F	45	8	One Anastomosis Gastric Bypass	118	32	86
K	F	54	24	Roux-en-Y Gastric Bypass	133	57	57
L	F	60	15	Roux-en-Y Gastric Bypass	111	47	64

The interviews took place in a location of participants' choice, including place of work, hospital, and their homes. Each participant gave written consent; the interview was audio-recorded and transcribed verbatim. The researcher also took written notes during the interview, to note areas of interest to be explored further, and to clarify any ambiguity to ensure that interpretation of data was veracious to the participants' experience and to minimise researcher bias. Transcripts were compared with earlier transcripts in a process known as constant comparative analysis, allowing researchers to identify concepts of interest. The concepts were discussed with the research team and a core set of emergent themes was identified and agreed (see Table 2) which informed the construction of the general survey questions, for phase 2.

Table 2

Themes constructed from interviews

Theme	In vivo quotes
Taking pills signifies illness	<p>My Dad died from kidney and liver failure and some of this was down to the medication he was on. Because of this, I did not want to take tablets the rest of my life, and I had side effects from my blood pressure tablets. I have lost weight and I do not have symptoms anymore and I want to come off the pills, I do not want any side-effects long or short term. With the vitamins I am on seven tablets a day and I do not want to take so many (Participant L)</p> <p>I understand that I am taking vitamins for my health and to protect myself in the future. I see it as a priority but it is still taking pills (Participant J)</p>
Feeling empowered by the pharmacist	<p>I wasn't as scared as I thought I would be because she [Pharmacist] talked us [self and partner] through what would happen around the medications after surgery and I think she made me feel more confident in myself (Participant A)</p> <p>The pharmacist told me that I would have to crush to tablets and it might taste bitter, and to have a drink afterwards to take the taste away. When I was on the ward, I got my tablet from the staff, and they just handed it to me whole. I felt good about telling them that the pharmacist told me the tablet needed to be crushed and I would need a drink with it to take the taste away (Participant G)</p>
Preparing to comply with post-surgical recommendations	<p>I had not thought through as to what medication was going to be needed afterwards, so it was good to have the update. If I had not had the appointment, then just been presented with tablets when I left the hospital, I would have been less prepared afterwards (Participant C)</p>

Theme	In vivo quotes
Informing and involving others in their care	<p>With my husband with me at the appointment, he heard everything the pharmacist said and why I needed to take these tablets. So now, he will tell me to make sure I take my tablets on a morning, and reminding me again at night, because I used to be terrible about forgetting to take my pills (Participant A)</p> <p>I had an appointment with my GP and I explained I had met with the pharmacist and I actually took the sheet of paper with me for the GP to have a look at and I went through with her what had been explained to me and the GP asked how I felt about things. I said that I felt a lot better and the information helped my GP to understand what I needed (Participant B)</p> <p>The GP gave me the tablets to stop the gallstones, but he did not give me enough, or the right dosage. I had to go back and back, so when the letter came I went back with it and said to the GP 'this is what I need to have, you are giving me the wrong dosage' (Participant E)</p>
Valuing the expertise of the pharmacist	<p>If I had not seen the pharmacist, I would have probably been more scared waking up the next day after the operation and someone coming up and saying I had to take these tablets. I thought it was quite interesting to speak with the pharmacist about this well before the operation (Participant A)</p> <p>Nobody, except the pharmacist, told me about not being able to take certain medications anymore. She explained why I could not take co-codamol after surgery. She said if I had a migraine, I would need to take paracetamol and that I had to cut codeine out completely. I was worried as I was reliant on it at the time, but I appreciated the time she took to explain everything to me (Participant K)</p> <p>My pharmacist appointment was critical. You need to understand what you are taking and why you are taking it, but also having the structure. It was really clear when I came out of the appointment what I needed to do and when. I think if I had not met with her, I probably would not be as informed as I am (Participant L)</p>
Wanting to help others	<p>When I was in hospital having the operation, I met a man in the next bed who showed me an app for my phone, where I entered all my medication, the time, the quantity etc. and it tells me when to take it and everything else. It's called Medisafe, and it has been so helpful. I'd recommend it to others, as it even tells you when you are running low, so you can order a new prescription (Participant E)</p> <p>After the pharmacist appointment, I bought a pill box, and it helped me to organise myself and my tablets. I would tell everyone to do this, as there is so much to think about after surgery and you need to be prepared (Participant H)</p>

Second Phase

A total of 28 (22 females, 6 males) completed the survey (on-line or print) (see Table 3). The types of procedures performed were Roux-n-Y Gastric bypass 64% ($n = 18$), mean pre-surgical weight was 128 kg. The most commonly reported health conditions were type 2 diabetes ($n = 8$), pain ($n = 6$), and hypertension ($n = 6$). Improvements to health conditions were reported by 71% ($n = 20$) of participants, with 7% ($n = 2$) reporting it was too early to notice a change, 3% (n

= 1) had a chronic disease flare-up post-surgery and 18% ($n = 5$) did not respond (see Table 3).

Table 3

Participant demographics—phase II (surveys)

Participant (surveys)	Gender	Age	Time since surgery (months)	Type of procedure	Self-reported weight at time of surgery (kg)	Self-reported pre-surgical health conditions
1	F	46	6	One Anastomosis Gastric Bypass	103	None reported
2	M	53	6	Roux-en-Y Gastric Bypass	142	Reflux
3	M	48	3	One Anastomosis Gastric Bypass	248	T2D (diet and tablet controlled), pancreatitis, Obstructive Sleep Apnoea, Asthma
4	F	42	2	Roux-en-Y Gastric Bypass	121	Irritable Bowel Syndrome, chronic pain, reflux, depression, anxiety, arthritis
5	F	43	6	Roux-en-Y Gastric Bypass	122	Pain
6	M	33	5	Roux-en-Y Gastric Bypass	133	Obstructive Sleep Apnoea
7	M	63	5	Roux-en-Y Gastric Bypass	107	Obstructive Sleep Apnoea, water retention, high blood pressure,

Participant (surveys)	Gender	Age	Time since surgery (months)	Type of procedure	Self-reported weight at time of surgery (kg)	Self-reported pre-surgical health conditions
8	F	64	6	Roux-en-Y Gastric Bypass	No response	No response
9	F	46	2	Roux-en-Y Gastric Bypass	No response	No response
10	F	49	2	Roux-en-Y Gastric Bypass	99	T2D, Para hyperthyroidism
11	F	58	N/R	Roux-en-Y Gastric Bypass	129	Hypothyroidism Fibromyalgia Depression
12	F	50	7	One Anastomosis Gastric Bypass	119	Back and groin pain
13	F	41	7	One Anastomosis Gastric Bypass	119	Back, knee and foot pain

Participant (surveys)	Gender	Age	Time since surgery (months)	Type of procedure	Self-reported weight at time of surgery (kg)	Self-reported pre-surgical health conditions
14	F	51	2	Sleeve Gastrectomy	91	T2D, high blood pressure
15	F	46	2	One Anastomosis Gastric Bypass	99	Rheumatoid arthritis
16	F	22	2	Roux-en-Y Gastric Bypass	141	None, just an exceptionally high body mass index (BMI)
17	F	62	19	Roux-en-Y Gastric Bypass	110	Angina, spine and neck spondylosis, irregular heartbeat, unstable blood pressure dropping very low then rising very high
18	F	31	1	Roux-en-Y Gastric Bypass	147	T2D, Polycystic ovarian syndrome
19	F	52	N/R	Roux-en-Y Gastric Bypass	119	None reported

Participant (surveys)	Gender	Age	Time since surgery (months)	Type of procedure	Self-reported weight at time of surgery (kg)	Self-reported pre-surgical health conditions
20	F	36	3	One Anastomosis Gastric Bypass	107	None reported
21	F	67	15	Roux-en-Y Gastric Bypass	121	Back and hip pain, mobility, constant and chronic pain, bladder issues
22	M	61	14	One Anastomosis Gastric Bypass	140	T2D, arthritis, high blood pressure.
23	F	61	15	Laparoscopic banding to Roux-en-Y Gastric Bypass	110	Obstructive Sleep Apnoea Hypertension Gastric Reflux Osteoarthritis Chronic Pain Breast Cancer
24	F	72	7	Roux-en-Y Gastric Bypass	110	T2D
25	F	27	6	Sleeve Gastrectomy	144	None reported
26	F	30	7	Roux-en-Y Gastric Bypass	136	Plantar fasciitis, asthma, depression and anxiety

Participant (surveys)	Gender	Age	Time since surgery (months)	Type of procedure	Self-reported weight at time of surgery (kg)	Self-reported pre-surgical health conditions
27	M	61	5	Roux-en-Y Gastric Bypass	155	T2D
28	F	31	7	One Anastomosis Gastric Bypass	155	High blood pressure, T2D, Fibromyalgia

AQ2

Most participants were aware they were going to see a pharmacist as part of pre-surgical assessment. Patients attended the appointment alone or with someone else and spent between 10 and 30 min with the pharmacist. The participant-reported experiences of the pharmacist appointment are shown in Table 4.

Table 4

Pharmacist appointment

Participant (surveys)	Were you aware you would see a pharmacist as part of pre-surgical assessment?	Length of appointment (minutes)	How did you attend?	Most valuable points made by pharmacist	If you had a pharmacist appointment, would you have any questions about the medication you need to take for life after surgery?
1	Cannot remember	15	Alone	What medications I would need to take for life after surgery	I was not sure if I had any questions about the medication I need to take for life after surgery.
2	Yes	15	With partner	What I should be eating and what I should avoid	Yes

3	Cannot Remember	Unsure	With partner	What medication will stop or start and why. Also gave me information on two types of procedures and the effects of these on medications, as I was not sure which operation I would have until the time	Yes
4	Cannot Remember	20	With partner	New ways of taking my medications after surgery	Yes
5	Yes	10	Alone	hHelp with weight loss after surgery	Yes
6	Yes	30	With partner	Awareness of what medication I would need after surgery	I wa any med so tl ques does appl
7	Cannot Remember	10	Alone	No response	Yes
8	Yes	30	Alone	The importance of taking medication after surgery	Yes
9	Yes	10	Alone	Everything	Yes
10	Cannot Remember	15	Alone	Stopping metformin/postoperative medication	Yes
11	Yes	15	Alone	To stop taking Naproxen or use Ibuprofen gel so as to not aggravate my stomach. Finding out what other medications I would need.	Yes
12	Yes	30	Alone	No response	Yes
13	No	30	With someone else	Better understanding of my medication	Yes
14	No	20	With partner	Explanation of what the new medicines I had to take were for	Yes
15	Yes	10	alone	Explaining what would change after surgery	Yes

16	Yes	10	With someone else	That I have to take certain medications for life and some for just 6 months	I wa any med so tl ques does appl
17	Yes	15	Alone	Need for vitamins the lady also had a bottle with salt in and explained how much salt was in soluble pain killers also told me not take certain pills at same time, i.e. calcium and iron	Yes
18	Yes	20	With partner	I was given a list of what I would be taken and for how long all my questions were answered and she noted all information so I left feeling confident	Yes
19	Yes	30	Alone	How important meds and aftercare are	Yes
20	Yes	20–30	Alone	the reasons why some medications cannot be taken and why it was important to take others	I wa any med so tl ques does appl
21	Yes	30	With partner	Some medication would change from tablets to liquid form	Yes
22	Yes	30	With partner		Yes
23	Yes	30	Alone	The pharmacist gave me the important information I needed to know about post-surgery so I was aware of what to expect and how important it was to maintain the regime. She was also kind enough to answer the questions I had and arranged my medications for discharge which was very helpful.	Yes
24	Yes	10–15	Alone	importance of not missing medication	Yes

25	No	10	Alone	None it was very un-informative	No
26	No	10	Alone	The importance of taking lansoprazole to protect my new stomach, that I would only take ursodeoxycholic acid along with lansoprazole for 6 months which was a relief to hear, and that the only medication I would take for life would be a multivitamin and mineral supplement.	Yes
27	Yes	20	With partner	Helped me understand what I needed to take and at what time of the day	Yes
28	Yes	20	With someone else	How I was going to take medication, i.e. soluble and why I was taking them	Yes

The pre- and post-surgical changes to medications are outlined in Table 5, with the majority showing a reduction in medications. Although phase 1 identified a dichotomy between prescription medications and nutrient supplementation in the context of taking pills daily, the majority of respondents in phase 2 did not perceive vitamins and minerals as ‘medication’.

Table 5

Pre- and post-operative medications and medical equipment

Participant	Type of procedure	Self-reported pre-surgical medications	Self-reported post-surgical medications	Self-reported medication post-op
1	One Anastomosis Gastric Bypass	None	None	n/a
2	Roux-en-Y Gastric Bypass	Lansoprazole	Lansoprazole	No medication Added: Vitamins

Participant	Type of procedure	Self-reported pre-surgical medications	Self-reported post-surgical medications	Self-reported medication post-op
3	One Anastomosis Gastric Bypass	Metformin, Ventolin® Buscopan®	Buscopan® Lansoprazole, Ursodeoxycholic acid	No metformin Added: Lansoprazole, Ursodeoxycholic acid
4	Roux-en-Y Gastric Bypass	Amlodipine Oramorph® Paracetamol Sertraline Tapentadol Lansoprazole Methotrexate Folic acid	Same as before surgery	No change
5	Roux-en-Y Gastric Bypass	Tramadol	Tramadol	No change
6	Roux-en-Y Gastric Bypass	None	Lansoprazole Ursodeoxycholic acid	Added: Lansoprazole, Ursodeoxycholic acid
7	Roux-en-Y Gastric Bypass	Amlodipine Doxazosin Omeprazole Allopurinol	None	All medications
8	Roux-en-Y Gastric Bypass	None	Lansoprazole Ursodeoxycholic acid	Added: Lansoprazole, Ursodeoxycholic acid
9	Roux-en-Y Gastric Bypass	None	Lansoprazole	Added: Lansoprazole
10	Roux-en-Y Gastric Bypass	Metformin Vit D Statin	Metformin Vitamin D,	- 1 (statin)
11	Roux-en-Y Gastric Bypass	Omeprazole Naproxen Amitriptyline Levothyroxine Sertraline, Atorvastatin Pregabalin Paracetamol, Tramadol Fultium® D3	Omeprazole Amitriptyline Levothyroxine Sertraline Atorvastatin Pregabalin Paracetamol Tramadol Adcal® D3	- 1 (Naproxen)

Participant	Type of procedure	Self-reported pre-surgical medications	Self-reported post-surgical medications	Self-reported medication post-op
12	One Anastomosis Gastric Bypass	Gabapentin Amitriptyline Nefopam Sertraline	Same as before	No change
13	One Anastomosis Gastric Bypass	None	Multivitamin	n/a
14	Sleeve Gastrectomy	Lisinopril Vitamin D Amlodipine Atorvastatin Liraglutide Metformin	Colecalciferol Lisinopril, Amlodipine Atorvastatin	- 3 Added: Lansoprazole (only) Ursodeoxy (6 months)
15	One Anastomosis Gastric Bypass	Sulfasalazine, Hydroxychloroquine Tramadol Methotrexate Folic Acid, Amitriptyline, Rituximab infusion (6 monthly)	Methotrexate, Hydroxychloroquine, Amitriptyline Tramadol (but not as many)	- 3 and rec Tramadol
16	Roux-en-Y Gastric Bypass	None	<i>'Just the ones that are necessary for post op patients'</i>	None Added: (Assumed Lansoprazole Ursodeoxy)
17	Roux-en-Y Gastric Bypass	Atorvastatin Digoxin Codeine Phosphate Tramadol Paracetamol	Lansoprazole Bisoprolol (2.5 mg am and 1.5 mg pm) Atorvastatin	- 4 Added: Lansoprazole
18	Roux-en-Y Gastric Bypass	Metformin	<i>'Only ones prescribed from operation'</i>	No metformin Added: (Assumed Lansoprazole Ursodeoxy)
19	Roux-en-Y Gastric Bypass	None	Acarbose	+ 1
20	One Anastomosis Gastric Bypass	None	Lansoprazole (6 months)	Added: Lansoprazole (6 months)

Participant	Type of procedure	Self-reported pre-surgical medications	Self-reported post-surgical medications	Self-reported medication post-operation
21	Roux-en-Y Gastric Bypass	Amitriptyline Bendroflumethiazide Felodipine Paracetamol Loratadine Carbomer Estriol Uriplan® Carbamazepine Pregabalin Zomorph® Lansoprazole	Medications have stayed the same, but doses have been reduced with some (not stated)	
22	One Anastomosis Gastric Bypass	Simvastatin, Doxazosin, Paracetamol Losartan Losec®	None	- 5
23	Laparoscopic banding to Roux-en-Y Gastric Bypass	Omeprazole Tramadol Paracetamol Fluoxetine Metoprolol	Omeprazole Loperamide Paracetamol Tramadol	- 1
24	Roux-en-Y Gastric Bypass	Diabetes medication × 3 (not stated) Amitriptyline Cetirizine Pantoprazole Statin	Amitriptyline, Cetirizine Spironolactone	- 4
25	Sleeve Gastrectomy	Omeprazole	Omeprazole	0
26	Roux-en-Y Gastric Bypass	Citalopram, Ventolin® inhaler	Citalopram Ursodeoxycholic acid Lansoprazole	- 1 Added: Ursodeoxy Lansoprazole
27	Roux-en-Y Gastric Bypass	Metformin	No response	No response
28	One Anastomosis Gastric Bypass	Metformin Pregabalin Lisinopril	Pregabalin Metformin Lansoprazole	Same Added: Lansoprazole

The final phase of the survey asked participants to reflect on the role of the pharmacist (see Table 6). Over three quarters felt that the pharmacist input was valuable or extremely valuable, with high levels of confidence in taking medication post-surgically. Over half ($n = 16$) stated the service could be improved with additional appointments with the pharmacist after surgery.

Table 6

Post-surgical reflections on the role of the pharmacist (phase 2)

Participant	If you were on any medication, how did you feel about taking your medication when after surgery?	Overall, how did you use the information you learned from the pharmacist after surgery	Should there be a follow-up appointment with the pharmacist after surgery?	If you said yes, when would be the best time(s) up to 24 months after surgery?	Value of pharmacist involvement in your assessment
1	Confident	No response	Yes	6 months	Extremely valuable
2	Very confident	Amended my diet	Yes	6/12/24 months	Valuable
3	Confident	Helped to understand what to expect and what to do	No	Not needed	Extremely valuable
4	Confident	Helped me to understand what effect the medications would have on me	Yes	3 months	Valuable
5	Confident	No response	Yes	6 months	Valuable
6	Very confident	Implemented advice into my routine, bought a pill organiser which has really helped me to keep on top of what medication I need to take	Yes	6 months	Extremely valuable

Participant	If you were on any medication, how did you feel about taking your medication when after surgery?	Overall, how did you use the information you learned from the pharmacist after surgery	Should there be a follow-up appointment with the pharmacist after surgery?	If you said yes, when would be the best time(s) up to 24 months after surgery?	Value
7	Very confident	No response	No	Not needed	Fair value
8	Very confident	Helped me to take my medication	Do not know	12/24 months	Extra value
9	Very confident	Overall the information was helpful	Do not know	3/6 months	Extra value
10	Unsure	I was more aware of what was needed after surgery	No	Not needed	Extra value
11	Confident	I made sure my General Practitioner altered my medication	Do not know	Not needed	Extra value
12	Very confident	No response	Yes	6 months	Value
13	Very confident	Helped me to understand about the vitamins	N	6/18/24 months	Value
14	Very confident	I was more aware of what I needed the medication and vitamins for	N	12 months	Extra value
15	Very confident	I was more prepared for what would happen after surgery	N	Not needed	Value
16	Very confident	I took it all in but found it all a little confusing	Y	Not needed	Fair value

Participant	If you were on any medication, how did you feel about taking your medication when after surgery?	Overall, how did you use the information you learned from the pharmacist after surgery	Should there be a follow-up appointment with the pharmacist after surgery?	If you said yes, when would be the best time(s) up to 24 months after surgery?	Value
17	Fairly confident	I do as I am told, but I am still having severe constipation, if I miss the iron tablets it is easier	N	Not needed	Extr valu
18	Very confident	Helped me to organise my tablets so I have certain ones accessible at home for the morning, some at work and some in my bag so I am always covered	Y	6/18/24 months	Extr valu
19	No response	Put advice into practice	N	Not needed	Fair valu
20	Very confident	To accurately take my medication	N	6 months	Extr valu
21	Very confident	I have the list of medications to hand when I take my tablets	y	3/6/12/18 months	Extr valu
22	Very confident	No response	Y	3/12 months	Extr valu
23	Confident	I followed the advice on the sheet and made sure I took the medications as prescribed	Y	3/6/9/12/18 months	Extr valu

Participant	If you were on any medication, how did you feel about taking your medication when after surgery?	Overall, how did you use the information you learned from the pharmacist after surgery	Should there be a follow-up appointment with the pharmacist after surgery?	If you said yes, when would be the best time(s) up to 24 months after surgery?	Value
24	Fairly confident	I knew what to take but was unsure of the length to take some medications	Y	3/12/24 months	Value
25	Fairly confident	Did not really get any information to use	Y	6/9/12/18/24 months	Not Value
26	Very confident	I used it to prepare myself for the changes to come and bought an am/pm pill sorter to ensure I stuck to my prescription post-op	Y	6/12/24 months	Extra value
27	Very confident	I knew what vitamins to buy and when to take my medication	Y	6/12 months	Extra value
28	Fairly confident	I booked an appointment with my General Practitioner to discuss everything after the pharmacist appointment	Y	6 months	Fair value

Participants were asked how the pharmacist service could be developed further with in vivo quotes suggested as recommendations:

‘I recommend that all patients are told to buy a pill organiser before surgery’

‘Having a pharmacist available for patients who are discharged on a weekend’

‘A more detailed leaflet which describes all the vitamins and what to take and when’

‘It was all explained very well to me, but listening to the other patients on the ward after surgery I feel that some people just don’t listen carefully to the pharmacist, who explained everything to me without being patronising’

‘It would be great to have an on-line Question and Answer session so that if your General Practitioner leaves you hanging, as mine did, you can get answers to your questions without needing a hospital appointment’

‘More information on being aware of how hard it is to take tablets after surgery’

‘I firmly believe that the pharmacists’ involvement in bariatric surgery is crucial. Patients such as myself need a lot of support pre- and post-operatively, and the information regarding medication and how/when to take them and why they are being taken is important to keeping us patients healthy and consistent in our progress’

Discussion

Many participants felt they had become experts in their medicines management and acted as an intermediary between the bariatric unit and the primary care team responsible for their long-term care and follow-up, reporting that general practitioners were often not aware of the need to both alter medication regimes, or the necessity of lifelong vitamin supplementation.

The act of taking pills was important for participants. For those on multiple medications for comorbidities, a reduction in the number of pills taken each day signified a positive improvement in their post-surgical lives. However, the need for additional pills in the form of vitamins and temporary (6 month) medications added a layer of complexity to the adjustment after surgery in terms of

expectations. Participants felt that although medications were ‘bad’ and vitamins were ‘good’ in terms of complying with post-surgical advice and being healthy, the act of taking pills itself was difficult. Additionally, there were reported side effects of vitamins and supplements (e.g. constipation with ferrous fumarate), and timing of vitamins to avoid interactions with medications was difficult to deal with and affected compliance. For some participants, it was difficult to separate pills in terms of medication and vitamins, for others, the dichotomy between good (vitamins) and bad (medications), despite the number of tablets taken increased after surgery, was not as much of an issue and was accepted as part of the post-surgical lifestyle. It was noted in Table 5 that there were inconsistencies in the patient-reported medicines after surgery, in that some patients did not mention the post-operative medications, or did not mention vitamins.

The discussion with the pharmacist was also thought to be an important step in self-care and empowerment following surgery. Patients reported downloading medication reminder apps on their mobile phones, carrying their medication list with them, and having pills in certain locations (home, work, handbags) to be accessible during the day and improve compliance.

Participants also reported using the information gained from the pharmacist to initiate discussions with others involved in their care, notably their general practitioners. Some participants reported using the information sheet supplied by the pharmacist in pre-surgical assessment as a tool to initiate discussion with their GPs around what was needed after surgery.

Conclusions

Overall, the pharmacist role in the pre-surgical assessment was largely perceived by all participants as positive. The findings are limited to a small sample size of patients in one bariatric surgical unit in the UK and may not be generalizable to other bariatric surgical populations. Additionally, it is noted that it was more difficult to recruit participants to take part in the surveys. It is accepted that there is a high rate of patients who do not attend for follow-up appointments after surgery, so they may also not wish to take part in research; therefore, it cannot be excluded that the participants recruited for this study may not reflect the opinions of the total patient population within our service. Owing to the underpinning interpretivist framework which focuses on participants’ experiences using self-reported information, many participants were not able to give specific information about the doses they were on and often expressed changes colloquially, e.g. ‘two tablets instead of four’, making it difficult to provide statistically valid information; however, the aim of the study was to

understand the patient-reported impact of the role of the pharmacist and not provide a quantitative measurement of compliance.

The themes of self-care and patient empowerment can be framed under an overall concept of gaining control, which has been identified as important within the bariatric surgical population. Pre-surgically, many people feel out of control, and afterwards regain a sense of control over their lives [13, 14].

The pharmacist is a valued resource by patients as part of their pre-surgical assessment, but consideration should be given to further appointments post-surgically to address medication issues following weight loss and changes to health status, to reinforce the importance of life-long vitamin supplementation and management of potential side effects. Currently, the pharmacist role is limited to pre-surgical assessment, but there is potential for pharmacists to become more involved in the management of patients following surgery, particularly in the management of long-term chronic diseases [15]. Further research into the role of pharmacist as an integral part of the MDT in bariatric patient care is recommended, along with ascertaining education and training for this specialist role in practice.

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Compliance with Ethical Standards

Ethical Approval Ethical approvals were granted by the National Health Service, Hospital and University research ethics committees. Data were collected between April 2017 and January 2018.

AQ3

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Conflict of Interest Author 1 has received a research grant from Roche Diagnostics. Author 4 has received speaker honorariums from Ethicon, Gore,

Olympus and Medtronic, and is on the Editorial Board of Obesity Surgery. All other authors have no conflicts of interest to declare.

References

1. Welbourn R, Small PK, Finlay I, Sareela A, Somers S, Mahawar K. The UK National Bariatric Surgery Registry: Second Registry Report. Henley-On-Thames: Dendrite Clinical Systems Limited, 2014.
2. Mechanick J, Youdim A, Jones D, et al. Clinical practice guidelines for the perioperative nutritional, metabolic and nonsurgical support of the bariatric surgery patient: 2013 update. *Surg Obes Relat Dis*. 2013;9:159–91.
3. Miller AD, Smith KM. Medication and nutrient administration considerations after bariatric surgery. *Am J Health Syst Pharm*. 2006;63(19):1852–7. <https://doi.org/10.2146/ajhp060033> .
4. Seymour K, Callejas-Diaz L, Woodcock S. Bariatric surgery: prescribing issues. *Hosp Pharm* 2008;15.

AQ4

5. Graham Y, Hayes C, Small PK, et al. Patient experiences of adjusting to life in the first 2 years after bariatric surgery: a qualitative study. *Clinical Obesity*. 2017;7:323–35. <https://doi.org/10.1111/cob.12205> .

AQ5

6. Sogg S, Gorman M. Interpersonal changes and challenges after weight-loss surgery. *Primary Psychiatry*. 2008;15(8):61–6.
7. National Institute for Health and Care Excellence. Obesity: identification, Assessment and management.: Department of Health; 2014.
8. Gooberman-Hill R, Burston A, Clark E, et al. Involving patients in research: considering good practice. *Musculoskeletal Care*. 2013;11(4):187–90. <https://doi.org/10.1002/msc.1060> .

9. Best practice in public involvement [Internet]. Health Research Authority. 2018. Available from: <https://www.hra.nhs.uk/planning-and-improving-research/best-practice/best-practice-in-public-involvement/> .

AQ6

10. Charmaz K. Constructing grounded theory. London: Sage; 2006.

11. Walker D-M, editor. An introduction to health services research. London: Sage; 2014.
12. Bowling A. Research methods in health. Maidenhead: McGraw Hill; 2009.
13. Ogden J, Clementi C, Aylwin S. The impact of obesity surgery and the paradox of control: a qualitative study. *Psychol Health*. 2006;21(2):273–93.
14. Ogden J, Avenell S, Ellis G. Negotiating control: Patients' experiences of unsuccessful weight-loss surgery. *Psychol Health*. 2011;26(7):949–64.
15. Bland C, Quidley A. Love, et al. long term pharmacotherapy considerations in the bariatric surgical patient. *Am. J Health Syst Pharm*. 2016;73(16):1230–42.