Understanding the Morbidly Obese Patient

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11.1 Introduction

In the early days of Bariatric Surgery, and to some extent even today, surgeons were often criticized for attempting to treat a psychological disorder with a surgical procedure. Unattractive, lazy, overindulgent, and lacking motivation or willpower—that is how many view obese patients. Their slow movements, avoidance of physical activity and social situations, and consumption of large portions of food fuel this perception. The 2013 decision by the American Medical Association to declare obesity a disease has helped somewhat to change the attitudes of physicians and the public, but the fact remains that those suffering from obesity and morbid obesity continue to be subject to ridicule, prejudice, and discrimination. Understanding the emotional and psychological profile of the bariatric patient will help the bariatric surgeon provide more complete and compassionate care for his or her patients. In this chapter, we will explore some of the psychological and sociological aspects of the morbidly obese patient and the effect that the MGB-OAGB has on this patient population's human experience.

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11.2 Early Childhood to Adolescence

From a very young age, obese individuals are subject to negative judgment and stigmatization in both the home and school environment [1]. Mistreatment typically begins in early childhood and continues throughout adolescence and increases with increasing body mass index [2, 3]. Frequently, this mistreatment can lead to an increase in disordered eating behaviors [4]. By the time these youths reach high school, their reputation as lazy and self-indulgent has become well-established and results in lower college acceptances and less financial support from families compared to normal weight students [5].

11.3 A Lifetime of Social Stigma

By the time bariatric patients present to their surgeon, they have been the object of a lifetime of social stigma. Life experiences vary from patient to patient, but the clear majority, especially among female patients, will report experiencing one or more of the following: discrimination in the workplace, body image dissatisfaction, poor interpersonal relationships, social isolation, and overall poor quality of life [6]. Simple tasks of daily living that most people take for granted, like putting on shoes and socks, crossing legs, fitting into a restaurant booth or theater seat, walking down stairs or even wiping one's self are major obstacles for the morbidly obese [7].

11.4 Medical Bias

The medical profession is not exempt from stigmatizing the obese. Obese patients frequently report feeling judged or mistreated by their primary care or attending physician because of their weight, which may actually lead to avoidance of care, mistrust of doctors, and poor adherence among patients with obesity [1, 8]. Some of this behavior arises from the false notion that shaming patients for their current condition will somehow motivate them to lose weight. This approach, however, clearly lacks any evidence of its effectiveness. As Puhl and Heuer point out in their report on obesity stigma: "…if weight stigma promoted healthier lifestyle behaviors and weight loss, then the documentation of increased weight stigmatization over the past several decades should be accompanied by a reduction in obesity rates, rather than the alarming increase" [9].

Despite the growing popularity of Bariatric Surgery, it is not uncommon to encounter patients who are having a difficult time getting the support of their primary-care physicians. Again, they focus on the patient's behavior, emphasizing more exercise and a healthier diet as the proper approach to weight loss. Although a healthy diet and exercise regimen are certainly good for one's health, even under the best of circumstances, overweight and obese individuals can expect to lose only 5–10% of their total weight, and most will gain some or all of it back over 5 years [9, 10].

Physicians are not the only ones that patients must deal with when pursuing Bariatric Surgery. Many insurance companies exclude weight loss surgery from their covered services, labeling it as cosmetic surgery or giving no explanation at all. Others will require patients to jump through multiple hoops, including 6 months of supervised weight loss by a physician, dietary consultations, psychological consultations, and a host of other requirements that often delay or prevent patients from receiving the definitive, lifesaving care that they seek. This has been particularly true for the MGB, which is frequently excluded from many insurance plans even though they cover other types of weight loss surgeries.

11.5 Psychological Characteristics

Compared to individuals in the general population, patients presenting for bariatric surgery tend to have a higher incidence of anxiety, depression, stress, food craving, and symptoms of eating disorders. They also have lower self-esteem and a lower quality of life, which appears to correlate with increasing BMI [11, 12]. As BMI increases, the incidence of co-morbidities increases, which may offer an additional explanation for the higher levels of depression and anxiety, since the co-morbidities themselves, may be associated with increased psychopathology [13, 14]. One must be cautious, however, about assuming that all obese and morbidly obese patients have a single psychological profile. The reality is, despite this lifetime of discrimination and prejudice, many patients live psychologically healthy and relatively stable lives [15].

11.6 The Surgeon's Role

It is important for the surgeon to recognize his/her role, not only as surgeon, but as patient advocate. From the patient's perspective, they have finally encountered a healthcare provider who understands that their struggles have been physiological more than psychological, and that the solution is metabolic and is accomplished through surgical intervention. Psychological support and positive reinforcement certainly do play a role, but the reality is that successful weight loss comes with a successful and properly selected operation. Besides the metabolic and physiological effects of the MGB and OAGB, these procedures also provide surgical behavior modification. It is essential to provide proper education to the patient pre-operatively regarding potential complications and side-effects of the surgery, such as marginal ulcer, vitamin and mineral deficiencies, bacterial overgrowth, and dumping syndrome. It is also essential that surgeons make sure that patients have counseling regarding the necessary changes in diet and lifestyle and also have long-term follow-up, both for data collection and for ongoing positive reinforcement to improve patient compliance.

11.7 The Psychiatrist's/Psychologist's Role

There is debate among bariatric surgeons whether a formal psychological work-up should be required to determine the candidacy of a patient for surgery. Although more than 80% of bariatric programs require pre-operative mental health evaluations, there is little consensus as to how results should be used in the context of surgical care [12]. Whether you agree or disagree with the need for a psychological evaluation, there is no question that in addition to a caring and compassionate office staff, the involvement of a qualified health-care professional to assist your patient with pre- and post-operative experiences is beneficial. The mental health care provider should be there for reassurance and reinforcement of the significant changes occurring in the patient's life after surgery. In addition, since pre-operative patients often experience depression, anxiety and other psychological issues associated with obesity and morbid obesity and the co-morbidities that accompany these conditions, the mental health care provider serves as a valuable member of the bariatric team to address these issues as well.

11.8 Life After Surgery

Few things in life are more satisfying to the professional life of a bariatric surgeon than to watch his patients grow and flourish in health and personality after a successful bariatric operation. Stories abound of the patients who go from couch potato to exercise enthusiast, or those who spent much of their life on the side-lines watching life go by and now are actively engaged in their work and family life. Promotions at work, new relationships, and new adventures are the stories eagerly told. Patients report significant improvement in their quality of life after MGB-AOGB surgery [16, 17]. There is still a need, however, to be vigilant about the doubts and insecurities common among individuals in this patient population. Weight loss plateaus, episodes of dumping, hair loss, sex and fertility, and changes in personality that can lead to stress in marriage are all very real mental-health problems that patients must deal with despite their improved physical health. The Bariatric Team must keep these very human elements in mind as they continue to care for their patients post-operatively.

Conclusion

Obese patients present with a lifetime of ridicule, prejudice, and discrimination. They have a higher incidence of depression and anxiety than individuals from the general population. As surgeons, we should strive to connect with these individuals on a human level and to provide the resources necessary for them to cope with the many life-changing events that occur because of surgery. Careful attention and sensitivity to the psychological needs of the bariatric patient are facilitated by having a caring and compassionate office staff and the inclusion of a qualified mental health care provider who is involved in both pre-op and post-op care. Providing long-term follow-up is a challenge, but should be emphasized to maximize patient compliance and to be able to report meaningful patient outcome data.

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