Understanding Motivations for Bariatric Surgery. Developing a Cultural Model

Poornima Vanguri
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Understanding Motivations for Bariatric Surgery. Developing a Cultural Model

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Understanding Motivations for Bariatric Surgery
Developing a Cultural Model

Poornima Vanguri
Senior Honors Thesis

April 1, 2005
Adviser: Dr. Frances Barg
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Abstract:

The purpose of this study was to understand people's reasons for getting bariatric surgery, often considered a medically necessary procedure for morbid obesity. The foundation of the study was based on participants' perceptions of themselves in terms of their obesity in the context of health and society's expectations. By using two anthropological investigative methods of freelistig and semi-structured interviews, I followed a number of patients through the process of first contacting a doctor's office, having an initial appointment and then eventually having the surgery. I assessed their viewpoints along the way with regards to their obesity and its treatment. Tabulation and analysis of the results led me to develop a cultural model of the motivations for bariatric surgery by recognizing that there must be both internal security as well as an external support system for every surgical candidate.
Introduction

One of today's biggest health concerns is obesity and its growing prevalence in the United States. Obesity transcends social and economic boundaries. It affects males and females, children and adults, and it poses many secondary health risks. Despite trying to fight the disease with diets or exercise, many people are left with no choice but to seek out the more recently available option of bariatric surgery. Bariatric surgery is a specific field within surgery that aims to help morbidly obese individuals lose weight dramatically by reducing the size of their stomachs. While many people might consider this a drastic measure for what seems like the simple motive of weight loss, it often becomes medically necessary for these individuals. These people are more likely to develop fatal diseases without reducing their weight, and in many situations such a procedure is viewed as a final choice.

The purpose of this study was to understand the cultural motivations for this surgery and develop a cultural model surrounding surgery for the morbidly obese. This research project aimed to understand the perceptions of the surgery from those who seek it and understand it in terms of their own battles with obesity. To achieve these ends, I followed surgical candidates all the way through the process of having the surgery from meeting a doctor, preparing for the procedure and then undergoing the treatment. Realizing that how people perceive diseases and treatments influences how they handle them shows that forming a cultural model for obesity and its treatment is beneficial for understanding people's actions.

A cultural model is an anthropological tool used to describe human behavior based on preconceived notions and experiences as related to their actions. The purpose of a cultural model is to find trends and commonalities in people's decision-making and actions as a way of explaining a certain kind of behavior. A person's cultural model of obesity or surgery for
obesity, for instance, can affect the way that they make decisions. How they perceive themselves and how others perceive them can shed light on how and why they choose to treat their obesity. This study revealed that people who face morbid obesity have a very shared experience even though their feelings about their size and health can be very isolating. Talking to prospective patients of bariatric surgery revealed such commonalities. The patients' cultural models are products of their own experiences and they are highly influenced by the emphasis of American culture on thinness. It is apparent, therefore, that many of these patients' actions are a result of these external and internal influences. By considering and identifying these specific influences on behavior, a cultural model was formed to explain motivations for seeking bariatric surgery.
Background:

According to the Center for Disease Control’s National Center for Chronic Disease Prevention and Health Promotion “during the past 20 years there has been a dramatic increase in obesity in the United States. Today, 20 states have obesity prevalence rates of 15-19 percent; 29 states have rates of 20-24 percent; and one state reports a rate over 25 percent.” Such statistics show how omnipresent obesity has become in the United States. The disease has completely infiltrated American culture. According to the CDC, “in 2000, the prevalence of obesity among U.S. adults was 19.8 percent, which reflects a 61 percent increase since 1991.” Adults are considered obese if they have a body mass index of twenty-five or more, and “in 2000, 38.8 million American adults met the classification of obesity… [and] currently, more than 44 million Americans are considered obese by BMI index. This reflects an increase of 74 percent since 1991.” The CDC shows that the tendencies towards obesity are growing and becoming more prevalent. In addition 300,000 people die every year of obesity and obesity-related diseases, and this number is only increasing. It is important to recognize that obesity is indeed a disease, and though eating and exercise are components of the treatment for the disease, there are also genetic factors that contribute. Therefore, the surgery does actually become medically necessary for those who have not found any other way to treat it.

Viewpoints of the surgery in the medical field vary. Some believe that it is not necessary, because a patient should be able to treat it, while others say that many of these people will not live without it. Dr. John Linner, a professor of clinical surgery at the University of Minnesota Medical Schools says that,

3Ibid
acceptance of bariatric surgery as a legitimate therapeutic modality has met with considerable resistance by many physicians for two principal reasons. The first relates to the rather prevalent but unjustifiable attitude both within and without the medical profession that morbid obesity is an expression of slovenliness, the result of a character defect, or a defect of the will, and that those so afflicted should not be extended the benefit of an "easy way out," but should "shape up" by rigorous diet and exercise.

It is apparent that many people within the medical field are desirous of dispelling such negative attitudes about the surgery. It is important though to consider the attitudes of individuals that may seek out the surgery. Do they consider it a last resort? How do they feel about their disease? Do they feel stigmatized? Do they think that having to receive such a surgery would cause further stigmatization? This study aimed to answer such questions and learn how the community views bariatric surgery. It is necessary first, however, to consider the background of obesity and its treatment in the United States.

In 1963 morbid obesity was defined to "draw attention to the life-threatening consequences of being 100%, or more than 100 lb, above average body weight."4 Because this degree of obesity is so drastic, many other medical interventions and therapies have been ineffective in stopping the obesity. Consequentially, a surgical technique was developed. The definition of morbid obesity can be extended to consider the percentage of body weight that is fat and a ""morbidly" obese individual may have 40-70% of body weight as fat."5 Currently body mass index, which is a ratio of weight in kilograms by height in meters squared, is used as the way to determine if someone is obese. Obese people have a BMI of 25 or more, and morbidly obese people have a BMI of 40 or more. At these high rates, obesity does indeed become life threatening. This degree of obesity can be linked to many secondary obesity syndromes such as endocrine disorders, genetic disorders, hypothalamic dysfunction and nutritional disorders.

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4 Ibid, 1.
5 Ibid.
Therefore, it becomes necessary to treat these individuals so that they may not only be of normal weight, but also begin to lead normal healthy lives and avoid the high risk of many diseases.

Consequences of obesity are not only medical, however. It is apparent in our culture that obesity serves as a popular reason for stigmatization. It appears that prejudice against overweight people is one of the few kinds of prejudice that is still tolerated in our society. Therefore, when people seek out treatment, they are aiming to not only make themselves feel healthier, but to also to try and increase confidence levels and feel better as a person in this society. One study revealed that “the stigma of obesity is very strong. Individuals will go to great lengths to prevent weight gain, and the possibility of becoming obese is considered a disastrous outcome. One survey reported that 24% of women and 17% of men said they would give up three or more years of their lives to be the weight they want.”

Many studies have revealed the kind of stigmatization that obese people feel in that it can affect one’s self-perception heavily. In addition the media portrayal of overweight people contributes to this self-perception in that, “fat jokes are common on television, overweight characters can be cast in very negative ways in movies, and children’s cartoons can ridicule characters who are overweight.”

In another case, one study “showed that both lean and obese adults and children rate obese children as less likable than children with other physical deformities such as paraplegia, a missing hand, or a disfigured face.” It can affect occupational and educational opportunities and can therefore lead to a person’s low placement in society. Success is often linked to appearance and confidence, and without satisfaction with either of these entities people are less likely to achieve all that they wish in the American culture.

7 Ibid, 214
8 Linner, 9
Non-surgical treatments have had a variety of avenues. For many people, they are not very successful and this is highly discouraging for the obese and the medical community. There have been such programs as in-hospital fasting and semi-starvation, protein sparing supplemented fasts, exercise programs, jaw wiring and other such drastic measures, but it appears that the problem is not just behavioral. For instance,

the area which is currently receiving the greatest attention is the metabolic adaptive response of the hypothalamus; this adaptation apparently develops in any person who starves and reduces weight below the established ‘set point.’ The concept is that in every individual the hypothalamus has a set point for energy balance, above which energy conservation becomes increasingly less efficient and below which energy conservation becomes increasingly more efficient. This homeostatic mechanism accounts for the fact that most adults keep their weight remarkably constant, despite large swings in energy input and expenditure and an average intake, between 20 and 60 years, of some 40 tons of food.9

Hence, no matter how extreme these diets and medical procedures are, they are not enough to modify a person’s homeostatic tendencies in weight constancy. The surgical treatment, therefore, was developed to make a more invasive attempt at weight reduction.

Bariatric surgery is an operation that restricts the calorie intake by reducing the size of the stomach. This is considered restrictive surgery. There are operations that cause restriction and some amount of malabsorption of the food that is consumed. When restriction and malabsorption are combined, this is called gastric bypass. In this operation, the surgeons cut down the size of the stomach and they bypass a segment of the small intestine. To bypass something means that the food will not travel through a certain segment of the stomach or the small intestine. Instead, the food will take a different path and the digestive juices will meet further downstream in the digestive system, so there is not enough time for all of the food to be digested. Therefore, less food and calories are taken into the body. An operation that was purely for malabsorption, called the intestinal bypass or jejuno ileal bypass, is no longer performed. It

9 Ibid, 12
is no longer done because of the complications involved with the bypassed segment of the small bowel.\textsuperscript{10}

Each person requires a certain amount of calories to sustain life. The energy requirements depend on the size and activity of the person. The main storage of energy is in the form of body fat. The patients who have weight loss surgery lose weight by not getting enough calories by restriction or malabsorption. They start utilizing the extra body fat as the source of energy. The weight loss, therefore, is from losing the extra body fat. To stay healthy after the weight loss surgery, the patients have to eat good food with high protein and low fat. They should take supplements of vitamins, calcium, iron and other minerals. Exercise helps to promote the weight loss by expending extra calories and it also helps to maintain muscle mass. Patients who seek bariatric surgery are obviously looking for a very definitive form of weight loss treatment and this study will aim to understand how and why these people consider bariatric surgery as an option.\textsuperscript{11}

There have not been many studies done on the motivations for bariatric surgery. Rather, in many cases, research has been done on the results of obesity surgery as well as the amount of weight loss and patient satisfaction. The research that has been used to show motivation, however, most often highlights the medical necessity of it and fails to consider the other external factors related to the actual decision to seek out the surgery. In one case, for instance, a study was conducted to see why obesity surgery has become more popular over time. Their results were more related to the fact that many patients have unrealistic ideas about weight loss and therefore begin to consider the "only treatment that achieves a sufficient and durable weight

\textsuperscript{10} Dr. Apparao Vanguri, bariatric surgeon in an interview conducted on December 10, 2003.
\textsuperscript{11} Ibid.
loss."\textsuperscript{12} Though the results of this study are valuable, the focus is mostly upon anthropometric measures, weight history, eating behaviors, previous treatment and viewpoints of what is a preferred weight.\textsuperscript{13} The methods of the study were mostly quantitative, so I believe that the more personal interviews in my study would provide further insight into the personal motivations for the surgery especially when coming from a group of people that is facing this problem on a day-to-day basis and have chosen to call this particular doctor.

Another former study focused, again, primarily on health issues and appearance but did not consider the societal and cultural aspects of obesity and its treatment. It highlights the fact that there are beneficial effects to weight reduction and that it is important for patients to be informed and be aware of the options available to them in terms of this surgery. This study involved a questionnaire that highlighted different attitudes about themselves as related to obesity such as appearance, medical condition, physical fitness, health concerns, embarrassment and physical limitation.\textsuperscript{14} The researchers concluded that, "health issues dominate the motivation for seeking...surgery. A large group of both men and women rate health concerns as their primary motivating factor. Women are more likely to be motivated by concerns regarding their appearance, whereas men are more likely to be motivated by concerns about future health and medical problems."\textsuperscript{15} Therefore, once again, the results were relevant to the goals of my study, but I wanted to build on these and find out how a group of overweight people individually came to the decision to pursue bariatric surgery and why they chose this doctor and office in particular.

\textsuperscript{12} V. Giusti, et. al. 2003. "Rising Role of Obesity Surgery Caused by Increase of Morbid Obesity, Failure of Conventional Treatments and Unrealistic Expectations: Trends From 1997 to 2001." Obesity Surgery. Lausanne, Switzerland. Volume 13, p. 696. It is apparent that this particular study is not from the United States but I believe that the trends that it highlights are uniform through different Western cultures such as Europe and North America.
\textsuperscript{13} Ibid, 694.
\textsuperscript{14} Marije Libeton, et. al. 2004. "Patient Motivation for Bariatric Surgery: Characteristics and Impact on Outcomes." Obesity Surgery. Victoria, Australia. Volume 14, p. 393. As stated above, though this study was not conducted in the United States, because similar weight issues and weight treatment options are available in Australia, I found that the results of this study were pertinent and important to my study.
\textsuperscript{15} Ibid, 396.
Research Questions and Aim

The goal of this study was to build a cultural model of obesity and the treatment of obesity through surgery. It was a patient-centered study to understand the way that they view themselves, their disease, the process of going to a doctor for help, surgery, and upon having surgery, how they viewed the process and results. I asked patients questions relevant to how they feel about themselves and how they felt about treating their disease. They considered and discussed perceived risks and fears overall. I intended to establish a foundation for beliefs concerning obesity and surgery that would serve as a nucleus for the rest of the study and its results.

Next, I moved in the direction of asking how perceptions of obesity surgery affect a person’s decision to seek it. Understanding how people came to know about the surgery, why they made the step of asking about it, and how they followed through with these questions demonstrated the kinds of people who are looking for help in terms of surgical treatment of obesity. Then, after developing an understanding of the cultural knowledge of prospective patients, they went through the general pathway of going to a doctor’s office and meeting a physician and his staff. Interviews throughout the process helped to answer questions about how people felt upon meeting a doctor and learning more about the procedure.

Finally, the last round of questions was centered on those who go through with the surgery and how they feel about themselves thereafter, how they felt about the process and how they view their future. This set of questions helped to assess the process of obtaining obesity surgery overall and also to understand how other factors such as family, experience of the physician and overall concerns could impact the decision to have the surgery.
Methods:

This study was conducted in three rounds. The first round focused primarily on those who showed interest in the surgery. The study was conducted through Dr. Apparao Vanguri’s office. Dr. Vanguri is a general surgeon in Baltimore, Maryland, whose specialty is bariatric surgery. Therefore, the bulk of his patients are those seeking help with morbid obesity. The beginning of the study focused on patients who initially contacted his office with questions about the procedure. Upon receiving names in the office, they were asked if they would like to participate in this study. Approval from the Institutional Review Board of the University of Pennsylvania permitted this project to be conducted with adult patients with acknowledgement of the fact that their care and treatment were not in any way affected by the study or the results from this study. Because the participants were all adults and the project was deemed exempt from any limitations by the IRB, there was no informed consent form necessary. Rather, before beginning the project, I explained the goals of the study as well as the way that each stage of the project worked so that the patients were fully informed. They were assured anonymity in that each patient was assigned a three-digit number and with the exception of the original list that was for my use only, their names were no longer linked to the study after the numbers were assigned.

Freelisting

Those who agreed to participate were contacted and asked to complete a freelisting exercise. Freelists are a tool used to measure cultural consensus within a domain. The goal of freelisting is to determine the amount of cultural knowledge within a group of people. It “elicits from members of a culture relevant items specific to categories of knowledge.”

knowledge, I was able to identify terms that were key to the domain of interest. These patients were limited to a certain amount of responses per question. The questions asked were as follows: 1) what words come to your mind when you think of a person who is healthy? 2) what words come to your mind when you think of a person who is unhealthy? 3) what words do you think of when you hear the word, "obesity," and 4) what words come to your mind when you hear the words, "bariatric surgery."

Freelisting allows people to answer the questions liberally, but they were instructed to try and limit their responses to one word or phrase. The information was collated and the frequencies were measured using Anthropac\textsuperscript{17} to determine the amount of cultural knowledge present in the group in terms of the surgery. It also served as a foundation in terms of understanding the basis of knowledge and expectations within this group of people. It helped to indicate the trends of obesity and the mental processes associated with asking for help with the life-threatening aspects of the disease. In this study, twenty-five different patients from diverse backgrounds were engaged in the freelisting exercise. The larger number helped to ensure that there was consistency within the data and made certain that the measuring of cultural knowledge was accurate.

Such measures of cultural consensus are valuable in that they can serve as a way of assessing commonalities within a group of people. For instance, the initial common bond between these people was that they were battling obesity and all chose to call the same office. However, the freelist exercises served as a way to find other measures of cultural knowledge in the domain. The idea of cultural consensus analysis comes from the field of cognitive anthropology and it is based on "systemic cultural patterns’ of language and meaning. [It]

\textsuperscript{17} Stephen Borgatti (1996) Anthropac 4.0, Analytic Technologies, Natick, MA.
assumes that cultural knowledge is shared and systematically distributed.”18 Based on these patterns that are identified, common themes beyond assessment of demographic and other visible data can be gleaned from a group of people. It can help to move research in a direction that is valuable and useful. I found the freelist methodology to be very helpful in further analysis of the motivations for the surgery. Because “cultural consensus analysis is based on the traditional ethnographic approach of in-depth, key-informant interviewing, coupled with a theoretically-derived, quantitative technique for assessing the degree of sharing of information among a group of key informants,”19 I used the analysis as a basis for my anthropological study. The freelists provided in-depth information but allowed me to look at it both quantitatively and qualitatively. In addition, the anthropological tool of ethnography was used to assess a person’s experience in a particular situation, and it was considered more in-depth in the personal semi-structured interviews.20

Semi-structured Interviews

The participants in the second round of the study were people who had gone through with their initial appointment with the physician. According to Dr. Vanguri, not everyone who calls for information is eligible, or actually desirous of going through with the medical process of the surgery. Therefore, this part of the study aimed to understand why people followed through after their initial call, and how they felt the office experience and how meeting the doctor impacted their decision to pursue the surgery. Because this group was a subset of the first, the attitudes and

responses were more thorough and in depth because of the interview format. The interviews were semi-structured, which means that they were open-ended, conducted one-on-one and I, as the investigator, suggested topics and allowed the respondent to answer. This is different from a structured interview, which has fixed questions. I was able to move along with the patient through his or her thought process but still make sure that the overall questions were answered.

The interview questions were constructed based on some of the initial results found in the freelistng exercise. The questions probed how people came to know about bariatric surgery and how they felt about contacting a doctor’s office. In addition, questions about the order of events in the office, interaction with the other patients, the staff and the doctor as well as expectations about the surgery were asked. The patients answered all of these questions and some commonalities as well as individual concepts became clear. The interview started with general information questions to get an idea of the demographic that was answering the questions and contacting this specific office for help. Since, “the biggest weakness in questionnaire design occurs when an investigator drafts a set of questions without sufficient background,” it is integral to find out what kind of people are looking into bariatric surgery. Where are they from? How old are they? Then, after these initial questions, more specific questions about their decisions to seek out the surgery were asked and formulated. Since these patients had already contacted the office for information, the questions were geared more towards the office experience. Did they feel welcome in the office? What did they think of the doctor? What is their next plan of action? What kinds of concerns are there? These and many other questions were asked. It was advantageous to have a general outline of questions to ask, but the ability to change and fix the questions as the interviews progressed was valuable. It ensured that the patient’s attitudes and feelings about the surgery and the clinical encounter were made clear.

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21 Ibid, 374.
Finally, the third segment of the project featured interviews with patients who actually had the surgery. They were people, who after contacting the doctor’s office, meeting the doctor and deciding if they could pay for it, went through with the surgery and learned about all the necessary health considerations they had to take into account. Once again, because the number of people was significantly less, personal interviews could be conducted after the patient had gone home from the hospital. They were asked what made them decide to go through with the surgery. How did they feel after the surgery? What is their outlook? What about the special diet and health considerations? Overall, it served as a way of understanding how people who have received bariatric surgery ultimately view themselves and the procedure. In addition, it gave further information about the importance of a healthy relationship with the doctor’s office. Questions such as how their relationship with the office staff and hospital staff impacted their progress and feelings about the procedure as well as the significance of the doctor’s role were important. The idea of satisfaction with the procedure and the changes to come were also considered. It provided significant insight into the cultural model of bariatric surgery especially in terms of this surgeon and his office. It helped to see how self-perceptions impact a person’s decision to receive a very invasive operation with significant health impacts.
Data Analysis and Results

Freelists

Twenty-five different prospective patients of Dr. Apparao Vanguri were asked to participate in a free-listing exercise. The participants were patients who called the office to set up appointments and I interviewed them before they came in for their initial appointments. They were asked to give their first fifteen responses to four distinct questions. The questions and their responses were then considered and put through the program, Anthropac 4.0, to determine the saliency of the responses and a corresponding measure of cultural knowledge within the group of people questioned. In freelists, the most common terms are a way of assessing the answers to the question according to the specific domain (the person being asked the question). The freelists were assessed in terms of frequency and saliency where frequency is the number of times a word is mentioned in a freelist and saliency is measured by Smith’s saliency score and is a product of frequency with which a word is mentioned and where on the list it usually falls.

The first question asked participants to list the first fifteen words that came to their minds when they thought of a person who is healthy. The most frequent responses to these questions can be seen in Table 1.1. The answers all come from the participants who were either spoken to individually or in small groups before their appointments and prior to meeting the physician. Analysis of the data, specifically the eigenvalues, reveals the strength of the consensus in the group. An eigenvalue is the total amount of variance that is explained by a particular factor, and in the case of this first question, the first eigenvalue of 3.503 is about three times larger than the second value of 1.477 meaning that there is a strong level of agreement within the group of participants. The responses to the questions were very much in line with those expected from the specific demographic as is described further in the discussion section of this paper.
Table 1.1

Most frequent items in the freecists associated with the word “healthy”

<table>
<thead>
<tr>
<th>Item</th>
<th>Frequency</th>
<th>Saliency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thin</td>
<td>18</td>
<td>0.601</td>
</tr>
<tr>
<td>Young</td>
<td>15</td>
<td>0.581</td>
</tr>
<tr>
<td>Happy</td>
<td>14</td>
<td>0.378</td>
</tr>
<tr>
<td>Active</td>
<td>13</td>
<td>0.413</td>
</tr>
<tr>
<td>Exercise</td>
<td>11</td>
<td>0.325</td>
</tr>
<tr>
<td>Fit</td>
<td>10</td>
<td>0.251</td>
</tr>
<tr>
<td>Eats Well</td>
<td>8</td>
<td>0.242</td>
</tr>
<tr>
<td>Fun</td>
<td>7</td>
<td>0.232</td>
</tr>
<tr>
<td>Healthy</td>
<td>6</td>
<td>0.142</td>
</tr>
<tr>
<td>Pretty</td>
<td>6</td>
<td>0.130</td>
</tr>
</tbody>
</table>

The second question asked participants to list the first fifteen words that came to their minds when they thought of a person who is unhealthy. The eigenvalues do not show as much shared knowledge as they fall in more of a 2:1 ratio, but this could be due to the nature of the question. People’s responses ranged from the more personal aspects such as family to the more common ideas linked to health such as “medication” and “hospitals.” There were still many responses related to obesity and size such as the “inability to move freely” and “early death.”

In the third question, patients were asked to give the first fifteen words that they thought of when they heard the word, “obesity.” The results can be seen in Table 1.2. Because of the relevance of the question to the group that was being interviewed, there was a very high degree of cultural consensus with eigenvalues falling in a ratio of 3.099:1.034. This indicates a high degree of cultural consensus in terms of the responses to words associated with obesity. The people who answered the question tended to answer the question in the same way highlighting certain trends and commonalities in attitudes towards obesity and self-perception.
Table 1.2

Most frequent items in the freelists associated with the word “obesity”

<table>
<thead>
<tr>
<th>Item</th>
<th>Frequency</th>
<th>Saliency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fat</td>
<td>18</td>
<td>0.674</td>
</tr>
<tr>
<td>Big</td>
<td>12</td>
<td>0.339</td>
</tr>
<tr>
<td>Overweigh:</td>
<td>11</td>
<td>0.338</td>
</tr>
<tr>
<td>Sick</td>
<td>10</td>
<td>0.243</td>
</tr>
<tr>
<td>Depressed</td>
<td>9</td>
<td>0.161</td>
</tr>
<tr>
<td>Ugly</td>
<td>7</td>
<td>0.176</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6</td>
<td>0.096</td>
</tr>
<tr>
<td>Sad</td>
<td>6</td>
<td>0.086</td>
</tr>
<tr>
<td>Unaccepted</td>
<td>6</td>
<td>0.146</td>
</tr>
<tr>
<td>High Blood-pressure</td>
<td>6</td>
<td>0.122</td>
</tr>
</tbody>
</table>

In the fourth question, I asked participants what were the first fifteen words that came to their mind when they heard the words, “bariatric surgery.” Because this is the reason that these participants have even come to the office in the first place, the responses were very interesting to hear. Similar to question two, there are very many different themes so there is not a statistically high cultural consensus since the eigenvalues fall in a ratio of 1:703:1.410. That is not to say that there is not cultural knowledge, but instead there are a variety of themes that are linked to bariatric surgery in the minds of these prospective patients as is later discussed.

Post-Appointment Interviews

I conducted interviews with ten of the prospective patients to ask them about their experiences in the doctor’s office during their first appointment. Realizing that environment and interaction with people can highly influence one’s opinion about a situation or an experience, I wanted to make sure that questions about the actual experience were asked, as well as further questions pertaining to their feelings about the environment and the people that surrounded them.
The complete list of questions asked can be seen in Appendix 1. In addition, questions more specific to their feelings about the surgery were asked. The interviews were all recorded with the knowledge of the participants and they were later transcribed and coded for common themes in a qualitative software program, QSRN6.22 The broad themes were then re-coded for more specific responses to the questions. The constant comparative method was used as a way to perform qualitative data analysis by moving between codes and the text with the intention of identifying specific themes. The results can be separated into two categories: first, a description of the overall experience and order of events and secondly, themes that I gleaned from the interviews that revealed how the first experience in the office can affect attitudes about the surgery.

General Descriptions

The first questions of the interviews aimed to get an idea of the order of events upon going to Dr. Vanguri’s office for an initial meeting. Prior to an appointment, it was necessary for the patients to hand in a detailed packet of information that included all medical history, referrals from all doctors including primary care, psychiatrists, and any other doctors giving care for the patient such as orthopedic doctors and heart doctors. Most of the interviewees described a similar experience of first coming into the office, meeting the staff and then waiting in the waiting room. They were then taken back individually by a nurse to be weighed and have a quick check-up. After that, they waited in the waiting room again, and then had an individual meeting with the doctor. In this meeting, they were asked for information about their family’s health history such as the trends of obesity in the family and other diseases such as diabetes or high blood pressure that run through family lines. In addition, they were also asked about all attempts to lose weight

such as diets and other medical procedures or programs. It is apparent that every patient that comes to this office has considered and tried many different ways to lose weight with little success. Hence, they often viewed the surgery as a last resort for weight loss and medically necessary. Financial matters were discussed minimally in this first appointment. For those who had not already been approved for the surgery by their insurance company, the doctor told the patients that he would write a letter to the insurance company describing why the patient needs the surgery and they would then wait for approval.

The next part of the appointment was a group meeting with however many new patients were present. The doctor came out with diagrams of the different kinds of gastric bypass surgeries, describing how different kinds of surgery worked for different people, mostly based on the size of the person. He then would answer any questions that people had about the surgery or anything else that was related. Some literature was also provided about the changes in diet and lifestyle that these patients would have to expect. All interviewees agreed that the explanations were clear and that if there were any questions, they felt that the doctor was willing to answer them or provide them with a resource for their questions. In general, the participants in this project found the staff in the office and the doctor welcoming and helpful. They then left the office and were given time to see if their insurance companies approved the surgery, and they also were given time to decide if they wanted to go through with the surgery. If so, they made further appointments and plans with the office staff.

Themes Based on the First Appointment

While these questions and their answers gave the general overview of the first appointment experience, more in-depth questions were asked as well to get a more global idea of
the way that the patients actually felt throughout this appointment and how the experience would later influence their decision. Some overall themes surfaced from these interviews. First and foremost, the idea of having this surgery is very personal and each person can cite different reasons as to why s/he has come to this particular decision. Coupled with this was the surprising result that the media’s recent attention to the study did not affect the patients to the degree that many would think. Rather, most patients cited the media influence as minimal and more like background to the overall situation. Secondly, patients discussed their frustration with other weight loss methods and how this had become a medically necessary procedure and that they wished to experience the freedom of being a less heavy person. Next, the idea of trust and experience also became apparent when the patients discussed why they had come to this particular office and contacted this particular doctor. In addition, the experiences of former patients particularly with the doctor and in support group meetings were particularly emphasized in these interviews as a reason for feeling more comfortable with the surgery. Lastly, there was a definite awareness of the gravity of the changes that were to take place and specifically, changes in diet and lifestyle overall. At the same time, there was acknowledgement of the fact that these changes were necessary in order for the surgery to be at all effective. They were once again, relying on the experience of former patients as well as the expertise of the doctor and his staff to learn how to deal with these changes.

*Personal Decisions*

Each patient cited different reasons to obtain the surgery beyond the medical necessity. Realizing that their weight has in some way limited them, they each shared personal motivations for getting the surgery. Therefore, it became apparent that each patient, from this community of shared experience had their own points of view as well. For instance, one patient mentioned how
her weight has been linked to her problems with infertility. She said, “Even though I’ve been going through infertility treatments, they were saying it was due to my weight and I wasn’t sure if I wanted to continue with infertility treatments or have the surgery but I just decided that I want to enjoy my pregnancy and not go through complications of being obese and pregnant at the same time and I want to enjoy my children and that was basically my main decision.”

Therefore, it is apparent that for this particular person, though she is facing a degree of obesity that many others deal with, her personal problems with infertility have led her to this particular decision. At the same time, another patient talked about listening to different points of view as related to the surgery, he still felt that in the end, it was his ultimate decision. He said,

I do a lot of listening and I make up my mind and I sit back sometimes and I listen to these persons and I watch them reveal themselves and I’m checking out character and nothing has frightened me and I think it’s something that I feel that if I want to live longer, this is something that I probably need to do. And I know that as the years go by a lot of people have to make changes in their life and so I guess this is my time. I guess it’s almost like fate. It’s inevitable. Something has got to be done and this is my course of action.

I found that talking to patients with such points of view was the most revealing and eye-opening way to see that in actuality, this surgery is in no way a quick decision. Rather, it is a conclusion that many people come to after much experience and thought.

Along those lines, when I first started this project, I wanted to see how the media’s attention and focus on obesity as a health issue would influence a person’s decision to seek out as drastic a solution as bariatric surgery. I asked all of the patients about the popular culture aspect of obesity and its treatment. It was very interesting to find that in most cases, people did not cite the media as a direct influence on their personal decision. Rather, it appeared to be background to their overall decision, because they felt regardless of the media coverage given to the surgery or the celebrities that were receiving it, they still felt that they had followed their own path to this decision. They would say that they would prefer to hear the experiences of everyday
people and doctors rather than those of celebrities. For instance, one patient said, when asked about the recent attention given to the surgery,

Well I heard about Al Roker and Randy Jackson and some other people, but no, it wasn't because they had it done. I didn't look into see what they were doing. It was just like my doctor said he had a patient that had it done and they tell me that they were real happy and more are having it done and the insurance is taking care of it now and he said it would be probably the right thing for us.

Therefore, it appears that though the patients were aware of both the positive and negative media attention given to the surgery, they still wished to hear about the success of local people and of the surgeon. Another patient especially emphasized the way that she felt about the surgeon as being the deciding factor. When asked if the media at all influenced her faith in the surgery, she replied, "no, because it's not my faith in the surgery, it's my faith in the surgeon. And the people that I've talked to that have used [this doctor] as their surgeon have all talked about how well things have gone and if there is any problem, he's always there to help them." It is apparent, therefore, that the decision to seek out this surgery is very personal and patients feel more secure knowing how their peers dealt with an experience such as bariatric surgery.

Medical Necessity

Many patients first listed their status of their health and disabilities as reasons for obtaining bariatric surgery. They viewed it as a way to have a new life and to avoid other possible poor health outcomes. Some cited previous health experiences of themselves or of family members, realizing that many of the consequences of obesity are genetic and could have been passed down from earlier generations. In one case, a patient said, "I'm getting older and I think the odds are against me if I keep the weight on." The fear of consequences of their obesity and of a premature death was common. Another patient said, "If I can get this started and do this surgery, I need to find a way to make my life healthier and if this going to do it then, this is what
I've got to do.” For many people, the surgery became a last resort as they had tried many other ways of losing weight and in the end this seemed to be the only way that they could have any permanent weight loss. In one case, a patient said,

I wanted to try, you know, I went back to Weight Watchers, I did some other diets and then, just over time, you try these things, I would do really well, and then I'd gain it back, and plus some. It just got so it was very discouraging and I did a lot of research online and I went to some support group meetings and tried to find different doctors and ended up where I am.

Therefore, it became apparent that none of the patients with whom I spoke saw bariatric surgery as an easy option for weight loss. Rather, it had become medically necessary and they feared the consequences of their obesity if they did not try and get the surgery.

*The Importance of Trust and Experience of the Doctor and Fellow Patients*

As the interviews progressed, a common theme of trust in the surgery and in the surgeon became apparent. Patients emphasized the importance of hearing about the surgeon’s experience ahead of time from those who had had the surgery, especially on the occasion of the first appointment. In addition, it was important to hear about former patients’ experiences with this doctor and the surgery. Secondly, the comfort level with the office staff was often cited as a benefit to contacting this particular physician. They felt that they could call the office freely and this was encouraging and helpful. Lastly, the support group meetings as described below were another way of learning about the doctor and the surgery so that they could feel supported throughout the process.

Contact with former patients contributes to the cultural model in that it shows how even though the medical condition that these people experience is very personal, they still relate to other people and their experiences. Most patients expressed comfort in having other patients to talk to at the first appointment because of the insight that they provided as well as their thoughts.
on the process overall. For instance, one patient talked about her first experience in the office and
the conversation that went on with other patients. She said, "Some of the follow-up patients were
talking about things they could do that they couldn't do before and I chimed in that it would be
nice to walk up some steps without getting winded. And some of the people were talking about
the different experiences they had before the surgery and after the surgery." Therefore, talking
with other patients could serve as a form of encouragement and security for the patient. In
addition, it was important for them to find that they could relate to and use the office as a
resource.

Though the surgery is performed in just a few hours, the effects and the process of
healing and seeing weight loss spans over a significant time and therefore, the patients may want
to call the office or contact the doctor again. Because this is so common, I asked to see if patients
felt comfortable calling the office and asking questions. Most people said that they felt that they
could call the office freely and that the office staff and doctor answered the questions well and
promptly. With regards to her first experience in the office, one patient said, "I've never felt like
it's been like, a 'why are you bothering us again' type call. And that's very encouraging and very
helpful because it is such a huge major thing and I don't want to feel like they're doing this just
for the money. 'Oh we have to be nice to her.' I don't get that feeling." Such positive responses
were common and I believe that they indicate how a person's experience and environment can
highly influence their behavior especially with something such as a life-changing surgery.

A subset of the attitudes towards other people's experiences were feelings about the
support group meetings offered once a month to former, current and prospective patients of this
doctor. Many people went to support group meetings before their surgery date and some began
going after surgery. They felt that it was valuable to hear another person's point of view about
the surgery even if it was to get recipes or learn about more comfortable exercises. Others saw it as a way to meet people who understand what they are experiencing in terms of their obesity as well as the life changes of such a complex procedure. One patient said with reference to her expectations of the support group meetings, “I think they’re a good idea. I’m going to go and find out more information about it. At first hand, other than reading about it, or getting hearsay, I’ll see what other people have said. Hopefully I’ll hear bad and good things, and not just good things about it.” Therefore, the support group meetings served as another medium for meeting and hearing about other patients’ experiences.

_Lifestyle Changes_

Another commonality that was apparent when talking to the patients was that of an awareness of the gravity of changes to come. That is to say, all of the participants saw that the surgery was not a simple decision. Rather, many considerations on their part as well as on the part of the doctor and staff had to be made. For instance, the packet of information that is necessary for each patient to submit is very elaborate, but all parts are necessary for the doctor to determine if a candidate should get the surgery. At the same time, I asked patients if they were aware of and ready for the great number of lifestyle changes that would have to be made, particularly in terms of diet and physical exercise. I found that all of the patients were in fact aware of the changes and they also saw them as a difficult but necessary part of the treatment. They realized that making the decision to get the surgery was not the only part of the decision, but rather they had to acknowledge that there are many other changes and consequences. Most people said that they were ready for these changes and would take them as part of the necessity of the surgery to deal with their obesity. When asked if she had learned anything and would be
ready for the changes, one patient was very realistic saying, "Food is an addiction. I'm not an overeater, but I just don't eat the right things. So, I'm not upset about not being able to eat, that's going to be a bit of a struggle, but I think the rewards will outweigh the fact that I can't eat certain things." Such realizations and attitudes were common among many patients when they acknowledged that by deciding to pursue the surgery, they were also deciding to adopt a new lifestyle.

Post-Surgery Interviews

Of the patients interviewed after their first appointments, five were interviewed after they actually had the surgery basically as a follow-up to the initial interview and to see how the patient felt about the process over all. The complete list of questions asked in this part of the study can be seen in Appendix 2. Since the focus of this study was primarily on the motivations for the surgery, the bulk of the revealing results came from the interviews before the surgery, but I wanted to see how patients felt after the surgery as well. They were asked a variety of questions particularly about the surgery and the hospital stay as well as their continued contact with the office and doctor. They also commented on the results of the surgery as well as the changes in diet and in physical exercise as well as the process overall. As with the other interviews, they were recorded, transcribed, and coded in the program, QSRN6 to find common themes.

Themes Based on the Post-Surgical Experience

As with the interviews conducted after the first appointment, the post-surgical interviews provided valuable information. I was able to identify particular themes that became clear through the conversations I had with patients in terms of their views of their experiences with this
particular doctor and with the surgery itself. The different patients cited similar experiences, saying for the most part that they felt comfortable with the surgery and the hospital stay. They also continued to feel that the office was a resource and available to them. They also found the support groups to be a valuable resource. In addition, they described how they felt about the changes in diet and lifestyle that they were already experiencing and others that they would come to experience. Lastly I asked if the patients could see any actual changes or results of the surgery yet to see how they felt about the surgery as related to why they sought it out in the beginning. This further reinforced how these external factors can directly influence attitude about the surgery and about health in general. I found that the patients were still very willing to share their experiences with me and give insight into what a patient thinks when seeking such a surgery.

Support Group Meetings and Office Support

Most of the patients were interested in attending the support group meetings after they had surgery because they felt that they could contribute as well as gather valuable information about how to deal with the surgery and its consequences. One patient said, after her surgery that she saw the support group meetings as being very useful in that she would,

be able to help new people coming in and thinking about having the surgery and being honest and up front, and also to be able to ask questions to other members that have already been through and can maybe help answer some any questions. Like what foods work and what don't. To use it as a sounding board almost. To get the support and answer the questions and a member might have a suggestion for a product or something and to just share our knowledge

In addition, they cited the office as an important resource even after the surgery. There were the very positive responses that said, “This doctor’s office is amazing. They work very well together,” and at the same time many people said that they still felt like they could call the office with questions and ask for advice.
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Diet and Exercise

The patients who had the surgery talked about the changes in diet that they were experiencing. Patients who have bariatric surgery must eat only liquid food for the first few days after the surgery and then pureed food for a month. Many patients expressed their unhappiness with this particular change, but they realized that it was part of the process of healing and eventual weight loss. One patient said that even though the pureed food was “terrible,” he knew that he “didn’t have much of a choice.” With regards to physical exercise, the patients saw exercise not only as a necessity but as a part of the new beginning that they were looking for when they sought out the surgery. For instance, one patient talked about how once she was able to start exercising, she was planning on making it an effort between her husband and herself in order to assure that they went together.

Changes and Family Support

I asked patients about how they viewed the surgery and if they felt that there were any visible changes in terms of appearance, things they could not do before that they could now do that they could not do before, and this question was often answered with very positive responses. I found it most interesting and revealing when the patient would identify something that they could now do now that I feel most people take for granted. For instance, one man said,

I was sitting in my family room on the sofa and my legs were crossed and I asked my wife, do you notice anything about me? And she said, yes, you have your legs crossed. There was a time when I couldn’t cross my legs and there was another time a week ago and I had some papers in my hand and a student knocked some papers out of my hand. And I used to hate when that happened because I would have to get down on one knee and pick them up.

As in this man’s case and in others, the role of family and friends in the process came out as a support system. In another situation, with respect to visible changes, one woman said days after her surgery, “I can’t tell that I’ve lost any weight yet, but my husband says that he sees it in my
face already, but you know we're always our harshest critics.” It is apparent that the opinion of those who care for them was very important to the patients and in other ways, family and friends' roles were often highlighted. The idea of having family support was also very important and most of the patients with whom I spoke talked about how having family support was really vital and would help them to deal with all the changes to come. The support system from both the office and family and friends, therefore, was key for the surgery and dealing with the consequences of the surgery. These themes were overall contributors to the cultural model for motivations for bariatric surgery.
Discussion

Freelists

The results from the freelists were valuable in gathering information about the kind of people that seek out surgery for their morbid obesity. It helped to get an assessment of people’s individual obesity as well as to see how they viewed bariatric surgery as an option for obesity treatment. The results from each question, as described below, served as a key to understanding how this particular group of people perceived themselves and their role in society. It also served as the basis of the cultural model to which the interview results also contributed.

In the first question, which asked what words patients thought of when hearing the word, “healthy,” there appeared to be many commonalities in the responses. Since these patients were all considerably obese and looking for solutions to their weight problems, many of their responses to the questions were linked to weight in terms of what is considered “healthy”. The most predominant answer with a saliency of .601 was “thin,” indicating that this overweight group considered thinness and a smaller size to be healthy. In addition, other words about self-image and self-perception arose amongst which the most common terms were “young” and “happy.” This shows that in addition to the physical aspect of health, there is also a mental and emotional aspect. The next few terms are those that some might expect when considering health such as “eating well” and being “active” and “exercising”, but there is also another element of being “pretty,” which was the tenth most salient term. It can be concluded, therefore, that physical health, and most likely obesity and its consequences can be linked to self-image in terms of physical attractiveness as well.

In question two, which asked the words associated with a person who is unhealthy, despite the fact that the eigenvalues do not give a clear indication of consensus in response, it is
still important to consider the range of responses, and the fact that many of these words came up with high frequency. The respondents gave answers that fell in a wide range but at the same time, there were identifiable themes as described above. They still related unhealthiness to their personal problems with weight and but they also brought up answers that could be associated with unhealthiness in many people's minds such as "hospital" or "sick." If the question was vague, it could also have elicited this divergence in responses. When actually speaking to the respondents, I found that they often felt pressured by the questions and claimed to "draw a blank." Therefore, the range and variety of responses could be explained by the difficulty of responding to these questions.

For question three, which asked about the words associated with the word, "obesity" and there was a high rate of cultural consensus. The most common response was "fat", which is a very colloquial definition of obesity, and other terms such as "big" and "overweight" also fall into this category of an actual definition of obesity. Because these words were most frequent in the responses, it can be reasonably concluded that these terms came as responses most easily to the participants and that they are the most relevant in terms of how the participants view themselves. In addition, the other ideas of being "sick" and "depressed" and "sad" and "unaccepted" show the emotional aspect of being obese, responses that are most likely linked more so to people who actually experience obesity than others. The high frequency of these words as well as the saliency to the group shows how obesity has affected their mindset about obesity and health. In addition, words such as "diabetes" and "high blood pressure" show the more physical aspects of obesity that are definitely relevant to the group of respondents, but at the same time are very public aspects of obesity and receive much media attention. This question
is one of the more telling of the exercise in that it shows how the central problem, obesity, is perceived by those who actually experience it and want to fix it.

The last question I asked was for the words associated with “bariatric surgery.” Because of the personal aspect of this surgery, many of the responses are linked to the emotional freedom that will be experienced after the surgery such as “life,” “happy,” “hope” and “new beginning.” At the same time, there also exists the element of “fear,” which in an exercise like this seems quite the opposite of the other words. The third most apparent theme seems to be linked more to that of health in that they consider it a “healthy” option as well as a way to become “thin” (what can be perceived by this group as the most common definition of healthy) and also to experience “less pain” across the board. The varied themes may show less consensus in the group, but each is relevant and sheds light on why these people are seeking out the surgery in the first place. Though they express fear of the actual surgery and anesthesia, they also see promise and help at the end of the process. The responses fell into different categories, but there was still high frequency of terms amongst patients and so, I believe that the baseline of information that can be collected from the freelist is still valuable and pertinent.

The freelisting exercises in this study were a productive way to get an initial idea of the sentiments and thoughts of the prospective patients for bariatric surgery. They demonstrate a high level of cultural knowledge and through word association, relevant themes and ideas can surface and give an impression of the standpoint of prospective patients. The semi-structured interviews that were later conducted allowed more specific questions related to the themes originally identified in the freelists. The results from the freelists corroborated with the results later found in interviews in that many of the motivations had to do with security, cultural stigma and expectations about size and health. The interviews were more revealing, however, in that
they showed how a personal decision can be aided or influenced by external factors as well as the experiences of other people and the interaction with the office staff and the doctor. These factors are direct contributors to the cultural model for motivations for bariatric surgery.

Cultural Model

With the baseline information that the freelists provided, the interview questions were molded to find out how people view themselves and the surgery. The interviews that were conducted after the first appointment were the most revealing for the formation of a cultural model. Essentially, it appears that despite the fact that each person has his or her own feelings about his or her own obesity, there are many commonalities about attitudes towards this surgery. That is to say that as described by the freelisting exercises, perceptions about health, obesity and bariatric surgery were common within this demographic. At the same time, personal questions revealed more specific sentiments about the surgery. To best explain this model, Figure 1.1 diagrams the influences that patients face when it comes to making the decision to seeking out the surgery. The model was developed as a result of lacing together the different themes highlighted above. After finding results such as the smaller level of influence that media has than I had originally thought and also the huge emphasis on talking to former patients, I aimed to emphasize the factors that directly influence a person’s decision to consider the surgery. Therefore, the model is a concise diagram that looks specifically at the inside and outside of a patient’s medical condition. I believe that those who have the internal influences balanced with the external support systems are the most prepared and the most aware of their motivations to seek out the surgery. Therefore, people such as this are the most likely to call the doctor’s office and make an appointment, and even follow through with the surgery.
The model identifies both internal and external factors. In this diagram, the person facing morbid obesity is in the center and there are three aspects to the internal influences. I believe that the internal factors lead to this very personal decision because they are so heavily linked to personality factors. For many people, internal feelings and thoughts are almost hardwired in place and it is only with experience and different situations that a person can change and mold these internal feelings and in the case of these patients their experiences with obesity are directly
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linked to their internal workings. I have identified three key components to a surgical candidate’s internal foundation. The person must be able to find trust in themselves and in the doctor and his staff before feeling comfortable enough to pursue the surgery. A willingness to change is integral and beyond acknowledgement, the person must be internally ready for such drastic changes in lifestyle especially with acknowledgement that it will not be an easy process. At the same time, as highlighted by the freestats, most prospective patients are not entirely satisfied with their current health situation in that they feel sad or depressed about the surgery in addition to feeling unhealthy. They also see the surgery as a possible outlet and a new beginning.

The external support system came through as the most interesting result of the study. The idea of feeling comfortable throughout the process was apparent throughout the analysis of the interviews and the biggest contributors to this feeling of comfort were the office staff and the doctor, family and friends and the experiences of other patients. Therefore, though patients might have felt the medical necessity for the surgery in terms of their health and appearance, they would not have made the step to seek out the surgery without such a support system. It was also apparent that those who felt that they did not have one aspect of the support system would find it in another form be it a new friend at a support group meeting or the friendly office staff. With an understanding of the combined external and internal influences, I believe that the motivations for bariatric surgery become clearest. Through this study I was able to develop this model and show that no part of this decision was unilateral. Rather, there are many factors that can influence an obese person, but it is the internal security and external support that eventually pushes them to actively pursue the surgery so that their obesity can be effectively treated.
Limitations

Because this was a small study with only one research investigator, there were a few limitations to the study. First, because the study was conducted in Baltimore, commuting from Philadelphia as well as getting in touch with patients was often difficult. Therefore, the results were tabulated over a very long period of time (from May 2004 to February 2005) to assure that the goal number of patients participated in the project. In addition, Dr. Vanguri is my father, so there was some concern that there would be bias in the responses from patients if they felt in anyway that it could affect their treatment. The patients were assured that the project was independent of their treatment and that the results would not be available to the doctor until well after they had gone through the surgery process. Despite this relationship, I felt that patients were actually more open with me because they knew that I had was familiar with the doctor and his staff. I also felt that after some time in the conversation, they were did not hold back when giving me their opinions. Rather, they felt that they could give me more information in the interviews, knowing that it could provide insight into the whole process of getting bariatric surgery and therefore benefit them and future patients.
Conclusion

The study proved to be effective in highlighting aspects of decision-making as related to bariatric surgery. The cultural model that I developed is clear and emphasizes factors that are not usually considered when understanding why people seek out particular kinds of treatments for their obesity, namely an external support system and internal motivations. This information will be valuable in future treatment of patients. In a concluding interview with Dr. Vanguri, he said, with regards to the study that “it helps me to realize the importance of these issues and I hope to make my staff more aware as well so that they can best attend to the needs of the patients. The patients are eventually responsible for understanding the implications of a major surgery on their life and they should not think of it as an easy fix. Surgery is only a tool that will help them to achieve their goal of weight loss and better health.”23 In addition, such information is beneficial to newer physicians in that they can see the cultural aspect of the surgery. Though obesity is a predominant health issue and not at all lacking in public attention, this aspect of the support that morbidly obese people need in order to make the choice of this particular kind of treatment has not been emphasized as much. Dr. Vanguri said, “The interviews helped to bring to light to the fact that patients are individuals with unique personalities and they need the support of the physician, the staff and their family to go through a major change in life. It’s all the more important for new surgeons coming into the field to realize this fact instead of thinking of them as just a number.”24 Overall, it can be concluded that motivations for bariatric surgery have many levels personally and culturally. The combination of all of these aspects can influence a patient to seek out this particular kind of treatment based on their comfort level with the physician and his

23 Dr. Apparao Vanguri in an interview conducted on March 30, 2005.
24 Ibid.
staff, support from others as well as their own experiences with obesity. This study provided a model that can be followed to more fully understand the motivations behind this decision.
Appendix 1. Questions from Interviews Conducted After the First Appointment

What is your age?
When was the appointment?
What would you say was the purpose?
How long did you have to wait for an appointment?
Please describe your experience coming to the office (order of events).
Was it a personal meeting or a group meeting?
How did you feel when you met the staff?
What kind of preparation did you need for the appointment?
How did you feel when you met the doctor?
What was addressed during the meeting?
Did you feel comfortable in the office?
How are you feeling about the surgery?
Do you have any idea when the surgery will be?
Were financial matters discussed?
Should financial matters be discussed?
Do you still feel that surgery is the best solution?
Do you feel that you will know how to take care of yourself after the surgery?
Do you have any questions or complaints? Any suggestions?
Do you feel that most of your questions were answered?
How would you describe your family’s role?
Why did you pick this doctor and this office?
How did you come to know about the surgery?
How has the media influenced you?
Have you been or do you plan to go to any support group meetings?
How do you feel about the lifestyle changes you will have to make (diet, exercise, etc.)?
Appendix 2. Questions from Interviews Conducted After the Surgery

When was your surgery?
How are you feeling now?
Do you still feel supported by the office?
Have you been taking care of yourself?
Is there anything you can identify that you can do now that you couldn’t before?
Are there any visible changes?
How would you describe your outlook and your attitude?
How was your hospital stay?
Have you had any contact with the doctor since the surgery?
Have you been to any support group meetings?
Do you have any suggestions for how the process could be made better?
How have you felt about the changes in diet?
How many times have you been back to the office since the surgery?
How many times did you go to the office before the surgery?
Did everything go as expected or were there any surprises or complications?
Bibliography

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