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Exploring patient experiences of adjusting to life in the first two years after bariatric surgery

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Abstract

Bariatric surgery is becoming an increasingly common intervention for the management of adult obesity. Bariatric surgery is usually recommended after a person with obesity has unsuccessfully attempted to lose weight through other methods such as diet and exercise. Surgery offers rapid and sustained weight loss, improves obesity-related illnesses and makes significant changes to a person's appearance and eating habits. As a result, bariatric surgery has a significant impact on a person's life, especially everyday social situations, which require a period of adjustment. The aim of this thesis was to explore how people adjust their lives in the first two years following bariatric surgery.

Constructivist grounded theory was used to establish mutual reciprocity between participants and myself to illuminate their experiences, whilst acknowledging my position as researcher at all times. Symbolic interactionism allowed an in-depth exploration of the meanings and actions of the participants. Semi-structured interviews were conducted with participants who had undergone bariatric surgery at City Hospitals Sunderland NHS Foundation Trust within two years of the time of interview. Eighteen participants were interviewed between January 2014 and April 2015.

The findings showed that participants conceptualised the adjustment process as underpinned by risk. Many of these risks were centred on social situations and

encounters and participants' attitudes towards risk and the meaning of risk underpinned their subsequent actions. The risk attitudes were underpinned by the meanings and actions of how participants handled social interactions as a result of learning to live with new ways of eating, a changed physical appearance and social interactions. Three risk attitude profiles were constructed from the data: Risk Accepters, Risk Contenders and Risk Challengers.

The act of choosing whether to disclose having bariatric surgery was particularly meaningful to the participants and highlighted a theme of feeling judged by others, which many participants sought to avoid. The findings also showed that participants felt that the social aspects of life after bariatric surgery were not widely understood by the public and healthcare professionals. This theory is a co-construction between the participants and me.

As rates of bariatric surgery increase, understanding patients' experiences of adjusting to life after bariatric surgery will assist patients to prepare for post-surgical life and healthcare practitioners to further support patients during this time.

This thesis is dedicated to Dr Diana Mansour

and the memory of Dr Anne Szarewski

All this will not be finished in the first one hundred days.

Nor will it be finished in the first one thousand days; nor

in the life of this Administration; nor even perhaps in our

lifetime on this planet. But let us begin.

John Fitzgerald Kennedy

From his inaugural Presidential address, 1961

Table of Contents

List of figures

List of tables

List of abbreviations

List of outputs

List of figures

List of tables

List of abbreviations

AMA	American Medical Association
ASMBS	American Society for Metabolic and Bariatric Surgery
BMI	Body Mass Index
BOMSS	British Obesity and Metabolic Surgery Society
CCG	Clinical Commissioning Group
CGT	Constructivist Grounded Theory
CHSFT	City Hospitals Sunderland NHS Foundation Trust
FDA	Food and Drug Administration (USA)
GORD	Gastro-oesophageal reflux disease
MDT	Multi-disciplinary teams
NBSR	National Bariatric Surgery Registry
NCD	Non-communicable Diseases
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NHS	National Health Service
NICE	National Institute for Health and Care Excellence (UK)
NIH	National Institute for Health (USA)
WHO	World Health Organisation

List of outputs

The following work has been undertaken concurrently with the thesis, which has further built upon findings and discussions with patients. The patient experience and interpretation of bariatric surgery is central to this work.

Publications

Journal papers

1. Graham, Y., Mansour, D., Small, P.K., Hinshaw, K., Gatiss, S., Mahawar, K., McGarry, K., Wilkes, S. (2016). A survey of bariatric surgical and reproductive health professionals' knowledge and provision of contraception to reproductive-aged bariatric surgical patients. *Obesity Surgery,* doi10.1007/s11695-015-2037-4.

2. Mahawar, K., Kumar, P., Parmar, C., Graham, Y., Carr, W., Jennings, N., Schroeder, N., Balupuri, S., Small, P.K. (2016). Small bowel limb lengths and Roux-en-Y gastric bypass: a systematic review. *Obesity Surgery,* 26, (3),660-671.

3. Mahawar, K., Graham, Y., Carr, W., Jennings, N., Schroeder, N., Balupuri, S., Small, P.K. (2015). Revisional Roux-en-Y gastric bypass and sleeve gastrectomy: a systematic review of comparative outcomes with respective primary procedures. *Obesity Surgery,* DOI.1007/s11695-015-1670-2.
4. Mahawar, K., Parmar, C., Graham, Y**.,** Abouleid, A., Carr, W., Jennings, N., Schroeder, N., Small, P.K. (2015). Routine liver biopsy during bariatric surgery: an analysis of the evidence base, *Obesity Surgery.* 26 (1) pp.177-181.

5. Graham, Y., Wilkes, S., Mansour, D., Small, P.K. (2014) 'Contraceptive needs of bariatric patients' *Journal of Family Planning and Reproductive Healthcare,* 40 (4), pp.241-244.

Published conference abstracts

6. Graham, Y., Mansour, D., Wilkes, S., Mahawar, K., McGarry, K., Gatiss, S., Hinshaw, K., Small, P.K. (2016) Comparing knowledge and provision of contraceptive care by bariatric surgical and sexual and reproductive healthcare practitioners. *British Journal of Surgery,* 103 (S2), p.6.

7. Graham, Y., Jennings, N., Small, P.K., Allan, L., Mahawar, K., Balupuri, S., Carr, W., Sekhar, A., Ling, J. (2016) The development of a bariatric surgical, patient-led mobile app to identify bariatric-friendly eating places. *British Journal of Surgery,*103 (S2), p.7.

8. Graham,Y., Crosland,A., Ling,J., Wilkes,S., Hayes,C., Small,P.K. (2015) An exploration of patient experiences of adjustment after bariatric surgery: a PhD research study*. British Journal of Surgery,* 102 (S4). p. 6. ISSN 0007-1323.

9. Graham, Y., Mansour, D., Hinshaw, K., Wilkes, S., Mahawar, K., Gatiss, S., McGarry, K., Small, P.K. (2015) 'Comparing Knowledge and Provision of Contraceptive Care By Bariatric Surgical and Sexual and Reproductive Health Practitioners' *Surgery for Obesity and Related Diseases*, 11 (6), S131.

10. Graham, Y., Small, P.K., Hayes, C., Wilkes, S., Ling, J. (2015) Risk Interpretation: Patient reported adjustments in the first two years after bariatric surgery. *Surgery for Obesity and Related Diseases*, 11(6): S151-S152.

Funding report

11. Graham, Y**.,** (2014) 'An exploration of patient experiences of bariatric surgery' *Society, Biology and Human Affairs*, 78 (1-2), pp. 60-61.

Invited speaker invitations

2016 British Obesity and Metabolic Surgery Society 7th Annual Scientific Meeting *Media and technology: help for the patient and professional* Cardiff. January 27-29th.

2015 British Association of Sexual Health and HIV Northern Regional Meeting. *Contraception and bariatric surgery: an overview.* Newcastle upon Tyne. September 11th.

2015 British Obesity and Metabolic Surgery Society 6th Annual Scientific Meeting. *Contraception and bariatric surgery: emerging issues* Newcastle upon Tyne. January 22-23rd .

2014 National Institute for Health Research: North East and North Cumbria Health Services Research and Delivery Specialty Group Meeting. *Exploring patient experiences of bariatric surgery*, Durham. October 9th.

2014 North East Bariatric Service Annual Meeting, *Contraceptive Needs of Bariatric Patients*, Hexham, Northumberland, October 14th.

Oral conference presentations

2016 British Obesity and Metabolic Surgery Society 7th Annual Scientific Meeting. *The development of a bariatric surgical patient-led mobile app to identify bariatric-friendly eating places.* Cardiff, January 27th – 29th.

2016 British Obesity and Metabolic Surgery Society 7th Annual Scientific Meeting. *Comparing knowledge and provision of contraceptive care by bariatric surgical and sexual and reproductive health practitioners.* Cardiff, January 27-29th.

2015 International Federation for the Surgery of Obesity and Metabolic Disorders 20th World Congress. *Ascertaining knowledge of contraceptive practices within bariatric surgical teams*, Vienna, Austria, August 26th – 29th.

2015 International Federation for the Surgery of Obesity and Metabolic Disorders 20th World Congress. *UK sexual and reproductive health professionals' knowledge of bariatric surgical procedures and associated contraceptive practices.* Vienna, Austria, August 26th – 29th.

2015 British Obesity and Metabolic Surgery Society 6th Annual Scientific Meeting *An exploration of patient experience of adjustment to bariatric surgery.* Newcastle upon Tyne, January 22-23rd.

2015 British Obesity and Metabolic Surgery Society 6th Annual Scientific Meeting *Ascertaining bariatric practitioners' knowledge levels of contraception.* Newcastle upon Tyne, January 22-23rd.

Conference poster presentations

2016 Aird, I, Evbuomwan, I, Green, A., Ling, J., Small, P.K., Mahawar, K. Out, H.J., Graham, Y. *Management of obese women in UK assisted conception units: A survey of current practice,* British Fertility Society, Gateshead, England. January 7-8th.

2015 Smith, B, Christopher, C., Graham, Y., Parmar,C., Mahawar, K., Jennings, N., Schroeder, N., Carr, W., Small, P.K., Balupuri, S. *AST to ALT ratio in NAFLD is non-predictive: Need for liver biopsy.* International Federation for the Surgery of Obesity and Metabolic Disorders 20th World Congress, Vienna, Austria, August 26th-29th.

2015 Graham, Y., Mahawar, K., Jennings, N.,Schroeder, N, Carr, W., Small, P.K., Balupuri, S., *Bariatric surgeons' perception of non-alcoholic fatty liver disease (NAFLD).* International Federation for the Surgery of Obesity and Metabolic Disorders 20th World Congress, Vienna, Austria, August 26-29th.

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Chapter 1: Introduction

This thesis uses constructivist grounded theory to explore patient experiences of adjusting to life in the first two years after bariatric surgery. The constructed theory presented is a co-construction between participants and the researcher. This thesis offers a theoretical explanation of the participant-reported interpretation of risk as related to the social processes involved in adjusting to life after bariatric surgery, and how this is conceptualised in terms of participant-defined meanings and actions.

This introductory chapter presents the rationale for the research, followed by an explanation of the outline for the thesis.

1.1 Rationale for the thesis

The rationale for undertaking the research study was influenced by my previous career in the pharmaceutical industry. During this time, I worked closely with the National Health Service (NHS), collaborating with clinicians in a diverse range of settings and areas of medicine. Many of these situations involved contact with patients as I worked with patient support groups and I was able to gain insight into the lives of patients as they underwent medical treatment and

utilized NHS services. Through these interactions I conceptualized that there often appeared to be difficulties in understanding between practitioners and patients which appeared frustrating for both parties.

When I made a career change into academia, my subject discipline was in healthcare sciences and my previous experiences working in the pharmaceutical industry and alongside the NHS provided a rich source of inspiration and research questions. I began to undertake research into bariatric surgery, inspired by the experiences of people I knew who had suffered with obesity and related illnesses. Initially, I explored the areas of Type 2 diabetes and obesity, nutritional considerations following bariatric surgery and pre-surgical psychological evaluation processes. Through examining and reflecting on my prior work, I felt there appeared to be a lacuna in the knowledge of bariatric surgery from the patient perspective. This informed my decision to explore the phenomenon of adjusting to life after bariatric surgery through the perspective of those who had experienced it. This subsequently influenced the conceptual framework and interpretivist research paradigm. To provide context to the thesis, a chronological perspective of science, medicine and health, incorporating the role of the patient, is given at the outset.

1.1.1 Science, health and the role of patients

With respect to medicine and health, the scientific approach has not always

been the dominant paradigm. The background to the scientific paradigm is presented, concurrently weaving in the role of the patient throughout. In medieval Europe, human beings were thought to be spiritual beings, with mind and body as one (Mehta, 2011). Ideas about health were embedded in religious beliefs which were communicated through priests and 'to tamper with nature was seen as immoral, because nature existed as it did because it was 'God's will'' (Russell, 2013,p.7). Illness and disease were attributed to 'non-material forces such as personal collective wrongdoing' (Mehta, 2011,p.3). I will argue that this concept is still very much a force in societal discourses towards obesity today. Descartes' concepts are seminal in the context of health, as he conceptualised the body and mind as two separate, but related entities (Mehta, 2011).

> Descartes, through mind-body dualism, demythologised body and handed over its study to medicine. Thus, the way was paved for progress in medical science through the study of physiology and anatomy. At the same time, by isolating mind, mind and body dualism denied its significance in individuals' experience of health.

> (Mehta, 2011,p.3)

Descartes is credited for laying the foundations of the shift from religion to science in the perceptions of health, by arguing 'the body could be seen as a

part of the physical world and the mind as part of the spiritual world' (Russell, 2013,p.7), which would provide the foundations of what is now known as the biomedical model. The biomedical model, also known as biomedicine, focuses solely on the biological and physical aspects of disease, relying on medical professionals to define, diagnose and treat patients and the illness. The acceptance of biomedicine, with its positivist underpinnings, led to a collective belief that scientific knowledge, through disciplines such as chemistry and physics, the rise of universities medical training and laboratories was the only legitimate approach to health (Russell, 2013).

The tenets of biomedicine are based on four key assumptions of the human body. Aside from the mind/body dualism, the three other beliefs were: the body was conceptualised as a machine, composed of working parts that could be taken apart and analysed, and finally, the dismissing of emotion and illness/disease having a single cause (Mehta, 2011, Gabe et al., 2004). Similar to the religious approach, the biomedical model ignored or dismissed the perspective of the patient (Atkinson, 1988), with people:

> [v]iewed as biological organisms (materialism), to be understood by examining their constituent parts (reductionism) using the principles of anatomy, physiology, biochemistry and physics. Disease was seen as a deviation from the biological norms, caused by some identifiable physical or chemical event and intervention involved introduction of a corrective

physical or chemical agent

(Mehta, 2011,p.4).

The status of doctors was increased as influential members of society, holders of expert knowledge and self-regulating their profession and patients as responsible for recognizing signs and symptoms and deferring to doctors for expert advice and treatment (Gabe et al., 2004). The objectivist tenets of biomedicine especially the concept of the body as a 'mechanical metaphor' (Nettleton, 2006), comprising of parts as opposed to a whole, led to practices such as dissection, previously shunned for religious reasons (Mehta, 2011) and other procedures such as blood-letting and purging (Jutel and Dew, 2014,p.5). The support of science, in particular medical advancements, continued into the 20th century. The reduction in communicable diseases, coupled with the advent of technology, communication, etc., led to changes in disease patterns in the Western world (Shenton, 2004).

Currently, the four most common non-communicable diseases (NCDs) are cardiovascular (e.g. heart attacks and stroke) cancers (e.g. breast, bowel, lung), chronic respiratory diseases (e.g. asthma, chronic obstructive pulmonary disease) and diabetes (particularly Type 2), with adult obesity a risk factor for these (World Health Organization, 2013b). NCDs are not always attributable to a single cause, with the factors leading to the development of these illnesses complex and multifactorial (World Health Organization, 2014). Acknowledgment

and understanding of these factors is central to prevention and management strategies. Models like the Determinants of Health (See Figure 1.1) provide a framework through which these factors can be identified.

Figure 1.1 Determinants of health
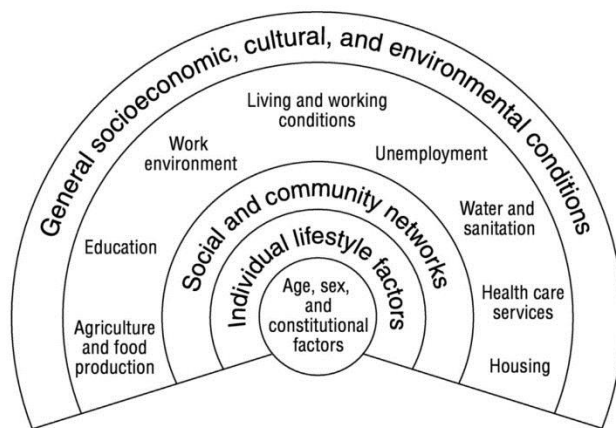
Source: Dahlgren and Whitehead (1991)

Therefore, I argue that the biomedical model, with its reductionist principle of illness having a single cause, fails to capture this complexity and cannot be used to understand the determinants of health.

An alternative perspective to the biomedical model was proposed by Engel (1977), who had believed that 'to understand and respond adequately to patients' suffering – and to give them a sense of being understood – clinicians must attend simultaneously to the biological, psychological and social

dimensions of illness' (Borrell-Carrió et al., 2004,p.576).

1.1.2 The biopsychosocial model

Engel defined a model as:

> Nothing more than a belief system utilised to explain natural phenomena, to make sense out of what it puzzling or disturbing. The more socially disruptive or individually upsetting the phenomenon, the more pressing the need of humans to devise explanatory systems. Such efforts at explanation constitute devices for social adaptation
>
> (Engel, 1977,p.130)

Engel had three main criticisms of the biomedical model; the dualistic nature of the model, the reductionist approach and the influence of the observer on the observed (Borrell-Carrió et al., 2004).

According to Engel, the biomedical model does not account for other factors which influence disease other than biological indices, however, 'the boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social and psychological

considerations' (Engel, 1977,p.132). By adopting a biopsychosocial approach, the scope for provision of treatments and patterns of care is broadened as this model encompasses 'the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of the illness' (Engel, 1977). By taking these factors into account, Engel proposed that it is possible to understand why 'some individuals experience as 'illness' conditions which others regard merely as 'problems of living', be they emotional reactions to life circumstances or somatic symptoms' (Engel, 1977,p.133).

His model expands medicine into social and psychological realms, which can provide context to internal and external factors influencing health and incorporate the perspectives of the patient. I argue this model is particularly helpful in understanding adult obesity which is far more complex than a reductionist calculation of energy intake versus energy expenditure, as presented in the Foresight Report (2007). Additionally, the biopsychosocial model supports acknowledgement of the presence of non-biological factors such as the individual reasons for, expectations of and adjusting to life after bariatric surgery as an intervention and how one adjusts to life afterwards as 'a possibility that the subjective experience of the patient was amenable to scientific study' (Borrell-Carrió et al., 2004,p.576). This implies that there are meanings to disease and illness, which are socially constructed by individuals as a result of their environment (Adler, 2009) and this is discussed next.

1.1.3 Social construction of illness

The interpretivist approach to this thesis reflects my personal belief that the concept of illness is based on social construction, with meanings and actions constructed from the society which is lived in, and interpreted through embedded cultural norms. Illness and medicine have evolved through the social constructions of religion and biomedicine and are continuously redefined as a result of the evolving and complex social world in which we currently exist in. What has remained consistent throughout history is the acquiescent role of the patient in the doctor-patient relationship. Traditionally, a patient is a passive recipient of healthcare, deferring to the expertise and knowledge of a clinician to diagnose and treat illness and affliction (Wade and Halligan, 2004).

As discussed previously, the interpretation of religious beliefs in medieval times were imposed on the patient, who was often perceived as culpable for his/her disease. I interpret this as an early form of stigma and/or judgement of the patient; these themes will recur throughout this thesis. Many constructions of health and illness are deeply rooted in social and cultural histories. The philosophical dualism proposed by Descartes meant that 'the field of medicine, by adhering rigidly to scientific method, mislaid its subject matter and gave up its moral responsibility toward the real health concerns of human beings' (Mehta, 2011,p.3) which again placed the patient in a passive position. Medicine in the 19th century relied on patients reporting symptoms to doctors,

which could then be investigated and treated, with the doctors' interpretation of illness superior to that of the patient.

Models of healthcare are evolving to encompass patients as partners in their treatments (National Institute for Health and Care Excellence, 2012), with patients and public questioning and challenging medical science and healthcare decisions. An early example of this was the thalidomide tragedy in the 1960s. At this time, the use of tranquilisers was popular and accepted practice and thalidomide was easily accessible as a result of being an over-the-counter remedy. As such, many people, including women who were pregnant, chose thalidomide for both its anti-emetic and relaxing properties. Thalidomide was considered safe for use in pregnancy although was never tested on pregnant women; this information was not made available to the general public. By the early 1960s, there were reports of nerve damage following long-term use and over 12,000 children were born world-wide with missing or malformed limbs attributed to thalidomide use (Russell, 2013).

Since this time, there was been an evolving social movement of challenging authority, particularly governments which regulate science and medicine, coupled with the shift from the idea of communicable, single-cause illness to a more complex perception of the construct of illness left the biomedical model open to criticism, a move to encompass patients wishing to be more involved in decisions about their healthcare (National Health Service, 2010).   The

'theoretical and empirical work on the philosophy and sociology of science has shown that the culture and values of those involved can influence research and the knowledge derived from it' (Entwistle et al., 1998,p.463).

As discussed previously, the views of patients towards constructs of health and illness may differ from those of the healthcare professional. Accounting for the views of the patients in terms of their perceptions of the meanings of health and illness may help to improve existing or develop new models of care. It is reported that:

> The NHS scores relatively poorly on being responsive to the patients it serves. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyle and aspirations. Too often, patients are expected to fit in around services, rather than services around patients.
>
> (National Health Service, 2010,p.8).

To address these concerns, the UK government instilled the concept of shared decision-making between patients and clinicians as a norm for the NHS, with the ethos of 'no decision about me, without me' (National Health Service, 2010). One of the proposed ways to achieve this was by collecting information generated from patients. The voices of the patients in clinical decisions and

care is now becoming a mainstream approach to healthcare and provision of services, with medical institutions such as the British Medical Association (BMA) mandating patient involvement in their activities, stating 'partnering with patients, their families, carers, advocacy groups, and the public as an ethical imperative, which is essential to improving the quality, safety, cost effectiveness, and sustainability of healthcare' (British Medical Journal, 2014).

Patient perspectives can be measured by different methods, depending on what is to be researched. Current discourse shows the term 'patient experience', which has a broad definition, appears to have no general consensus and is limited to clinical encounters (Wolf, 2014). For example, one definition of patient experience is 'the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care' (The Beryl Institute, 2015). It has also been noted that patient experience is also used interchangeably with the term 'patient satisfaction' (Coulter, 2005). In order to avoid confusion with regards to the aim of this thesis, I offer my own definition of patient experience.

In the context of this thesis, the term patient experience refers to the participant-reported adjustments to life after bariatric surgery. This thesis does not aim to explore patient satisfaction with their experiences of care, nor ask them to reflect on their experiences of care during bariatric surgery. This thesis focuses on the social contexts of adjusting to a body altered by bariatric surgery, which

exist outside routine clinical care, as reported by the participants. These aspects are important for several reasons. From a patient perspective, this thesis aims to provide an awareness of what life may be like after bariatric surgery which may assist them in decisions about their choice of weight-loss intervention. For patients who have undergone surgery, the information may be a source of support in terms of learning from other patients' experiences. For clinicians, having an awareness and knowledge of the non-clinical aspects of bariatric surgery from the patient perspective may assist them to provide a greater understanding of what their patients experience in terms of social adjustments to their lives following surgery.

1.2 The structure of the thesis

This thesis is divided into seven chapters. Following this introductory chapter, Chapter 2 provides background information on adult obesity and bariatric surgery. The initial literature review is presented in Chapter 3, along with a discussion of the place of a literature review in a grounded theory study. Chapter 4 presents the conceptual framework of the study, focusing on the philosophical and methodological underpinnings. Preparation for data collection, including ethical considerations and patient involvement are examined in Chapter 5. Chapter 6 focuses on the findings of the study, including the data collection and analysis procedures. The findings are discussed in Chapter 7 and

situated within a secondary literature review, followed by the implications for practice. The thesis concludes with a critical reflection and evaluation of the research process.

Chapter 2: Background

2.1 Introduction

In order to understand patient experiences of adjusting to life after bariatric surgery it is important to know about adult obesity, which is the condition that leads to the decision to seek bariatric surgery.   This chapter provides information on adult obesity in the UK, exploring the complexity of the condition, in particular examining the social framing of adult obesity, using Jutel's model of the Social Understanding of Illness and Diagnosis to construct a framework in which to situate bariatric surgery as an intervention (Jutel, 2011). A chronology of bariatric surgery for treatment of obesity and related illnesses is given, along with an explanation of the procedures performed in the UK. A discussion of the current policy and provision of bariatric surgery in the UK followed by a critical examination of the emerging and the patient perspective in healthcare concludes the second chapter.

2.2 Background to adult obesity in the UK

From a traditional perspective, weight gain is caused by consuming excess calories which are not burned off through physical expenditure, leading to an

accumulation of fat (Hill et al., 2003). This is offered as an 'energy balance' calculation and while true, on its own is too reductionist because it fails to capture the wider determinant factors underlying the calculation (Foresight, 2007). The human condition of adult obesity is a multifactorial phenomenon, described as a 'complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain" (Foresight, 2007,p.3).

Obesity is conceptualised in the Foresight Report (2007) as being underpinned by seven themes (See Figure 2.1) of biology, activity environment, physical activity, societal influences, individual psychology, food environment and food consumption.

Figure 2.1 Obesity systems map
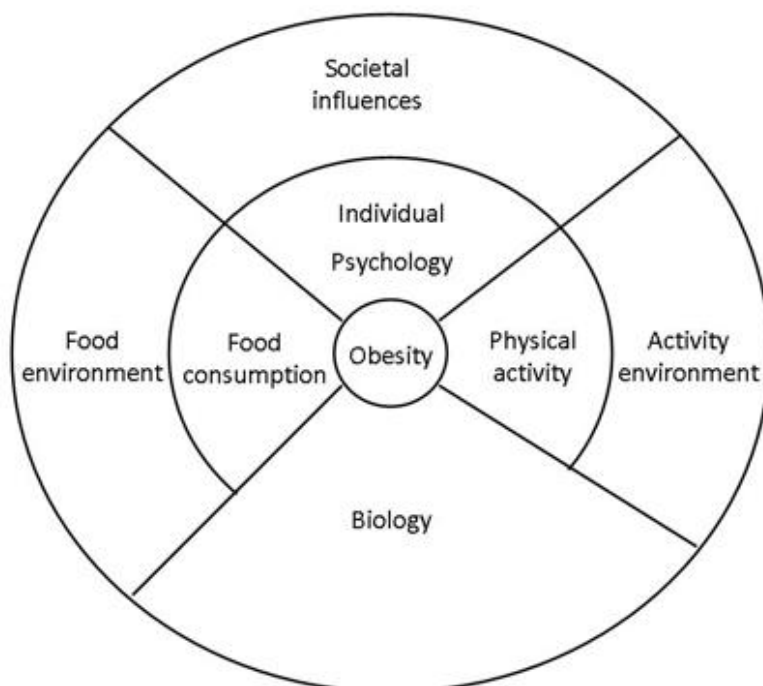
Source: Foresight systems map, 2007

The Systems Map extends the energy balance into a series of processes; understanding the complexity of these processes and their influence on individuals and populations are needed in order to develop a range of different solutions and interventions for adult obesity.

These themes are defined as:

Biology: the influence of genetics and ill health on an individual.

Activity environment: the influence of the environment on an individual's activity behaviour, for example, cycling to work may be influenced by road safety, air pollution, etc.

Physical activity: the type, frequency and intensity of activities an individual carries out.

Societal influences: the impact of society, e.g. influences such as media, education, peer pressure or culture.

Individual psychology: for example, individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences.

Food environment: influences on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of these items and an individual's ability to access these.

Food consumption: the quality, quantity and frequency of an individual's diet.

(Foresight, 2007)

Currently, obesity is argued to be one of the greatest threats to population health in the UK (National Obesity Forum, 2014) and globally (World Health Organization, 2013c). Additionally, obesity is a risk factor for the development of other diseases related to excess weight such as Type 2 diabetes, obstructive sleep apnoea, hypertension and non-alcoholic fatty liver disease (Fabbrini et al., 2010, Lavie et al., 2009, Must et al., 1999).

2.3 Economic impact of obesity

In 2007, the costs of both obesity and overweight to the UK economy was estimated at £15.8 billion, inclusive of £4.2 billion to the NHS (Public Health England, 2015). In order to provide a framework for prevention and treatment strategies for overweight and obese children and adults, the National Institute of Clinical Excellence (now the National Institute for Health and Care Excellence) issued guidelines in 2006, which were updated in 2014.

Recently, the perceptions of obesity have been challenged by the classification and recognition of obesity as a disease (American Medical Association, 2013). Disease may be defined as a 'complex intellectual construct, an amalgam of biological state and social definition' (Rosenberg, 1962,p.5) with the 'afflicted' perceived as either sufferers or perpetrators (Herek et al., 2003), with obese adults generally perceived as the latter and culpable for the condition. The social and cultural perceptions of the obese state are associated with personal and moral failure (Brewis, 2011, Brownell et al., 2010, Jutel, 2005), which in many cases lead to negative attitudes and stereotypes towards the afflicted. Labels such as lazy, lacking self-control, undisciplined and weak are ingrained within obesity discourses in Western society (Puhl and Heuer, 2009, Hofman, 2010). It is well evidenced that the obese encounter prejudice as a result of their weight (Hofman, 2010, Puhl and Brownell, 2001a, Schwartz et al., 2003). The rates of obesity-related discrimination increased by 66% between 2000 and 2010; these rates are comparable to those of racial discrimination in the United States (Puhl and Heuer, 2010).

Despite nearly 24% of adults in the UK being classified as obese (National Obesity Observatory, 2013) with the trajectory predicted to reach 50% of adult female and 60% of adult males by 2050 (Foresight, 2007), a larger body size is still perceived as deviant and subject to stigmatisation. There is a pervading parlance of obesity being a 'medical, financial and social problem, and this problem threatens individual, national and global well-being' (Throsby, 2007,p.1562). The framing of obesity as a danger to society has led to a

perception of obesity as an epidemic or pandemic in studies on the subject (Boero, 2007, Saguy and Almeling, 2008). An epidemic is defined as 'the occurrence in a community or region of a group of illnesses of similar nature, clearly in excess of normal or from a propagated source' (Gordis, 2014,p.23). The framing of an illness or condition as epidemic may conjure feelings of fear, panic and destruction; such terms are traditionally reserved for outbreaks of contagious diseases. The terminology for communicable diseases is consistently applied to the construction of obesity, framing it in terms of a spreadable contaminant that has propensity to affect the masses (Saguy and Almeling, 2008). The World Health Organisation (WHO) has identified four major non-communicable diseases (NCDs): cardiovascular, respiratory, diabetes and cancer, which accounted for 36 million out of 57 million global deaths in 2008 (World Health Organization, 2014). NCDs are predicted to overtake communicable diseases as a leading cause of death globally by 2030 (World Health Organization, 2013b). The WHO (2013c) states the main risk factors for NCDs are physical inactivity, unhealthy diet, excessive alcohol consumption and smoking; the first three are also risk factors associated with obesity, thereby reinforcing the epidemic discourse and risk perception of obesity.

The epidemic discourse is reinforced by health agencies and reports within the UK though messages of obesity threatening to bankrupt the NHS (NHS England, 2014a) with the cost of obesity to the UK estimated to be £44.7 billion in 2012 (Dobbs et al., 2014) These messages of obesity as an epidemic may

further perpetuate stigma and the perception of the obese as perpetrators and culpable for the ramifications of obesity. Despite the inferences of obesity as a personal culpability (Puhl and Heuer, 2010), UK population health is argued to be situated in an 'obesogenic environment', defined as the 'sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals and populations' (Swinburn and Egger, 2002), with many of these factors out of individual control. Factors contributing to an obesogenic environment include increasing sedentary lifestyles and decreased levels of physical activity (Brewis, 2011), developing unstructured eating habits and increased availability of takeaway and restaurant food (Lake and Townshend, 2006).

In the social construction of an affliction or disease, 'theories of origin, transmission, prevention and cure are formulated, propagated, criticized and revised' (Herek et al., 2003,p.533). The anthropological perspective adds further insight into the notion of the obesogenic environment. Adaptation, whether permanent or not, is defined by the changes in which an organism becomes more suited to its environment, which can be genetic, developmental or technological responses (Brewis, 2011). Mammals possess an ability to store energy as fat, which provides a source of energy when food sources are scarce (Wiley and Allen, 2009). In the modern, industrial Western world, food scarcity is not a problem, but the evolutionary change in diet, with the high proportion of mass-produced and processed food, high in saturated fat, salt and calories, low levels of micronutrients, fibre is (Brewis, 2011). The argument for obesity as an

adaptive process to an increasingly obesogenic environment is congruent with the framing of obesity as a complex phenomenon. All perspectives of obesity, whether biomedical, socio-cultural or anthropological share this view of obesity. What is not known at this stage, nearly three years after the American Medical Association classification of obesity as a disease (American Medical Association, 2013), is whether this classification will impact upon the current societal discourses and change or challenge the current perceptions of obesity, which are not positive.

To further consider the social framing of adult obesity and its management through bariatric surgery, the concepts of the sociology of diagnosis are discussed to provide a deeper, conceptual understanding of diagnosis as 'reflecting the power that putting a name to a condition generates and the fixed disease substance entity around which support and interest can rally and a range of agendas be met (Jutel, 2011,p.142). A diagnosis of obesity is a mandatory requirement for eligibility for bariatric surgery (National Institute for Clinical Excellence, 2006, National Institute for Health and Care Excellence, 2014).

2.4 The diagnosis of adult obesity

The act of diagnosis is 'an important site of contest and compromise. It is a

relational process, with each party (lay and professional) confronting illness with different explanations, understandings, values and beliefs' (Jutel, 2011,p.5). Once the diagnosis is made, the condition or illness is recognized and the condition and the pathways to management, treatment or interventions available to the person through the practitioner. For the adult with obesity, the diagnosis is central to treatments such as bariatric surgery.

Using the model as developed by Jutel (2011), the social understanding of diagnosis can be divided into two categories: social framing and social consequences (see Figure 2.2) each with four quadrants. I will discuss these using adult obesity as the example.

Figure 2.2 The social understanding of illness and diagnosis
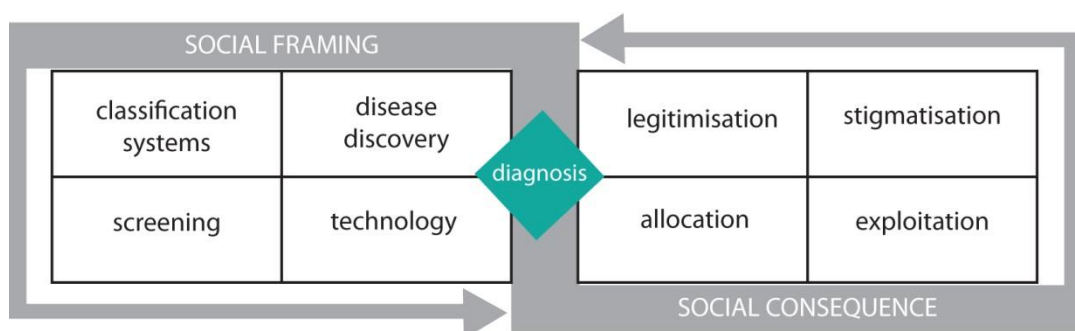
Source: Dr A. Jutel (personal communication), adapted from Jutel, 2011

2.4.1 Classification

The social framing of adult obesity commences with the classification systems used in diagnosis. Differentiation of weight categories and diagnosis of adult obesity is governed by a determinant of weight classification, calculated by Body Mass Index (BMI).

2.4.1.1   Body Mass Index (BMI)

An individual's BMI is calculated by the weight in kilograms divided by the square of the height in metres (kg/m^2). (World Health Organization, 2013a), based on the calculation developed by Quetelet in 1832 (Eknoyan, 2008). BMI is a commonly used method of weight classification (World Health Organization, 2013a). A classification of obesity, as determined through BMI (see Table 2.1) is one of the eligibility criteria for bariatric surgery (National Institute for Clinical Excellence, 2006, National Institute for Health and Care Excellence, 2014).

Table 2.1 Body mass index (BMI) classification

BMI Classification	Calculation of kg/m^2
Normal	18.50 – 24.99
Overweight	≥ 25.00

Pre-obese	25.00 – 29.99
Obese	≥ 30.00
Obese Class I	30.00 – 34.99
Obese Class II	35.00 – 39.99
Obese Class III	≥ 40.00

Source: World Health Organisation, 2013

BMI gives a diagnosis of obesity. A diagnosis of any condition defines and legitimises disease concepts for society (Rosenberg, 2002).

2.4.1.2   Impact of weight classification

The increase in mortality and morbidity increases with weight; thus a diagnosis of Obese Class II is deemed to be more of a health risk than Class I. Each BMI classification has associated descriptors, with inherent risk inferences. The classification of obesity commences with a BMI (kg/m^2) reading of ≥ 30 after which the patient may enter a range of interventions for obesity management. A normal body weight generally does not carry any association of risk and is societally perceived as healthy and acceptable (Carr and Friedman, 2005).

The UK National Institute for Health and Care Excellence (NICE) guidelines

focus on 'the prevention, identification, assessment and management of overweight and obesity' (National Institute for Clinical Excellence, 2006). The definition of diagnosis as 'an indispensable point of articulation between the general and particular, between agreed knowledge and its application' based on weight classification means that interventions can take place, such as bariatric surgery. Although overweight and obesity are often spoken about as the same entity, it is important to differentiate between the classifications of overweight and obesity as the 'semantic and diagnostic differences have important consequences for medical practice and social attitudes towards the body' (Jutel, 2005,p.122). Diagnosis and classification of weight status are 'central to the analysis and presentation of risk estimates' (Nicholls, 2013,p.9) and may further contribute towards the perception of obesity as an epidemic or pandemic (Byles, 2009, Swinburn et al., 2011).

A classification of overweight implies an increased risk of becoming obese unless action is taken, but the idea of overweight is more societally accepted than being obese (Jutel, 2006). This may be challenged by the emerging discourses surrounding the framing of those with perceived risk factors for a health condition as being in a pre-disease state, such as the WHO labelling of a BMI (kg/m^2) being referred to as pre-obese (see Table 2.1) and therefore possibly subject to increased opportunities for stigma, given the word obese replaces overweight. For example, having risk factors for diabetes may label a patient as pre-diabetic; regardless of whether he/she goes on to develop symptoms or the disease itself (Magalhães et al., 2010). With weight

classification of adults, being overweight may be challenged or interpreted differently as a result of being labelled as pre-obese, which may increase opportunities for stigmatisation. However, as an emerging discourse, the social ramifications of this are not yet known and require examination.

2.4.2 Disease discovery

The framing of obesity as a disease was only been 'officially' recognised by the medical profession in 2013, following the published statement by the American Medical Association (AMA) (American Medical Association, 2013). Previously, adult obesity was conceptualised and regarded as a condition, state, affliction, and possibly an illness. It is important from an interpretivist perspective to distinguish between illness and disease in the context of diagnosis in terms of trying to understand the reframing of obesity as disease. Broadly speaking, illness is a subjective entity where problems:

> [r]esult from undesirable changes in social or personal function. How an individual perceives these problems, explains or labels them, and seeks remedy originates from a cultural context. This in turn influences the decision to access, or response to, medical services.

> (Jutel, 2011,p.64)

By contrast, disease is framed by notions of biological or psychological dysfunction, which although not lacking in socio-cultural perspective, is a conceptual entity (Jutel, 2011). Disease is comprised of what are referred to as 'categories of clinical taxonomy…extrapolated from an aggregate of similar illnesses on the basis of what is thought to be common to the illnesses so classified' (Fleischman, 1999). The semantic differences between weight classifications of normal, overweight and obese are important for contextualising bariatric surgery as an intervention for adult obesity. Obesity generally carries higher health risks to an individual than an overweight or normal health status. The perceived biological or psychological associations of the label of obesity as a disease, and its effects on the perception of obesity by the lay public is the subject of debate (Beal, 2013).

It has been suggested that a disease label, with acknowledged symptoms, may contribute towards a different socio-cultural understanding through a perceived legitimisation of adult obesity but there is no evidence to support this at present. By giving obesity a disease label, advocates state this will contribute towards lessening the stigma of obesity, the culpability of the individual and encourage patients and practitioners to discuss weight issues (Allison et al., 2008, Puhl and Liu, 2015). Additionally, in countries with insurance funded health systems, such as the USA, recognition of obesity as a disease is proposed to lead to increased coverage of all weight interventions. There were no specific studies examining the arguments against the disease classification identified, but Puhl

and Liu (2015, p.1) state 'it will lead to an overreliance on medications and surgery to treat obesity, shift focus away from important environmental factors that contribute to obesity and increased stigma towards those who have obesity and that is it simply a response to recently approved Food and Drug Administration (FDA) medications for weight'. The same authors aimed to examine public opinions on the disease classification by undertaking a survey of 1118 American adults examined their opinions of statements for and against the label (Puhl and Liu, 2015). There was more public support for the disease classification and attitudes towards the disease label were unaffected by demographic factors, although participants who claimed to be overweight and not obese were more likely to oppose the disease label. The study findings were limited by self-reported height and weight measurements and to those with computer access. The sample was proposed to be similar to that of the US Census Data, but may not be reflective of other Western populations which may have different rates of overweight and obesity. The disease label for obesity and how this affects diagnosis, treatments and societal perceptions requires further research to more fully assess and understand the impact.

There is an argument to suggest that obesity is a risk factor for other diseases and that risk factors are not diseases. Stoner and Cornwall (2014) argue if the same classification was applied to other risk factors, then cigarette smoking should also be labelled a disease. The same authors also postulate the disease labelling may encourage a shift from personal responsibility for weight management resulting in negative health behaviours.

2.4.3 Screening

There is no formal screening programme for adult obesity in the UK (National Institute for Health and Care Excellence, 2014). Weight may be measured in routine clinical appointments such as with a General Practitioner or Practice Nurse. There are generic screening programmes for risk factors for health, such as the NHS Health Check programme, which aims to assess the risk of cardiovascular health in men and women aged 40-74, identified through Primary Care registers in the UK (National Health Service, 2014). Individual Primary Care practices may run specific clinics for the diseases and conditions associated with obesity, such as hypertension, diabetes and asthma, where weight management may be raised through raising the issue as a medical problem or a risk factor for other illnesses (Scott et al., 2004), although this can be difficult for healthcare professionals for fear of upsetting or embarrassing the patient (Briscoe and Berry, 2009). Raising the issue of obesity as a medical issue has been suggested as a way to increase the frequency of opportunities to counsel patients when they present in Primary Care (Scott et al., 2004). This suggestion is congruent with the AMA's decision to classify obesity as a disease (American Medical Association, 2013).

2.4.4 Technology

The technology required to diagnose adult obesity does not involve

sophisticated tools which may be needed to diagnose other diseases; a simple set of scales and a BMI chart serve as diagnostic tools. Following the confirmation of the obese status through BMI measurement, the confirmed diagnosis may mean an increased risk of other related conditions such as Type 2 diabetes and hypertension. Additional technological measures may be undertaken to assess these, but in the context of adult obesity, technology is more apparent in the management of weight, for example, mobile applications to manage levels of physical activity, or calories consumed.

The four quadrants of classification, disease, screening and technology provide context for the social framing of adult obesity. Diagnosis is the conduit between social framing and social consequences, the latter which is discussed next. The four quadrants of the social consequences following diagnosis of adult obesity are legitimisation, stigmatisation, allocation and exploitation are considered in turn.

2.4.5 Legitimization

Legitimisation of adult obesity can be conceptualised through the perspectives of the patient and the practitioner. For the patient, the diagnosis of obesity can give meaning to the suffering a patient is experiencing and open up avenues for intervention and treatment (Jutel, 2011). For the practitioner, the diagnosis may legitimate eligibility criteria through which to seek access to treatments (Jutel,

2011). The framing of obesity as a disease (American Medical Association, 2013) may reduce the perceptions of negative characteristics associated with obesity and the notion of obesity as a personal culpability, all of which lead to stigmatisation which is discussed next.

2.4.6 Stigmatisation

Stigma is defined as 'the situation of an individual who is disqualified from full social acceptance' (Goffman, 1963,p.9). Disease stigma happens when groups are blamed for their illness by being perceived as immoral or lazy (Puhl and Heuer, 2010). The stigmatisation of obesity has long been ingrained in cultural discourses in the Western world and is a generally accepted form of societal prejudice (Puhl and Brownell, 2003) as the cultural notion of a thin body is constructed as social norm and valued (Helman, 1997, Gracia-Arnaiz, 2010). The stigmatisation of obesity results from negative attributes such as lazy, weak-willed, unintelligent, slovenly, out of control, unproductive, physically and sexually unattractive and personally culpable for their body size (Greenberg et al., 2003, Puhl and Heuer, 2009, Puhl and Heuer, 2010).

The impact of a diagnosis on the stigma of adult obesity is difficult to evaluate owing to obesity being a visible state prior to diagnosis and so the person may already be suffering from stigmatisation prior to diagnosis.

2.4.6.1 Stigma in healthcare settings

As diagnosis places the patient in the hands of the medical profession, the attitudes of clinicians towards obesity by clinicians should be explored. Obesity discrimination is known to exist in medical settings (Kaminsky and Gadaleta, 2002, Puhl and Heuer, 2009), and it has been shown that obese people feel misunderstood and have experienced negative attitudes from healthcare professionals (Foster et al., 2003, Puhl and Heuer, 2009), who have professed to have negative attitudes towards obese patients (Jay et al., 2009).

For areas of medicine which specialise in treating obese patients, the environment for the patient – practitioner encounters is generally tailored towards the needs of the obese. For example, bariatric surgical units are recommended to be equipped with large- sized equipment, for example, bigger chairs which can accommodate larger bodies, scales which are capable of providing higher weight readings, and larger-sized examination gowns (Rudd Centre for Food Policy and Obesity, n.d.). Provision of these larger-size items may lessen the chances for the obese to feel stigmatized. In other medical settings, this may not be the norm. The stigma of obesity extends beyond and is not limited to medicine, it also exists in employment, education, social and media settings (Schwartz et al., 2003, Puhl and Heuer, 2009, Rosenberger et al., 2007).

2.4.6.2 Stigma and employment settings

With employment, the obese may be subject to teasing, judgement from employers, be overlooked for promotion or not hired because of their size and the associated stereotypes (Puhl and Brownell, 2001a). It is difficult to assess the impact of stigma in educational settings, but attitudes of teachers, childhood educational experiences such as bullying and peer pressure have been suggested as factors which may affect educational experiences and attainment in adulthood (Puhl and Heuer, 2009).

2.4.6.3 Stigma and the media

The media is a powerful influence in shaping societal opinions on health and illness (King and Watson.K, 2005). The media 'is an important and influential source of information about obesity. The way that obesity, weight-loss and weight maintenance are portrayed, described, and framed by the media profoundly shapes the public's understanding and attitudes toward these important health issues and the individuals affected by them' (Rudd Centre for Food Policy and Obesity, n.d,2). The media tends to play to the acknowledged stereotypes of obese people, and fuels the perception of obesity as an epidemic (Boero, 2007) which in turn reinforces the negative social construction of obesity. As a powerful force in social communication, the role of the media in reinforcing stigmatising messages should not be underestimated.

The media may contribute to the exploitation of obese individuals by reinforcing cultural stereotypes and scare-mongering of obesity through television, newspapers, magazines and websites, which has been coined 'fattertainment' (Heuer, 2016). Television programmes in the UK and the USA broadcast programmes such as 'The Biggest Loser', with its double entendred title, chronicle obese people's weight loss struggles and are argued to exploit the obese (Babel, 2011). Movies such as 'Shallow Hal' and 'The Nutty Professor', where normal weight actors 'dress up in fat suits and engage in clichéd slapstick, (such as getting stuck in small spaces because of their girth) have earned millions of dollars at the box office by mocking the obese' (Heuer, 2016,p.1). Similar to stigmatisation, 'fattertainment' is accepted and rarely challenged (Heuer, 2016, Babel, 2011) and appears to be a lucrative industry.

Newspapers such as the Daily Mail have contributed to the scaremongering and dangers of obesity with lurid stories about obesity (Collis, 2012). In addition to reinforcing dangers of obesity, such stories often make insinuations of economic ramifications, horror and shock, an obese size being difficult to deal with and causing wider problems for those who have to deal with the obese. This reinforces the negative stereotypes and shows the deep-rooted apathy for obesity; the obese are not redeemed even in death.

Guidelines for the media have been produced (Rudd Centre for Food Policy and Obesity, n.d) in order to provide a framework for the portrayal of obesity across

a wide range of media source to reduce stigma, suggesting:

- − Respect diversity and avoid stereotypes

- − Appropriate language and terminology

- − Balanced and accurate coverage of obesity

- − Appropriate pictures and images of individuals affected by obesity, i.e. pictures which do not reinforce stereotypes or cause offence.

2.4.6.4 Stigma and quality of life

The impact of stigmatisation often leads to a poor quality of life for the obese who may suffer from social exclusion (Westermann et al., 2015), not only as a result of physical disabilities (Public Health England, 2016), but to avoid situations in which they may be subjected to stigmatisation (Puhl and Brownell, 2001b, Lewis et al., 2011). The obese are already likely to suffer from pre-existing mental and physical health problems. Incidence of depression may be 3 to 4 times higher in obese populations than those of normal weight (Greenberg et al., 2005). Compared with normal weight populations, there are reported higher rates of eating disorders, anxiety and affective disorders in

those with obesity (de Zwaan, 2007). Stigma may increase prevailing poor rates of mental health for obese people (Puhl and Heuer, 2010).

2.4.7 Allocation (of resources)

The diagnosis of adult obesity is central to the allocation of resources required to manage adult obesity. The biomedical management of adult obesity in the National Health Service (NHS) is under the auspices of a tiered system (see Figure 2.3).

Figure 2.3 **NHS obesity management tier system**
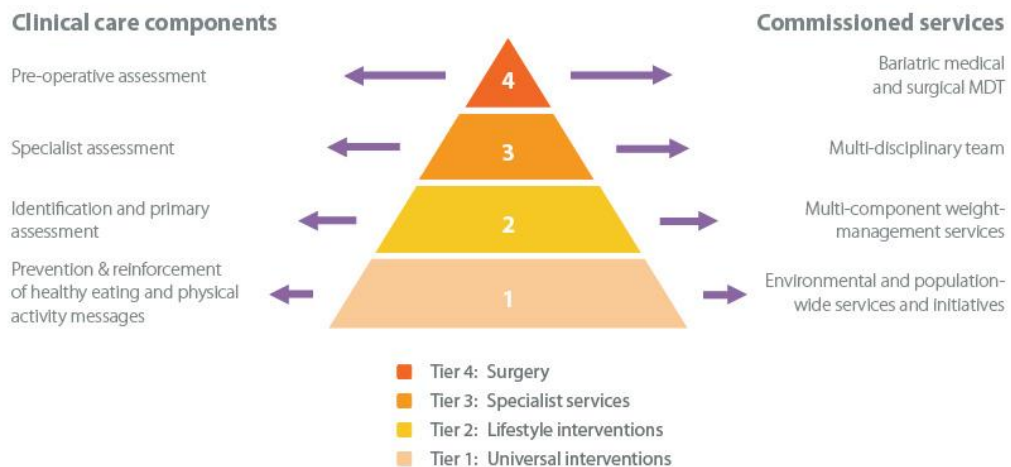
Source: Welbourn et al., 2014

Allocation of obesity interventions is dependent on a tier level. Tiers 1 and 2 are undertaken in community settings, Tier 3 is a combination of community and hospital settings, and Tier 4 in hospital settings. Patients can enter, exit and move between tiers. There is an acknowledged lack of consistency in the

provision of medical obesity services in the UK (Royal College of Surgeons, 2014).

2.4.7.1 UK Tier system of obesity management

Patients with overweight or obesity typically enter medical management at Tier 1 and progress through the Tiers, with bariatric surgery positioned at Tier 4. Tier 1 services are universal interventions, such as reinforcement of health-related messages such as healthy eating and undertaking physical activity (Royal College of Surgeons, 2014). These usually align with local and national public health campaigns and are commissioned by local authorities. Tier 2 offers diet, exercise and lifestyle interventions, usually in a Primary Care or other community settings. This can be through self- or other referral. Tier 2 services are commissioned by local authority in collaboration with the NHS and Clinical Commissioning Groups (CCGs) (NHS England, 2014b). Tier 3 are clinically-focused services led by multi-disciplinary teams (MDTs) such as consultants, general practitioners, nurses, dietitians, psychologists, psychiatrists and physiotherapists (NHS England, 2014b). Patients whose are obese are referred into Tier 3 services. Commissioning for Tier 3 is undertaken by CCGs. Patients referred into Tier 4 have usually not achieved significant weight loss offered in the other tiers, such as diet, exercise and pharmacotherapy. Tier 4 positions bariatric surgery as a last resort option, when other methods have not worked (National Institute for Health and Care Excellence, 2014). Following bariatric surgery, patients will be typically referred by their care providers back into Tier 3

for long term weight management. Presently, commissioning for bariatric surgery (Tier 4) comes from NHS England, but from April 2016, this responsibility will be undertaken by Clinical Commissioning Groups (Department of Health, 2015). The impact of this on provision of bariatric surgical services in England has yet to be determined and will be discussed in Chapter 7.

2.4.8 Exploitation (of obesity)

The final quadrant of the social consequences of the diagnosis of adult obesity is concerned with the exploitation of the disease. Exploitation may occur in commercial, political and personal domains (Jutel, 2011). The commercial sector stands to profit from the disease of obesity, as promotional messages can be constructed around the health risks of the obese state, in addition to promoting the idea of a normal body weight. The weight loss industry includes pharmaceutical companies and manufacturers of 'medical equipment, complementary and alternative therapies, nutritional supplements and food products equally have an interest in promoting particular disease states' (Jutel, 2011,p. 142-43) for financial gain, as opposed to curing illness. Other commercial concerns such as gyms and weight loss clubs contribute to the social framing of obesity and the need to manage it. The UK diet food industry was worth 1.8 billion in 2013 (Mintel, 2014). A diagnosis can also be exploited on a personal level. An individual may use the diagnosis as an opportunity to

avoid responsibilities such as work, and claim benefits to which they may have not been entitled to previously (Jutel, 2011). The discovery of such exploitations may reinforce the negative stereotypes of obesity such as laziness. Exploiting the disease of obesity may draw further attention to those who are obese, who may already be experiencing unwanted scrutiny. I argue that this exploitation may provide opportunities for further stigmatisation. For example, by attending slimming clubs, purchasing weight loss aids, or attending gyms are all visible activities which may opportune situations for obese people to be stigmatised.

In summary, the exploitation of a diagnosis alludes to the potential power that the naming of a condition has, which has a range of consequences for agencies who may benefit from this (Jutel, 2011).

2.4.9 Summary of adult obesity

The social constructions underpinning diagnosis of adult obesity are of interest in the context of weight management, as diagnosis offers 'social categories that organize, direct, explain and sometimes control our experience of health and illness' (Jutel, 2011,p.145). The diagnosis of adult obesity is central to pursuing bariatric surgery through the UK obesity tier system. The social framing of diagnosis in the context of adult obesity is argued to be central to understanding the wider contexts of bariatric surgery and providing a foundation on which to

position the patient experiences of the intervention.

2.5 Bariatric surgery as a treatment for adult obesity and related diseases

Typically, following diagnosis and subsequent progression through the obesity tiers and meeting eligibility criteria, patients may be offered bariatric surgery. The eligibility criteria are based on the NICE guidelines, which are referred to throughout the chapter. To contextualise bariatric surgery, a history of the discipline is presented, followed by an overview of policy and practice in the UK, the role of the patient in the process of bariatric surgery and the current picture of bariatric surgery in the UK. A critical examination of the patient perspective in healthcare follows and a summary concludes the chapter.

2.5.1   Overview of bariatric surgery

Bariatric surgery procedures exhibit their effects through malabsorption, restriction or a combination of both and are either permanent or reversible. Surgical procedures for weight loss were pioneered at The University of Minnesota in 1950s, where morbid obesity was thought to be a serious enough health condition to warrant surgical intervention (Pories, 2008). Surgical weight loss procedures commenced with the jejunoileal bypass. Weight loss was

achieved by bypassing the intestines, but leaving the stomach untouched (American Society for Metabolic and Bariatric Surgery, 2004). This caused a malabsorptive effect on the digestive system, and although patients lost weight, there were considerable side effects of the operation, such as renal failure, electrolyte imbalances, nutrient deficiencies and in many cases, death (Singh et al., 2009). Over 30,000 operations were performed until risks were proven to outweigh the benefits and were eventually reversed (Pories, 2008) and the jejunoileal bypass was eventually phased out (Mahawar, 2012).

The effect of malabsorption on weight loss continued to be researched, with procedures such as the duodenal switch, bilio-pancreatic diversion and gastric bypass evolving from the original surgical techniques (Moshiri et al., 2013). The duodenal switch and bilio-pancreatic diversion are technically challenging procedures with higher rates of mortality and morbidity (Mahawar, 2012) and are not generally performed in the UK.

Bariatric surgery has evolved from open, surgical techniques to laparoscopic procedures, with 95.4% of primary bariatric surgical procedures in the UK performed laparoscopically (Welbourn et al., 2014). Laparoscopic bariatric procedures have been proven to be beneficial in terms of reduced hospital stays and increased safety, but need to be balanced against the known risks of performing surgery on a morbidly obese person (Flum et al., 2009).

Vertical banded gastroplasty developed in the 1970s; this was the first restrictive procedure for the treatment of obesity (American Society for Metabolic and Bariatric Surgery, 2004). It is colloquially referred to as 'stomach stapling', as stomach size is reduced through the insertion of internal staples and a band. Complications and high levels of revisional surgery led vertical banded gastroplasty to be phased out and lay the foundation for the gastric band, which was first performed in 1990 by Kuzmak (Mahawar, 2012). There are three procedures commonly performed in the UK at present: the gastric bypass, sleeve gastrectomy and gastric band.

Table 2.2 shows the latest data from the second National Bariatric Surgery Registry on the rates of primary bariatric surgical procedures performed in the UK, defined as the first operation a patient undergoes, between 2011 and 2013.

Table 2.2 Rates of primary bariatric surgical procedures in the UK 2011-13

Type of procedure	No of procedures performed in UK	Percentage of all UK procedures
Gastric bypass	9,133	53.86%
Sleeve gastrectomy	3,631	21.41%
Gastric banding	3,633	21.42%
Other procedures	559	3.29%
Total procedures	16,956	

Source: Welbourn et al., 2014

Reflecting back on my interactions with the patients in the bariatric surgery patient support group and participant in this thesis and our discussions around the subject of adjusting to life after bariatric surgery, I recalled they had repeatedly discussed a lack of knowledge of bariatric surgery by others who had not undergone procedures themselves. I learned from the patients and participants that on repeated occasions, they needed to explain to others what the different bariatric surgical procedures were and how they worked when speaking to others about their experiences. When I undertook the literature review and engaged with the patients and participants, I found that having knowledge of the 3 main procedures and how they worked enabled me to gain a greater understanding of the participants' experiences. I was also told by many participants that my knowledge of the procedures was reassuring to them, and they often commented that they were pleased that they could focus on their experiences, without having to explain the mechanisms of bariatric surgery to me. As a result, I decided to include a section describing the 3 bariatric surgical procedures and how they work to provide background information which may help to give context to the participants' experiences of adjusting to surgery and not to supply detailed medical information.

2.5.1.1   Gastric bypass

Gastric bypass (See Figure 2.4), also referred to as the Roux-en-Y gastric

bypass is the most common procedure performed in the UK (Welbourn et al., 2014). It was first performed by Mason and Ito in the 1960s at the University of Iowa (Mahawar, 2012, American Society for Metabolic and Bariatric Surgery, 2004). It is classed as a malabsorptive procedure. A gastric bypass procedure involves 'the creation of a small pouch separate from the rest of the stomach. The small intestine is divided in the middle of the jejunum into two limbs. The lower limb is attached via an anastomosis to the gastric pouch and the upper limb is attached further down the jejunum, bypassing the stomach, duodenum and proximal jejunum. The stomach pouch is only able to hold a small amount of food (restrictive); malabsorption occurs as a result of bypassing the proximal small bowel' (Graham et al., 2014).

Figure 2.4 Diagram of a gastric bypass procedure
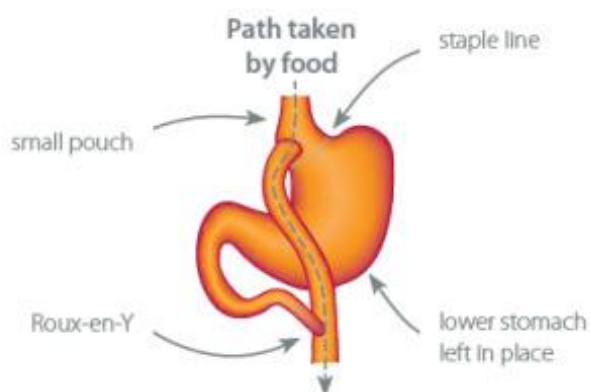
Fig. 2. Diagrammatic representation of a
Roux-en-Y gastric bypass procedure

Source: Welbourn et al., 2014

The malabsorptive effects of gastric bypass necessitate lifelong vitamin and mineral supplementation to prevent nutrient deficiencies (Malone, 2008, Mechanick et al., 2013). Variations on the technique include the mini-gastric bypass, developed by Rutledge in 1997, which has a single anastomosis (Mahawar, 2012). It is a particularly effective procedure for improving type 2 diabetes, with improvement rates of up to 75% (Mingrone et al., 2012). A common side effect of gastric bypass is 'dumping syndrome', which is characterised by light-headedness and sweating after eating food or drink high in sugar, fatty foods or dairy products (Fujioka, 2005). Dumping syndrome occurs in up to 85% of patients following gastric bypass and usually improves as patients learn which foods are tolerated (American Society for Metabolic and Bariatric Surgery, 2008). As the knowledge of the effects of malabsorption evolved and were refined in bariatric surgery, restrictive procedures were developed. The sleeve gastrectomy and gastric band are the two most common restrictive procedures performed in the UK (Welbourn et al., 2014).

2.5.1.2 Sleeve gastrectomy

Sleeve gastrectomy evolved from the duodenal switch procedure (Mahawar, 2012) and exhibits a restrictive effect through removal of 70% of the stomach, leaving a 'sleeve' shaped organ (See Figure 2.5). A sleeve gastrectomy can be converted to a gastric bypass for several reasons including the onset of reflux or

failure to lose weight (Langer et al., 2010). A sleeve gastrectomy is not recommended for patients with active reflux disease. The mechanisms of gastric sleeve are not fully understood, but is theoretically proposed to inhibit appetite through suppression of ghrelin, a hormone responsible for hunger (American Society for Metabolic and Bariatric Surgery, 2012).

Figure 2.5 Diagram of a sleeve gastrectomy procedure
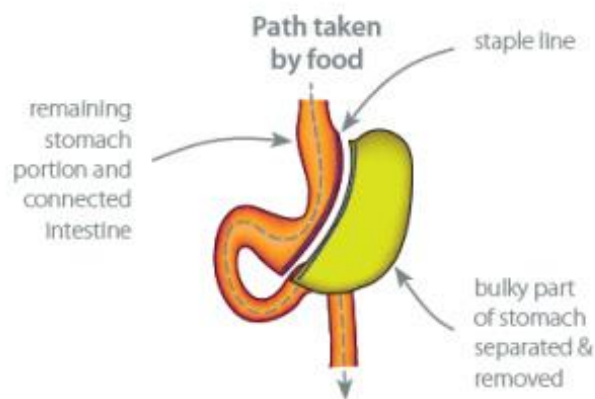
Fig. 3. The basics of a sleeve gastrectomy procedure

Source: Welbourn et al., 2014

2.5.1.3 Gastric band

This procedure consists of an adjustable band being placed around the top of the stomach, restricting the amount of food the stomach can hold (See Figure

2.6). Patients generally feel full quickly and are only able to eat small portions of food. As the food is passed through the band, it goes into the lower part of the stomach, and is digested normally, so there is no malabsorption (American Society for Metabolic and Bariatric Surgery, 2008). The band can be adjusted according to individual patient requirements; this is generally carried out in the bariatric surgical unit. The first adjustable gastric band was performed by Kuzmak in 1986 (American Society for Metabolic and Bariatric Surgery, 2004). Gastric banding is a reversible procedure, which patients often perceive as less drastic than gastric bypass or sleeve gastrectomy (Mahawar, 2012).

Figure 2.6 Diagram of a gastric band *in situ*
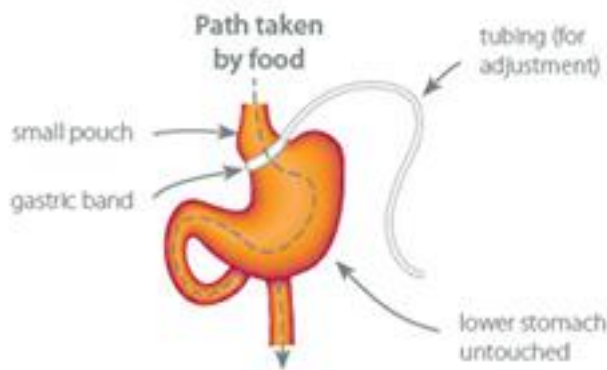
Fig. 1. Diagrammatic representation of a gastric band in place

Source: Welbourn et al., 2014

The band is filled with saline, which can be adjusted via a port which is also

inserted at the time of surgery. Whilst still widely performed, it has declined in popularity owing to high rates of slippage, reflux and patient intolerance, resulting in increasing rates of removal and/or conversion to other bariatric surgical procedures (Brown et al., 2013). Percentage of excess weight loss with gastric banding is not as high compared with gastric bypass and sleeve gastrectomy. Follow-up with 30,993 entries into the NBSR in 2011-12 on average showed excess weight loss at one year after primary surgery as gastric bypass (68.7%), sleeve gastrectomy (58.9%) and gastric banding (36.6%) (Welbourn et al., 2014).

2.5.1.4   Other non-surgical procedures

The gastric balloon is generally used as a precursor to further bariatric procedures, and can be used from a psychological perspective to assess the ability of the patient to tolerate more permanent methods of bariatric surgery, or to reduce a patient's weight to reduce the risk of surgery (Welbourn et al., 2014). It consists of a silicone balloon inserted into the stomach, which is then inflated, reducing the capacity of the stomach (See Figure 2.7). The balloon is a temporary procedure and is removed after a maximum of six months. The procedure is carried out as a day case procedure in a hospital setting, requiring no general anaesthetic. As this is not a surgical procedure, it is not explored in the thesis, but information is provided with the aim of providing an awareness of the different procedures offered in bariatric clinics and to contextualise the

patient experience.

Figure 2.7 Diagram of a gastric balloon *in situ*
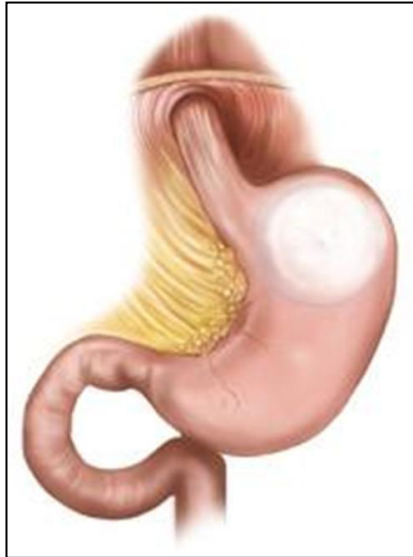
Source: Obesity Surgery Experts (Online), 2015

2.5.1.5   Selection of bariatric surgical procedures

The main reason for recommending a specific procedure is based on consideration of existing medical conditions and physiological factors. For example, patients with a history of gastro-oesophageal reflux disease (GORD) may be unsuitable for a gastric sleeve, as this procedure may potentially increase reflux symptoms (Laffin et al., 2013, DuPree et al., 2014). Psychological considerations are also taken into account by the multi-disciplinary bariatric surgical team which generally comprises of surgeons,

psychologists, dieticians and nurses who collectively make decisions with regards to patient selection (National Institute for Health and Care Excellence, 2014). Additionally, patients undergo a pre-operative endoscopy to screen for anatomical factors which may contribute towards choice of procedure. In some cases, it is not possible to determine the choice of procedure until the patient is in theatre where a more comprehensive assessment can be made. The policy and provision of bariatric surgery in the UK is examined next.

2.5.2 Policy and provision in the UK

The policy and provision of bariatric surgery in the UK is influenced by NICE guidelines (National Institute for Health and Care Excellence, 2014). These are based on American guidelines. In 1991, the United States' National Institute of Health (NIH) released a position statement on Gastrointestinal Surgery for Severe Obesity. This statement is consistently referred to in bariatric surgery literature and is accepted a crucial juncture in the provision of bariatric surgery (Kalarchian, 2010, de Zwaan, 2007). The recommendations on criteria for surgery (National Institutes for Health, 1991) were:

- Patients seeking therapy for severe obesity for the first time should be considered for treatment in a non-surgical program with integrated components of a dietary regimen, appropriate exercise and behavioural

modification and support.

- Gastric restrictive or bypass procedures could be considered for well informed and motivated patients with acceptable surgical risks.

- Patients who are candidates for surgical procedures should be selected carefully after evaluation by a multidisciplinary team with medical, surgical, psychiatric and nutritional expertise.

- The operation should be performed by a surgeon substantially experienced with the appropriate procedures and working in a clinical setting with adequate support for all aspects of management and assessment.

- Lifelong medical surveillance after surgical therapy is a necessity.

These recommendations have formed a foundation for the criteria for bariatric surgery, which have influenced the guidelines in the UK for bariatric surgery. The NICE guidelines, the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) report and the National Bariatric Surgery Registry (NBSR) have all contributed to the policy and provision of bariatric surgery in the UK. The salient points of each report are discussed.

2.5.2.1   National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) publishes guidelines for the management and treatment of a range of illnesses based on the best available evidence. The first guidelines for the management of both childhood and adult obesity were published in 2006. The recommendations for bariatric surgery as an intervention for adult obesity were based on the 1991 NIH guidelines (National Institute for Clinical Excellence, 2006) comprising of the following eligibility criteria:

- A BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 40 kg/m^2 and other significant disease (for example, Type 2 diabetes or high blood pressure) that could be improved if they lost weight.

- All appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months.

- The person has been receiving or will receive intensive management in a specialist obesity service, is generally fit for anaesthesia and surgery, and commits to the need for long-term follow-up.

- Bariatric surgery is also recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more

than 50 kg/m2 in whom surgical intervention is considered appropriate.

The NICE guidelines were updated in 2014. The eligibility criteria was extended from the first guideline to encompass people with recent-onset Type 2 Diabetes in response to the increasing evidence on the efficacy of bariatric surgery on the improvement of Type 2 diabetes (Sjöström, 2013). Patients with Type 2 Diabetes with a lower BMI (kg/m^2) ≥30.0-34.99 being treated in Tier 3 services, people with recent-onset Type 2 diabetes with a BMI (kg/m^2) ≥35 who are also receiving treatment in Tier 3 services, and people of Asian origin with recent-onset Type 2 diabetes and a lower BMI, who are also being treated in Tier 3 services (National Institute for Health and Care Excellence, 2014) are all potential candidates for bariatric surgery. NICE guidelines are an integral reference point for the management of illness in the UK and eligibility treatment in UK bariatric surgical units follows the recommendations.

2.5.2.2 National Confidential Enquiry into Patient Outcomes and Deaths

In 2012, the provision of care of patients who underwent bariatric surgery in the UK was reviewed in a report produced by NCEPOD. The report acknowledged the increase in rates of obesity in the UK over the last 20 years and the need for management of obesity and its related illnesses. The main recommendations of the report were as follows:

– Bariatric surgery is a specialist discipline and should be carried out by surgeons who perform these procedures on a regular basis.

– Patients should have access to specialist practitioners to meet their individual needs as recommended in NICE guidelines.

– More emphasis should be placed on psychological assessment earlier in the obesity care pathway.

– Information on risks and benefits of bariatric surgery should be given, along with written information. Consent should be taken in two stages, with time for the patient to consider the information.

– Postoperative dietary advice and a comprehensive discharge plan should be provided to the patient and to the patient's General Practitioner (GP), the latter within 24 hours of discharge.

– A long-term follow-up plan must be made for every patient undergoing surgery, accounting for surgical, dietitian, General Practitioner and nursing input, with psychological care if needed.

(National Confidential Enquiry into Patient Outcomes and Deaths, 2012,p.9)

The report recognised that bariatric surgery was an effective intervention, but was not proposed to be a universal solution to adult obesity management.

2.6 The National Bariatric Surgery Registry

The National Bariatric Surgery Registry (NBSR) began in 2009. The rationale for the creation of a voluntary, national registry was to provide a 'comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland' (British Obesity and Metabolic Surgery Society, 2015). There have been two published editions, in 2011 and 2014 (Welbourn et al., 2011, Welbourn et al., 2014).

2.7 The patient perspective of healthcare

Returning to the idea of the evolving nature and social construction of healthcare and the increased focus on the role of the patient:

[T]he current interest in incorporating lay perspectives into health services research reflects broad social and political trends and developments in

healthcare that have involved breaching some of the boundaries between medical professions and others. The assumptions that 'experts' – doctors and biomedical researchers – are best judges of what research is needed and should be exempt from democratic accountability are questioned

(Entwistle et al., 1998,p.463).

This move to more fully involve patients in healthcare was highlighted in the report, led by Lord Darzi, High Quality Care for All (Department of Health, 2008). This idea was further embedded into NHS policies in 2010 with the publication of a report entitled Equity and Excellence: Liberating the NHS. This aimed to place patients at the centre of healthcare by strengthening the voice of the patient with the ethos of 'no decision about me, without me' (National Health Service, 2010). This document laid the foundations for embedding patient involvement and experiences within healthcare to increase their knowledge and understanding of their health, and adherence to interventions to improve this. In order to capture this, the report suggested that research based on patient experiences of healthcare services was carried out using tools such as interviews, surveys and a variety of other methods such as Patient-Reported Outcome Measures (PROMS) (National Health Service, 2010).

NICE published guidance on the constituents forming the basis of a good patient experience, with 12 quality statements supporting the ethos of patient experiences of adult NHS services in England (National Institute for Health and

Care Excellence, 2012). Patient experience is underpinned by a set of quality statements which put the patient at the centre of healthcare. The provision of bariatric surgery at CHSFT falls within these categories.

As the term patient experience can be nebulous and open to interpretation, the working definition of the broader remit of patient experience of healthcare can be summarised as 'the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care' (The Beryl Institute, 2015). For this thesis, the timeframe was limited to the first two years following bariatric surgery, where the intervention has already taken place, and the patient is adjusting to the physical and social changes, whilst under the care of the NHS. To understand the patient experience of undergoing NHS treatment, it is important to understand and respect patients:

> Acknowledging their individuality and the unique way in which each person experiences a condition and its impact on their life. Patients' values, beliefs and circumstances all influence their expectations of, their needs for, and their use of services. It is important to recognize that individual patients are living with their condition, so the ways in which their family and broader life affect their health and care need to be taken into account.
>
> (National Institute for Health and Care Excellence, 2012,Online)

This ethos of knowing and respecting each patient as an individual is congruent with the research aims of the thesis and the methodology employed to carry this out. Although this thesis was a self-financed project and was not funded by the NHS, the concept of interviewing patients to gain an understanding of how they adjusted to life after bariatric surgery was supported by CHSFT. It was agreed from the outset of the project that the findings of the thesis would be made available to patients and the Trust in order to contribute towards the development of the bariatric surgery service. Taking a patient perspective towards the research means that the findings of the thesis may have potential to contribute to towards Domain 4 of the NHS Outcome Framework (Department of Health, 2013) (See Figure 2.8), which demonstrates an intention to understand the patient experience as an integral part of assessing healthcare in addition to supporting the NICE ethos of acknowledging individual patient experiences.

Figure 2.8 The NHS Outcomes Framework 2014-15
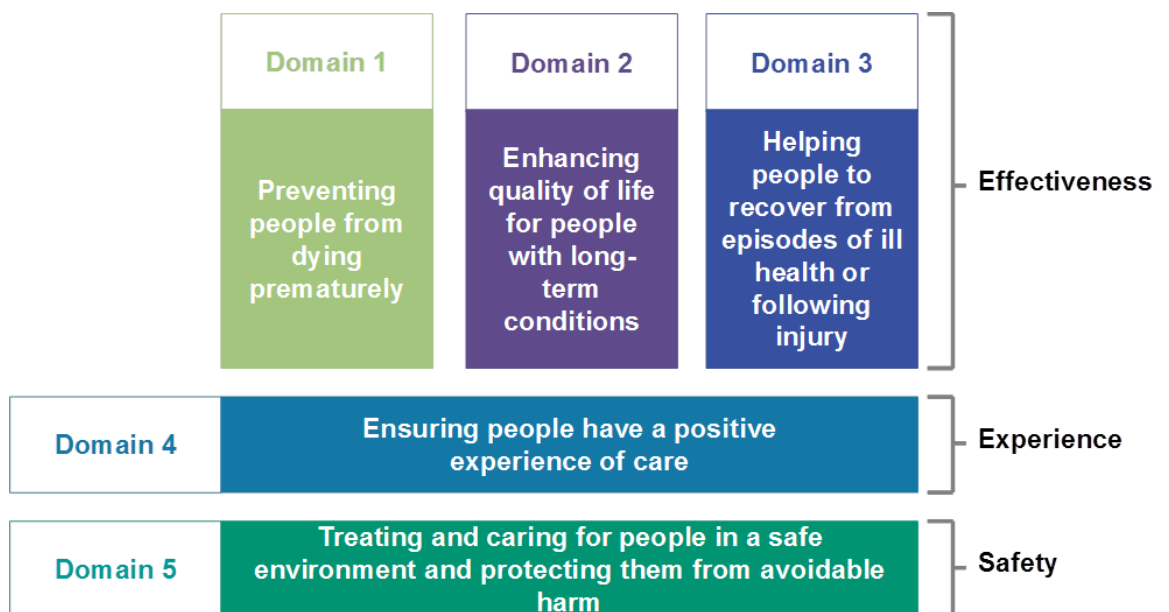
Source: National Health Service, 2013

2.8 Summary of chapter

The background and social framing of adult obesity, the tiered management system, the chronology of bariatric surgery and the policy and provision of bariatric surgery in the UK have been discussed. This was undertaken to provide a comprehensive introduction and context of bariatric surgery.

Chapter 3: Initial literature review

3.1 Introduction

The place of the literature review in a grounded theory study is a subject of debate amongst proponents of the methodology (Dunne, 2011). The aim of the original version of grounded theory by Glaser and Strauss (1967) was to *discover* theory from the data. To achieve this, the researcher is instructed to approach the substantive area of inquiry *tabula rasa,* with a dictum not to undertake a literature review/approach the literature until after theory emerges from the data (Charmaz, 2006, Glaser and Strauss, 1967). This was done in an attempt to keep the researcher free of any preconceived notions when approaching the data, allowing a theory to emerge as opposed to being forced. Other grounded theory scholars suggest that it is impossible to set aside prior knowledge, and attempting to do so is problematic:

> First, if this dictum is taken seriously, it makes it impossible for researchers to conduct studies in their own areas of expertise which appears odd and counter-intuitive. According to Bruce (2007), a "responsible" researcher has to admit his or her theoretical understandings from the outset of the study. He or she cannot "unlearn" what is already known (Schreiber, 2001). Alternatively, the dictum might force the informed researcher to

pretend to be a "theoretical virgin" (Clarke 2005), which in turn might mask unreflective, pre-conceptive forcing as well'.

(Thornberg, 2011,p.244).

The concept of 'theoretical agnosticism' (Henwood and Pidgeon, 2003,p.138) suggests that researchers should view previous theories critically and 'as problematic and then look for the extent to which their characteristics are lived and understood' (Charmaz, 2006,p.166). These debates all lean towards the concept of an 'informed grounded theory', where both the research process and study are embedded in grounded theory methods, enlightened by the existing corpus of literature (Thornberg, 2011). This is congruent with the Constructivist Grounded Theory methodology where abduction informs the research process and the literature review may serve as a creative tool (Charmaz, 2006). Thus, there appears to be a general consensus amongst scholars of grounded theory that it is impossible to put pre-existing knowledge aside.

Much of the debate around pre-existing knowledge focuses around the undertaking of an initial literature review prior to collecting data, with many grounded theory scholars acknowledging the requirements of a literature review as part of the research process by universities (permissions, grant applications etc.) and concur *tabula rasa* is indeed both impossible and impractical (Hallberg, 2010, Clarke, 2005).

62

This information guided me through the initial literature review and supported my concerns that I would not be able to enter my research free of any previous knowledge. I was aware of my existing knowledge and reflected on this throughout the research process, and followed the advice of Charmaz and the other authors who supported the idea of using the existing literature as a creative tool. Whilst engaging with the literature prior to commencing the thesis, it appeared that the procedure of bariatric surgery, along with the evidence base of results, such as comorbidity improvement had been researched extensively.

What appeared to be lacking was how bariatric surgery affected the lives of the patients. For example, my perceptions of a gap in knowledge were related to questions such as what were the social aspects of life after bariatric surgery and how did these impact on their day to day lives, how did patients feel about losing a drastic amount of weight by undergoing an operation that fundamentally changed so many aspects of their lives. I noted any thoughts and feelings I had after reading the literature in my research diary.

Compared with the biomedical literature, the interpretation of the experiences of the patients who undergo bariatric surgery is not as widely understood or published. Following surgery, patients must contend with adjustments to their lives as a result of a permanent, surgically-altered digestive physiology. How this impacts on their individual lives is subjective; bariatric surgery is a weight-loss intervention which is acknowledged not only to be life-changing in terms of

physical changes, but also to social, emotional and mental changes (Sogg, 2008) which may be more difficult to interpret.

There is published literature on patient adjustment post-surgically based on psychological studies, which employ quantitative measurement. This has demonstrated that patients experience interpersonal changes as a result of surgery, but not why or how this impacts on their everyday lives. For example, bariatric surgery may reduce depression associated with the obese status, but depression may present after surgery which is thought to be attributable to lifestyle adjustments in the postsurgical period (Greenberg et al., 2005, Kalarchian and Marcus, 2003, McAlpine et al., 2010). In addition, studies examining eating showed prevalence rates of 11-50% of disordered eating, especially binge eating, in individuals presenting for bariatric surgery (Niego et al., 2007, Sallet et al., 2007) and following surgery, this can either be resolved or exacerbated (de Zwaan et al., 2010). Therefore, these empirical studies show how bariatric surgery may impact on patients' lives, but not why individuals experience these effects and how they deal with these in their everyday lives.

In order to more fully appreciate the experiences of individual patients, the initial literature review focused on studies which utilised qualitative methodology, which focuses on 'human beings in social situations' (Robson, 2011) p. 17, to discover what had been published from the perspective of the patient. I

compared the findings of the initial literature review to the observations which I had seen, recorded and reflected on in my research diary, which is a process referred to as memoing in grounded theory (Charmaz, 2006). Memoing is an integral part of grounded theory methodology and the use of memoing is discussed in further detail in Chapter 6. These activities helped with methodological considerations such as choosing semi-structured individual interviews as the method of data collection and shaping the topic guide.

3.1 Initial literature review

Once the decision was made to focus on bariatric surgery from the patient perspective, a literature search was carried out to identify existing work. The initial literature search was carried out between October 2012 – March 2013 using defined eligibility criteria (See Table 3.1).

Table 3.1 Eligibility criteria for literature review on patient perspectives of bariatric surgery

Inclusion	- Adult (>18) - Primary studies - Irreversible bariatric surgical procedures (gastric bypass or gastric sleeve) or combination of irreversible and reversible - English language - Aim of surgery was weight loss and comorbidity resolution and not cosmetic - Literature published from 1991 - 2013 - Qualitative methods - Patient or lay perspective - Post-surgical experiences, accounts or narratives
Exclusion	- Children and adolescents (<18) - Studies using secondary data - Studies including only reversible bariatric procedures (gastric band) or temporary bariatric procedures, i.e. gastric balloon - Disused or superseded procedures (e.g. vertical banded gastroplasty) - Languages other than English -aim of bariatric surgery was purely cosmetic - Literature published prior to 1991 - Quantitative or mixed method studies - Practitioner or non-patient/lay perspective - Pre-surgical experiences, accounts or narratives

3.2 Search strategy

The literature screening followed the four step flow diagram as adapted from the PRISMA model (Moher et al., 2009), (See Figure 3.1). This served as a systematic guide to record the search and screening process and show how data were filtered throughout all stages.

Electronic sources accessed for published studies were Web of Science, Social Science Citation Index, Embase, Google Scholar, PubMed, Medline, CINAHL and the University of Sunderland DISCOVER databases. Key words (See Table 3.2) in each column were used with Boolean operators in various permutations with each database to identify potential studies. Initial searches produced a high number of results (22,900 records), which included studies clearly outside the defined inclusion criteria and scope of the research, for example, literature which was quantitative, medical and unrelated to the research question. This has been cited as a common problem with qualitative literature searching (Atkins et al., 2008) with electronic databases. Therefore, a considerable amount of literature had to be screened out in order to narrow down, and identify a core body of qualitative, patient-focused literature on the post-surgical timeframe. In order to reduce the number of studies, literature where the title or subject matter did not meet the inclusion criteria were eliminated. The literature search ceased when duplicate records were consistently produced and no new titles emerged. This initial screening process took four months (October 2012-

January 2013) and once duplicates were removed, 263 potential studies remained.

Table 3.2 Keywords

(Patient OR person OR lay person OR individual OR service user OR adult) AND (experience* OR account* OR perception* OR interpretation* OR narrative* OR stor* OR stud*)AND (bariatric surgery OR weight-loss surgery OR obesity surgery OR gastric bypass OR Roux-en-Y bypass OR gastric sleeve OR sleeve gastrectomy OR bariatric operation OR bariatric procedure OR gastric procedure OR gastric operation)

3.2.1 Additional search strategies

Reference lists of identified records were screened and specialist social science and obesity journals were accessed. Further searches for additional publications and authors in identified journals and for identified authors were undertaken. The British Library Ethos database was accessed for published theses and a search of grey literature including bariatric surgery publications, bariatric surgical professional society websites and obesity-related professional society websites were undertaken. This produced a further 5 studies, bringing the total to 268 papers, which were added to an Endnote database.

3.2.2 Screening and eligibility

The identified records were screened against eligibility criteria and the abstracts of the selected studies were read. This reduced the number of studies from 268 to 38. At this stage, the full text of each of the identified studies was accessed and appraised using the Critical Appraisal Skills Programme (CASP) tool for evaluating qualitative research (Programme, 2013). This resulted in a further 23 studies being eliminated.

Figure 3.1 Summary of literature search strategy

Identification	Articles identified from electronic databases at initial screening (n=22,900)

↓

Screening	Records excluded (Title or subject did not meet inclusion criteria) (n=22,613)

↓

Records remaining after initial screening

(n=287)

↓

Records remaining after removal of duplicates

(n= 263)

↓

Records identified from other sources (reference lists, hand searches and grey literature) (n=5)

Total number of records identified (n=268)

↓

Records remaining after abstracts screened against inclusion criteria (n=38)

↓

Eligibility	Records remaining after abstracts screened, full text accessed and appraised using CASP tool for appraising qualitative research (n=15)

↓

Inclusion	Records included for the literature review (n=15)

Adapted from the PRISMA model (Moher et al., 2009)

3.3 Results of the initial literature search

There were 15 studies identified which met the inclusion criteria for the initial literature review (See Appendix 2a). The 'psychosocial phenomenon' of gastric surgery was explored with a grounded theory approach (Bocchieri et al., 2002), using interviews and focus groups with 31 participants (23 female, 8 male), who underwent gastric bypass within a 6 month to 11 year timeframe. The findings of the study showed an emergent core theory of '*rebirth/transformation'* which was conceptualised by the participants in terms of pre- and post-bariatric surgery. Surgery offered a *second chance* at life, perceived as a *rebirth*. The authors concluded transformation created tension, and the degree to which participants coped with these changes may have affected on surgical outcomes including weight loss and psychosocial adjustment.

The changes were categorised into three areas; self/existential, social and skills acquisition and further subdivided into positive and 'tension-generating' changes. The latter was purposely not stated as negative, but as 'challenges to be negotiated', with patients reporting more severe psychosocial impairment experiencing the most significant rebirth/transformative changes. The strengths of the paper included detailed categorisation of the life changes, with each category offering examples of both positive and tension-generating changes. For example, the self/existential category discussed vulnerability positively as participants realised weight was used as an excuse for not achieving certain goals. This was contrasted with the tension-generating aspect of surgical

weight-loss eliminating the weight excuse, with the participants having to negotiate this new aspect of self, supporting the theory of transformation/rebirth. The limitations of the paper were a lack of direct quotes from participants, which would have provided more detailed accounts of individual experiences. Furthermore, interviewing patients many years after surgery may not have resulted in accurate recall of experiences, as patients may have forgotten specific events.

Through interviews with 35 participants (29 females, 6 males), the majority who had undergone bariatric procedures, Throsby (2008) used discourse analysis to explore ways in which the participants viewed bariatric surgery as a rebirth, which was identified in the work of Bocchieri et al. Following surgery, the interpretation of the concept of rebirth 'which has been, or is being rescued from obesity and being restored to a more authentic, socially legitimised, disciplined self' (Throsby, 2008,p.129). There were identified themes of trying to establish a new normality with the surgically altered body and dealing with the scrutiny from others. This supported the concept of surgery creating tension-generating changes which must be negotiated and dealt with. A personal account of undergoing two bariatric procedures was offered by Ryan, (2005), who described her experiences as a difficult process to deal with. In particular, changes to social relationships after bariatric surgery, and how this was a particular source of tension:

Our marriage was failing miserably and my husband's temper escalated. He started taking his anger out on our daughter and that is when I made the decision to end our marriage, approximately one year after the surgery. I later found out that it is common to experience marital difficulties and/or divorce after this surgery because of the spouse's feelings of insecurity. He has always blamed the surgery as the cause of our problems.

(Ryan, 2005,p.289)

This further supports the concept of change, and the reaction to surgery by others emerged as a theme. This was explored by Drew (2011), who undertook a mixed qualitative methods study, using content analysis of weight-loss surgery in the media and comparing with open ended surveys (n=55) and interviews (n=44). Her aim was to understand bariatric patients' reactions to media representations of surgery and how these were interpreted pre and postoperatively. Although Drew did not offer insight into individual experiences of bariatric surgery or the type of procedure undergone, the participants reported stigmatisation with obesity similar to that reported by Puhl and Heuer (2010). What emerged from this study was that bariatric surgery as a weight loss method was subject to scrutiny by others; this was a consistent finding in all work used for the initial literature review.

Thematic analysis was used to discuss the experiences of a morbidly obese woman who underwent surgery by Earvolino-Ramirez (2008). Two themes were offered; 'be careful who you tell because the stigma continues' and life after surgery as being 'totally different, but still evolving'. This supports the concept of the stigma of surgery offered by Drew (2011) which is reinforced in the sub-theme 'reactions of others':

I just talked to my mother in law the other day, and she goes 'Oh Jenny (sister in law), she's lost 36 pounds and she's not going to have sagging skin because she's doing it the right way'. And of course I'm thinking 'because I did it the wrong way, right?' But I'm getting away from that I did something wrong. But I didn't.

(Earvolino-Ramirez, 2008,p.21)

The second category of 'totally different but still evolving' supports the transformation theory of Bocchieri et al., (2002), described in physical and mental changes:

[The surgery] changed my life; it's everything, every aspect....Well I deal with depression quite a bit and it has gotten tremendously better; in fact

I'm slowly off my medicine now. My psychologist just thinks it's wonderful that I'm doing this.

(Earvolino-Ramirez, 2008,p.22)

The limitation to this study was that it was an individual's experience, with the author noting the participant's age, ethnicity, socioeconomic status and gender may have influenced the findings. However, both individual narratives, Ryan (2005) and Earvolino-Ramirez (2008) showed similarity of experience with the larger studies and provided rich, descriptive accounts. Drew (2011), with 99 participants, supported the collective themes of transformation, difficulties and stigma.

The idea of being stigmatised for revealing weight loss methods was discussed in the context of non-disclosure of surgery by bariatric surgical patients. Sutton et al., (2009) interviewed 11 females who had undergone bariatric surgery (timeframe not given) and found that secrecy about having bariatric surgery was common. The reasons for non-disclosure included fear of others' reactions; participants reported discussions with others about bariatric surgery that were negative. This may lead to changes in interpersonal relationships, which was raised with Ryan's work.

The stigma of obesity has been identified as both a public and personal issue. In all studies, bariatric surgery was interpreted as a solution to the problem of obesity. Magdaleno et al., (2011) discussed the idea of replacing obesity through interviewing 7 females who were between 1.5 – 3 years post-surgery. The findings showed participants felt an improvement in body image, but many were apprehensive about reintegrating themselves into society, having felt marginalised previously. The problem of excess skin was problematic, as stated by one participant 'When I'm dressed, I'm no longer ashamed, you know…Now without my clothes on, that's another story, I feel ashamed' (Magdaleno et al., 2011,p.338). This study further highlights the emotional changes that surgery brings and that the drastic weight loss, although reducing the problem of obesity, may be replaced with further challenges.

One of the most profound changes after surgery is learning to eat differently. With gastric bypass, a common side effect experienced by patients is dumping, which occurs when the wrong types of food are eaten, or food is eaten too quickly. The experience of living with bodily changes, focusing in dumping, was explored with 22 Norwegian women. Using individual interviews, Groven (2012) conceptualised three themes; experiences of illness in conjunction with eating, learning to relate to changes in the 'inner' body and feelings of losing and regaining control. As gastric bypass is a largely irreversible procedure, patients must learn to live with the permanency of the procedure, which profoundly affects how they eat. New eating habits are required, but can be a source of angst, with dumping reported in this study as problematic.

Wysoker (2005) aimed to understand the surgical experiences of 8 participants (5 female, 3 male) using a phenomenological approach. The surgical timeframe was described as taking place at least a year prior to taking part in the study, so there may be limitations in participants' abilities to accurately recount experiences. The inclusion criteria were not clear and appeared to be determined by pre-surgical weight. Four themes were identified: surgery being a 'last resort', reality setting in, positive about the decision to have surgery and providing structure that was not present before surgery:

> Not being able to eat anymore and not being able to eat certain food products provides structure. Also the negative effects provided structure not to continue to eat. This structure took the decision making away from the individual. They no longer had to make decisions what to eat; the physiological effects of the surgery provided the structure to stop.

(Wysoker, 2005, p.29)

The theme of reality setting in was divided into three concepts: mandatory life changes, concern over not losing weight and weight regain. Wysoker (2005) identified the most powerful theme as the positive decision to have surgery, despite reported difficulties, with no participants reporting regrets. Engstrom and Forsberg (2011) undertook a prospective study, with 16 participants before surgery, and then at one and two years afterwards, using a grounded theory

approach. They proposed a theory of 'wishing for deburdening through a sustainable control over eating and weight'. The participants were described as being 'burdened by obesity due to a total loss of control regarding food intake'.

The concept of deburdening was classified into three time points; before surgery, one year after surgery and two years after surgery. Before surgery, participants *hoped for deburdening* and control. One year post-surgery, participants reported *starting to feel deburdened*. In addition, control over food was practiced through physical restriction and a transformed relationship with food. Two years post-surgery, participants reported *feeling deburdened*, with changes divided into positive and negative, the latter which was not reported at one year or presurgically, which suggests the two year period may be a turning point. Positive aspects included sustained control over food, changed tastes in food which led to healthy choices, and feelings of what was described as 'acceptance of a new normality'. This was also reported in the Wysoker (2005) study. Negative aspects included weight regain, feelings of self-blame for being 'weak or lazy because of their inability to mentally control their eating habits and weight'.

This study also reinforced the Bocchieri et al., (2002) concept of transformation. The issue of control, as identified in the Engstrom and Forsberg (2011) study was further explored in the next study, with Ogden (2006) postulating a 'paradox of control', underpinning four themes: personal weight histories; the

decision making process, the impact of surgery on eating behaviour and the impact of weight loss. They used a phenomenological approach to analyse data from 15 men and women who had undergone bariatric surgery within a four year timeframe. The control paradox was described as surgery imposing control which in turn provided a sense of control over patient lives that was not present presurgically, in the four identified themes (Ogden et al., 2006).

Overall, the findings leaned towards positive changes following surgery, but examples of negative experiences were also shown, which was consistent with findings from other studies.

Magdaleno (2010) looked at the experiences of seven Brazilian women after bariatric surgery using content analysis. Their aim was to understand meanings for women when undergoing bariatric surgery. The interviews took place from 3-35 months post-surgery. The emergent categories were defined as social reinsertion, social discrimination, self-esteem and personal identity (Magdaleno et al., 2010). I found it difficult to unpick these themes, as there appeared to be a focus on justifying qualitative methodologies and not discussing the themes. There were general statements made such as 'many patients arrive in the hope of solving all the problems of their lives after surgery' (Magdaleno et al., 2010) which were not supported by individual quotations which would have provided context, for example, what are the identified problems that surgery was thought to solve? Therefore it was difficult for me to position this study in relation to the

other qualitative literature. However, the study does highlight social difficulties following surgery, which are reflected in more detail in other literature.

Zunker et al., (2012) examined the patient perception of the eating behaviour grazing, using focus groups (n=29) to understand how post-bariatric patients perceive grazing and explore eating behaviours. As a result of all bariatric procedures, the physical size of the stomach is surgically reduced, which means patients must eat smaller portions of food. One of the ways of adapting to this is by grazing, which is defined as 'the consumption of smaller amounts of food continuously over an extended period of time' (Colles et al., 2008,p 616). Generally, grazing is perceived by healthcare professionals as a risky behaviour which implies a loss of control for bariatric surgery patients (Saunders, 2004). However, for patients, grazing may be perceived as a healthy behaviour which can help the adjustment to new eating habits after surgery (Zunker et al., 2012).

Grazing has been associated with a group of eating disorders which do not have formal diagnostic criteria, referred to as EDNOS (eating disorders not specified) in the DSM – IV disease classification criteria. This group of disordered eating behaviours is common in clinical practice, yet not widely understood or researched (Fairburn and Bohn, 2005), which may further reinforce negative discourses as there is no set criteria upon which to make a formal diagnosis. All participants in this study were at least one year post-operative, but the type of surgery was not specified. However, Zunker (2012)

highlights the differences in meanings between patient and practitioner, which may cause potential for misunderstandings to occur, which I had witnessed during my professional career and discussed in the introduction to the thesis. Acknowledging that patients may interpret the meanings of actions, such as the grazing example above, differently to others, including healthcare professionals, after bariatric surgery may be important when trying to understand post-surgical adjustments from the patient perspective. This may have potential to help to reduce the propensity for misunderstandings and provide opportunities for discussion and support.

3.3.1 The complexity of post-surgical life

The post-surgical timeframe appears to be complex. Although many of the studies reported difficulties after surgery, there was still an overarching theme of not regretting the decision to undergo bariatric surgery. Literature was found which explored the negative aspects of bariatric surgery, which is discussed next.

Groven et al., (2010) interviewed five women who had undergone gastric bypass procedures, were between 8 – 36 months post-surgery and had lost significant amounts of weight. These women were part of a larger study, but were selected for their negative interpretation of their post-operative quality of life. Participants had reported that pre-surgically, 'some struggled with comorbidities (including diabetes, high blood pressure and discomfort during

physical activity), whereas most of the women emphasized they were not having any health problems prior to their surgery' (Groven et al., 2010,p.3), which appears contradictory and I found difficult to interpret.

The participants' reasons for seeking bariatric surgery were discussed later in the study as being health-related, which appears to conflict with the previous statement and may have to do with subjective interpretations of their health and well-being. The findings revealed themes of 'healthy, but worried about their situation', 'a positively life-transforming period', 'unexpected pain and loss of energy', 'the radical change of bodily appearance', 'feelings of being damaged on the inside', and 'comparing one's old life with the "new" life'. All participants stated that they felt surgery was to blame for their problems. Although these themes differ from other literature, there is commonality in the complexity of the physical and social changes highlighted in other literature used for this review.

A further study examining patient-reported experiences of 'unsuccessful weight-loss surgery' was conducted with 10 participants (8 female, 2 male) who had undergone gastric banding and gastric bypass (Ogden et al., 2011). Out of the cohort, 5 had undergone an additional surgical procedure from gastric banding (reversible) to gastric bypass or gastric sleeve (permanent). All participants were post-operative up to a period of 10 years. Using individual interviews, the interpretation of 'failed weight-loss surgery' was explored, with an identified core theme of loss of control. Failure was apportioned to the procedure itself,

'cheating the operation' by challenging the operation by not following advice by eating larger amounts of food than what had been recommended after bariatric surgery and types of food that they had been advised not to eat. Another theme was 'emotional regulation' in that the comfort of eating had been removed through surgery, along with the feeling that only the body had been treated by surgery and the mind had been neglected in the process. However, the secondary bariatric procedures had resulted in a changed outlook, with themes of 'changed eating behaviour' and 'changed mind-set', resulting in gaining control. Overall, this study found, that further surgery had resulted in a more positive interpretation of living with a bariatric surgical procedure.

3.4 Summary

The existing body of qualitative literature shows that that bariatric surgery is a transforming experience and impacts upon many aspects of the lives of those who undergo it. Although there are limitations to some of the studies, such as lack of detail of some of the sample groups and broad timeframes, the rich description of the individual accounts allude to a complex social process which patients undergo following surgery. Although description provides detailed information, which is valuable for understanding patient experiences, it does not always show why or how social processes happen or the context informing them. Through conducting an initial literature review and reflecting upon the insights gained with my existing knowledge including interactions with bariatric patient support groups, I was able to build an awareness of concepts which

would eventually be acknowledged as sensitising concepts, which are one of the tools of grounded theory methodology (Kelle, 2005).

Although an initial literature review is not recommended under traditional grounded theory methodology, in reality, it is impossible in today's academic processes not to conduct one as part of postgraduate study (Clarke, 2005). My approach to the knowledge gained from conducting the initial literature review, was to acknowledge the existence of already published studies, which Thornberg (2011) suggests is an 'informed grounded theory'. I reflected on the findings of the initial literature review, compared it with my existing knowledge of patient experiences of bariatric surgery, and used this information as a point of departure (Charmaz, 2006). Thus, I acknowledge that existing literature, personal knowledge and experiences are embedded in this study and may have influenced the construction of the grounded theory.

Chapter 4 Philosophical and methodological underpinnings

4.1 Introduction

The purpose of this chapter is to clarify and justify the theoretical framework which underpins the methodological design of the thesis. This commences with consideration of the philosophical underpinnings of the research which is used to explain my abstract ideas and beliefs and locate this within an interpretivist paradigm. Interpretivist research is influenced by researchers' personal beliefs on how the world should be understood, interpreted and studied; these beliefs can be conceptualised as a research paradigm, described as a 'net containing the researcher's ontological, epistemological and methodological premises' (Denzin and Lincoln, 2000,p.19). Figure 4.1 shows my vision of the research net.

Figure 4.1 The interpretivist research paradigm
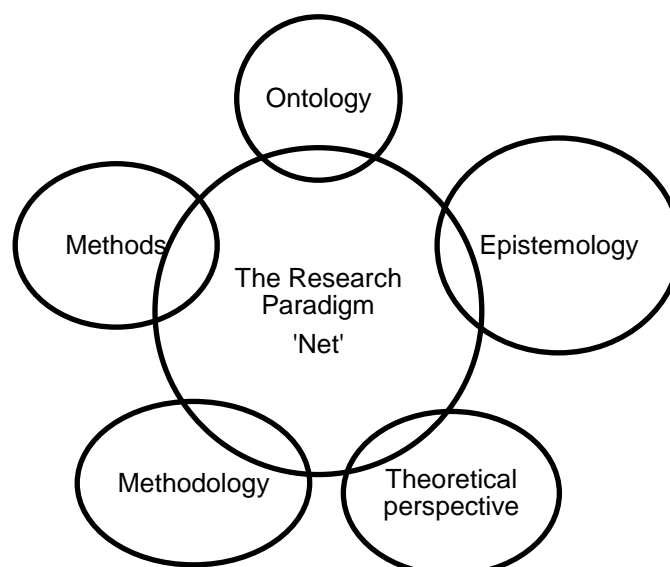
The philosophical approach to this thesis is located within an interpretivist paradigm, which aims to *understand* and is embedded on subjectivity as opposed to *explanation*, which is based on objectivity and aligned with a positivist paradigm (Grix, 2010). The interpretivist approach seeks to understand and illuminate participants' interpretations of the situation or phenomenon being studied; its roots grew from the philosophy of phenomenology (as opposed to phenomenology as a methodology) which seeks to understand the human *lived experience* (Mackenzie and Knipe, 2006). The philosophical assumptions of this thesis are congruent with Heidegger's phenomenological approach, which seeks interpretation and extending beyond description to seek meaning of the experiences of those experiencing the phenomena (Reiners, 2012). Both an interpretivist philosophy and the paradigm (framework for this thesis), assume individuals seek to understand the world they live in and assign meanings to their subjective experiences, which focus on objects or things in their lives (Cresswell, 2013).

4.2 Researcher background and philosophical assumptions

Every researcher brings an *a priori* set of beliefs, assumptions and personal experience which unconsciously influence the research. These are generally 'taken for granted, invisible, only assumed whereas others are highly problematic and controversial' (Denzin and Lincoln, 2000,p.19). With respect to my embedded stance, this was influenced by my background, which involved

working alongside healthcare professionals within the pharmaceutical industry. On many occasions and under different circumstances, I observed what I interpreted as a perceived disconnect between practitioner and patient interpretations of healthcare experiences. From both sides, this seemed to lead to misunderstandings and mismatched expectations of the other party, which seemed to be frustrating to both sides. When I moved into academia, I undertook a critical literature review of pre-surgical psychological evaluation for bariatric surgery for my undergraduate dissertation and found that psychological evaluation did not necessarily predict successful outcomes post-surgery. I felt one of the reasons for this was a lack of understanding of individual experiences, which would not be captured in standardized testing and that much of the published literature I had found had not accounted for this.

4.2.1 Refining my research question

As my initial literature review progressed, I engaged with the Patient Support Group at Sunderland Royal Hospital, which was largely comprised of patients who had already undergone bariatric surgery. There was a core group who came every month, some who attended more sporadically and a further group of pre-surgical patients who came as a one-off. I attended the patient support group on numerous occasions and my position as the partner of someone who had undergone a bariatric procedure appeared to allow me acceptance into the group. I was able to speak informally to individuals; as a result, my existing

hunch that bariatric surgery was a life-changing event which required a period of adjustment which affected their everyday lives was made explicit. I became aware there was more to these adjustments; individuals appeared to interpret the adjustments based on personal situations and the process of undergoing bariatric surgery had significant meanings to them. These meanings were noted in my research diary and I compared these to my other written reflections and observations on what I thought was a knowledge gap in the literature. Inspired by this, I focused on searching for literature which sought to explore the patient experiences of life after surgery. As I compared what I had learned from the patients to what I had read in the literature, I perceived a gap in existing knowledge from the patient perspective, which pragmatically had potential to inform practitioners and help other patients. When I attended the patient support group meeting and listened to patients discussing their narratives, they often used phrases such as 'I wish I had known this before I had surgery' along with reporting feelings of being misunderstood. These themes were often picked up by others who reiterated feeling the same way. Through interacting and observing patients in this environment and one to one settings, and comparing this with my thoughts, I realized I had developed the research questions for my thesis.

Despite an increasing prevalence of obesity, with 25% of UK adults estimated to be obese (National Obesity Observatory, 2013), socioculturally it is a stigmatized condition which leads to reduced quality of life for the individual (Puhl and Heuer, 2009). My initial literature search showed that there are social

difficulties which occur after bariatric surgery. Bariatric surgery imposes many changes on a patient's life, with the meaning of these of these changes constructed through social interactions.

Through reflecting on my observations, engagement with literature and getting to know the patients in the support group, I arrived at a decision to adopt an interpretivist approach to understand the patient perspective, using patients as research participants and to construct a theoretical explanation of their experiences. The findings could then be used by both patients and practitioners to more fully understand the patient experience and contribute towards improved communication between the two parties. The individual components of the interpretivist research paradigm are presented in Figure 4.2.

Figure 4.2 The thesis: A constructivist/interpretivist paradigm

Ontology	Epistemology	Methodology	Theoretical Perspective	Methods
Relativist	Interpretivist	Constructivist Grounded Theory	Symbolic Interaction-ism	Semi-structured Interviews
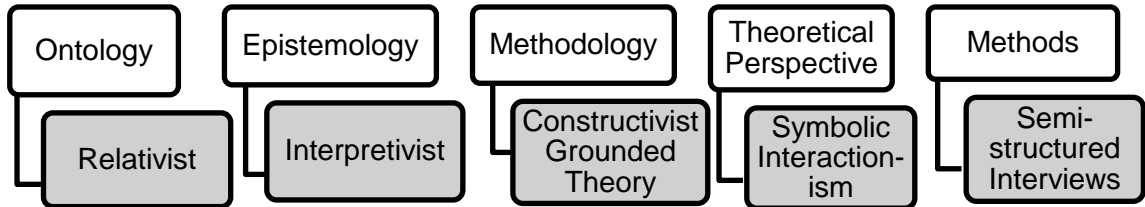
Each of these components are discussed in the remainder of the chapter.

4.3 Ontology

Ontology refers to the study of the nature of social phenomena and the researcher's perceptions of the nature of the social world. It answers the question regarding what the form and nature of reality is and what can be known about it (Crotty, 1998). A researcher's ontological position is unconsciously inherent in their beliefs, assumptions and experiences (Grix, 2010) of the area of substantive interest. My ontological position is aligned with relativism, which asserts there are multiple realities and interpretations of the social world, with meanings and actions constructed by the people experiencing or living the phenomena (Bryman, 2008).

The interpretation of the social world is influenced by cultural and historical norms (Cresswell, 2013), is temporal in context and constantly evolves. The 'truth' about the patient experiences of bariatric surgery can only be understood by the patients who have undergone the procedures. This may be shaped by the current societal construction of obesity as an epidemic (Saguy and Almeling, 2008), and the social and biomedical framing of bariatric surgery as a final option, where other weight-loss methods have failed (National Institute for Clinical Excellence, 2006, National Institutes for Health, 1991). The notion of structure and agency, which examines whether social context determines human action, or if human action shapes social context (Grix, 2010) is an ontological concern and is examined in the thesis.

4.4 Epistemology

Epistemology is defined as the theory of knowledge (Grix, 2010), which questions how the researcher understands the world and the relationship between the researcher and what can be known. This provides a philosophical foundation for determining 'what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate' (Maynard, cited by Crotty, 1998), which means the epistemological stance must be made explicit. An interpretivist (also referred to as constructivist) epistemology was adopted for the thesis. I believe subjective experiences of a phenomenon such as bariatric surgery can only really be understood by listening to those who have

experienced it. There is a large body of biomedical literature which provides information on bariatric surgical procedures, weight loss, health and quality of life improvement, but this is generally measured quantitatively, providing explanation and prevalence, based on biomedical evidence and quantitative measures, such as standardized tests and deductive hypotheses, but is argued to lack subjectivity, understanding and individual circumstances, which could offer context to the findings. For example, exploring subjective experience in the context of adjustment after bariatric surgery may help to explain factors such as why some patients lose more weight than others, how they feel about their health or what aspects of quality of life mean more than others.

Epistemology underpins the methodology of this thesis and informs the theoretical perspective which is inherently shaped by a researcher's beliefs. As discussed in the introduction, the emergence of both the patient as an active participant in healthcare, and the incorporation of wider determinants of health such as social and cultural factors into the medical model, as conceptualised in the biopsychosocial model proposed by Engel (1977), has challenged the biomedical model, which is socio-culturally more established and accepted. Traditionally, the biomedical perspective assumes healthcare practitioners as active bearers of knowledge and patients as passive recipients of this knowledge through care (Jutel, 2011). The NHS has made attempts to alter the dynamics of this relationship by more actively involving patients in their care, with the Equity and Excellence directive urging a 'no decision about me, without me' stance toward patient care (Department of Health, 2010).

An interpretivist epistemology examines the interpretation of the social world by those who are involved with it (Robson, 2011), with the truth emerging from meanings constructed between the knower and the respondent (Denzin and Lincoln, 2005). Meanings arising from a common phenomenon are subjective and individually interpreted, thus no two experiences are entirely similar (Charmaz, 2014). Patients who experience bariatric surgery are experts in the subject with their interpretations and accounts of surgery providing the knowledge in collaboration with the researcher. Meanings can be further explored by using symbolic interactionism as the theoretical perspective.

4.5 Theoretical perspective

A theoretical perspective is the philosophical stance which contextualises the methodology used in the thesis, underpins the epistemology and explicates the researcher assumptions and views of human interaction in the social world (Crotty, 1998). Adoption of symbolic interactionism as the theoretical perspective allows for exploration of the different ways in which research participants' experiences form meaning as the focal point of the research (Flick, 2014).

Symbolic interactionism is a sociological perspective, based on the work of the pragmatic philosophies of Mead, of the Chicago School of sociology. His work

was posthumously advanced by Blumer, a former student (Crotty, 1998). Symbolic interaction is attributed to both scholars, with contributions positioned as Mead providing the philosophy and Blumer advancing symbolic interactionism as a sociological theory and a research approach (Jeon, 2004).

Symbolic refers to the 'underlying linguistic foundations of human group life' (Denzin, 2001). Symbols are names or labels for objects available in specific cultures; the definitions of these objects are provided by the symbols, usually in the form of spoken or written words, emphasized with pictures, images and other descriptors (Fulcher and Scott, 2007) to give meaning to social situations which actors are involved in. The term *interaction* states humans interact with each other, not towards each other, with symbols interpreted and exchanged through social action; thus *symbolic interactionism* can be defined as the study and analysis of action, occurring when two or more people (agents) combine their individual actions together (Denzin, 2001).

The following are epistemological and conceptual assumptions which underpin symbolic interactionism. Firstly, grand theories such as liberalism and socialism (Wiarda, 2010) are not perceived as useful and are rejected, with interactionists such as Foucault and Lyotard advocating the use of narratives or biographies of local actors to portray the human experience under investigation, refuting objectivist and quantitative theories (Denzin, 2001). Secondly, interactionists discount theories borrowed from other disciplines such as natural sciences, and

do not value theories which disregard history, history is constructed from people, but not necessarily through their own choices or interactions (Denzin, 2001), this is crucial to understand human experience.

The pragmatist concept which underpins symbolic interactionism is reality being characterized by indeterminacy, fluidity and open to multiple interpretations which are provisional and relativistic (Charmaz, 2006). Humans are active, creative and meanings are created through the actions taken to solve problems, and through these actions, people learn to understand the social world, with facts and values intertwined (Charmaz, 2006). Pragmatism conceptualizes cultural understandings as influencing actions of human social life (Crotty, 1998).

Social life through a symbolic interactionist perspective places an emphasis on individual social identity and how a person publicly presents oneself to others underpinned by the concept of a 'creative, consciously acting self', with the self-developed through learning and socialisation in social settings (Bilton et al., 2002). Obesity is a visible disease, it cannot be hidden. In the context of determining obesity, vision is the strongest sense for this; obesity cannot be heard, tasted or smelled (Jutel, 2005). Visibility contributes to the stereotypical judgements of physical appearance in adult obesity lean towards personal culpability, described in terms as 'lazy, weak-willed, unsuccessful, unintelligent, lacking in self-discipline, willpower and non-compliance' (Puhl and Heuer,

2010), alluding to a moral failing. This can translate into bias and stigma in social situations, employment, and healthcare settings (Kaminsky and Gadaleta, 2002, Schwartz et al., 2003). From this negative social construction of adult obesity, it is understandable that weight-loss interventions such as bariatric surgery are sought by people who are obese.

Symbolic interactionism assumes 'society, reality and self are constructed through interaction and thus rely on language and communication' (Charmaz, 2006,p.7) with interactions being dynamic, interpreted and reflected upon, rather than an unconscious response. My initial literature review showed that there is a need to understand the social processes of adjustment to bariatric surgery and that people who undergo bariatric surgery are scrutinized by others. I suggest that that the use of symbolic interactionism as a theoretical perspective helps to explore the meanings and actions of those who are adjusting to life after bariatric surgery. The complex aetiology and social framing shapes societal perceptions of adult obesity; bariatric surgery imparts a rapid and recognizable change to one's appearance; this may influence how people act.

Blumer (1969) posited three pivotal assumptions of symbolic interactionism:

Human beings act towards things on the basis of the meanings that these things have for them, e.g. physical objects, people or categories of people, institutions, virtues, and other aspects of day to day living.

The actions taken as a person adjusts to life following bariatric surgery will have different meanings for those who experience the phenomenon and the context and conditions in which these actions take place will be illuminated.

The meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows.

Each of Blumer's assumptions will be used as a framework in this thesis to explore the social interactions which bariatric patients have with others following surgery and the meanings associated with such interactions and how these impact upon adjusting to life after bariatric surgery.

That these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.

The processes in which meanings are constructed may be different for individuals after bariatric surgery. Undergoing a drastic change to one's

97

personal appearance may impact other areas. The underpinning concepts of symbolic interactionism assume humans actively choose courses of action, as opposed to biological or mechanical conduct, and this behaviour is learned through interaction with others (Blumer, 1969). This identity leads to conscious 'self' with behaviour being the result of conscious action and not simply a response to stimuli, defined as the *definition of the situation,* described as the 'actor's interpretation of an event or experience' (Blumer, 1969). Symbolic interactionism highlights the diverse nature of human social life, including social roles and identities which are constructed by people through interactions with others (Bilton et al., 2002). The ontology, epistemology and theoretical perspectives have been discussed, the next section focuses on the methodology for the thesis.

4.6 Methodology

Methodology seeks to find the most appropriate way of gaining knowledge of the phenomenon under enquiry (Grix, 2010). Grounded theory was chosen for its ability to provide an explanatory theory of the phenomenon and the systematic method of constant comparative data analysis, which creates an interactive process of moving back and forth between empirical data and emerging analysis, which focuses data collection and encourages theoretical analysis of the data (Bryant and Charmaz, 2007). Grounded Theory is defined as a high-level conceptual framework that possesses explanatory power

underpinned by analytical processes which would allow me to explore my interest, acknowledge my pre-existing knowledge but ensure it is not thrust onto the data, but defined by concepts constructed from it (Birks and Mills, 2011). Grounded theory has been proposed as suitable for areas of inquiry where little is known about the area to be researched, the intended outcome is an explanatory theory and a known process is rooted in the situation to be studied in which there is a probability of explication (Birks and Mills, 2011). The constant comparative analysis is supplemented by further analysis techniques such as memo-writing, which allow reflection and challenge of ideas and interpretations. It is a qualitative methodology able to answer the question 'why' which is necessary to provide context for the underpinning of a theoretical explanation (Bryant and Charmaz, 2007).

4.6.1 The 'evolution' of Grounded Theory methodology

The concept of grounded theory was conceived by Glaser and Strauss at the University of California in the 1960s, in the second 'Modernist Phase' of qualitative research in which post-positivism was the dominant paradigm (Denzin and Lincoln, 2000). The book, The Discovery of Grounded Theory was Glaser and Strauss' response to their criticisms of both quantitative and qualitative research approaches which they felt did not address the gap between theory and empirical research (Glaser and Strauss, 1967).

This inductive approach challenged the pervading quantitative 'logico-deductive' approach. Grounded Theory incorporated the different backgrounds of the creators; Glaser was proficient in quantitative methods and mid-range theories under the tutelage of methodologist Paul Lazarsfeld and sociologist Robert Merton. Strauss hailed from the Chicago School of sociology (University of Chicago), which was noted for its pragmatist philosophy and symbolic interactionist roots, influenced by the works of Dewey and Mead (Bryant and Charmaz, 2007).

The Discovery of Grounded Theory (Glaser and Strauss, 1967) was the first text on Grounded Theory methods. It is generally accepted as the foundation of the method, which later provided an inspirational source for a second generation of grounded theorists such as Kathy Charmaz and Adele Clarke, the former a student of Glaser and Strauss; the latter of Strauss, who have taken grounded theory in new directions and applied their own 'versions' of the method (Birks and Mills, 2011).

By adapting a systematic and rigorous approach to data analysis which, when followed correctly, allowed a theory to be discovered from the data, which could be verified. In order to achieve this, the researcher was told to approach the substantive area of enquiry *tabula rasa:* with a dictum not to undertake a literature review/approach the literature until after the theory emerged from the

data (Charmaz, 2006). This was prescribed in an attempt to keep the researcher free of any preconceived notions when approaching the data to allow a theory to emerge as opposed to being forced (Hall, 2013). The place of the literature review in grounded theory is a contested issue amongst both authors and researchers (Dunne, 2011). (See Section 3.1 of this thesis).

There are debates as to what is defined as true grounded theory owing to the methodological split between Glaser and Strauss. In addition, the influences of the various philosophical paradigms on the methodology of Grounded Theory, as developed by authors such as Charmaz (2006, 2014), Clarke (2005) and Corbin and Strauss (1998, 2006) have taken the methodology in new directions, most noticeably from positivist to constructivist and post-modern stances (Mills et al., 2007) (See Figure 4.3). This evolution is interpreted as a testament to both the flexibility of Grounded Theory and researchers of the methodology accepting the invitation by Glaser and Strauss (1967) to use the theory in their own way.

Grounded theory has undergone an evolution from the original method developed by Glaser and Strauss in 1967, with different interpretations from Glaser, Strauss and Corbin, Charmaz and Clarke (Mills et al., 2007). The different approaches to the methodology were conceptualized in terms of shifts in paradigms which influenced evolution of grounded theory and individual authors' interpretation of the method. The quandary of choosing a grounded

theory author to follow is a common dilemma amongst researchers, for example Cooney (2010) Niekerk and Roode (2009) and Breckinridge (2012).

In order to decide which version of Grounded Theory I would use for my thesis, I had to fully comprehend this evolution of grounded theory. Each of the authors and their identified ontological, theoretical, epistemological stances were evaluated and compared to determine which authors' outlook was similar to my own. This process is recommended by other grounded theory researchers (Hunter et al., 2011) to neophyte users of the method.

Figure 4.3 The methodological evolution of grounded theory

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                    ┌─────────────────────┐
                    │ Glaser and Strauss 'The │
                    │ Discovery of Grounded   │
                    │   Theory' (1967)        │
                    └─────────────────────┘
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| Glaser 'Theoretical Sensitivity' (1978) | Strauss and Corbin 'Basics of qualitative research' (1990) | Charmaz 'Constructing Grounded Theory ' (2006) | Clarke 'Situational Analysis' (2005) |

'Basics of Grounded Theory' (1992)

Further editions (1998), (2008)

Bryant and Charmaz 'The Sage Handbook of Grounded Theory' (2007)

'Doing Grounded Theory' (1998)

'Constructing Grounded Theory' 2nd ed (2014)

Post-positivist – **constructivist** – **postmodernist**

The social world has become increasingly complex since The Discovery of Grounded Theory was published in 1967 (Denzin and Lincoln, 2005). The complexity of society may be attributed to elements associated with the Postmodernist movement, globalisation, including elements of instant and mass communication which were not around in the second era. The possibility of these influences on the data obtained from participants cannot be ignored, and it could be argued the original grounded theory method may not take this complexity of society into account. In terms of qualitative research chronology, society currently exists in the 8th Era, coined the 'fractured future' (Denzin and Lincoln, 2005), which challenges the current penchant for evidence-based social information and supports the legitimacy of subjective interpretations in research studies. The participant narrative is very much the focus of Constructivist Grounded Theory.

4.6.2 Constructivist Grounded Theory

Constructivist Grounded Theory was developed by Charmaz, a former student of both Glaser and Strauss. It is positioned between positivism and postmodernism on the grounded theory methodological spiral, with theory produced through the methodology as an interpretive portrayal of the subject of inquiry and theory as constructed rather than discovered in the data (Charmaz, 2006). The methodology is located between positivism and postmodernism, offering both a constructive approach and the creativity of inductive reasoning which was valued in the original method (Breckenridge et al., 2012). Charmaz is

credited as being the first author to claim a constructivist paradigm in grounded theory (Hall, 2013). The element of discovery is dismissed, with a theoretical explanation of the phenomena constructed through 'past and present involvements and interactions with people, perspectives and research practices' (Charmaz, 2006) which differs from the original method. Constructivist Grounded Theory posits that the principles of grounded theory should be viewed by researchers as guidance through a research study; these can be adapted to the methodological assumptions that a researcher brings to the subject of inquiry, demonstrating the adaptability and flexibility of grounded theory (Charmaz, 2006).

Using grounded theory analytical techniques such as coding, memoing and constant comparative analysis enables the researcher to go beyond superficial description and find tacit meanings and actions which can be brought out and explored using symbolic interactionism as the theoretical perspective to more fully understand the processes involved in the adjustment to life after bariatric surgery. The interpretive rendering is an acknowledged co-construction between participant and researcher; the interaction between the two parties in constructing a theoretical explanation means an external reporting of events are unlikely. In addition, the employment of grounded theory analysis, such as open and focused coding, using gerunds to identify tacit actions, the use of memos to explore concepts constructed from the data and constant comparative analysis techniques minimises the possibility of superficial data interpretation.

In Constructivist Grounded Theory, there is an acknowledgement that undertaking a literature review is required as part of fulfilling academic requirements, e.g. as part of the registration process for a PhD, but to let this lay dormant until categories and relationships have been developed (Charmaz, 2006) following data analysis. Grounded Theory concepts are assumed to be neutral (Charmaz, 2006), but the utilisation of the concepts and the researcher's beliefs and their impact on the thesis are not (Birks and Mills, 2011). I chose Constructivist Grounded Theory as the methodology for my thesis, as this version focused on the co-construction of theory between researcher and participant, was flexible rather than prescriptive in analytical procedures whilst remaining faithful to central tenets of original grounded theory but incorporating constructivist underpinnings which were congruent with the research paradigm and my personal beliefs. The process of Constructivist Grounded Theory methodology is shown in Figure 4.4.

Figure 4.4 A visual representation of the constructivist grounded theory process
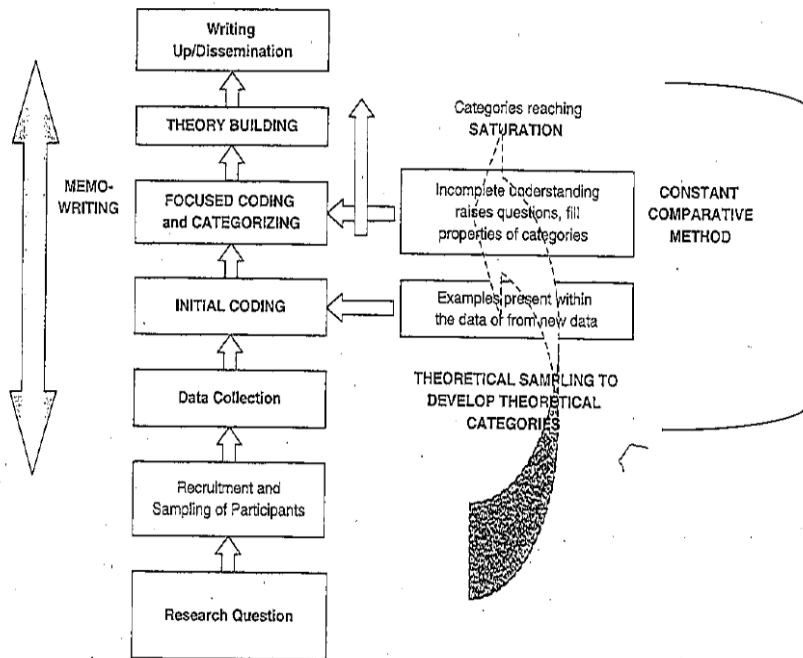
Source: (Charmaz, 2014,p.18).

4.7 Method of data collection

The method of data collection needed to be congruent with an interpretivist research paradigm and allow data to be collected in a way that would allow for exploration, account for subjectivity, relativity and analysed using grounded theory.

In order to understand the patients' experiences of surgery, individual, face to face interviews were felt to be the most appropriate means of data collection. Interviewing allows for a detailed exploration of an experience and is an established and useful method of interpretive inquiry (Charmaz, 2006). Interviewing is a popular method of data collection in grounded theory studies and is used to focus on the participants' experiences, how it is portrayed and the underlying meanings and actions (Charmaz, 2014). With a constructivist approach, rich, detailed data is sought within the context of a particular phenomenon. To attain this, a semi-structured approach to the interviews was used to create a space for the participant to speak openly about his/her experiences. The interviews were guided by a framework of topics to be covered, but allows flexibility on the part of the researcher to ensure the participant was active in directing the flow of the conversation and has opportunities to shape and influence the interview (Robson, 2011).

With constructivist grounded theory, Charmaz suggests the use of intensive interviewing, which she defines as 'a gently guided, one-sided conversation that explores a person's substantive experience with the research topic' (Charmaz, 2014,p.56). This slightly conflicts with my interpretation of interviewing, as I perceive the process to be more interactive on the part of the researcher, for example, asking for clarification or elaboration of points of interest in order to ensure the researcher understands the meanings and actions from the participant perspective. This alludes to an interview being more than a than a one-way conversation. Interviews are textual and negotiated, and reflect 'what

interviewers and participants bring to an interview, impressions during it, and the relationship constructed during through it' (Charmaz, 2006,p.27). This means the resulting analysis is a co-construction of both interviewer and participant, which means the conversation needs to be more than one-sided.

There is a semantic difference between being a one-sided conversation and a conversation which encourages a participant to become central to the shaping and direction of the interview, which echoes the tenet of mutual reciprocity. Whilst in agreement with Charmaz that the researcher should create a 'special interactional climate for the interview and in encouraging the research participant to talk', (Charmaz, 2006,p.56) which means the conversation would not be one sided. However, whilst I disagree with the definition of intensive interviewing, I agree with the characteristics of the process (Charmaz, 2006,p.56), which include:

- Selection of research participants who have first-hand experience which fits the research topic

- In-depth exploration of the research topic

- Reliance on open-ended questions

- Objective of obtaining detailed responses

- Emphasis on understanding the research participants' perspective, meanings and experience

- Practice of following up on unanticipated areas of inquiry, hints, and implicit views and actions

With the majority of ethnographic research, the goal is to obtain an 'insider's depiction' of the studied world, with the researcher remaining open to the 'setting, actions and people' within that world, and pursue what is found to be of the greatest interest (Charmaz, 2006). Participants in ethnographic studies allow the researcher to have insight into their worlds and actions within them; however the researcher must strive to maintain an open mind and accepting demeanour (Charmaz, 2006) whilst being aware of the personal influences they may inadvertently bring to the study.

The use of interviews for the method of data collection, using a semi-structured approach, shaped by a flexible topic guide was selected as the most appropriate method to gain an understanding of patient experiences of bariatric surgery.

4.8 Summary

Grounded theory is underpinned by symbolic interactionism and pragmatism, and Corbin and Strauss (1990) posit two principles, derived from these perspectives, that are ingrained into grounded theory. The first is the principle of change. Phenomena does not stand still in time, it constantly evolves as a result or response to influential conditions. Through prior knowledge and undertaking the initial literature review, it became apparent that the concept of change is central to the adjustment to life after bariatric surgery, including what appear to be personal and social changes.

The second principle is determinism, which states actors have the option of influencing events by responding to conditions by choosing what they perceive to be as options available to them. Examples of determinism in the context of bariatric surgery are choosing to undergo procedures, choosing to tell others, choosing to seek support, choosing to make a conscious decision to improve health and other personal situations which may influence perception of options. The events/social processes which present following bariatric surgery and why patients choose particular options in response will be explored through interviewing.

These principles influence the aim of grounded theory, which strives to discover the 'relevant conditions, but also to determine how the actors under investigation actively respond to these conditions, and the consequences of their actions' (Corbin and Strauss, 1990,p.5), with the onus on the researcher to capture this relationship. These concepts are central to an interpretivist paradigm and will be captured through semi-structured interviews as the method of data collection.

Additionally, data must not be taken at face value, but analysed to preserve an emphasis on language, meaning and action and construct an 'interpretive rendering of the worlds we study rather than an external reporting of events and statements' (Charmaz, 2006,p. 184). Theorizing through an interpretivist paradigm as an 'emergent process is fully compatible with Mead's philosophical pragmatism that informs symbolic interactionism' (Charmaz, 2014,p.231), therefore the use of grounded theory and symbolic interactionism is proposed a congruent 'theory/methods package', which is supported by other grounded theorists such as Clarke (2005).

An interpretivist paradigm calls for the imaginative understanding of the studied phenomenon (Charmaz, 2006) . The central goal of the thesis is to co-construct an explanatory theory of how patients adjust to life in the first two years after bariatric surgery. This type of theory 'assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual' (Charmaz, 2014,p.231). Thus, the individual components which

comprise the interpretivist paradigm are argued to be appropriate tools in which to meet this goal.

Chapter 5: Preparation for data collection

5.1 Introduction

This section outlines the activities that were carried out before data collection commenced. The first section will discuss ethical considerations and how favourable ethical opinion was obtained. The next section discusses the role of patients in the research design and how this helped to develop sensitising concepts to ensure the research was carried out to keep the participant at the forefront of the research at all stages of data collection and analysis. This chapter discusses the research design and informs the next chapter of the thesis, which focuses on data collection and analysis.

5.2 Patient involvement in research design

Conducting research with human participants requires consideration of ethical aspects. With health research conducted with participants who are National Health Service (NHS) patients, there are additional ethical requirements which must be fulfilled prior to embarking on the research; these were incorporated as part of the research design process. In health research, ethical decisions are made with consideration to the consequences of taking part in research, or the

outcomes of participation (Robson, 2011). In addition to NHS ethical requirements, the thesis needed to be approved by the University of Sunderland Research Ethics Committee.

The well-being of the participants in the study was priority and this needed to be considered in the research planning process to ensure that any potential for discomfort or embarrassment, be it emotional, mental or physical would be identified and procedures put in place to minimise any potential for harm. I was also aware through existing knowledge and the findings of the initial literature review, that speaking with patients about their experiences of adjusting to life after bariatric surgery could be a sensitive issue, and that this needed to be taken into consideration in the research design. This knowledge was also presented in all ethics applications.

To ensure that any possibility of causing discomfort to the participants was reduced, I sought advice and input from patients from a bariatric surgery support group running at the local hospital. Three of the patients met me one to one, outside the support group, at their request, to discuss their experiences with me. Additionally, the bariatric surgeons put me in contact with former patients with whom I was able to discuss the research design with. By involving a group of participants who were similar to the ones who would be recruited for the study, I felt confident that any potential for discomfort could be identified and dealt with before the study took place.

These encounters formed the basis of a pilot study. Engagement with a pilot group with potential similar characteristics was also thought to provide further opportunities to develop sensitising concepts (see Section 5.3), which is a notion developed by Blumer (1969) as knowledge and interests which give a researcher ideas to follow and reflect on how to ask types of questions about the topic (Charmaz, 2006). I specifically wanted participants' views on the patient information, consent and contact letters, choice of incentive and topic guide to ensure that the former was easily understood and explicitly showed voluntary participation and withdrawal without penalty, the incentive would not cause offence and was acceptable, and lastly that the issues raised in topic guide were raised and discusses in a manner which would not cause discomfort or distress.

The participants for piloting the research were approached via the bariatric patient support group which meets monthly at CHSFT. The bariatric surgeon facilitating the meeting approached the group on my behalf, requesting voluntary participation, and any prospective participant would not be a current patient at the Trust, as this would have been against Trust protocol. Participants in the patient support group voluntarily agreed to support the research and provided insight and advice into the following aspects of the research design; method, participant documentation, choice of incentive and topic guide.

5.2.1 Confirming acceptability of method

I had chosen semi-structured interviews as opposed to focus groups as the method of data collection as I felt participants would be more comfortable discussing their stories one to one. I viewed the access to the patient support group as an opportunity to establish whether my choice of the method of data collection was appropriate through discussions with people who would be similar to the participants I would be recruiting for my research.   Through discussions with individual members of the group and in the group setting, I learned there were incidents and issues relating to individual experiences surrounding bariatric surgery that people were not comfortable discussing in a group, despite attending a patient support group, but which they would be happy to discuss these in a one to one setting. I was thus reassured that individual semi-structured interviews were an appropriate method of data collection with this cohort.

5.3 Ethical considerations

The research project was a collaboration between the University of Sunderland and City Hospitals Sunderland NHS Foundation Trust and the ethical considerations of both institutions and the National Health Service (NHS) had to be met before data collection could commence. The research was approved by

the National Health Service on August 6, 2013 (See Appendix 2a), The University of Sunderland Research Ethics Committee in August 2013 (See Appendix 2b) and City Hospitals Sunderland NHS Foundation Trust approval was given on December 3rd 2013 (See Appendix 2c).

5.3.1 Participant documentation

In order to satisfy the Trust and the ethics committees reviewing the research that documentation to be read by participants invited to participate would be clearly understood, I asked patients in the support group to read the invitation letter, the information letter and the consent form and advise if the documents were easy to understand, especially around aspects of consent, voluntary participation, being able to withdraw without giving reason and that participation did not affect any treatment the participants may be concurrently be receiving by the Hospital.

5.3.2 Choosing an Incentive

I discussed amount of the incentive £15 with my supervision team and the patient support group. They all agreed that this was an acceptable amount, and

in line with incentives that were given out for participating in research studies conducted by University of Sunderland students, which were usually vouchers. The patient support group unanimously agreed that types of vouchers which could be redeemed in food or clothing stores would be embarrassing and impractical for participants, as food shopping was difficult for them and clothing stores were impractical, as participants had trouble buying clothing in the high street shops where the vouchers could be redeemed.

The patient support group suggested a book about bariatric surgery called 'Cut Down to Size' by Jenny Radcliffe, which many of them had found helpful and they suggested it would be an appropriate and appreciated incentive for others. I checked with Amazon, the publisher, the author and the purchasing department at the University, in order to negotiate a bulk purchase of £15 per book, but I was unable to achieve this discount. I returned to the patient support group and asked how they felt about a £15 Amazon voucher, which could be used towards the on-line purchase of the book, or something else on the Amazon website. The patient support group unanimously agreed this would be appropriate for an incentive and Amazon vouchers were subsequently purchased.

5.3.3 Topic guide

In order to test the topic guide for flow, timing and participant well-being, I asked the support group if anyone wold volunteer to participate in a mock interview.

Two members agreed to do this, and I met them individually to undertake this. Following the interview, both participants agreed to provide honest and open feedback on all aspects of the process. Both participants reported there were no situations which arose during the interview where they felt uncomfortable. They also felt that the flow, pace and timing of the interview was appropriate.

5.4 Patient involvement: establishing sensitising concepts

Through engaging with the patient support group and individuals who were representative of the study participants, I began to gain an insight into their lives, which allowed me to construct an initial impression of what I might expect from the participants when I began to interview them. I did not interpret this as picking up prior assumptions, but to further develop sensitising concepts to allow reflection of the participants 'standpoints and situations' (Kearney, 2007,p.130).

Charmaz (2014) suggests researchers use sensitising concepts to give initial, but tentative ideas to pursue and to use these to raise questions about the topic under investigation. Sensitivity requires a researcher to put his/herself into the research and according to Strauss and Corbin (2008, p.32), being intuitive enough to:

- possess insight

- be able to pick up pertinent issues, events and happenings in order to present the views of the participants

- be able to take on the role of others through immersion in the data

Sensitivity may be developed through the existing knowledge a researcher possesses, which may unconsciously influence the research, but there should be an awareness of this and how it shapes the response to the data (Corbin and Strauss, 2008). There are suggested tools to use to enhance a researcher's sensitivity in grounded theory, such as keeping a reflective research diary (known as memoing in grounded theory). As discussed in the initial literature review, constructivist grounded theory encourages the use of prior knowledge, with Dey (1993, p. 65-66) suggesting 'there is a difference between an open mind and an empty head. To analyse data, we need to use accumulated knowledge, not dispense with it. The issue is not whether to use existing knowledge, but how'.

I reflected constantly on my experiences and knowledge of bariatric surgery and my interactions with patients during the pilot study. All my thoughts were captured in memos, and used during data collection and analysis. Table 5.1 shows a summary of the sensitising concepts extracted from my memos.

Table 5.1 Sensitising concepts: the researcher perspective

Concept	Self-reflection and contribution to research
Bariatric surgery is a process of adjustment to change	I know this because I have close friends and family who have undergone bariatric surgery Choice of constructivist grounded theory which uses social processes as the unit of analysis
People from the patient support group have told me that they feel that many people do not know what bariatric surgery is and they have to explain to others what it is and there is a general lack of understanding towards bariatric surgery	Make sure that I am familiar with the different procedures and how each procedure works, so I when I interview the participants, they do not have to explain what procedure they have had done. This will help to establish rapport and allow the interview to focus on participants' experiences and not on explaining surgical procedures (See section 2.5.1)
Adult obesity is a condition which is socially constructed as unhealthy	This may have an effect on the participants and what they tell me
Current discourse around the biomedicalization of obesity and other sociocultural arguments	I am aware of the recent move by the American Medical Association (2013) which recognizes obesity as a disease. I am also aware of the complexity of obesity as outlined in the Foresight report (2007), but that many people view obesity as a simple calculation of too many calories consumed and not enough energy expended and do not accept the complexity argument
I am aware that both obesity and bariatric surgery are subject to stigma and that people I know can be very sensitive about both these issues	I need to be careful when interviewing participants and choose my words carefully Patients involved in the research design informed me it was important to ensure that propensity for embarrassment and discomfort are minimised when speaking to participants
I have undertaken previous academic work into adult obesity and bariatric surgery	Being aware of this means I can understand some of the processes that patient go through, but need to ensure that I focus on the participant interpretation of these processes and not what I know

I do not have a weight problem, yet I am researching a surgical intervention for weight loss	Will this make a difference to the participants? If appropriate, ensure I let the participants know my personal experiences surrounding bariatric surgery, which may be used to build trust, rapport and empathy My experiences were drawn upon were appropriate to create rapport, but the issue of myself being a normal weight was not raised
I have close contact with a bariatric surgical unit and some participant documentation has hospital logo on	Will participants view me as part of the hospital team and thus try to answer to please me? Ensure that I stressed this was a research project which was separate to any care they were receiving at the hospital. This was stated on participant information, but I also emphasized this when interviewing participants.

Thus, I used the sensitising concepts as points of departure (Charmaz, 2014) and I felt these enhanced my relationship with each participant, during the pilot study and data collection, as my prior knowledge and experience appeared to establish my position as the interviewer as someone who could relate to bariatric surgery and not exist outside the world of the participants.

5.5 Participant criteria for taking part in the thesis

As part of ethical considerations and to ensure participant well-being, I agreed a specific set of inclusion/exclusion criteria for participants with CHSFT. These were as follows:

Table 5.2 Inclusion/exclusion criteria

Inclusion	Adult (≥18 years of age) Up to 2 years post-surgery at time of interview Under the care of CHSFT Able to provide informed consent No active psychological conditions for which treatment is currently being provided Gastric bypass or gastric sleeve procedure
Exclusion	Persons ≤ 18 years of age After 2 years post-operatively Discharged from CHSFT Inability to provide informed consent Psychological conditions for which treatment is currently being provided Gastric band or gastric balloon procedures

Patients are under the care of CHSFT for two years after bariatric surgery. After this time they are discharged into the community. NHS ethical approval was given for the research to take place at CHSFT only, so no other patients could be approached. The Research and Innovation Department required me to exclude any patients with active psychological conditions for which treatment was being sought. Additionally, it was agreed by my supervision team and CHSFT to focus on gastric bypass and gastric sleeve only and exclude gastric band patients, as the hospital did not perform many gastric bands at the time data collection was going to take place. Patient with gastric balloons were also excluded, as this is not a permanent surgical procedure. Participants recruited to the thesis had to meet these criteria to be included.

5.6 Summary

Following these activities, I was confident that I had taken steps to ensure participant comfort and well-being at all times. Once all ethical approvals were obtained, the data collection and analysis commenced. The process is discussed in Chapter 6.

Chapter 6: Findings

6.1 Introduction

This chapter presents the findings of the research. It commences with an overview of the constant comparative analytic process, beginning with sampling and data collection. Following this, the data analysis process is presented to reveal how the properties of the categories were constructed. Although these processes are discussed separately, in practice they were used concurrently to inform each other as the research progressed.

6.2 The constant comparative analysis process

The interpretive nature of qualitative research means ideas and concepts are initially shrouded in ambiguity until the meaning and properties of these can be defined (Charmaz, 2014). The systematic approach to concurrent data collection and analysis in grounded theory allows a foundation for the theoretical concepts to be established in order to be able to construct a theory. This thesis used this approach to explore concepts interpreted in the collected data, to understand the participant-reported tacit meanings and actions. Additionally, the application of the theoretical perspective of symbolic

interactionism provided further insight into the subjective accounts of the experience of adjusting to life after bariatric surgery.

Although the process is shown in a linear diagram, in practice the analysis was conducted concurrently with data collection and alongside and underpinned by theoretical sampling, memo-writing and cluster mapping. This formed the basis of the constant comparative analysis technique (Figure 6.1) which was used to develop codes and categories which formed the construction of the grounded theory.

Figure 6.1 Steps taken in the process of constructing the grounded theory in the thesis

Data collection through semi-structured interviews informed by initial purposive and subsequent theoretical samping → Transcription of audiotaped interviews to text documents → Initial coding (concurrent memo-writing and cluster mapping) → Focused coding (concurrent memo-writing and cluster mapping) → Theoretical coding → Construction of theory
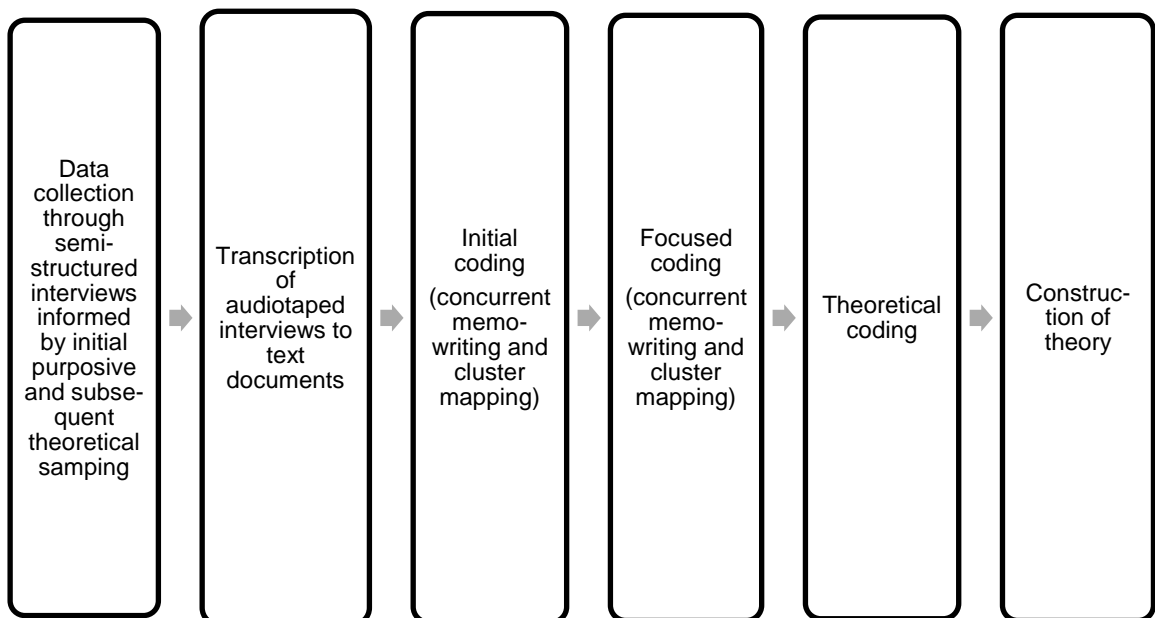
6.2.1 Sampling and data collection

There were a total of 18 participants in the thesis. Initially, participants were identified and purposively sampled from patient records at CHSFT, by the bariatric surgical administration staff. At this stage, I wasn't sure what the response rate would be, so 12 letters were sent to prospective participants, to identify a potential response rate. This was done to avoid the possibility of over-recruiting and potentially having to turn participants away who were willing to participate. Participants (n=12) meeting the inclusion criteria were contacted by post and 4 responses were received. This gave an idea of what future response rates were likely to be. This informed the remaining recruitment process with all subsequent recruitment invitations sent out in batches of 12 during the thesis. This was done a total of four times. Response rates varied between 25-33%; all participants who returned the invitation to participate were included in the study. All participants consented to be interviewed, with these initial interviews taking place between January and February 2014.

Once the data were transcribed, coded and compared with other data, further recruitment using theoretical sampling was used to explore concepts found in the data which informed subsequent data analysis and further theoretical sampling. The remaining 14 participants were recruited using theoretical sampling to explore the properties of the concepts constructed through the data using the constant comparative analytic procedures. The remaining interviews were carried out between March 2014 and April 2015.

All 18 interviews were face-to-face with the participants, but in three cases, the participant requested his/her spouse to be present. The location of the interviews was chosen by each participant; 14 interviews took place in the participants' homes, one at the participant's place of work, one asked to be interviewed at the University of Sunderland, and two took place in cafés selected by the participants. By asking the participants to choose the location of the interview, their comfort and well-being was taken into account, and it gave each participant the opportunity to become involved in the research from the outset, and helped to establish the constructivist grounded theory tenet of mutual reciprocity between participant and researcher (Charmaz, 2006).

There did not appear to be a difference in the detail of the data given the different locations in which the interviews took place, nor did the presence of the spouse in three of the interviews. All participants stated they were comfortable being interviewed in the different locations and consented to have their interview audio recorded and for me to take concurrent written notes. I wrote down any points which I felt needed explaining in more detail. This was done to understand the meaning and concepts raised which I wanted to explore further, without having to interrupt the participant. This was generally done at the time of interview, but I contacted some participants as I transcribed some of the interviews to clarify the meanings of words and phrases which I felt were ambiguous and I wanted to capture participants' meanings, as these would influence my interpretation, so a co-construction of the data was produced.

All interviews were transcribed verbatim by myself, which allowed me to reflect back on the interview and listen to the tone of voice, and compare the interviews with the field notes to ensure I had clarified any ambiguities in order for the transcription to reflect the participants' words. The transcriptions were saved as anonymised documents, with each participant assigned a letter of the alphabet, and then copied to a sheet I had produced (see Table 6.1) to facilitate line by line coding. Once the audiotapes were transcribed into text, they were erased from the recorder.

6.2.2 Data analysis: the coding process

The analysis began with the coding process; below are examples of how open, and then focused coding was used to identify concepts and categories. This formed the foundation upon which the co-constructed theory was developed from.

6.2.2.1 Initial coding

In all versions of grounded theory, initial coding is the first step in the analysis procedure and is done to move the text from a descriptive account to uncover

the implicit processes in the data (Charmaz, 2006). The text from the interviews was initially coded line by line using gerunds to raise awareness of underlying actions and potential meanings of these actions. This was done to fracture the data, reduce the influence of researcher bias and preconceived notions (Corbin and Strauss, 1990). Data from each interview were then compared to identify actions and emergent patterns which I studied to try to conceptualize what was happening within the data, as recommended by Glaser (1978). As demonstrated in Table 6.1, making these actions and meanings explicit through the initial coding process provided concepts for exploration in subsequent interviews.

Table 6.1 Examples of initial coding

Interview transcription (Participant G)	Initial coding
Well mentally I felt that I had done something really positive by having surgery…this might seem overdramatic but I felt like I had a new lease of life…I've done something now that's going to have a really positive effect and this is it…I'm going to really try and stick to everything. Lose the weight, become more active, because one of the things I regret now but my kids are now 7 and 11 and I regret not being able to go on a playing field and kick a ball about with them…because I would be in utter agony...but this is a turning point and I'm going to make sure I spend more time with the kids and do things… before I used to walk from one side of the	Feeling positive about undergoing surgery Gaining a new lease of life Achieving a step towards a new life Making a commitment to self to comply with postsurgical advice Regretting effects of obesity on others Feeling guilty Feeling pain when trying to exercise Interpreting surgery as a pivotal step Making up for lost time Comparing ability to do

school to another and by the time I got there, this is how bad it got at some point I…literally it was a two minute walk…I did a seclusion duty at the end of my lunch and I used to have to go ten minutes early because my knees would be hurting and I would be out of breath and I would have to go into the toilets and have to have a couple of minutes to get me breath back….with the pain...	things pre and post operatively Having to time activities previously to allow time to recover Dealing with pain and side effects of obesity Comparing pre and post-surgical incidents Experiencing no pain Feeling more energized as a result of surgery
and now this is obviously further on but now in comparison I am like a spring chicken, I'm not out of breath, my pain is gone and I feel brilliant. I had the same sensation right after the operation…	Conceptualising surgery as a turning point/start of something new Knowing it will be hard work, but worth it to him Feeling effects of surgery through rapid weight loss initially
This is a turning point and I'm going to make sure it's all not in vain…this is going to be really great…I felt brilliant straight away...I lost a stone very quickly and I was able to walk straight away with less pain	Being able to live with less pain Feeling good about self

6.2.2.2 Focused coding

Focused coding is the next step in the analysis after initial coding. The most frequent or significant codes are selected and compared against the collected data (Charmaz, 2014) and become focused codes. These codes were conceptualized from the initial codes and were selected using a list of questions as recommended by Charmaz (2006) (See Table 6.2). By using these questions as a framework to study and compare data with, I was able to immerse myself in the data, which Charmaz (2014) states encourages a researcher to remain

open to all possibilities of interpretation, which in turn will reduce the chances of a superficial analysis.

Table 6.2 Focused coding questions to guide analysis

What do you find when you compare your initial codes with data?
In which ways might your initial codes reveal patterns?
Which of these codes best account for the data?
Have you raised these codes to focused codes?
What do your comparisons between focused codes indicate?
Do your focused codes reveal gaps in the data?

Source: Charmaz (2014)

The initial coding sheets were studied concurrently with the initial memos. The most common initial codes from all participant narratives were used to produce a list of focused codes, which were more 'directed, selective and conceptual' (Charmaz, 2006,p.57) than the initial codes. Through studying the initial codes, there were similarities of experience and meaning, but the wording of the initial codes was different. The meanings of the codes were also studied and grouped together in terms of similarity of experience and these also became focused

codes. Examples of how these were categorized into focused codes are shown

in Table 6.3.

Table 6.3 Focused codes from initial codes

Initial codes	Focused codes
Not losing weight Worrying about previous failures to lose weight Expecting but not getting improvement of health issues Coping with unmet expectations	Failing
Taking control Learning to live in a new body Buying smaller sizes Wearing different clothes Feeling healthier Increasing confidence Learning when to stop eating Eating differently Feeling free from burden of obesity Being noticed	Discovering
Feeling disconnected between head and body Learning signals from new body Experiencing side effects of eating (being sick, choking, pain, dumping) Comparing self to others	Feeling uncertain
Fearing disclosure Avoiding disclosure Lying to others Pretending Protecting self Fearing judgment Feeling stigmatized	Keeping secrets
Seeking support for self Supporting others Recommending surgery to others Reassuring others	Support seeking
Reflecting on pre and post-surgical life (dichotomous process) Reflecting on positive changes to life Accepting negative aspects of life	Moving forward

Improving personal relationships	
Having no regrets	
Increasing ability to do more physically	
Increasing desire to do more socially	
Having more energy	
Fulfilling expectations and desires	

6.3 Constructing the conceptual framework: concurrent analysis tools

I used two tools used concurrently during data analysis which supplemented the coding process and were used to help raise the analysis from description to abstract categories and theoretical interpretation. The first tool was memo-writing, which captured my personal reflections during the entire data collection and analysis process. The second tool was clustering, a form of mapping suggested by Charmaz (2014), to provide a visual representation of the data to help to see the processes and connections between codes. This is discussed in more detail in Section 6.3.4. Together these formed an integral part of the constant comparative analysis. These are subsequently discussed in further detail in the next two sections.

6.3.1 Memo-writing

In order to explore and capture my thoughts and feelings during data collection and analysis, I employed memoing which provided me with a written record of my reflections. These personal reflections formed an integral part of the

constant comparative analysis and helped me to explicate my ideas and reflect on the development of the conceptual theory. For example, the initial coding process revealed there were issues surrounding comorbidities that were interpreted by participants as important. This was explored in memos and comparing data from other participants. An example of how memos were employed is shown when exploring the importance of comorbidities to participants, based on their narratives. To demonstrate this, the following quote is taken from the transcript of the interview with Participant E:

> I'm going to the hospital next week about my sleep apnoea, but I think I'm over that now. I'm expecting to come off my CPAP machine [for treatment of obstructive sleep apnoea]….the sleep apnoea is almost gone, I can sleep. I used to go a week with hardly any sleep, an hour or two a night and it used to really concern me that I didn't sleep, it would affect my behaviour, I work for myself, I need to work and because I was so tired and lethargic it was so hard.
>
> (Participant E)

I returned to the first four interviews and realised this concept existed in the participant narratives, but I had not picked it up. I compared all interviews with each other. I also compared the interviews against the initial codes with the data to see if there were any new codes which could be identified, but the existing ones captured the meanings and actions in all narratives. An in-vivo quote from

an earlier interview with Participant D related to the hunch that comorbidities had meaning to the participants and the actions needed exploring. This in-vivo code had originally been coded differently:

> I wanted rid of it [Type 2 Diabetes]. I hate having to inject myself…I have five needles a day, two in the morning, one at lunchtime and two in the evening… Five injections a day and to me that's a hell of a lot, but now I suppose it is part of my life and I have to get on with it. I just need a kick up the ass to get myself back into gear really.

(Participant D)

I had originally been interested in exploring the concepts surrounding disclosure with Participant D, and had only superficially touched on the impact of co-morbidities and had only really thought about comorbidities in the context of Type 2 Diabetes, which Participant D had discussed. I returned to the original memo written after the interview with Participant D (see Figure 6.2) which was the fourth interview I undertook. This was the first time I noticed the concept of comorbidities and how the presence of these affected the adjustment process after surgery.

Figure 6.2 Memo from interview with Participant D

Memo after interviewing Participant D

This participant seemed to have had a more complex journey than the others. She had been refused surgery twice, and had to resort to almost lobbying to be referred. She referred to her preoperative self as a 'fat blob' and talked at great length about her long-term diabetes, which she referred to as '*very depressing'*. She was 15 months post operation, and had lost 5 ½ stone, but had plateaued and experienced some weight gain, despite trying to increase the amount of exercise and reducing her food intake and found this weight gain distressing. She was fearful about contacting the hospital, in case she found out something she didn't want to know, such as the operation had failed. She told me she was very uncomfortable disclosing her decision to undergo surgery and despite having two grown up children, as well as siblings, had chosen only to tell her mother.

She had no regrets about having surgery, and framed it as a new beginning for her after a series of personal setbacks. She was disappointed that she had to continue with her daily insulin injections, despite being happy with her post-surgical appearance and improved self-confidence. She had been told preoperatively there was a chance bariatric surgery would possibly eliminate the need for injections, and she had hoped this would happen.

She appeared to be weaving between unmet expectations, fear of unknown reasons for weight gain and wanting support but being afraid to seek it and being happy with her appearance. Receiving compliments was something new to her after surgery and she said enjoyed receiving these.

I was interested in her account of dining out with friends and feeling she was being watched. She had not disclosed having had bariatric surgery, so admitted she was worried about being 'caught' , feeling 'under pressure' and 'being watched' when eating out, and found herself lying to her friends and colleagues about the reasons for her weight loss. Difficulties when eating out came out in the first two interviews with participants, but this participant is different – there is deep-rooted fear, stigma, judgement and persecution.

I need to unpick disclosure – what does this mean? Where and when is it 'safe' – with whom and why and also explore the participants feelings and meanings towards comorbidity improvement – is it only Type 2 diabetes, long-term conditions which they feel are 'part of themselves', expectations of surgery? Go back to the first three interviews and see if these concepts are there, they might have been implicit and need to be brought out. Explore these in following interviews and see what comes out.

From the memo, I could see that I had identified comorbidities as potentially important, particularly Type 2 Diabetes, but I had also acknowledged that it may not be the only illness that caused difficulties for the participants. This memo had identified both disclosure and comorbidities and I realized I needed to focus on both.

After interviewing Participant E, I compared the transcripts of both D and E and felt both highlighted the importance of comorbidities to the participants and its relation to adjusting to life after bariatric surgery, but Participant E had discussed Obstructive Sleep Apnoea as the illness most impacting on his life prior to surgery, and he used it as a marker in which to measure his progress and adjustment after bariatric surgery. Following the interview, the memo I wrote (See Figure 6.3) focussed on exploring comorbidities and not specific illnesses.

Figure 6.3 Memo on exploring the impact of comorbidities

The impact of comorbidities on adjustment after surgery

The interview with Participant E sparked my curiosity about how comorbidities impact adjustment to bariatric surgery. E was very 'progress conscious' after surgery and kept a diary of not only weight loss, but monitored how the weight loss was improving his sleep apnoea. E had suffered from sleep deprivation, not only from the sleep apnoea, but from wearing the CPAP mask, which interrupted his sleep unless he slept in a chair, which did not afford him a good

---

night's sleep. He was aware that his lack of sleep was affecting his behaviour and he worried about the effects of this on others, as ran his own business and wanted to be seen as a good boss and liked by his employees. I picked up a sense of guilt from him; he seemed to think he had been moody towards his employees in the past and seemed to want to make it up to them. As he spent the majority of time running his business, the social relationships he had with his employees were important to him, and he had remarked on the support he had received from his employees before and after surgery.

'*After a month [post-surgery], I was coming down and doing a few hours…sitting in the kitchen and doing an hour and a half, supervising, but sitting down...an hour and a half would wipe me out for the rest of the day. I would literally sit and the girls would give me something to do...chop some mushrooms, prepare veg….and by six weeks I was back part time, I could do up to 2 ½ hours, slowly building meself up, but with assistance from others…members of staff*'

I also picked up a sense of frustration that he had to rely on others, and wanted to establish himself as the boss, not in terms of control, but in terms of self-esteem, which he remarked had been low before surgery.   He had a forthcoming appointment at the hospital, and was expecting to be told he no longer needed the CPAP mask, which meant he would have an uninterrupted night's sleep, which he felt would improve his behaviour and mood and he would be able to reassert himself and increase his self-esteem.

The meaning of comorbidities was important to E and I wanted to see if this has been discussed in other interviews. I returned to the interview with Participant D, who had expressed difficulty coping with her diabetes after surgery and realise now there are parallels between the two interviews. I reread all interviews to date, but D and E are the only ones who explicitly discuss the meaning of comorbidity. This needs to be explored in further interviews as the current interpretation is likely to be too superficial at this stage in data analysis.

I realised that the insulin injections (Participant D) and CPAP mask (Participant E) represented the meaning of illnesses associated with being obese. Following surgery, the actions of not using, reducing or cessation of these illness-related devices and the rituals associated with them, was symbolic of the success of bariatric surgery and a personal milestone in terms of the adjustment to life after bariatric surgery. Thus, memoing helped to conceptualize these meanings and actions which were captured in the coding process.

In addition, all concepts that I derived from the data had to earn a place in the emerging conceptual theory (Glaser, 1978) and this was done by exploring the properties and dimensions using the constant comparative analysis process. With the previous example of comorbidities, memoing was found to be a good way of exploring concepts. However, not all concepts identified ended up as focused codes or theoretical concepts and some were eliminated. For example, Figure 6.4 shows how a memo was used to unpick the concept of age, originally picked up as potentially interesting and important, but was eliminated after using memoing as part of the analytic process.

Figure 6.4 Memo: exploring importance of concepts

> **Does age have any bearing on bariatric surgery?**
>
> During one of my PhD supervision sessions, the subject of the ages of participants was raised. The team discussed the idea of theoretically sampling for participants who were older than the ones interviewed to date, to explore if the emerging categories could be applied across the adult life course.
>
> Informed by data analysis, there were many participants under the age of 45, so informed by the guidance of my supervisors, I requested the hospital to recruit older patients meeting the inclusion criteria for the thesis to consider participating in an interview. Theoretically sampling for older participants would allow me to explore the categories constructed from the data in the context of age and explore experiences of older patients. Recruitment letters were sent out and a selection of older participants was recruited. At the time of her interview, Participant H was the oldest person to take part in the research, at the age of 64. I had planned on exploring age during the interview; however H raised this before I had a chance to. I felt this meant the concept could be

explored with H directing the topic rather than myself, which I felt would be much better in terms of eliciting a natural response from the participant perspective.

H raised a very interesting point, positioning her weight gain later in life as a good thing, as it had enabled her to have had a life previously.

'I was a middle-aged woman when I got my weight problem'

When I asked her what this meant, she explained this as

'I didn't have the problem when I was a teenager…I could go dancing, ice skating, I could run, go to work…do all these things, have a family'

H had attended patient support groups whilst she waited for bariatric surgery and had met younger people there, and had observed their situations and compared them to her own:

'At least I'd had something of a life where as these young people who have had it [obesity] since being children never really had a life and a lot of them found a partner who accepted them as they were, and then when they got slim and healthy because it was a life-saving operation, the partner wasn't happy about it…it changed all of that'

H felt there was an age cut-off for bariatric surgery:

H: I got that impression in terms of operating, there is a cut off age'

YG: what age do you think that is?

H: I think it could be 65 and I'm nearly there and I think that's why I got pushed in, plus I had waited four years

YG: that's interesting

H: The ones on the ward who revealed their age were younger than me, I was the oldest, but I think would you impose bariatric surgery on a 70 year old? Would they recover as well as a 40 year old? I have ageism at work…until there is a crisis, then it's good to be the oldest one, the younger ones cry and said we are glad you are there, so there is a lot to be said for being older and wiser…I get students at work, they ask me a lot of questions because I have more experience

I felt this may be potentially interesting, but I wasn't sure where it was going, but I was able to explore this in the next interview with I, who was 60. The issue of age was not a problem with her, she discussed the surgery as getting her life back; she had a family, and had experienced health problems throughout her life, some , but not all related to obesity, and bariatric surgery had been the

catalyst to being able to claim her life back.

What was interesting was that I's husband was in the room with us, and participated in the interview at times.

I's husband: Even I say, as her husband…go for it [recommending bariatric surgery to others], it changed her life; it changed our life, completely, hasn't it?

I: We have a marriage now…

I's husband: We had a marriage before

I: I know, but it was one-sided, you did all the work, looking after me and our son…

I's husband: I never complained about her weight before, she was 23 stone, I never said she was fat or insulted her, I wouldn't have done that and when she said she was having it done I was all for it and now…I'm all for it. Every time she loses weight I'm pleased for her and as far as I'm concerned, she's turned 60, but I've got a new wife

YG: That is so lovely

I: I can do more, I can do the dinner, I can stand…Sunday lunch is always made for you when you come in now…

I's husband: It has to be a partnership; you need someone on your side with you, supporting you. You don't want people putting you down, it makes you feel awful. I never did, but other people did and it was horrible…you don't want a stick thin wife; I like something to grab hold of…

I: (laughing)…Eee, don't say that!

Age and the passing of time was mentioned, but the interview revealed concepts which had been expressed in other interviews with younger people and with H, which were unrelated to age. No further participants interviewed were in this age category; nor did younger participants mention age in any context. As a result, this was not explored further as age did not appear to impact on the experiences of adjustment to life after bariatric surgery or appear important to participants.

Thus, memos provided a space in which to determine the importance of concepts and the reasons for not pursuing some concepts were justified by

showing how and why these concepts were not included. As the analysis progressed, the memos became more conceptual (See Figure 6.5) and this was helpful in determining properties of concepts. This memo was written following the interview with Participant P. This was the first of three interviews conducted after the grounded theory was constructed and was undertaken to ensure that theoretical saturation had taken place and to ensure the properties of the categories supporting the theory were defined.

6.3.1.1 Example of a later conceptual memo

This memo was written in the later stages of data collection (See Figure 6.5). Initially, I reflected on whether the reasons for his obesity, which were different to all other participants, would have an impact on his adjustment to life after surgery. I thought it might mean this participant may be different somehow, but I was conscious this was something I had thought of, and may not represent the participant interpretation. By writing this memo, I was able to separate my curiosity as to the cause of his obesity and focus on the experiences of adjustment. Through this process, supplemented by coding, I found similarities of adjustment experiences with others, which meant the differences I had originally perceived were my interpretations, but the data showed that these differences were not part of the adjustment process.

Figure 6.5 Example of a later conceptual memo

Iatrogenic obesity:

The circumstances behind bariatric surgery were different from the other participants. P had suffered from a benign brain tumour, which had been removed 10 years ago, affecting the optic nerve and pituitary gland. The latter necessitated lifelong steroid therapy which had attributed to his weight gain. He was referred for surgery by his endocrinologist to combat the weight gain associated with the steroids. This is the first participant to have a case of iatrogenic obesity.

'My pituitary gland was damaged, that was the main thing, the gland is totally dysfunctional now, so all the things the pituitary gland secretes naturally, I have to take artificially which involves steroids. I've been taking them for ten years now and also hydrocortisone, high doses and within three years of my brain tumour operation, I had put on 10 stone…if I sat in a quiet room, I could literally hear myself growing and getting bigger...the speed with which I put weight on was incredible...my trousers didn't fit anymore and I became depressed and miserable and couldn't stop eating...the steroids gave me an uncontrollable appetite, I could never be satisfied….

This is the first participant who presented with a disability (registered blind) and was living with a lifelong condition needing medication which was associated with weight gain. I compared his experiences with Participant M who had a long-term back injury resulting in paralysis of his leg, which could be rectified with surgery providing enough weight was lost to be able to be 'safe' for surgery. Theoretically, his paralysis and disability would go away with back surgery, but P had to live with this condition for the rest of his life.

P reported the weight loss had increased his confidence and self-esteem and he no longer felt isolated, and had joined a sports club where he had met other people and took part in team activities which had extended his social circle. Owing to his vision, he had to rely on carers who he reported had taken advantage of his condition, so his mother had taken over these responsibilities.

P had a good social circle of friends he went out with, but from the time after his brain surgery to the time of bariatric surgery, he reported being at a low point in his life, and thought that marriage and a family were not things he would be able to have, owing to his appearance and disability. P reported these feelings had decreased, and that these aspects he felt were now a possibility and his confidence levels were increasing.

Surgery might reduce the risk of him spending the rest of my life alone, he can now see himself maybe getting married and having a family. Before surgery he

was worried he would spend the rest of his life alone.

The risk of bariatric surgery was a good risk compared with the imposed brain tumour risk. Bariatric surgery has changed my life for the better, but brain surgery was necessary to save my life, for which I am grateful, but it has changed my life and made me obese. Both operations have been life-changing, but the bariatric surgery was a good life change, which overrides the bad effects of the brain surgery and I can live and accept the risks associated with bariatric surgery as these are not as bad as the ones from brain surgery.
Happy to disclose to friends about the decision to have surgery and as such I have no problems eating out. Although I eat and drink differently, this is not a big problem for me, I am learning to deal with volume, choices etc.
The choice of the bariatric surgical procedure was not made by me, it was imposed on me because the effects of bypass would affect the absorption of steroids I need to take every day and the dose has to be exact. But this was not a problem; I was just felt lucky to have had bariatric surgery.

The choice of procedure being driven by disease or illness and not the choice of the participant had come through in other narratives (Participants E and M) but when prompted, had not been a problem; as long as a bariatric surgical procedure had been performed, the choice was not really a problem. Participants were aware that weight loss with a sleeve may not be as great as that which could be achieved with a bypass, but this appeared to be accepted by the participants. Although the reason for his obese state was different to the others, his experiences of the adjustment process were congruent with some of the other participants

To show how I had interpreted this co-construction, I have shown a page from the transcript of Participant P which shows the initial codes (see Figure 6.6), which, when compared to coding from the other transcripts, showed that Participant P had similar experiences as others and that no new codes were found in the analysis. I realised that my curiosity around the reasons for his obesity unrelated to any aspect of his experiences of adjusting, and that writing the memo had helped me to organise my thoughts, feelings and not thrust concepts into the data that did not exist or belong in the analysis.

Figure 6.6 Excerpt from coding of Participant P transcript

Text	Coding
P – for sure…your body gives you new signals and you need to learn them...I had an incident early on…I was eating, I ate a bit too much and ended up vomiting...but I'm in tune with the signs now….as soon as I feel remotely full, I just stop eating…. it's kind of hard to describe because I now kind of forgot about the way I ate before…for the last ten years I never knew what it was like to feel full because I was constantly hungry and never felt full...but now say, I could be eating a banana, and after I've eaten three quarters of it, I'm like 'I'm full'...it was such a new thing. YG – you mentioned vomiting before can you tell me about this P – well…the first real major shock to my system happened when I drank a carton of apple juice…I wasn't thinking about it, I was on autopilot, I wasn't sure whether it was dumping or something, I must have drank it too quickly but my stomach hurt, I went to the sink, tears streaming down my face….my stomach was in such pain…my mother was rubbing my back and saying what the hell is going on with you….I was retching and retching…for about ten minutes…I might have drank too much…I don't know but it was awful….but it did happen once with a coffee, maybe it was the volume...how much I drank.. I don't think I've ever experienced dumping…it used to happen when I ate sweet things but now it doesn't anymore…. YG-You have mentioned so many good things that have happened for you after bariatric surgery, can you tell me about anything that maybe isn't so	Learning new signals from body Eating as process of trial and error Forgetting about past habits Feeling positive about changes Feeling different is a good thing Comparing past and present Learning from side effects Reflecting on reasons for the reaction to food Not blaming self, but realising it is part of the process of adjustment Moving on Thinking about potentially difficult situations

good?	Making plans to deal with these
P – I thought maybe going out with friends for a meal would be awkward, but it isn't….I just have a starter and maybe less of a main course…it was my friend's birthday and we all went to a curry house and I ordered a starter…it took me a long time to eat it and they kept wanting to take the plate away and I was like no...I'm not finished...I told them a few times and they did get bit shirty, but that was the only real trouble I've had...my friends are really supportive. I've been quite lucky…my friends and my family are there for me….really supportive. The only trouble I've had was on Facebook...a friend, this girl I used to know from school, she sent me a message saying 'I think it's absolutely disgusting people getting this surgery...fat people getting surgery for free, when there's people who can't conceive, who can't afford IVF' and I thought to myself 'what's that got to do with it?'…	Asserting self in awkward situations Feeling grateful for support he has Reflecting on reactions of others towards bariatric surgery

6.3.2 Using in-vivo quotes as reflective tools

Charmaz (2006) recommends paying attention to language to learn about participants' meanings of words rather than the researcher making assumptions about what the words mean. As I listened to their stories, transcribed and read the interview transcriptions, I picked up on words and phrases which I thought needed further exploration and wrote these down. As I identified them, I was aware that these words and phrases only seemed to have a particular meaning for the individuals who expressed them. I wanted to make sure I understood the subjective meaning of the words as opposed to just a literal translation and

not assume that my interpretation was the same as the participants. I noted these and discussed with participants as soon as I identified the words and phrases. Sometime this happened during interviews, but other times it did not become apparent that the words of phrases may have a different meaning until I undertook the transcription process or when comparing and analysing data. Identifying words in the narratives as stated verbatim by the participants, encapsulating these in quotation marks are referred to as 'in-vivo' quotes (Saldana, 1013). These are used in qualitative research to provide evidence of how theory was constructed from the data collected but need to be interpreted early in the analysis (See Table 6.4 for examples).

By studying the words in the data, I learned the nuances and meaning of the words to the participants, which helped foster an awareness of participants' feelings and views (Charmaz, 2006). Exploring participants' words and phrases also builds theoretical sensitivity, which is the ability to 'understand and define phenomena in abstract terms and demonstrate abstract relationships between studied phenomena' (Charmaz, 2014,p.161) and central to constructing a conceptual theory. This further builds on the constructivist grounded theory tenet of establishing a mutual reciprocity with the participants and ensuring that the eventual theory is an acknowledged co-construction between the researcher and participants as opposed to a sole interpretation by the researcher.

Table 6.4 Exploring emergent concepts found in participants' language

The following quotations were stated by the participants, both individually and collectively, with ideas to help define and delimit the concepts noted, to help unpick these in further interviews and when comparing data with data.

In-vivo quote/Concept	Defining properties of concepts
'I'm not ill, I'm just different' (B)	How has surgery changed the perception of illness? Is different good/bad? In what ways? What does being different feel like and why? What does it mean to be different and not ill?
'Normal' (expressed by all participants)	What is meant by normal? What actions signify normal? Was there a pre-surgical normal and if so, has it changed after surgery? If it has, how? Do participants have different ideas on the concept of normal? Is normal related to self/life/social activities/eating?
'Feeling weird, frightened or different' (A,B,C,D,F,J,L,N,O,P)	What is the difference between these three words and what action is taken as a result? What is meant by each word?

	How do these feelings impact on actions understand to adjust to post-surgical life?
Feeling a disconnection between head and body after surgery (A,B,C,D,F,N,O,P)	What does it mean to be disconnected (physical, mental, emotional)? What does head disconnect and body disconnect mean? Are they the same? How does this disconnect underpin actions (social, eating, self)

The in-vivo quotes were used as reflective tools for memos (Figure 6.7) and mapping (Figure 6.8) to further immerse and engage with the data. This allowed a bridge to be built between the participants' experiences and the researcher's interpretation of the experience (Charmaz, 2006) with neither overshadowing the other. This is the essence of mutual reciprocity which establishes the theory as a co-construction between the two parties.

Figure 6.7 Memo written from an *in vivo* code

Using the phrase 'I'm not ill, I'm just different' as an example, Figure 6.7 shows how the participant language was explored to understand the subjective meaning. Once defined, the concept was explored with other participants and in the collected data to establish its properties.

Exploring in-vivo words and phrases

'I'm not ill I'm just different' Participant B

During the interview with B, she stated this phrase and her wording fascinated me. I discussed this with B after the interview and took notes, clarifying all aspects with B to ensure that my interpretation was co-constructed and reflected her meanings. She was making an inference to perception of herself after surgery and I felt there was something in this statement that I needed to unpick with her. B discussed her concept of illness as being related to her former obese state, with illness manifesting from obesity-related physical symptoms such as sore knees and the inability to move without pain or feeling short of breath:

'I was so big and I was so tired I would sit and I couldn't exercise because my knees were causing me problems...I couldn't do the housework properly, I couldn't get down on my knees to do cleaning and things like that'

B reported bariatric surgery as a cure for her illness. As following bariatric surgery, these symptoms alleviated and she expressed no longer feeling ill as a result of physical changes and self-reported mental adjustments to surgery, the concept of illness changed into a concept of being different, and we discussed this as one set of problems/issues resolving, but new and different issues emerging as a result of surgery.

B's concept of being different was rooted in adjusting and managing the changes to her body and mental state/head from bariatric surgery and the effects of this on her life. For example, she worried about a situation in which she would have to be intubated:

'When the ambulance picked me up that time, they didn't know about bariatric people, I don't think I can ever have a tube put down my nose into my throat and then into my stomach because of the surgery...they wouldn't have known about my restricted stomach...not that they were going to do that, but what if?'

There was the worry of being damaged through a routine procedure as a result of having a different body; the worry was more like fear I thought, she was very agitated when she discussed this.

Being 'different' had meanings which led to specific actions for B. She reported being challenged in restaurants about portion sizes, such as ordering a child as opposed to adult meal. She compared this to someone with a nut allergy requesting special considerations being an accepted problem, and bariatric surgical requirements as different, possibly as a result of apathy, ignorance or feeling they are losing out by offering a smaller, cheaper portion:

'I went to the Toby carvery a few weeks ago, I asked for a child's portion, they didn't have a problem with that, it was a small tea plate which was enough for me, but when I went in to the one in Middlesbrough she was funny with me and said, Oh we're not supposed to so that so I said look I've had bariatric surgery, I can't eat a full portion, I can only eat a little bit. I was annoyed to the point that I thought if she says no to me I'm going to leave, walk out of here, I'm not going

to pay for an adult portion because that is like as if someone had gone in with a special dietary need, they would have gone out of their way to help them, like a nut allergy, but because I asked for a smaller portion she thought I was trying to pile on the vegetables and the plates, the ones you use to help yourself, using a child's plate to get away without paying, I thought if you don't let me have a child's portion, I'm leaving. In principle, I've asked you for a smaller portion for <u>my</u> dietary requirements, <u>my</u> needs and she said well we really shouldn't, I'm not supposed to……having to ask for a child's portion, they think you're being greedy. I think they [bariatric surgical units] should write to companies and say that more people are having surgery, its more popular and you should have smaller adult portions as an option, if you can offer it to children why can't you offer it to us without us having to explain our life stories away….its discrimination, but we have to stand up for ourselves'

Being and feeling different had meaning and was important when deciding where to eat out, to avoid difficult situations like the above. Being different meant there were actions to be taken to prepare oneself for going out.   B professed to going on-line to decide where to eat:

'Before I go out, I go online and look at the menu to decide if there is something I can eat, like jacket potato, or do they do vegetables and I'll just eat those…I can't eat bread, I can't eat pasta, I can only have certain things…I need to have bland and boring food, like vegetables and some meat, I didn't know my new body and if I can't go and eat out, I can't socialize the rest of my life and then what am I going to do? I've been out, I order meat and scrape the sauce off, I eat in stages, I eat a bit, then wait and eat some more, it gets cold, but I live with that'

Different was interpreted by B in coming to terms with her changing appearance. Although she was pleased with her weight loss, she was still getting used to looking different :

'I look in the mirror and I think, that's not me…I had trouble with that…looking in the mirror 'cause that's not my body. I don't know how to explain it to you, but it's weird, I've looked in the mirror for all these years and its big, bubbly me and all of a sudden that's not my body shape…I've gone through so much, which I am really grateful for, over the moon that I've lost the weight, but it just messes with your head….it's crazy, I look in the mirror and it frightens me, I have to walk away because I think, do I look like what I have just seen? I don't know if I am used to that, if I can accept that…it's really really strange. I look sideways and I've got a shape, there's not fat hanging there, I wear different clothes now. I used to live in skirts, I never wore tights because I was too fat, I never wore boots because my legs were too big, but now I live in leggings and boots and things like that. It's just like this is a new person, just not me, it's weird. I can go into a clothes shop and buy anything. I don't have to go to the back of the rail and see if they have bigger sizes, I can go in the middle and get a size 16 or 18 now. I don't know in my life when I was a 16 or 18, but it's like I say to people, it's <u>my old head coming to terms with this new body and I'm still coming to terms with it, it's weird, it's really strange and it's happened so quick</u>'

The concept of a transformation from being ill to being different has really

intrigued me. B thought of herself as ill in terms of obesity, and bariatric surgery as the cure for this, but I am picking up that although she is happy with her weight loss, has no regrets about having undergone surgery but is still working out the adjustment process in some aspects of her life.

I need to explore this in further interviews, do others feel the same and what does it mean to them?

Thus, using memos was an effective tool for understanding, exploring and supplementing the coding procedures. The second analytic tool, which supplemented both coding and memos, was cluster mapping.

6.3.4 Cluster mapping

The purpose of all types of mapping is to give a visual representation of the data, which can be useful for trying to understand what is happening in the data. Clustering is defined as providing the researcher with a 'non-linear, visual and flexible technique to understand and organize your material' (Charmaz, 2014,p.184). After the first four interviews were carried out, and the first memos had been written, I was aware that there were concepts in the data, but it was difficult to understand the properties of these by simply reading and re-reading documents. I subsequently drew the first cluster map (see Figure 6.8) to try to construct a framework in which these relationships could be understood. Once concepts were mapped out, it was easier for me 'see' what was happening. In order to provide a broad framework, the concepts were classed into areas which appeared to be problematic to the participants when adjusting to life after

surgery. These were mapped out using the guidance provided by Charmaz (2014) to see how the areas related to each other and whether any new concepts emerged.

Figure 6.8 Cluster map

Figure 6.8 Cluster map
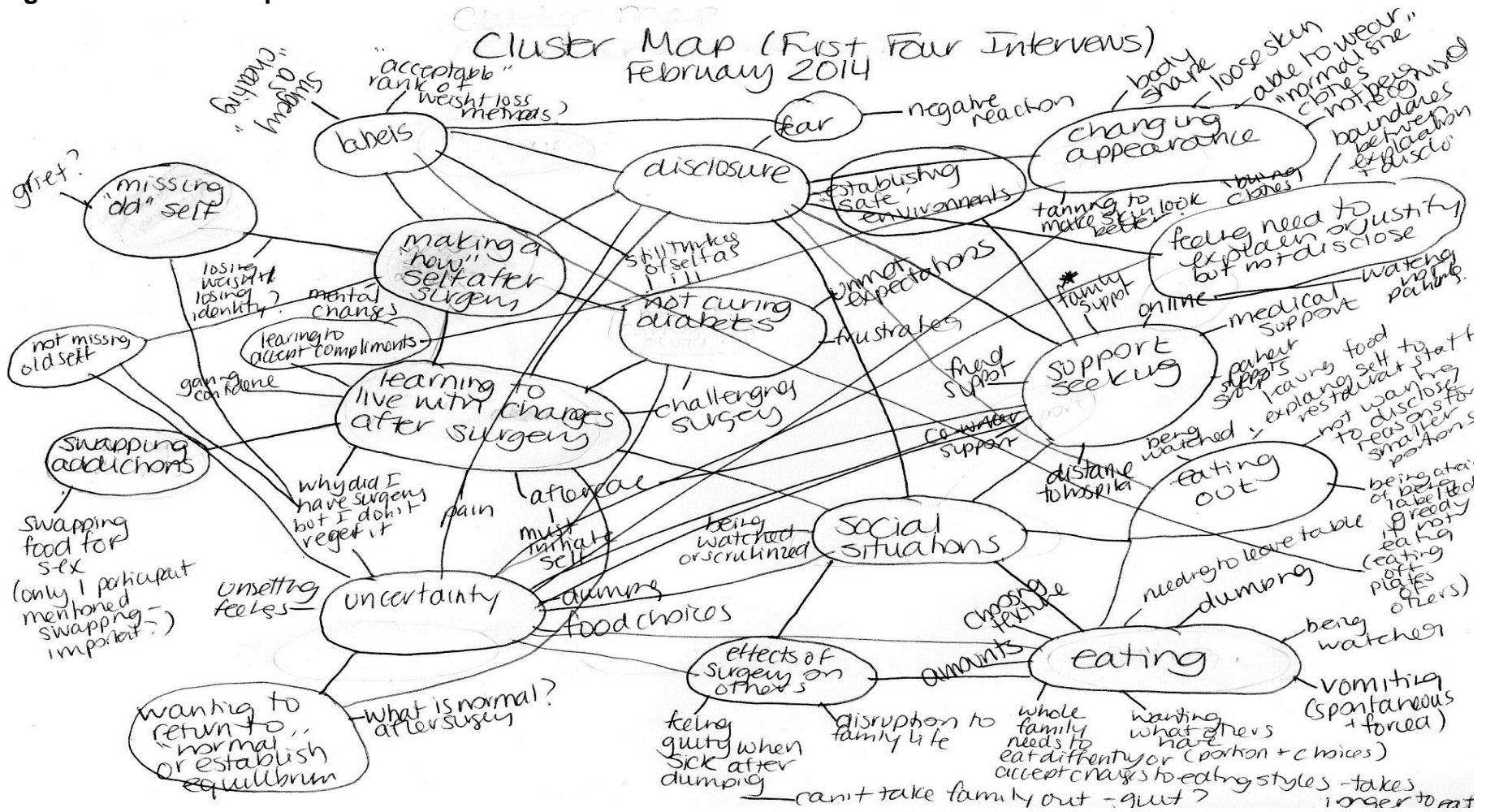
By using mapping early in data analysis, I was able to visualise emerging processes associated with adjusting to bariatric surgery. This visualisation assisted me to gain a deeper understanding of the participants' lives and identify areas for further exploration. I continued to use mapping throughout the entire data analysis process. By having visual maps to read concurrently with written text, I felt able to more fully understand what was happening in the data, and it provided me with a source of inspiration and creativity, which increased my confidence when analysing the data.

As constant comparative analysis involves concurrent data collection and analysis, so this chapter returns to data collection, and recruitment of the participants, of which theoretical sampling is an integral part. The data analysis informed the sampling of participants to take part on the study.

6.3.5 Theoretical sampling

In order to obtain an initial sample of bariatric surgical patients to take part in the research, purposive sampling was used to initially recruit the first participants. Potential participants were selected from post-operative lists by the bariatric surgical administration staff and who met the inclusion criteria for taking part in the study, which were having undergone bariatric surgery within 2 years of taking part in the interview, the ability to provide informed consent, and no active psychological issues. The two year timeframe was selected because

patients who undergo bariatric surgery are under the care of CHSFT for two years following surgery which would mean a greater chance of recruiting participants to be interviewed.

The remainder of the participants (n=14) were recruited using theoretical sampling. This permitted exploration and construction of the properties of the developing categories. Theoretical sampling provided a platform for creative thinking and reflection on which I was able to define the properties, boundaries and relevance of the categories (Charmaz, 2014) that I had constructed from the data, for example, to explore age and experiences of bariatric surgery discussed earlier (see Figure 6.4).

Theoretical sampling involves abductive reasoning, which is defined as:

Considering all plausible theoretical explanations for the surprising data, forming hypotheses for each possible explanation, and checking these hypotheses empirically by examining data to arrive at the most plausible explanation.

(Charmaz, 2014,p.201)

Abductive reasoning consists of three inter-related ideas; explaining patterns of data, entertaining multiple hypotheses and inference to the best explanation (Reichertz, 2010) which means grounded theory in itself is an abductive method as it involves reasoning about experiences found in empirical data to make theoretical conjectures. Theoretical sampling was undertaken with the remaining 14 interviews and recruitment ceased once theoretical saturation had been confirmed after 18 interviews.

6.3.5.1 Reaching theoretical saturation

The grounded theory was constructed from the data collected from these interviews. Theoretical saturation was thought to have been achieved after 15 interviews. To reflect on whether I had or was reaching theoretical saturation of the data, I used a checklist to assess my thoughts (see Table 6.5):

Table 6.5 Determining theoretical saturation

Which comparisons do you make between data within and between categories?
What sense do you make of these comparisons?
Where do they lead you?
How do your comparisons illuminate your theoretical categories?

In what other directions, if any, do they take you?

What new conceptual relationships, if any, do you see?

Source: (Charmaz, 2006)

I wanted to be certain that the conceptual theory I had developed was saturated in terms of its meaning and enactment (Charmaz, 2006) as co-constructed with the participants through their narratives. I returned to the tenets of symbolic interactionism as the theoretical perspective for the research to confirm that the context and temporality of the meanings and actions constructed from the data were defined, and that I had been critical in my interpretations and analysis. I did not want to purport to have achieved theoretical saturation too early.

To confirm theoretical saturation and test the construction of the theory, three more interviews were conducted between March and April 2015. Theoretical saturation is achieved when, during data analysis 'no new properties, dimensions, conditions, actions/interactions or consequences are seen in the data' (Strauss and Corbin, 1998,p.136). Analysis of interviews 16-18 did not reveal anything new; thus saturation was deemed to be confirmed and recruitment ceased.

6.4 Constructing the grounded theory

To construct a grounded theory, four theoretical concerns are of concern to a researcher using a constructivist approach; these are discussed with the emphasis on their influence on the constructed theory. Four theoretical concerns affect data and how this is collected in order to construct theory, which are theoretical plausibility, direction, centrality and adequacy (Charmaz, 2014). These are outlined to show how these concerns shaped and influenced the construction of the grounded theory.

6.4.1 Theoretical plausibility

To strive for theoretical plausibility in a grounded theory is similar to achieving accuracy in other forms of qualitative research (Charmaz, 2014). The concept of accuracy is socially constructed, and in a subjective interpretation such as this thesis, the aim is to make tacit actions and patterns explicit. Therefore accuracy is not a concern, but theoretical plausibility is. In the spirit of mutual reciprocity embedded in a constructivist approach, it is not for the researcher to specify what is accurate; congruent with Thomas' (1928) concept of the 'definition of the situation', in that if 'men [participants] define a situation as real, then it is real in its consequences' (Thomas and Thomas, 1928,p.572) Thus, the participants' accounts and their subjective meanings and actions, in line with the

epistemological and theoretical perspectives of the research paradigm, were acknowledged as veracious.

Glaser (1978) states that participant accounts should not judged for accuracy, but analysed to uncover the underlying actions and the meaning of these actions to the participants (Glaser, 1978), contributing towards theoretical plausibility. Thus, the grounded theorist is more concerned with whether the data collected were theoretically plausible than to question the accuracy of the participant's narratives. Collecting an extensive body of data which is embedded in 'broad and deep coverage', reduces the chances of a superficial exploration and strengthens the theoretical plausibility of the analysis (Charmaz, 2014, Glaser, 1998).

6.4.2 Theoretical direction

As the data were collected and analysed, the open coding, focused coding, memos and field notes shaped the theoretical direction. Patterns emerged, which shaped the topic guide; prompts were amended as the interviews progressed (see Appendix 4a for examples of early and later topic guides used to direct the interviews). Mapping was used to visualize emerging patterns and to understand how concepts may be related to each other which contributed to theoretical direction. To construct the basic social processes underpinning the

adjustment to life after bariatric surgery, the common storyline which underpinned each participant's journey was mapped out.

Although the research focuses on the first two years following bariatric surgery, as stated in the inclusion criteria (see Section 5.5) many participants acknowledged that their subjective accounts of post-surgical experiences were inextricably linked to events which occurred pre-surgically, which was conceptualised as a pre- and post-surgical dichotomy. As I mapped the collective journey the participants appeared to experience, I was guided by the application of symbolic interactionism as an abstract theoretical framework, helped to understand and situate the meanings of these experiences and subsequent actions, which allowed me to gain a deeper awareness and conceptual understanding of participant experiences.

Based on the narratives of the participants, a collective framework was created which explicated the social processes in which the participants travelled through in their bariatric surgical journey (see Figure 6.9). Through this framework, the concepts identified in the data could be situated, and used to show how the process of adjusting to bariatric surgery was temporal and changed over time and where the roots of the meanings and actions in the post-surgical timeframe were situated.

Figure 6.9 Mapping the collective participant social processes linked to bariatric surgery

Presurgical timeframe

| Worrying about remaining obese | Deciding to seek bariatric surgery | Preparing for bariatric surgery | Learning to adjust to life after bariatric surgery |

Postsurgical timeframe
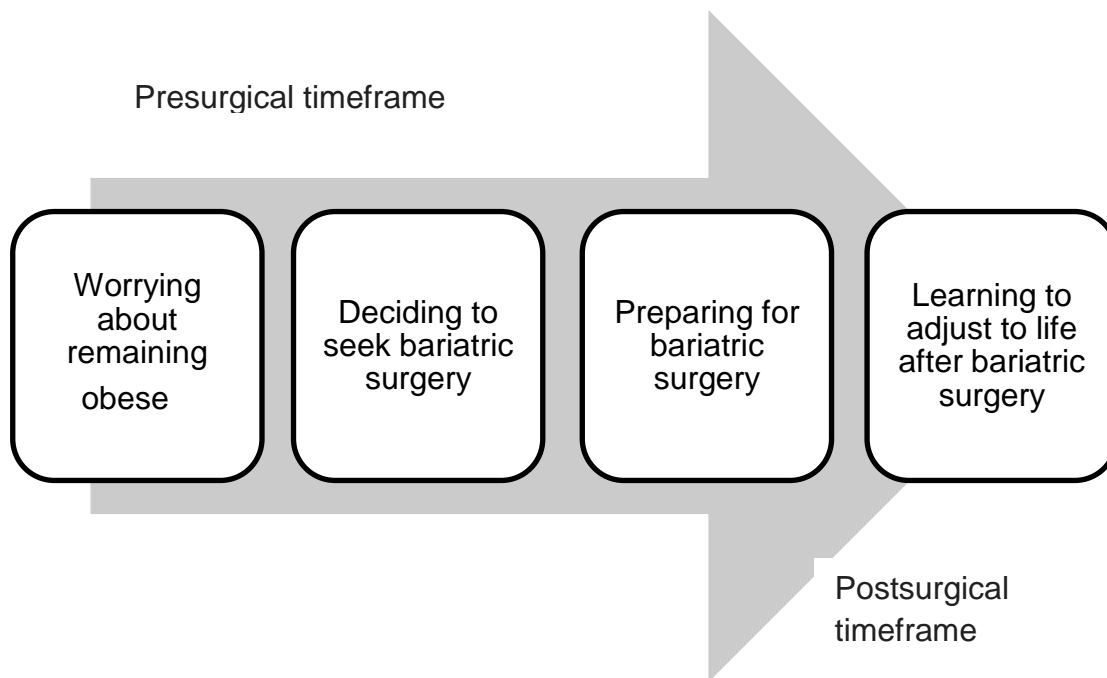
6.4.3 Theoretical centrality

As theoretical direction evolves, the concept of theoretical centrality developed. Theoretical centrality is the process of focusing on concepts which emerged as focused codes and concepts evolved (Charmaz, 2014). As data were collected and analysed, certain concepts stood out, mainly because of interest to the researcher as a result of the interpreted significance of these to the participants. This was determined by the participants repeating or reinforcing certain points during the interview. At first, many of these appeared to be tacit, but there seemed to be implicit interpretations which needed to be explored in order to gain a deeper understanding of the subjective meanings of these concepts. Mapping and memoing helped to make these concepts explicit and these were

followed at the expense of concepts which did not seem to be supported or fit into the emerging conceptual framework. I was conscious of allowing data to emerge as opposed to being forced to fit the evolving theory (Kelle, 2005) which would potentially bias the findings to the perspective of the researcher and not take into account the participant contribution. Concepts which did not appear to fit were discounted, but as the previous section demonstrated, only after rigorous scrutiny through the constant comparative analytic process. Theoretical centrality became more important as data collection progressed, which progressed into theoretical adequacy. Below, I clarify how I determined theoretical adequacy had been achieved.

6.4.4 Theoretical adequacy

The concept of theoretical adequacy is based on ensuring that the constructed theory fits the situation it is seeking to explore and helps the people in the situation to make sense of their experiences and possibly assist them to manage the situation better (Charmaz, 2014). This was achieved by amending the topic guide as data collection progressed, especially towards the end of data collection to account for the emerging properties of each category. During this time, participants were prompted to discuss concepts which pertained to the emerging theory, but I was careful to position these prompts after participants had recounted their narratives, so as not to influence their stories. For example, I prefaced some prompts using phrases such as 'Some participants reported….tell me how you feel about this' to create opportunity for open

discussion, which would offer further insights, as opposed to a closed answer, such as 'yes' or 'no' which would preclude any further data or concepts being identified.

Thus, the acknowledgment of the four theoretical concerns and maintaining awareness of these provided direction during initial data collection and subsequent constant comparative analysis.

6.4.4.1 Theoretical coding

This is the third stage in coding through which theoretical integration turns data into theory. It is defined as 'applying a variety of analytic schemes to the data to enhance their abstraction' (Stern, 1980), Charmaz (2014) states that the purpose of theoretical coding is to assist with theorizing the data and focused codes and conceptualizing the relationship between them. There is speculation as to whether theoretical coding is an application or emergent process with this issue still unresolved (Charmaz, 2014). Theoretical coding was used as the final stage in the coding process which allowed clarification of the 'general context and specific condition in which the phenomenon is evident' (Charmaz, 2014,p.151). In order to more fully understand the data, the tenets of symbolic interaction were further applied to ensure that theoretical coding captured the reciprocal events and actions of the participants and the associated underlying meanings were captures. Examples of how focused codes were

conceptualized as theoretical codes, together with the properties of each code

are shown in Figure 6.10.

Figure 6.10 Theoretical codes and their properties

Focused code	Theoretical code	Properties
Failing	Understanding failure as embedded in risk	Worrying about the risk of failing Accepting setbacks as temporary failures which can be rectified Not caring about failing
Moving forward	Adjustment period interpreted as a risk-laden process both positive and negative	Accepting and working with the changes that surgery brings Challenging the changes to life imposed by surgery Worrying that surgery causes problems Finding mechanisms for dealing with awkward situations Not regretting the decision to have surgery Feeling head and body are reconnected Knowledge as empowering and gaining control
Keeping secrets	The fear of being judged forcing participants to not disclose having surgery	Defining difficult situations and in what context they occur Explicating the difficult situations and the reasons underpinning these Identifying which participants

		find certain situations more difficult and why
Support seeking	Conceptualizing the role of support in the adjustment process	Defining factors affecting support seeking
		What/who are defined as sources of support
		What are the properties of support seekers and those who do not seek support?

6.5 Defining the situation to position the constructed grounded theory

From the narratives of the participants, it was apparent that the adjustment to life after bariatric surgery was underpinned by events that led to the decision to seek bariatric surgery, with life conceptualized as a pre and post-surgical dichotomy. This appeared to position the pre-surgical timeframe as important in terms of constructing meanings and actions. The participants' accounts of adjusting to life after bariatric surgery therefore, were clearly connected to their pre-surgical lives; the pre-surgical journey was conceptualized as three interconnected processes (see Figure 6.11). This influenced and underpinned the subjective meanings and actions performed during the post-surgical adjustment process. All participants anticipated bariatric surgery would change their pre-surgical obese state and the self-reported associated physical and social issues that surrounded each individual and their social world.

Figure 6.11 Conceptualizing participants' collective interpretations of meaning pre-surgically as points of departure for adjusting to life after bariatric surgery
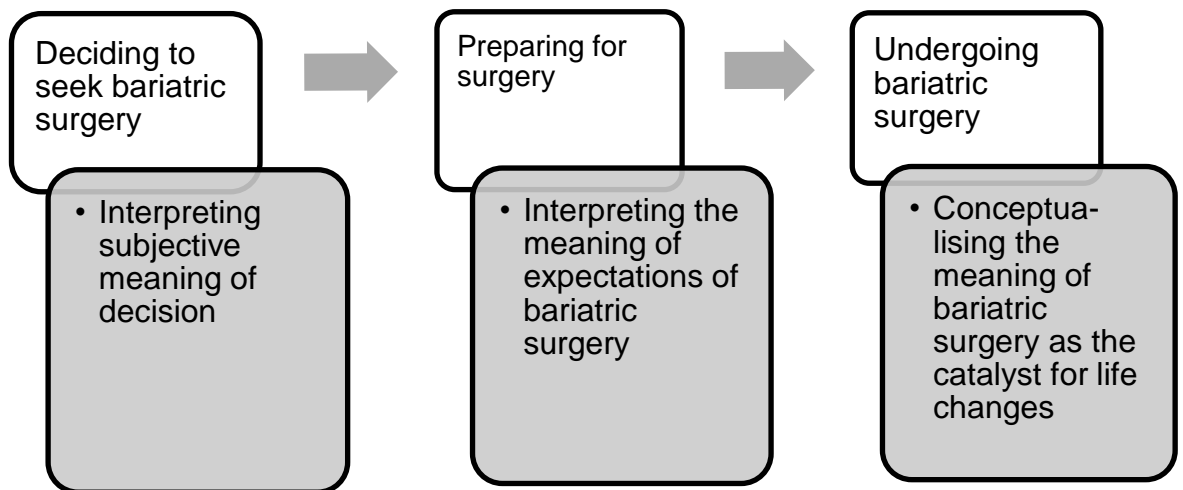
All participants were aware that they would experience post-surgical changes relating to food and eating, such as portion size, types of food and consistency, and were expecting to eat differently. They made direct comparisons with eating and food pre- and post-surgically. The participants were more ambiguous about social issues, such as relationships with family and friends when they discussed how they felt at the time of surgery. The discussion around post-surgical social issues was a more complex one; many participants reflected that they had expected their lives to change after they had had bariatric surgery, they were not were aware of the impact of the changes which took place during the adjustment process. As one participant explained:

You need to know that your life is going to change massively and what's going to happen to you…don't go in thinking 'I'm going to lose weight and it will all be great'…really it isn't that easy…you need to be strong, you need to understand the ins and outs, the changes, the dietary changes…you go to being a different person

(Participant B)

As such, the meanings of many of the actions taken by the participants when adjusting to life after bariatric surgery were embedded in events which had taken place in their pre-surgical lives which clarified and confirmed the concept of a dichotomy by comparing life as before and after surgery. There were six concepts which came up in all interviews and were interpreted as being the most important to the participants, and capturing the nuances of their experiences. These concepts underpinned many of the meanings and actions taken by the participants as part of their adjustment to life after bariatric surgery. These were failing/giving up, moving forward, feeling uncertain, keeping secrets support-seeking and feeling guilty. These concepts appeared to be rooted in the participants' pre-surgical lives, but continued post-surgically and took on different meanings to the participants. By understanding the roots of the meanings pre-surgically, a more comprehensive understanding of the complexities of these concepts in adjustment to life after bariatric surgery could be gained. The six concepts are discussed in detail below.

6.5.1 Failing or giving up

All participants portrayed obesity as a problematic state, impacting on aspects of their lives such as physical mobility, personal relationships, eating and social interactions, with many experiencing obesity-related stigma which was particularly distressing. All had made unsuccessful attempts to improve the situation by trying to lose weight. Participants reported trying a variety of methods of weight loss including diet, exercise, pills and psychological interventions, but these had proved unsuccessful, resulting in professed feelings of being a failure, failing and wanting to give up on themselves, as the struggle to overcome obesity had become too great to bear.

These feelings underpinned both the decision to seek surgery and the participant-reported perception of surgery being their final option for losing weight. Participants reported they had to accept they had failed with other weight-loss options in order to be considered for surgery. This failure may be reinforced by one of the NHS criteria for bariatric surgery, which states that 'all appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight-loss' (National Institute for Clinical Excellence, 2006,p.25). The feeling of giving up appeared to resolve following bariatric surgery, but the concept of failing was carried over into this timeframe. Failure to lose weight through other methods and accepting this failure meant the end of one journey and the beginning of one:

I blame the tablets, the amphetamines because they had something in them [to help with weight loss]...seemingly they had 'speed' in them and it speeds you up of course…they were bought from a legal clinic that sells them; you have to see a doctor to get them. We took them and both my friend and I lost weight then put it back on, so I joined Slimming World, lost a bit of weight, put it back on, starved myself, you know what I mean? I went to Weight Watchers but I never, ever got thin so I went to the doctors and they referred me for bariatric surgery.

(Participant A)

I'd been seeing the GP about numerous diets and I was conscious of my weight because me Mum died when she was 58 of a heart attack and I have a young son. I had him when I was 41 and I didn't want to die…the doctor asked if I had ever considered bariatric surgery and he put me forward.

(Participant K)

Giving up on themselves and/or on other weight–loss methods and seeking bariatric surgery as a solution was also reported:

I'd given up after me wife died. I was fat, my future was bleak and my kids were up and away.

<div align="right">(Participant L)</div>

I put on loads of weight because I was in a violent relationship and when I got rid of him and got with my husband now, he wasn't bothered about what I was eating, so I thought I could eat what I liked because my other partner was so controlling…I got to the point where...I'd been trying for years to lose weight…I've tried slimming pills, from what you buy from the body builders and I've had them from the doctors. I've tried laxatives…different things, not eating…it got to the stage I couldn't walk to the end of the street because of my hip and that affected my back and I had trouble with my knees, so I went to the doctor and said I can't do this anymore

<div align="right">(Participant O)</div>

After accepting failure to lose weight, bariatric surgery was perceived as the final option:

Surgery was my last chance or I'd be screwing the rest of my life up.

(Participant N)

I am only in this position because I am obese, it's my fault I am having to do this [undergo bariatric surgery] I'm a single parent with one child, I mean he's older now but he's still my child, but then I thought, if I don't do this the weight is going to kill me anyway, so I've got to give myself this chance.

(Participant Q)

The concept of failing continued to be an important aspect of adjusting to life after bariatric surgery but the focus of these changed from being centred on obesity to issues surrounding having had bariatric surgery, mainly in relation to failing to lose or reaching a plateau with their weight.

There was a time when I didn't lose weight, for about 2-3 weeks, not long after surgery. It was very disheartening and I was obsessed with going on the scales…every day. I'd lost a couple of stone then it stopped, but this is

normal if you talk to others. It went wrong for about three weeks, then I

started losing again and it stopped.

(Participant B)

Now I'm at a standstill, I can't lose anything…I've put weight on, half a

stone which obviously I am not happy about. I can't get it off again; I'm

trying and not succeeding. Last week I walked into town three times, I

went swimming which I've gone back to doing anyhow and on top of that I

walked over 12 miles last week and I put 2 ½ pounds on.

(Participant D)

6.5.2 Moving forward

The decision to undergo bariatric surgery was conceptualized by all participants

as a positive one, with the operation the catalyst for a new life. Opting in and

preparing for bariatric surgery was interpreted as a positive step and moving

forward in their lives.

All potential bariatric patients are invited to 'Seminar', a group meeting with the

bariatric team at CHSFT. The aim of Seminar is to ensure potential patients

understand what is involved should they choose to opt for bariatric surgery and have resources needed to make an informed choice. Patients are referred to the meeting by their GP, they are given a talk by members of the bariatric surgical multi-disciplinary team (MDT), and after this time, they are asked to decide for themselves if they wish to 'opt in' for surgery. Once they attend Seminar and opt-in, they are set weight-loss and lifestyle change targets, which need to be attained in order to progress to surgery. Opting in does not guarantee they will undergo bariatric surgery

As soon I went to Seminar, something clicked. I had to lose 4 kg to have surgery and it was like, this is my last chance or I'm screwing the rest of my life up. I lost the weight and managed to keep it off, but it was going to that Seminar, I knew then that I had to do it. Something clicked after that Seminar, it was a turning point. If I didn't lose the weight, I would have been snookered, something just clicked after the Seminar, I lost the weight, kept it off and lost a little bit more, so I could have surgery!

(Participant N)

My doctor said some of his patients who had weight gain due to steroid treatment had this bariatric surgery and he asked me if I had ever thought of it and I said I didn't know I could have it. I went to the Seminar and I

was just blown away, it was incredible and I started to think, this could the thing to change my life.

(Participant P)

Every participant expressed that despite the difficulties that they had experienced relating to bariatric surgery, they did not regret the decision to undergo the procedure. Overall, participants reported surgery as making a positive change to their lives. This was conceptualized as allowing them to be able to move forward and carry on with their lives in a more confident and optimistic manner. The only regret expressed was not having surgery earlier in their lives which they felt would have enabled them to experience the affirmative benefits sooner:

Mentally I really feel that I have done something positive by having surgery…this might seem overdramatic but I feel I have a new lease of life, I've done something now that's going to have a really positive effect and this is it…I'm going to stick to everything…lose the weight, become more active, because of one the things I regret now is my kids are 7 and 11 and I regret not [then] being able to go in a playing field and kick a ball about with them because I would be in utter agony, but this is a turning point and

I'm going to make sure I spend more time with the kids and do things.

(Participant G)

It's been fantastic for us; we've got our lives back as such. Before we would go to a pub and I would be looking for the biggest seat or the one with more room behind the table…when we went for walks I would stop every two minutes to catch my breath…but I would say 'oh look isn't that nice' and point to something, but my husband knew because I was red in the face and panting….I needed to stop….when we used to fly I would buckle up and not move the whole time…so the cruises we used to go on were from Southampton, but after the operation we flew to Barcelona and it was the first time I had flown since the operation and I was thinking eee... Oh God, the belt is not going to fit…I had to tighten the belt on the seat for the first time and I started crying and my husband said 'what the hell are you crying for?' and I said 'Do you know what…for all these years I've not been able to do this' I had no marks on my body where the seatbelt had dug in, or not been able to get the table down…I just sat and cried, I'm going to cry now, it was something as silly as that, but it was a great feeling.

(Participant N)

These quotes show the significance of symbols associated with moving forward. The positive aspects such as being able to tighten a seat belt, or commencing a sporting activity, which had not been an option before, were all representative of progress and moving forward with their lives, and participants were aware that bariatric surgery was the catalyst for these positive steps.

6.5.3 Feeling uncertain

Although electing for and undergoing bariatric surgery was reported as a move forward for all participants, there were concurrent feelings of uncertainty about the process of awaiting surgery and life afterwards. By choosing bariatric surgery, participants opted into a pre-surgical programme which entailed meeting weight-loss and lifestyle targets set by the bariatric surgical team. Participants reported that the regular monitoring required in order to demonstrate evidence of being able to cope with the commitment needed to deal with the life changes that surgery would impose, led to feelings of uncertainty as to whether the operation would take place. Additionally, there are unknown factors, which the bariatric surgical team made explicit to all participants, which could mean that the choice of procedure, or indeed bariatric surgery being able to be performed, could not be accurately determined until the participant was on the operating table.

Examples of unknown factors were the effects of pre-existing medical conditions or anatomical or physiological risks. This was interpreted as a 'no-guarantee' discourse on the part of the bariatric surgical team, which was reported as being made explicit to participants at the outset of the pre-surgical journey by the bariatric team. However, this caused feelings of uncertainty in the participants, who were relying on bariatric surgery as their last chance to lose weight, resolve their health issues and improve their lives. Examples of the concept of uncertainty were evident in being anatomically unsuitable for surgery, not meeting the required targets to undergo surgery and the feeling that the signals between their head and body had become disconnected.

6.5.3.1 The uncertainty of being anatomically unsuitable for surgery

Participant E had a pre-existing medical condition that potentially prevented him from having a gastric bypass, which was the preferred procedure because it had the most potential for weight-loss. The bariatric surgeon had not given him any guarantees, which caused uncertainty:

I thought I would have a bypass but they said no, we will try but you will most likely have the sleeve first and then we will see where we from there….that's how it was really.

(Participant E)

Participant N had been given a more severe 'no-guarantee' promise, which had caused considerable worry and uncertainty:

> The surgeon said because of my hernia that until I was on the operating table, they wouldn't know if what, or if they could even do anything….if your bowels are attached to the gauze then we won't be able to do anything…we have to wait and see. I waited until he left and then I burst into tears, it was horrendous, the worst part, not knowing anything.

> (Participant N)

6.5.3.2 Uncertainty of not meeting targets and not having surgery

The need to fit in the weight-loss targets into everyday life events could be problematic. Participant C was called for surgery prior to going on holiday with her family, which had been booked in advance, and could not be cancelled without expense and would have meant the rest of her family not having a holiday. Being away from home meant she relied on the hotel for food, which was not suitable for the pre-surgical diet, which she tried to compensate for by eating less, but had not been successful, and the uncertainty of not knowing whether or not she was losing weight was evident:

They booked me in for surgery when I came back from holiday so I had to do the pre-surgical diet on holiday. I tried to do it by eating the yoghurt, milk, but after a couple of days I didn't stick to it, I had a salad for lunch and not milk because the hotel served goat' milk and it was revolting…I couldn't stomach it…and with the heat, but goat's milk was the only available milk, so I had a small plate of salad, only went to the buffet once and when I came back I went to the hospital, was weighed and I had put a couple of pound on…the surgeon was not impressed, he said if you can't do it, you can't come for the operation, so I said I know that, I get it, it's down to me, simple as that…so I went home, lost the weight and a little more and then it was ok…I had the surgery in the end.

(Participant C)

The issues surrounding uncertainty were resolved by undergoing surgery, but uncertainly as a concept evolved in the post-surgical timeframe, with the focus on the process of adjustment as being ambiguous and unknown. The main concept associated with uncertainty after bariatric surgery was that of a head and body disconnect, which is discussed in the next section.

6.5.3.3 Head and body disconnect after bariatric surgery

Participants reported that following surgery, they felt as if the communication between their head and body had somewhat become disconnected, and their mind and bodies had become unfamiliar and separate entities. This lack of communication was problematic in different situations:

Participant O talked about her mind still 'thinking' her body was obese, even after weight loss. The physical changes to her body meant that clothing had gone from fitting to being loose, which she felt was proof that her mind was thinking differently and that the two entities were working differently after surgery:

> My mind was telling me to do things and my body couldn't. Your mind is telling you that you are still big, but it's your clothes that tell you that you aren't.
>
> (Participant O)

Participant P described the body as giving out new signals, with the mind needing to learn what these were and how to interpret them. He described his body as being different before surgery, for example, when he was obese, he

would never feel full. Without knowing what the new signals were after surgery, the adjustment was a learning process of trial and error:

> Your body gives you new signals and you need to learn them. I had an incident early on, I ate too much and ended up vomiting, but I'm fine with the signs now. It's kind of hard to describe because I forget about the way I used to eat before; for the last 10 years I never knew what it was like to feel full.

> (Participant P)

Learning to understand the new surgically-altered body was an important aspect of the adjustment process. The learning process was also underpinned by uncertainty, as until the signals were learned, the consequences were unknown until experienced, such as the vomiting being the signal for eating too much.

6.5.4 Keeping secrets

For many, bariatric surgery was felt to be the final option after numerous unsuccessful attempts at weight loss and feeling stigmatized for being obese

and for failing to lose weight. Obesity is a stigmatized health condition (Puhl and Heuer, 2009); many participants reported experiences of being stigmatized as an obese person before undergoing bariatric surgery:

I've always been the fat one in the family….as a child I had to get weighed every Sunday night…I used to dread a Sunday night….my weight was always an issue…I've been on all kinds of diets, I even took slimming pills...the lady at the slimming club told me to go to the local weighbridge and get weighed…I was mortified…absolutely mortified, but I knew I had to be slimmer, but I just couldn't do it.

(Participant B)

I used to hate eating in public, especially anything that was fattening because you think people are judging you all the time.

(Participant Q)

From the above examples, it is evident that as an obese person, the participants were subject to stigmatisation and as such, were the focus of unwanted attention. By being able to successfully lose weight through bariatric surgery, the participants felt the stigmatisation would cease. However, in many cases, participants were worried about disclosing the decision to have bariatric

surgery, either before or after for fear of being judged for their choice of weight loss.

At this point, it is important to clarify the meanings of stigmatisation and judgment in the context of this thesis, in order to be able to understand how these were applied to the participants' experiences. The concept of stigma as related to obesity closely mirrors the work of Goffman (1963), in which stigma is socio-culturally perceived as a deeply discrediting bodily abomination, a physical deformity. Once stigmatized, society 'exercises varieties of discrimination, through which we effectively, if not unthinkingly, reduce his life chances. We construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents' (Goffman, 1963,p.15). The concept of stigma applied more in the pre-surgical phase when the participants were still classified as obese, but the effects of being stigmatized for being obese carried over into the post-surgical phase and were influential in the adjustment process, impacting actions and meanings of actions:

I was ready for it...mentally ready...it's not nice being the fattest bloke in the office. I was self-conscious about my weight, but I used to try and laugh it off, but they took the mickey and it did hurt...I didn't show it, but I felt it.

(Participant J)

The concept of judgment was more applicable in the post-surgical phase and was more subtle. My interpretation of the differences between stigma and judgment are discussed next.

6.5.4.1 Stigma and judgement

In this thesis, the concept of judgment is applied to the subjective accounts of adjustment after bariatric surgery and differs from stigma in that the participants did not report any stereotypes associated with judgment of bariatric surgery. I define judgments as value-laden opinions expressed by others, who seem to largely be people who have not experienced bariatric surgery, but appear to have strong opinions about it. Judgment, similar to stigma was reported as a difficult situation, but as bariatric surgery is still a relatively unknown entity compared with obesity, there were seemingly no associated, socio-culturally embedded stereotypes to attribute to the participants. This I argue to be because surgery removes the obese state, therefore the surgically-altered body is more in line with what society constructs as a normal bodyweight, and thus not subject to stigma. What is judged, rather than stigmatised, is the choice of the weight-loss intervention, which participants report worrying about what others think of them if they disclose:

I wouldn't judge her [recounting a friend who was questioning D about her weight-loss] because it would be her choice…to me it's the best choice she could make for herself…I could tell her look I've had it done, it will change your life forever, but I can't say that…I mean people judge you before they know you…that's the way I look at it…even now, I worry about what people will think, definitely…even more than before, even now I worry but I worry not what people are thinking, more than before [when she was obese].

(Participant D)

Sometimes I think I should just come clean about it, but I don't want to be judged, or talked about…. maybe its self-perpetuating, maybe those of us who have had it done should talk about it more, but I don't want to be judged… I don't have any regrets, I want to tell others, look I had it done, you could too.

(Participant Q)

Compared to obesity, which is a visible condition, bariatric surgery itself is invisible; it is the drastic weight loss as a result of bariatric surgery which invites scrutiny and thereby potential opportunity for judgement. As participants had already experienced stigma for being obese and saw bariatric surgery as an

opportunity to remove the burden of stigma and improve their lives. As such, in order to avoid judgment, the participants frequently decided to avoid revealing the reason for their weight loss. Keeping secrets as a concept spanned across the pre- (choosing bariatric surgery) and post-surgical (revealing having bariatric surgery) timeframe, but the meanings and actions appeared to change over the individual adjustment periods.

6.5.4.2 Exchanging stigma for judgment

Following surgery, the stigma of being obese changed into feelings of being judged for having undergone bariatric surgery if they disclosed:

6.5.4.3 Feeling judged for having bariatric surgery

> Once I was out for dinner with friends and one of them said to me if I find out you've had an operation, I will never speak to you again. She said it was wrong and it was cheating.

> (Participant D)

The issue of being judged for having bariatric surgery was common amongst the majority of participants. Additionally, there was a recurring theme of bariatric surgery being misunderstood and at times contested by others:

If you [restaurants] can offer children smaller portions, why can't you offer us smaller portions without us having to explain ourselves…our life story, its discrimination, but we need to stick up for ourselves…..the world doesn't understand bariatric surgery, it's not talked about, they put these programmes on the telly which show the wrong side of it….I would show people after surgery, what they have to go through to change their life.

(Participant B)

These opinions were not limited to lay people, there were accounts of healthcare professionals not understanding bariatric surgery:

I think doctors need to stop viewing it as major surgery and start realising it can change your life and the effect it can have on someone's life…..they need to understand more.

(Participant L)

This alludes to a lack of knowledge and understanding from those who have not experienced bariatric surgery and is therefore judged by others. To avoid this, many bariatric surgery patients, like Participant Q, lie about how they lost weight. The problems associated with obesity appear to transform into new ones following surgery. In line with the concept of a pre- and post-surgical dichotomy, many participants reflected on the stigma of being obese and living as a non-obese person:

I think people should be fat…once in their life, just to be a little less narrow-minded. Not every fatty is, like, a waste of space. If I said to someone, hey I'm a drug addict, they would be so, oh my God, I'm so sorry, what's wrong. I sit here, but I was and I am addicted to food and it's like, piss off you greedy bitch, Jesus Christ, get over it…right, lock the door, lock the fridge, but if I'm an alcoholic or a drug addict it's all fine, even if I'm an anorexic…that's so bad, poor thing, can't eat, but you, you're a greedy bitch and you've got diabetes because you've eaten all that chocolate…you've done all this to yourself.

(Participant C)

Many of the participants in this thesis were employed, however this quotation specifically framed the stigma of obesity in employment settings, which was identified earlier in the literature review (Puhl and Heuer, 2010). Participant Q reflected on the pre-operative obese state and others' perceptions of her after she had lost weight:

People respect your professional opinion more when you are not obese anymore….people take you much more seriously if you are not fat. It's happened to me, so it must have happened to others. It's hard when you are trying to be professional and taken seriously and your weight is being judged, I really noticed that, it comes from clients and colleagues. I've certainly noticed you get much more respect when you are thinner. When I was at my biggest, a client's husband said to me in clinic, it was a private one, 'We saw you earlier and we thought you were the cleaner.' Now I was very well dressed, in my line of work you have to be, he didn't say his perception was based on the fact I was fat, but I knew it…people have this idea that you belong to a certain social class if you are fat, you are fat and stupid, so I would have to be a cleaner and not a healthcare professional.

(Participant Q)

Fear of judgment following disclosure led to many participants being secretive about their decision to have bariatric surgery. The concept of disclosure was a

mutually agreed important concept between myself and the participants and I

explored this in a later memo (See Figure 6.12).

Figure 6.12 Later memo on properties of disclosure

Option or feeling obligated? Choosing to disclose having bariatric surgery

For some participants, the decision to tell others about undergoing bariatric surgery was to be a difficult one, fraught in uncertainty and worry about the consequences. On the contrary, other participants were not worried about disclosing and were open about having bariatric surgery. The context and conditions in which the decisions to either disclose or not disclose are explored. The subject of disclosure is usually precipitated by a comment from others (positive or negative) about the person's changed appearance as a result of drastic and/or rapid weight loss, or in a social situation where a person feels obligated to disclose. The latter usually occurs in a restaurant or public house surrounding food.

Positive comments/questions directed to the person include a comment on a changed appearance, as a result of drastic weight loss. This happens from family, co-workers and friends, who were not aware that the person has undergone surgery. This seems to be an important incident in the bariatric surgery journey

I went to one pub and asked for a child's portion and they were fine about it but when I went to the one in Middlesbrough she was funny with me and said we're not supposed to do that so then I had to say to her I had bariatric surgery, I can't eat a full portion...I was annoyed...if someone had special dietary needs there wouldn't be a problem, like a nut allergy…this is my dietary requirement…my needs...why can't they offer us smaller portions without us having to explain ourselves? (Participant B)

Worrying about disclosing

The decision to disclose seems to warrant a considerable amount of worry in terms of assessing the consequences of disclosing. Participants seem to worry about being judged by others and thus weigh up the potential reactions of others before taking action:

People are jealous…it's jealousy. I don't mind telling strangers, but its people that I know..outside work and family..I don't' know why, but its my business, if they want to think let them think, if they want to know, well its my choice

..people in this village, its quite close knit, they don't know I've had surgery..but I work ten miles away, so Im okay about work knowing(Participant J)

Its not a problem, at first people would say things like you look well, and I said thanks I've had surgery and she said that's great..but sometimes I feel guilty, when people used to say you're doing great, keep it up, because I'm expected to lose weight because I've had surgery, feeling guilty because I havent' done it on my own..I feel guilty when they say I look fab and it wasn't me, it was the surgery that made me lose weight (Participant K)

Safe environments for disclosure

Participants had safe places where they could talk openly with others about bariatric surgery, but this seemed to vary according to the level of intimacy with the each participant and the people involved in the various settings. For example, for participants who enjoyed close relationships with work colleagues, disclosing to these people was interpreted as safe. For those participants who did not have have close relationships with work colleagues, disclosing was considered a contentious issue for fear of being judged by others.

I think the support group was super, they were delightful, so open and truthful..they were so open about sharing their experiences (Participant H)

I've never kept any secrets from them (work colleagues), they covered lessons for me when I had to go for appointments (Participant G)

I don't mind telling people and tell the truth about surgery…its not easy and also, people know you can't lose weight so fast with diet and exercise..people do call us behind my back but I don't care…I'm happy (Participant 0)

Contentious environments for disclosure

The rapid change to the appearance of participants' bodies attracted attention from others, particularly as to the reasons for this. Examples from participants who were employed and disclosed at work are highlighted:

When I went back to work, one person said are you alright...you've lost so much weight so quickly...I haven't seen you and I thought something was wrong, are you well and I said I'm fine…I'm not telling everyone but I've had bariatric surgery and she said oh alright, I thought you were poorly..(Participant B)

This comment was particularly interesting, as the reason for the enquiry seemed to evoke concern, rather than curiosity, which seemed to suggest that the risk of judgment would be reduced, and the participant disclosed, but stated this disclosure was not going to be made to everyone, which implies some people are safer to disclose to than others.

Everyone said what diet have you been on and I said Weight Watchers…just cutting down smaller portions and getting more exercise...that's all I answer with, I think some of them (work colleagues) would say its cheating, being called a cheater and taking the easy way out...that's what I've done, in their eyes…everyone talks about diets, it does my head in, I don't talk about it (Participant D)

In this situation, the participant lied to others about the method of weight loss on the basis of worrying about being judged if she disclosed undergoing bariatric surgery. In this situation, the participant appears to be viewed by others with disdain and curiosity rather than concern and there is an element of contending with risk in order to find a solution to avoiding disclosure. Although both situations were interpreted as difficult, the second situation clearly shows the judgment of bariatric surgery.

Work was not the only difficult situation, participants reported encountering scrutiny with family, friends and strangers.

I returned to all narratives to explore the concept of disclosure and discussed this further with participants who wished to remain in contact and discuss the findings. Based on their responses and our conversations, the concepts surrounding the risks of disclosure seemed to be attached to the level of intimacy in the relationships people had with others.

To the majority of participants, disclosure was a deeply personal issue. It appears that the level of intimacy in a social relationship and the degree to which the participants felt comfortable with others affects the disclosing decision. For example, a transient, one off social encounter, such as encounters with staff in a restaurant, a superficial social exchange would normally take place. For many participants, this encounter was not always superficial, as some felt they were forced to disclose having bariatric surgery in order to justify their requests for smaller portion sizes, a children's' meal, or types of choices that warranted scrutiny. Eating out appeared to be particularly problematic in this sense.

Having safe people to disclose to was important for each participant which was supported by the individual narratives with four groups identified; family, friends work and/or colleagues and others (See Table 6.6). Each participant had strong views about whom and which group was considered safe to disclose to. Participants who were unemployed were not included in the work/colleague findings.

Table 6.6 Participant-reported disclosures with others

Participant	Family	Safe?	Friends	Safe?	Work and/or Colleagues	Safe?	Others	Safe?
A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
B	Yes	Yes	Select	Sometimes	No	No	Yes	No
C	Yes	Yes	Yes	Yes	N/A	N/A	Yes	Yes
D	Select	Sometimes	No	No	No	No	No	No
E	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
F	Yes	Yes	Yes	Yes	N/A	N/A	Yes	Yes
G	Yes	Yes	Select	Sometimes	Yes	Yes	N/A	N/A
H	Yes	Yes	Select	Sometimes	N/A	N/A	Sometimes	Sometimes
I	Yes	Yes	Select	Sometimes	N/A	N/A	No	No
J	Yes	Yes	Select	Sometimes	Yes	Yes	No	No
K	Yes	Yes	Select	Sometimes	N/A	N/A	Sometimes	Sometimes
L	Yes	Yes	Select	Sometimes	Yes	Yes	No	No

Participant	Family	Safe?	Friends	Safe?	Work and/or Colleagues	Safe?	Others	Safe?
M	Yes	Yes	Select	Sometimes	N/A	N/A	Sometimes	Sometimes
N	Yes	Sometimes	Select	Sometimes	N/A	N/A	N/A	N/A
O	Yes	Sometimes	Select	Sometimes	Yes	Yes	Sometimes	Sometimes
P	Yes	Yes	Yes	Yes	N/A	N/A	Sometimes	Sometimes
Q	Yes	Yes	Yes	Yes	No	No	No	No
R	Yes	Yes	Select	Sometimes	Yes	Yes	Sometimes	Sometimes

Many participants reported experiencing difficulties in social situations as a result of their decision to either disclose or not.

6.5.5 Support seeking

Although the ultimate decision to have bariatric surgery was made by the participant, many sought the support of family, friends and colleagues before and after. As shown in Table 6.6, each participant had identified sources of support, which varied with each person. In addition, participants wanted to help others who were awaiting surgery by providing accounts of their experiences.

6.5.5.1 Support from family:

My wife has been my biggest supporter, me colleagues and the school…they've all been so supportive, some people wouldn't, but they've been brilliant. My wife is always there, encourages me, when I miss my Sunday dinners she says remember your long-term goals….she reminds me of the good things when I miss things like having a big helping and she says remember why you went on this journey…we'll have a nice retirement, see the kids graduate.

(Participant G)

6.5.5.2 Support from others:

> After the surgery I felt I needed to go to the support group…I need to go to see other people and how they are doing…just listen to other peoples' problems, you need it…you need that support. You just can't go away and do it yourself…I go to the support group with the girl who had surgery the day after me and we've kept in touch…we talk all the time and we've more or less lost the same amount of weight

> (Participant B)

6.5.5.3 Support for others:

Participants expressed a desire to help and support others undergoing bariatric surgery. Many of the participants reported seeking peer support, which I define as having and being in contact with others who had undergone bariatric surgery. This was important to many of the participants.

> Her nephew's wife was going in for the same operation as me, and she says to me, what do you think? I says you've got to make your mind up, but the sleeve has suited me...the bypass has suited the other girl, but the sleeve suited me.

> (Participant A)

The hospital asked if some medical students could come in to chat to us which I didn't mind…I am happy to chat to anyone about having surgery anytime…I would do it for Sunderland [talk at Seminar]….I've just never been approached.

(Participant J)

Support was needed and given in a variety of situations by a range of people. The 'safety' of the support was dependent on whom they were comfortable disclosing their decision to have surgery to. Thus, support seeking was linked to keeping secrets, which highlighted the importance of the concept of disclosure.

6.5.6 Feeling guilty

Feelings of guilt seemed to commence pre-surgically, but appeared to change after bariatric surgery, with the focus going from feeling guilty for being obese to feeling guilty for having had bariatric surgery.

Feeling guilty for the effects of their obese state on others:

I wanted to be able to do things with him [son]….I've never been able to go for a walk with him …I felt so guilty, it was so unfair on him….it was like turning him into something he shouldn't be…like stopping in all the time and I didn't want that for him because he is pretty active, loves his football and that. I used to take him to play football and it used to hurt us standing for so long, but I would go with him and look for a seat so I could sit down.

(Participant K)

I've been big for 25 years….when the kids were growing up they missed out [on things] because of my size, we never went swimming or anything….I held back because of it…from doing things…I feel bad about it, so I can say it ruined our lives to be honest.

(Participant N)

There is part of you that feels guilty. I am only in this position because I am obese, it's my fault I am having to go through this…I'm a single parent with an only child… I know he is older, but he's still my child but then I thought if I don't do this [have bariatric surgery], the weight is going to kill me anyway, so I've got to give myself this chance.

(Participant Q)

Following surgery, some participants expressed feelings of guilt focusing on the perception of bariatric surgery being responsible for their weight loss, as opposed to them as a person:

My friend said you look well and I said thanks, I've had surgery and she said that's great, but sometimes I feel guilty, when people used to say you are doing great, keep it up, things like that, I used to….em…it's like I'm expected to lose weight because I've had surgery…know what I mean, feeling guilty because I hadn't done it on my own, I felt guilty when they says I look fab and to keep it up and I think it wasn't me, it was the surgery that made us do it…lose the weight…I used to feel guilty like what would people think of the NHS paying for me to have surgery, but then I was thinking when I got compliments I would brush them off because I was thinking it was the surgery, not me that made me lose the weight and I felt guilty.

(Participant K)

One participant reported feeling guilty for taking the time off to have bariatric surgery:

They told me I would need 1-2 months to recover, but I was back at work in a fortnight and I would have felt guilty staying off longer, as I just didn't feel ill, but even after the operation I lay back and thought, have I done the right thing? Was it too drastic?

(Participant Q)

Other participants reported that others tried to make them feel guilty for choosing bariatric surgery:

I have been told by others that surgery is the easy way out, and that surgery means you are a failure, that was another one, or how do I feel knowing I have cheated….they see it as other people doing it for you, like the surgeons doing the operation is losing the weight for you and you are not doing it yourself, they've done it and you've played no part in it…it's a miracle you're not part of…they don't like it for some reason, I don't know, but that's how I think…jealousy maybe…but people who are still big are the ones who ask me do I feel like I've failed or guilty because I've not done it on my own, so I ask them do you feel guilty because you have not done it on your own?

(Participant R)

Therefore, guilt appeared to underpin the adjustment process. Unpicking the complexities of the six concepts: failing/giving up, moving forward, feeling uncertain, keeping secrets, support-seeking and feeling guilty, I argue to be pivotal to understanding the processes associated with adjusting to life after bariatric surgery and underpinned the construction of the conceptual theory.

6.5.7 Summary and lead into conceptual theory

Before presenting the conceptual theory, I reiterate the foundations of constructivism as the research paradigm and the theoretical perspective of symbolic interactionism. These influenced the interpretation of participant narratives, my role as a researcher, the analysis process and subsequently how the realities have been made. Constructivism is summarized as:

> This perspective assumes that people, including researchers, construct the realities in which they participate. Constructivist inquiry starts with the experience and asks how members construct it. To the best of their ability, constructivists enter the phenomenon, gain multiple views of it, and locate it in its web of connections and constraints. Constructivists acknowledge that their interpretation of the studied phenomenon is itself a construction.

(Charmaz, 2006,p.187)

Through the process of constructing the conceptual grounded theory, I have attempted to capture the multiple realities, meanings and subsequent actions involved in the experience of adjusting to life in the first two years after bariatric surgery. I acknowledge myself as a researcher and as such, an active participant in the study. I am aware that although I made every attempt to understand the participants' interpretations of their individual experiences, that my personal assumptions and possible biases are ingrained in the conceptual theory, which is an acknowledged co-construction between myself and the participants.

6.6 The conceptual theory: interpreting risk as underpinning adjustment

As the research progressed and the constant comparative analysis continued, the concept of risk became evident and appeared to underpin the process of adjustment to post-surgical life. This conceptual framework of risk was unpicked by applying symbolic interactionism to understand the properties, conditions, subjective meanings and actions which were found in the participant narratives. The conceptual framework surrounding risk was then discussed with participants who had offered to read and comment on the findings. By adding this to my interpretation of the findings, the eventual constructed theory is offered to be a co-construction of the data, so the underpinning ethos of mutual reciprocity within constructivist grounded theory between the participants and myself as a researcher (Charmaz, 2006) was respected. In order to

present the constructed theory, it is important to understand how the concept of risk was defined within the thesis. The constructed process of the collective bariatric surgical process is presented in terms of risk and its meanings to the participants.

For those who seek bariatric surgery, the pre-surgical state of obesity is laden with risks, such as the risks of ill health, dying, limited social interactions, stigmatisation leading to exclusion and the risks of the effect of obesity on others such as family members. Seeking bariatric surgery furthered the interpretation of risk. In order to be accepted for surgery, all participants had to commit and adhere to an individual programme of weight loss and lifestyle targets, set by the bariatric MDT, to demonstrate commitment and an understanding of what life after bariatric surgery would entail. The risk of not achieving these targets would mean not undergoing surgery and having to continue with the risks of being obese. In addition, each patient who is considered a candidate for surgery is required to be endoscoped prior to this, to ensure there are no physiological problems within the digestive system, which may prevent surgery from taking place.

The chance of being unsuitable for surgery despite meeting targets was another risk the participants had to deal with. Therefore, the concept of risk was embedded in the pre-surgical phase. Undergoing bariatric surgery continued to present themes surrounding risk. Aside from the risks of being an obese person

undergoing a surgical procedure, the other risks were having a general anaesthetic, dying on the operating table and the surgeon being unable to perform the procedure for reasons unknown until the time of surgery.

The themes of risk continued after bariatric surgery and appeared to underpin the adjustment process, with the six theoretical concepts discussed above underpinning this (see Table 6.7).

Table 6.7 Concepts underpinning risk perception

Theoretical concepts	Theoretical code	Properties
Failing or giving up	Understanding failure as embedded in risk	Worrying about the risk of failing Accepting setbacks as temporary failures which can be rectified Not caring about failing
Moving forward	Adjustment period as interpreted as a risk-laden process both positive and negative	Accepting and working with the changes that surgery brings Challenging the changes to life imposed by surgery Finding mechanisms for dealing with awkward situations Knowledge as empowering and gaining

		control
Feeling uncertain	Framing expectations, worries and beliefs as embedded in risk	Uncertainty is worrying Uncertainty is accepted part of the adjustment process Worrying that surgery causes problems
Keeping secrets	Fearing the risk of disclosure about having bariatric surgery will lead to being judged; continuous worries about what others think of them	Defining the difficult situations and in what context they occur Explicating the difficult situations and the reasons underpinning these What situations are more difficult and why
Support seeking	Acknowledgement of wanting or not needing support and the risks associated with both during adjustment	Defining factors affecting support seeking What/who are defined as sources of support What are the properties of support seekers and those who do not seek support
Feeling guilty	Reflecting on the effects of their previous obese state and its effect on themselves and others Having had surgery (surgery did the work, not the person)	Making up for lost time Accepting that surgery is a weight-loss method which involves the person

The interpretation of risk was conceptualized differently by the construction of three identified risk adjustment profiles which are discussed in turn.

6.6.1 The constructed risk attitude profiles

Three risk attitude profiles were constructed after the initial fifteen interviews, when data were proposed to be saturated. To test the conceptual framework, theoretical categories and confirm data saturation, three further interviews were undertaken between March and April 2015. The data from these three interviews were compared with the data collected from the earlier ones. Memos and field notes on the three interviews were compared with the collected data. Open codes were compared to the existing ones; no new open codes were identified. The focused coding and categories were compared with existing narratives and confirmed the data collected from these three interviews fitted into the existing data and no new insights had emerged. Theoretical saturation was thus confirmed. The concept of risk appeared in all patient narratives although it had different meanings for the different participants. These meanings influenced the actions undertaken by each participant as they adjusted to life after bariatric surgery.

Following bariatric surgery, the adjustment to what was reported as a new, different life was underpinned by the continuing interpretation of risk. From the constructed concepts, the conceptual risk of keeping secrets was congruent with, and influenced the risk perception and subsequent meanings and actions. Its importance and relation to the constructed theory of risk interpretation is shown in Figure 7.16. Through analysis of the participant narratives, the

interpretation of risk was constructed into three profiles based on the constructed attitude towards the interpretation of risk which were: Risk Accepters, Risk Challengers and Risk Contenders. Each profile had different interpretations of risk which influenced the meanings of situations and subsequent actions. Common to all profile types were perceptions of the decision to undergo bariatric surgery as a positive step and moving forward. All professed to an understanding of bariatric surgery requiring adjustments to their lives and how this was interpreted in the collective meanings and actions are discussed in terms of the three risk attitude profiles.

6.6.1.1 The Risk Accepter Profile

The Risk Accepters reported being comfortable with the risks associated with bariatric surgery. In the pre-surgical timeframe, these participants expressed a desire to adhere to the targets set the bariatric surgery team. Risk Accepters were aware that failure to do so would result in them not progressing to surgery. This risk of not progressing to surgery was the reason for complying with the targets:

> If I didn't lose the weight they wanted me to, I couldn't have the surgery and I would have been snookered…something just clicked after the seminar and I lost the weight, kept it off and lost a little bit more, so then I could have the surgery.

Following surgery, these participants understood that changes to their lives were needed to lose weight and that failure to adjust to the surgically-imposed life changes would mean the risk of not losing or a slower weight loss and their individual expectations of surgery would not be met. It was important for Risk Accepters to comply with the adjustments and changes needed in order to be able to achieve their goals and expectations of surgery. As such, Risk Accepters tended to be disciplined with their approach to post-surgical life:

I'm not going to do without…but I've got rules…that I do not eat cakes, I don't eat chocolate, sweets, fizzy drinks and I never touch alcohol… I know people who eat them… chocolate, cakes, alcohol and fizzy drinks…they just water it down with ice so it doesn't fizz up, but I just think I've probably….I've had my surgery and up to now it has probably cost £25,000, maybe £30,000 by the time you think of the surgery, the doctors, the staff who looked after me, the fees…right…I'm not prepared to waste that…or the opportunity I have to live the same life….because I would have stayed, I wouldn't have had the operation, I've had to make changes

(Participant C)

Risk Accepters tended to be positive in their outlook and approach to the changes to their lives. They recognised there were difficulties, but looked for solutions and ways to lessen these difficulties and related these to the advice they had to follow after bariatric surgery:

I had a huge problem getting the amount of vegetables in they say you need to have after the operation…it was difficult, but I make soup and you can get them all in there…because you boil them and blend it...they're all in there. Boy, you can get your five a day no problem…chewing was a problem, but not with soup…I'm careful about the soups I make, we've always got a failsafe one, which we can eat if we are hungry…demented with hunger…have a bowl of soup, but we usually aren't, it's a habit we've got into with the soup, but the operation and how I feel now, has been absolutely life-changing.

(Participant H)

This positive outlook was reflected in their reported attitudes towards life after bariatric surgery; however this was underpinned by having realistic expectations and that there may be difficulties, but learning to deal with these difficulties in their day to lives was part of the adjustment process:

If you go to a restaurant, you still enjoy yourself and the company, but you have a small bit to eat and you're done…like we use food as a reason for going out and talking…a ritual, and then they order poppadoms and someone says have some and I have to say I can't because I need the meat, I need the protein and it's so trivial in the grand scheme of things. Our friends are so supportive. I did make the mistake of overeating once… I've never been a heavy drinker, I just enjoy the social interaction when we go out, but now when we go out for a meal, I feel a bit out of it…but my friends and family know what I've been through, they support me so it's not really a problem.

(Participant G)

For this participant, going out for a meal had changed after surgery, as eating was different in terms of food choices and portions, but acknowledged he was still able to partake in social activities, albeit under changed conditions, but being able to do this was important to him.

The Risk Accepters tended to have social support but acknowledged the difficulties associated with disclosing the decision to have surgery, and although were more open about their disclosing than the Risk Contenders, they were also careful about who they revealed their decision to:

When I am in a restaurant my friends say eating out is a waste of money for me, I says look, I either pay for it, because I'm here with everybody, or I sit here and don't have it and the restaurant staff will think….uhhh, I bet she's going to pinch something off someone's plate, you know [……] my friends ask me why I tell the servers and I'll say because I feel like I have to explain why…I know it's just me, like my friend doesn't think I should ever have to explain or have to tell anyone what I'm doing, but I feel I have to.

(Participant A)

I have told very few people, eight in total. I have lied.

(Participant Q)

Over half of the participants (n=12) fell into the profile of Risk Accepter (see Table 6.8).

6.6.1.2 The Risk Contender Profile

The adjustment process with this cohort appeared to be more difficult than with the other profiles. All Risk Contenders reported experiencing setbacks within their narratives, which were conceptualized as problematic situations which

required actions taken to try to continue to adhere and comply with the post-surgical advice. There were two types of setbacks; self-inflicted and incidents out of the participants' control:

An example of a self-inflicted setback, weight gain, was discussed in terms of accepting the setback, feeling remorseful and needing to get back on track:

> You find you are easily led…me, I was easily led along that path [not adhering to post-surgical advice i.e. eating too much or the wrong type of food] and then I think Christ almighty, I shouldn't have done that….you've got to stop…you can't have that stuff anymore, but you are so easily led and that's why I think I've put the weight on…I just need a kick up the ass to get myself back into gear really…you have to be [hard on yourself], I have to be, if I phone the hospital and they say you have to do this, then you've got to do it, that's it…I think Oh God, I have to get myself back into it.
>
> (Participant D)

One participant's account was underpinned by his perception of control, which was paramount to his adjustment experience. To understand this, an overview of his situation is given. Participant M had previous health issues which made a

gastric bypass too risky a procedure for him to undergo, a gastric sleeve was performed and he had a significant amount of weight as a result. At the time of interview, he had not lost enough weight to enable him to undergo back surgery. This was needed to resolve paralysis in his leg as a result of an industrial accident, which was preventing him exercising which would help him to lose more weight. He was therefore caught in a cycle, with factors deemed to be out of his personal control which prevented him from moving forward and as such was contending risk continuously:

I was a bit upset when he [surgeon] said he didn't expect me to lose more than another 5 kilos…I needed to lose weight and be under 123 kilos to be able to have back surgery and when he said he didn't expect me to be more than 130 kilos that was upsetting…I've been waiting for back surgery….and since the bariatric surgery, the wife and I have been having problems, she may have Alzheimer's so things go missing and it's so frustrating…so I've had some chocolate...it's wrong, but I've tried to eat more fruit, in the morning I have porridge oats or cornflakes with semi-skimmed milk…but since that news from the surgeon I bought 24 cans of beer and I've still got 1 or 2 left...that was 3 months ago…I'm not a big drinker…but it was a downer being told I wouldn't lost as much weight as I wanted to.

(Participant M)

This resulted in him dealing with the setback by temporarily eating the wrong foods (similar to Participant D) and drinking more alcohol than he usually did as a means of dealing with the news he would be unlikely to lose more weight, but acknowledged that he had got himself back on track and was now eating sensibly. In this narrative, the issue of a lack of control and associated feelings of helplessness were particularly evident.

As they lost weight, Risk Contenders expressed feelings of guilt:

I used to feel guilty like what would people think of the NHS paying for me to have surgery…but then I was thinking when I got compliments I would brush them off because I was thinking it was the surgery, not me that made me lose weight and I would feel guilty….I go to Boots and weigh myself and get the ticket and I know when I am just under each stone.

(Participant K)

Similar to the Risk Accepters, Risk Contenders also expressed the positive effects of the weight loss associated with bariatric surgery, comparing these to life before surgery:

With big people they sweat a lot and I was conscious of sweating down below…I always had deodorant and spare pants if my pants got damp….I used to panic….now I don't worry…there always used to be a damp patch and I would have to spray with deodorant…so that is a big thing for me, to be clean.

(Participant K)

The main difference between the Risk Contenders and the other patient types was the worry with situations relating to adjusting to the post-surgical life changes, despite the processes taking place within the same time as the other types. Risk Contenders acknowledged the problematic situations, but learning to deal with these was difficult:

For all my body's stopped eating, my head still wants to eat…and I really struggle with this. I didn't initially, the first six months I was champion, but since Christmas….all those nibbly bits…I'm thinking am I going down this route again…of eating rubbish and I shouldn't be….but I feel…I think because I didn't have chocolate for months I'm thinking I'm not going down that route…I'm not going to eat it because I've got a new chance at life and I'm not going to waste it…I had trouble looking in the mirror cause that's not my body I see…I don't know how to explain it to you, but it's weird….I've looked in the mirror for all those years and its big, bubbly me

and all of a sudden that's not my body shape…I've gone through so much, which I am really grateful for…over the moon that I've lost the weight…but it just messes with your head…it's crazy…I look in the mirror and it frightens me…I have to walk away because I think do I like what I've just seen…I don't know if I'm used to it...it's really strange.

(Participant B)

I have no regrets whatsoever….even if I stay the way I am at the moment, at my weight, I'll have no regrets because at least I am thinner than I was before when I had all my weight...I don't know if you've heard that before…but my legs kill me sometimes….I get tired easily and there's some nights I can't sleep…and I've recently been told I will always be a diabetic….it really hit me hard when I got told that…and I think that's why I put the weight on….I don't produce enough insulin so I'll always need it, and that make me depressed.

(Participant D)

What made the Risk Contenders different from the other constructed risk types were the lack of resolution and/or acceptance of the situation or problem; it was ongoing process.

Your mind is telling you you're too big, but it's your clothes…they tell you something else…like on an airplane, you don't have to struggle with the seatbelts like before…my belly was hard and this year when I went away, I felt like I had to try and hide my belly because it's loose now….it's weird, I don't think I will ever get rid of my stomach….I exercise…I go to the gym and I swim…I exercise 5 days a week…I try and get things done when I can...but when I was going to the gym a lot I got dizzy and the nurse said I was burning more calories than I was taking in, but I don't want to put the weight back on so I go to the gym….it's weird.

(Participant O)

The other types had found solutions to their dilemmas or had learned to deal with it in a manner that didn't cause further worry. Some Risk Contenders had other health issues which could be improved or resolved through the significant weight-loss afforded by bariatric surgery, but this had not as yet happened. For example, one Risk Contender was going through a phased approach to bariatric surgical procedures, as he was deemed too high a risk for surgery and anaesthesia. He had a gastric balloon inserted to assist with weight loss to make him less risky for surgery. Then because of unforeseen circumstances during the surgery, a gastric sleeve was performed, which will be converted to a bypass eventually:

The gastric sleeve is the first step to the bypass…I want the bypass because I don't ever want to be big again….I don't want to be at a stage where I will lapse back to where I was…it's partly about surgery, partly about changing my lifestyle…it's not going to happen overnight.

(Participant E)

As with the other risk types, the decision to tell others about undergoing surgery was difficult and each Risk Contender had people they considered safe to tell, and others who weren't. Participant K previously revealed feeling guilty for receiving compliments after telling others about surgery being the reason for her changed appearance. Risk Contenders were also apprehensive about disclosing:

I never told anyone, except my Mum...I just didn't want to be talked about...I didn't want that from anybody, so I made that decision…the only person I can talk to about it is my mother, who has been really good and supportive…she wasn't it first because she was afraid of losing me on the operating table….I have two brothers but I don't talk to one of them….it's very very difficult so I'd still never tell the...even now….and I have two children and they don't know a thing….people judge you and I worry what

people will think...definitely…even now I worry more now what people are thinking, more than before.

<div align="right">(Participant D)</div>

The common themes to all these in-vivo quotes were the ongoing issues surrounding adjustment, which formed the basis of the Risk Contender profile. Five participants categorized as Risk Contenders (see Table 6.8).

6.6.1.3 The Risk Challenger Profile

One participant's narrative appeared to be different in the interpretation of risk from the Risk Accepter and Risk Contender types (Participant F). He was conceptualized as a Risk Challenger owing to his acknowledgement of the life adjustments required post-surgically, but a refusal to adhere to the recommendations and advice for these. Participant F's narrative account of his journey through bariatric surgery and the adjustments afterward appeared to be different from the other interviews. What stood out initially was an underlying perception of a blatant and openly challenging attitude towards the adjustment to life after bariatric surgery, but his ideas were, like other participants, rooted in his pre-surgical life. When I explored this concept of challenging, F said it was linked to the advice given to him by the bariatric surgical team.

He acknowledged a desire to have what he stated as a 'normal life', as opposed to a life he felt was dictated by the 'demands' (advice and recommendations given by the bariatric surgical team) to facilitate adjustment after surgery. Participant F was aware of the recommendations for adjusting to life after bariatric surgery and acknowledged awareness to the need to commit to these as part of process of progressing to bariatric surgery, but appeared to have commenced challenging these prior to surgery:

I had to lose weight before surgery….I lost 2 or 3 stone before the operation and in the run up to Christmas I put it all back…I went for my weigh in in November or December and I'd lost the weight and was all geared up to go in for surgery in January and over Christmas I drank too much….alcohol...I put me weight back on and I went to get weighed in January and she just looked at me and I thought…whey...I've lost more weight and she said nah, you've put it back on, you're back to the size when you started…,so I had to lose more weight before they would let me have the surgery…I just drank too much over Christmas.

(Participant F)

This was interpreted as understanding that not losing weight would put him at risk of not being able to have bariatric surgery, but he challenged this risk and drank alcohol over Christmas, which led to weight gain.

After bariatric surgery, his attitude to challenging continued as he adjusted:

> They [the bariatric surgical multi-disciplinary team (MDT)] weren't very happy with us….they wanted me to lose more. I went back after 6 months and they said you should have lost more….a stone a month…I've lost weight, what more do you want?

I had noticed that when Participant F had come for the interview, he was drinking a bottle of Coke®. Sugary and fizzy drinks are not recommended after surgery, which I had found interesting. After the interview had finished and we were both walking to the car park, Participant F had lit up a cigarette; again this is a habit that is actively discouraged by the bariatric MDT pre-surgically. I had documented these in my notes afterwards, not as a judgment, but thought the bottle of Coke and the cigarette might be symbols and I wanted to remember this information. Upon reflection, these symbols were interpreted as symbols which represented a 'normal life' for the Risk Challenger.

Following transcription and coding of the interview, I returned to the five interviews that I had conducted prior to this one to see if there were any other accounts of challenging risk on an on-going basis. Accounts of weight gain or not losing weight were present, but these were expressed in terms of remorse

and wanting to get back on track. This was not interpreted from Participant F's narrative.

Pre-surgically, the Risk Challenger acknowledged he was obese and suffering from poor health, but had opted for a gastric sleeve as he thought it would have a lesser impact on his life:

> I said I wanted a sleeve as I thought I wouldn't have much of a life with a bypass. The way I understood it, it was just a tube, just bypassed the stomach and went straight down…but I would like to eat something…have a drink, so I didn't look into it because I just wanted the sleeve.

(Participant F)

During the interview, the Risk Challenger stressed his desire to lead what he called a 'normal life' and not be constrained by the effects of surgery. This was achieved by challenging the risks of not strictly adhering to post-surgical advice and devising his own way of eating and drinking to allow him to feel normal:

I rarely have a cup of tea now…I used to drink it like it was going out of style….I don't know if I'm replacing the sugar hit now, but I drink more pop than I did before and I still put sugar in my tea when I have it now.

(Participant F)

I pick…I used to pick all the time and still do, but now I pick sensibly….if I'd kept on drinking and eating and smoking I would be dead by the time I was 50…I still do these things, but moderately.

(Participant F)

From these examples, Participant F was constructed as an outlier, as he only accepted risk to a point, but was not worried or struggling with any aspect of adjustment. This interpreted defiance was what set him apart from the other risk profiles. There was only one Risk Challenger identified (see Table 6.8).

A summary of the demographics of the participants and their risk attitude profile is shown in Table 6.8.

Table 6.8 Demographics of participant/patient risk types

Participant	Gender	Age	Status	No Children	Pre-op Weight (stone) Self-reported	Time from surgery (Mths)	Weight Loss (stone)	Type of Operation	Risk Attitude Profile	% of weight lost Self-reported	Weight at interview (stone)
A	F	51	Married Self-employed	3	17.4	14	5	Gastric sleeve	Accepter	28%	12.4
C	F		Cohabiting, unemployed	2	20.3	9	7	(mini)Gastric Bypass	Accepter	34.4%	13.3%
G	M	44	Married Full time Employed	2	31.5	8	7.5	Gastric Sleeve (balloon first)	Accepter	23.8%	24
H	F	64	Married Part time Employed	3, 3 grand-children	16.7	5	3.5	Gastric bypass	Accepter	20.9%	13.2
I	F	60	Married Unemployed	3 children 1 grand-children	23	12	7.5	Gastric bypass	Accepter	32.6%	15.5
J	M	47	Married Full time employed	2 children 2 grand-children	21	10	7.5	Gastric bypass	Accepter	35.7%	13.5

Participant	Gender	Age	Status	No Children	Pre-op Weight (stone) Self-reported	Time from surgery (Mths)	Weight Loss (stone)	Type of Operation	Risk Attitude Profile	% of weight lost Self-reported	Weight at interview (stone)
L	M	52	Widowed Full time employed	2 children	19.3	16	7.5	Gastric Bypass	Accepter	38.8%	11.8
N	F	50	Married, Part time employed	2 children 1 grandchild	20.0	15	9 set	Gastric bypass	Accepter	45%	11
O	F	38	Married, unemployed	2 children	21.1	13	11.6st	Gastric bypass	Accepter	54.9%	9.5
P	M	36	Single, unemployed	0	32	5	7.7	Gastric sleeve	Accepter	23%	24.5
Q	F	52	In a relationship Employed Full-time	1	16.4	6	3.12	Gastric Bypass (conver-sion from Gastric Band)	Accepter	25%	12.4
R	F	50	Single, full time employment	0	18.10	24	6.7	Bypass	Accepter	37%	11.4
B	F		Cohabiting, Full time employed	1	24.1	7	8.5	Bypass	Contender	35%	15.4

Participant	Gender	Age	Status	No Children	Pre-op Weight (stone)	Time from surgery (Mths)	Weight Loss (stone)	Type of Operation	Risk Attitude Profile	% of weight lost	Weight at interview (stone)
D	F	47	Divorced Full-time employed	2	20.8	14	5.5	Bypass	Contender	26.4%	15.3
E	M	49	Single Self-employed	0	33	15	9	Sleeve (after balloon)	Contender	27.2%	24.0
K	F	52	Cohabiting Unem-ployed	2 children	21	10	4.7	Sleeve	Contender	21.4%	16.5
M	M	55	Married, unemployed	2 child, 1 grandchild	24.12	6	3.1st	Sleeve	Contender	12.8%	21.0
F	M	48	Cohabiting, Unem-ployed	0	23	14	7	Sleeve	Challenger	30.4%	16.0

None of the participants discussed their weight in a biomedical context, i.e. moving from an obese state to an overweight or normal one. They discussed their weight loss as an experience rather than a change in weight-loss category.

6.7 Summary

Despite difficulties adjusting to life after bariatric surgery, none of the participants regretted their decision to undergo the operation:

> I wish I had done it sooner...this isn't a regret but an observation…I think doctors need to stop thinking about it as major surgery and start realizing it can change your life and the effect it can have on someone's life...they need to understand more

> (Participant L – Risk Accepter)

> I have no regrets and I would encourage anyone to have it done…definitely…definitely…no matter what has gone on in my life, I would still encourage anyone to have it done...it changes your life

> (Participant D – Risk Contender)

No regrets…na…not at all…it's a different person, a different life

<div align="right">(Participant F – Risk Challenger)</div>

Additionally, all participants unequivocally recommended bariatric surgery to others. Of the 18 participants, 16 used the same phrase 'go for it' when asked if they would recommend bariatric surgery, to emphasize this recommendation:

Go for it…without a doubt…I mean it depends what you what, it's not cosmetic surgery and you are in it for the long haul...it's life changing, it really is…my mind was made up before I went to the doctor….me arthritis, me mother who is obese, just massive, she's housebound, has diabetes, heart problems and I thought I don't want to be like that

<div align="right">(Participant J - Risk Accepter)</div>

I would tell you to go for it…just go for it, don't be worried or anything…I

have no regrets…I would do it all again in a minute…wish I did it years ago

(Participant K – Risk Contender)

Just go for it…do it…it turns your life around

(Participant F - Risk Challenger)

Participants fell into one of the three distinct categories which were shaped by similar, yet individual experiences, but the interpretation of risk associated with the adjustment process was the differentiator. The demographics such as age, gender, employment and family status were diverse across the Risk Accepter and Risk Contender categories, which show that the attitude of risk applied across a range of participants. There was a mixture of types of bariatric surgical procedures in the Risk Accepter and Risk Contender categories, so the interpretation of risk was not thought to be important in terms of the perception of risk with specific procedures. As only one Risk Challenger was identified, no comparisons could be made in this category. All participants interviewed were up to two years post-surgery, ranging from 5 – 24 months, with a range of times in each category. The time at which the participants were interviewed did not appear to influence the risk interpretation, as similar concepts and experiences were consistently found throughout the analysis.

The interpretation of risk is therefore proposed to underpin patients' adjustments to life after bariatric surgery. The next chapter situates these findings in a secondary literature review and discusses the proposed implications of these findings for patients, practitioners and practice.

Chapter 7: Discussion

7.1 Introduction

This chapter situates the findings of this thesis within the context of existing published work and clarifies its contribution to this field of research. I argue that whilst the dominant biomedical discourse is needed to show evidence of the success of bariatric surgery through quantitative measurement, it fails to capture the subjective meanings of the experience of bariatric surgery and its impact on the individuals who undergo the procedures. The knowledge gained by exploring the patient-reported experiences I argue allows a more comprehensive perspective of the social processes involved with adjusting to life after bariatric surgery.

The exploration of the themes of risk interpretation and the social construction of bariatric surgery as a contested intervention will first be explored through a secondary literature review. Following this, I will argue that in order to understand patients' experiences of adjusting to life after bariatric surgery, the knowledge must be available to others such as healthcare professionals, those who may encounter people who have undergone bariatric surgery, such as family, friends and co-workers, and the lay public. Raising awareness of the wider context and impact of bariatric surgery on patients is proposed to give

additional context to the overarching biomedical discourses surrounding the discipline.

The findings have shown that the participants in this thesis reported that there are societal misconceptions surrounding bariatric surgery, which appear to largely exist in social situations where they felt that aspects of bariatric surgery could not be openly discussed. Within these environments, discourses surrounding bariatric surgery can potentially be a source of angst and risk, which may negatively affect the participants' adjustment to life after surgery. This subjective social knowledge is still relatively unknown and understood outside those who have undergone bariatric surgery, with the exception of healthcare professionals who work within the discipline and other bariatric surgical patients.

The interpretation of risk, particularly towards fear of judgment, after having being stigmatized for their previous obese state, can lead to selective or non-disclosure of bariatric surgery. The participant-reported experiences of everyday social interactions following bariatric surgery will be framed under the concept of hermeneutical injustice (Fricker, 2007), social construction and its relation to the interpretivist research paradigm. I argue that the interpretation of the risk surrounding the experience of adjusting to life after bariatric surgery and the social processes underpinning this have not been conceptualized in the existing literature; this is an original contribution to the knowledge on bariatric

surgery. Next, the proposed implications for practice are highlighted. There are five identified groups which may benefit from these findings; these are bariatric surgery patients, multi-disciplinary teams, the National Bariatric Surgery Registry, general practice and commissioners of bariatric surgical services. These implications are followed with suggestions for future research and a critical evaluation of my research. The chapter and thesis concludes with a personal reflection on the process.

7.2 The secondary literature review

As patients lose weight through interventions, their BMI decreases, which removes the label of morbid obesity to obese, overweight or normal, which may reduce the likelihood for stigmatisation. There is a semantic difference between overweight and obese (Jutel, 2005), with the former being subjected to less stigmatisation. I argue that the mechanisms of weight loss through bariatric surgery appear to be open to scrutiny and criticism by others, and as such are conceptualised as a disputed form of weight loss. As a result, many of the participants in this thesis reported that they were often reluctant to disclose to others that they had undergone bariatric surgery. The participants in my thesis reported there are risks involved with the act of disclosure in everyday social situations which, depending on individuals' attitudes towards risk, may have

social ramifications which can be difficult for those living with a bariatric surgery-altered body.

The concept of risk can be more clearly understood through an interpretivist approach, which seeks 'neither to predict and control the 'real' world nor to transform it but to reconstruct the 'world' at the only point which it exists; in the minds of constructors' (Guba, 1990,p.27). The notion of extending the inquiry into bariatric surgery to encompass the subjective social and cultural influences upon a person's experiences is congruent with Engel's seminal ideals of a biopsychosocial approach to health and illness (Engel, 1977).

The conceptualisation of the biopsychosocial approach added the 'critical psychological and social factors to the traditional, linearly conceived biomedical model' (Sadigh, 2013,p.362) which I argue to be limited in its perspective as a result. The rationale behind the biopsychosocial model was to:

> Provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of healthcare, a medical model must take into account the patient, the social context in which he lives, and the complementary social system devised by society to deal with the disruptive effects of the illness.

(Engel, 1977,p.132)

The acknowledgement of social context, subjective experiences and the need for understanding echoes the interpretivist paradigm of this thesis and assists in framing the experiences of the participants through a wider lens than that which could have been achieved by an objectivist research paradigm. All interpretivist research is acknowledged to be temporal and that these social situations, their meanings and actions which are presented in this thesis may indeed change or evolve over time.

Overall, the participants in this thesis conceptualised the adjustment to life after bariatric surgery as a positive experience, which was underpinned by their attitudes towards the social risks involved. These influenced and shaped actions which were formed as part of the adjustment process. One of the important themes contributing to the participants' attitudes toward risk was the reported lack of understanding from others towards themselves as people who had undergone bariatric surgery.

This thesis presents three constructed risk attitude profiles which underpinned the participants' adjustment process. The risk theme which was interpreted as being the most significant was the decision to tell others about the reason for

their weight loss. The act of choosing whether to disclose meant opening up opportunities for judgment, which participants generally conceptualised as negative and wished to reduce or avoid. The judgments surrounding the choice of bariatric surgery appeared to be encapsulated in the framing of surgery as a contested intervention for weight loss. The reluctance to fully or partly disclose the decision to undergo bariatric surgery may prevent the knowledge of the social experiences of adjusting to bariatric surgery to remain silent and thus not challenge the contested intervention label.

Following construction of the grounded theory, a second literature review was conducted in order to 'claim, locate and defend' (Charmaz, 2014,p.305) the findings of the research within the context of the theoretical framework and existing literature and position the thesis' original contribution to knowledge. The participant-reported perception of risk and six theoretical concepts underpinning this: failing/giving up, moving forward, feeling uncertain, keeping secrets, support seeking and feeling guilty are embedded in the current social construction of bariatric surgery as a contested medical intervention.

7.2.1 Conceptualising risk

The concept of risk has many strands and interpretations; this discussion critically examines risk from a social constructivist perspective focusing on the symbolic and cultural aspects, aligning with the interpretivist paradigm of this

thesis. A social constructivist approach argues that 'risk is never fully objective or knowable outside of belief systems and moral positions: what we measure, identify and manage as risks are always constituted via pre-existing knowledges and discourses' (Lupton, 1999,29). The participants' attitudes towards risk influenced the meanings and actions taken after bariatric surgery.

An interpretivist approach conceptualizes risks as 'social constructions, produced through shared understandings and past experiences' (Lupton, 2013,636). The act of disclosing may arise after inquiry from others for reasons such as questioning a person's rapid weight loss, changed physical appearance or eating patterns. Before deciding whether to take a risk such as disclosing:

> Individuals weigh up or decide what a risk is, making assessments of the social meaning of the phenomena and their place within cultural norms. They are deciding how these phenomena cohere with their values about what is acceptable and what is harmless against what is dangerous or threatening.

(Lupton, 2013,p.638)

The three risk attitude profiles of Risk Accepters, Risk Challengers and Risk Contenders which were constructed from the participant narratives in this

thesis, are congruent with Lupton's (2013) definition of the subjective interpretation of risk. Participant attitudes towards risk appeared influenced by the social situations they encountered, many of which were felt to have occurred because of the effects of bariatric surgery. Risk is discussed by the participants in the context of attitudes towards social situations and their meanings and actions will be explored and unpicked to gain a greater understanding of these situations. Such social risks are 'discursively constructed in everyday life with reference to the mass media, individual experience and biography, local memory, moral convictions and personal judgments' (Zinn and Taylor-Gooby, 2006,p.60).

Compared with other weight loss methods such as diet and exercise, bariatric surgery produces rapid weight loss, resulting in a visibly changed appearance in a relatively short period of time. A bariatric surgical patient thus moves from an obese, stigmatized state to one that invites scrutiny. Stigmatized afflictions fall into two categories: ones that cannot be disguised or hidden as 'discredited' and ones which are less visible and enable people to appear 'normal' are 'discreditable' (Goffman, 1963). The visibility of adult obesity places obesity as a discredited state, but bariatric surgery places the formerly obese into a discreditable state as the physical appearance has changed and the person has moved to a more socially accepted state of overweight or normal body weight. The discredited state of bariatric surgery leaves the person open to judgment from others which differs from further stigmatisation.

The participant-reported accounts which underpinned the co-constructed theory of this thesis was that bariatric surgery is a relatively unknown entity outside those who have undergone procedures, and is closely associated with adult obesity, which is a stigmatized condition. Many participants felt or reported accounts of stigmatisation from others. Stigmatisation tends to be associated with conditions or afflictions which possess deep-rooted socio-cultural perceptions such as mental illnesses (Pinfold et al., 2003) and Human Immunodeficiency Virus (HIV) (Fordham, 2015) in addition to obesity. The stigma of obesity is rooted in the perceptions of negative attributes towards the affliction, such as laziness, being weak-willed and out of control (Puhl and Brownell, 2003). For those who have undergone bariatric surgery, it is the rapid change from the obese body and rapid change in bodily appearance that warrants scrutiny and questions which lead to issues with self-disclosure to others.

7.2.1.1   The risks of self-disclosure

Participants reported that the change in appearance led to scrutiny, with many participants questioned by others about the reasons for their weight-loss. Participants were often reluctant to disclose their decision to undergo bariatric surgery, resulting in what Goffman (1963) coined 'information management', which was shown to lead to difficult social encounters. Disclosure of bariatric

surgery as the method of weight loss often left the person open to judgment from others. Current rhetoric shows that 'dieting and exercise are commonly depicted as appropriate mechanisms' for weight loss (Drew, 2011,p.2343) and as such are not subjected to the same scrutiny as bariatric surgery. Participants reported that bariatric surgery was conceptualised by others as doing the work of weight loss without any effort on the part of the person who had had the surgery. The perception of bariatric surgery as a constructed inappropriate mechanism of weight loss was reported elsewhere, where a participant was asked 'You didn't have one of those silly stomach stapling operations, did you?' (Throsby, 2008,p.127). Admitting to undergoing bariatric surgery to others where the outcome of the disclosure is unknown or may inadvertently leave the person open to negative judgments about the intervention may be a form of social risk.

The attitudes towards the risks surrounding disclosure, as co-constructed in the thesis by three risk attitude profiles, are discussed using Social Penetration Theory. Developed by Altman and Taylor in 1973, this theory seeks to show how social relationships between people develop through self-disclosure. Altman and Taylor describe the process of self-disclosure as similar to peeling the layers of an onion, with levels of self-disclosure possessing breadth and depth. Breadth refers to the amount of interaction a person undertakes with others and has two aspects: breadth category and breadth frequency. Breadth categories can include family, community, gender and interests, whilst depth is

concerned with the level of detail revealed in the disclosure (Altman and Taylor, 1973).

Using the analogy of an onion (see Figure 7.1), there are five phases of intimacy associated with self-disclosure, which the creators analogize to peeling the layers of an onion. The first phase is the 'orientation stage', where social exchanges are at a superficial level, with minimal personal or intimate details being revealed. Following this, the social exchange enters the 'exploratory affective stage' where more information is revealed, but not at a deep or intensely personal level. At the next level, self-disclosure at the affective stage reveals more personal and private information and communication between the two parties is defined as comfortable. In the 'stable stage' disclosure is freely open and comfortable. The final phase is depenetration, where the risk of self-disclosure outweighs the benefits, so no communication takes place (Altman and Taylor, 1973).

Figure 7.1 Stages of Social Penetration Theory

Orientation stage

Exploratory affective

Affective

Stable
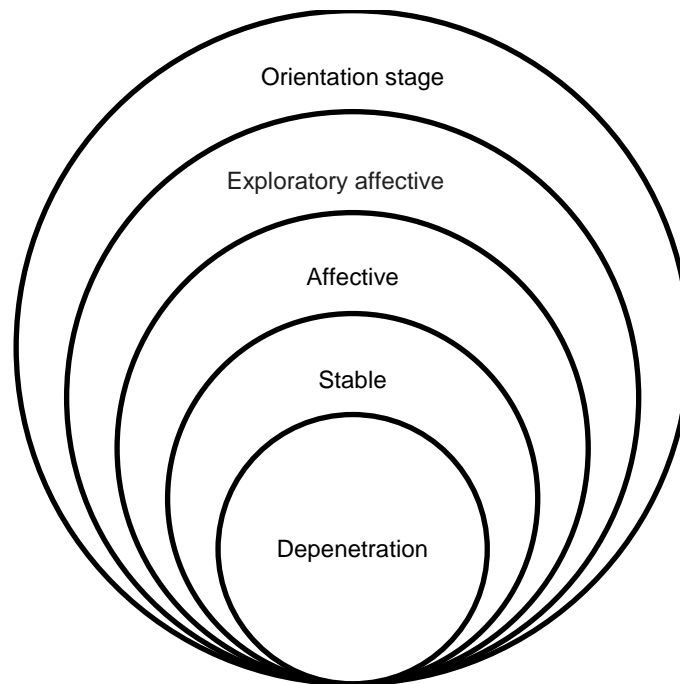
Depenetration

Source: Altman and Taylor, 1973

Social Penetration Theory as applied to bariatric surgery may offer a more detailed understanding of the three risk attitude profiles and the resulting social complexities around adjusting to life after bariatric surgery. The majority of the participants in this thesis appeared to frame the choice of bariatric surgery as an intimate and personal matter. The act of self-disclosing such information, depending on the individuals involved in the social exchange, would likely take place at the exploratory affective or stable stage. Many participants felt difficulties were experienced when intimate social exchanges were forced at an earlier stage such as the orientation stage, where non-intimate information was the norm. For example, an exchange with a waiter in a restaurant over the portion size or choice of a meal, which is usually an exchange which does not

require intimate disclosure, is challenging and difficult when a person feels compelled to disclose having undergone bariatric surgery in order to have food requirements met. The outcome of such social exchanges is often shrouded in uncertainty which appears to intensify the feelings of possible judgement. A critical examination of the participant narratives showed that there were many accounts of 'forced intimacy' at the orientation stage, however, despite deeper personal relationships at the different stages, choosing to reveal having undergone bariatric surgery invited judgment which confirmed the 'contested intervention' label.

The interpretation of the six co-constructed themes of this thesis of failing/giving up, moving forward, feeling uncertain, keeping secrets, support seeking and feeling guilty all involved social exchanges with others. Often these themes underpinned social interactions and situations, which did not appear to follow the stages of Social Penetration Theory, where intimacy increased as relationships developed. This appears to be an unavoidable consequence of a changed appearance following bariatric surgery. Examples of participants' accounts of these situations are given below. In the first example, B reported difficulties with a waitress in a restaurant when requesting a smaller portion of food:

She said we're not supposed to do that, so I said look, I've had bariatric surgery, I can't eat a full portion, I can only eat a little bit. I was annoyed to

the point that I thought that if she says no to me I'm going to leave, walk out of here….I thought if you don't let me have a child's portion, I'm leaving. In principle, I've asked you for a smaller portion for my dietary requirements, my needs and she says well we really shouldn't, I'm not supposed to…..more people are having bariatric surgery, its more popular and you should have smaller adult portions as an option…if you can offer it to children, why can't you offer it to us without us having to explain our lives away….its discrimination, but we have to stand up for ourselves

(Participant B)

The decision to reveal having had bariatric surgery was one that Participant B would have felt more comfortable disclosing to someone with whom she had an intimate social relationship with, which would likely be at an Affective or Stable stage. As this particular encounter appears to have taken place at the Orientation stage, revealing information about herself which she feels is private, has caused her to be uncomfortable in this social encounter. Participant B was categorized as a Risk Contender.

Another participant, P, expressed difficulties with staff in a restaurant, but did not feel the need to disclose he had undergone bariatric surgery to them:

It was my friends' birthday and we all went to a curry house and I ordered

a starter. It took me ages to eat it and they kept wanting to take the plate

away and I was like…no, I'm not finished…I told them a few times and

they did get a bit shirty, but that was the only real trouble I've had

(Participant P)

Participant D was able to keep the conversation with the restaurant staff at an Orientation level, without disclosing that bariatric surgery was the reason behind his eating differently. Participant D was categorised as a Risk Accepter and as such may be more comfortable asserting himself in social situations.

The three constructed risk attitude profiles appeared to influence the adjustment process in different ways. This scrutiny of sudden and drastic weight-loss contributes toward the proposed social construction of bariatric surgery as a contested intervention. I will next explore the possible reasons behind this framing.

7.2.2 Bariatric surgery as a contested intervention

In many social situations, participants who admitted undergoing bariatric surgery were negatively judged. According to Goffman:

> [T]he stigmatized individual can also attempt to correct his condition indirectly by devoting much private effort to the mastery of areas of activity ordinarily felt to be closed on incidental and physical grounds to one with his shortcoming.

(Goffman, 1963,p.20)

Bariatric surgery can be interpreted as a way of correcting the stigmatized status; however the discourses pervading socio-cultural attitudes towards bariatric surgery are not well understood. Despite biomedical evidence which clearly demonstrates bariatric surgery's efficaciousness in terms of safety, sustained weight loss and comorbidity improvement (Sjöström, 2013), surgical intervention continues to be 'viewed with a degree of suspicion by both health professionals and the lay public. While some of this scepticism may be a response to the newness of the procedures, the aetiology of the disease may also prejudice peoples' attitudes' (Williamson, 2012,p.1).

The findings from this thesis support this statement, with participant reports of suspicion around bariatric surgical procedures from both practitioners and the lay public. There appears to be a link with the stigmatisation of obesity on which the foundation of the suspicion is based. With respect to the procedures themselves, it appears to be the self-reported accounts of judgments surrounding the treatment of obesity through surgery which underpins the scepticism. Participants felt they were judged for their choice of weight-loss intervention. They reported that bariatric surgery is perceived as a contested intervention by those who have not had it, as participants reported a pervading assumption that bariatric surgery achieves the weight-loss as opposed to any effort on the part of the patient.

Other work has found that bariatric surgery is framed as bypassing more culturally accepted methods of weight-loss such as dieting and exercise (Ferris, 2003), and referred to as form of cheating (Drew, 2011). There has been little work done on societal attitudes towards bariatric surgery, with three studies identified. Sikorski et al., (2013) used telephone interviews (n= 1,008) to seek the public's views on the effectiveness of bariatric surgery and other interventions for obesity in Germany. They found that exercising more (98%) and eating less (82%) were perceived as effective weight-loss interventions, compared with only 56% towards bariatric surgery. As a result, only 22% would recommend bariatric surgery, compared with 87.7% and 97.1% towards eating less and exercising more respectively. Although this study examined perceptions of attitudes towards bariatric surgery in terms of effectiveness and

subsequent recommendations, it did not examine the underlying socio-cultural assumptions surrounding the perceptions of bariatric surgery which may not be generalizable to other countries. Nonetheless, their findings are congruent with the present findings where participants' experiences showed societal preferences for weight-loss interventions such as diet and exercise.

Using a web-based questionnaire with 1,141 members of the public in Denmark, Lund et al. (2011) examined the attitudes towards public funding of obesity-related healthcare interventions. With bariatric surgery, 33% felt public funding was warranted, 46.5% felt this should be self-funded and 20.3% didn't know. One question asked if the notion of obesity as a personal culpability could be disproven, the response found that 74.5% changed their minds about the acceptability of bariatric surgery, for example if a life-saving argument for surgery was presented. Whilst acknowledging that the findings need to be considered within the context of the Denmark and the Danish health care system this finding supports those of this thesis with respect to the stigma of adult obesity being inextricably linked to bariatric surgery as a contested intervention and subject to judgment.

The final study identified aimed to determine whether providing information to the lay population about the lifestyle changes needed to lose weight after bariatric surgery would assuage negative judgements towards bariatric surgical patients (Vartanian and Fardouly, 2014). The authors asked 275 participants

(138 women, 137 men) to rate impressions of an obese woman before and after learning she had lost a substantial amount of weight through 1) diet and exercise, 2) bariatric surgery or 3) bariatric surgery and diet and exercise. Weight loss through surgery was rated the most negatively, followed by surgery and diet/exercise, with diet and exercise alone being valued the highest. This is consistent with the findings from this thesis, but this paper also highlighted the notion of a lack of personal responsibility for weight loss by others, which may be an important consideration when interpreting judgment of bariatric surgery. A perceived lack of responsibility may feed into the pervading discourses of laziness, weak willed and so on, which surround bariatric surgery. The authors suggest that 'educating people about the amount of effort that surgery patients invest in their weight loss might mitigate some of the negative attitudes about surgery and surgery patients' (Vartanian and Fardouly, 2014,p.1234). This is supported by the findings of this thesis.

A critical examination of the influences surrounding the contested intervention and judgments framing the social construction of bariatric surgery may help to provide understanding of these interpretations. The factors which are thought to contribute to the social framing of bariatric surgery as a contested intervention include, but are not be limited to:

- The prevailing stigma of adult obesity (Puhl and Heuer, 2009)

251

- The framing of bariatric surgery as failing/a final option in NHS eligibility criteria (National Institute for Clinical Excellence, 2006, National Institute for Health and Care Excellence, 2014)

- Negative portrayal of bariatric surgery in the media (Drew, 2011)

These social forces assist to shape the cultural discourse surrounding bariatric surgery. I argue that the risk of disclosure, which invites judgement, means that subjective, in-depth knowledge of adjusting to life following bariatric surgery is lacking. Partial or non-disclosure of experiences means that detailed experiential knowledge cannot be fully understood unless it is situated in an environment free of the fear of judgement, otherwise knowledge of social experiences following bariatric surgery and will be silenced. The participants' subjective experiences appear to be encapsulated in a cycle (see Figure 7.2) where they feel their knowledge is not heard fairly.

Figure 7.2 The silenced knowledge of bariatric surgery

Fear of judgment leading to non- or selective disclosure (experiences not shared so knowledge does not become avalable`

Participant knowledge based on experiences of adjusting to life after bariatric surgery

Negative socio-cultural perceptions and stigmatiation of adult obesity

Eligibility criteria for bariatric surgery rooted in perception of failure

Negative media portrayal of bariatric surgery

People who experience phenomena first hand are often conceptualised as possessing specialist knowledge and an interpretive research paradigm strives to:

Make concerted efforts to learn about participants' views and actions and

try to understand their lives from their perspectives. Yet we do not necessarily adopt or reproduce their views as our own; rather we interpret them. Thus, we must test our assumptions about the worlds we study and not unwittingly reproduce these assumptions. We need to discover what our research participants take for granted or do not state, as well as what they say and do.

(Charmaz, 2014,p.33-34)

This co-constructed knowledge is proffered to be useful in challenging and dispelling the current negative perceptions of bariatric surgery. Following, the three factors which are proposed to contribute towards the concept of bariatric surgery as a contested intervention are discussed.

7.2.2.1   Prevailing stigma of obesity

The notion of bariatric surgery as a contested intervention may be rooted in the underlying sociocultural negative perception of adult obesity. In the United States, obesity has only recently been recognized as a disease (American Medical Association, 2013). It is uncertain at present whether this will contribute to a more positive perception of adult obesity as cultural stereotypes are deeply

ingrained and are hence difficult to both challenge and change (Puhl and Brownell, 2003).

There has been debate as to whether framing obesity as a disease will legitimise the condition (Heshka and Allison, 2001, Kopelman and Finer, 2001). While this is outside the scope of the thesis, my findings support Kopelman and Finer's suggestion that obesity, whether labelled as a disease or not, needs to be understood in terms of the personal consequences (Kopelman and Finer, 2001, Puhl and Heuer, 2009) to explore how obesity affects the lives of individuals and to challenge the stigmatized attributes of the disease. This work may contribute towards the perception of bariatric surgery as being less of a contested intervention and more of a societally accepted intervention for obesity and related disorders, thereby reducing judgment of those who undergo procedures. As a diagnosis of obesity is crucial to NHS eligibility for bariatric surgery in the UK (National Institute for Health and Care Excellence, 2014), bariatric surgery patients are likely to encounter negative societal attitudes towards obesity (Drew, 2011). The thesis has shown that these two concepts are inextricably linked throughout a patient's bariatric surgical journey.

7.2.2.2   Reinforcement of failure: NICE criteria for bariatric surgery

The concept of failing is embedded in the discourse surrounding bariatric surgery. Many participants reported seeking bariatric surgery because they had either failed at other ways of losing weight and/ or given up on themselves and perceived themselves as failures. This perception maps onto the NHS tiered obesity management system in the UK (National Health Service Commissioning Board, 2013), which positions bariatric surgery after other weight-loss methods have been unsuccessfully attempted. There is clinical rationale for the steps in the different obesity tiers, the rationale for which is outside the scope of this thesis. In the original clinical guidelines, the word 'failed' was used in the eligibility criteria: 'all appropriate non-surgical measures have failed to achieve or maintain adequate clinically beneficial weight loss for at least 6 months (National Institute for Clinical Excellence, 2006,25). This reinforces the obesity stereotypes and may have been a contributing factor in the 'contested intervention' label attributed to surgery. Eight years later, the word 'failed' was removed and the criteria rephrased as 'all appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss (National Institute for Health and Care Excellence, 2014,p.26). However, the concept of not achieving or maintaining, although less explicit, still alludes to a perception of obesity as a failure, which may be transferred to the judgment of those who seek bariatric surgery.

Eligibility guidelines are mostly used by healthcare professionals (HCPs) such as General Practitioners, nurses and bariatric surgical teams rather than the general public. However, NICE guidelines are freely available on the Internet and can be accessed by lay people. The interpretation of guidelines by HCPs may influence their attitudes and acceptance of bariatric surgery (Sikorski et al., 2013) which in turn shapes subsequent discussions with obese patients surrounding management and interventions. The traditional interaction between doctor and patient presumes the doctor holds a more important position as the bearer of medical knowledge, including recommendation of medical treatments (Stoeckle, 1987). In most NHS patient cases, the General Practitioner is central to the referral process of a patient to a bariatric surgical unit. Several participants reported encountering difficulties being referred for surgery as a result of their GPs' attitudes towards surgery. This finding is supported elsewhere, which suggests these attitudes may be down to ambivalence or misconceptions towards bariatric surgery (Al-Namash et al., 2011, Afonso et al., 2010, Perlman et al., 2007) or by personal attitudes towards obesity (Kaminsky and Gadaleta, 2002, Foster et al., 2003).

The ambivalence of some General Practitioners towards bariatric surgery, as reported by two of the participants in this research, may influence the opinions of others such as colleagues and patients. A further influence shaping the framing of bariatric surgery as a contested intervention is the media.

7.2.2.3 The media and social framing of bariatric surgery

A major influence on the social construction of attitudes, opinions and beliefs is the media. The media is described as:

> An interface between the medical community and the lay public. It therefore plays a critical role in shaping public opinion regarding health issues.[….] The media decides on what issues to present to the population and the level of importance attached to them, influencing public understanding and awareness. Articles depicting medical subjects may not be in-depth and are often influenced by non-medical issues, such as celebrity status or significant public events

(Williamson, 2012,p.1691)

Media-constructed images of bariatric surgery have contributed to the contested intervention perception. Figure 7.3 shows the September 30th 2014 cover of a UK tabloid magazine, Bella, with the main picture of Dawn French, an obese celebrity, with the heading 'Dawn: Gastric Band Rumours', suggesting that bariatric surgery may be the reason for her weight loss. This speculation surrounding weight-loss is similar to the experiences of some of the participants in this thesis. Additionally, another formerly-obese celebrity, Fern Britton

underwent drastic weight loss and attributed this to diet and exercise; she later admitted to having had bariatric surgery (Gamman, 2013).

Figure 7.3 Example of UK media construction of bariatric surgery discourses

Several participants specifically mentioned hearing 'rumours' about the method of their weight-loss from others, which conjured up further feelings of being scrutinized, influencing their perceptions of the risk of being judged and consequences of disclosure. The denial of bariatric surgery appears to be

significant and Gamman (2013) proposes this may be associated with cultural notions of a bariatric surgically altered body not being interpreted by the lay public as natural and therefore not acceptable. The participants in this thesis did not report any accounts of bariatric surgery as being unnatural from others, but there were judgements of bariatric surgery as being unacceptable in comparison to weight-loss due to diet and exercise. In other literature, Drew (2011) analysed newspapers and magazines to identify bariatric discourses, followed by interviews and surveys with 99 bariatric surgical patients. She concluded that patients who underwent bariatric surgery felt stigmatized owing to representations in the printed media of bariatric surgery being risky, extravagant, an easy way of tackling obesity and only acceptable when other methods had failed. Drew (2011) also suggested that through negotiating these media discourses, participants perceived themselves as possessing expert knowledge of bariatric surgery.

One of the largest media influences is the Internet. In terms of medicine, the Internet is suggested to be 'an unregulated area where market forces and consumer interests define medical conditions and construct legitimate therapeutic approaches, relegating physicians to the background' (Salant and Santry, 2006,2446). Online information on bariatric surgery has been found to be of varying quality (Akbari and Som, 2014, Madan et al., 2003), which may contribute towards the current societal perceptions of the interventions. The Internet is home to many social media sites for patient support groups, who use these as forms of social support after surgery. Participants in this thesis

reported accessing online chat rooms and member-only sites on platforms such as Facebook. Members-only sites suggest that those who seek online support wish to share their experiences with a particular group of individuals, which supports the reporting of selective disclosure by participants in this thesis. The three main reasons participants seek on-line support are reported to be participants' desire to seek information, advice, and guidance; a need for peer support and networking and finally, a safe place in which to disclose information (Das and Faxvaag, 2014). These reasons both support and reflect the participant narratives in this thesis.

Many participants in this thesis reported seeking online support and information before and after surgery. Social penetration theory was used in a study into self-disclosure, which sought the views of 1,027 bloggers on the depth and width of nine topics, of which was body shape and size (Tang and Wang, 2012). Although this was a study of bloggers in general and not related to bariatric surgery, the degree of self-disclosure to identified groups of on-line communities, close friends and parents show that Social Penetration Theory may be useful in identifying audiences which are considered safe to report disclosure of personal matters to. The findings revealed that bloggers appeared to disclose less to online audiences and more to family and friends; this is similar to the face to face disclosures of the participants in this thesis. This may be an area for further research in terms of the relationship between the identified theme of 'support seeking' in this thesis and levels of disclosure.

The current social framing of bariatric surgery does little to incorporate the perspectives of the people who have undergone procedures. The ambivalent and sometimes negative messages surrounding bariatric surgery have been shown to lead to various levels of self-disclosure, so in present circumstances, it appears difficult for people to fully articulate their experiences for fear of judgment. Despite the increased provision of bariatric surgery in the UK, the present research showed a lack of knowledge and subsequent understanding towards patients who often experience a complex process of adjustment following surgery. The difficulties associated with participant-reported need to increase the knowledge and understanding of the experiences of life adjustment after bariatric surgery is conceptualized as a form of epistemic injustice.

7.3 Framing the patient voice with the concept of hermeneutical injustice

Epistemic injustice is defined by Fricker (2007, p.1) as a 'wrong done to someone specifically in their capacity as a knower'. She proposes two forms of this concept:

– Testimonial injustice which occurs when prejudice causes a listener to give a deflated level of credibility to a speaker's word.

- Hermeneutical injustice is caused by prejudice in the economy of credibility and caused by structural prejudice in the economy of collective hermeneutical resources.

An example of testimonial injustice in the context of adult obesity may occur when an obese person recounts his/her failure to lose weight. Owing to the ingrained societal prejudices towards the obese state (Puhl and Heuer, 2009), this admittance may be somewhat contentious owing to associations of obesity with negative attributes (Puhl and Heuer, 2010, Throsby, 2007). Testimonial injustice was explored in terms of framing the experiences of the participants, but I felt it may be potentially limiting in terms of being able to capture the social complexities in which the adjustment to life after bariatric surgery is situated; this process can be explicated more thoroughly by the application of hermeneutical injustice.

I felt that the concept of an economy of credibility in terms of hermeneutical injustice would be allow the social complexities associated with adjusting to bariatric surgery to be illuminated. Through the application of the concept of hermeneutical injustice (Fricker, 2007) to the participant-reported information of bariatric surgery, there is an implication of a prevailing discourse of silenced knowledge underlying their social experiences. This was co-constructed as having an underpinning stigma of obesity which led to fear of judgments by those who have undergone surgery. This appears to lead to selective or non-

disclosure, for fear of the risk of judgment from others. From the findings, the participant-reported adjustment experiences following bariatric surgery were co-constructed as being societally unacknowledged as an acceptable weight-loss intervention and consequently perceived by those who had had surgery to be not fully understood by others. This was a concept consistently found in other studies from the patient perspective in the initial literature review (Earvolino-Ramirez, 2008, Wysoker, 2005). Thus, the knowledge of the experiences of those who have undergone bariatric surgery is currently:

> Situated in a hermeneutical lacuna whose existence is owing to the relative powerlessness of the social group to which the subject belongs. Such a lacuna renders the collective interpretive resources structurally prejudiced.

(Fricker, 2008,p.69)

This thesis has shown that participants' attitudes towards risk of judgement led to them being secretive and being careful about disclosing that surgery was the reason behind their significant weight loss. Figure 7.4 offers a summary of the reasons for the current social framing of bariatric surgery as a contested intervention and the resultant actions taken by those who have experienced surgery.

Figure 7.4 Reasons underpinning the social framing of bariatric surgery as a contested intervention

Post-surgical timeframe

| Adult obesity as stigmatised affliction resulting from socio-cultural attitudes | Participants giving up/or failing to improve/resolve affliction through other socio-culturally accepted interventions | Choosing a contested intervention which involves the risk of being judged for the choice | Selective or non-disclosure in order to avoid judgment (hermeneutical injustice) |

Pre-surgical timeframe

Humans may partake in what Holstein and Gubrium (2000) refer to as 'interpretive practice', meaning:

> People continually react to and build upon the existing societal discourses they are exposed to. Individuals do not always subscribe to intended discursive messages; in particular, people with increased information or special access to a topic may reflectively negotiate, rather than automatically accept, discursive messages.

(Drew, 2011,p.2342)

This thesis has shown that the participants' interpretation of the social processes involved in adjusting to life after bariatric surgery appears to be structurally prejudiced which, especially for the Risk Contenders, appears to cause difficulties in everyday life. Therefore, given the increasing rates of adult obesity, as more people become eligible for and choose bariatric surgery as an intervention, the need to understand the social adjustments afterwards is becoming more important. Currently, the rates of adult obesity in the UK are predicted to reach 50% of females and 60% of males by 2050 (Foresight, 2007). Additionally, the increasing body of evidence to show the favourable effects of bariatric surgery on metabolic disorders such as Type 2 Diabetes (Keidar, 2011, Sjöström, 2013) has led to revised UK guidelines which extend eligibility criteria (National Institute for Health and Care Excellence, 2014) for bariatric surgery and potentially increases the opportunities for provision.

Hence, the dissemination of the knowledge produced from this thesis is an important consideration in order to support patients who decide to seek bariatric surgery. In the following section, I offer suggestions for these thesis findings on the implications for practice for the suggested target audiences of patients, practitioners and commissioners of bariatric surgery.

7.4   Implications for practice

The dissemination of the findings contributes towards raising awareness of the social processes involved in adjusting to bariatric surgery. In collaboration with the participants, the co-constructed theory suggests a lack of knowledge from others, in particular the lay public, of the social experiences of adjusting to bariatric surgery. I argue that the attitude towards the participant-reported social risks are central to understanding the underlying meanings and actions which patients may undertake as part of this process. Based on the narratives of the participants and the subsequent co-construction of the findings, four groups were identified as audiences for the findings; bariatric surgical patients, bariatric surgical multidisciplinary teams, general practice and commissioners of bariatric surgical services.

7.4.1   Bariatric surgical patients

During the recruitment and consent processes, the majority of participants requested information on the findings of the study. One of the main reasons for this stated by the participants for this, was to know the extent to which their experiences matched those who had had bariatric surgery. This information may have not been available or accessible to them before, for example they did

not have access to or know of other people who had undergone surgery in order to compare experiences.

When discussing the conceptual theory and sharing the thesis findings with the participants, it was interesting to note that those in the Risk Contender category seemed to be more curious and to question more than those in the other categories. The constructed themes which underpinned the risk attitude profiles also resonated with the participants. Participants also felt that the complexity of disclosure had been captured and that this is something they felt others considering bariatric surgery should think about and prepare themselves for.

Participants who requested to know the findings of this thesis reported they would have benefited from having access to such detailed information on the experiences of other patients after bariatric surgery. They told me that such information would have helped them to prepare and understand what types of social situations they might encounter after surgery. They reiterated their experiences of adjustment as a process of trial and error which could be difficult to deal with. All participants who discussed the findings with me suggested that a summary of the thesis should be made both available to patients awaiting surgery and for those who have already undergone procedures as tools for reflection and for support.

The format and presentation of the findings of this thesis will be agreed and pilot tested with a representative group of bariatric surgical patients. Several participants in the study asked to remain involved with this research by assisting with the development of information material and to help inform the dissemination strategy. These participants reported their motivation for this as being driven by a desire to help others in their bariatric surgical journey.

The attendees of the patient support group at Sunderland Royal Hospital who have acted as advisors on patient-related aspects of the thesis such as participant documentation, incentives, and testing requested the information be made available to themselves and others who attend the support group. Feedback from the support group was for this information to be made available in lay terms as a short report, but also as a presentation, which they felt would also provide opportunities for discussion within the support group.

As a result of these discussions, the main themes of this thesis will be written in lay terms as source of information to bariatric patients presenting for bariatric surgery and be made freely available within the bariatric surgical unit at City Hospitals Sunderland NHS Foundation Trust. I will be working with the members of the bariatric surgical multidisciplinary team to ascertain how to incorporate this additional information into clinical practice.

7.4.2   Bariatric surgical multidisciplinary teams

From the outset of the thesis, there was an agreement between City Hospitals Sunderland NHS Foundation Trust and myself that the findings would be given to and used by both the bariatric surgical multidisciplinary team (MDT) at Sunderland as well as with patients. The findings were discussed with all members of the MDT, both as a group and individually. There was a clear consensus that the findings needed to be disseminated to patients, practitioners in hospital and community settings and to commissioners. The bariatric surgical team is involved with the patient support group and concurred with the recommendations made by the group in terms of patient leaflets and presentations for the group.

The initial findings were presented as an oral abstract at the British Obesity and Metabolic Surgery Society 6th Annual Scientific Meeting in January 2015 to a national audience. I was able to discuss the findings with members of national bariatric surgical teams here. I was told that clinicians in other units also saw patients who were reflective of my three risk attitude types, and that these appeared to accurate representations of the categories of bariatric surgical patients that they had encountered. It may be that the risk attitude profiles have potential to be generalizable to other bariatric surgical patient populations and settings; further research is needed to determine this.

7.4.3 The National Bariatric Surgery Registry

The implications for practice are relevant to the National Bariatric Surgery Registry (NBSR). This is a voluntary register conceived and managed by the British Obesity and Metabolic Surgery Society (BOMSS) which are comprised of members of various UK bariatric surgical teams. Based on my research, I propose there are potential new categories for the NBSR which include patient-reported outcomes and experiences. The patient-reported interpretation of aspects of the already measured outcomes of bariatric surgery have potential to give bariatric surgical teams greater insight into patient experiences, which can be used to provide more tailored support to patients. For example, the NBSR has a category of 'functional status' which assesses patients' reported ability pre- and post-surgery, to climb parts of a flight of stairs before experiencing shortness of breath. This can be explored further by asking a patient to reflect on the personal effects of the changes in functional status related to surgery, to help a patient to see how far he/she has come in their weight-loss journey.

Other measurements of patient-reported outcome measurements (PROMS) of bariatric surgery would also give further context to the current comprehensive collection of data in the NBSR. Further research into the most appropriate areas should involve patients, to identify areas of importance to them, which may inform clinical practice. I recommend that the NBSR consider establishing a group of bariatric patients, recruited from the UK bariatric surgical units, who

would be prepared to provide a patient perspective of bariatric surgery outcomes, which would be congruent with the NHS Outcomes Framework aims of improving patient experience of healthcare.

7.4.4 General Practice

Interventions such as bariatric surgery which take place in hospitals often require long-term follow up and management in General Practice. However, communication between the two settings is not always straightforward (Kripalani et al., 2007). This may affect patient perceptions of care they receive. During data collection, some participants reported varying levels of support from General Practice regarding different aspects of their individual bariatric surgical journey. Examples of this ranged from a reluctance to refer individuals for surgery (Participant L), a collective learning experience together (Participant B) and moving from a supportive General Practitioner to one who appeared indifferent, or did not know how to provide participant-interpreted adequate support (Participant D).

Studies have shown an indifference from some General Practitioners towards bariatric surgery from both clinician (Foster et al., 2003) and patient perspectives (Kaminsky and Gadaleta, 2002), but others have reported that many Primary Care physicians do not feel prepared to provide long-term care to

bariatric patients (Balduf and Farrell, 2008). The reasons behind this are likely to be complex. There are limited studies which explore management of obesity in Primary Care which encompass management of bariatric surgery (Ferrante et al., 2009, Goritz and Duff, 2014, Doolen, 2005) and a survey of 165 family physicians in Canada found little knowledge of bariatric surgery as an obesity intervention (Auspitz et al., 2016). Therefore, I argue that further research into management of bariatric surgical patients in Primary Care is needed from both practitioner and patient perspectives to provide a more comprehensive understanding. Patient attitudes towards risk might provide a framework for contextualising factors and managing patient compliance in clinician-identified areas such as weight and psychological management (Goritz and Duff, 2014, Doolen, 2005).

Several participants I interviewed felt that an increase in understanding of the adjustments required by bariatric surgery would improve communication between patients and members of Primary Care teams. Patients who undergo bariatric surgery are under long-term management of their weight and health in Primary Care, therefore the findings of this thesis may contribute to improving the understanding of the social support needs of post-bariatric patients.

7.4.5 Commissioners of bariatric surgical services

This thesis has shown that bariatric surgical patients have a set of social adjustments as a result of their surgically altered bodies and that this will impact on the provision of services which the bariatric patient will utilise. Patients are generally referred back into Primary Care after discharge from a bariatric surgical service. I found that social adjustments and experiences encountered by bariatric patients as a result of their surgically-altered bodies show they have a unique set of requirements which differ from those who lose weight through other means. The eating requirements of a bariatric patient are different to those who have lost weight through other means, and this needs to be accounted for when providing services for this cohort. Additionally, the three risk attitude profiles, which give context to the complexity with disclosure and judgment of bariatric surgery shows that patients, especially risk contenders, may need additional support in dealing with these issues. The participants in this thesis reported accessing support face to face, through social media and written information. I recommend that research is conducted to ask bariatric surgical patients to ascertain what they feel are the most appropriate methods of obtaining information about their surgery and the potential impact on the social aspects of their lives afterwards. The patients should also be consulted to ensure that the language, format and availability of such information meets their needs. This will support the current NHS patient-centred approach and may contribute to Domain 4 of the NHS Outcome Framework (Department of Health, 2013) which strives to ensure patients have a positive experience of care.

7.5   Suggestions for Future Research

The perceptions of risk and disclosure were constructed as important aspects of adjusting to life after bariatric surgery. As this thesis focused on the first two years of bariatric surgery only and patients generally live with a surgically-altered body for the rest of their lives, a longer-term follow up study may show if these perceptions change as time passes. For example, does a Risk Accepter always remain a Risk Accepter or can he/she move between profiles?

The reported risks of disclosure, particularly in the context of the categories of the Social Penetration Theory need to be further researched. As the rates of adult obesity and related comorbidities increase (Public Health England, 2014), so the rates of bariatric surgery reflect the same trajectory (Welbourn et al., 2014) . This potentially positions bariatric surgery away from a specialist area towards becoming a more mainstream and common procedure. The impact of this on disclosure and other social risks is an important aspect of the adjustment process and requires further exploration to prepare and support patients throughout all stages of their journeys through bariatric surgery.

It is evident from the findings of this thesis that the adjustment to life after bariatric surgery is a complex social process. Continued research from the patient perspective and using qualitative methodologies, will continue to build a more biopsychosocial approach towards bariatric surgery and encompass all

aspects which may help to reduce the reported judgments surrounding those who undergo bariatric surgery and challenge the seemingly negative public perceptions of the intervention, whilst maintaining the confidentiality of those who experience judgment or issues with disclosure.

7.6   A critical evaluation of the thesis

Deciding how to best appraise the quality of a qualitative study is not straightforward. There is little consensus about which evaluative criteria should be used. According to Corbin and Strauss (2008, p.287), 'Quality in qualitative research is something we recognise when we see it; however explaining what it is or how to achieve it is much more difficult'. There are well-established criteria for quantitative research which are based on the standardized methods of data collection, analysis and interpretation of quantitative methods; however:

> This raises the question of how far these criteria, with their strong emphasis on standardization of procedures and the exclusion of communicative influences by the research, can do justice to qualitative research and its procedures, which are mainly based on communication, interaction and the researcher's subjective interpretations.

(Flick, 2011,p. 207)

Corbin and Strauss (2008) suggest criteria for quantitative research such as validity could be replaced by terms such as rigour, truthfulness or integrity, but these may not be applicable across the many types of qualitative research, and that postmodernist and constructivist approaches may further contribute to difficulties in evaluation.

Four criteria for evaluating qualitative research are offered by Lincoln and Guba (10985), credibility, transferability, dependability and confirmability. The notion of credibility seeks to determine if the findings are a true representation of the phenomenon, transferability demonstrates the applicability of the findings to other contexts, dependability evaluates the consistency of the findings and if they could be repeated; confirmability examines the extent to which the findings are based on participant perspectives and not researcher assumptions and biases.

These criteria can be applied to a wide variety of qualitative research. Charmaz suggests credibility, originality, resonance and usefulness for evaluating grounded theory studies (Charmaz, 2006), which I argue has the same ethos as Lincoln and Guba, but are specific to grounded theory and a constructivist paradigm. These criteria address both the scientific and creative aspects of qualitative research (Corbin and Strauss, 2008). I used Charmaz's framework

for the self-evaluation of this thesis. The criteria of 'usefulness' was of particular interest, as the dissemination and impact of the research findings were important personal aims of the thesis.

Each of the four criteria was used to evaluate and reflect back on the thesis to ensure that the process and end product would make sense for the intended audiences, as they will 'judge the usefulness of our methods by the quality of the final product' (Charmaz, 2014,p.337).

7.6.1 Credibility

A researcher aims to establish credibility by demonstrating that a detailed and veracious picture of the phenomenon under investigation has been presented (Shenton, 2004). The patient perspective of adjusting to life after bariatric surgery has been co-constructed as a relatively unknown entity for those who have not undergone surgical interventions. Therefore, it follows that familiarity with the topic and the setting needs to be provided in detail, so that audiences can become acquainted with and understand the phenomenon. With this thesis, the social context of adult obesity was provided to lay a foundation for an understanding of the social construction of bariatric surgery. A chronology of bariatric surgery, descriptions of current procedures, eligibility criteria, an initial literature review and the rationale for approaching the study from the patient perspective was given to acquaint the audience with the phenomena.

Credibility also relies on sufficient data to support the claims made in the research; the constant comparative analytic procedures ensured that data was rigorously scrutinized and interrogated through coding, memoing and theoretical sampling. This research also adhered to the constructivist grounded theory tenet of mutual reciprocity between researcher and participants. The claims made are an acknowledged co-construction between the participants and myself, and efforts were made to maintain researcher reflexivity through memoing.

7.6.2 Originality

The concept of risk underpinning the adjustment to bariatric surgery offers a different insight into the social processes the participants experienced. The participants' attitudes towards social risks offer a new insight into how everyday social situations change after bariatric surgery and how participants negotiate these encounters. The use of symbolic interactionism allowed the meanings and actions surrounding these to be explored in detail and assisted in constructing the conceptual rendering from the participant perspective.

7.6.3 Resonance

The co-constructed theory of risk attitudes towards the social adjustments to bariatric surgery allowed a comprehensive range of participant-reported situations to be explored. The everyday encounters which were reported to change after bariatric surgery were examined in the social institutions of family, friends, employment and transitional categories, which were identified by the participant narratives. The meaning of risk, the resulting actions, and the consequences have been explored in detail and applied across a range of social situations which have been reported by the participants who wished to be informed of the findings, as helping to make sense of their experiences. The thesis is therefore, from the perspective of the participants, proposed to resonate with them.

7.6.4 Usefulness

This final category is concerned with ensuring that this research will be of use to the people who took part in the study and for those whose lives are affected by bariatric surgery, including patients and practitioners. Encapsulating the phenomenon of adjusting to life after bariatric surgery in the attitudes towards risk may offer insights which may:

- provide insight for patients undergoing bariatric surgery into how others have adjusted to social processes afterwards, so the information can be used to prepare themselves for life after bariatric surgery

- help the participants to gain a deeper awareness of their lives after surgery and how their lives have changed

- be used to help patients who have undergone bariatric procedures to make sense of their experiences by comparing these with the research findings

- be a source of information to those who live or work with bariatric surgical patients to understand how everyday social situations change after surgery, so support can be provided from a multitude of agencies

These four categories guided my reflective evaluation of the thesis which is discussed in terms of strengths and limitations.

7.6.5 Strengths

The thesis benefits from the use of constructivist grounded theory; the aim of the methodology is to construct a substantive theory which extends beyond rich

description of the lived experiences of the participants The constructivist grounded theory approach 'looks back into its past, explores its present and turns forward into the future' (Charmaz, 2006,p.183). This study sought to explore patients' experiences of the phenomena surrounding adjustment to life after bariatric surgery. With grounded theory 'a constructivist would emphasize eliciting the participants' definition of terms, situations and events and try to tap his or her assumptions, implicit meanings and tacit rules. An objectivist would be concerned with obtaining information about chronology, events, settings and behaviours' (Charmaz, 2006,32). The strong pragmatist underpinnings of the constructivist approach encouraged me not to take data at face value, but to explore the tacit meanings and actions taken by the participants along with the language they used to when discussing their experiences. This was further reinforced by using symbolic interactionism as the theoretical perspective which allowed me to gain further insight into how these meanings and actions were created and enacted.

This thesis adhered to the need for mutual reciprocity between researcher and participant, acknowledging that the theory produced is a co-construction between the two parties and acknowledges that a researcher brings existing knowledge into a study. Meaning is therefore 'constructed through the qualitative researcher's interpretive understandings, an emic perspective that assumes a relativist and reflexive stance toward the data' (Barnett, 2012,p.47) These principles contributed to an 'interpretive rendering of a reality, not

objective reporting of it' (Charmaz, 2008,p.206) which were a strength of the methodology.

The findings showed that many participants were reticent to discuss their experiences in social situations, with partial and non-disclosure of the method of their weight loss. This research offered a safe environment in which participants could freely discuss their experiences without fear of judgment, which means a more detailed and in-depth understanding of the social processes of life after bariatric surgery could be captured.

The conceptual theory of risk attitude embedded within the phenomena of adjusting to life after bariatric surgery offers new insight and understanding of the patient journey, which can be used by patients and practitioners. The findings have been discussed with both groups. The participants in this research who wished to be informed of the findings have fed back that the thesis captures and describes their experiences, with comments such as seeing themselves as one of the risk attitude profiles.

7.6.6 Limitations

There are acknowledged limitations to this thesis which include the selection of participants into the study, the two year timeframe and my affiliation to the

bariatric surgical unit. The potential implications of these on the research are evaluated.

All participants for this thesis were selected using specific inclusion and exclusion criteria. This means that the findings are based on the experiences of the participants who took part and therefore may not be reflective of the whole bariatric surgery population. In order to meet NHS ethical approval requirements, patients with any identified active psychological conditions and who were receiving psychological intervention were not permitted to be recruited. As there are high levels of psychological conditions reported within the bariatric surgery patient population, a significant number of patients were unable to be recruited to this study who may have differed in their views from the participants that were part of this thesis.

Additionally, the findings systematically showed many participants were fearful of judgment of their decision to undergo bariatric surgery and many actions involving disclosure were embedded in risk. Although the study information sheets sent to prospective participants stressed the aim of the research and offered assurances that participation was confidential and that data would be anonymized, many bariatric surgical patients may have chosen not to participate in this research. The response rate for each phase of recruitment varied between 25-33%, which shows a significant number of potential participants declined to participate and this may be because they may have felt

they would be putting themselves in a situation where they may be judged. As the findings and conceptual theory are based on the experiences of the participants who took part in the thesis, these findings may not be representative of or generalizable to the entire bariatric surgical patient population of City Hospitals Sunderland NHS Foundation Trust. The small sample size of qualitative research studies, including the fact that this research took place in a small geographical area, limits the ability to generalize the findings to other contexts such as different bariatric surgical units.

This thesis focused on understanding the adjustment processes involved in the first two years following bariatric surgery. This timeframe was selected in order to be able to recruit participants who had undergone bariatric surgery at City Hospitals Sunderland NHS Trust. Patients are under the care of the hospital for two years after bariatric surgery, after which time they are discharged into the community for long-term care. This means the findings are limited to this timeframe, and may not represent experiences beyond two years. As participants were only interviewed once, it is unknown if the risk attitude profiles may have potential to change over time.

The research was undertaken in collaboration with City Hospitals Sunderland NHS Foundation Trust. As a requirement of ethical approval, all participant documentation relating to the study was printed on hospital letterhead which may have influenced the perception of the study by participants. Despite

explaining the study was being conducted in collaboration with the Trust; the possibility of giving answers to please the researcher owing to the association with the hospital cannot be excluded. This potentially gives the researcher a position of power over the participant which goes against the ethos of co-constructivist nature of the methodology. The mutual reciprocity tenet of constructivist grounded theory (Charmaz, 2006) was implicitly stated during contact with the participants in all contacts, not just at time of interview, as well as the fact that they were equal partners in the process. Participants were reminded they were central to the research and that the aim was to understand their experiences as opposed to them telling me what they thought I wanted to hear. Nonetheless, despite these concerted efforts to ensure mutual reciprocity between participants and myself at all stages of the research process, it is impossible to know if all participants subscribed to this ethos, and as such this may be a potential limitation to the research.

The interpretivist paradigm adopted within this thesis means that there is an explicit acknowledgement of multiple realities of the attitudes towards social risks as individuals adjust to life after bariatric surgery. Attitudes are based on subjective interpretations, which I have attempted to capture with this thesis, however I acknowledge that it may only be possible to achieve a partial understanding of this phenomenon, owing to the 'complex and contradictory ways in which people perceive and respond to the risks they face in the social contexts of day-to-day life' (Wilkinson, 2001,p.2).

7.7   Personal reflections on the process

Undertaking this thesis has afforded me an opportunity to explore a controversial subject within health and medicine of great interest to me. Adult obesity is a complex issue, for example, there are social, cultural, biological and economic factors, as highlighted in the Foresight report (2007), and the solutions to both management and prevention of obesity are not straightforward. Through this thesis, I have discussed the social construction of adult obesity, which is largely negative in terms of perceptions, and explored the intervention of bariatric surgery as one of the solutions, focusing on the experiences of the participants.   Surrounding and shaping these experiences of adjusting to bariatric surgery are what the participants felt were negative societal constructions of bariatric surgery and judgements of those who choose to tell others of their decision to have surgery.   Goffman's (1963) work on stigma, particularly around discredited and discreditable states resonates with adult obesity and bariatric surgery. The discredited state of obesity moves into a discreditable one once weight loss occurs, yet many of the participants still feel judged for not losing weight by other means.   Similar to obesity, bariatric surgery is also a complex issue; the biomedical evidence shows great success of rapid and sustained weight-loss yet it appears that patients may be judged for their choice of weight-loss method, despite achieving in many cases what is either an overweight or normal body weight, which are more societally accepted. If obese people lose weight and achieve a reduced body size, why does it matter so much to others how the weight was lost?

Currently, bariatric surgery is moving into new frontiers, owing to the increasing body of evidence showing the efficacy of bariatric surgery on metabolic diseases such as Type 2 diabetes. With revised NICE eligibility criteria (National Institute for Health and Care Excellence, 2014) reflecting this evidence, many diabetic patients may be offered surgery as opposed to drug therapies or diet and exercise, which, similar to obesity management, are the common interventions offered. Although this thesis did not investigate if Type 2 diabetes was subject to stigmatisation, it would be interesting to discover whether diabetics who undergo bariatric surgery are judged differently from non-diabetics who meet eligibility criteria for surgery for weight loss.

By approaching the study inductively and from the patient perspective, I have gained insights into the complexity and social processes which influence and surround adult obesity and bariatric surgery through those who have experienced these first hand. By using a constructivist grounded theory approach, I was conscious of maintaining mutual reciprocity and reflexivity to ensure that the voices of the participants were captured and my pre-existing knowledge acknowledged. The co-constructed notion of bariatric surgery as a contested intervention is a continued source of fascination and reflection for me. When this was conceptualised as a recurring theme in this research, it reminded me I had come across this notion previously, when I worked within the discipline of women's health, focusing on assisted reproduction. This connection also came up during the interview with Participant P:

Table 7.11 Excerpt from interview with Participant P

YG – that's something I wanted to ask you…some people will not tell anyone they've had surgery and others are quite happy to. How do you feel?

P – I've been quite lucky…my friends and my family are there for me….really supportive. The only trouble I've had was on Facebook...a friend, this girl I used to know from school, she sent me a message saying 'I think it's absolutely disgusting people getting this surgery…fat people getting surgery for free, when there's people who can't conceive, who can't afford IVF' and I thought to myself 'what's that got to do with it?'…

YG – this is so interesting…I used to sell IVF drugs and I see such a similarity between bariatric surgery and IVF, the politics, the judgement…but I bet you that your so called friend was waiting for IVF herself….

P -(laughs) Yitka, that's exactly what my Mum said!

This excerpt was taken from the interview between P and myself and came up whilst exploring the issues surrounding disclosure. I was fascinated that a participant raised the issue of in-vitro fertilization (IVF) and had made a connection between the two interventions, as this was something I had been reflecting on. I felt that both bariatric surgery and assisted reproduction techniques such as IVF were both contested interventions by those who had not

experienced them, and both were subject to judgment. With the subject of assisted reproduction techniques having no clear link to bariatric surgery, it would have been difficult to raise the subject. I was conscious of appearing to force my ideas on to the participants as this would have been contravening the methodology as well my personal aim of not doing this. Therefore, when this was raised by Participant P, I was intrigued that someone else had made a similar, but less-conceptual connection between the two interventions.

My interpretation of assisted reproduction interventions is that they are similarly framed as contested interventions and were subject to scrutiny by others. The socio-cultural burden of infertility affects both men and women, and similar to adult obesity, is a stigmatised condition that is not always societally accepted as needing medical intervention, for example the woman or couple have other options, such as adoption or to remain childless. I see these options as paralleling obesity interventions such as diet and exercise, with both assisted reproduction procedures such as in-vitro fertilisation (IVF) mirroring bariatric surgery procedures as contested interventions. What I clearly remember from my time working in this field, were the national disparities around funding and NHS eligibility for assisted reproduction, which were regularly in the media and the attention focused on infertility was a constant source of worry for patients, many of whom wished to keep their treatment secret. This resonates with the current debates over funding, eligibility criteria and media constructions of bariatric surgery. The parallels between these conditions and treatments became apparent as I began to write the discussion chapter. Without wishing to

digress from the research question on patient experiences of adjusting to bariatric surgery, I feel there is further social and medical research needed to conceptualise the link between bariatric surgery and assisted reproduction, not only for the reasons stated, but also given the increasing prevalence of obesity, the high number of women seeking treatment for both obesity and infertility, which are now understood to be linked (Royal College of Obstetricians and Gynaecologists, 2015), and the evidence to show the link between obesity and infertility.

I remain fascinated by the social construction of health and illness. I was interested in a remark made by Participant C during our interview, where she said, 'why do people feel sorry for anorexics, but not for the obese?' Both are recognised illnesses related to body image and disordered eating, yet this participant felt that anorexia elicited more sympathy than obesity. Although anorexia is not explored in this thesis, her comment did prompt me to undertake a brief literature search to see if there was any evidence to support this. I found two articles which suggested obesity and anorexia were both subject to stigma (Murakami et al., 2016, Puhl and Suh, 2015), which may show the two diseases may be linked in terms of their perceptions by others and should be explored further.

The complexity and increasing rates of obesity and emerging evidence to show that bariatric surgery has favourable effects on illnesses and conditions relating

to obesity broaden the scope for eligibility for bariatric surgery (National Institute for Health and Care Excellence, 2014); it follows that more people may opt for surgical procedures as a means of improving their health (Sjöström, 2013, Mingrone et al., 2012).

7.8   The patient experience

The patient experience of healthcare can be defined as 'the sum of all interactions, shaped by an organisation's culture, that influence patients' perceptions of care across the continuum of care' (The Beryl Institute, 2015). This thesis explored the social adjustments following bariatric surgery and did not specifically focus on the interactions between the participants and the hospital or its clinicians. However, I propose that the co-constructed themes and resulting theory have the potential to contribute to an increased understanding of what patients could encounter after undergoing bariatric surgery. Understanding patient experiences of adjusting to life after bariatric surgery is central to providing support to patients who choose this as an intervention. Through dissemination of the findings of this thesis, my aim is to provide a space for the collective voices of the participants, raise awareness of the experiences of adjusting to life after bariatric surgery, which may lead toward a better understanding of the social processes by others. This may contribute to an increased societal acceptance of bariatric surgery, reduce the notion of a

'contested intervention', resulting in less judgment of those who undergo surgical procedures.

7.9   Summary

I acknowledge the interpretation of the findings is based on situations and social contexts which were present at the time of the research. These are temporal and likely to evolve or change with time. The findings are also based on a small group of participants who underwent bariatric surgery in a single hospital in the North East of England. There may be socio-cultural attitudes and beliefs which may have influenced both the participants and my construction of the findings.

Through the use of reflexive tools such as memo writing and conceptual mapping to support the grounded theory analytic procedures I have tried to recognize and demonstrate the position of the researcher throughout the study. I acknowledge that there are likely to be concepts within the data which may not have been picked up during the thesis, and as such throughout the coding processes and in the conceptual theory.

This thesis has shown that there are many social risks associated with adjusting to life after bariatric surgery, and the interpretation of these risks may influence the meaning and actions that a patient takes after bariatric surgery. There were three types of risk attitude profiles constructed from the data. This information may be helpful to patients who are considering or have undergone bariatric surgery, to help practitioners who work with bariatric surgical patients to have a deeper understanding of the social aspects of adjusting to bariatric surgery which exist outside routine clinical care, and to those who encounter people who have undergone bariatric surgery across a range of relationships and social settings. The findings also confirmed that disclosure was a contentious issue and that for many people who were formerly obese and subject to stigma, the decision whether to disclose or not was conceptualised in the risk of being judged for their decision. Exploring the attitudes towards risk allowed a deeper understanding of the meanings and actions which the participants performed in their everyday lives.

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Appendices

Appendix 1: Studies used for initial literature review on patient perspectives

No	Author Year Country Journal	Aim	Data collection	No and Characteristics of participants	Methodology
1	Bocchieri, L., Meana, M., Fisher, B. (2002) Perceived psychosocial outcomes of gastric bypass surgery: a qualitative study. *Obesity Surgery,* 12,781-788	Construct a theory that typifies the psychosocial phenomenon of gastric bypass patients, while honouring the uniqueness of each individual's experience	Semi structured interviews and focus groups	31	Grounded theory
2	Drew, P. (2011) But then I learned..weight loss surgery patients negotiate surgery discourses. *Social Science and Medicine,* 73, 1230-1237	To explore commonplace discursive depictions of obesity surgery and individual reactions to these depictions	Surveys and interviews	99 participants Surveys n=55 Interviews n=44	Content analysis
3	Earvolino-Ramirez, M. (2008) Living with bariatric surgery: totally different, but still evolving. *Bariatric Nursing and Surgical Care,* 3(1) 17-24	To describe the lived experience of an individual who underwent bariatric surgery	In-depth interview	1	Hermeneutic phenomenology
4	Engstrom, M. and Forsberg, A. (2011) Wishing for deburdening through a sustainable control after bariatric surgery. *International Journal of Qualitative Studies in Health and Well-being,* 6, 1-13	An in-depth investigation of the change process experienced by patients undergoing bariatric surgery	Interviews before surgery, at 1 year and at 2 years	16 before surgery 12 female 4 male 16 1 year after surgery 12 female 4 male 11 2 years after surgery 9 female 2 male	Grounded theory

5	Groven, K (2010) My quality of life is worse compared to my earlier life. *International Journal of Qualitative studies on Health and Wellbeing,*5 (4), 1-15	To focus on the experiences of women whose life situation became worse after bariatric surgery	Interviews	5 females	Phenomenogy Thematic analysis
6	Groven, K (2012) Living with bodily changes after weight-loss surgery: women's experiences of food and dumping. *Phenomenology and Practice,* 6(1), 36-54	To explore women's experiences of 'dumping' following weight loss surgery	interviews	22 women	Phenomenology
7	Magdaleno, R., Chaim, E., Turato, E. (2010) Understanding the life experiences of Brazilian Women after bariatric surgery: a qualitative study. *Obesity Surgery,* 20, 1086-1089	To understand the significance of bariatric surgery for women and how these factors influence the outcomes	Interviews	7 women	Content analysis
8	Magdaleno, R., Chaim, E., Pareja, J., Turato, E. (2011) The psychology of the bariatric patient: what replaces obesity? A qualitative research study with Brazilian women. *Obesity Surgery,* 21, 336-339	To understand the postoperative significance of bariatric surgery for women suffering from morbid obesity and how these factors influence the outcome with an emphasis on body image and possible psychological complications that may jeopardize the operation's success	Interviews	7 women	Qualitative content analysis
9	Ogden, J., Clementi, C., Aylwin, S. (2006) The impact of obesity surgery and the paradox of control: a qualitative study. *Psychology and Health,* 21(2),.273-293	Explore patients' experiences of having bariatric surgery in the last four years	Interviews	15	Phenomenology
10	Ogden, J., Avenell, S., Ellis, G (2011) Negotiating control: patients experiences of unsuccessful weight-loss surgery. *Psychology and Health* 26 (7) 949-964	To explore patients' experiences of weight loss surgery that was deemed unsuccessful	Interviews	10 8 females 2 males 10 primary op	Phenomenology

317

				7 had secondary procedure	
11	Ryan, M (2005) My story: a personal perspective on bariatric surgery. *Critical care nursing quarterly* 28 (3) 288-292	To use personal narrative to inform decision making for bariatric surgery	Narrative	1	Individual narrative by author
12	Sutton, D., Murphy, N., Raines, D., (2009) I've got a secret: non-disclosure in persons who undergo bariatric surgery. *Bariatric Times.* Available at: http://bariatrictimes.com/2009/02/27/i/e/80/99ve-got-a-secret-nondisclosure... (Accessed:29/2/2012)	To explore the experience of 14 women who underwent weight-loss surgery and their decision-making processes	Interviews	14	Phenomenology
13	Throsby, K. (2008) Happy re-birthday: weight loss surgery and the 'new me'' *Body and Society,* 14 (1), 117-133	What is signified by this discourse of re-birth in the context of weight loss surgery	Interviews	6 males 29 females	Discourse analysis
14	Wysoker, A., (2005) 'The lived experience of choosing bariatric surgery to lost weight' *Journal of American Psychiatric Nurses Association,* 11 (1), pp.26-34	To explore issues relating to having a surgical procedure performed to lost weight	Interviews	5 females 3 males	Phenomenology
15	Zunker, C., et al., (2012)' Eating behaviours post-bariatric surgery: a qualitative study of grazing' *Obesity Surgery,* 22, pp.1225-1231	To explore eating behaviours among post-bariatric surgery patients, including developing a better understanding of the term 'grazing' as interpreted by patients	Focus groups	29 27 females 2 males	Nominal group technique

Appendix 2a: NHS ethical approval letter

NHS

Health Research Authority

NRES Committee London - Camberwell St Giles

Bristol Research Ethics Centre
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1334

06 August 2013

Mrs Yitka N H Graham
PhD Student
University of Sunderland
Dept of Pharmacy Health and Well-being
The Sciences Complex
Wharncliffe Street,
Sunderland
SR1 3SD

Dear Mrs Graham

Study title:	**An exploration of how bariatric surgery affects peoples' everyday lives in the first two years following surgery**
REC reference:	**13/LO/1072**
IRAS project ID:	**119847**

Thank you for your letter of 17 July 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 05 July 2013.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		17 July 2013
Letter of invitation to participant	1.1	10 July 2013
Other: Participant confirmation letter	1.1	11 July 2013
Protocol	1.1	10 July 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

0

Document	Version	Date
Covering Letter		26 June 2013
Covering Letter		17 July 2013
Evidence of insurance or indemnity		02 August 2012
GP/Consultant Information Sheets	1	18 June 2013
Interview Schedules/Topic Guides	1	18 June 2013
Investigator CV		
Investigator CV		
Letter from Sponsor		26 June 2013
Letter of invitation to participant	1.1	10 July 2013
Other: Participant confirmation letter	1.1	11 July 2013
Participant Consent Form	1	18 June 2013
Participant Information Sheet	1	18 June 2013
Protocol	1.1	10 July 2013
REC application		27 June 2013
Summary/Synopsis	1	18 June 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/LO/1072	Please quote this number on all correspondence

Yours sincerely

Mrs Ruth Avery
Committee Co-ordinator

E-mail: nrescommittee.london-camberwellstgiles@nhs.net

Copy to: *Professor Ann Crosland,*
Sr Lynne Palmer, City Hospitals Sunderland

1

**University of
Sunderland**

RESEARCH ETHICS COMMITTEE

Application Number: 196b
Project Title: An exploration of patients' experiences of bariatric surgery
Chief Investigator: A. Crosland
Co workers: Y. Graham, J. Ling
Date: 23/8/13

THE COMMITTEE DECISION IS SHOWN BELOW

APPROVED WITH NO CONDITIONS: *This means you may start the project immediately.*	√
PRE-CONDITIONS: *This means you must complete the conditions listed below before you start the project. However, you DO NOT have to send any information back to the Committee. The Committee will assume completion of these conditions.*	

COMMITTEE-CONDITIONAL: *This means you must complete the conditions listed below before you start the project. You MUST send the information requested back to the Committee before you start the project. Once the committee has received this information, it will contact you again about its decision.*	
REJECTION: *This means the committee does not wish this research to commence. You should not start this research. The Research Ethics Committee will explain why it has reached this view. Please contact the Committee Chair if you have any questions.*	
RECOMMENDATIONS: *These are simply points of advice from the committee. They are OPTIONAL. You do not have to undertake them or contact the committee about them.*	

Signed by the Committee Chairperson

Appendix 2c: City Hospitals Sunderland NHS Foundation Trust approval letter

City Hospitals Sunderland **NHS**

NHS Foundation Trust

Director of Research and Development: Kim Hinshaw

KH/LP/GW

Date: 3rd December 2013

Mrs. Yitka Graham
PhD Student
University of Sunderland
Dept. of Pharmacy Health and Well-Being
The Sciences Complex
Wharncliffe Street
Sunderland
SR1 3SD

Research and Development
The Education Centre
Sunderland Royal Hospital
Kayll Road
Sunderland
Tyne & Wear   SR4 7TP

Tel: 0191 565 6256 Ext: 42143
Fax: 0191 569 9767

Kim.Hinshaw@chsft.nhs.uk

Dear Mrs Graham,

Study title: An Exploration of how bariatric surgery affects people's everyday lives in the first two years following surgery

REC reference: 13/LO/1072   **R&D Reference: 13~65**

Thank you for your recent application for Trust approval. Approval has now been granted for the research to be carried out within City Hospitals Sunderland NHS Foundation Trust.

Study sponsor: **University of Sunderland**

Site Specific Assessment has been undertaken by Research and Development City Hospitals Sunderland.

Please note it is a requirement of the approval given by the Trust that the research project is being conducted in line with the guidance given within the Research Governance Framework as issued by the Department of Health. As chief/principal investigator you should be aware of and have a duty to comply with the Research Governance Framework (www.doh.gov.uk/research) throughout the duration of the research.   We also draw your attention to the need to comply with all relevant legislation including for example the Health and Safety at Work Act, the Data Protection Act and the Human Tissue Act 2004.

This project has been registered on the Trust research database and you should keep the R&D team informed of your progress. In particular the R&D department must be notified of;

- Commencement and completion of the study
- Any significant changes to the study design as submitted to the Medicine and Health Regulatory Authority and Research Ethics Committee
- Any changes to research teams
- Any changes in the circumstances of researchers that may have an impact of their suitability to conduct research
- Any suspension or abandonment of the study
- Any subsequent funding, awards or grants pertaining to this study post approval
- Any publications and/or conference presentations

Neurophysiology Department
Sunderland Eye Infirmary
Day Case Unit

Please ensure that all serious/clinical incidents are reported via the Incident Reporting System accessed via the Trust intranet.

Trust Standard Operating Procedures must be adhered to and can be accessed via the intranet, under central services, research. Some trials are supplied with SOP's please review in parallel to Trust SOP's and inform R&D Manager immediately should any discrepancies occur.

Yours Sincerely

Mr Kim Hinshaw MB BS FRCOG
Director of Research
Consultant Obstetrician & Gynaecologist
Department of Obstetrics & Gynaecology

Approved documents

The documents reviewed:

Document:	Version/Reference:	Date:
IRAS R&D Form		26 June 2013
SSI Form		03 July 2013
NRES Favourable Ethical Opinion		05 July 2013
Participant Information Sheet	V1.0	18 June 2013
Participant Consent Form	V1.0	18 June 2013
Participant Confirmation Letter	V1.1	11 July 2013
Participant Contact Form	V1.0	18 June 2013
Patient Letter	V1.2	04 October 2013
Reply Pre-Paid Envelope	V1.0	Undated
Investigator GCP: Yitka Graham		13 June 2013
Investigator CV: Yitka Graham		24 June 2013
Investigator GCP: Mr Peter Small		03 February 2013
Investigator CV: Mr Peter Small		25 June 2013
Protocol	V1.2	04 October 2013
PI Agreement for Research: Mr Peter Small		03 July 2013
Caldicott Guardian Approval		29 November 2013
PR Risk Assessment		15 July 2013
Sponsorship Letter		26 June 2013

Appendix 2d: Introduction to Good Clinical Practice Certificate

This was required by CHSFT as part of the approval process

NHS
National Institute for
Health Research

Clinical Research Network

Certificate of Completion
yitka Graham,

has completed

**Introduction to Good Clinical Practice (GCP)
e-learning course**

A practical guide to ethical and scientific quality
standards in clinical research
on 13 June 2013

Modules completed

Introduction to Research in the NHS
Good Clinical Practice and Standards in Research
Study Set-up and Responsibilities
The Process of Informed Consent
Data Collection and Documentation
Safety Reporting
Summary

Informed Consent in Paediatric Research
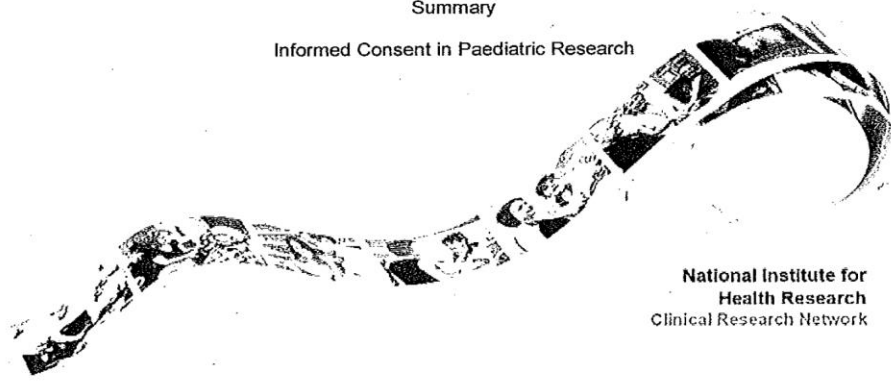
National Institute for
Health Research
Clinical Research Network

Appendix 3a: Participant information form

University of Sunderland

PARTICIPANT INFORMATION FORM

Project Title: An Exploration of Patient Experiences of Bariatric Surgery

Chief Investigator: Yitka Graham, PhD Student, University of Sunderland

You are being invited to take part in a research study. Before you make a decision whether or not you wish to be involved, it is important for you to understand why the research is being done and what it will involve if you choose to take part. Please take the time to read through this information and to discuss it with others. If you would like any further information, please contact the researcher (contact details are at the end of this sheet). The decision to take part in the research study is up to you, please take your time to decide if you wish to participate or not.

Why have I been asked to take part in this study?

You have been invited to consider taking part in this research study because you have had bariatric (weight-loss) surgery at City Hospitals Sunderland. Taking part in the research is not part of any treatment you may be having at City Hospitals Sunderland.

Why is the research study being done?

This study is being carried out as part of a PhD at the University of Sunderland. The aim of the study is to understand the experiences of patients who have had bariatric (weight-loss) surgery and how they adjust to life after the operation. This information may be used in the future to help to develop support for patients.

What will I have to do?

You will be asked to take part in an interview, either at home or at City Hospitals Sunderland. This should take about an hour. You will be asked about your experience of having surgery. The interview will be audio taped and typed up, then the tape will be erased and the written account of the interview will be anonymised, so no one will be able to identify you. With your permission, you may be contacted briefly afterwards to clarify any points in the interview.

What risks are there?

Although every effort will be made to make you feel comfortable talking about your experiences, you may feel uncomfortable about talking about your surgery. If this happens, you do not have to continue with the interview or you can have a break if you do wish to continue.

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Taking part in the research or withdrawing from the study is not part of any treatment you may be having and will not affect any treatment you may be having at City Hospitals Sunderland.

What are the benefits of taking part in the study?

There will be no direct benefit to you, but the information you give will be helping to understand how patients adjust to life after bariatric surgery. It is hoped that the results of the research will used to help other people undergoing bariatric surgery in the future.

Will I be paid for taking part in the study?

A £15 Amazon voucher will be offered as a thank you for taking part in the study.

Will my taking part in the study be confidential?

The data (the written interviews) will be accessed and used by the researcher as part of the study. All data will be anonymous; the real names of the people interviewed will not be used. There may be times when a direct quote will be used, but this should not be able to be traced back to the person who said it. It may be appropriate that certain staff at the University of Sunderland may be given access to the data for monitoring or audit of the research study to ensure compliance with standards and regulations.

The written data will be stored in a locked file at the University of Sunderland and will be destroyed after five years. The data will form part of the researcher's academic project, which will be submitted to the University of Sunderland as part of the program of study. A final copy of the thesis will be given to the University library and retained by the researcher and the supervisors.

Every effort will be made to maintain confidentiality and protect the identities of the participants in line with current laws and practice.

What if I decide not to take part?

Taking part in the study is voluntary, and you are free to withdraw from the study at any time without giving reason. Participating and withdrawing from the study will not affect any treatment you may be having at City Hospitals Sunderland. There may be a time after your interview that we will not be able to withdraw your data from the study, as it will have been anonymised and formed part of the research, therefore we would not be able to identify your specific data in order to remove it. Once the results are published, we would not be able to withdraw your data for the same reason, however at this stage, all data will be anonymous.

What happens next?

Please take the time to read this information sheet. It is up to you to decide if you wish to take part in the study. If you do, you will be given this information sheet to keep and asked to sign a consent form to show that you understand and agree to what is being asked of you. We will then arrange a time for an interview at a convenient time.

2

How do I contact you if I wish to participate or would like more information?

Once you have had time to read this sheet and if you have decided you want further information, about the research study, please contact the researcher, Yitka Graham at yitka.graham@research.sunderland.ac.uk or on 07980 686228. For any other information, please contact Peter Small, Principal Investigator 0191 565 6256 ext. 41252, or Professor Ann Crosland at ann.crosland@sunderland.ac.uk .

Thank you for taking the time to read this information sheet.

This study has been approved by the University of Sunderland

Research Ethics Committee

Appendix 3b: Invitation to participate

City Hospitals Sunderland **NHS**
NHS Foundation Trust

University of
Sunderland

Patient Name

Address

Postcode

Date

Dear (Patient)

Re: Invitation to Participate in Thesis 'An Exploration of Patients' Experiences of Bariatric Surgery'

The Bariatric Surgery Unit is one of the largest in the country. As such we have an excellent opportunity to study problems associated with excessive weight and the surgical treatment. Currently we are supporting a PhD thesis which examines the patient experience of bariatric surgery and how it affects their everyday lives. This study is in collaboration with the University of Sunderland.

Participation in the study would involve you consenting to be interviewed by the research student, Yitka Graham, for about an hour, and you would be asked to discuss your experiences of having bariatric surgery. Taking part in the thesis is not part of, nor will it affect, any treatment you may be having at City Hospitals Sunderland. It is entirely up to you whether you wish to take part.

I have enclosed an information form, a contact form, a consent form and a reply paid envelope. I would be pleased if you would take the time to read these, and if you would like to take part, please fill in and return the enclosed contact form in the reply paid envelope. Keep the other forms for your information and Yitka can answer any questions you may have when she contacts you.

Many thanks for taking the time to read this letter.

Yours sincerely

Mr P K Small

Consultant Surgeon

Contact details: 0191 565 6256 ext.41252 (secretary)

Encl. Contact form v.1.0 18/06/13, participant information sheet v.1.0 18/06/13, consent form v.1.0 18/06/13, reply paid envelope, Patient Letter v.1.0 18/06/13

Appendix 3c: Participant contact form

City Hospitals Sunderland **NHS**
NHS Foundation Trust

University of Sunderland

Participant Contact Form

Title of Thesis: An exploration of patient experiences of bariatric surgery Chief Investigator: Yitka Graham

Dear Yitka

I have received the letter from Mr Small inviting me to consider taking part in the thesis along with the participant information and consent sheets.

I would like to take part in the study, please would you contact me to discuss this further.

Name	
Address	
Telephone Number	
Best time to contact	
I agree to be contacted by Yitka Graham to discuss taking part in this study (please sign)	

Please note that your details will be kept confidential by the researcher and not passed on to anyone else. Please return to Yitka Graham using the enclosed reply-paid envelope.

Email: yitka.graham@research.sunderland.ac.uk

Participant Contact Form v.1.0   18/06/13

Appendix 3d: Participant Consent Form

City Hospitals Sunderland **NHS**
NHS Foundation Trust

University of
Sunderland

PARTICIPANT CONSENT FORM

Project Title: An Exploration of Patient Experiences of Bariatric Surgery

Name of Researcher: Yitka Graham, University of Sunderland

Name of Participant:

Address:

Telephone Number (for contact purposes):

Please initial

box

1. I confirm that I have read and understand the information
   sheet for the above study. I have had the opportunity to
   consider the information, as questions and have had these
   answered satisfactorily.

2. I understand I am being asked to take part in the study
   by being interviewed about my experiences of bariatric
   surgery. I consent to my interview being audiotaped and
   written up anonymously, forming part of the thesis.

3. I understand that the tape will be erased after being transcribed
   and the written report destroyed after five years. I am aware that
   my data will be anonymous but direct quotes may be used, but
   will not refer to me by name.

4. I understand I am free to withdraw from the study at any time,
   without giving reason and without my care being affected.

Participant Consent Form v.1.0   18/06/13

5. I would like to be informed about the study findings. Please contact me when the findings are available. (tick box if yes) ☐

6. I have read and understood the Participation Information Sheet and I have kept a copy for my records. ☐

7. I consent to taking part in the above thesis ☐

Signed:

_____   _____   _____

Participant   Date   Signature

_____   _____   _____

Researcher   Date   Signature

1 copy to participant, 1 copy to researcher, 1 copy(original) for hospital notes

Participant Consent Form v.1.0   18/06/13

Appendix 4a: Topic guide

University of Sunderland

Title of Project: An Exploration of Patient Experiences of Bariatric Surgery

Chief Investigator: Yitka Graham

Principal Investigator: Peter Small

Topic Guide for Interviews

Prompts

1. **Life Before Surgery**

   Tell me how you came to have bariatric surgery (events/actions/knowledge/).

   Can you describe what your life was like before surgery?

   Tell me how you would describe yourself before surgery.

   Tell me how you prepared yourself for surgery (choice of procedure/actions/feelings/anyone involved).

2. **Surgery Itself**

   Tell me about when you had surgery (events/hospital stay/feelings).

3. **Life After Surgery**

   Tell me what happened after the operation (actions/events/feelings).

   Can you describe any positive changes to your life as a result of surgery.(Actions/events/feelings)

   Can you describe any negative changes to your life as a result of surgery (if any). Why do you think they are negative and how do they affect you? How do you deal with them?

   Tell me about a typical day for you now.

   Has any person/group helped you throughout your experience? (Who/how)?

1

14

Tell me how you see yourself now compared to before surgery. Have you learned anything about yourself?

4. The Future

Tell me where you see yourself in the future (hopes/expectations/actions/events)

5. Looking back

Looking back on your experiences, what would you tell me if I was a person waiting for bariatric surgery.

From your personal experience, tell me if there is anything I should know or be aware of so I can understand what people go through when they have bariatric surgery