

ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Explore how different ethnic groups perceive their weight and how cultural differences affect this

The data was collected at The Royal London Hospital, in Whitechapel, which has great ethnic diversity especially when compared to the rest of the United Kingdom. It was believed that this would play a role in the perception of an individual's weight. The most recent National Census from 2011 has shown that 86% of the population is classified as Caucasian (White), leaving the remaining 14% as a combination of different ethnic minority groups. Yet, the data collected shows 58.5% of the patients were Caucasian, 28.5% Asian, 12.5% Afro-Caribbean and the remainder as other ethnic minorities. This was vastly different from the national evaluation as reported by the Office of National Statistics (2011).

No significant difference in weight was seen across different ethnic groups. Thus, no relationship can be determined within this collective of patients. There is minimal statistical data available on the prevalence of obesity in ethnic minorities in the United Kingdom. Due to this, it is not possible to say whether there is an observable difference in weight classes between different ethnic groups.

Patient awareness of their own weight is an important factor as it gives insight of how patients perceive their weight. This also calls to attention how society perceives weight. Caucasian patients had a greater awareness of their weight compared to the ethnic minority groups (77.4% vs 64.4%, respectively) within the overweight (25.0 – 29.9) classification of body mass index (BMI). Additionally, with increasing BMI, the difference in patient awareness grew even more. The data shows that between a BMI of 30.0 and 39.9 Caucasian patients were more aware than their counterparts (80.5% vs 63.6%, respectively). However, due to lack of patients with a BMI greater than 40 in the ethnic minority groups, it is not possible to comment on the comparison to the Caucasian group.

There may be a number of factors leading to the discrepancy in awareness between the ethnic minority patients and Caucasian patients. But, the most likely is the opinion of body image and weight variation within different cultures and generations. Given that the majority of patients were older, it is reasonable to assume that their body image is unlikely to be as important a priority than in younger patients. Additionally, cultural preference for thinness has been incorporated into Western society, whereas overweight and obese individuals are seen as a representation of success and affluence in some non-Western communities. (Grace C, et al, 2009)

How does obesity effect the length of stay in a hospital as an inpatient? Does it effect readmission rates?

Obesity is an important risk factor for multiple conditions, which is why it should be taken into account when treating a patient. It was hypothesised that obesity would increase the length of an admission due to its effect on other co-morbidities. Analysis of variance (ANOVA) was used to analyse length of stay and readmission rates. The data does not show a significant difference ($p > 0.05$) between the BMI of a patient and the length on their admission. In addition, the presence of a few outliers are likely to have skewed the data. Nevertheless, a significant difference ($p < 0.05$) was observed when comparing BMI groups against the number of readmissions. The average number of readmissions for patients in the 30 – 39.9 BMI group was greater than the 18.5 – 24.9 BMI group (1.69 vs 1.53, respectively).

Nonetheless, attrition needs to be taken into account because since the initial data was collected 13.6% of the patients (60 out of 441) have died. This is likely to have had an effect on the number of readmissions and skewed the outcome. The cause of each death is also relevant as the presence

overweight and obesity, as well as underweight, may have had a detrimental effect on patients' health. Alternatively, a number of patients were not residents of Tower Hamlets or neighbouring boroughs, thus their initial admission is the only one on record. Any readmissions they may have had were not accessible on the Care Records Service (CRS). This again would have altered the overall outcome.

How does primary care differ from secondary/tertiary care in regards to weight management?

Primary care develops strategies to manage overweight and obese patients as part of national guidelines for diabetes and ischaemic heart disease. The general practitioner should use every chance to recognize overweight and obese patients. Unfortunately, weight is underreported in primary care; as a result, it is rarely documented in patient notes. Thus, follow up of these patients becomes a challenge. Regrettably, due to time restraints weight management is more of an opportunistic intervention brought up on occasion in primary care. However, many patients may be referred to secondary care for specialist review. (Laws R, 2004)

In secondary care, a weight assessment and management clinic has a primarily goal to monitor patients' weight management. A multidisciplinary approach is taken including, but not exclusive to, a bariatric physician, specialist nurse and dietician. The patient has height and weight measured and an assessment in BMI tend is made. Many methods are used in these clinics such as dietary history to establish a patient's views about their weight and inclination to consider treatment options. The physician should investigate for previously undiagnosed obesity-related comorbidities, especially obstructive sleep apnoea, hypertension, type 2 diabetes mellitus, non-alcoholic fatty liver disease, and chronic kidney disease. (British Obesity and Metabolic Surgery Society, 2014) Overall, secondary care and primary care need to work together to optimise patients' weight management.

To improve academic writing skills

To be able to produce an academic poster presenting information appropriately for its audience

This project entailed a large amount of data collection, which showed some interesting findings. The best way to present these findings was by producing an academic poster. In order to do this, I had to produce an abstract and thus prepare a poster presentation for a medical conference. The project was given the opportunity to be presented at two different conferences, one at the Association for the Study of Obesity (ASO) conference in London, and another at the European Congress on Obesity (ECO) conference in Prague, Czech Republic.

I had produced academic posters in the past, so I was familiar with the type of language to use. However, the previous posters produced were all internal medical school posters primarily targetted at other medical students. These posters were targetted to a larger audience with a greater knowledge in the field. I had never produced an abstract for submission before, which meant I had to do background reading on the subject and also had great assistance from my supervisor. I condensed all the findings are picked out the most important and relevant text to write. In combination with statistical graphs, I was able to convey what the project was about and why it was carried out, as well as demonstrate the most important findings of the project.

References

- British Obesity and Metabolic Surgery Society. Commissioning guide: Weight assessment and management clinics (tier 3), 2014. Available at: <https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services>. [Accessed 01/05/15]
- Grace C, et al. Understanding barriers to healthy lifestyles in a Bangladeshi community. *Journal of Diabetes Nursing* 2009; **13**(2):58–9
- Laws R. Current approaches to obesity management in UK Primary Care: the Counterweight Programme. *J Hum Nutr Diet*. 2004; **17**(3):183-90.