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LETTER

Comments on – Experiences of Obese Polish Patients When Interacting with Healthcare Professionals [Letter]

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Dear editor

We read with interest the original work by Sobczak[1] et al investigating the experiences of Polish patients, whom suffer with obesity, when interacting with healthcare professionals. As UK-based medical students and future clinicians we appreciate that as a society, improvements can be made in both our attitudes and our care of individuals with high body mass index (BMI). Therefore, we would like to offer our comments and address certain topics arising from the study.

Whilst the closed-ended, dichotomous question design of the study provides an insight into the discrimination faced by obese patients, there are legitimate issues with this format. The closed-ended survey questions seen in Table 2[1] may have limited the nuanced experiences of obese patients with health care providers to a single response, a phenomenon described by Schlesinger et al.[2] There should be no doubt that the discriminatory attitudes reported should be subject to change.

Consequently, we propose the inclusion of patient narratives within this study. This will enable healthcare professionals to reflect upon the patient experience and examine their own attitudes towards obese patients. Moreover, allowing participants to detail their experiences may encourage widespread societal participation, which will be necessary to determine the pervasiveness of stigmatising attitudes in our society towards high BMI individuals.

The self-reporting approach utilised in the study can increase the risk of response bias, termed as the difference between the actual experiences of participants and their surveyed responses.[3] Response bias is often affected by acquiesce bias, the inclination to report affirmative responses, irrespective of the content of the statements.[4] This is in combination with the existence of recall bias due to the retrospective questioning of this study. These biases may adversely affect the external validity of this study and diminish the conclusion that women and those with higher education face greater instances of improper behaviour by medical professionals. This response bias can be reduced during the design phase, by ensuring participants subjected to validation represent the general population. Such information is unavailable in this report, however it should be accessible for evaluation.

In general, we agree with the use of numerous socio-demographic factors seen in the study, however 88% of participants were women, which inevitably makes the

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author's conclusion that women are subjected to greater occurrences of stigmatisation self-evident. Going forward, gender parity would be useful in determining if patient gender affects the type and intensity of discriminatory remarks.

Furthermore, ethnicity and socio-economic status as potential confounders should be considered in the study therefore we recommend their inclusion in future work. Haines et al demonstrated that participants from a lower socio-economic status and ethnic minorities reported greater instances of discriminatory remarks about their weight.[5]

In conclusion, we recognise the issue of prejudiced behaviour reported by participants in this study. With our proposed changes of narrative additions, validation transparency and potential confounder inclusions there is potential to increase the impact of this study. With these revised changes, focus can shift on how to improve attitudes towards obese patients in healthcare.

Disclosure

The authors report no conflicts of interest for this communication.

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