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The Patient-Practitioner Interaction in Post Bariatric Surgery Consultations: An Interpersonal Process Recall Study

ABSTRACT

Purpose: The patient-practitioner relationship is fundamental to rehabilitation practice and patients' health and wellbeing. Dissonance between patients who have had bariatric surgery and health care practitioners about what supportive care and good outcomes are can undermine care. To address the mechanisms of this process, we conducted an Interpersonal Process Recall study. *Materials and Methods:* We interviewed patients (11), video recorded consultations (10), conducted video-assisted individual interviews with patients (10) and practitioners (11) and a dyadic data analysis. *Results:* We identified relational states and shifts in the clinical encounter 2-3 years post-surgery, described in themes: a) Playing by the Book – Making it Easier for Each Other, b) Down the Blind Alley – Giving up on Each Other, and c) Opposite Poles – Towards and Away from Each Other. *Conclusions:* The post-surgery consultations facilitated responsibility for health and self-care but did not invite dialogues about the psychosocial burdens of living with obesity and undergoing bariatric surgery. Patients and practitioners tried to avoid creating conflict, which in turn seemed to foster distance, rather than human connection. This limits the encounter's benefit to both parties, leaving them frustrated and less willing to either meet again or take any gains into their future lives.

INTRODUCTION

The relationship between patient and health care practitioner (HCP) is fundamental for patient outcomes and their overall health and wellbeing. Within the clinical encounter, patients and HCPs establish common ground about the meanings of illness and their different experience of the patient's illness. In the current study, clinical encounter means human interrelation and interaction in face-to-face health care settings. In illness, dependency on other people and bodily vulnerability are aspects of the human condition that becomes magnified [1,2]. Most importantly, patients depend on the HCPs who can provide the help and support they need to recover, live through or -with the illness. The distinction between illness as lived experience versus illness as perceived through bodily signs, symptoms and science, has been described as a profound gulf that often separate patients and HCPs and impede the interpersonal understanding that is central to clinical care [3].

The lived experience of illness typically involves a biological disruption of the lived body that involves losses, bodily alienation and altered perception of time, space, identity and social interaction [4,5]. Practitioners approach the patient, equipped with knowledge and skills to undertake assessments, and attempt to cure or relieve symptoms. To address illness intellectually, HCPs approach the body as something that may need treatment, and the patient often start relating to their body the same way. Scholars have approached this challenge by expanding disease management to clinical care, including support, empathy, and trust [4,6,7]. Relationships between patients and HCPs have been investigated and analysed through the lens of patient-provider interactions, clinical communication, and working alliance [8-11]. Clinical encounters hold potential for care, support and certainly help to facilitate health and wellbeing, but seem easily led towards disease management. In the latter, the relationship is more static, and exchanges of services occur between HCPs as expertise providers and patients as recipients.

In the clinical field of obesity, one key encounter is the consultation that occurs after patients with severe obesity have had bariatric surgery. This consultation is part of a process in which patient bodily identity and wellbeing, and maximizing, and sustaining surgical outcomes are all at stake. Unfortunately, research on encounters at obesity clinics illustrates how the dynamics between HCP and patient can be less than optimal and undermine the patients' health outcomes in the longer term [12-14]. In this study we aim to address the complexity and mechanisms of this process, and therefore filmed the post bariatric surgery consultation, watched the recording with the patient and the HCP separately, and interviewed them individually and in-depth about the interactions they found helpful or less helpful afterwards. [rework into the abstract for clarity]

Dissonance between patients and HCPs about what supportive care and good outcomes are, can undermine bariatric care. Kirk and colleagues [13] explored experiences of individuals living with obesity, practitioners' perceptions, and the structures for obesity management in Canada. The results indicated that blame and power relations affected practice negatively, created tensions in the obesity management and that patients sought support from a system that they believed was failing them. Practitioners tended to blame patients for being obese, rendering them unable to provide the support that individuals living with obesity needed.

In a similar vein, contrasting beliefs between patients and HCPs on the quality of bariatric aftercare, different perspectives on what counts as successful outcomes and important priorities, can undermine clinical encounters [12]. Practitioners focused on achieving surgical outcomes, whereas patients emphasised long-term issues and unmet psychological needs. Raves et al. [14] studied the differences between patients' and practitioners' understanding of the relationships between weight stigma and diet. Patients attributed the challenges of sticking to the new diet to social life, work, and family demands.

Practitioners approached postsurgical eating as largely a question of responsibility and compliance to the recommendations they had introduced to patients [14]. In a study on surgeons' perception of patients' suboptimal outcomes after bariatric surgery, they placed responsibility with the patient, or framed the patient as victim of own life circumstances that limited their chances to care for themselves and recover [15]. Clearly, significant tensions between different roles and responsibilities persist.

Encounters between patients and practitioners in obesity clinics are bodily and intersubjective practices. In phenomenology, intersubjectivity means that people get to know themselves in and through encountering the world and others [16]. Intersubjectivity points to the dynamics between people, involving a certain letting go of oneself and an open and interested attitude towards the other, their perspective and contributions [17]. People do not have access to each other's thoughts and emotions, but rather need to perceive the other's bodily expressions, interpret them, and respond to them. For example, one can understand that another person experiences grief, but not in the same way as living through grief [16,18]. While holding potential for objectification, rejection and shame, the attention of the other also is crucial for wellbeing and development. For example, the experience of being recognized can validate and strengthen a person's sense of self and belonging in the world. Although under pressure, clinical encounters hold supportive dimensions that can be developed and nurtured.

In Nordic countries, severe obesity gives one the right to a multidisciplinary assessment and possible treatment and follow-up. For example, conventional weight loss interventions (medication, combinations of diet, exercise, and cognitive/behavioural therapies) or bariatric surgery would be covered by the welfare state. Safe, high-quality health services are a central tenet of the Nordic health care system, and in this, the patient-HCP

relationship plays a fundamental role. However, procedural consensus or explicit mandates governing which services should be offered during follow-up are not clear.

Taken together, illness evokes feelings of stress and uncertainty and is experienced very differently from the perspective of patients and HCPs, who encounter each other in a field fraught with tension. Previous research indicates that stigma, dissonance, and different beliefs can undermine the dynamics between patient and HCP in bariatric aftercare, risking unhelpful clinical encounters that can affect health outcomes negatively in the longer term.

The post bariatric surgery consultation offers a lens into the dynamic between patients and HCPs, and how the clinical encounter can facilitate or undermine patient health outcomes. The aim of the current study was to investigate how patients and HCPs view, experience and make meaning of their interactions after bariatric surgery. The research questions were: How did the patients and practitioners experience the post-surgery clinical encounter? How did they make meaning of the dynamics between themselves and the other when watching the recording of it? What did they perceive as helpful or less helpful?

METHODOLOGY

The current study has a qualitative design and is anchored in phenomenology, using in-depth interviews, video recordings, video assisted interviews and collaboration with service users. Methodologies are guided by *Reflective Lifeworld Research* (RLR) [19,20]. To obtain rich and detailed descriptions of post bariatric clinical encounters, we adapted and applied *Interpersonal Process Recall* (IPR) [21-23] combined with in-depth interviews. RLR is developed from core insights in the phenomenological and hermeneutical tradition and emphasises common ground between different philosophies rather than differences. A reflective, open attitude guides the methodological procedures and analysis, followed by

insightful use of theory. Lifeworld is a central concept in phenomenology, referring to the shared world of experience that includes everyday activities, encountering others, and the environments people are embedded in with all accessible objects. It is an experiential, pre-scientific and unquestioned world, loaded with unvoiced and explicit meaningful dimensions [16,24].

As a basis for our data collection, we filmed consultations in bariatric aftercare for subsequent exploration in interviews, within an IPR methodology. IPR interview means using video-assisted recall to access conscious yet unspoken experiences of recent social interaction to help participants putting experiences into words [22]. IPR interviews are particularly suitable to facilitate exploration of intersubjective processes [23]. Recording the clinical encounter and reviewing it afterwards assists the researcher and participant in identifying key moments that were not addressed explicitly in the consultation. The fundamental assumption is that the participants reviewing their recordings have rich experiences of the interaction not obvious to an observer. The interview dialogue between researcher and participant is at the core of IPR, whereas the recording facilitates experiences and perceptions of concrete processes. Capturing social interaction in a natural setting gives access to taken-for-granted complexities in ways that would not be possible with observation or interview alone [25].

A group of five female service users were involved throughout the research process. This group and two of the researchers (EN and KOL) collaborated through four annual workshops during a period of three years; three two day retreats and nine full-day local workshops. The aim was to establish common ground and facilitate mutual learning and reflection [26,27]. The group discussed recruitment criteria and procedures, ethical considerations, interview questions, transcript extracts, findings, and dissemination strategies. As the service users were new to research, the researchers guided and included the team throughout the research processes and discussions of methodologies and ethical

considerations. The workshops were facilitated with awareness of different perspectives on the post-bariatric clinical encounter. In this, the group collaborated on and contributed to the current research findings.

Recruitment, Participants and Study Setting

Two research nurses in obesity clinics in Norway identified eligible participants, informed them about the study, and first author scheduled the interviews with those who volunteered. In total 17 participants were interviewed, four male and seven female patients, aged between 39 and 56 (Insert Table 1). Six female practitioners aged between 28 and 47 were also interviewed, and were educated as nurses, clinical nutritionists, and medical doctors (Insert Table 2). Participant demographics are not linked on an individual case by case basis and can therefore not be linked to individual quotations due to the needs to maintain anonymity. In line with sampling principles within qualitative research, the final sample size depended on our evaluation of the quality of the data material [28-30].

First, EN met with patient participant for an in-depth pre-interview a few months prior to a scheduled consultation. Second, we filmed the upcoming consultations for the participating patients, to use for assistance in the IPR interview. Immediately after the consultations, KOL met with the HCP and EN met with the patient separately and implemented the IPR interview while watching the consultation. One patient participated in the in-depth interview but withdrew from videorecording, because of stress related to current health problems and need of care. As the data produced was rich and varied, we decided not to recruit more participants to replace the IPR interview we lost.

Researchers and Reflexivity

The interviews with patient participants were conducted by EN, who is an experienced physiotherapist, associate professor, PhD, postdoctoral fellow, and trained interviewer. The IPR interviews with practitioners were conducted by KOL, who is a clinical psychologist, PhD candidate and trained IPR interviewer. The interviewers are not affiliated with obesity clinics and do not participate in treatment of patients attending obesity clinics, including the study participants and expert by experience group. The research team has longstanding clinical and/or research experience, are experienced in qualitative research designs and talking with people about their weight, health, eating and emotions.

The term reflexivity points to the researcher's conscious process of reflecting upon their position, knowledge and experience of the phenomenon under investigation, and as this makes it possible for readers to consider to which extent they trust the results presented, reflexivity and trustworthiness are interconnected [19, 20, 29]. This means that the researcher's skills, how we negotiate pre-understandings, sensitivity and fairness and communicate relevant research results, affects the current study's trustworthiness. Therefore, we emphasised a systematic and reflexive collaborative approach throughout the research process.

Ethical Considerations

Interviewing patients and HCPs about a video recorded clinical encounter warranted a particular ethical sensitivity and dialogue with participants. In-depth pre-interviews provided an important basis for the subsequent video recording of, and IPR interview about, the clinical encounter. As we interviewed participants who had shared a common experience separately, and disseminate the results within the context of dyads in the current article, we have added an assessment of how we have protected participants' right to confidentiality [31]. All

participants provided written consent. The Norwegian Regional Committees for Medical Research approved this study [number].

Data Production

In the current study, we (a) conducted in-depth pre-interviews with 11 patients, (b) videorecorded their upcoming clinical encounters and (c) interviewed the patients and the practitioners individually about the consultation immediately afterwards, assisted by the video recording (Table 1). We conducted one pilot dyad of a full data-production cycle and made some adjustments on the interview guides and technical equipment afterwards. (Insert Table 3).

All patient participants were pre-interviewed separately three months before their upcoming visit at the obesity clinic, to gain insight into each participant's current situation, build rapport for research purposes, and release potential tension about the IPR interviews. We used an interview guide, first gathering demographic information and surgery specifics, and then focusing on the participant's (1) life post-surgery (2) relationships with others (3) expectations of post-surgery life vs. reality (4) post-surgery follow-up care: types, content/context, experience of needs being understood and met or not. Next, the interviewer summed up the pre-interview and prepared the participant for the IPR interview by re-explaining the process, asking what the participant would need to feel comfortable in the IPR interview, clarifying and answering questions. The interviewer aimed to be attentive and sensitive to the participant's experiences, facilitating concrete examples and elaborations. The interviews were audio taped and transcribed verbatim.

In line with IPR methodology, we recorded the annual consultation with two cameras in the room. After a short break, we interviewed the patient and the practitioner separately. In these interviews, we viewed the recording together, and both the participant and researcher

could stop it to elaborate or ask about specific interactions from the encounter. We aimed to identify moments they experienced as particularly helpful or less helpful, and moments they experienced as evoking their emotions. A prepared introduction and interview guide for the IPR interviews was helpful to keep the study's objectives in mind, to be present and participate fully in the dialogues, using open questions and probed for rich descriptions. The IPR interview was prepared and guided yet required spontaneity and flexibility. Interviews were transcribed including transcription of one minute from the video recording leading up to each stop and new interview dialogue. The dyadic approach yielded multidimensional data, different from those resulting from pre-interviews about interaction from the past that cannot be recaptured.

Data Analysis

In the current study, we conducted a dyadic analysis. This means that we treated the data material from patient and practitioner as a unit to get access to both collective and divergent meanings from an experience of interaction from two distinct but complementary perspectives [31-33]. As a methodology for analysis of IPR data seems to be lacking, we adapted RLR for dyadic analysis, aiming to derive a nuanced and complete description of post-surgery encounters in bariatric aftercare. RLR is an approach to qualitative research that articulates some explicit methodological principles anchored in the phenomenological and hermeneutical tradition, rather than a step-by-step agenda [19, 20]. When guided by RLR, we analyse texts for meaning in a circular process between gaining an overall sense of the data (the whole), examining more in-depth (the parts) and searching for a meaning structure (a new whole) [20]. EN, KOL and CM separately read and viewed the materials dyad by dyad, marked keywords and took notes, and met for a seminar to reflect on core meanings in the material. The researchers discussed the variations in stakes, intensity and dynamics between patient and

practitioner. Our first overall impression was that consultations involved dynamics of "encountering/not encountering" each other. Aiming to move the analysis beyond generic impressions of each consultation, comparison, or "best practices", we investigated dynamics of meaningful interactions within and across selected dyads in depth individually. This means that we re-read transcripts, extracted clusters of meaning and labelled them, before we discussed preliminary themes in seminars; one with the researchers and one with the group of service users. Meaning clusters were adjusted, synthesised, transformed into analytical text and linked to quotations by EN, and discussed with JO and CK throughout the writing process. Finally, MS and KOL read and verified the results.

Across the IPR interviews, we identified three core themes within a meaning structure entitled, Relational States and Shifts of the Post Bariatric Surgery Encounter, in which quotes were selected that conveyed particularly rich and vivid variation. Results are presented dyadically to make use of the current study's rare opportunity to gain insight into how patient and practitioner experienced and made meaning of the post-surgery encounter immediately afterwards. In the following, we present the core themes a) Playing by the Book– Making it Easier for Each Other, b) Down the Blind Alley – Giving up on Each Other, and c) Opposite Poles – Towards and Away from Each Other.

FINDINGS

Relational States and Shifts in the Post Bariatric Surgery Encounter

The post bariatric surgery encounter was both a predictable and uncertain situation, in which clinical activities gained priority over the patient-HCP relationship. In planning and standardizing patient trajectories according to best practice, it was impossible to know exactly how the unique patient would respond to surgery and achieve the weight loss they needed. This uncertainty, and a strong emphasis on patients' responsibility to follow practitioners'

lead became backdrop of the clinical encounter, otherwise structured according to measurements and patient reported outcomes. Across dynamics of the post bariatric surgery encounter, shifts towards and away from each other were common, and seemed to foster exchange of information, rather than human connection.

Playing by the Book – Making it Easier for Each Other

The clinical encounter was approached as a medical event by the patient and practitioner, rather than a relationship. Interpersonal contact was indeed a part of practice but subordinated to health monitoring and advice. This added to the tensional fields between predefined positions and expectations of being patient/practitioner and being oneself, between ideals of evidence-based care and spontaneous human-to-human interaction. One practitioner expressed this contradiction:

> We wish to signal that we are truly interested in them, to be a safe space (…). We are a check point, with a medical approach, we emphasise the somatic. This is our duty as we (the clinic) are responsible for this treatment (follow-up).

The framing and form of the clinical encounters functioned to sustain order and boundaries between patient and practitioner, between knowledge as obtained and provided and knowledge as experienced. Below, we illustrate how they navigated this tension, by describing how one patient and practitioner experienced their recent consultation.

One patient had lost weight and changed his life after surgery and had carried out extensive physical activity for two years. He was happy and proud, particularly about the discipline he had established regarding food and eating. Within the last months, he had needed abdominal surgery because of acute and painful illness. This meant that he had not been able to adhere to his exercise routines. To compensate, he had walked excessively. As he

had decided to weigh himself only at the obesity clinic, he had been slightly worried when coming to see the clinical practitioner:

> I was positively surprised, actually... I hope to stabilize on the weight that I have now… I hope that I can go back to my strength training again, build some more muscle mass. … I have lost one kilogram muscle mass. I was prepared, because I have been through two operations now and not accomplished strength training since last time when I spoke to you (interview three months before). If I had gained 10 kilograms, I would probably not feel that happy. I do not know how they (the clinical practitioners) would react.

The patient' initial worries were related to previous experience of regain following weight loss, now activated by new illness, abdominal surgery and having to slow down while recovering. When pausing his exercise routines, he had stayed active and was relieved that it sufficed. Facing no substantial weight gain and no judgement seemed to diminish worry and negative emotions related to weight loss maintenance. From that point, he relaxed, and the communication seemed effortless. Afterwards, the patient watched himself in the consultation, elaborating on how strict he is on his diet and walking long distances every day, and the practitioner's responses, her smiling, confirming, and cheering his results. The practitioner's responses seemed to strengthen his belief in the weight loss maintenance process and himself. The patient emphasised that talking about himself and his actions and receiving approval from her was "fun" and made him "feel good" and satisfied with own efforts.

Expressing gratitude, efforts, ownership to his weight loss process, and under-communicating difficulties and problems, this patient gets the practitioner's full attention. The

atmosphere is good, they interact and move in and out of the practitioner's agenda. The patient's responses and actions seemed to mirror the clinic's teaching and expectations. By going by the book, he confirmed the treatment's value and usefulness and the practitioners' efforts at the obesity clinic. His attentive and proactive ways of living life after surgery, and good outcomes, made the encounter "easy" and uplifting according to the practitioner. She said:

> He should be satisfied … He has a good result. Keeping it as today is more than good enough. He must get feedback that he has followed the recommendations he has got. And he has followed up as we (clinical staff) wish that they do, and eh (short pause). And he has achieved, yes, what we wish, and even more than that. And that does not come by itself. No. We are aware that he (stops). In fact, he has managed to handle this in a good way.

The practitioner approved of his ways of dealing with post-surgery life, comorbidities/late side effects, in line with the clinical practitioners' recommendations. She seemed to lean towards the clinic's values and medical framing of their encounter when using "we" instead of I, and at the same time was very clear that she liked him and his ways of managing:

> We know him and his life circumstances well. And we want that he, how can I say this? What we want for all patients, is that they have a good outcome and, in a way, perhaps not succeed - but yes - with their projects. More that they have good lives! But there are some that you feel more empathy with and a different relation to.... He is a patient I remember!

The practitioner describes her relationship to this patient, that she sees his potential and therefore probes more deeply and tries to do more for him than what was expected. For

example, she encouraged him to talk a little more about his current life, dreams, and worries. He responded immediately, looking forward to a holiday abroad, had some symptoms and so forth. She facilitated their interactions and a good atmosphere. This became significant, as they also discovered that he probably had an infection and needed antibiotics. She said:

> I am extra flexible for this patient. It is easier to give extra to a patient who follows recommendations, shows up to his appointments, expresses that he is very satisfied with the follow-up he gets and that he feels seen.

The practitioner said that she often discussed with the others how their relationship with patients might affect the treatment and follow-up:

> Does it depend on the relationship with the patient, what we offer them? I think that would be … ehm. No, we hope that it is not like that and that all of them are offered the same. But at the same time... it is the way the patients express themselves that makes us worried. And when the patient expresses that everything is just fine, when such a patient says something, then we are perhaps quicker to explore that further. But if a patient has been complaining throughout, I might not take the symptoms that seriously (quiet laughter). It is almost a little disgusting to feel it like that, but that is how it is.

The practitioner elaborates on how her insight into the patient's situation, and how she relates to him in this situation, became decisive in his getting the medical help that neither of them knew that he needed. The practitioner points to the absence of complaints and criticism, and how this might contribute to her curiosity and interest in helping patients. This helped her connect the dots between his symptoms and blood samples. Together, they discovered that he needs medical treatment, and she made it easy for him to get a prescription for antibiotics.

Across dyads, the practitioners described the clinical encounters as easier when patients demonstrated ownership to their process and showed extra effort, such as establishing regular exercise with a friend, engaging with a personal trainer, becoming member of a gym, or starting a new sport. In these cases, the practitioners did not express being alarmed by some weight fluctuation. Patients expressed that maintaining weight, being positive about lifestyle changes and being responsible made the visits at the obesity clinic easier.

Down the Blind Alley – Giving Up on Each Other

Guideline-based follow-up after surgery did not fully work out in every clinical encounter and sometimes this limited the encounter's benefit to both parties, leaving them frustrated and less willing to meet again. One patient had tried to stop further weight gain together with the practitioner. He knew from experience what could help him turn the situation around, but the practitioner was hesitant, bypassed his specific question and suggested other strategies. He said:

> They are picking on me. They want me to do better. No one else takes you in the ear and tries to drag you in the right direction, I understand that it is for my best. They are there to help. But there is this feeling that I should have been better. I feel a little ashamed of myself. It is some of this every time.

The practitioner commented the situation like this: "He seems less motivated, and he likes to be pushed and supported but is perhaps not that good at taking initiative and doing it himself."

Below, we describe in depth how one patient and practitioner experienced parts of a consultation that had become difficult and exhausting. Before the annual visit at the outpatient clinic, one patient came prepared to address certain issues regarding follow-up, with which

she was not satisfied. With several other illnesses and long-term pharmacological treatment, she was particularly interested in the results of her blood samples. The practitioner who reviewed them the previous year had not been a medical doctor, which worried her. This time, she had not been referred to take new blood samples and expressed frustration: “I find it extremely peculiar; I even rang them up about it. And then she (practitioner) says that my GP was supposed to do it, but he does not know that much about this!” The practitioner was new to this patient and did things differently from what she had expected. This seemed to fuel dissatisfaction:

> I sat there, not knowing whether I was going on the scales or not, because we usually do that first. When we passed the room with the scales, I thought: damn it, are we not going to do that either? I felt slightly annoyed (short pause). And I did not quite understand where they could go from (without blood samples). Then they only have what I say, they do not have control on anything, I think.

The practitioner had come from a state of being open and curious and was caught a little off guard: “At first, I got a different impression, she was this great woman.” When the patient who had lost weight successfully introduced herself by conveying disapproval, dissatisfaction and criticising the obesity clinic, the practitioner reacted immediately. She observed this on the film and commented: “I notice that she makes me feel slightly insecure (..) I can feel it, that she, she has expectations that have not been fulfilled.” The practitioner described that she felt accused of not knowing and doing her job appropriately. This invoked discomfort and momentary uncertainty about how to act. The critical attitude was hard to take from someone she had just met for the first time.

In response to the challenging opening, the practitioner tried to find out if the clinic had made any mistakes. As she could not see any medical issues requiring more or different care, she quickly decided that the criticism was not appropriate, and that she would not take it. The practitioner explained that some patients tend to express themselves like this woman did. In her reflections, she connected the dots between how this patient approached the clinic, her previous medical record of illness, longstanding pain, and current life circumstances: "She is this typical woman pondering a lot, thinking a lot. Very aware of her body and a lot of ideas on how things should or should not be done."

The practitioner interpreted this patient's actions as a way of being, an attitude or behaviour, rather than expressions of illness or suffering that could be cared for medically. She reflected on how encountering the patient this way affected her as a practitioner and their interaction:

> It is difficult to feel it (empathy) for her. She is too much, in a way. Yes. Now, I feel guilty for sitting here and saying this about her. Her strategy is perhaps (stop). It is something about how she relates to the world and her own body. I just accomplish, close, and move on.

This recognizing and categorizing the patient shaped the practitioner's actions, particularly in that she did not go beyond the minimum of what was necessary and expected at the obesity clinic. She did not open for a conversation about needs, alternative or additional health care that could help the patient to feel better after bariatric surgery. She made no effort to please. In this case, the practitioner had closed this encounter before the patient left.

The patient commented that her main concern had been communicating her thoughts and opinions on follow-up and whether this came through to the practitioner. When watching

the recording, she expressed resignation and described what went through her during the encounter:

> I sit there, thinking: No. No, huff (sighs). There is no point in telling her this. Because this is what you have learned for years and, no one does anything. You must do the work yourself, and you just get what you already know: You must continue to exercise, and... I have been here so many times, I cannot take it any longer. I just cannot be bothered. This is not useful for me. Why should I be bothered to continue coming here? This is what I am thinking while sitting there.

This patient longed for something or someone who could help her towards a better life. Instead, she had expressed frustration, had been critical, and had raised many issues, including some that perhaps were not within the scope of what the obesity clinic could help her with. She expressed exhaustion and that frustration constrained rather than facilitated her possibilities of getting what she sought. Although she had lost weight successfully, she constantly had to fight an urge to eat for comfort. She was ashamed and did not bring it up at the clinic. For her, it was easier to talk about lacking care, longstanding and widespread pain and family issues. She described missing working life, lack of financial resources and loneliness and expressed sadness and frustration after the encounter. Despite successful weight loss, she somehow communicated failure, and blamed both herself and the clinic that she could not get the support she needed.

According to the practitioners, the clinical encounters/sequences they perceived as difficult or less engaging had to do with the patients, their approach to their own health challenges and their verbal style. Typically expressing helplessness, complaining about a multitude of problems, asking for more than was offered and/or criticising others would be

perceived as difficult. A patient not communicating their own difficulties clearly, not saying much at all, or trying to reach out to the practitioner in other ways, for example through gifts, also seemed to threaten the interaction. Both patients and practitioners faced a situation of not encountering each other, that the consultation lost its meaning. They described such sequences or encounters as immensely draining and had been eager to get out of them as soon as possible, even if this meant that neither of them got anything out of it.

Opposite Poles – Towards and Away from Each Other

Postsurgical weight loss and health gain meant, required, and yielded radically different engagement from patients and practitioners. How patients felt about themselves, their relationships, and lives and how they kept themselves going through the bariatric surgery process were mostly approached as potential risks for weight regain. Beyond motivation, the practitioners expressed that the patients' emotional work was outside the obesity clinic's domain. When patients voiced struggle and despair related to their own weight, regain or exhaustion from keeping weight off, the practitioners responded with encouragement, smiling and belief in that the patient could turn the situation with additional follow-up. In this response, emotional struggles were toned down, bypassed or reframed into a departure point for action. This means that patients and practitioners encountered weight issues in an atmosphere of dissonance between being proactive and being reluctant, initiative and passivity, one leaning towards and one leaning away.

One patient described how shyness made him listen carefully to the practitioner and reluctant to talk about his life, what matters to him and his struggles with health and weight. He described leaning away like this: "I am not that good at opening up about myself, it is difficult. She would have had to ask me." Practitioners described leaning away when they did not engage emotionally in the situation:

> I do not remember her. I do not have a relationship to this patient. … I am not worried at all. I hear what she says about fatigue [treated elsewhere] and such things, but [stops]… This is a consultation that did not Particularly engage me. Here, I was not moved. It is fun and we laugh a little and such things, but I am not personally touched.

In the following, we describe how one patient and one practitioner experienced the dynamics of leaning towards and away from each other. The patient expressed that he knew the practitioner well and liked her, but he seemed to keep her at arm's length, adding distance to the encounter. He expressed that he did not want anything from her: "so, this is more like a repetition, and that she is trying to follow up." The practitioner took him through a list of topics, checked off and confirmed his responses. He described that it meant a lot for him that she approved of him and his process: "She put a stamp on it." This was important because it marked and underscored how good his life is now compared to before, when he was bullied and avoided other people: "I used to be a lone wolf." His life had dramatically improved. He explained that he did not want to bother himself or his helpers with minor things that could have been better. He was reluctant to show himself and his needs.

Using the clinical encounter to get positive feedback and reassurance was deeply valuable to him. He took initiative to "come clean" in talking about weight fluctuations related to holidays. A lot was at stake for him, he had to continue this good trajectory: "I am terrified of going back to how I was."

The practitioner perceived his reluctance and expressed that it made her a little uncertain about how to move towards him: "It is alright to see him again, things go well, and at least he follows our advice, but what are we going to talk about?" Even if she knew him well, she was slightly stressed, and described using her experience to concentrate on the patient rather than her performance as a clinician:

> Looking at him, eye contact, right. Show him that I am really interested. This is what it is about right, getting that relation. That I do not sit there on my computer … because when he is here, I must focus on him. Then I can capture more, right? It is important to calm down, get the eye contact like that. And then he looks at me and I look at him. And I feel that it runs smoother after that.

She tried to build relationship and trust, showed him that he had her full attention and that she cared about him. As the patient did not talk much, she tried to grasp what the patient did not say. For example, she had wondered if he was sitting there thinking about something else that bothered him, without saying anything.

The patient reported that everything worked out with his diet, but the practitioner kept asking him about issues that most patients find problematic, such as craving for sweets, soda, and alcohol and eating larger amounts of food. She wanted to normalise the sharing of setbacks in addition to successes, but she did not get any response:

> This conversation is about uncovering challenges that the questionnaire cannot capture. Really finding out how he is, not just blood pressure and weight… So, I think most of this conversation is about (getting to what might be difficult). I must say that if things have just been… Everything is good. Food is fine, and this and that. Everything is superb. Then you start thinking. Hm. It rarely is that smooth, right? After all it is a huge life change… I want to be a good helper.

She was concrete when bringing up typical issues and the patient accepted her probing questions into this, as food and eating was a sensitive issue, even if he was doing well after surgery. However, the questions affected him. Guilt related to weight and eating seemed to require immediate processing. Food seemed synonymous to guilt, and this guilt seemed to sit

in him, ready to pop up when being asked about what and how much he usually ate right after being weighed at the obesity clinic.

All patients described having their own ways of avoiding criticism or experiences that made them feel guilt and shame. They expected to be asked about potential problems, such as cravings, snacking and alcohol, and preferred being asked about these directly. According to the patients, a sense of guilt and shame related to weight and eating was always already there. This seemed a gulf between patients and practitioners and a barrier against building trust and relationship. No matter who the practitioner was or whether they knew each other, for patients, there was a high risk of experiencing guilt and shame at the obesity clinic. Avoiding situations that spiked negative emotions and "keeping it light" seemed a strategy for patients and practitioners. Moreover, they preferred to emphasise physical activity and healthy choices or talk about other issues, for example related to work or close family members' weight and health. Patients and practitioners tended to concentrate on positive aspects and downplay difficulties.

The practitioners were aware of shame and guilt related to weight. They tried to avoid doing something that could trigger this by keeping the consultation practical and distant, asking questions, providing answers and advice. By focusing on actions and solutions relating to food, eating and weight, they attempted to support patients' avoidance of difficult emotions like guilt and shame. Patients and practitioners seemed to tacitly agree that the obesity clinic was not the place for bringing up or handling difficult emotions related to post surgery life, body weight and diet. The medically informed, educative, and lifestyle-oriented structure of the clinic seemed to narrow the scope of which issues and questions patients and practitioners perceived natural to raise after bariatric surgery.

DISCUSSION

In the findings of the current study, we presented three core dynamics of the post bariatric surgery consultation a) Playing by the Book– Making it Easier for Each Other, b) Down the Blind Alley – Giving up on Each Other, and c) Opposite Poles – Towards and Away from Each Other. The main task of the clinical encounters was described as monitoring postsurgical health and weight, supporting weight loss maintenance and self-management. The practitioner guided the consultation by questioning and encouraging responses, mainly structured by a questionnaire. In this, re-visiting familiar issues and repeating information drove the interaction between patient and practitioner. The practitioner's listening and recognition was deeply important for the patient's experience of being helped. For patients, expressing and concretizing their efforts to take responsibility for own health seemed a strategy to supress shame and culpability related to one's own body, particularly related to one's weight and eating practices. This indicates that shame connected to one's weight may be more permanent regardless of changing weight status following surgery and can be understood as *chronic body shame* [34]. Phenomenologist Dolezal defines this variant of shame as feelings that come repetitively into one's awareness and form a backdrop of recurrent pain and self-consciousness that becomes more acute in moments of exposure, and always links to appearance, body functions and bodily control [34]. Hence, clinical encounters hold potential both to induce and alleviate shame.

In the current study, a light atmosphere, smiling, being in a good mood, sustaining weight loss and a restrictive diet, and being physically active all seemed to strengthen the patient-HCP relationship. Although stress, criticism, emotional struggles, and bodily illness were expected and unavoidable aspects of the post-surgery weight loss process, such expressions seemed to adversely affect the interaction. Responses could be withdrawal, expressions of doubt regarding the patient's adherence to the treatment or the practitioner's

competence. Rather than engaging with and exploring issues perceived as difficult, they were often reframed into a point of action for self-management, a referral for lifestyle intervention or for pharmaceutical treatment.

The findings presented resonate with results of an ethnographic study on patient-practitioner interactions at the obesity clinic when assessing and prioritising patients for bariatric surgery [35]. Results describe how self-responsibility and culpability seem to exist within pre-determined narratives, such as repeated failures to achieve sustained weight loss. Practitioners were conflicted by their responsibility to ration scarce health care resources versus relating to the individual patient's needs. Making self-responsibility for health and weight key topic of the consultation was one way to navigate this tension [35]. Although being responsible for oneself and one's health is foundational for human life, stressing this in specialized health care may evoke dissonance and stress the patient-provider relationship (Owen Smith 2017). One recent study reported that not only HCPs but also most patients with obesity (82%) perceived that weight loss is their own responsibility [36]. Hence, it seems likely that both patients and HCPs easily perceive weight gain/ insufficient weight loss as personal failing and therefore risk to reproduce weight stigma and stereotypical beliefs within the clinical encounter.

Our findings indicate that the repetitive mode of the post-surgery consultation served to reconfirm responsibility for health and self-care but did not facilitate reflective dialogues about clinically meaningful issues. The encounters were advisory on eating practices, physical activity, weight regain, side-effects and excess skin. While providing structure, predictability, and efficiency, drawing on a questionnaire seemed to restrict the interactional space between patient and practitioner. Tensions or divergence in perceptions between them, discomfort and weight related shame and guilt largely remained unaddressed or passed by. The reporting-approach seemed to exclude a more explorative one, such as facilitating patient's stories of

being in and sustaining change *at present*, and their thoughts about the future. Our findings indicated that from their distinct perspectives, patients and practitioners expressed resignation and lack of engagement regarding the clinical encounters 2-3 years post-surgery.

Despite rigorous documentation of bariatric surgery as a profound and lifechanging experience, according to our findings, the psychosocial burdens of living with obesity and its aftermath were not invited into the clinical encounters. This was surprising, given that surgery is not expected to remove all excess weight and patients must manage their own weight, which they never have before, which is likely to set patients and their weight under pressure. In bypassing psychosocial aspects of bariatric surgery, important opportunities for providing/getting support are lost, and the clinical encounter instead is used for repetition, registration, control, and advice. In a recent and comprehensive systematic review, Zulman and colleagues [37] identified five practices to promote presence and meaningful connection with patients in the clinical encounter:

> (1) prepare with intention, (take a moment to prepare and focus before greeting the patient); (2) listen intently and completely (sit down, lean forward, avoid interruptions); (3) agree on what matters most (find out what the patient cares about and incorporate these priorities into the agenda); (4) connect with the patient's story (consider life circumstances, that influence the patient's health; acknowledge positive efforts; celebrate successes); and (5) explore emotional cues (notice, name, and validate the patient's emotions) [37].

Our findings indicate that emphasise on interpersonal interactions, understanding and connection with patients is necessary to strengthen the engagement and outcomes of the post-surgery clinical encounter. In the context of bariatric aftercare, the challenge to "explore

emotional cues" seems particularly potent to engage the patient and practitioner and facilitate meaningful interaction. Difficult emotions related to body, food and eating are to be expected when undergoing bariatric surgery, but currently encounters orient to behaviours and not to explicitly "notice, name and validate" emotions. Moreover, our findings suggest that in addition to being able to validate emotions, HCPs can benefit from a deeper understanding of how shame can manifest in interaction, to guide them in the dynamic dance where both parties also need to protect their vulnerabilities. Our findings indicate that the patient who struggles to communicate and relate to the HCP under stress may lose this opportunity for necessary help and support and risk leaving the clinic with sense failure, shame, potential loss of motivation and unresolved health issues. Moreover, the HPCs seem to share the sense of failure, and to some extent question the meaning of bariatric aftercare and expressing their situation as overwhelming because of restricted resources.

Adopting a more complex practice of exploring emotional cues may even require some extra resources/time for professional development, but the beneficial association between emotional awareness and clinical outcomes may justify some additional time [37]. Such development would be in line with recent clinical guidelines for psychological support pre- and post-bariatric surgery, suggesting to include psychology in all services using a stepped care model [38]. Making interpersonal connection and interaction the centre of bariatric aftercare may add meaningfully to current medically informed and guideline-driven practice.

Obesity is defined as a *chronic* illness, but what this implies for bariatric care is unclear. In a systematic review, Boehmer and colleagues [39] highlight that the patient with chronic illness must be able to mobilise resources to both use health care and enact self-care. The study describes patient capacity as a complex eternal process driven by interaction and the cognitive, emotional, and experiential work involved when using health care and

performing self-care tasks. This work is often invisible and central to living with chronic illness, adding to the ongoing rewriting of one's own biography, mobilising of resources, and engaging with social environments [39]. Hence, exploring what support patients need in the clinical encounter and helping them build and maintain capacity to navigate postsurgical life and health may be the first step towards facilitating the human connection that is central to clinical care.

Strengths and Limitations

There are several problems with this study that need to be considered. First, due to ethical considerations of using dyadic data and the need to maintain participant anonymity, we were unable to link quotes to individual participant demographics. This limits our ability to draw inferences between what people say their context and background which does limit the impact of our findings to the wider population. Second, the interviewers did not have the opportunity to review the recorded consultations before they simultaneously and separately conducted the IPR interviews. This means that vital moments had to be identified and not just explored in the interview situation, and while the participants were already familiar with the content of the recorded consultation, the interviewers' preparations relied on re-reading pre-interviews and interview guides. In this, this research design held potential to somewhat diminish the asymmetries between interviewer/researcher and interviewee, which is a strength. As the IPR interviews required attentive presence and reflection in action on both parts, they were exhausting, and as this may have affected the data negatively, for example in that vital moments or points were passed by. As a guideline for analysing IPR interviews dyadically seems to be lacking, we adopted a recognised approach to phenomenological health research (RLR). Hence, explaining and discussing our analysis with sufficient detail and clarity within the scope of this empirical article was difficult and can be considered a limitation. However, the combination of pre-interviews, video recorded consultations and IPR-interviews yielded

varied, vivid data materials and insights that qualitative interviews or video recordings alone could not have produced.

Concluding remarks

In interviewing patients and HCPs about their recent and videorecorded interactions, the present study sought insight into intersubjective processes in bariatric aftercare, from two distinct yet complimentary perspectives. This in-depth and dyadic approach adds a new perspective on bariatric aftercare, pointing to a key role for the patient-practitioner relationship and interaction. The results indicate that whilst human connection between patient and practitioner is central to clinical care, it can be undermined by shifts towards and away from each other as both parties avoid creating conflict. This in turn seemed to facilitate exchange of information, rather than fostering patient-HCP relationship and spontaneous interaction, and limited benefit to both parties leaving them frustrated and less willing to either meet again or take any gains into their future lives. The post-surgery consultations can therefore be largely conceptualised as practitioner-led and medically oriented interactions which downplay psychosocial aspects and indicate untapped potential and lost opportunities in bariatric aftercare.

Author contributions

EN conceived the study and led the data collection, analyses and writing of the manuscript. EN and KOL collected the data. EN, KOL, JO and CM participated in the interpretations of findings. All authors read and approved of the final manuscript.

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