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Nurses' Perceptions of Patient Encounters During Bariatric Weight Loss Surgery Education

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Walden University

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Tracy Cullins-Clark

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Walden University
2019

Abstract

Nurses' Perceptions of Patient Encounters During Bariatric Weight Loss Surgery

Education

by

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MS, Western Kentucky University, 2000

BS, Austin Peay State University, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Community Health Promotion and Education

Walden University

April 2019

Abstract

Many researchers have suggested positive patient-health provider relationships can positively impact patient outcomes. A few focused explicitly on bariatric weight loss surgery (BWLS) professional-patient interactions. This study is significant because BWLS is a recommended tool to combat obesity. The purpose of this study was to analyze the perceptions of BWLS education nurses regarding their patient encounters. This mixed methods research study used an online survey combining quantitative Likert scale questions and open-ended qualitative questions, with social cognitive theory as the theoretical foundation. These explored viewpoints relate to their patient relations expressed by a health professional. Health professional beliefs incorporated into patient interactions has merit within BWLS continuum from presurgery requirements, to the procedure, and postsurgery lifestyle. Many respondents are employed in obesity services programs and received 'snowballs' from other contacted health professionals. The analyzed written response word clouds favor patient-focused care. Participation reluctance by not answering or skipping short answer perspective questions was a quantitative trend. Data revealed survey specific noticeable qualitative tendencies favorable toward patient-centered care and patient health accountability. The anticipated positive social change is a better understanding of issues surrounding the choice for and against BWLS and improved healthcare and health professional-patient communications.

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In remembrance:

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Dr. K

LDC

KLJ

No grit. No pearl.

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Chapter 1: Introduction to the Study

Introduction

In several long-term studies researchers have suggested that bariatric weight loss surgery (BWLS) patients maintain successful weight loss long-term. The term, *successful* is defined as weight loss equal to or greater than 50% of excess body weight and determined by the standardized estimate improved patient quality of life (American Society for Metabolic and Bariatric Surgery, 2017; Strongwater and Becker, 2011). BWLS is considered the most effective and sustainable treatment option for severe obesity by the American Society for Metabolic and Bariatric Surgery (Courcoulas et al., 2013; Das and Faxvaag, 2014). It is possible that the views of BWLS education nurses holding Bachelor of Science in Nursing degrees (EdBSNs) on patient interactions and viewpoints could provide further insight for current patient encounters, processes, and outcomes for BWLS (Godin, Belanger-Grave, Eccles, and Grimshaw, 2008; Jain and Kreiger, 2011; Karlsson, Sjostrom, and Sullivan, 1998). BWLS education nurses (EdBSNs) work within three important areas of the BWLS patient process. The first area is presurgery assistance which includes recording required patient protected health information (PHI). The second area is immediate pre and postprocedural care. The third area is postsurgery guidance with lifestyle management, including patient support activities, and some patient encouragement. This study's key concept was to better understand how BWLS HP-patient interactions throughout the BWLS process, the surgery and patient support continuum impact the treatment, care, and outcomes of BWLS patients.

Social cognitive theory, the theoretical foundation of this study, was selected because it offered a framework for considering the connection between the BWLS health professional (the human), work demeanor (behavior), and milieu (the work environment). The BWLS EdBSN interface with the patient enabled recording of some of the following indicators for this study: treatment (recorded presurgery body weight and vital signs), care (completed BWLS surgery), and outcomes (patient support activity participation). BWLS staff opinions, applied treatment, and care were important mediators of patient outcomes. These indicators were recorded in the PHI by the EdBSN while interacting with the patient to show the condition of the BWLS patient at different stages in the BWLS continuum. In this study I examined the personal and professional perceptions of BWLS nurses. An individual's perception included vocational and personal perceptions, beliefs, and attitudes. Thus, a BWLS EdBSN's narrative contained her or his outlook and experiences, which include patient encounters. Chapter 2 provides the expanded discussion about BWLS HP viewpoints. The study's purpose was to better understand how the BWLS EdBSN interacts with her or his patients and how these interactions and patient relationships affect patients using word and expertise frequency, similar and shared themes, and recalled PHI indicators with Constant Comparison Analysis (CCA). CCA analyzes the four major data sources in qualitative research: talk, observations, illustrations, and documents using any collected data examining the gathered data text from completed e-questionnaires.

BWLS HP stories could relate accounts or events with common themes, common patient indicators, and experiences about BWLS patient outcomes. CCA provided points

of correspondence within this qualitative research study. After the initial research implementation, the study instrument's revision produced an e-questionnaire using both quantitative and qualitative data.

Patient interactions (encounters, exchanges, and relations) provided an accumulation of social experiences with the interpretative schemes implied woven together and constructed into practical knowledge for health professionals. HPs were encouraged to establish rapport, obtain patient progress information, confirm that which was understood by both the HP and the patient, relay relevant information to the patient health team, and educate the patient and patient's support system. BWLS patients and their support systems benefited from formal and informal encounters with BWLS HPs (Street, 2013). Formal encounters were necessary to obtain vital signs, PHI, and manage to schedule. In informal encounters patients and HPs exchanged psychosocial information such as emotions, viewpoint, and behaviors associated with the gathering of PHI. Formal and informal patient encounters were equally important because patients benefit from *healing moments* described as being outside usual patient-health professional dynamic (Street, 2013). The professional rapport relating to the patient could be critical for future independent patient lifestyle maintenance, helping the patients to succeed (Lahti-Koski, Pietinen, Heliövaara, and Vartiainen, 2002, p. 817).

Health professional-patient rapport was necessary because a current trend in public health is emphasizing the collaborative nature of the patient team, including the patient, her or his family, and their health professionals (including the doctors, nurses, and other clinic staff). By studying how BWLS health professionals relate to and interact

with patients, and meaningful lifestyle decisions, public health may have a more in-depth understanding. My research originally identified the following: (a) interactions that influence the patient team's decisions and (b) decisions and measures that are predominant in influencing successful outcomes in BWLS patients. Where this researcher considers the patient perspective as necessary, this study focused on the health professional's perspective. The patient perspective will be the subject of another investigation.

Chapter 1 includes the background, problem statement, this study's purpose, the theoretical framework, and the study's research questions (which are listed later in this chapter). This chapter also presents the study's nature, definitions, assumptions, scope and delimitations, limitations, and significance, concluding with a chapter summary.

Background

There were data regarding how BWLS HPs' viewpoints impacted their patient encounters. The Longitudinal Assessment of Bariatric Surgery (LABS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) 2013 Clinical Guidelines (CG) are cornerstone documents in the BWLS field. LABS is an ongoing study including BWLS staff and recipients from across the United States (Courcoulas et al., 2013). CG is updated approximately every two years and includes continuing education for BWLS surgeons, staffing, and some patient information (Mechanick et al., 2013). Both documents, the ASMBS CG, and the LABS referenced each other and are considered ongoing research and are reference material for this research study. I found that more research was needed to support the BWLS EdBSN-patient interaction from the

health professional perspective. For example, Ross (2014) presented the need for patient-provider impacts on individual health and lifestyle management (pp. 4-5). The mixed method study of narratives may have provided insight into social constructs created, used, and reinforced by perspectives, emotions, and experiences (Leung, 2015, p. 6).

Qualitative research was the original choice for this research because of the nature of narratives and SCT. Because of the revised research instrument and the data collected therefore the research choice transitioned to mixed methods.

I found limited qualitative and quantitative data addressing BWLS HPs' views on patient encounters. Researchers have previously explored cognitive and interpersonal functioning for BWLS recipients. There were not many studies that focus specifically on BWLS health professional-patient interactions. An example is Vertino's (2014) advice regarding the need for the discovery of how personal internal variables affect our interpretation of the world as we see it impacting our professional opinion and work environment. Further, Reese, Simmons, and Barnard (2016) studied relationships, dynamics, and other factors impacting healthcare teams, attitudes, and perceptions of patient outcomes. This research study was an opportunity to explore staff opinions about possible social change within BWLS.

There were data regarding how BWLS HPs' viewpoints impacted their patient encounters. The LABS and the ASMBS 2013 CG are cornerstone documents in the BWLS field. LABS is an ongoing study including BWLS staff and recipients from across the United States over the past decade (Courcoulas et al., 2013). CG is updated approximately every two years and includes continuing education for BWLS surgeons,

staffing, and some patient information (Mechanick et al., 2013). Both documents, the ASMBS CG, and the LABS referenced each other and are considered ongoing research and are reference material for this research study. I found that more research was needed to support the BWLS EdBSN-patient interaction from the health professional perspective. For example, Ross (2014) presented the need for patient-provider impacts on individual health and lifestyle management (pp. 4-5). The mixed method study of narratives may have provided insight into social constructs created, used, and reinforced by perspectives, emotions, and experiences (Leung, 2015, p. 6). Qualitative research was the original choice for this research because of the nature of narratives and SCT. Because of the revised research instrument and the data collected therefore the research choice transitioned to mixed methods.

Problem Statement

There was vast literature about health provider-patient relations. This researcher found minimal literature specifically about BWLS HP viewpoint working with patient treatment, care and outcomes after four years of research. The research focused on health professional-patient interaction, health care work systems and various social models which are essential to the body of knowledge (Holden et al. 2013). More study of the health professional viewpoint may have provided relevant information for the evolution of healthcare, health quality of life, and human engagement (McGovern, Miller, and Hughes-Cromwick, 2014).

Johnson (2017) pointed to the need for further exploration of health professional-patient interactions and has made obesity a community health priority and testing of

implementation strategies another level for exploring health processes (Johnson, 2017, p. 249). Practitioners can look for common themes in strong patient interactions; information access, creation, or sharing; clear communication (Sarkis and Mwanri, 2014). My study's originally focused on HP impacts within BWLS patient treatment, care, and outcomes that support trending patient-centered aspects within combating obesity and public health. The efficacy of BWLS fighting obesity is both an individual concern and public health concern. There was merit within discovering the role of the BWLS education nurse (EdBSN) within the HP-patient relationship that can increase the effect of BWLS. This type of increase could empower individuals, thereby impacting communities.

US Surgeon General Regina Benjamin reported that more than two-thirds of adults and one in three children are overweight or obese (Benjamin, 2010; Wang et al., 2015). Obesity has social aspects affecting diet, physical activity and weight; and is associated with income variation, age, gender, and ethnicity. Patient treatment, care, and outcomes are an integral part of BWLS patient lifestyle changes. The health care industry strongly emphasizes the collaborative efforts of health professionals and patients for successful patient treatments and outcomes (Delamater, 2006). Successful patient treatment and results are rudimentary to preventive health efforts. Much of public health policy, theory and practice rely on preventive health, patient treatment and outcomes, and community efforts (Proctor et al., 2011). Patient consideration for the BWLS is dual; as preventive health issue and for weight/lifestyle management. (Ten Have, Van Der Heide,

Mackenbach, and De Beaufort, 2013). Together, these social dynamics are motivated by humans.

The US Surgeon General calls HPs to research and design health programming and teaches skills, incorporating daily routines using social interests, abilities, and patient change readiness (Ogden, Carroll, Fryar, and Flegal, 2015). Professional collaborative efforts are critical to effective, efficient patient treatment and care, and the outcomes of this care, given the complexity of patients' health care needs (Reeves, Perrier, Goldman, Freeth, and Zwarenstein, 2013). HPs who are encouraged to express and exchange information may have better patient outcomes, more workplace satisfaction, exhibit more discretionary effort, and remain committed in their facility (Wachter, 2010). Research is essential to the discipline because it may address social change with HPs and patient relations. This study offered an opportunity to research rapport-based encounters in health care from the HP-patient collaborative from the HP perspectives. Increased rapport-based public health research could lead to a more fine-tuned strategy to combat obesity with a social change imprint.

The purpose of this study was to understand better how BWLS education nurses EdBSNs interact with their BWLS patients and how these interactions and patient relationships impact BWLS treatment, care, and outcomes. In this study I compared and examined qualitative events. Treatment, care, and outcomes are BWLS markers specified below.

- Treatment: The time when the patient enters to the BWLS continuum transitioning toward scheduling BWLS surgery.

- Care: The time when the patient gains the selected surgical procedure itself and immediate postoperative care.
- Outcomes: The time of transitioning the patient into lifestyle management includes ongoing patient support events and support education.

The study population included BWLS education nurses (EdBSNs) working in professionally recognized clinics in the Denver, Colorado metropolitan area. Contact occurred through their professional organizations and local industry contacts. BWLS EdBSNs work with their patients throughout the BWLS process. This process develops over three, six, nine or more months. Humans develop perceptions, beliefs, and attitudes daily through personal experiences and encounters. BWLS HPs must consider the patient interaction, the decision team and patient timelines, and the changes that occur during the process. While the patient perspective has merit, this study focused on HP's perceptions of the effect of their relationship with patients on the process and outcomes of treatment.

The patient experience is recorded in the protected health information and secured by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (United States Department of Health and Human Services, 2013). I have direct experience from the patient point-of-view and the patient advocate viewpoint. I have served as a BWLS patient advocated and received a Roux-en-Y Gastric Bypass procedure in 2011. Patient experiences formed the base of this research proposal supported by limited BWLS patient relations literature (Annesi, Unruh, Marti, Gorjala, and Tennant, 2011; Garcia-Lago, 2013; Lahti-Kosi, Pietinen, Heliövaara, and Vartiainen, 2002).

This study's key concept was to better understand how BWLS HP patient interactions throughout the BWLS process, the surgery, and patient support continuum impact treatment, care, and outcomes of BWLS patients. The EdBSN works with many patients, their PHI, and assist the patient through the BWLS continuum including those that seek a second BWLS or subsequent procedures that result from weight loss success. This study's findings potentially could educate BWLS health professionals by offering further personal introspection; possibly improving the quality of patient care and lowering readmittance. Tay, Tan, Diener, and Gonzalez (2013) stated that studying social relations and the different associations with health suggested correlations that directly impact physical and behavioral health (Pilchik, 2013; Tay et al., 2013). BWLS and other health care are part of management strategies critical to health care in improving implemented patient-focused strategy, processes, and relations (Jack and Powers, 2009). Further, health professionals may consider fine-tuning treatments to individual patients by specific needs (Garcia-Lago, 2013, p. 58).

Research Questions

Research Question 1: What BWLS health professionals' perceptions, beliefs, and attitudes impact the success of their BWLS patients' outcomes?

Research Question 2: How do BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' care and perspectives (i.e., care-completed BWLS surgery and related complications)?

Research Question 3: What BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' outcomes (i.e., outcomes-patient support activities and

recorded lifestyle management)?

Theoretical Framework

In this qualitative study I used Bandura's SCT as the theoretical framework. SCT reflects the reciprocal relationship between environment, behavior and the human. The individual must consider the perceived difficulty of a task using existing prior knowledge, individual coping strategies, task performance, and the job itself (Bandura, 2001, p. 198). Using self-efficacy (i.e., self-awareness), SCT can assist in identifying HP work function with patient social impacts. An HP's measure of control over personal thoughts, feelings, and actions can affect their work and demeanor (Sugiura, 2010). Confidential semistructured interviews could discover a BWLS HP's viewpoint. Using the narrative approach to capture stories may improve HP workplace professionalism by detailing the use of HP perceptions, beliefs, and attitudes. SCT relates to narratives because the telling of one's story reveals an individual's opinions, ideas, and perspectives. Anonymity could offer the opportunity to discuss information that would not be available. This study's research questions are guided by the BWLS HP perceptions, beliefs, and attitudes as they encounter BWLS patients during the BWLS process stages before, during, and after surgery via patient progression through the BWLS processes, the operation itself, and patient interactions. There will be a further explanation about SCT and SE in Chapter Two.

Nature of the Study

The original choice was for a qualitative, narrative study approach, to provide BWLS HPs the opportunity to express their viewpoints about their patient encounters.

Again, this study's key concept is to better understand how BWLS HP-patient interactions throughout the BWLS process, the surgery, and patient support continuum impact treatment, care, and outcomes of BWLS patients. This study uses Bandura's SCT as the theoretical foundation linking to successful lifestyle management. This research defines a viewpoint as an individual's perceptions, beliefs, and attitudes. *Viewpoint* is defined as a way of looking at or thinking about something. An HP viewpoint comprises of a single experience or multiple experiences. Stories (i.e., narratives) tell the individual's experience, their behavior, and environment of the narrator. The narrative links individual human actions and events as interrelated.

Narratives

The original research approach was the accrued narrative. Narratives are emphasized story construction through an individual's thinking. Tales or stories accrue over time assisted by daily routine, corroboration, repetition, and norms. Storytelling can present the relationship between a person's behavior and the individual's experience. Accrued stories created culture, expectations, and social standards. Together, action and experience provide transparency to perceptions, beliefs, and attitudes (i.e., the viewpoint). By reinforcing past comprehension, daily lessons, and future efforts, humans evaluate their environment by relying on perspective or views. The narrative approach has the potential to be valuable in future research that would have been ideal for this study had subject recruitment been more successful.

Counted tendencies, frequencies and commonalities found within the data presented themselves. The intent of the qualitative findings was to produce a richer

understanding of BWLS outcomes from the health professionals' perspective; however, with the change in the study's focus due to the lack of participants, the approach was modified to become mixed methods enabling the use of some narrative data.

This study used HP's narrative detailing her or his personal experience in-depth, with intent and purpose; potentially displaying trends and themes. The confidential interview was the initial data collection instrument. The online survey interview is a revision of the 33 question face-to-face interview. The interview was comprised of open-ended queries containing some recalled PHI. The revised online survey queried about percentage and opinions about working with patients. Collected qualitative data were analyzed using the CCA method. The collected quantitative data was raw.

Definitions

The following is a list of definitions for this qualitative, narrative research study.

American Society for Metabolic and Bariatric Surgery (ASMBS): The largest society for this medical specialty in the world. The vision of the ASMBS is to improve public health and well-being by lessening the burden of the disease of obesity and related diseases throughout the world.

Attitude: A feeling and/or way of thinking that affects a person, behavior, or environment.

Belief: The conviction of the truth of reality for a human being or phenomenon.

Bariatric weight loss surgery: Refers to all types of weight loss surgeries. Weight loss surgery helps people with extreme obesity lose weight. It may be an option if you cannot lose weight through diet and exercise or have serious health problems caused by

obesity. There are different types of weight loss surgery (American Society for Metabolic and Bariatric Surgery, 2013).

1. *Adjustable Gastric Band*: the band or the lap band – involves an inflatable band that is placed around the upper portion of the stomach, creating a small stomach pouch above the band, and the rest of the stomach below the band.
2. *Biliopancreatic Diversion with Duodenal Switch*: abbreviated as BPD/DS – is a procedure with two components. First, a smaller, tubular stomach pouch is created by removing a portion of the stomach, very like the sleeve gastrectomy. Next, a large portion of the small intestine is bypassed leaving the stomach about the size of a chicken egg and the small intestine restructured. This surgical choice differentiates from others mentioned because it includes a longer portion of the intestines.
3. *Laparoscopic Sleeve Gastrectomy*: the sleeve – is performed by removing approximately 80% of the stomach. The remaining stomach is a tubular pouch that resembles a banana (American Society for Metabolic and Bariatric Surgery, 2013)
4. *Roux-en-Y Gastric Bypass*: gastric bypass or RNY – has two components. First, a small stomach pouch of approximately one ounce is created by dividing the top of the stomach from the rest of the stomach. Next, the first portion of the small intestine is divided, and the bottom end of the divided small intestine is brought up and connected to the newly- created small stomach pouch. The procedure is completed by connecting the top portion of

the divided small intestine to the small intestine further down to allow the stomach acids and digestive enzymes from the bypassed stomach and first portion of small intestine to eventually mix with the food. RNY is considered the epitome of weight loss surgery and is the most commonly performed bariatric procedure worldwide (American Society for Metabolic and Bariatric Surgery, 2013)

5. *Education Nurse: (EdBSN)* - a licensed health-care professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting, maintaining, and educating patients regarding their own health. The Education Nurse holds a Bachelor of Science degree in Nursing from an accredited four-year university.
6. *HIPAA: The Health Insurance Portability and Accountability Act of 1996* – is the federal law that protects personal health information exchanged between patients, health professionals, health entities, and health information clearinghouses for individual and communal health, wellness, wellbeing, and research purposes (United States Department of Health and Human Services, 2013).

Patient encounter: an accumulation of stock-of-knowledge, social experiences, with the interpretative schemes implied, woven together and constructed into the knowledge of the other for use by health professionals

Perception: the way humans think and understand their environment and those they encounter.

Viewpoint: a way of looking at or thinking about something.

Assumptions

This study included several assumptions about BWLS EdBSNs. A first assumption is that weight stigma exists among health professionals. Negative personal perceptions of obese persons are prevalent in society (Puhl and Heuer, 2010, p. 1). Reports of negative attitudes regarding overweight patients by various health professionals occur (Puhl, 2011, para. 7). Puhl states that some HPs who specialize in the treatment of obesity hold negative attitudes toward obese persons (Puhl, 2011, para. 7). These choices may lead to inadequate treatment, care, and outcomes. A second assumption is that there is a lack of rapport between BWLS HPs and their patients. At times, encouraging maintaining professional rapport could be important for HP work outcomes. Her or his action could diminish work effectiveness. This action may lead to adverse patient treatment, care, and outcomes. BWLS HPs could unintentionally encourage unhealthy behaviors: binge eating, low or no exercise, and eating high-fat content foods.

Scope and Delimitations

This study's scope was to spotlight the HP viewpoint within social exchanges with patients. Whereas the patient viewpoint is pertinent in all aspects of health, it was not the focus of this study. The researcher has personal experience as a BWLS patient and has worked as a BWLS patient advocate. This research intended further investigation of the patient perspective in the future. This study researched BWLS EdBSNs' stories about their patient exchanges short and long-term. The BWLS process can be lengthy, and the

patient is engaging in it may become impatient and chose to leave before the surgery.

The frequent close health professional-patient interactions of involved treatment, care and outcomes could provide the basis of a relationship. HPs can relate to social engagement points by the retelling of their stories and capture by this research study. The aspects of this study were: treatment, care, and outcomes through the health professional narratives. The stories will reveal patterns in the HP-patient relationship: exchanges, dynamics, situations, obligations, processes, occasions, and one-time opportunities.

BWLS HPs direct patient treatment by moving the patient down the surgery continuum toward the actual surgery; surgery would not occur without BWLS HP input. The collection of vital signs, PHI, and presurgery patient activities require social exchanges that could be helpful in the BWLS process, the surgery itself, and postsurgery lifestyle management.

Care is an aspect of the research problem. BWLS HPs postsurgery care comprises treatment delivery, in-clinic visits, and checking patient outlook-physical and mental health. This work is crucial because their nursing function strives to restore patient health. The nursing function (i.e., the traditional bedside manner) is a social exchange.

Outcomes are an aspect of the research problem. BWLS HPs provide patient education during patient outreach and activities. These HP-patient interactions are encouraged by the ASMBS CG. Again, the patient perspective is not the focus of this study.

Several public health theories consider behavior, action, and viewpoint. Narrative accrual provides an opportunity for participants to speak in their own words about their

work experiences. The professional allowed an avenue to study HP-patient encounters without exposing PHI. PHI contains patient records, notes, identifiers, and other information that may cause stigma. There may be a need to seek de-identified PHI. Therefore, this researcher will request permissions to enable a more objective assessment. Thus, incorporating more HP-patient encounters that may show the relationship between the self, the behavior, and the action within the individual.

This qualitative study did not encompass all BWLS HPs. I included BWLS EdBSNs contacts from the Denver, Colorado metropolitan area through HP organizations, networking, and personal referral. The selected professionals were required to hold a Bachelor of Science in Nursing degree and assigned as in-clinic EdBSNs. These HPs are assigned explicitly to BWLS clinics and have daily encounters with BWLS patients both in-clinic and at patient-support activities. Typically, these events and locations serve as information centers for BWLS HPs and patients. These participants were selected because BWLS EdBSNs utilize the patients' current vital signs (i.e., intake blood pressure, weight, and pulse), and update patient PHI incorporating the patient's viewpoints on each patient visit. The EdBSNs were chosen because of their professional training, their work within the BWLS clinics, the frequency of their encounters with BWLS patients, and their familiarity with the BWLS patient's viewpoints.

BWLS EdBSNs work directly with patients throughout the entire BWLS process. EdBSNs compile the patient notes that operate alongside the approval processes. EdBSNs are part of the actual procedure day; preparation; the procedure; and post-

surgical care. Further, EdBSNs work with the patient throughout the postsurgery visits: weekly assessments, fielding patient telephone calls, and patient support activities throughout the BWLS continuum.

Many HPs working within other clinics, facilities, and capacities do not have this access to BWLS patients. BWLS surgeons were not selected because they do not have the patient encounter frequency. The nonselection of BWLS Licensed Practitioner Nurses was because of their more limited professional education requirements. The nonselection of BWLS Medical Technicians because they do not work patient support events. It was hoped that this study could extend the LABS and ASMBS CG with qualitative research.

Although Colorado has some of the lowest obesity rates in the United States, the proportion of obese Colorado adults has more than doubled during the past 15 years, and childhood overweight, and obesity has increased at alarming rates says the Colorado State health department. The Colorado Department of Health flagship aim is to reverse the upward obesity trend by aligning and intensifying efforts to develop a culture of health and creating conditions for Coloradans to achieve healthy weight across the lifespan encouraging usage and access to walking and riding trails and decreasing fresh food deserts, as well as other strategies. Colorado's bariatric education nurses have access to a patient population that has propelled themselves into this flagship strategy.

Limitations

The original research instrument was the confidential, semistructured, response interview created by the researcher; however, instead a survey instrument was

constructed to collect data from interested volunteers including ‘snowballs’.

“Snowballs” are the result of forwarding links to interested parties from interested volunteers. This researcher used Atieno’s guidance for instrument construction in order to gather data. Atieno advises researchers to become immersed in the subject's culture and experiences using flexible inquiry. Again, this would have been great, but without the face-to-face interview, open-endedness was constrained to limited written responses. (Atieno, 2009, p. 14-15). The e-survey is the result of the revised face-to-face interview.

Patient perspective

The BWLS patient perspective was not the focus of this study and therefore a limitation of this study. The patient is integral to the health professional-patient encounter. The ‘public’ in public health infers to many individuals that are the communities the health industry serves; these individuals are occasionally BWLS patients. Acute, preventive, and research service for the patient was the primary focus. There is a potential influence in the patient decision-making from the aspect of the health professional. This study’s focus was the BWLS EBSN’s perspective and its potential influence with the patient.

Location

The selected location was central Colorado. Many Colorado BWLS clinics are adjacent to the Interstate 25 corridor. Denver is the state capital, and where much of the state’s population resides. Denver was the closest and largest health professional population accessible to this researcher.

Participants

Again, these participants were selected because BWLS Education Nurses (EdBSNs) utilize the patients' current vital signs (i.e., intake blood pressure, weight, and pulse), update patient PHI, and incorporate patient's viewpoint within the PHI on each patient visit. The participants had the option to leave the study and to adjust, keep, and clarify their input. The analysis process was time-consuming due to the time needed to complete all the interviews and analyze them. Efforts were made to cultivate rapport, calm, and an atmosphere to which the participants will want to share. The recording and analysis technology may malfunction. This researcher opted to use field notes; record with multiple technologies; and transcribe one interview at a time. The data was situation specific, which is a qualitative research requirement. Outliers and discrepant cases were included, which are the focus of the Constant Comparison analysis method (CCA). Chapter Three contains further discussion of CCA.

The nature of qualitative studies regards themes, participant emotions, and other intangible information that impact human life (Warburton, Moore, Clune, and Hodgkin, 2014, p. 3). Dependability could be a limitation because humans can change their minds. This research explored what lies behind or supports decisions and other phenomena by encouraging health professionals to "tell their story" and find the associations that occur in their reported behavior. By using narratives with a qualitative study, this study attempted understanding contradictions between qualitative findings including the participant's viewpoint and voice. Qualitative work well with the collection of vibrant, comprehensive data combined with how humans tell and collect stories (Wisdom and Creswell, 2013, p. 3). Social interactions may be difficult to measure. The qualitative

analysis could help characterize multifaceted human qualities influential to decisions, interactions, outcomes, and clinic culture (Curry, Nembhard, and Bradley, 2009, p. 1443).

The researcher selected the research design and the methodology. This researcher cannot control participant survey responses/non-responses, availability, accessibility, or employment conditions/responsibilities. The researcher does not manage natural and weather events that may cause research restrictions such as avalanches, snowstorms, flash floods, and rockslides. Such events are native to the proposed research metropolitan geographical area.

Again, the researcher cannot test the integrity of each participant. Besides, human expression and experience do not always ensure correct message delivery. Verbal and nonverbal comprehension reinforced understanding and fundamental for this narrative research study. All interviews were to be recorded and transcribed for dual documentation. The small population may be limited yet are an integral part of qualitative research.

Researcher Bias

Researcher bias is a limitation of qualitative, narrative research. This researcher has been a BWLS recipient and experienced HP support during BWLS processes. The researcher is living with post-BWLS life management. The researcher is an HP committed to improving patient relations and is a BWLS patient advocate. The researcher's concern is gathering scientific information with health professional and layman utility. The researcher used several recording tools and transcription to ensure

accuracy and decreasing researcher bias. Participant clarification follow-ups decreased researcher bias. Participants had the release option if s/he identifies as a researcher acquaintance. The analysis method choice required the use of all collected data including discrepant cases and outliers; further reducing researcher bias. This researcher opted to keep a journal of this research process.

Significance

This study was significant because it could help to bridge the knowledge gap in understanding psychosocial issues within health professional-patient relations combating obesity. BWLS HPs and their patients need to have a thorough understanding of their viewpoint as a contributing factor to patient outcomes. It may be beneficial for HPs to regard how their behavior may affect patient relations, treatment, care, and outcomes. The intent was to use NVivo 12 software and the comparison contrast analysis (CCA). Low subject enrollment necessitated a change in approach to survey responses which did not require the use CCA. NVivo was used to find qualitative themes. The raw quantitative data produced the found frequencies and quantitative themes. Again, qualitative data addressing the social interaction between HPs and their patients may have supported BWLS HP efforts in treatment, care, and outcomes.

Social Change

A positive social change implication was the comprehension of the BWLS HPs' viewpoint. Because HPs work individually and with the patient, understanding of viewpoint utility may disclose more about the professional-personal aspect. This research could have revealed moments within BWLS HP-patient encounters that solidify

an HP's encouragement for a BWLS patient's participation in the patient's health journey.

BWLS HPs work with reducing obesity and its contributing factors: weight stigma/discrimination; reduced life expectancy; reduced quality of life; and chronic health problems. Further, this study may offer an opportunity to research rapport-based encounters in health care from the HP-patient collaborative from the HP perspectives (Leach, 2005, p.263-264). From this juncture, rapport-based healthcare research could potentially lead to HPs incorporating more of the patient's ownership within their health possibilities (Fetter, 2004). Improved personal health can lead to improved quality of lifestyle and quality of life- a positive social implication.

Summary

Chapter One introduces this study. It provided the background, the problem statement, and purpose. This study's purpose was to better understand how the BWLS HP interacts with her/his patients and how these interactions and patient relationships impact patient success throughout the BWLS continuum. This study's theoretical foundation was the Social Cognitive Theory (SCT) using narrative accrual with the comparison-contrast analysis (CCA) method using NVivo 12 software. Additionally, Chapter One presented the study research questions, study nature, definitions, and assumptions. The study's scope and delimitations, limitations and significance are discussed concluding with social change implications.

Chapter Two discusses relevant literature. Also, there is some discussion concerning information not previously found within BWLS and SCT research relating to the research questions in Chapter Two. Moreover, this study's literature review with key

variables and a synthesis of literature comprises Chapter Two.

Chapter 2: Literature Review

Introduction

The problem is that the BWLS HPs viewpoint appears underutilized. The purpose of this study was to better understand how BWLS HPs interact with their BWLS patients and how these relations impact healthcare outcomes. Again, there is vast literature regarding provider-patient relations, but I have found little or no qualitative literature about BWLS HP viewpoint working with patient treatment, care, and outcomes. Chapter two discusses literature relevant to the study of BWLS HPs' viewpoints and their patient encounters. However, within SCT, only limited qualitative literature was discovered related to this subject. Therefore, Chapter 2 also includes concerns not previously found within BWLS and SCT research.

Additionally, this chapter contains the study's literature search strategy and theoretical foundation. Moreover, Chapter 2 includes a literature review of the key variables and synthesis of the relevant literature. The chapter summary is last.

Theoretical Foundation

Social cognitive theory (SCT) is the theoretical foundation. SCT emphasizes that an individual, their environment, and their behavior have a reciprocal relationship (Bandura, 2001, p. 3). Additionally, Bandura discusses SCT's many sides including self-efficacy (i.e., self-awareness) operating within an HP: professional goals, expected patient outcomes, environmental aids and hurdles. Motivation and well-being present the nature of efficacy where beliefs are widespread and continue as concepts assisting HP behavior. Values are reinforced by direct incorporation into her/his value system through

use (Torres, Riba, and Freeman, 2015, p. 39-40) which influences viewpoint. Self-awareness identifies differing factors in cause and effect are accruing-not as singular events. SCT relates to this study through the relationship the HP, her or his work experience, and her or his work behavior. The research questions can build upon existing SCT impacts via HP's narrated expertise as it works with patient treatment by looking at clinical activities and interactions. Also, these research questions working with SCT may show impacts on BWLS patient care and outcomes with long-term activities and decision making. Narration allows the HP to tell their experiences in their voice.

In this qualitative, narrative study, the BWLS HP is the human, her or his work function is the behavior, and varied work environments are the identified SCT components. Another part of the HP work environment is the patient's decision team. BWLS HP perceptions can act as a motivator by encouraging patients to change their health habits. The deeper exploration of HPs' reciprocity of behavioral, environmental, and personal decisions in the BWLS HP-patient relations is the focus of this study. While some existing research on patient interactions and relations implies Bandura's SCT usage, this researcher found no studies that explicitly used SCT exploring the HPs viewpoint. The choice for SCT and narrative for their focus on the individual, her/his behavior, her/his actions, and her/his accumulated experiences.

As mentioned in Chapter 1, accrued narratives tell the self's experience containing the viewpoint, behavior, and environment of the narrator. Accrued descriptions link individual human actions and events as interrelated (Denning, 2015, para 6). 'Telling your story' is an achievement of memory recall. The autobiographical

account has merit that is a mirror for personal cultural, social, and language influences. This study uses participants' particular descriptive words detailing personal accrued experiences, with intent and purpose; potentially displaying trends and themes. All participant interviewed will be analyzed because CCA uses all gathered data including outliers and discrepancies.

Literature Search Strategy

SCT is the theoretical foundation. SCT emphasizes that an individual's environment, behavior, and self, have a reciprocal relationship (Bandura, 2001, p. 3). Additionally, Bandura discusses SCT's many sides including self-efficacy (i.e., self-awareness) operating within an HP: professional goals, expected patient outcomes, environmental aids and hurdles. Motivation and well-being present the nature of efficacy where beliefs are widespread and continue as concepts assisting HP behavior. Values are reinforced by direct incorporation into her/his value system through use (Torres et al., 2015, p. 39-40) which influences viewpoint. Self-awareness identifies differing factors in cause and effect are accruing-not as singular events. SCT relates to this study via the relationship the HP, her/his work experience, and her/his work behavior. The research questions can build upon existing SCT impacts via HP's narrated expertise as it works with patient treatment by looking at clinical activities and interactions. Also, these research questions working with SCT may show impacts on BWLS patient care and outcomes with long-term activities and decision making. Narration allows the HP to tell their experiences in their voice.

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Literature Review Related to Key Variables

The reviewed literature focuses on obesity, patient relations, professional attitudes, treatment, care, and outcomes. Previous studies reflect aspects of SCT but not

the complete theory. Additionally, earlier studies explored the patient viewpoint only regarding the BWLS continuum; individual treatment, care, and outcomes; and individual satisfaction. Research regarding patient treatment, care, or outcomes and HP viewpoint did not appear. Both approaches offer information that can be used. This study's SCT methodology addresses BWLS HP perspective on individual patient progress using their words and experiences. SCT can help to explain how BWLS HP viewpoints can impact components of patient relations that are critical to the BWLS process. The BWLS process is all the steps before, during, and after the patient's receiving BWLS, including the required approvals from various agencies.

Obesity

Obesity is a tremendous societal focus on public health. Much of the literature is primarily available from the patient perspective and outcomes. The National Institutes of Health's (NIH) National Institute of Diabetes and Digestive and Kidney Diseases and the 2009-10 National Health and Nutrition Examination Survey present national population data on obesity. Two-thirds of United States adults are overweight or obese; one out of 20 adults are considered extremely obese, and approximately one-third of children and teens (ages 6-19 years) are overweight or obese (Liebman et al., 2003, p. 691). Obesity's associated illnesses differentiate weight loss choices: natural effort, weight loss with prescriptions, and BWLS as an effective long-term treatment. Overall, BWLS improves patient health quality of life outcomes with improved physical indicators at 6 and 12 months postsurgery the patient perspective within patient care (Karlsson, Sjostrom, and Sullivan, 1998). Only 10% weight loss is associated with current obesity treatment

prescriptions and combating obesity to lower blood pressure and diabetes (Sugerman, Wolfe, Sica, and Clore, 2003, p. 754). The HP viewpoint or its potential impact was not studied applying the 'Coach' approach alongside SCT study patients psychologically changing physical outcomes via an exercise program motivation and adherence (Annesi, Unruh, Marti, Gorjala, and Tennant, 2011). This literature presented patient treatment, care, and outcomes by pointing out the need for a qualitative study to reveal HP patient dynamics.

Patient Relations

Most research categorizes patient relations as either formal or informal. These two categories are described distinctly and are presented here as formal and informal. Formal communication is necessary to obtain vital signs; and, other treatment data directed by private and public health practices alongside legal directives (federal, state, and local policies). Informal exchange is equally essential; resulting in patient data, applied decisions, and lifestyle changes.

Formal interactions guide the HP individually and within the BWLS decision team. Patient relations is the supportive therapy that brings about behavior change (Moyle, 2003). There is a noted necessity for comprehensive communication between the HP and patient (Mishraa, Hansen, Sabroe and Kafled, 2006, p. 35): patients were more compliant with fair communication (OR=2.7) and are less compliant (OR=11.7). During informal HP-patient relations, BWLS patients can benefit from a 'healing moment.' The healing moment is a person-to-person social exchange that motivates the patient to participate in her/his treatment. These informal exchanges are beneficial and

personable by the patient. Further, the value of these informal interactions could be significant for the BWLS HP-patient rapport.

These studies are part of the ongoing obesity conversation, but neither the HP viewpoint nor voice is present. The BWLS HP can have frequent, long-term, patient encounters. Patients and their support systems benefit from formal and informal interaction with the BWLS HP. Moreover, none of the found studies regard BWLS HP influence on patient treatment, care, and outcomes.

There are substantial studies regarding the effects of health professional-patient relationships. Wellness is central to the United States' Surgeon General's aim to provide people accurate, usable information for personal health information to influence healthy behaviors before, during and after a patient's transition to wellness: a goal of health professionals (CDC, 2014). Bylund, Peterson, and Cameron (2012) presented information about the reciprocal effects for professionals and patients during their interactions, such as how and why a patient complies, patient-professional requests, and even a professional's interaction choice and information emphasis (p. 7). Friedman, Ashmore, and Applegate discovered that "it may be useful to focus bias reduction efforts toward health-care professionals and students, especially those who will eventually work in clinical settings" (Friedman et al., p. S73). Lahti-Koski et al. (2002) found that when patients apply the professional's suggested treatment, they are more successful in maintaining a lower weight (p. 817). Karlsson, Sjostrom, and Sullivan (1998) demonstrated improved health quality of life with improved physical indicators peaking

at 6 and 12 months postsurgery. This study also provides information from the patient perspective.

Communication- and information-related issues are one of the most frequent complaints in health and wellness. Health professionals using emotional skills tend to be more open to patient perspective and display empathetic concern (Amutio-Kareaga, Garcia-Campayo, Delgado, Hermosilla, and Martinez-Taboada, 2017, p. 44). Health professional narratives gather information regarding provider-patient relations awareness of experienced emotions such as frustration, self-care, anger, hopelessness, monitoring patient prejudices (Amutio-Kareaga, Garcia-Campayo, Delgado, Hermosilla, and Martinez-Taboada, 2017, p. 43)

Gordon, Deland, and Kelly (2015) discussed health communication for providers, the health care teams, and patients, individuals, groups, and as one. Clear communication is paramount for understanding treatment, care, and outcomes to transform care delivery industry-wide. Moreover, the goal of a health care team is to overcome cultural, structural, and belief barriers to good health (Gordon et al., 2015, p. 25). Labrie and Schultz (2014) disclosed patient-provider conflict (an aspect of provider-patient relations). Conflict arises from the differing expectations of the provider-patient relationship eventually arriving at a compromise that negotiate patient care through a decision-making process. The idea of 'conflict' provides an opportunity to investigate personal psychosocial behavior such as persuasion, viewpoint, patience, compliance, and frustration from the provider perspective as the beginning of patient outcomes (p. 996; p. 1006).

Some professional and personal attributes that may impact patient care during office visits. Office visits characteristically are intense, psychosocial experiences fulfilling patients' issues alongside the current patient care (both needs and dispel misconceptions) (Lorenzetti, Jacques, Donovan, Cottrell and Buck, 2013, p. 422). Haskard, Zoinierek and DiMatteo (2009) studied patient compliance and found that patient compliance is more than twice as high if their health provider communicates effectively. This measurement is comparable to other high scoring predictors in their study: (practical social support (3.6) and emotional support (1.83)¹⁷, depression (3.03)¹⁸, and perceptions of disease severity (2.5) (Haskard, Zoinierek and DiMatteo 2009, p. 8). These authors present the pertinence of communication between health provider and patients focusing on both verbal and nonverbal pathways to improve patient care (p. 8). Roter, Frankel, Hall, and Sluyter (2006) discussed health care quality, consequences, and their implications with regard to the following: financing, resources, utilization, satisfaction, malpractice litigation, and other issues. Health consequences and implications need additional research for better comprehension of pathways to patient outcomes with other effects: gender, culture, ethnicity, race, literacy, social class, age, health status, trust, and continuity of care (Roter, Frankel, Hall, and Sluyter, 2006, S32).

Provider-patient relations vary because of illness, attitude, diversity, gender, background, education, comprehension, communication style and other aspects. Continued research is necessary for provider-patient relations concerns especially with sensitive, psychosocial situations. Such interactions are vulnerable both the patient and provider making perception and perspective valuable. This value could be substantial

enabling both provider and patient to communicate more openly (Shattell, 2004, p. 720). This variety demands further inquiry expanding our understanding of our field. All echelons of healthcare workers share a responsibility to create a health care environment that supports an interdisciplinary team and its development. This capability delivers quality, patient safety outcomes, and equitable healthcare work environment factors (i.e., workload, decisions, and psychosocial aspects) (Bogaert, Timmermans, Weeks, van Heusden, Wouters, and Frank, 2014). Educated, motivated health care providers are inclined to be more patient care quality (Rahman, Jarrar, and Don, 2015). Further, patient care is an agreement between patients, providers, and administration who are knowledgeable and skilled (Green, Hibbard, Sacks, and Overton, 2013).

Treatment, care, and outcomes

BWLS HPs encourage patients to adjust her/his lifestyle choices throughout the BWLS continuum. The found literature does consider treatment, care, and outcomes as successful individual events and as parts of the patient wellness continuum. However, there was no found research using SCT as a basis for qualitative discussion looking at treatment, care, and outcomes from the BWLS HP's viewpoint.

Treatment is generally with the recorded medical monitoring, also referred to as 'vital signs,' is part of PHI. Vital signs consist of blood pressure, temperature, physical weight, the patient expressed symptoms, and occasionally a urine sample. PHI supports BWLS HP work behavior and is used to complete patient treatment. BWLS HPs potentially gather PHI outside the treatment room at the patient support venues (i.e., meetings, social media, and community happenstance). The written, registered, and

recorded medical monitoring reflect daily applied patient decisions. The compilation, sharing or disclosure of PHI is governed by federal guidelines including HPs working within the patient. However, the researcher did not find literature addressing BWLS HP work behavior and work environment.

During care, BWLS clinics comply with federal regulations using the information within the patient's electronic health record. When a patient's blood pressure, temperature, physical weight, and expressed symptoms improve, the decision team collaborates more frequently (i.e., HP work behavior); transitioning from presurgery care to BWLS. Das and Faxvaag (2014) state that BWLS health professionals must encourage BWLS recipients to adjust their lifestyle choices to achieve and maintain weight loss avoiding negative outcomes (Das and Faxvaag, 2014, p. 7). Courcoulas et al. (2013) found considerable variability in sustained weight loss, decreased diabetes and blood pressure, and other outcomes in BWLS patients (Courcoulas et al., 2013, p. 2422). These physical changes demonstrate improved patient decisions incorporating presurgery patient education supporting continued lifestyle adjustments postsurgery. The found information does not discuss BWLS HPs' potential influence with patients, qualitative research or use SCT.

HP's opinions and interactions influence patient outcomes. Outcomes are influential to compliance and continuing health services. National, state and local mandates manage BWLS decision team compliance endorsing better-individualized health promotion (Cherala,2012) (Puhl, 2009). Patients' self-management and lifestyle choices are essential to postsurgery outcomes; improving the health quality of life. HPs

may negatively affect some obese patients; resisting crucial preventive health services, canceling medical appointments, and refusing treatment altogether (Puhl, 2009, p. 1).

This researcher did not find any studies that focus on SCT and BWLS related to the healthcare process and clinical outcomes.

Wellness

Wellness is central to the United States' Surgeon General's aim for providing people accurate, usable information to adopt healthy behaviors. It is incorporated throughout the BWLS process, patient education, and continued lifestyle adjustments. Healthy lifestyle changes permit a patient's transition from care to wellness, which is the epitomized goal of HP. These life changes assist to maintain BWLS-assisted weight loss and to avoid adverse outcomes (Das and Faxvaag, 2014, p. 7). Coordinated patient self-management/education are part of post-BWLS care. Mishraa, Hansen, Sabroe, and Kafled (2006) noted the necessity for comprehensive communication between the HP and patient (Mishraa et al., 2006, p. 35). Poor communication ($OR = 11.2$) resulted in poor patient compliance and fair communication ($OR = 2.7$) resulted in some patient compliance. Better communication between health professionals improves treatment adherence (Mishraa et al., 2006). In 2003, Moyle stated patient relations is a supportive therapy that brings about behavior change (Moyle, 2003, p. 107). Further, health professionals (HPs) should address the more intricate, complicated public health, community health, and personal wellness issues (Tariq and Woodman, 2010, p. 3).

Obesity Stigma: Professionals

Bandura acknowledged the reciprocal nature of one's environment, behavior, and self (Bandura, 1978). Conversely, there is a widely held belief that obese persons lack self-responsibility; even among health professionals. This view impacts social distancing and rejection of obese individuals and can discourage obese persons from seeking health care (Puhl and Heuer, 2010, p.1023). BWLS HPs are advised to consider the whole human, rather than to focus solely on compiled PHI or procedure (LeMont, Moorehead, Parish, Reto, and Ritz, 2004, p. 8; Puhl and Latner, 2008, S1). HPs appear to need to understand the nature of social influences on the patient and quite possibly their personal (negative and positive) impact on their patient(s). This type of control may sway an obese person from seeking and participating in their health care. The stigma of obesity impacts the health and well-being of obese persons (Friedman et al., 2008, p. S73). BWLS professional-patient interactions are integrated using personal and professional aspects (Frood, Johnston, Matteson, and Finegood, 2013, p. 320). Further, some HPs expressed considerable pessimism about treatment, care patients' nutrition motivation, lifestyle management, and other outcomes for obese patients (Puhl, Latner, King, and Luedicke, 2014, p. 72). Sarkis and Mwanri (2014) direct HPs to treat obesity as a priority in all aspects of health research and testing implementation strategies; empowering individuals and impacting communities. Given the complexity of patient health care needs, professional efforts are critical to effective, efficient patient treatment and care and outcomes (Reeves et al., 2013). Moreover, Puhl and Bronwell (2003b) present that negative personal perceptions of obese persons are common in society (p. 1). Puhl (2011)

also presents that negative attitudes regarding overweight patients reported by various health professionals (para. 7). Some of HP's who specialize in the treatment of obesity hold negative attitudes toward obese persons (Puhl, 2011, para. 7). These choices may lead to inadequate treatment, care, and outcomes of obese persons.

Better HP-patient relations may benefit patient lifestyle changes, processes, and other factors. More in-depth research into the HP-patient encounter frequency; both the short and long-term suggested by this particular study (Jain and Kreiger, 2011, p. 102). Specifically, these authors support cultivating better HP-patient relations as it benefits patient lifestyle changes, processes, and other factors. Such factors point to the proposed study, suggesting using other theories for more in-depth research into the HP-patient encounter frequency; both the short and long-term (Jain and Kreiger, 2011, p. 102). Using SCT, BWLS HPs' intentions and behavior could explore potential themes via semistructured interviews from BWLS HPs (Godin, Belanger-Grave, Eccles, and Grimshaw, 2008, p. 2). Godin et al. (2008) say SCT could predict BWLS HP's intentions and behavior (p. 2). These authors suggest that SCT could be used to explore potential themes via semistructured interviews from BWLS HPs. Supportive information regarding patients avoiding HPs because of body-size embarrassment, disrespectful treatment, and negative attitudes does exist (Puhl, 2011, p. 3). This avoiding emphasizes the possibility of HPs' impact on patient treatment. Positive experiences may lead to certain attitudes and enhanced experiences (Pearl, Puhl, and Brownell, 2012, p. 6). Pearl, Puhl, and Brownell (2012) state that positive experiences lead to certain attitudes and enhanced experiences (p. 6). These authors acknowledge the reciprocal nature of one's

environment, behavior, and self as theorized by Bandura (Bandura, 1997; Community Tool Box, 2014). Puhl (2011) presents supportive information regarding patients avoiding HPs because of body-size embarrassment, disrespectful treatment and negative attitudes (Puhl, 2011, p. 3). Their study emphasizes the possibility of HPs' impact on patient treatment but does not discuss it. Unfortunately, during the period of this research, they did not study the HP viewpoint.

The US DHHS agencies, advocacy organizations, ASMBS, for-profit and nonprofit organizations have produced research supporting combative obesity strategies. They also agree that LABS monitored the progress of thousands of BWLS recipients. Each study and agency agree as a combative obesity strategy BWLS results are successful in half of all recipients. Overseas health organizations and institutions show successful outcomes alongside social impacts from patient support from outside the clinic. These studies demonstrate that there is a potential for HP-patient interactions to have more social implications within treatment, care and outcomes than realized. Qualitative research researching such influences may meaningfully insight person-to-person; not merely professional and client. Further, HPs may gather valuable patient relations skills. Again, capturing such data will improve HP daily professionalism.

Summary

Chapter two discussed the found, relevant literature about BWLS HPs and explored some of the body of knowledge regarding BWLS HP viewpoints and SCT. This section included research on obesity, patient relations, formal and informal exchanges, treatment, care, outcomes, and professional attitudes. Additionally, the chapter covered

many HP-patient encounters from other perspectives. Together, these studies point to future qualitative research using SCT. Moreover, there is a gap in the study omitting the HP viewpoint. This researcher sees the importance of finding deeper qualitative themes for understanding obesity's societal impacts. Understanding these societal impacts continue the ongoing fight against obesity.

Chapter three discusses this study's qualitative, narrative research design. Additionally, Chapter three presents the research methodology.

Chapter 3: Research Method

Introduction

Chapter 3 includes my research design for gathering qualitative data on the perceptions of BWLS EdBSNs about their experiences, interactions, and encounters with patients. This chapter's major sections are research design and rationale, the role of the researcher, methodology overview, issues of trustworthiness, and summary. The methodology overview section describes participant selection logic, procedures for recruitment, and participation; instrumentation and researcher-developed instrument criterion; data collection and analysis plan. The study's purpose is to better understand how BWLS HPs interact with their BWLS patients and how these interactions impact successful treatment, care, and health outcomes. Examples of treatment, care, and outcomes are listed later in this chapter. This researcher chose not to use the patient perspective because of her personal BWLS experience. The patient perspective is important one-half of the health professional-patient encounter. However, the patient perspective it is not the focus of this study. I found that the BWLS HPs viewpoint dynamic for several reasons: (a) HP-patient interactions are center to patient-focused public health; (b) current research points to the need for deeper comprehension of the HP-patient dynamic for improved health care delivery, health communication, and community health promotion; (c) there are HP-patient exchanges that occur that are recorded as part of a patient's PHI and researching with a BWLS HP is an avenue to this information within federal regulations; and (d) I have BWLS personal experience, as well as a BWLS patient advocate working with patients, support postsurgery.

Research Questions

Research Question 1: What BWLS health professionals' perceptions, beliefs, and attitudes impact the success of their BWLS patients' outcomes?

Research Question 2: How do BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' care and perspectives (i.e., care-completed BWLS surgery and related complications)?

Research Question 3: What BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' outcomes (i.e., outcomes-patient support activities and recorded lifestyle management)?

Research Design and Rationale

BWLS EdBSNs enter several pieces of individual patient PHI that are part of patient encounters as well as plan some patient support activities and events. As mentioned before, the patients do have their opinions and personal information included within the PHI during their mandated clinical visits. Inquiry about patient interactions, professional state of mind, expectations, and other personal insight is essential. This information is recorded by the BWLS education nurse (EdBSN) within the patient's PHI throughout the BWLS continuum. This action is a standard in BWLS patient engagement.

Below is a list of quantitative indicators used with BWLS EdBSN qualitative narratives that have quantitative merit.

- Treatment indicators (staff monitors): Presurgery weight loss, blood sugar, blood pressure, patient opinion about their progress before surgery, patient attendance in

patient support activities, whether those patients required to lose weight before surgery were on track or not; whether the duration of time from one presurgery checklist reference point to another was shorter or longer based upon the nature of the staff-patient interactions. (RQ1)

- Care indicators: completed surgery, patient surgery satisfaction, no surgery but the patient has developed better eating habits and consistent exercise, whether the patient's targeted BMI objective was higher or lower than projected or the patient survived for a stated period (either pre- or postsurgery) (RQ2).

- Postsurgery indicators: weight loss, personal satisfaction, patient support activity participation, patient habits disclosed, lifestyle compromises that are not BWLS cooperative (i.e. 'cheat foods,' alcohol consumption, little or no exercise) (RQ3).

These intended indicators were to be coded and analyzed using NVivo 12. NVivo 12 is a software designed to search, organize, analyze and find insights into narratives about health provider-patient relations and other qualitative data sets.

However, the use of mixed methods required the analysis of both qualitative and quantitative data. There were thirteen participants and little data that reported findings related to the above indicators. The raw quantitative data was presented alongside the qualitative findings that did not reveal the chosen codes. Both data sets were compared. Together, the compared data presented together presenting the participant outcomes with noticeable tendencies.

Denver metro area BWLS clinics, Colorado Nursing Association, and other professional organizations will receive an announcement email calling for volunteers.

Volunteers that respond to the research announcement will be encouraged to complete the online informed consent.

Informed consent process. Initially, the informed consent process was via the internet. Initial emails were sent to The Colorado Nursing Association, several local BWLS clinics, and several interested persons about this study. Interested persons were directed to a website that contained a small number of questions to inform individuals interested in volunteering for this study via a link with the original semistructured interview. Ideally, upon interview exit, each participant had the option to confirm their interview's transcript to clarify their conversation. A participant may recall a patient's personal choices and their emotions/connections to that patient. Participants had a one-week opportunity to refine their transcription upon request for one and one-half hours. Then the participants would exit using the strategy as mentioned earlier. Each participant would have been offered an incentive for their participation. Each incentive was a five-dollar gift card to a local coffee shop at the completion of the interview. Appendix A contains the participant informed consent form. The interview revision became the e-survey for the second implementation phase. For e-survey, participant consent was implied if the participant continued to the e-survey. Several of the participants accessed the online survey via its defunct link <https://www.surveymonkey.com/r/NSKNDJC> or Quick Response (QR) code. Below are several anticipated participant questions if the ideal scenario had occurred.

•Besides the researcher, will others have access to my interview transcription?

Answer: No.

- If I agree to be a participant, will I be able to drop out of the study later if I change my mind? Answer: Yes
- Will it be possible for me to be informed of the final study results? If so, how? Answer: Yes. Participants will be notified of the availability of the results and the actual dissemination of results. The distribution of the results will be determined as needed.
- Will my employer, fellow employees, or my professional organization(s) will treat me differently if I decide not to be in the study. Answer: No
- If I feel stress at any time during the study, may I stop? Answer: Yes

After deciding to participate, volunteers were directed to a second web page with the informed consent to be signed. Once signing the consent, an electronic schedule for the participants to select a date for their interview along with personal contact information for this researcher to verify their selection and inform the participant of the local branch of the public library for the interview. All interviews were to occur in private rooms in local branches of the Denver Public Library. Again, the interview was revised into an online survey with implied consent, and the interviews did not take place.

The second research implementation volunteers were considered participants once they began the online survey using implied consent. The application of confidential participant identifier strings (e.g., unique study identification number) identified with the completed e-surveys. www.random.org, a free online service, provided the identifier strings. The all-call, the clinical invitation, and snowballing strategies were selected to capture a range of professional perspectives and beliefs.

As mentioned before, BWLS EdBSNs access several pieces of individual patient PHI that are part of patient encounters and plan some of the patient support activities and events. The BWLS EdBSN-patient relationship is significant because recurrent interactions foster trust, credibility, and idea sharing (Schoenherr, Narayanan, and Narasimhan, 2015). Trust, credibility, and idea sharing informs and assists the HP viewpoint as it evolves. Several previous studies' sample sizes were small to accommodate qualitative research (and possibly participant availability). For example, LaFond, Van Hulle Vincent, Oosterhouse, and Wilkie (2016) conducted a qualitative study of forty nurses' opinions about their critically ill minors and pain management. The participant sample size goal was 50.

Additionally, Rees and Williams (2009) studied small groups of university health students to gather opinions about working with geriatric patients following studies designed with similar theory promoting social change or advocacy. A small sample provides an opportunity for scrutiny. A small sample allows in-depth analysis of conversation also called relation. A small sample permits inspection of personal exchanges, collaboration, specific connection (better known as a relation) (Knoke and Yang, 2008).

The chosen design was to use BWLS EdBSNs' narratives and answers via social cognitive theory (SCT) and constant comparison analysis (CCA) regarding impacts on BWLS patient success. Thus, the findings would ideally have produced a richer understanding of BWLS outcomes using the BWLS EdBSNs' perspectives via NVivo 12. Instead, this research incorporated several avenues for qualitative and quantitative

information. There were CCA comparison of similarities, differences, and discrepancies among the qualitative data. The raw quantitative data was gleaned for descriptive data.

These narratives could correlate BWLS health care, health processes, and successful patient outcomes; detailing the BWLS continuum, patient frequencies, patient compliance, and active participation in lifestyle management. The Education Nurse works with the patient through the presurgery treatment checklist, the procedure itself and postsurgery care, and onto patient weight loss and lifestyle management (indicators). Also, BWLS EdBSNs enter several pieces of individual patient PHI that are part of patient encounters and patient viewpoint about their progress in the BWLS continuum (qualitative indicators). Third, BWLS EdBSNs work with other in-clinic HPs to process patients throughout and at different points of the BWLS continuum collecting, processing, gleaning information about the patient progress (indicators). In the earlier Research and Design section is a list of health indices to be assessed using CCA demonstrating the multiple workings within the health professional viewpoint.

The central research phenomenon is the BWLS HP narrative about patient encounters. The narrative accrual approach is relevant because the telling of one's story exhibits her/his daily actions. Confidential, semistructured interviews would be used to encourage BWLS HPs to share their experiences. Bandura's Social Cognitive Theory (SCT) is this study's theoretical foundation. Narrative accrual can provide a portal into the reciprocal relationship between personal/professional beliefs, behaviors, and self. The researcher captures the HP viewpoint using the narrative. The quantitative data is then sorted into participant responses.

Researcher bias management occurred several ways. A public health expert was sought out by the researcher and has validated the research instrument. The gathered narratives were validated by triangulation using qualitative data simultaneously and giving both equal weight. Further, this study follows the National Institutes of Health (NIH) Office of Extramural Research guidelines for Protecting Human Research Participants. The research field notes and random string identifiers will be destroyed after five years.

Role of the Researcher

The role of the researcher was to interview BWLS HPs and observe. The researcher is a BWLS recipient. This researcher is a former BWLS patient advocate and patient support organizer in the Washington, District of Columbia area.

Additionally, the researcher has patient relations experience working with BWLS and other health professionals. The researcher has specialized knowledge of the BWLS continuum and could have a bias. The researcher's procedure was more than six years ago and performed in a different region from this proposal's selected area. A health professional, in a third region, validated the proposed interview. A small participant group may provide a better perspective on the research topic. The choices for Contrast Comparison Analysis and Social Cognitive Theory are to include any external or discrepant information that researcher bias may desire to exclude. The intention of the data analysis plan was the collection the HP experiences as narrated by the participants.

The researcher has relocated to the Denver, Colorado metropolitan area. The researcher's employer is the Denver Public Schools. She has limited collegial or

vocational ties to the proposed participant population area: Denver, Colorado.

The researcher has no known conflicts of interest, nor personal or professional leverage over the participants. Also, to reduce researcher bias, each volunteer will participate in the informed consent process. Using all the collected data including outliers and discrepant cases is used in comparison-contrast analysis method; further controlling researcher bias. Moreover, the researcher chose against including the patient perspective. The researcher has personal experience as a BWLS patient advocate and is a BWLS recipient herself.

Methodology Overview

The identified participants for this study were BWLS Education Nurses (EdBSNs) working in Denver, Colorado metropolitan BWLS clinics. BWLS EdBSNs work with patients and their protected health information (PHI). Also, they participate in the patient decision team. Individually, BWLS EdBSNs work in-clinic with other HP's asks to process patients through the BWLS continuum including the pre-, during surgery and postsurgery lifestyle. BWLS EdBSNs work with professionals outside the clinic to establish and provide patient support opportunities for both patients and patient support persons. Moreover, BWLS EdBSNs input individual patient notes within the PHI alongside the current visit vital signs as dictated by the patient. The patients could review and edit these notes just before the BWLS EdBSN enters them into the PHI.

This study's population was bariatric weight loss surgery (BWLS) education nurses (EdBSNs) working in BWLS clinics. Potential participants were contacted through-Colorado's nursing associations and direct contact with local BWLS clinics in

Denver, Colorado. The study criteria were as follows: the completion of a Bachelor of Science in Nursing (BSN) degree is part of the professional nursing associations' membership requirements, thus verifying their BSN from a four-year university or college. Second, potential participants had to have been employed in a Denver, Colorado metropolitan area BWLS clinic.

Originally, if a participant showed initial interest by responding to the "Call to Research," they were directed to a website to the online consent to the participants. After electronically signing the consent form, the participants were to download the interview script for personal perusal and select a meeting location for the confidential, semistructured interview. This research study's recruitment letter appears in Appendix B. This study's original, unused interview script appears in Appendix A. Due to the poor participant response, recruitment letters and the instrument were revised. A second call to research was made with the QR code and link to the survey website with the implied consent was made available to research volunteers; these actions gathered participants and data.

Ideally, the best way to learn about human experience is to engage in conversation; thus, allowing researchers to delve into feelings, beliefs, and experiences via social dialogue, but none of this experience occurred with this study. Where the BWLS patient perspective is best at gathering patient success, access to patients' PHI is restricted. Therefore, using the health professional viewpoint allows some disclosure of sensitive information. The interview is established to explore the human experience

(Kvale, 2006). The researcher engages in a professional interaction, utilizing careful listening and inquiry devised to glean data for themes within HP-patient interactions. This study presents ideas infrequently discussed in the research realm. The approach is methodical and systematic.

There were three recruitment strategies for additional participants if too few responses to the initial recruitment. First, the Colorado Nursing Association (CNA) will receive a letter requesting the announcement of research in their newsletter and during their monthly membership meeting. The choice for the CNA is to ensure contact with the desired participant pool. Second, the local BWLS community periodic meeting will be contacted to recruit participants.

Instrumentation

The first instrument was a confidential researcher-developed semistructured interview questionnaire with probes. The interview was created using the proposed research questions, Atieno's guidance, and Walden University Career Services Center's CART technique (a shared resource from Wayne State University, 2015). The original instrument was refined and validated by an epidemiologist who is former Walden University faculty member. A copy of the interview script is in Appendix B.

The original script originated from the researcher and was intended to encourage conversation. The instrument/interview intent was to raise topics to interviewees helping them to tell their story. Narratives present storytelling that is concrete, individualized, and open. These characteristics could reflect the collaborative nature of the BWLS HP and the patient, working toward the patient's health, wellness, treatment, lifestyle, and

outcomes. These encounters lend attention to the BWLS HPs' influence with the decision team. The intent was to capture BWLS HPs' perceptions, beliefs, and attitudes about their patient outcomes via these interaction stories.

The original instrument was unused despite a flurry webpage traffic. The original instrument was constructed with validated open-ended questions meant to evoke with knowledge and understanding memories regarding BWLS HP-patient encounters. The second instrument was an online survey and created from the validated semistructured, open-ended questions intended to encourage rapport and elicit BWLS HPs' narratives. Appendix D is the location of the second instrument. The online survey is closed and its link <https://www.surveymonkey.com/r/NSKNDJC> is defunct.

Qualitative researchers must consider the interview's context, the researched relationships alongside the investigated indicators. Semistructured interviews precede observations, and follow-ups enable the researcher's comprehension of the research subject (Cohen and Crabtree, 2006). Further, the interview and e-survey's natures isolate the researcher's role in assisting with researcher bias control. The questions were intended to collect relevant HP-patient encounter information that could formulate health initiatives and patient education program development. The data collected elicit a deeper understanding of HP-patient interactions. The research may add to existing public health components and HP professional development.

Data Analysis

Data analysis used NVivo 12 for Constant comparison analysis (CCA). NVivo 12 is a software designed to search, organize, analyze and find insights into narratives about health provider-patient relations.

Ideally, data collection would have occurred weekly or as participant schedules allow. The usage of several recording methods for clarity (for clarity and dictation purposes): field notes, NVivo 12, a digital voice recorder, and Dragon for Mac voice-recognition. The interviews were to be confidential and semistructured. Research question one addresses interview questions addressing patient situations before surgery. Research question two addresses interview questions regarding treatment and the next weeks before and after surgery. All questions involving more than two weeks after surgery address research questions two. Research question three addresses questions regarding postsurgery activities. The revised e-survey followed a similar structure.

This research used the Constant Comparison Analysis (CCA) method. CCA allows the use of discrepant and outliers in the data. In this research study, discrepant cases and outliers are useful because they provide contrast data amplifying similarities and differences. Discrepant cases can deliver qualitative data that is essential differing, informative outcomes. Outliers can present qualitative data contrasting against quantitative data sets. CCA is useful when addressing the participant's viewpoint, narrative accrual, and the PHI indicators while working with the inner workings of the health professional's perspective (SCT). These are limiting, yet credible identifiers of mixed methods research (Boeije, 2002; Dye, Schatz, Rosenberg, and Coleman, 2000).

The health professional's perspective reflects the internal operation of SCT while functioning with recalled patient relations. These experiences' themes and PHI indicators are the goals of each narrative transcription search. Both differing and similar qualitative data will be compared and contrasted to gather themes, frequencies, differences, and polar results. These are limiting, yet credible identifiers of research (Boeije, 2002; Dye, Schatz, Rosenberg, and Coleman, 2000).

The completed participant surveys were assigned an alphanumeric code using www.Random.org's random string generator. Each interview will be transcribed by and verified by the researcher. NVivo 12.0 software analysis required imported transcriptions. NVivo searches for recurring participant-used trends and themes. The software will seek out the usage of certain words and the frequency of certain words with those words used grouped into data sets. These datasets will be sorted and categorized for research conclusions.

Again, each response received an alphanumeric string code. As data is collected codes will be developed for frequently used words, phrases, and sentences will use descriptive or inferred data as applied by the participants (Reeder, 2009). Additionally, code sets will be to represent observations and field notes. Further, a codebook will be devised to organize all the sets to look for: patterns, themes, similarities, and differences. Categorizing classifies data into mutual groupings for comparison between similar datasets with similar description (Elo and Kyngas, 2008, p. 111). Identified trends and ideas capture both individualized and shared experiences (Ayers, Kavanaugh, and Knafl, 2003, p. 873; Rennie, 2012). Verification requires cross-checking; revisiting the data to

verify the results confirming validity. Validity will be determined by having HP's reveal data during their interviews.

Research Tools

The chosen tools for this research are field notes, random string participant identifiers, NVivo 12 qualitative study software, a digital voice recorder and Dragon for Mac voice recognition software. Capability between interviews prompted the selection of these tools. The data analysis will seek themes and trends from participant responses.

Field notes

Field notes are handwritten, scientific recordings that are organized and accumulated to accompany observations or interviews. This research's accompanying field notes will be arranged using time, day, and date. The field notes contain the participant random string code for distinction recorded on the researcher's copy of the interview script. The field notes were few.

Random strings

The participant identifiers were generated using a random string generator. This generator creates randomized integer sequences (Haahr and Haahr, 2017). Each strand served as a participant identifier rather than individual names. The researcher chose this action to keep the narratives confidential.

Analysis software

The chosen data analysis software is NVivo 12.0. This tool will search for similarities and themes within open-ended interviews. NVivo helps to explore and identify phenomena within qualitative research and sorts themes and trends within the

data. One possible limitation of this software is the similarity of sorted trends and themes within the found dataset. The researcher will be sure to create a hard copy of the dataset and search for differences within similar data sets, by hand.

Voice recognition software

The voice-recognition software choice was Dragon for Mac. Dragon for Mac allows for full speech cadence recognition that is comparable to previous Dragon technology. One possible limitation is incompatibility of participant voices and the software. Another limitation could be software malfunction or annual updating. The researcher does not control either of these software aspects. Dragon software is known for its accuracy and its adjustment to the user's voice cadence. This capability is vital because clarity is necessary for word use and comprehension. The interviews did not occur, and the software unused.

Digital voice recorder

The interviews will be recorded using a digital voice recorder (i.e. VR) for clarification. VRs are lightweight and small. VR files transfer easily via USB for transcription and data storage. The interviews did not occur and the software unused.

Coding

All participants surveys were assigned an alphanumeric code using www.Random.org's random string generator to retain participant anonymity. Participants may share more willingly with anonymity. Ideally, the first and second round of interviews would have been coded differently to designate initial and follow-up interviews. There were only thirteen completed online surveys and used in data analysis.

NVivo 12.0 applies codes to data qualitative regarding situation differences/similarities, patient compliance, and other data as they present themselves. The coded data was used to find trends and themes in BWLS HPs 'perceptions, beliefs, and attitudes about their patient interactions. Ideally, the researcher would conduct and record the interviews and collect the data in addition to note-taking. Instead, the completed surveys processed via assigned code strands and analyzed using CCA comparing appearing themes, the research questions, and the literature review. Collected data was transferred to a research-purposed external hard drive. The external hard drive will be protected for seven years. Data protection is further discussed in the Ethical Procedures section of this chapter.

Issues of Trustworthiness

Trustworthiness in research lends support that the study results are worthy of scientific scrutiny. Research reflects an outlook acknowledging the existence of equally, individualized truths (Barbour, 2001, p. 1117). Some of these aspects are credibility, dependability, and confirmability; all of which are necessary for successful research.

Credibility

Ideally, the selection of face to face interviews for specificity and intimacy. This format works well with triangulation and participant scheduling flexibility; removing opportunities for researcher bias and misinterpretation. CCA compares participants with different viewpoints, at different points in time, and in differing settings. This choice possibly provided well developed, rich, triangulated information leading to deeper comprehension (Cohen and Crabtree, 2006).

The collection of online surveys allowed for anonymous content and quick participant completion. Online surveys allowed a paper copy of each completed survey; thus automatic transcription and reduced researcher interpretation.

Transferability

This research contains a thick description and some variation in participant selection. Thick description expresses themes and positions. Participant variation included age, work location, job duties, employment length, ideals, and vocation length. These are essential aspects encourage the study's internal and external transferability. Ideally, interviews and follow-ups describe the HP viewpoints in full detail potentially transferable to another HP and worker research. This study's recordings and notes would have detailed accounts display sociocultural relationships and context (Holloway, 1997; Cohen and Crabtree, 2006). The e-survey transcriptions did provide participant variation and written responses.

Dependability

Detailed description marking sociocultural context is essential to qualitative research. This study attempted to describe HP viewpoints about their patient relations. The researcher intended to collect data and describe it to its fullest. Below are several strategies to reduce this study's data corruption; using in-person interviews, applying the previously mentioned tools, probes for possible recall and accuracy, and follow-up interviews.

Confirmability

Confirmability is the degree to the data collected shape the findings (Brian, 2011). Qualitative research provides intimate social detailing that may escape study based only on statistics. The responsive interview ideally releases the participant to freely express her/his professional thought while functioning ethically (Macfarlane, 2010, p. 9-15). Fluidity (i.e., scheduling, comfort, and openness) allows participant rapport and encourages honesty. This researcher does not work for a health facility, thus reducing the conflict of researching in her workplace. Even so, the researcher did not have to find locations that are not workplaces to further enhance participant rapport because the surveys were online.

Initially, this study followed Seidman's recommendation that interviews be three days to a week apart. This choice provided a realistic time for reflection and interpretation between sessions and scheduling (Watt, 2007, p. 9). Interview locations would have been local branches of the public library, approved by WU IRB. The collect survey transcriptions were used to create data input shapes using NVivo 12. These data will encompass richly detailed reports of HPs views, their meanings and interpretations given to events, as well as their behavior. These confirmed BWLS HP-patient interactions may lead to data transferability to the general application for the industry-wide practice of patient treatment, care, and outcomes.

There is no intercoder reliability. As the only coder, there was no additional interpretation or confusion as to the definition of this study's codes. This researcher considers keeping an audiotaped and written journal of the research process for future

transcription and publishing. This action allows reporting of viewpoints, assumptions, and positions that may have come into play during this research process. This researcher assigned random strings to each transcription and considered the same for projected categories for each piece of data text (interview transcripts, direct notes, and field observations). These codes will start with a generated list (Haahr and Haahr, 2017).

Ethical Procedures

This section addresses Several ethical considerations. The interview questions, the informed consent, confidentiality, the interviews, the transcriptions, the data analysis and data storage, are all the duty of the researcher. During the first implementation phase, each potential participant was offered a link accessing a consent form and a sample interview script. During the second implementation phase, the same avenues were used and provided a link to the online implied consent and survey. Ideally, the recorded interviews, their transcriptions, the data analysis, and data storage were to be secured and destroyed after seven years. The secured survey transcriptions are locked in a file cabinet in the researcher's domicile. The secured items will be burned at a location approved by WU IRB.

The participants responded about professional information that may have a personal impact on themselves. Participating in this research may have a therapeutic effect on daily work struggles (Allmark et al., 2009). The participants may change their work behaviors after the initial interview or the follow-up. The participants may desire to withdraw from the study because of personal viewpoints; resulting in reducing the collected data. Again, the nature of mixed methods health research incorporates people,

their daily routine, their viewpoint, and their wellness. The chosen research design regards these ethical aspects as part of the worker research to be incorporated and discussed within the research process (Bowen, 2005) (Orb, Eisenhauer, and Wynaden, 2000).

This narrative exploration used human participant guidelines from Walden University's Institutional Review Board (WU IRB) and the United States Department of Health and Human Services' (HHS) National Institutes of Health Extramural Research standards. These guidelines include complete confidentiality of participants and disclosure for work themes, practices, and processes. WU IRB approval number for this study is 11-20-17-0137945.

The researcher did not foresee a limitation in the recruitment material. The researcher sent several invitations including an individual invitation to local professional agencies and BWLS organizations. After verification, the provided consent form contained statements requesting participant agreement to audiotaped interviews is in Appendix A. Participant agreement is required to join the study. All contact forms mentioned above appear in Appendices A, B, C, D, and E.

There may have been ethical concerns regarding the participant pool and several participants. A sufficient pool of participants was attempted from the onset to anticipate predictable adverse events during both rounds of implementation. Participant withdrawal from the study was possible if a volunteer refuses participation or requests an early departure. The participant group was not part of the identified vulnerable populations. Mixed methods study includes all participants, discrepant cases, and outliers. The

researcher preferred that all volunteers remain with the research and disclose the number of participant withdrawals if any.

There may have been an ethical concern regarding data storage. The researcher followed the WU IRB Student Responsibility for Technology Backup. Data storage is on a separate sixteen-gigabyte external hard drive as well as fee-for-service secure cloud storage. Weekly data backups are occurring. The researcher is responsible for keeping the hard drive safe. There are seven years of protection for confidential data, data storage procedures, and data dissemination. Eight years and six months after research completion, data incineration occurs at a location approved by WU IRB.

There may be an ethical concern regarding participant recruitment. The participants are a particular group. Both sets of recruitment included Colorado's nursing associations' memberships, monthly professional BWLS groups and several interested individuals that could forward the information if they opted. During the second implementation phase, if a participant showed initial interest, they were automatically moved to the first e-survey question thus implying consent.

Protections for confidential data are applied. WU IRB data storage procedures and data dissemination determine when data destruction. Other ethical issues such as research within one's work environment; conflict of interest, incentives use justification, or power differentials do not apply. The researcher has little or no collegial or professional ties to the Denver, Colorado metropolitan area. The researcher did not foresee an ethical issue that could include doing a study within this investigator's

residential metropolis including questions of whether data are confidential or confidential and any concerns related to each participant.

The original research plan was approved with face-to-face interviews starting in January 2018. After three months of recruiting and over 100 website views, there were zero respondents and zero participants. At the committee's suggestions, adjustments were made to the study instrument and informed consent, thus becoming an anonymous online survey with implied consent. The new tool was released early April 2018. The new research instrument contained both qualitative and quantitative data reflecting a transition to mixed methods study. The research questions remained the same.

Summary

Chapter Three presented the study's design, population, methods, and analysis plan. Additionally, this chapter described the recruitment process for this research. Also, this study followed the guidelines for human participant research from WU IRB and the United States Department of HHS National Institutes of Health Extramural Research standards. Finally, Chapter Three addresses ethical concerns and data handling. Chapter Four will focus on the study's results detailing a description of the data collection.

Chapter 4: Results

Introduction

Chapter 4 contains the description of the data set. The data set includes the time frame for data collection, actual recruitment, response rates, discrepancies. Also, Chapter 4 comprises any accompanying data set information and themes. The study's purpose was to better understand how BWLS health professionals (HPs) interact with their BWLS patients and how these interactions impact successful treatment, care, and health outcomes. Examples of treatment, care, and outcomes are listed later in this chapter. The patient perspective is essential and one-half of the health professional-patient encounter; however, the patient perspective is not the focus of this study.

In this research study I utilized mixed methods. The switch to mixed methods pertained to an April 2018 transition: the interview became an anonymous online survey. This dissertation committee suggested the alteration because there were zero participants between January and March 2018. Walden University Institutional Research Board was notified. The research questions remained the same.

This researcher considered BWLS HPs viewpoint as dynamic for several reasons:

1. hp-patient interactions are center to patient-focused public health;
2. current research points to a deeper comprehension of the HP-patient dynamic for improved healthcare delivery, health communication and community health promotion;
3. there are HP-patient exchanges that occur that are recorded as part of a patient's PHI and researching with a BWLS HP is an avenue to this information within federal regulation, and
4. this

researcher has BWLS personal experience as a patient advocate working with patient support postsurgery.

Research Questions

Research Question 1: What BWLS health professionals' perceptions, beliefs, and attitudes impact the success of their BWLS patients' outcomes?

Research Question 2: How do BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' care and perspectives (i.e., care-completed BWLS surgery and related complications)?

Research Question 3: What BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' outcomes (i.e., outcomes-patient support activities and recorded lifestyle management)?

Data Collection

December 2017 through April 2018 was this study's data collection phase which included recruitment and responses. During the first implementation phase, participants were recruited primarily through the participant recruitment webpage-<https://tracycullins-clark.wixsite.com/researchwebsite>. The participant group recruitment occurred from the Colorado Nursing Association, local clinics as well as independent forwarding to interested persons (e.g. 'snowballing,' 'snowball'). Bariatric weight loss surgery education nurses were chosen for their specified patient contact.

Early March 2018, there had been no respondents to the two previous 'All Calls' for volunteer study participants. It was necessary to open a second implementation phase. The interview was revised into an online survey using a free survey building

website that provided a direct access link and a quick response (QR) code for the new survey. Again, a QR Code is a two-dimensional barcode that is readable by smartphones that can allow the encoding of over 3000 characters in a two-dimensional barcode. QR Codes are used to display text to the user, to open a URL, or other information (Unitag, 2018). Once completed, a third 'all call' occurred including a link and QR code. The 'all call' was forwarded (i.e. 'snowballing') to other health professionals that expressed interest. The third 'all call' contained a link and a QR code that directly accessed the implied consent and online survey. Figure 1 is an illustration of the link and QR code. Participant using the QR code increased the 'snowballing' possibilities. Participants that knew other possible volunteers easily forwarded the QR code. The code could be accessed using a mobile device. Mobile devices allowed for more avenues for

Thanks in advance for your interest in this research study. To access the questionnaire, copy the link below in your internet browser and press enter. You may also scan the QR code on the right to have direct mobile access.



<https://www.surveymonkey.com/r/NSKNDJC>

Figure 1. Link and QR Code.

Volunteers that accessed online survey first read the implied consent. Once volunteers selected 'yes'; they consented to participate in the study and proceeded to the online survey's first question. By April 30, 2018, thirteen participants consented to participate in this research completed surveys.

Because of the new data instrument, there was a revision of the analysis portion of the study. The survey includes some data collected using Likert scaling. The study's analysis has a few qualitative and quantitative data points which required using mixed methods with Social Cognitive theory and Constant Comparison analysis. NVivo remained the study's analysis software because of its mixed methods utilization.

Data Analysis

Each completed e-survey was downloaded to a portable document format (pdf) file becoming an automatic transcribed document. This action simplified the transcription process as it was part of the features that accompanied using the survey builder. During download, each completed survey received a random alphanumeric eight-character identification string; increasing confidentiality. Transcription allowed this researcher to glean information from each study completed via uploading to NVivo 12. The researcher downloaded a printed copy of each survey for scrutiny. This researcher has previous experience with NVivo's capabilities with data. The qualitative queries and their responses are listed here as individually written in their responses. The qualitative queries included the three sample population demography identifiers. Below, Table One describes their ages and gender identification. On the next page, Table Two describes their roles in patient interactions and their roles in patient interactions.

Table 1

Participant Identifiers

Age	Participant Responses	Gender	Participant Responses
Prefer not to Identify	2	Agender	0
75 or older	2	Androgynous	0

65-74 years	2	Bigender	0
55-64 years	0	Female	9
45-54 years	4	Fluid	1
35-44 years	1	Male	2
25-34 years	2	Transgender	0
24 years or younger	0	Prefer not to identify	1

Table 2

Participant Roles and Education Levels

Role in Patient Relations	Participant Responses	Education	Participant Response
Prefer not to Identify	3	Doctorate degree	3
Intake Nurse	1	Professional degree	0
Patient Education	5	Master's degree	4
Surgery Nurse	0	Bachelor's degree	5
Surgeon	0	Associate degree	0
Anesthesiologist	0	Technical degree	0
Insurance Verification	0	Some college credit, no degree earned	0
		High school graduate, diploma, and/or equivalent	0
		Prefer not to identify	1

Quantitative

These are the quantitative responses to the e-survey found in Appendix E.

Research questions organize the findings. These findings are integral and support this study. They reveal important information about bariatric weight loss surgery (BWLS) as regards the health professional-patient interaction frequency and occasion. Additionally, these findings disclosed some of the varied health professionals that work with BWLS patients. The e-survey link and QR code were snowballed (e.g., independent forwarding to interested persons) to health professionals that expressed interest in the study.

Table 3

Patient Interaction

	20% or less	21-40%	41-60%	61-80%	81% or more
Q7: Estimate how many patients do you have frequent interaction with such as a patient you see in-clinic as scheduled, prepared with all information as asked?	2	3	3	3	2
Q8: Approximately, how many patients you have infrequent interaction AND desiring the BWLS procedure but does not attend clinic as scheduled.	6	3	2	2	0
Q9: What percent of your immediate postsurgery patients would you estimate adhere to the preset treatment and care?	1	6	2	3	1
Q10: What percent of about your typical patient interaction with a patient more than two-week post BWLS that is now eating solid food?	2	3	5	1	1
Q11: What percent of your atypical patient interactions more than two weeks after BWLS such as a patient who has returned with complications with the surgical site?	5	5	3	0	0

Table Three (above) presents questions seven through twelve. Question seven addressed participants for their perceived frequency with patient interactions with patients adhering to the prescribed schedule, paperwork, and activities pre-BWLS-almost equal ratios across the categories. Question eight had six out of thirteen in the twenty percent or less category for infrequent patient interaction with patients desirous of the BWLS procedure but do not adhere to the requirements. Data for atypical patient interactions for more than two weeks post-BWLS (question nine; combining both of the first two categories) with complications was seven out of thirteen for twenty percent or less.

Question 7 addressed participants for their perceived frequency with patients that adhere to the prescribed schedule, paperwork, and activities. There was almost equal distribution across the Likert scale. Question 8 had six out of thirteen in the twenty percent or less category for infrequent patient interaction with patients desirous of the BWLS procedure but do not adhere to the requirements. Data for atypical patient interactions more than two weeks post-BWLS with complications was seven out of thirteen for twenty percent or less. Participants perceptions regarding those that consume state regulated adult substances (like alcohol or marijuana) were as follows: 5 out of 13 report 20% or less; five out of thirteen reported 21-40%; three out of thirteen reported forty-one to sixty percent; zero out of thirteen for sixty-one percent or more.

Using the BWLS expected weight loss of 50% or more, participants reported the following: one participant-twenty or less; one participant-twenty-one to forty percent; five participants-forty-one to sixty percent; four participants-sixty-one to eighty percent; and two participants-eighty-one percent or more. Question nine queried the perceived percent immediate postsurgery patients would you estimate adhere to the preset treatment and care as follows: one out of thirteen reported twenty percent or less; six out of thirteen reported twenty-one to forty percent; two out of thirteen reported forty-one to sixty percent; three out of thirteen reported sixty-one to eighty percent; and one out of thirteen reported eighty-one percent or more. Question ten asked the participants about typical patient interaction with patients that are two weeks post-BWLS eating solid foods with these results: two participants-twenty percent or less; three participants-twenty-one to

forty percent; five participants-forty-one to sixty percent; one participant-sixty-one to eighty percent; one participant-eighty-one percent or more.

Table 4 displays Question 12. Question twelve was about perceived adult substance consumption. Participants perceptions regarding those that consume state regulated adult substances (like alcohol or marijuana) were as follows: five out of thirteen report twenty percent or less; five out of thirteen reported twenty-one through forty percent; three out of thirteen indicated forty-one to sixty percent; zero out of thirteen for sixty-one percent or more.

Table 4

Estimated post-BWLS patient consume state regulated adult substances

	20% or less	21-40%	41-60%	61-80%	81% or more
Q12: Estimate the percentage of your post-BWLS patient consume state regulated adult substances such as alcohol or marijuana?	5	5	3	0	0

Table 5 presents findings from questions thirteen, fourteen, fifteen, and sixteen were combined into a single table for easier comparison. Each question regarded the health professionals' perceived patient post-BWLS weight loss. Most of the ratios were similar except for the first category of question sixteen. Nine out of thirteen is statistically significant number of those that perceive that they have twenty percent or less patients with no weight loss.

Table 5

Perceived Patient Postsurgery Weight Loss

	20% or less	21- 40%	41- 60%	61- 80%	81% or more
Q13: 50 pounds lost	0	2	4	2	3
Q14: 100 pounds lost	3	3	3	2	2
Q15: 150 pounds lost	5	5	2	0	1
Q16: No pounds lost	9	2	1	1	0

Above, Table Five presents combined findings from questions thirteen, fourteen, fifteen, and sixteen. Each item regarded the health professionals' perceived patient post-BWLS weight loss. Most of the ratios were similar except for the first category of question sixteen. Nine out of thirteen is a statistically significant number of those that perceive that they have twenty percent or fewer patients with no weight loss.

Again, the findings presented in Chapter Four are from the use of the revised instrument in Appendix E. Table Six represent findings for question seventeen. Question seventeen asked the participants about their estimation of patient adherence to the post-BWLS patient support activity requirements. Responses were as follows: three participants-twenty percent or less; three participants-twenty-one to forty percent; five

participants-forty-one to sixty percent; one participant for both categories sixty-one to eighty percent and eighty-one percent or more.

Table 6

Patient Adherence

	20% or less	21- 40%	41- 60%	61- 80%	81% or more
Q17: What percentage of patients would you estimate adhere to the patient support activity requirement?	3	3	5	1	1

Table seven represents questions eighteen and nineteen. Questions eighteen and nineteen asked about participant perceived percentages for patient support attendance more than twelve months and more than twenty-four months post-BWLS. These numbers were nearly identical.

Table 7

Patient Support Attendance

	20% or less	21- 40%	41- 60%	61- 80%	81% or more
Q18: more than 12 months postsurgery	0	1	2	5	5
Q19: more than 24 months postsurgery	0	1	2	6	4

When queried about their patient support activities attendance, the participants responded: weekly-three out of thirteen; twice a month-one out of thirteen; monthly-four

out of thirteen; every other month-one out of thirteen; once every three months-zero out of thirteen; every six months-one out of thirteen; once a year-three out of thirteen.

In Table 8, Questions 24, 25, 26 and 27 inquired about participant beliefs about patient adherence more than six months, more than twelve months; more than eighteen months, and twenty-four months, respectively. The ratios for questions twenty-three and twenty-four were similar. Questions twenty-six and twenty-seven presented comparable data. Moreover, resembling proportions presented each of these four questions for 21-40% category as well as 61-80% category.

Table 8

Post Surgery

	20% or less	21- 40%	41- 60%	61- 80%	81% or more
Q24: More than 6 months postsurgery	3	4	2	2	2
Q25: More than 12 months postsurgery	4	4	1	1	3
Q26: More than 18 months postsurgery	5	4	0	2	2
Q27: More than 24 months postsurgery	6	5	0	1	1

Qualitative-Written responses

The lists below present the poignant and brief participant written responses. The written answers are informative. They provide insight into the respondents' beliefs about their patient interactions. The chosen definitions of health professional-patient interaction and the participants own word choice deliver a viewpoint seldom seen. These survey questions and the responses are in no particular order.

Question 6 asked about participant beliefs about their role in a BWLS patient's likelihood of success. All participant responses are listed below.

- I hope they get information that will give them great results
- n/a
- My belief is that I play a critically important role in that BWLS patients have a lot at stake dependent upon their success in the BWLS program. Education of the patients regarding the program, its risks and benefits, alternative weight control options and associated risks and benefits, and the need for their commitment and perseverance is critically important.
- Encouragement
- I have supported them in whatever way I can.
- Anyone who stays with a task can do anything.
- Goal to engage the patient, educate, and support behaviors that will lead realistic weight maintenance. That stated, the provider- patient relationship, as perceived by the patient, may be important if I'm to be successful when delivering these services.
- I help motivate patients to make changes prior to surgery to help improve their outcomes.
- My beliefs are that a patient's soul always have a choice to choose a weight loss treatment they believe in
- Nutrition is one of the keys to success in BWLS success. However, in a hospital setting all the food is controlled. Nutrition plays a bigger role once they are released to go home. This is where we see the most complications. Non-compliance to the diet because they assume BWLS is a quick fix and don't fully understand what they are getting themselves into.
- I can provide knowledge regarding the bariatric diet pre and postsurgery. I can provide motivation and encouragement to patients to assist them on their weight loss journey.
- My role as a patient education coordinator is vital to the patients' postsurgery success.
- Patients sometimes report unusual things in our support group.

Question 21 required a written explanation about an atypical patient-support interaction.

- n/a
- I have often observed one patient become very weak and lethargic when she

- does not eat enough protein
- they stare at me
- n/a
- Patients sometimes report unusual things in our support group.
- Typically, support is listening, feedback, evaluation of patient goals and possible delivery of tools/tactics to reduce patient stressors, etc. The patient's needs just be prioritized, so that care, education, or behavior modification can be continue. Atypical support interactions are those that are aborted or missed by the patient or interrupted by a patient emergency.
- I have met patients shopping for food and clothing and used the opportunity to reinforce health-related education and to encourage and compliment them.
- n/a
- I saw one that I did not recognize until she spoke my name and I recognized her voice.
- No comment
- Some are extremely successful if the follow the program.
- Seen a patient at a restaurant and they ordered a small salad and tea.
- n/a

Question 4 regarded individual participant roles in patient interactions before in ensuring the patient is fully prepared before BWLS. The participants' work roles are listed below in no particular order.

- 1 participant-Intake nurse
- 5 participants-Patient Education
- 3 participants-Patient nutrition
- 0 participants-Surgery nurse
- 1 participant-Vitals nurse
- 0 participants-Surgeon
- 0 participants- Anesthesiologist
- 0 participants-Insurance verification
- 3 participants- Other (please specify)

Question 29 addressed an individual definition of patient interaction. The participants were provided four cited definitions using the Publication Manual for the American Psychological Association (APA). The responses are listed below.

- 1 participant- "...influences hope, meaning in life and self-transcendence in

cognitively intact nursing home patients and might be an important resource in relation to patients' health and global well-being (Haugan, G. (2014) Nurse–patient interaction is a resource for hope, meaning in life and self-transcendence in nursing home patients, <https://doi.org/10.1111/scs.12028>.)

- 1 participant- “...interplay comprises the social aspects of a confidential relationship shared by physician and patients (doctor-patient interaction. (n.d.) McGraw-Hill Concise Dictionary of Modern Medicine. (2002).
- 11 participants- “...communication in medical encounters: (1) fostering the relationship, (2) gathering information, (3) providing information, (4) making decisions, (5) responding to emotions, and (6) enabling disease- and treatment-related behavior” (King and Hoppe, R. B. (2013). “Best Practice” for Patient-Centered Communication: A Narrative Review. *Journal of Graduate Medical Education*, 5(3), 385–393. <http://doi.org/10.4300/JGME-D-13-00072.1>)
- 0 participants- “...interplay which comprises the social aspects of a confidential relationship shared by physician and patients. Each ‘player’ in the dyad has an appropriate role (doctor-patient interaction. (n.d.) Segen's Medical Dictionary. (2011).

Qualitative-Written Responses

The lists below present the participant written responses. The written answers are informative. They provide insight into the respondents' beliefs about their patient interactions. The chosen definitions of health professional-patient interaction and the participants own word choice deliver a viewpoint seldom seen. Question 6 asked about participant beliefs about their role in a BWLS patient's likelihood of success.

- I hope they get information that will give them great results
- n/a
- My belief is that I play a critically important role in that BWLS patients have a lot at stake dependent upon their success in the BWLS program. Education of the patients regarding the program, its risks and benefits, alternative weight control options and associated risks and benefits, and the need for their commitment and perseverance is critically important.
- Encouragement
- I have supported them in whatever way I can.
- Anyone who stays with a task can do anything.
- Goal to engage the patient, educate, and support behaviors that will lead realistic weight maintenance. That stated, the provider- patient relationship, as perceived by the patient, may be important if I'm to be successful when delivering these services.
- I help motivate patients to make changes prior to surgery to help improve their outcomes.
- My beliefs are that a patient's soul always have a choice to choose a weight loss treatment they believe in
- Nutrition is one of the keys to success in BWLS success. However, in a hospital setting all the food is controlled. Nutrition plays a bigger role once they are released to go home. This is where we see the most complications. Non-compliance to the diet because they assume BWLS is a quick fix and don't fully understand what they are getting themselves into.
- I can provide knowledge regarding the bariatric diet pre and postsurgery. I can provide motivation and encouragement to patients to assist them on their weight loss journey.

- My role as a patient education coordinator is vital to the patients' postsurgery success.
- Patients sometimes report unusual things in our support group.

Question 21 required a written explanation about an atypical patient-support interaction.

- n/a
- I have often observed one patient become very weak and lethargic when she does not eat enough protein
- they stare at me
- n/a
- Patients sometimes report unusual things in our support group.
- Typically, support is listening, feedback, evaluation of patient goals and possible delivery of tools/tactics to reduce patient stressors, etc. The patient's needs just be prioritized, so that care, education, or behavior modification can be continue. Atypical support interactions are those that are aborted or missed by the patient or interrupted by a patient emergency.
- I have met patients shopping for food and clothing and used the opportunity to reinforce health-related education and to encourage and compliment them.
- n/a
- I saw one that I did not recognize until she spoke my name and I recognized her voice.
- No comment
- Some are extremely successful if they follow the program.
- Seen a patient at a restaurant and they ordered a small salad and tea.
- n/a

Question four regarded individual participant roles in patient interactions before in ensuring the patient is fully prepared before BWLS. The participants are listed below in no order.

- 1 participant-Intake nurse
- 5 participants-Patient Education
- 3 participants-Patient nutrition
- 0 participants-Surgery nurse
- 1 participant-Vitals nurse
- 0 participants-Surgeon
- 0 participants- Anesthesiologist
- 0 participants-Insurance verification
- 3 participants- Other (please specify)

Question twenty-nine addressed an individual definition of patient interaction. The participants were provided four cited definitions using the Publication Manual for the American Psychological Association (APA). The responses are listed below.

Codes

NVivo analyses resulted in a defined health professional focus on patient participation and outcomes. NVivo analyses displayed word cloud codes and percentages favorable of the first findings. Each automatic transcription was uploaded into NVivo 12 for analysis three times. The first run of wording codes applied to the transcriptions using word combinations, and similar wording: ‘patient interaction’, ‘patient education’, ‘check’, ‘checks’, ‘schedule’, ‘effectiveness’, ‘bariatric’, ‘BWLS’, ‘success’, ‘successful’, ‘lose’, ‘outcomes’, ‘information’, ‘work’, ‘surgery’, and ‘surgical’. Most prominent is the use of the words ‘patient’, ‘check,’ ‘outcomes,’ ‘interaction,’ ‘surgery.’ It is evident that the participants used the emphasized words frequently; designating these word selections’ importance in their written narrations. Figure 2 is the NVivo 12 first



Figure 3. Word Cloud 2.

Figure Four also presents the third NVivo 12 analysis displaying patient focus as well as bariatric healthcare outcomes. The third word code set was applied transcriptions, word combinations, and similar wording: ‘patient’, ‘patient interaction’, ‘check’, ‘weight’, ‘management’, ‘bariatric’, ‘BWLS’, ‘treatment’, ‘successful’, ‘lose’, ‘outcomes’, ‘relationship’, ‘medical’, and ‘surgey’. The resulting word cloud was similar to the first; emphasizing the words ‘patient’, ‘check,’ ‘one,’ ‘surgery’ and ‘check.’



Figure 4. Word Cloud 3.

The word clouds demonstrated the prominence of the one-on-one patient interaction within the received responses. This research concludes that with more time and in-person interviews more information regarding the working of Social Cognitive Theory within

the respondents' work behavior could be obtained and analyzed.

Themes

Several themes are extant. These ideas became notable. One theme corresponded to national data.

Twenty Percent or Less

Participant responses reflected answers in the twenty percent or less category regarding patient interaction-appearing response resistant or lessening the responses to appear indistinct. Many participants seem to favor a lower percentage. These choices seemingly indicate the participants' reluctance to report professional activities and decisions.

Professional Beliefs

When asked about professional beliefs regarding their role in patient success likelihood, 46% of participants reported twenty percent or less. This question queried participants to respond with their opinion about their beliefs. Most refrained from answering. This resistant action frequently reoccurred with participant response and belief questions- a prominent theme. Questions eighteen and nineteen reflected the same direct reactions to patient outcomes as earlier mentioned. The immediate answer questions gathered defined responses. Questions about professional opinion were skipped or unanswered. These choices seemed to reinforce an error for reluctance.

Personal Identifiers

Two themes identified in the personal identifier categories: four out of thirteen

participants identified as ages 45-54 and seven out of thirteen stated their educational level as Masters' degree or higher. Zero participants provide contact information for the study results. Such participants are aware of the research, research necessities, and the need for current field research. Also, such participants were mindful of research confidentiality and constraints. The trend of unanswered and skipped questions persisted.

Specific Definition

Eleven out of thirteen participants selected King and Hoppe's definition of patient relations. The definition is as follows: "...communication in medical encounters: 1. Fostering the relationship, 2. Gathering information, 3. Providing information, 4. Main decisions, 5. Responding to emotions, and 6. Enabling disease- and treatment-related behavior" (King and Hoppe, 2013). The definition may also be found using the citation King, A., and Hoppe, R. B. (2013). "Best Practice" for Patient-Centered Communication: A Narrative Review. *Journal of Graduate Medical Education*, 5(3), 385–393. <http://doi.org/10.4300/JGME-D-13-00072.1>.

The selection of the 'twenty percent or less' category was irrefutable. Gathering information from this participant group was scant. The participant group identified their beliefs in patient-driven care despite their response choices regarding their personal or professional behavior. The participant genders and national data are similarly proportioned. There was a distinct allusion between the participant choices with specific queries and other decisions that were manifest. An example of the conflicting information is the differing information in tables five and six. The identified themes are consistent and reinforced the reluctance.

Confirmability was not an issue because the researcher did not have to find locations that are not workplaces to further enhance participant rapport because the surveys were online. Dependability and credibility were not an issue because online surveys were collected allowing for anonymous content and quick participant completion, automatic transcription, and reduced researcher interpretation.

Themes v. Research Questions

The data presents themes that relate to the research questions both quantitatively and qualitatively. This section provides comparison and contrast using the research questions.

Research Question 1

The dataset presents BWLS health professionals' perceptions, beliefs, and attitudes impacting the success of their BWLS patients' outcomes. Forty-six percent of participants reported 20% or less successful outcomes which are less than national reporting. Many refrained from answering or skipped questions. These actions reinforce the appearance of an air of reluctance regarding reporting their role in patient success likelihood, although many factors may have contributed to the poor response rate and incomplete survey responses.

Research Question 2

The dataset presents BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' care and perspectives (care-completed BWLS surgery and related complications). The reporting was limited hindering data collection. The

participant group identified their beliefs in patient-driven care despite their response choices regarding their personal or professional behavior. The selection of the ‘twenty percent or less’ category was undeniable. This small sample’s frequent selection of a category may not truly represent the overall population’s beliefs.

Research Question 3

The dataset presents BWLS health professionals' perceptions, beliefs, and attitudes impact their patients' outcomes (i.e., outcomes-patient support activities and recorded lifestyle management). Again, eleven out of thirteen participants selected King and Hoppe’s definition of patient relations. The description refers to fostering the relationship while gathering and providing information for decisions regarding patient treatment care and outcomes working with treatment-related behavior (King and Hoppe, 2013). Almost all of the respondents selected a definition with a word selection tying nurturing behavior that is beneficial to patient-centered care.

There was a specter regarding the participant choices with specific queries and other decisions. The resistant reporting manifested. The identified themes were consistent and small in number, such that interpretation did not require statistical analysis.

Summary

This study’s findings displayed that BWLS health professionals’ perceptions, beliefs, and attitudes can impact their patients’ interactions and outcomes. An example of the findings was the written response inferring that nurses’ personal beliefs play a

critically important role in that BWLS patients also have some influence upon their patient's success. This influence is critically important in the BWLS program with commitment and perseverance for patient treatment, care, and outcomes. Incorporating beliefs into working patient interactions has merit within BWLS continuum from presurgery requirements, the procedure, and postsurgery lifestyle. BWLS health professionals' perceptions, beliefs, and attitudes impacted some of their patients' care and work perspectives. The written responses collected mirror a particular trend for the patient, patient participation, and patient ownership of the expected outcomes. An example was the eleven out of thirteen selected the 2013 King and Hoppe definition. A second example was the question six participant response list discussing professional viewpoints. Moreover, NVivo analyses resulted in a defined health professional focus on the patient as seen in Figures Two and Four.

Chapter Five is the discussion regarding this study's findings. The next chapter is a discussion about the limitations, assumptions, and other revealing information regarding this study's potential following steps.

Chapter 5: Discussion, Conclusions and Recommendations

Introduction

This chapter is about the challenges and limitations of this research study, its positive social contribution, and recommendations for future research on health professionals' and BWLS patient outcomes. It is also in this chapter that this mixed methods study's data merits further inquiry.

Health professionals' narratives about their BWLS patient outcomes via the lens of SCT was the purpose and nature of the study. One intriguing finding was the participant effort to not answer the online queries. SCT does address the intertwined nature of the human, her/his selected actions, and behavior; narratives are the vehicle conveying the events where all three SCT aspects were recorded, promoted, and reflected.

This study is mixed methods yielding data meriting further inquiry. Initially, the study had no respondents; triggering a research instrument revision. The second instrument resulted in a qualitative and quantitative dataset. There was a similarity in reported participant genders and national data. Specific participant responses were clear. The identified themes are consistent and reinforced reluctance. The found data presented mostly formal patient interaction guiding the individual health professional. The data did not address several of the issues brought forward by the literature review. For example, study subjects did not discuss Friedman, Ashmore, and Applegate's bias reduction efforts toward health-care professionals (Friedman et al., p. S73). Study subjects did not address patients improved health and quality of life as they were expected.

This study's findings confirm and extend knowledge in the discipline by presenting information undiscovered in the peer-reviewed literature. Peer review literature did not capture health professional perspectives outside of physicians. This study's findings offer a small glimpse vast gap in knowledge surrounding clinical staff behaviors and communications as they impact on BWLS outcome success in the future.

Limitations of the Findings

This section describes the limitations to trustworthiness that arose from this study. There were several concerns with the shift from the one and one-half hour recorded face-to-face interviews to the anonymous online survey. Foremost, interviews allow for small, discriminant analysis of facial expression, voice inflection, and other participant reactions. The public library locations were the purposed setting for discussions with specified space for confidentiality (Miller, 2018). The online survey allowed anonymity. Another concern with the shift from qualitative inquiry to some quantitative and some qualitative questions. Quantitative data is analyzed using statistical analysis. However, quantitative data analysis suffers when sample sizes are small.

The quantitative questions were revised from the semistructured qualitative interview, reinforcing the intended qualitative insight. The online survey uses the Likert scale. Proportional versatility in the application made the Likert scale part of the mixed methods analysis. Many patient support health professionals construct and use Likert scales and therefore usability would not pose difficult.

The small sample sized impacted the study. There were only 13 participants. It was not in-depth enough for a qualitative study. It was too small for quantitative

analysis. The small sample size is a trend of treatment focused healthcare research, yet ineffective for cognitive and behavior analysis. A small sample size allows an opportunity to understand a specific population better. Alexander notes that this research trend potentially could have more community impact with a larger sample and a less specific population (Alexander, 2018, p. 55). There are less than fifteen bariatric clinics in the local area. The Colorado Nursing Association does not meet monthly, and the membership could only access the study information from the CNA members page. Despite reassurances, participant reluctance prevailed. Snowballing (e.g., participants forwarding the study information) occurred. Moreover, there were several sets of personal stressors that limited research implementation.

Recommendations

This section describes recommendations for further research based on this study and Chapter 2. The recommendations do not exceed study boundaries.

Themes v. Literature Review

This section compares and contrasts found themes and the literature review. The found ideas point to continued research. Continued research is necessary for provider-patient relations concerns especially delicate, psychosocial situations. Such research proves pertinent and substantial; enabling provider-patient communication (Shattell, 2004, p. 720).

Patient Relations

The found data presented mostly formal patient interaction. Formal interactions guide the HP individually and within the BWLS decision team. Again, patient relations

regard supportive therapy that brings about behavior change (Moyle, 2003). This study's quantitative responses were in the twenty percent or less category regarding patient interaction-appearing. Many participants appeared favorable to a lower percentage. These choices seemingly indicate the participants' reluctance to report professional activities and decisions.

Wellness

Wellness remains the focus to the United States' Surgeon General's aim to provide people accurate, usable information for personal health information influential for healthy behaviors before, during and after a patient's treatment, care, and outcomes (CDC, 2014). This study did not address Bylund, Peterson, and Cameron's 2012 studied reciprocal effects for professionals and patients. Additionally, this study did not address Friedman, Ashmore, and Applegate's bias reduction efforts toward health-care professionals (Friedman et al., p. S73). This study's findings did not address patient improved health quality of life with enhanced physical indicators; yet another future research study.

The study's findings did not address several issues in this study's literature review discussion; thus creating more research opportunity. These issues are as follows: 1. health professionals using emotional skills tend to be more open to patient perspective and display empathetic concern; 2. health professional narratives gather information regarding provider-patient relations partially using personal emotions, i.e., frustration, self-care, anger, hopelessness, monitoring patient prejudices; 3. clear communication is paramount for understanding treatment, care, and outcomes to transform cared delivery

industry-wide; 4. cultural, structural, and belief barriers to good health; and 5. patient-provider conflict (an aspect of provider-patient relations). Conflict arises from the differing expectations of the provider-patient relationship eventually arriving at a compromise that negotiate patient care through a decision-making process.

Obesity Stigma Professionals

This study's findings did not reveal insight into health professional stigma toward the obese; another research opportunity. BWLS HPs are advised to consider the whole human, rather than to focus solely on compiled PHI or procedure (LeMont, Moorehead, Parish, Reto, and Ritz, 2004, p. 8; Puhl and Latner, 2008, S1). Health professionals appear to need to understand the nature of social influences on the patient(s). The reported dataset did not reflect influences that may sway an obese person from seeking and participating in their healthcare nor stigma impacting the health and well-being of obese persons (Friedman et al., 2008, p. S73).

BWLS professional-patient interactions are integrated using personal and professional aspects (Frood, Johnston, Matteson, and Finegood, 2013, p. 320). This study did record few health professionals' expressions about patient treatment, care patients' nutrition motivation, lifestyle management, and other outcomes for obese patients (Puhl, Latner, King, and Luedicke, 2014, p. 72). Sarkis and Mwanri (2014) direct HPs to treat obesity as a priority in all aspects of health research and testing implementation strategies; empowering individuals and impacting communities. Complex patient health care needs, professional efforts remain critical to effective, efficient patient treatment and care and outcomes (Reeves et al., 2013).

However, this study's findings did not record negative personal perceptions of obese persons or negative health professionals' attitudes regarding overweight patients (Puhl, 2011, para. 7); another opportunity for further research. Moreover, this study focused on health professionals specializing in the treatment of obesity. These findings did not reflect negative attitudes or choices may lead to inadequate treatment, care, and outcomes of obese persons. The study's findings did reflect a reluctance to provide information or insight regarding these inquiries. The results point to future research of this specific participant pool.

Using SCT, this research inquired BWLS HPs' intentions and behavior via semistructured interviews from BWLS health professionals at first (Godin, Belanger-Grave, Eccles, and Grimshaw, 2008, p. 2). Godin et al. (2008) say SCT could predict BWLS HP's intentions and behavior (p. 2) by exploring potential themes via semistructured interviews. In March 2018, the study's instrument revision from a face-to-face interview into an anonymous online survey released in April 2018. The new instrument collected data that demonstrated Bandura's acknowledgment of the reciprocal nature of one's environment, behavior, and self (Bandura, 1978). The participants' responses displayed a definite choice to unanswered, skip, or selected options that had low quantitative value. Moreover, the qualitative data favored specific short response answers. Individually, each response (e.g., an action) also demonstrated the singular human cognition to choose how to respond (e.g., a behavior). Collectively, the answers allowed for a tremendous qualitative and quantitative tendency for reluctance. Discovery for these reluctance types affords more research opportunity.

Other impacts

There were several other impacts. There are less than fifteen bariatric clinics in the local area. The Colorado Nursing Association does not meet monthly, and the membership could only access the study information from the CNA members page. Despite reassurances, participant reluctance prevailed. Snowballing (e.g., participants forwarding the study information) occurred. Moreover, there were several sets of personal stressors that limited research implementation. Several dynamic stressors discussion is here. There are less than fifteen bariatric clinics in the local area. The Colorado Nursing Association (CNA) does not meet monthly, and the membership could only access the study information from the CNA members page. Despite reassurances, participant reluctance prevailed. Snowballing (e.g., participants forwarding the study information) occurred. Moreover, there were several stressors that limited research implementation; pointing to further research opportunity. Several dynamic stressors discussion is below.

Winter excitement

Research implementation began in December 2017. This timeframe proved difficult because of winter social excitement. Human socialization can impact human research participation. Seasonal events did timely pass. Networking did not increase participation and decrease confidentiality concerns in February 2018. Networking afforded increased interest in the research study while following the dissertation committee's suggestion to revise the instrument. The increased interest may have encouraged 'snowballing' once the instrument revision was complete by the end of

March. The second round of research implementation yielded data for this study. All activities for this study occurred simultaneously with expected employment activities.

Phishing

In early January 2018, a 'phishing' event occurred via the internet. Phishing is the action of sensitive information accessed without permission, consent or knowledge of the owner. This phishing event affected both this researcher's university's and employer's internet networks. Many organizations were prompted to switch cloud services in-house computing servers. Most persons using company- or employment-owned computers were encouraged (and mandated) to change personal use passwords and decrease outside organization exchanges. The local newscasts and internet social networks/websites galvanized these actions as well. This researcher did attempt several face-to-face activities to work with occurring difficulties and the earlier expressed concerns.

Walden University Student Support Access encouraged this researcher to change her student use internet browsers and passwords for security purposes. These issues appeared to affect email and cloud computing services this study's oversight committee communications. The researcher passwords were changed for participant e-tools websites, www.Wix.com and www.SurveyMonkey.com as well.

Moreover, the phishing event encouraged this researcher to further confidentiality and security efforts for the study's data. Fee-for-service cloud computing vendors were contacted. One vendor selected and utilized as well as stored on external storage. Further, the few field notes, external storage, and hard copies were created and stored locked in a file cabinet in her domicile.

Assumptions

A local university began hosting new clinical trials for bariatric surgery recruiting local, previous unsuccessful bariatric patients. There is a possibility that the new study's participant source referrals originated with this study's potential participant group. If this is true, there would be understood concerns from those potential volunteers that voiced confidentiality concerns.

Personal comfort with professional confidentiality is essential to health professionals, and it can be detrimental to look directly into a researcher's face and continuously adjust facial expression especially when the researcher lives locally, and the research could have a local professional impact. Reluctance and no response to several 'all calls' met this researcher. An illustration of this reluctance was Dr. X's response in snowball; mentioning the few numbers of BWLS clinics in the local area and concern for confidentiality. Simultaneously, there were several local news exposes detailing health professional licensure issues. These events could have drawn negative attention and concerns to health professional-patient relationships. This scrutiny could have impacted this study's implementation easily.

Another assumption is that weight stigma exists among health professionals. Negative personal perceptions of obese persons are prevalent in society (Puhl and Heuer, 2010, p. 1). Reported negative attitudes regarding overweight patients by various health professionals do exist (Puhl, 2011, para. 7). These choices may lead to inadequate care and outcomes, and yet go unacknowledged. Research studies such as this one may lead to positive social change for better health practices and better health delivery.

Another assumption is that there is a lack of rapport between BWLS HPs and their patients. At times, encouraging maintaining professional rapport could be essential for HP work outcomes. Her/his action could diminish work effectiveness. Actions like these may lead to adverse patient treatment, care, and results. BWLS HPs could unintentionally encourage unhealthy behaviors: binge eating, low or no exercise, and eating high-fat content foods. Rapport (or affinity) is a sound rationale for this study. Rapport has been considered the tertiary, yet pertinent trend in public health. Rapport emphasizes the collaborative nature of the health team. For bariatric surgery, the patient, her/his family, and their health professionals; including the doctors, nurses, and other clinic staff comprise the health team. By studying how BWLS health professionals relate to and interact with patients, and meaningful lifestyle decisions, public health may have a more in-depth understanding.

Implications

This section describes the potential impact for positive social change at individual, family, organizational, or societal level. There are additional implications listed as well.

Social Contribution

This study does have a positive social contribution. The local area is known for active lifestyles. This research yielded very little information locally; demanding another effort in the Denver metropolitan area. Future community obesity research efforts in an area known and researched for active lifestyles could reveal impactful data for patient relation. Better understanding of the obese with active lifestyles can be helpful. Health

professionals working with patient outcomes should have an awareness of their perceptions, beliefs, and opinions functioning within their work actions. However, the findings reflected a tendency for health professionals' reluctance for further scrutiny amid local news investigation about health professional licensure.

Personal

The obstacles faced during this study were strenuous, yet effort worthy. This study taught the researcher about working within new communities, getting acquainted with new colleagues; better access to participants using technology; and priority management. Also, there were numerous lessons on maintaining a personal balance between family, academia, employment, and mindset. Further, this researcher intends to continue her advocacy work.

Patients

The BWLS choice is a result of a health professional (HP) and an obese patient that have worked together for an extended time with several unfavorable outcomes. BWLS does not work without the patient efforts. Patient efforts are more successful with patient support from family and others. A similar study could be the foundation for differing future assessments behavioral and clinical cogency. Patients could be even more successful with knowledge of health professionals working within their beliefs.

Health professionals

Health professionals' (HPs) practice is paramount to delivering high-quality, patient-centered care and transforming our health care system (Donald, King-Shier, Tsuyuki, Al Hamarneh, Manns... and Hemmelgarn, 2017). Simply put, individuals think

and then choose their actions; definitive Social Cognitive Theory processing. HP awareness of personal SCT operating within their employment function is integral to their patients' outcomes.

One particular professional function that occurred during this study was 'snowballing'. Snowballing (e.g., participants forwarding the study information) occurred resulting in volunteer interest flourished into participation. The use of the 'snowball' was encouraging. My fellow health professionals were discussing this study in work function and choosing to forward the QR code and link to other health professionals. The study received professional attention and scrutiny; both are desirable. Discussion requires thought. Thought may lead to action.

Conclusions

The dynamics of health professional-patient relationship is the essence of this study and demands more in-depth research. The decisions made together by the health professional and patient have merit and long-term impact for the quality of healthcare and health quality of life. Patient treatment, care, and outcomes are work for the health professional. Work is part of the human choice selected by behavior cognition. The human choice demands scientific investigation. Further study of health professional-patient interactions is imperative.

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Appendix A: Interview Script

Welcome! Thank you for participating in this study. Your responses will provide an insight into BWLS health professionals' perceptions, beliefs, and attitudes and how they believe they impact their patients' treatment, care, and outcomes. This confidential interview will last about ninety (90) minutes and is being audio recorded. Additionally, notes will be taken during the interview. At the end of this interview, the notes will be briefly reviewed with you to assure their accuracy. You may be contacted for a follow-up interview if necessary, to verify response accuracy. You may ask questions at any time during this interview. Do you have any questions before we begin? Let us begin.

Additional prompts:

How would you define a “formal patient interaction” versus an “information patient interaction”?

Describe your BWLS patients with whom you frequently interact.

I noticed you became excited/agitated with your response, please expand on your description

Is this your usual professional norm?

Please expand further.

Please tell me more.

How do you feel about your work with BWLS patients?

How do you think you could improve/maintain in your work effectiveness?

Why did you choose that aspect of your work effectiveness?

Is there anything that you may have inadvertently left out?

How do you define a “successful” patient treatment, care, and/or outcome?

How do you define an “unsuccessful” patient treatment, care, and/or outcome?

Tell me about a typical patient interaction before BWLS for you such as a curious person comes in ‘off the street’?

1. Talk about your typical work day at in-clinic with BWLS patients when you take blood pressure and blood sugar. (RQ1)
2. How do you define “patient interaction”?
3. How would you describe an infrequent ‘patient interaction’? (RQ1)
4. Tell me about a negative patient interaction for you. For instance, when a health provider brought in information that the patient did not want rather than a patient with a bad attitude...(RQ1)
5. Tell me about an atypical patient treatment interaction for you. For instance, a patient that does not cooperate. (RQ1)
6. How many patients do you interact with in-clinic? is this a single average day? A week? A month?
7. Tell me about an atypical patient interaction in clinic. For instance, the insurance approved patient that does not follow the program’s presurgery checklist or schedule. (RQ1)

8. Tell me about an atypical patient interaction for you before BWLS. (RQ1)
9. Tell me about a typical patient interaction for you before BWLS. (RQ1)
10. What are your beliefs about your role in patient interactions before in ensuring the patient is fully prepared before BWLS? (RQ1)
11. What are your beliefs about your role and the patient likelihood of BWLS success? (RQ1)
12. In your words, explain your role in the patient's progress to BWLS at this point. (RQ1)
13. Tell me about the type of BWLS patients you interact with daily. (RQ2)
14. Tell me about an atypical patient interaction after BWLS for you. (RQ2)
15. Tell me about a patient you have frequent interaction with such as a patient you see in-clinic as scheduled, prepared with all information as asked...(RQ2)
16. Tell me about a patient you have infrequent interaction with who does not have BWLS outcomes such as patient desiring the BWLS procedure but does not attend clinic as scheduled... (RQ2)
17. What are your beliefs about your patient outcomes and what impacts patient likelihood of success at this point of the BWLS process at the time of surgery (RQ2)?
18. Tell me about your typical, routine patient interaction directly after the BWLS procedure. (RQ2)
19. What percent of your immediate postsurgery patients would you estimate adhere to the preset treatment and care? 30%? 40%? 50%? (RQ2)
20. Tell me about an atypical patient interaction more than two week after BWLS such as a patient who has returned with complications with the surgical site. (RQ2)
21. Tell me about your typical patient interaction with a patient more than two-week post BWLS that is now eating solid food (RQ3)
22. What are your beliefs about your patient interactions four weeks after surgery with nutrition? (RQ2)
23. What are your beliefs about your patient outcomes at this point of the BWLS process? (RQ2)
24. In your words, explain your role in the patient's progress to life post-BWLS. (RQ2)
25. How do feel about your patients' BWLS outcomes at this juncture post-BWLS regarding alcohol consumption? (RQ2)
26. What percentage of your patients lose 50 pounds? 100 pounds? 150 pounds? Nothing at all? (RQ2)
27. What percentage of patients would you estimate adhere to the patient support activity requirement? 30%? 60%? 90%? (RQ3)
28. How do feel about your patient outcomes with patients more than twelve months postsurgery? More than 24 months postsurgery? (RQ3)
29. Tell me about a typical patient-support interaction for you such as a monthly meeting or clinic social activity. (RQ3)
30. Tell me about an atypical patient-support interaction for you such as a happenstance in a public space or retail store. (RQ3)
31. Talk about your typical work day at before/after BWLS patient support activity. (RQ3)

32. Talk about an atypical work day before/after BWLS patient support activity. (RQ3)
33. Tell me about your typical interaction at a patient support activity such as a monthly meeting of BWLS recipients... (RQ3)
34. How often do you interact with patients at support activities? (RQ3)
35. How often do you interact with patients more than 24 months postsurgery? (RQ3)
36. Tell me about a typical interaction with a more than 24 months postsurgery patient i.e. routine check-ups or release from care. (RQ3)
37. Tell me about an atypical interaction with a more than 24 months postsurgery patient such as a patient returning for band adjustment and/or additional surgery. (RQ3)
38. What are your beliefs about the impact of your patient interactions during the postsurgery lifestyle management period? (RQ3)

Appendix B: Letter of All Call

Month Day, 20XX

Dear XXXX,

My name is Traci Cullins-Clark. I am a doctoral candidate at Walden University. I am in the process of planning my research for the completion of my dissertation. I would like to request a reading of my enclosed participant invitation letter to be announced at your next meeting during ‘Announcements’. Additionally, I request my invitation for volunteers to be posted on your organization website. I look forward to hearing from you and your members.

Respectfully,

Traci Cullins-Clark, Doctoral Candidate
College of Health Sciences, Walden University



Appendix C: Organization Invitation

Month Day, 20XX

Dear XXXX,

My name is Traci Cullins-Clark. I am a doctoral candidate at Walden University. I am in the process of planning my research for the completion of my dissertation. My dissertation topic is: Bariatric Weight Loss Surgery (BWLS): Education Nurses' Viewpoints of Patient Outcomes. The study involves a confidential, face-to-face interview regarding your personal perspectives and professional ideas relating to your patient interactions. The interview is estimated to take approximately 90 minutes. You may also be asked to review your transcribed interview for clarity and accuracy. Your participation in this study is voluntary. No one with Walden University will treat you differently if your choice to participate or not. If you choose to join the study now, you can still change your mind during the study. If you feel stress at any time during the study, you may stop. Participants may withdraw at any time.

All participant interviews are confidential and voluntary. All gathered data would be secured for at least five years. All collected interviews are audio recorded and transcribed. Each participant will be assigned a random string identifier by the researcher and provided a transcription of their interview. This study type involves some risk of the minor daily life discomforts, such as fatigue, stress or becoming upset. If, because of your participation, you feel you need mental health support services, you may contact the Colorado Crisis Support Line at 1-844-493-TALK (8255) or Text TALK to 38255. This study may offer an opportunity to research rapport-based encounters in health care from the health professional (HP)-patient collaborative from BWLS HPs' viewpoint. Because HPs' work individually and with teams, understanding of perspectives may disclose more about the professional-personal aspect within health. Your participation may affect the reduction of obesity-related contributing social change factors: weight stigma/discrimination; reduced life expectancy; reduced quality of life; and chronic health problems.

Thank you for your time and attention. If you are interested in participating in this study, please feel free to contact me directly so I can answer any questions you might have and set up an appoint to conduct the interview. I look forward to hearing from you.

Respectfully,

Traci Cullins-Clark, Doctoral Candidate
College of Health Sciences, Walden University

Appendix D: Participant Online Survey

Bariatric Weight Loss Surgery: Nurses' Viewpoints on Patient Outcomes

This study is about Bariatric Weight Loss Surgery (BWLS) Health Professionals' Perceptions, Beliefs, and Attitudes about Their Patient Encounters. You were selected because you work in a bariatric weight loss surgery (BWLS) clinic as an Education Nurse and you hold a Bachelor of Science in Nursing. The following implied consent will assist in your understanding this study before you decide whether to participate. This study's researcher is Traci Cullins-Clark, who is a doctoral student at Walden University.

Below are some additional prompts to help your thinking process during this survey:

- How do you describe a “formal patient interaction” versus an “information patient interaction”?
- Describe your BWLS patients with whom you frequently interact.
- How do you feel about your work with BWLS patients?
- How do you think you could improve/maintain in your work effectiveness?
- Why did you choose that aspect of your work effectiveness?
- How do you define a “successful” patient treatment, care, and/or outcome?
- How do you define an “unsuccessful” patient treatment, care, and/or outcome?
- Write about a typical patient interaction before BWLS for you such as a curious person comes in ‘off the street’?

For this survey, the below definition for a ‘patient relation’ is used.

“...interplay which comprises the social aspects of a confidential relationship shared by physician and patients. Each ‘player’ in the dyad has an appropriate role (doctor-patient interaction. (n.d.) Segen's Medical Dictionary. (2011). Retrieved March 28, 2018 from <https://medical-dictionary.thefreedictionary.com/doctor-patient+interaction>).

1. How many patients do you interact with in-clinic each day? Check one
 - 8 or less
 - 9-16
 - 17-24
 - 25 or more
2. How many patients do you interact with in-clinic each week? Check one
 - 40 or less
 - 41-90
 - 91-96
 - 97 or more
3. How many patients do you interact with in-clinic each month? Check one
 - 200 or less
 - 201-370
 - 371-400

- 401 or more
4. Which is your role in patient interactions before in ensuring the patient is fully prepared before BWLS? Check all that apply.
- Intake nurse.
 - Patient Education.
 - Patient nutrition.
 - Surgery nurse
 - Vitals nurse.
5. About how many percent of your patients have successful BWLS outcomes? Check one
- 20% or less
 - 21-40%
 - 41-60%
 - 61-80%
 - 81% or more
6. Estimate how many patients you have frequent interaction with such as a patient you see in-clinic as scheduled, prepared with all information as asked? Check one.
- 20% or less
 - 21-40%
 - 41-60%
 - 61-80%
 - 81% or more
7. Approximately, how many patients you have infrequent interaction AND desiring the BWLS procedure but does not attend clinic as scheduled. Check one.
- 20% or less
 - 21-40%
 - 41-60%
 - 61-80%
 - 81% or more
8. What percent of your immediate postsurgery patients would you estimate adhere to the preset treatment and care? Check one.
- 20% or less
 - 21-40%
 - 41-60%
 - 61-80%
 - 81% or more
9. What percent of about your typical patient interaction with a patient more than two-week post BWLS that is now eating solid food (RQ3) Check one
- 20% or less
 - 21-40%
 - 41-60%
 - 61-80%

- 81% or more

10. What percent of your atypical patient interactions more than two weeks after BWLS such as a patient who has returned with complications with the surgical site. Check one (RQ2)

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

11. Estimate the percentage of your post-BWLS patient consume state regulated adult substances such as alcohol or marijuana? (RQ2) Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

12. What percentage of your patients lose 50 pounds? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

13. What percentage of your patients lose 100 pounds? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

14. What percentage of your patients lose 150 pounds? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

15. What percentage of your patients lose nothing at all?? Check one

- 20% or less
- 21-40%
- 41-60%

- 61-80%
- 81% or more

16. What percentage of patients would you estimate adhere to the patient support activity requirement? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

17. How do feel about your patient outcomes with patients more than twelve months postsurgery? (RQ3) Check one

- Highly unlikely to succeed
- Unlikely to succeed
- Neither successful or unsuccessful
- Likely to succeed
- Highly likely to succeed

18. How do feel about your patient outcomes with patients more than 24 months postsurgery? Check one (RQ3)

- Highly unlikely to succeed
- Unlikely to succeed
- Neither successful or unsuccessful
- Likely to succeed
- Highly likely to succeed

19. How often do you interact with patients in public space or retail store? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

20. Write about an atypical patient-support interaction for you such as a situation

21. What percentage of your patients lose 50 pounds? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

22. How often do you attend the patient support activities? Check one (RQ3)

- twice a month
- monthly
- once every 3 months
- once every 6 months

23. How often do you interact with patients more than 6 months postsurgery? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

24. How often do you interact with patients more than 12 months postsurgery? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

25. How often do you interact with patients more than 18 months postsurgery? Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

26. Approximately how many patients do you have a typical interaction with a more than 24 months postsurgery patient i.e. routine check-ups or release from care. Check one

- 20% or less
- 21-40%
- 41-60%
- 61-80%
- 81% or more

27. Approximately how many patients do you have an atypical interaction with a more than 24 months postsurgery patient such as a patient returning for band adjustment and/or additional surgery. (RQ3) Check one

- 20% or less
- 21-40%
- 41-60%

- 61-80%
 - 81% or more
28. How do you define “patient interaction”? Check one.
- “...influences hope, meaning in life and self-transcendence in cognitively intact nursing home patients and might be an important resource in relation to patients' health and global well-being (Haugan, G. (2014) Nurse–patient interaction is a resource for hope, meaning in life and self-transcendence in nursing home patients, <https://doi.org/10.1111/scs.12028>.)
 - “...interplay comprises the social aspects of a confidential relationship shared by physician and patients (doctor-patient interaction. (n.d.) McGraw-Hill Concise Dictionary of Modern Medicine. (2002). Retrieved March 28, 2018 from <https://medical-dictionary.thefreedictionary.com/doctor-patient+interaction>).
 - “...communication in medical encounters: (1) fostering the relationship, (2) gathering information, (3) providing information, (4) making decisions, (5) responding to emotions, and (6) enabling disease- and treatment-related behavior (King, A., and Hoppe, R. B. (2013). “Best Practice” for Patient-Centered Communication: A Narrative Review. *Journal of Graduate Medical Education*, 5(3), 385–393. <http://doi.org/10.4300/JGME-D-13-00072.1>)
 - “...interplay which comprises the social aspects of a confidential relationship shared by physician and patients. Each ‘player’ in the dyad has an appropriate role (doctor-patient interaction. (n.d.) Segen's Medical Dictionary. (2011). Retrieved March 28, 2018 from <https://medical-dictionary.thefreedictionary.com/doctor-patient+interaction>).

Please help us identify you!!!

29. Gender Identification: How do you identify yourself? Check one
- Agender
 - Androgynous
 - Bigender
 - Female
 - Fluid
 - Male
 - Transgender
 - Prefer not to identify
30. Age: What is your age? Check one.
- 24 years or younger

- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older
- Prefer not to identify

31. Education: What is the highest education you have completed? If currently enrolled, highest degree completed

- High school graduated, diploma or equivalent received
- Some college credit, no degree received
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree
- Prefer not to identify

If you would like to receive the findings of this study, please provide your email address below. Thank you for your time and consideration.

Appendix E: Third Participant All Call

2 April 2018

To whom it may concern,

My name is Traci Cullins-Clark, and I am a Ph.D. candidate at Walden University. I would like to request The Colorado Nursing Association (CNA) to post my updated “all call” for my research study to the CNA website for members' access and any additional conversations about this research project. I am coordinating a second data collection phase. Interested volunteers may access the online research proposal website at <https://tracycullins-clark.wixsite.com/researchwebsite>. It contains an overview of the research, frequently asked questions about the research, implied informed consent, and a link to the e-survey. My approval number is 11-20-17-0137945 and my Institutional Review Board is aware of my changes.

A few months ago, I contacted CNA recruiting about recruiting its members that work as education nurses for Bariatric Weight loss surgery clinics for a research study to complete my dissertation. If there are any questions or concerns, feel free to contact me at tracy.cullins-clark2@waldenu.edu. I look forward to hearing from your members.

Respectfully,

Traci Cullins-Clark, Doctoral Candidate
College of Health Sciences, Walden University
E: Tracy.cullins-clark2@waldenu.edu

Traci Cullins-Clark

Researcher Educator E: t.cullins.clark.2001@icloud.com

The majority of my career history has been spent in various educational positions within health and educational services. My public health experience has primarily focused on issues related to Adolescent Health, Cultural Issues in Health, and Underserved communities. One of my major interests is to combine the traditions mathematics & science for personal use in our daily lives. I am passionate for the moment a student transitions to a scholar by discovering a personal connection for lifestyle and living.

EXPERIENCE

FLORIDA PITT-WALLER ECE-8 SCHOOL

INTERVENTION TEACHER | 2017- PRESENT

Small group, grade-level appropriate instruction with mathematics with IEP and 504-plan students. Including organization skills, accountable academic language. Extra-curricular, after-school STEM student groups to reinforce student comprehension and camaraderie. Participating in DPS Culturally Responsive Teaching Fellowship.

MATH FELLOW | 2014 – 2017

Responsible for small student group, grade appropriate instruction with mathematics, including organization skills, accountable academic language.

WESTWOOD COLLEGE

ADJUNCT INSTRUCTOR, DENVER-SOUTH CAMPUS | 2013-2014

Instruction in Allied Health working with medical assistant certification. Also taught: Professional Development and Patient Relations. Medical Ethics, Medical Insurance, Billing and Coding, Anatomy/Physiology, and Introduction to Word Processing. Familiar with several software and systems: Blackboard, Microsoft (Excel, Word, PowerPoint, and Publisher), Adobe (Reader, Shockwave, Flash, Connect, and Articulate) for instruction, management, and preparation.

ADJUNCT INSTRUCTOR, ARLINGTON CAMPUS | 2010-2013

Instruction in Allied Health working with medical assistant certification. Also taught: Professional Development and Patient Relations. Medical Ethics, Medical Insurance, Billing and Coding, Anatomy/Physiology, and Introduction to Word Processing. Familiar with several software and systems: Blackboard, Microsoft (Excel, Word, PowerPoint, and Publisher), Adobe (Reader, Shockwave, Flash, Connect, and Articulate) for instruction, management, and preparation.

UNIVERSITY OF MARYLAND

PROCTOR, | 2008-2010

Proctor service for both University of Maryland and University of Maryland
University College distance learning students during assigned examinations.

SKILLS

Several software and systems: Blackboard, Microsoft (Excel, Word, PowerPoint,
and Publisher), Adobe (Reader, Shockwave, Flash, Connect, and Articulate)

EDUCATION

Ph.D, Community Health Promotion and Education

Walden University, 2019

Master of Science, Public Health Education

Western Kentucky University, 2000

Bachelor of Science, Healthcare Administration

Austin Peay State University, 1992

****REFERENCES AND PERSONAL INFORMATION UPON REQUEST**