

Allied Health Concept

Empowerment and Self-Management after Weight Loss Surgery

Martha M. Funnell, MS, RN¹; Robert M. Anderson, EdD²; Jessie H. Ahroni, PhD, ARNP³

¹Director of Administration, Clinical Nurse Specialist, Michigan Diabetes Research and Training Center, Division of Endocrinology and Metabolism, Department of Internal Medicine, Ann Arbor, MI; ²Professor of Medical Education, Department of Medical Education, University of Michigan, Ann Arbor, MI; ³Family Nurse Practitioner, Bariatric Program Coordinator, Northwest Weight Loss Surgery, Kirkland, WA, and Clinical Assistant Professor, Department of Biobehavioral Nursing and Health Systems, School of Nursing, University of Washington, Seattle, WA, USA

The bariatric surgery health-care professional team are often frustrated and discouraged when patients are unwilling or unable to follow their advice to achieve ideal outcomes after obesity surgery. The acute care model that suffices for other types of surgery is inadequate after a surgery that requires chronic life-long behavioral changes. Practical interventions that facilitate collaborative relationships and foster patient-centered practices are the key to giving up feeling responsible for the choices that patients make, by being responsible to them, and achieving better outcomes.

Key words: Morbid obesity, bariatric surgery, psychological support, compliance, empowerment

Introduction

In spite of the great strides that have been made in the surgical treatment of morbid obesity in recent years, many patients do not achieve optimal outcomes and experience complications that result in a decreased length and quality of life. Providers often struggle to give the recommended level of postoper-

ative care within the constraints of a busy office setting. The health-care system and many surgical practices are designed to deliver acute, symptom-driven care, and thus are poorly configured to effectively treat chronic diseases (such as obesity) that require the development of a collaborative daily self-management plan. Providers also struggle with the realities of dealing with a chronic disease for which daily care is in the hands of the patient. In spite of attempts to encourage, cajole, and persuade patients to perform self-care tasks, the bariatric health-care team are often frustrated and discouraged when patients are unwilling to follow advice to achieve the desired outcomes.

Traditionally, the success of patients to manage their postoperative care has been judged by their ability to adhere to a prescribed therapeutic regimen. Considerable effort has been spent in developing methods for measuring compliance and techniques and strategies to promote adherence. Unfortunately, this approach does not match the reality of postoperative weight loss surgery care. The serious and chronic nature of obesity, the complexity of its management, and the multiple daily self-care decisions required have shown that being adherent to a predetermined care program may not be adequate over the course of a patient's life.

Reprint requests to: Jessie H. Ahroni, PhD, ARNP, Northwest Weight Loss Surgery, 12333 N.E. 130th Lane, Suite 415, Kirkland, WA 98034, USA. Fax 425-899-4610; e-mail: Jessie@NWWLS.com

This is particularly true when the self-management plan has been designed to fit the patient's surgery, but has not been tailored to fit the patient's priorities, goals, resources, culture, and lifestyle. To manage bariatric surgery successfully, patients must be able to set goals and make frequent daily decisions that are both effective and fit their values and lifestyles, while taking into account multiple physiological and personal psychosocial factors. Intervention strategies that enable patients to make decisions about goals, therapeutic options, and self-care behaviors and to assume responsibility for daily care can be effective in helping patients care for themselves.

Models of Care and Education

In the past, most health professional training was based on a medical-surgical model designed to treat acute health-care problems. In this model, the health professional was the authority responsible for the diagnosis, treatment, and outcomes that patients experienced. Patient education was generally prescriptive (e.g., "do as I say"), and health professionals set therapeutic goals. This model promotes the concept that health professionals know best. This approach was based on the belief that after bariatric surgery patients have an obligation to follow the directions of their surgeon and that the benefits of compliance outweigh the impact of these recommendations on patients' quality of life. Education was designed to promote compliance using motivational and behavioral strategies in an effort to get patients to change.

As the literature on noncompliance indicates, these models have not been effective. Some studies report 36% noncompliance to postoperative treatment regimes.¹ A new approach is needed that recognizes that patients are in control of and responsible for their daily self-management after bariatric surgery and that, to succeed, a self management plan has to fit patients' goals, priorities, and lifestyle as well as facilitate their weight loss.

This approach is based on three fundamental aspects of chronic illness care: *choices*, *control*, and *consequences*.² The *choices* that patients make each day, have a greater impact on their outcomes than those made by health professionals. Once patients

leave the clinics, they are in *control* of which recommendations they implement or ignore. Because the *consequences* for these decisions accrue directly to patients, the patients have the right and the responsibility to manage their weight loss course in the way that is best suited to the context and culture of their lives.

Empowerment is a patient-centered collaborative approach tailored to match the fundamental realities of postoperative care. Patient empowerment is defined as helping patients discover and develop the inherent capacity to be responsible for one's own life.³ This concept was initially proposed in diabetes care,⁴ and there has been a growing recognition that, although health professionals are experts on health care, patients are the experts on their own lives. This approach recognizes that knowing about an illness or operation is not the same as knowing about a person's life and that, by default, patients are the primary decision-makers in the daily self-management of their health.

Embracing this philosophy requires that health-care professionals practice in ways that are consistent with this approach.⁵ Empowerment is not a technique or strategy, but rather a vision that guides each encounter with patients and requires that both professionals and patients adopt new roles. The role of patients is to be well-informed active partners or collaborators in their own care. The role of health professionals is to help patients make informed decisions to achieve their goals and overcome barriers through education, appropriate care recommendations, expert advice, and support. Professionals need to give up feeling responsible *for* their patients and become responsible *to* them.

Health care then becomes collaboration between equals; professionals bring knowledge and expertise about obesity and its treatment, and patients bring expertise on their lives and what will work for them. To effectively implement this approach, patients need education designed to promote informed decision-making, and providers need to practice in ways that support patient efforts to become effective self-managers. Kinzl et al⁶ showed that psychosocial support is necessary for many patients to adapt to the new postoperative demands and deal with psychological, social and environmental problems.

Self-Management Education and Support for Patient Empowerment

Self-management education is the essential foundation for the empowerment approach and is necessary for patients to effectively manage their postoperative care. The purpose of patient education within the empowerment philosophy is to help patients make decisions about their care and obtain clarity about their goals, values, and motivations. Patients need to learn about their surgery and how to safely care for themselves on a daily basis. Patients must be aware of the consequences of the surgery to avoid unrealistic expectations.⁷ They also need information about various treatment options, the benefits and costs of each of these strategies, how to make changes in their behaviors, and how to solve problems. In addition, patients need to understand their role as a decision-maker and how to assume responsibility for their care.

Approaches to education within the empowerment philosophy incorporate interactive teaching strategies designed to involve patients in problem-solving and address their cultural and psychosocial needs. Using patient experiences as the curriculum helps to individualize group educational programs and ensure that the content provided is relevant for the needs of the group. Attendance and participation in bariatric support groups can make after-care easier and more efficient for both patients and surgeons.⁸⁻¹⁰

Behavioral experiments offer opportunities for patient involvement and help teach the behavior-change skills needed for ongoing self-management. As an example, during our support group meetings, content is presented in response to issues and questions raised by participants. At the end of each session, patients are encouraged to choose a short-term goal as a behavioral experiment for the month. Each subsequent support group begins with a group discussion of the results of these experiments. These experiences and other problems and questions raised by the group are then used as the curriculum to discuss self-management, psychosocial issues, coping, and other concerns.

A one-time educational program is rarely effective to sustain the types of behavioral change needed for months or years of weight loss and a lifetime of postoperative self-care. Patients need ongoing self-

management support from their providers and the entire health-care team to maintain gains achieved through education.

Part of this ongoing care and educational process includes setting goals with patients. Goal setting is an effective strategy; patients who participate in the selection of goals and have clarity about them are more likely to be successful in achieving their goals.

Goal setting within the empowerment approach is a five-step process that provides patients with the information and clarity that they need to develop and reach their lifestyle related goals. The first two steps are to define the problem and to ascertain patients' beliefs, thoughts and feelings that may support or hinder their efforts. The third step is to identify long-term goals towards which patients will work. Then, in the fourth step, patients commit to making behavioral changes that will help them to achieve their long-term goals. The final step is for patients to evaluate their efforts and identify what they learned in the process.

Helping patients view this process as behavioral experiments eliminates the concepts of success and failure. Instead, all efforts are opportunities to learn more about the true nature of the problem, related feelings, barriers, and effective strategies. The role of the provider is to provide information, collaborate during the goal-setting process, and offer support for patients' efforts. A behavior-change protocol is given in Table 1.

Practice Design for Empowerment and Self-Management

Providers can also design their interactions with patients to better support self-management efforts. A first step for providers and their team is to define their shared vision of postoperative care and education. We express our vision in each encounter with patients and in the relationships that we create with them.

For example, we often start out an interaction with a new postoperative patient by saying, "I understand that living with weight loss surgery can be difficult. You have many decisions to make each day that will have a large impact on your weight loss, future health and well-being. We are here to help you. We know a great deal about weight loss surgery and

Table 1. Behavior change protocol**Step 1: Explore the Problem or Issue (Past)**

- What is the hardest thing about losing weight?
- Please tell me more about that.
- Are there some specific examples you can give?

Step 2: Clarify Feelings and Meaning (Present)

- What are your thoughts about this?
- Are you feeling (insert feeling) because (insert meaning)?

Step 3: Develop a Plan (Future)

- What do you want?
- How would this situation have to change for you to feel better about it?
- Where would you like to be regarding this situation in (specific time e.g., 1 month, 3 months, 1 year)?
- What are your options?
- What are barriers for you?
- Who could help you?
- What are the costs and benefits for each of your choices?
- What would happen if you do not do anything about it?
- How important is it, on a scale of 1 to 10, for you to do something about this?
- Let's develop a plan.

Step 4: Commit to Action (Future)

- Are you willing to do what you need to do to solve this problem?
- What are some steps you could take?
- What are you going to do?
- When are you going to do it?
- How will you know if you have succeeded?
- What is one thing that you will do when you leave here today?

Step 5: Experience and Evaluate the Plan (Future)

- How did it go?
- What did you learn?
- What barriers did you encounter?
- What, if anything, would you do differently next time?
- What will you do when you leave here today?

how to care for it. But you know yourself better than anyone; you know what you want and what you are able and willing to do to help you lose weight. By combining what you know about yourself with what we know about weight loss surgery, we can come up with a plan that will work. If it doesn't work, it does not mean that you are not doing the best that you can or that we are not doing all that we can. It simply means that we need to keep trying until we figure out a plan that will work for you. We are partners and we need to work together."

Reflecting on what we believe our role to be, what we have the right to expect of our patients, and what our patients have the right to expect of us, helps to clarify our vision and can then be used to guide practice redesign.

In the empowerment approach, there are both strategies that can be used by providers and strategies that can be implemented within a practice to promote patient empowerment.^{11,12} First and foremost, we need to listen to our patients and ask what they need to obtain from their interactions with us to better manage their weight loss journey. Patients have many issues about living with bariatric surgery that are rarely addressed by their providers. Even patients who are achieving desired results and other positive outcomes might struggle with the demands of changing their behaviors, eating differently, and the uncertainty that weight loss surgery adds to their lives. In addition, providers can become more patient-centered and collaborative and thereby improve patient outcomes and satisfaction with their care.

We can also show that we care about our patients as individuals first and about their weight loss second. Rather than beginning the visit with a review of the patients' diet, exercise and weights, we can ask how they are feeling (psychologically as well as physically) and how they believe that they are doing in reaching their self-selected goals and caring for themselves. This not only acknowledges their expertise, but also conveys that they are viewed as more than just a number on the scale.

As providers, we also need to spend more time listening and less time offering advice. Asking questions and using active listening techniques can help patients reflect on issues or problems and lead to identification of effective strategies to which patients are willing to commit.

In addition, during patient visits, providers can:

- Stress the importance of patients' role in self-management and daily decision-making. Describe our role as coach or partner in the care process. Acknowledge the patients' rights and responsibility to make self-care choices and to be the primary decision-makers.
- Offer referrals to a patient education program, a registered dietitian, an exercise physiologist or psychological support.
- Begin each visit with an assessment of patients' concerns, questions, and progress towards weight

loss and behavioral goals. Some providers ask patients to complete a short, open-ended one- to three-question form to ascertain any questions or concerns that they would like addressed during the visit.

- Listen to patient-identified fears and concerns.
- Ascertain patients' opinions about weight loss results and other outcome measures.
- Review and revise care-plans as needed, based on patients' and providers' assessment of their effectiveness.
- Provide ongoing information about the costs and benefits of therapeutic and behavioral options. Acknowledge that there are many options after obesity surgery, and determine patients' interest in or concerns about each option.
- Take advantage of teachable moments that occur during each visit.
- Establish a partnership with patients and their families to develop collaborative goals.
- Provide information about behavior change and problem-solving strategies.
- Assist patients in solving problems and overcoming barriers to self-management.
- Support and facilitate patients in their role as self-management decision-makers.

There are also system-specific strategies that can be implemented by a practice to promote patient empowerment and self-management. These efforts involve creating patient-centered practices and providing active, ongoing self management support. This is most readily accomplished through a team approach to care. Within the practice, professionals can:

- Link patient self-management support with provider support (e.g., system changes, patient flow, logistics).
- Supplement self-management support with information technology.
- Incorporate self-management support into practical interventions, coordinated by nurse educators, nurse case managers or other staff members.
- Create a team with other health-care professionals in your system or area that have additional experience or training in the clinical, educational, behavioral, or psychosocial aspects of bariatric surgery.
- Replace individual visits with group or cluster visits to provide efficient and effective self-management support.

- Assist patients in selecting one area of self-management on which to concentrate that can be reinforced by all team members.
- Create a patient-centered environment that incorporates self-management support from all practice personnel and is integrated into the flow of the visit.

Making the Shift

Health professionals face several challenges in making this shift to the empowerment model of care. Change is no easier for us as providers than it is for our patients, and it is often difficult to give up our role as the authority and develop an equal partnership with patients. As providers, we have to give up the illusion that we have control of our patients' self-management decisions and outcomes. While some professionals struggle with this new role, most find that it enables them to be more effective and satisfied clinicians than more directive models of care. These professionals often define success by the relationships that they create with their patients, as well as by the outcomes achieved by their patients.

A common concern raised by professionals is the limited time that they have to spend with their patients. There is a common misperception that addressing emotional and psychosocial needs will greatly increase visit time. It has been our experience that these approaches actually increase the efficiency of visits and decrease the time spent. Time spent offering recommendations that are not relevant for patients or will never be implemented is time wasted.

In addition, addressing patients' agendas at the beginning of visits helps to prevent the "hand on the doorknob syndrome", in which patients bring up an important issue as the provider is concluding the visit. Dealing with problems at this point often doubles the length of the visit. Some providers find that it helps to establish the amount of time that the visit is scheduled to take at the beginning with statements such as, "We have 15 minutes to spend today, and I want to be sure that your needs are addressed. Are there issues that you would like to discuss?" Others indicate the length of the visit on the form used to assess patient concerns.

Although we advocate using a collaborative approach, we realize that it presents challenges to providers as well. Setting goals with, rather than for, patients can be difficult. This is particularly true if patients set goals that are different from what providers would choose or when patients choose issues that professionals view as a low priority. It may seem faster and easier to provide answers to our patients' problems than it is to help them use their own problem-solving skills. Also, it can be difficult to listen when patients express negative feelings. Although it is tempting to ignore these emotional concerns or to offer statements to allay rather than address concerns in an attempt to spend the time focusing on other issues, these strategies are rarely effective for any period of time. In addition, patients may continue to bring up these concerns, thereby actually lengthening the visit.

Although there are potential costs to changing from traditional, expert-directed care to a collaborative approach, there are also benefits. Many providers find it more satisfying. They find that their frustration with trying to get patients to make changes decreases dramatically once they realize that their patients' behavior is not their responsibility. Patients who are actively collaborating in the decision-making process are better able to achieve the outcomes that they identify as important to them. This allows providers to spend less time trying to provide external motivation, because patients are able to find internal motivation once they are involved in the goal-setting process. Also, many health professionals are relieved to find that they no longer have to feel responsible for developing solutions to difficult problems. Patients as a whole become the focus of the visit, rather than just their surgery.

Conclusion

The empowerment approach is based on actively involved patients working with informed proactive health-care teams. This approach involves establishing partnerships with individual patients and creating truly patient-centered practices. The benefits for patients include better communication with providers, greater satisfaction with care, improved

psychosocial and metabolic outcomes, and emotional well-being. The benefits for providers include achievement of recommended standards of care, improved outcomes, and greater professional satisfaction.

Permission to reproduce and modify this article was obtained from the American Diabetes Association. The original article is from Funnell MM, Anderson RM. *Empowerment and Self-Management of Diabetes*. *Clinical Diabetes* 2004; 22: 123-7 copyright 2004, American Diabetes Association.

References

1. Gentry K, Halverson JD, Heisler S. Psychologic assessment of morbidly obese patients undergoing gastric bypass: A comparison of preoperative and postoperative adjustment. *Surgery* 1984; 95: 215-20.
2. Rubin RR, Anderson RM, Funnell MM. Collaborative diabetes care. *Pract Diabetol* 2002; 21: 29-32.
3. Funnell MM, Anderson RM, Arnold MS et al. Empowerment: an idea whose time has come in diabetes education. *Diabetes Educ* 1991; 17: 37-41.
4. Funnell MM, Anderson RM. Patient empowerment: a look back, a look ahead. *Diabetes Educ* 2003 29: 454-62.
5. Anderson RM, Funnell MM, Butler PM et al. Learning to empower patients. *Diabetes Care* 1991; 14: 84-590.
6. Kinzl JF, Trefalt E, Fiala M et al. Psychotherapeutic treatment of morbidly obese patients after gastric banding. *Obes Surg* 2002; 12: 292-4.
7. Kinzl JF, Traweger C, Trefalt E et al. Psychosocial consequences of weight loss following gastric banding for morbid obesity. *Obes Surg* 2003; 13: 105-10.
8. Algazi LP. Transactions in a support group meeting: A case study. *Obes Surg* 2000; 10: 186-91.
9. Marcus JD, Elkins GR. Development of a model for a structured support group for patients following bariatric surgery. *Obes Surg* 2004; 14: 103-6.
10. Shen R, Dugay G, Rajaram K et al. Impact of patient follow-up on weight loss after bariatric surgery. *Obes Surg* 2004; 14: 514-9.
11. Glasgow RE, Funnell MM, Bonomi AE et al. Self-management aspects of the improving chronic illness care breakthrough series: design and implementation with diabetes and heart failure teams. *Ann Behav Med* 2002; 24: 80-7.
12. Glasgow RE, Eakins EG. Medical office-based interventions. In: Snoek FJ, Skinner TC, eds. *Psychology in Diabetes Care*. Chichester, England: Wiley: 141-68.

(Received October 25, 2004; accepted December 12, 2004)