Reviewer's report

Title: Obese Older Adults Report High Satisfaction and Experiences with Care

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Reviewer: Chris Graham

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The paper presents useful findings about a subject where there is little published evidence (obesity and patient experience of general acute care). The finding that obese older patients respond more positively than normal weight counterparts to a range of measures adds to existing literature and is intriguing given that there is good evidence that people in poorer health (which should be associated with obesity) typically report worse experiences. However, the paper would benefit from revisions to more clearly set out statistical methods and the interpretation of results.

Major compulsory revisions

1. Rating scores have been dichotomised into => 90 and <90 (out of 100). This has important implications for the analysis and findings but the rationale given is too limited: it would be useful to explain and justify the choice of 90 as a threshold, and to consider the implications of this. One important consequence of using dichotomised variables for the main outcome measures is that the scale of differences between patients in different weight groups cannot be quantified.

2. The methods section would benefit from more detail on the approach taken to non-response adjustment. The adjustment appears to have normalised to the original sample size. This can artificially reduce variance and cause false positives unless appropriately handled. The handling of this is not described.

3. Statistical reporting of results is unclear in places (see 3.1 & 3.2, below):

3.1. Results from the multiple logistic regression are reported as follows: “obese individuals reported 8%-22% higher satisfaction in each of the categories measured”. This is based on a range of odds ratios for the obese group of OR=1.086 to OR=1.217. Notwithstanding rounding errors re: both numbers, but the odds ratio do not quantify satisfaction. The more appropriate interpretation is that an odds ratio of 1.217 reflects people in the obese group reporting a global satisfaction rating of =>90 21.7% more often than those in the normal weight group.

3.2. In reporting the results from table 4, differences are reported in the following format: “obese individuals were almost 10% more likely to report their doctor prescribed avoiding a particular food”, etc. In this example, the difference is 9.8 percentage points – 29.1% of obsess vs 19.3% of normal weight respondents were told to avoid particular foods. In other words, obese individuals were more
than 50% more likely to be given this advice – reporting the absolute percentage point difference as a difference in relative likelihood has the effect of underreporting the difference by a factor of five.

4. The introduction section of the paper is very short and, for the most part, is narrowly focused on studies looking at relationships between obesity and patient satisfaction. The discussion section expands this to cover issues related to quality of care, service utilisation, and health outcomes. As this goes beyond the objective set out initially, the paper would be strengthened by moving some of this content to the introduction to better set the scene and establish the aims and potential implications of the work.

5. BMI categories used in the study are based on self-reported data, but the accuracy of this is not considered. This is important because it is well known that average people report themselves to be taller and lighter than they are – leading to lower BMI scores and significant underestimates of obesity prevalence (eg Spencer et al, 2002). Moreover, some studies have shown an association with age, with older people more likely to overestimate height and underestimate weight (eg Kuczmarski et al, 2001; Elgar & Stewart, 2008). Consideration should be given to what impact this might have on the analysis.

Minor essential revisions

6. Abstract (3rd sentence), introduction (last sentence), and discussion (1st sentence): “objective of this study was to examine the relationship between weight, as a function of body mass index (BMI), on patient satisfaction and experiences with care”. None of the analysis looks directly at weight or height, only at BMI categories – so it would be more accurate to say that the study looked at the relationship between obesity, categorised by BMI, and patient satisfaction and experiences of care’.

7. Some sections could be clearer for international readers. For example, the first line of the introduction cites obesity prevalence rates – but does not state that these are for the US only.

8. Second sentence of introduction: there is a missing ‘and’ after ‘chronic conditions’. The word ‘independent’ at the end of the sentence should be deleted, too.

9. Introduction, second para. “The women in this study indicated that they were less likely to CONSIDER their physician” – should the word in caps be ‘consult’?

10. p5, sentence following reference [12] – ‘studies’ should be ‘studied’

11. Table 3 – footnote needs rewording as doesn’t currently make sense (“Results of the main the outcome measures…” – deleting the second ‘the’ should fix it).

12. p12: “...this population was 21% obese compared to the 37% that would be expected based on national statistics”. The 37% quoted is for men aged over 60; the 21% is men and women aged over 65. It doesn’t detract from the finding that
the population reports lower than expected obesity, but the 37% is definitely an overestimate when compared against the population in this study. Also – see point 5, above, re: bias from self-reporting as an explanatory factor in differences in the observed vs expected obesity rate.

13. p13, sixth line: “contributed” should be “contribute”

14. First line of page 5 – survey used is normally referred to as the Picker Institute Adult Inpatient Survey.

Discretionary revisions

15. p5 and throughout – inconsistent hyphenation of ‘fee-for-service’

16. p12: “our conclusion that many of the sicker obese, [sic] adults are no longer living at this age is supported by the fact that the mean age of the obesity category was 75 years versus 79 in the normal BMI group”. An alternative hypothesis would be that individuals are likely to lose weight as they age, reducing the prevalence of obesity in older groups.

17. p13 second para raises an interesting point about stigma and notes that “this stigmatism is especially true of younger, obese adults” (which probably needs a referencing). But this isn’t fully elaborated as a potential mechanism for an age/obesity interaction: it could be more clearly stated that experiences of stigma and/or reduced access to healthcare could cause younger obese people to report poorer care.

Refs


Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published
**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I am employed by an organisation (Picker Institute Europe) that conducts surveys of people's experiences of healthcare in the UK and Europe. One of our surveys, the Picker Institute Adult Inpatient Survey, is mentioned as having been used in another study referenced. However, neither I nor my organisation stand to gain or lose from the publication or not of this paper, and I am content that I have no material competing interests.