Author's response to reviews

Title: 'No need to worry': an exploration of family physicians' reassuring strategies

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Author's response to reviews: see over
Dear Prof Carolyn Chew-Graham,

Please find attached a revised version of our manuscript that carried the following title when we originally submitted it: 'No need to worry': exploring family physicians' expertise in reassuring patients. We would like to resubmit our manuscript for publication as an original article in BMC Family Practice.

Thank you for the opportunity to revise our manuscript. The reviewers’ comments enabled us to improve the clarity of our manuscript and our reflection on the existing literature. Moreover, the comments triggered us to make our title and abstract more consistent with our study aims and conclusions. Below we outline our response to the reviewers’ comments. Revisions in the article text itself are shown using bold text.

We hope that the revisions in the manuscript and our accompanying responses will be sufficient to make our manuscript suitable for publication in BMC Family Practice.

We look forward to hearing from you at your earliest convenience.

Yours sincerely,

Also on behalf of the co-authors,

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Reviewer 1: Sarah Alderson

Reviewer's report:
This article explores general practitioners recall of techniques used to reassured patients during consultations. The background describes why reassurance is important in primary care and the lack of evidence supporting the variety of reassurance techniques doctors’ use. They adequately explain why they wish to understand which techniques the doctors’ use as a starting point to understanding which techniques are effective in practice. The methods are appropriate and well described for understanding which techniques doctors use. The data appears to be sounds and the writing acceptable. This study is an exploratory study and as such, no recommendations regarding reassurance techniques can be made. It is therefore interesting but unlikely to change practice.

We appreciate the reviewer’s positive feedback regarding our study aim, methodology, results and writing.

Major Compulsory Revisions.
1. In the methods section, dataset B, they mention that before and after consultations patients rated their level of concern. In the data characteristics for dataset B they mention the patients' mean level of concern was 4.9 but fail to mention if this was before or after the consultation. We have added that patients’ mean level of concern was 4.9 before the consultation. Following the reviewer’s suggestion (discretionary revision 1), we have transferred the data characteristics into a table (Table 1, page 28).

There does not appear to be any mention of the difference in before and after scores for the patients’ level of concern, or any relation of the change in scores in relation to reassurance techniques used or in relation to the physicians rating of the importance of reassurance to that consultation. I would suggest further analysis is needed to include the results of the patients’ level of concerns and how this changed after the consultations, its relation to how important the physician believed reassurance was to the consultation and its relationship to the techniques used by the physicians. Whilst the discussion accurately says that no conclusions can be drawn on the effectiveness of the strategies, this information was collected and should be represented in the results.

Thank you for pointing out this important issue. We agree with the reviewer that it would be interesting to do a further analysis of the change in patients’ level of concern, and its relationship to physician’s rating of importance of reassurance and reassurance techniques. However, we do not feel comfortable presenting this data in the current article. This may rise the suggestion that we want to draw conclusions on the actual effectiveness of physician’s strategies, which is firstly not the aim of this qualitative study and secondly not desirable based on a study population of 24 patients. However, in a different ongoing study we have collected this data from a much larger patient population that had a consultation with a GP (N=140). In addition to patients’ level of concern pre- and post-consultation and physicians’ rating on importance of reassurance, we have gathered data on ‘level of concern after 1 week,’ ‘patients’ type of concern’, ‘physicians’ estimation of patients’ level and type of concern’, as well as patients’ characteristics (e.g. patients’ age, gender, complaint). We do feel that this data
deserve a separate article in which we are able to extensively report the course of patients’ level of concern and its relation to the factors mentioned above. We are currently analyzing this data and plan to write and submit the article as soon as possible.

We want to emphasize that for this study, the sole purpose of collecting data on physicians’ importance of reassurance and patients’ level of concern before the consultation was to facilitate the selection of relevant consultations for the interview. To prevent any confusion, we have changed ‘before and after the consultation’ into ‘before the consultation’ (page 7, line 3), as only the patients’ rating before the consultation was relevant for the selection of the consultations.

2. Further information needs to be provided on how the videotaped consultations were selected, such as who did the selection and what criteria did they use, particularly as it mentions that physicians’ communication techniques were used as a selection tool.

We have provided more information about the selection of the videotaped consultations (page 6, lines 10 to 15). We added that the researcher selected the consultations and explained that the physician’s communication techniques were assessed by the Maas-Global instrument. The researchers strived for a maximum variation in sampling regarding the factors mentioned in this paragraph. A reference of the original study was added to give the reader more information on the selection process.

3. More information is also needed on how the GP’s in dataset 2 were identified and recruited, e.g. from research practices, all GP’s in an area etc. as this may affect the results obtained.

We have added that we approached GPs in the Southern part of the Netherlands who were not recently approached for other research projects by our university. Another selection criterion was that GPs needed to have a minimum of 5 years of working experience (Page 6 , lines 18-20).

4. It is difficult to see how the conclusion that “Medical schools could adopt this approach to train students in breaking bad news” has been obtained from the data. The results describe techniques to reassure and promote alternative diagnoses rather than to discuss a diagnosis of a serious condition. Its use in medical student teaching is not validated or supported.

We believe that the reviewer has misread the sentence, as we wrote that ‘medical schools could adopt this approach to train students in breaking good news’ (Page 25, line 6). Here we interpreted reassurance as ‘good news’. This is meant as a wordplay, yet in case the reviewer/editor believes that this sentence might raise confusion we are willing to change it.

5. Many of the findings listed in table 1 are similar to the consultation skills mentioned in the Calgary-Cambridge consultation model. No comparison is made to how the reassurance techniques employed relate to consultation models, particularly the Calgary-Cambridge which cites evidence for understanding patient’s ideas, concerns and expectations, as well as listing techniques to make the patient feel listened too, understood and reassured.

Thank you for raising this important point. We have added to the discussion that many of the strategies related to making patients feel heard and understood as well as strategies for making patients understand information are similar to the skills mentioned in the well-known
consultation models such as the Calgary-Cambridge model and the SEGUE Framework (page 22, lines 3 to 5).

6. The abstract background, methods and results accurately summarize the study; however the conclusion suggests that this can be used to guide physicians on choosing reassurance techniques and teaching medical students. This is not supported by the results as this is an exploratory study rather than one of effectiveness, although its use in planning future research is correct.

We have changed “This detailed description can be used to guide physicians in choosing appropriate types of reassurance, in future studies exploring the effectiveness of reassurance strategies and to inform medical communication training” into: “This detailed description may provide practicing physicians with new tools and can inform future studies exploring the effectiveness of reassurance strategies”. (Page 2, line 22).

Although we agree that the actual effect of the identified strategies needs to be subjected for further research, we still support our conclusion that this study may be informative for practicing physicians, who may learn about some new strategies based on the experience from their colleagues. Moreover, since we describe the underlying mechanisms of reassuring actions, physicians may gain insight into how reassuring actions may work, which may help them to experiment with reassuring strategies in their own practice and observe the effects of these strategies. Therefore we belief this study may provide them with some helpful tools until the effectiveness of reassuring strategies is examined. We now have addressed this issue more clearly in the discussion section (page 24, lines 22-23).

Minor Compulsory Revisions
1. There is a typo on line 9 page 22 (discussion) “For patients some less anxious patients….”
We have removed the typo (Page 21, line 9).

Discretionary Revisions

1. The data characteristics in results could be condensed and much of the information transferred into a table which would make it easier to read and to compare characteristics between the two data sets.
Thank you this suggestion, we have transferred the data characteristics into a table (Table 1, Page 28).
Reviewer 2: Tamar Pincus

Reviewer’s report
This study describes qualitative work through two approaches, primary and secondary analysis of interviews focused on consultations between physicians and patients with varied problems. The study aimed to achieve a better understanding of reassurance. The study of reassurance is seriously neglected and the authors should be applauded for taking on this important topic, and for considerable methodological rigour in their method of coding. The findings add important information and will be, in my opinion, of interest to many readers.

We appreciate the reviewers’ compliments regarding the relevance of our study and our methodological rigor.

There are several aspects that could improve the manuscript further (major revision indicated by (M)):

1. The title is misleading. The study explored family physicians’ perception and decision-making reasoning around reassurance, but there can be no comment on expertise until we understand the impact of these techniques on patients. (M)
   We understand why the title might be misleading, therefore we have changed the title into: ‘No need to worry’: an exploration of family physicians’ reassuring strategies

2. The abstract claims in the conclusion that the findings could be used ‘to guide physicians in choosing appropriate types of reassurance’. This is misleading too – see above - until we know which of these techniques are effective, for whom, and under what circumstances. (M)
   We understand why this claim might be misleading, in particular the words ‘choosing appropriate strategies’. Instead of ‘this description can guide physicians in choosing appropriate types of reassuring strategies’, we have stated: ‘This detailed description may provide practicing physicians with new tools’ (Page 2, line 22).
   We do believe that other physicians reading this article might learn about new types of strategies and the mechanisms by which they may create their effects (see also our response to comment 6 of reviewer 1). Doctors will be challenged to reassure patients on a daily basis, despite the fact that at the moment there is little evidence available on effective reassuring strategies. We believe this study may provide them with some tools in the meantime, of which they can experience the effects in their own practice. We now have addressed this issue more clearly in the discussion section (page 24, lines 22-23).

3. The background is missing some seminal articles in the field, notably, Linton et al., 2008 and Pincus et al, 2013, both in Pain. The latter is particularly pertinent as it offered a model that the findings from this study fit into nicely. (M)
   Thank you for the literature suggestions, which are indeed very relevant for our study as they explore reassurance in the context of unexplained pain conditions. Both articles also emphasize the limited amount of studies examining the impact of reassurance on patient outcomes. We have now incorporated both articles in the introduction section (page 3, line 5, line 22). In the discussion we have linked our findings to the model of cognitive and affective reassurance.
described in Pincus et al. This model is indeed in line with our findings that reassurance is directed at influencing emotions as well as influencing cognitions. We have also added some comments on the pathways of cognitive and affective reassurance based upon our findings (Page 22, lines 7 to 16).

4. Some sections in the introduction could be improved. Line 11 states that ‘there is support for some approaches to reassurance used in groups of patients that are known to be highly anxious... What support? The section on realist theory adds little and is confusing. I would simply remove.
We have added that with ‘support’ we mean ‘empirical support’ (page 3, line 11). We have shortened the section of Realist theory, now only explaining the relevance of understanding the underlying mechanisms (Page 4, line 19).

5. Method- some wording are odd and require explanation- such as ‘purposively triggered on page 5 line 18.
We have changed ‘were purposively triggered about’ into ‘were prompted to reflect on’ (Page 5, line 18).

6. Some detail is need on the acquisition of data set A: why were the interviews recorded? (M)
We have clarified the original study aim of dataset A. The interviews of dataset A explored how physicians’ selected their communicative actions during their patient encounters. For more details on the original study aims the reference of the original article was added (Page 5, line 14).

7. It would be helpful to have some quantitative data too- what was the mean of reassurance as goal (sd)? What was the correlation between practitioners and patients in reference to reassurance? (M)
The mean physicians’ rating on the importance of the goal reassurance and the mean patients’ rating on level of concern were already reported and have now been transferred to a new table (table 1, page 28). Here it can be seen that physician’s mean rating is higher than patients’ mean rating.
However, further analysis of correlations between physicians’ and patients’ ratings will be presented in a separate article based on a dataset of 140 patients. We do not feel comfortable to report any correlations in this qualitative study since this would be based on study population of only 24 patients. For this qualitative study, the sole purpose of measuring patients’ level of concern and physicians’ rating on the importance of reassurance as a goal was to facilitate the selection of relevant consultations for the interview (see also our response to comment 1 of reviewer 1).

8. In places the information on interviews is repetitive and could be collapsed.
We have removed repetitive information regarding the interview procedure, substantially shortening this paragraph (Page 7, line 14 – page 8, line 2).

9. The paragraph on saturation (page 10, lines 9-13) is confusing and needs to be re-phrased.
We have rephrased the paragraph on data saturation (Page 9, lines 8 tot 12).

10. Please change the word ‘invalidating’ patients’ beliefs. 
We have changed the word ‘invalidate’ into ‘challenge’ (Table 2 on page 29 and in the text wherever the word invalidate was used).

11. Some comment should be given in reference to practitioners perception that they created trust through giving causes- what happened when causes remained unknown? 
First, we have clarified that physicians mentioned that trust is derived from ‘thorough explanations’ in general, of which explanations about the physicians’ procedures and about the causes of symptoms are specific examples of ‘thorough explanations’ that physicians’ related to trust. We also added another type of explanation: ‘explaining why symptoms are not serious’ (Page 11, lines 15-16). Physicians did not specifically reflect upon creating trust in relation to situations in which the causes remained unknown. However, physicians did reflect upon a few cases in which there was no somatic cause explaining the symptoms in relation to changing cognitions. Then, they tried to promote insight into patients’ tendency to worry in case they experience physical symptoms, e.g. due to an anxious personality or due to serious illness in patients’ family (Page 15, line 17). We added to this paragraph that physicians did this after excluding a serious disease. However, physicians did not specifically link this to creating trust, therefore we did not mention this in the paragraph about trust.

12. Some thought should be given to possible adverse reactions to the strategy employed in page 16 lines 8-10. Similarly, page 20 12-14. Some of these strategies could enhance anxiety, at the least- I would not define these behaviours as expertise! 
Thank you for raising this issue, which we now have addressed in the discussion (page 23, lines 5 to 7). Physicians explained that some strategies can only be effective under certain conditions. According to them, the effectiveness of these strategies highly depends on the context, e.g. when they are applied. For example, they mentioned that not responding to new symptoms at the end of the consultation can only be done in case the physician already sufficiently invested in making the patient feel heard and understood. We have also clarified this point in the results section (page 19, line 12 - 14).

13. Discussion - correct sentence page 22 line 9. This section also appears to accept that providing reassuring information for non-anxious patient is sufficient based on what evidence? 
Later the phrase ‘shown to be effective’ is used- there is nothing in this study that shows any of these strategies to be effective. (M) 
We understand the confusion. We did not mean to judge whether providing reassuring information for less anxious patients is indeed sufficient. We have clarified in the text that we wanted to point out that physicians considered it to be sufficient to provide reassuring information to less anxious patients (in contrast to letting highly anxious patients construct the reassuring information themselves) ( Page 21, line 9).
The phrase ‘shown to be effective’ refers to the study off Hall-Patch et al, not to our study. To prevent any confusion, we have removed the word ‘also’ between ‘were’ and ‘reported’ (Page 21, line 14).

14. Figure 1 is very simplistic. We purposively kept Figure 1 simple as we aimed to give the readers a clear overview of the general structure of a reassuring consultation, including the goals that are pursued within such a consultation. For a more detailed description of the specific actions and mechanisms promoting these goals, we have included the table.