Caring for the Bariatric Surgery Patient: Insights from a USA Model

Improving patient care is an ongoing pursuit in Sweden, and care for the bariatric surgery patient is no exception to this. To know if the healthcare system is meeting patients' needs, it's important to make their voices heard. Results from the 2020 Obesity Operation from a Patient's Perspective survey (Obesitasoperation utifrån ett patientperspektiv or OOPP) conducted by the Health Independent of Size non-profit organization in Sweden (Hälsa Oberoende av Storlek or HOBS) show that certain needs and expectations of bariatric surgery patients are often not met. These shortcomings could, in part, improve by setting country-wide standards for the care of the bariatric surgery patient. Fortunately, a team of experts is working on this and are projected to present their recommendations in 2021.

To aid in this process, it is useful to look at other healthcare systems to see how Sweden could possibly model their weight loss surgery (WLS) care standards. In the United States, where over 252,000 bariatric surgeries were performed in 2018 alone, there has been care standards for accreditation for bariatric surgery centers since the early 2000s (English et al., 2020). The American Society for Metabolic and Bariatric Surgery (ASMBS) and the American College of Surgeons (ACS) both had accreditation programs, formed in 2004 and 2005, respectively (American College of Surgeons, No Date-b). To create one unified international accreditation program across the USA and Canada, the ASMBS and ACS joined forces in 2012 to create the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). While bariatric surgery centers do not have be accredited by the MBSAQIP, that vast majority are with over 840 members (American College of Surgeons, No Date-a). The standards put forth do not constitute a standard of care, but they nevertheless create a unified system to improve quality of care for the bariatric surgery patient.

Much of what the MBSAQIP focuses on is the surgery itself, including the types of equipment needed, hospital support systems, number of surgeries performed, and more. To see the full MBSAQIP standards from 2019, please click here or see source in the references. For the purposes of this comparison, the focus will be on how the standards for accreditation in the US relate to the four main areas of needed improvement in Sweden as indicated by the OOPP survey. The four areas include having unified information, conversation support, more appointments with dietitians, and increased knowledge in the primary care system and at annual appointments. This paper will also put forth general examples of how some clinics in the US meet the MBSAQIP accreditation standards and patient wishes expressed in the OOPP. Finally, the paper will present a short summary of recommendations for the Swedish system.

Areas of Needed Improvement

Unified Information

In the OOPP report, patients express a desire to access more information about the long-term effects and types of complications that can result from bariatric surgery, including a central location to find this information. This is something that the United States struggles with as well. However, practitioners in the field know they can go to the ASMBS website to find surgery information and professional development tools. The ASMBS also has an application to aid in the treatment of WLS patients. In addition, they have a patient learning platform where patients can get answers to frequently asked questions, watch informational videos, and learn about the disease of obesity. See the ASMBS website here. The trouble with this is that not every practitioner, especially those that don't typically work in WLS, nor every patient would know to go to the ASMBS site. It also lacks comprehensive information related to what patients encounter after surgery, but more information is being added.

Part of the reason unified information is not as widely available as it could be is that there lacks consensus on what the best practices are both before and after surgery. Some aspects of care are quite standardized in the US, such as vitamin and mineral supplementation, how much protein to eat, and the subjects to cover in a psychological evaluation. However, information around many other aspects of care vary quite a bit including diet progression after surgery, calorie and carbohydrate recommendations, how many times people should eat per day, rules around consumption of carbonated beverages, and more. In addition, every patient has different needs. There are some basics that can and should absolutely be assembled in a place that all patients and healthcare professionals can access, like what the ABMBS is doing. However, those guidelines also need to convey that all people are different and not everyone has the same needs as the next person.

Access to unified information and avenues to ask questions is as important for healthcare professionals as it is for patients. Aside from the ASMBS, the Academy of Nutrition and Dietetics (AND) in the US has a Nutrition Care Manual that covers general aspects of medical nutrition therapy. Here, RDs can look up basic information and nutrition support needed for all diseases and conditions, including WLS. The AND also has dietetic practice groups much like the Dietisternas Riksförbund (DRF) does in Sweden. Being part of a group gives RDs the opportunity to connect with other RDs in the field, ask questions, share insights, complete continuing education, and more. The Weight Management Practice Group covers both surgical and non-surgical weight management. Having a similar group in the DRF could be a way to increase knowledge for RDs, improve care for patients, and create a unified front.

Conversation Support

Swedish WLS patients expressed the need for more discussions with peers and professionals about the physical and psychological changes that occur after surgery. According to the OOPP, only about 20%% of patients who have bariatric surgery in Sweden see a psychologist

or mental health professional prior to surgery, and only about 40% are even asked about their mental health before surgery. Meanwhile, almost 40% of patients would have wanted to talk with a psychologist after their surgery. In contrast, for a center to be accredited by the MBSAQIP, all patients must undergo a psychosocial evaluation prior to surgery. The center's multidisciplinary team must include a psychologist or other behavioral healthcare provider that patients can access both before and after surgery as needed. The ASMBS has recommendations to guide the presurgical psychosocial evaluation, covering a full range of topics including disordered eating/eating disorders, social support, psychosocial history, quality of life, substance abuse, physical activity, knowledge of procedures and risks, outcome expectations, and more (Sogg, Lauretti, & West-Smith, 2016).

Peer support is also a requirement for MBSAQIP accredited centers. Support groups must be offered at least once every two months and be supervised by a licensed health care provider. The provider is often an RD, psychologist, social worker, and/or a bariatric nurse. Many clinics offer support groups at least once a month, and sometimes more often at different sites if the program covers a large geographic area. These groups can be offered in-person or remotely via teleconference or web-based platforms. Programs that typically offer in-person groups are still able to provide support via web-based platforms during COVID-19. By utilizing support groups, patients are not only able to talk with their peers but there are able to get support from healthcare professionals.

More Appointments with a Dietitian (RD)

A common theme in the OOPP survey was the desire to have more education around food and nutrition including more appointments with a dietitian, with almost half of respondents stating they wanted to see an RD more often after surgery. This goes in line with 41.8% stating that changes in diet were the most challenging aspect of surgery, and many have problems with nutrient deficiencies and satiety as the years pass.

MBSAQIP centers must provide access to a registered dietitian as needed before and after surgery. This can include referring patients to a trusted RD outside of the clinic. Clinics must also have patient education pathways regarding instructions around pre- and post-surgery diet, exercise, lifestyle changes, and vitamin and mineral supplementation. Given these vague guidelines along with varying insurance coverage for dietitian visits, patients will not necessarily have the access to RDs that they want or need in the US. However, many programs have patient care pathways that utilize dietitians to a large extent.

Part of this patient care pathway could include pre-surgery visits with a dietitian to prepare the patients for surgery. Specific examples of this will be discussed further on in the paper. Regardless of the standards set by the clinic itself, many patients have an insurance requirement of three to six months of medically supervised weight loss (MSWL) before

surgery. The MSWL is often monitored by a dietitian in either one-on-one or group appointments. This is the perfect time to prepare patients for life after surgery by practicing new eating behaviors, adopting a diet similar to what is expected after surgery, discussing supplement needs, and more. This time working together also allows the patient to develop a trusting relationship with the RD which will be helpful in the months and years after surgery as well.

In the care after surgery, there are many ways clinics set up appointments with the RD. It is not uncommon to have post-surgery appointments at a few weeks, three months, six months, 12 months, and yearly thereafter. These appointments may be held individually or in a group. Some programs include additional appointments at nine and 18 months, some have monthly visits, and still others may not have any set appointments with the dietitian after surgery. Regardless of the program's predetermined appointments with the RD, patients are required to have access to an RD if needed or desired.

Patients can additionally access the RD through phone calls, emails, and support groups. This is congruent with the OOPP respondents' desire to be able to talk to providers on the phone and in person as well as have access to support groups. Most electronic medical record (EMR) systems in the US offer secure ways to email providers with questions. Support groups are also a very efficient, cost-effective way for patients to get support from both healthcare professionals and peers.

Increased Knowledge in Primary Care and Yearly Follow-Up

About 55% of respondents to the OOPP survey stated that the knowledge of bariatric surgery is very lacking in the primary care system in Sweden, and only 35% received a reminder call for their yearly follow-up appointment. Patients also tend to have low trust in the healthcare personnel and have concern over how they will be treated in the healthcare setting. It has also been shown that different regions have different protocols for post-surgical blood tests. An environment in which patients do not feel comfortable or listened to that also lacks knowledge of their needs is unlikely to provide quality care for this patient population.

For MBSAQIP centers, they must provide follow-up care at 30-days, six-months, 12-months, and yearly thereafter. This care can be provided by a number of staff members including physicians, physician extenders (nurse practitioners and physician's assistants), clinical nurse specialists, or a supervised registered nurse with special WLS certification and experience. If patients miss these appointments, the center must make two attempts per follow-up period to contact the patient until two consecutive follow-up appointments are missed (see chart below for example). Patients can still come back to the center if they miss too many appointment in a row, but the center no longer attempts to contact the patients at that

point. This system helps ensure that patients receive long-term support from professionals that know their needs.

Requirements for Follow-Up Attempts*

Patient IDN	30-Day	6-Month	1-Year	2-Year	3-Year	4-Year	5-Year	6-Year
00001	No assessment	No assessment	No assessment	x	x	x	x	x
00002	Assessment	No assessment	No assessment	x	x	x	x	x
00003	Assessment	Assessment	No assessment	No assessment	x	x	x	x
00004	Assessment	Assessment	Assessment	No assessment	No assessment	x	x	x
00005	Assessment	No assessment	Assessment	No assessment	No assessment	x	x	x
00006	Assessment	No assessment	Assessment	No assessment	Assessment	No assessment	No assessment	x
00007	Assessment	No assessment	Assessment	No assessment	Assessment	No assessment	No assessment	x
00008	Assessment	Assessment	Assessment	No assessment	Assessment	Assessment	Assessment	Assessment

Assessment	Patient is contacted and receives scheduled clinical assessment
No assessment	Patient is not seen for scheduled clinical assessment or Patient has no appointment scheduled; two attempts to contact patient must be documented
x	No further attempts to contact patient are required

*The table above provides an example of possible follow-up scenarios. Attempts to follow patients annually must continue beyond the six-year follow-up period until the patient is not assessed for two consecutive follow-up periods.

Source: American College of Surgeons, 2019, p. 62.

In many cases, if a patient moves away or no longer has insurance to see the providers at their surgical center, they can ask for referrals to other surgical centers so that they continue to be seen by a specialist. However, this is not automatic and patients will often see their general practitioner (GP) rather than a bariatric team since many insurance programs in the US cover a yearly check-up with a general practitioner. Many GPs do not necessarily know how to care for the WLS patient, much like in Sweden, which unfortunately puts it on the patient to coordinate care between their surgical center and their GP. That being said, it is often easy for doctors to share patient information through electronic medical records if needed.

In addition, to recognize obesity treatment as a specialty, the Commission on Dietetic Registration recently introduced the interdisciplinary designation of Certified Specialist in Obesity and Weight Management (CSOWM). Much like becoming a Certified Diabetes Educator (CDE), having the CSOWM shows the healthcare system and patients alike that the provider has extensive experience treating obesity and has passed the CSOWM registration exam. An overview of what the exam covers, including bariatric surgery, can be found here, and eligibility requirements can be found here. While this is a relatively new certification, it will hopefully work much like the CDE as time passes, signifying those providers who know how to care for people who struggle with overweight and obesity. In addition to the CSOWM, there are many programs, conferences, courses and classes that providers can access as part of their required continuing education hours. These all elevate the specialty of obesity from “eat less and move more” to seeing it as a chronic disease that needs appropriate care.

Examples of Meeting Requirements in Practice

There are many ways that clinics meet the MBSAQIP standards. Some will cover the bare minimum while others will go far beyond the requirements. Below I will give some examples of programs I have worked with and discuss what worked well and what I felt was still lacking.

Unified Information

A place to find trustworthy, unified information was a high priority from patients in the OOPP survey. Having unified information can be difficult between clinics, much less at a national level, but it can be done in a similar way as the ABMBS has done as discussed previously. Along with a place to find unified information in Sweden as a whole, patients should feel comfortable in knowing that the individuals on their surgical team are providing unified information. Yes, there will be always be differences between practitioners, their styles, their tricks of the trade, but the information provided to the patient overall should be a product of the interdisciplinary team. This is where truly working as a team can make a big difference in the type of information and care a patient receives.

This team effort should be within and between practitioner groups. For example, in a program I joined, the surgeon had set the diet progression after surgery as three weeks of liquid diet, three weeks of soft foods, and then on to regular foods. As RDs, we heard the patients' troubles around this diet progression. We also brought experience from other programs that didn't require as long of a liquid phase and incorporated pureed foods to add variety. We also had worked with liquid diets that allowed for options like yogurt and gelatin whereas this program had only allowed protein drinks. We worked together as an RD team to present our suggestions for changes in the diet progression, and then as a full interdisciplinary team including surgeons, physicians assistants, and nurse practitioners, we decided on changing the diet progression to allow for more variety in the liquid diet and to decrease the length two weeks.

Our team also worked together to decide which patients were ready for surgery and which were not. While certain medical issues would cause the surgeon to delay surgery now and then, it was most often us dietitians or the psychologists who would determine that the patient wasn't ready to move onto surgery from a behavioral standpoint. It could be that the patient hadn't yet demonstrated the ability to adopt the diet expected post-surgery or that he or she was exhibiting destructive behaviors such as heavy drinking or binge eating that needed to be rectified before surgery. To accomplish this working relationship, we not only had patient review meetings each month to discuss each patient and their progress toward surgery, but many of our appointments were stacked where the patient would see a medical provider, dietitian, and psychologist all in a row. This allowed us to talk with each other

about what was happening with the patient from each other's points of view and provide continuity for the patient between providers.

As far as providing general information, there are easy ways to do this. Every clinic could have extensive information about their diet progression, ideas for meals, frequently asked questions, vitamin regimen and recommendations, complications and what to do about them, and much more on their website. The clinics I worked in did not have this on their websites, but we did have a Facebook group to provide support and Pinterest page for meal ideas. In a small country like Sweden that provides universal healthcare, it would also be appropriate to have general information for both patients and practitioners on 1177.se since it's already an established source of health information.

Conversation Support

Having both professionals and peers to talk with after surgery is incredibly important, and the OOPP survey results clearly pointed to a need for more of this in Sweden. Many bariatric clinics in the US have psychologists on staff who see all patients in the program to make sure they are psychologically fit to have WLS. Having a psychologist on staff allows patients direct, easy access to a trained professional who has expertise in bariatric surgery rather than patients needing to find their own psychologist who may or may not have experience working in this area.

In a clinic I worked in, our psychologists would see every patient who came through our program. Most of the time, they would have at least two one-on-one appointments and one group appointment with each patient before surgery. If a patient needed more support than this, the psychologists would either work with the patient more, ask the patient to see his mental health provider if he already had established care, or refer him to a trusted colleague outside of the clinic. The psychologist would also determine and/or monitor many of the behavioral requirements patients needed to meet prior to surgery including smoking cessation, reduction in or termination of alcohol consumption if warranted, management of eating disorders, and management of depression or other mental illness, especially if suicidal ideation or attempts had been present. They would often screen for psychological medications to help determine which type of surgery would be best for the patient considering the absorption of medications and the availability of alternative treatments.

After surgery, our psychologists would meet with each patient at three months and at six months and 12 months if they or the patient felt it was needed. They could also provide referrals to other mental health providers outside of our clinic. Ideally, the team's psychologist would be able to meet with all patients as needed, but unfortunately the patient to psychologist ratio we had could not handle this need. To help fill this gap, the psychologists facilitated our twice-monthly support groups along with one of us dietitians.

This allowed patients to get general advice and support on a regular basis regardless of insurance coverage or ability to have appointments during the day.

All bariatric clinics in the US that are accredited by the MBSAQIP must provide support groups for their patients at least every other month. Our clinic provided two support groups per month, one at each of the sites where we operated. One was on a Saturday morning and one was on a Tuesday evening. Each group was led by both an RD and psychologist as most of the questions that come up after surgery relate either to food or mental health and support. While each session had a theme (ask the surgeon, recipe exchange, social situations, etc.), there was always time for patients to ask questions and get support from peers and professionals. It was also a good place for patients to meet others and make friends with people going through similar challenges and triumphs as they were. Adding an online support group to this could bring in even more people who don't live nearby or who don't have the time to come in person. In addition, one of our patients ran a peer-led support group on Facebook for patients that came through our program. While we did not facilitate this or get involved other than to let patients know that it existed, it gave them a group to talk with online that came from the same program and therefore had a similar base for their weight loss journey.

More Appointments with a Dietitian

Meeting with a dietitian before and after bariatric surgery is one of the items that came up repeatedly in the OOPP survey. As discussed above, how this works in the US varies greatly from clinic to clinic. From my experience, the more the patient has access to an RD, the smoother their journey after surgery goes. This is because not only can a dietitian help with making sure the patient is getting the right nutrition after surgery, but she can also help the patient learn how to handle food intolerances, dumping syndrome, reactive hypoglycemia, constipation, eating in social situations, and much more. The dietitian is also far more likely to look for a solution that can be solved with changes in eating behaviors rather than going to medications or other interventions. Dietitians can also be a liaison between the patient and surgeon or medical provider, especially if they've been working with the patient closely over the course of their weight loss journey.

In the time leading up to surgery, meeting with patients one-on-one or even in a group for a few months prior to surgery can make a big difference in how well the patient adjusts to new ways of eating after surgery. By meeting with patients multiple times before surgery, they have a chance to practice new eating behaviors, learn about and try vitamins, and, of course, ask questions about what and how to eat after surgery. Group appointments work very well in situations where general information is presented, such as teaching patients about diet progression, while one-on-one appointments allowed us to work through patients' unique challenges and concerns.

In our clinic, patients regularly had four one-on-one appointments and one group appointment before surgery. These one-on-one appointments were sometimes required by insurance as the Medically Supervised Weight Loss described earlier. Even without MSWL, we required at least two one-on-one appointments to give us a chance to prepare the patient for surgery and for the patient to show us they were ready for surgery. If we could see that the patient wasn't ready for surgery from a dietary standpoint, we would require her to see us until she exhibited readiness for surgery. Once the surgery was scheduled, we had a group appointment to go over the liver-shrinking diet, clear-liquid diet, full-liquid diet, and vitamins. This was in conjunction with the psychologists' group appointment and a final medical evaluation with the surgeon or physician extenders (physician's assistants and nurse practitioners).

After surgery, we had a similar group appointment at two weeks post-surgery to advance patients to solid foods and make sure the vitamins they were taking were working for them. Patients would also see a medical provider one-on-one at this appointment to check how wounds were healing and address any other concerns. After the two-week appointment, patients would see an RD at three-, six-, and twelve-months post-surgery and yearly thereafter. These appointments would also be stacked with a medical provider and perhaps a psychologist to help ensure we were addressing all of the patient's needs as a team. Patients could also call, email, attend support groups, or make extra one-on-one appointments with the RD as needed. While this does provide quite a bit of access to an RD, even more time with an RD can prove to be helpful.

In a program I worked in for five years, we had 23 telephonic appointments with our patients over the course of the year around their bariatric surgery. This included:

- One appointment every other week in the two months leading up to surgery
- One appointment per week for the first month post-surgery
- One appointment every other week for the next six months
- One appointment per month for the next three months

Few people needed *this* much contact with an RD. However, it did give me a strong understanding of what patients need after surgery and how to help them overcome challenges. For many patients, the first three months can be a great struggle of learning how to eat, what to eat, what their body will let them eat, how/when to take vitamins, which sensations are normal, which are not, how to stay hydrated, how to alleviate constipation, etc. By having so much contact with them, I was able to help them establish good habits and fix problems when they arose. In contrast, having three months between appointments, I would encounter patients who had been struggling with something for months that could have been alleviated easily if only they had talked with an RD earlier. For example, patients often struggle with advancing to regular foods, tolerating certain foods,

taking vitamins, nausea/vomiting, etc. Since these are common issues and somewhat expected, patients often don't even think to call or write with questions because they think these challenges are just part of the process. By seeing the patients more often during the first three to six months, we can help them adjust to new ways of eating, assist them in overcoming challenges, and improve their overall experience and quality of life.

What both of these programs showed was that while an in-person, team approach worked well to have the patient monitored in all aspects of care, having more frequent telephonic or video-based nutrition appointments was extremely helpful in addressing patients' needs that did not require a physical examination. By combining in-person with telephonic or video appointments, we can establish a working relationship with our patients where they get the care they need while making it easy to access support along the way.

Meeting with an RD more often can also help prevent vitamin deficiencies which came up as a somewhat common problem in the OOPP survey. There is a lot to keep track of before and after WLS, and vitamins are easy to let fall by the wayside. This could be due to patients not realizing how important vitamins are after surgery, forgetting to take them, or not tolerating them. This is where RDs need to step in and help patients find products that work for them. Programs can accomplish this by having samples of different products on hand, following-up with patients who have troubles with their vitamins, and offering complete information of which vitamins to take and why. Many programs in the US carry vitamins for purchase right there in the clinic to help ensure the patient gets what he needs. While this may not be allowed in Sweden, providing patients with options and going over vitamin needs on a regular basis could help improve compliance.

Increased Knowledge in Primary Care and Yearly Follow-Up

The OOPP survey showed that the primary care system in Sweden lacks adequate care for the WLS patient. Finding general practitioners and other healthcare providers who have experience in bariatric surgery is also a struggle in the US. However, between bariatric programs providing long-term follow-up, patients having annual appointments with their GP, charting systems that have transferable information, specialization in obesity medicine, and networks providing resources for practitioners, there are opportunities for patients to get the care and follow-up needed in the years following bariatric surgery in US. One of the main snafus in the US system is that a patient's insurance coverage often determines who they get to see and what lab tests are covered.

With Sweden's universal healthcare system, there is great opportunity to rise to patient need and provide quality care after bariatric surgery. These include but are not limited to:

- National recommendations and standards that are easily accessible for all patients and practitioners, for example on 1177.se

- Electronic medical record (EMR) systems that automatically send reminders to patients about yearly follow-ups.
- EMR systems that show when a patient has had bariatric surgery no matter where they go for care.
- EMR systems that have transferable medical records.
- An application with easy-to-access information on WLS for practitioners
- Automated lab orders for those with WLS
- Automated questions to ask WLS patients at their follow-up appointments
- Recognition of obesity as a disease and a specialty area, not just in theory but in practice
- Recognition of practitioners who specialize in obesity and WLS to guide patients in who to see
- Options to see the bariatric surgery team long-term
- Obesity practice groups for dietitians, nurses, doctors, etc, where professionals can exchange information and get support from each other.
- Continuing education related to WLS offered at primary care clinics
- Continuity of care with GPs that would allow patients who have had WLS to see the same GP year after year, hopefully one who has been trained in the care of WLS patients.

Recommendations

Sweden is already on its way to creating national guidelines for the care of WLS patients. This is a big step in creating a unified system where patients and practitioners can access information about care before and after bariatric surgery. The suggestions listed above would improve both access to unified information and the quality of long-term care for WLS patients. Some of the recommendations would require large organizational changes, like changing the EMR system. Others, such as creating practice groups through already existing platforms like the Dietisternas Rikförbund, could be accomplished quite easily. The main thing is that progress is made to have information available and care improved.

One of the most apparent changes that would improve care with little cost to the healthcare system in time or money is to require surgical centers to have support groups for their patients led by healthcare providers, such as dietitians and psychologists, who have expertise in bariatric surgery. This would cover at least two of the four areas of needed improvement indicated in the OOPP. Increased support could leave patients better educated about their surgery and empower them to be more involved in their own care, thus improving their overall experience. If surgical centers are not able to do this on their own, perhaps different clinics could pair up to create support groups in their communities. This would also improve access to unified information if clinics begin working with each other

and sharing resources when possible. For example, if one clinic has a psychologist on staff and another does not, that psychologist could help run support groups for both.

It also seems imperative to require that patients have a psychological evaluation before surgery and that they have access to a mental health care provider that is familiar with bariatric surgery both before and after surgery. We check the physical health of our patients for major surgeries, so checking their mental health when undergoing a procedure that affects both mind and body so significantly is only fitting. Addressing the many psychological aspects of surgery that people experience, including changes in how the world interacts with them, shitting body image, and digging into underlying reasons for things like emotional eating, are a big part of learning how to live their lives after WLS. Navigating these subjects without the guidance of a professional is like driving across the country without a map. You may end up where you want to be, but it's going to be a bumpy ride.

Lastly, there is no reason for patients to undergo an operation that fundamentally affects how they eat without guidance from a dietitian. Many of the complications that come up after surgery including food intolerance, reactive hypoglycemia, constipation, vitamin and mineral deficiencies, troubles with hydration, and more, lie in the dietitians' realm. By giving patients access to experienced, knowledgeable RDs, they will be more knowledgeable about how to care for themselves thus allowing them to get the most out of their surgery and improve their experience and quality of life.

Conclusion

There is much to be improved upon in patient care no matter where we look. While the system in the US has its faults, using the MBSAQIP guidelines as a base for bariatric surgery teams to build their programs helps ensure that patients receive a basic level of care. By adopting a similar strategy in Sweden with the adoption national guidelines, many of the desires expressed by patients in the OOPP survey could be addressed and improved upon with little strain on healthcare system. Yes, creating a structure where WLS patients' needs are met will take time and effort. It will require a shift in the way the medical community understands obesity. It will require educating more practitioners in the treatment of obesity. And it will require a unified front so that patients know they can receive trustworthy care no matter where they are. It will be exciting to see how the new national guidelines address patient needs so that, regardless of size, patients can get the care they require and deserve.

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