Author's response to reviews

Title: Multiple perspectives on symptom interpretation in primary care research

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Author's response to reviews: see over
Dear editor

Thank you very much for being willing to consider our paper for the BMC.

Below you will find a point-by-point response to the reviewer comments and requests.

Kind regards,

On behalf of the authors

Marianne Rosendal
Reviewer Hanna Kaduszkiewics

This paper is neither a review nor a research article but has been submitted as a debate manuscript.

Reviewer Norbert Donner-Banzhoff

This is a very thorough discussion of an everyday phenomenon in medical care that looks easy and straightforward at first glance, i.e. symptoms presented (or not presented) in general practice. The authors take a broad perspective, including biomedicine, psychology and anthropology. They show clearly the ambiguity and multiple layers of meaning that come with the notion of a ‘symptom’.

Thanks

Background/last paragraph – although it is true that general practice is placed between the population (life world) and secondary care, here one should stress the fact that general practice is at the border between the professional system and the population (lay or life world). General practice is not just the channel between population and secondary care but GPs treat most problems themselves and therefore absorb most of the uncertainty presented to them by their patients.

Good point – manuscript revised

Discussion/The biomedical perspective on symptom interpretation – this part reads in many ways like a clinical introduction to the topic rather than a specific presentation of a biomedical perspective. Perhaps the authors would like to discuss the following two points:

1) The subjective-objective nature of symptoms and signs should be extended to a discussion what counts as reliable and relevant evidence in biomedicine. Most currently practicing doctors, especially in Continental Europe and the US, have been socialized in an intellectual system which regarded the pathophysiological disturbance as the primary process and the clinical presentation by the patient as a secondary phenomenon. From this has resulted the privileged position of biomedical tests and imaging in modern biomedicine because they promise more immediate elucidation of the patho-mechanism of the individual patient. A systematic neglect of the history (=referring to symptoms) has ensued. It remains to be seen whether early exposure in alternative training programmes does lead to different views and clinical behaviours.

2) Another limitation of the biomedical perspective that the authors may wish to discuss is its obsession with the sensitivity of symptoms and diagnostic tests. In other words, the error to miss serious pathology causes more regret than the complementary error of wrongly assuming disease in a healthy person. However, it is difficult to disentangle an intellectual bias (I presume this is what the authors mainly had in mind here), group and financial interests. General practice is perhaps less susceptible to this kind of bias than secondary care. But this varies from health care system to health care system and the position a group or specialty has within that system.

Although we make an introduction to the biomedical understanding/description of symptoms, we also include a discussion of these characteristics in this section. Rather than making an overall discussion of the biomedical field, we find it important to base the discussion on specific characteristics used in everyday clinical practice and challenge the reductionistic understanding of these characteristics.
However, we have changed the section in some places to underline the perspective in focus here—especially with focus on comment 1. With regard to comment 2, we agree with the reviewer, that the error of wrongly assuming disease in a healthy person is as important as the opposite, but we find it too extensive to include a separate discussion of defensive medicine. We do, however, think we touch upon the issue raised by including MUS in our discussion throughout the paper.

**Psychological perspective/wind turbine and sick building – a reference for each would be in order.**

We have followed the reviewer’s suggestion and have inserted two references:

**Anthropological perspective – One should add here ‘and social science perspective’. Whether (not yet) patients have access to a health care system will determine whether their symptoms / problems are visible. The problem of access especially in relation to social class should be mentioned.**

The visibility of symptoms: This is an interesting point brought forward and it might be related to social class, as suggested by the reviewer. We have not been able to identify any studies suggesting differences in access due to the visibility of symptoms, and are not sure how to address this issue properly in the manuscript. There are differences in access and social class, but this is not only related to differences in symptom experiences and we do not find it relevant for this specific discussion.

**Anthropological perspective/Gender differences – The link between the evidence discussed in this paragraph and the lower utilization threshold for consultation demonstrated in most health care systems (i.e. more women than men in most practice samples) should be made clearer.**

Gender differences: The argumentation in this section has been improved. It is now clearer that we speak about gendered differences in bodily experiences, not differences in gender and access. Lower utility threshold for women may possibly be evidence of differences in symptom experiences (or what counts as symptoms). However, healthcare utility and symptom experiences are not necessarily correlated or linear, and we are not convinced, that this would work as evidence for gendered differences in symptom experiences.

*I admit that the gender perspective is important, but cultural heterogeneity in an increasingly mobile world even more so. There should be some discussion of international and intercontinental migration causing discrepant cultural backgrounds of patients and health professionals and how that impacts on the presentation and interpretation of symptoms. This applies to migrating patients as well as migrating doctors.*

Cultural heterogeneity: This is a relevant point. We have added a sentence about this in the section on ‘the clinical setting’.
Cross-disciplinary discussion/consequences of different perspectives for diagnosis/last sentence – The final question regarding future research (symptoms vs. constructs) sounds a bit nebulous to me. What do the authors mean by that? Please clarify.

The sentence has been rephrased.

Overall this is a comprehensive discussion of insights related to symptoms from diverse fields. After the points mentioned above have been accommodated in a revised version of the paper, acceptance can be recommended.

Thanks – and thanks for your thorough and constructive review and comments.

Reviewer: Jean-Marie Degryse

Minor Essential Revisions.

1. In the section of the anthropological perspectives on symptoms, reference to the work of one of pioneers in this field Cecil Helman seems indicated (e.g; to his book Culture, Health, and Illness or some of his articles

Thanks – good point. We have integrated some of his work

2. In the same section: a paragraph / note on the what is known in medical anthropology as the "ethnomedical" perspective would be appropriate (ethnomedicine = the implicit culture system of values and significance that is given to symptoms (disease and illness) within a particular cultural group).

Some would consider ethnomedicine as sub-discipline within medical anthropology. It is a large and important sub-discipline, and it would be of interest to discuss this work further, if we in more detail were able to cover cross-cultural issues related to health and illness. This was, however, not our intention with this manuscript. Again, due to the length of the manuscript we are only able to touch briefly on a few overall issues, serving to illustrate the social and cultural embeddedness of bodily experiences.

Discretionary Revisions

P6 Symptom nature and appearance: May I suggest to make reference to the Bayesian logic that underpins clinical epidemiological reasoning.

Although the Bayesian logic is applied in the consultation when interpreting symptom presentations, an introduction of this will move focus from symptoms to the diagnostic process itself. We would prefer to keep our focus in this section on symptoms as they are presented.

P7 third paragraph "When Gps face...: a nice example to illustrate things is the way the "seriousness" of a common complaint as "cough" is measured/approached (Lecompte Sophie et al. Validated methods of cough assessment: a systematic review of the literature. Respiration 2011;81:161-74.

Thanks for a relevant reference. We included it – but in the section about symptom nature.
P9 last paragraph and P10 first sentence: one or more references are lacking to support such strong statement. (“However growing evidence suggests...)

The referred paragraph is a summary of the section dealing with the psychological perspective on symptom interpretation and as such the sentence is a conclusion based on the many psychological issues described on the preceding pages. Meanwhile, we have followed the reviewer’s request and inserted one of the core references (Petrie & Weinman (2006): Why illness perceptions matter) and the review mentioned in the point below.


We thank the reviewer for drawing our attention to this highly relevant reference and direct the attention to our response to the previous point.

In the discussion section maybe a separate paragraph might be dedicate to the way “symptom scores" are embedded in Quality of Life Questionnaires that are very popular. Most of them contain indicator items next to causal items (Feyers and Machin 2007)

Symptom scores are used in various screening questionnaires – both quality of life and mental health assessments. There is some evidence of correlation between number of symptoms and subjective health but we think it will change the focus of this paper if we include a discussion of this – otherwise a very relevant issue.