Author's response to reviews

Title: Motivations for consulting complementary and alternative medicine practitioners: A comparison of consumers from 1997-8 and 2005

Authors:

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Author's response to reviews: see over
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Dear Editor,

Please find attached a copy of the final revised manuscript “Motivations for consulting complementary and alternative medicine practitioners: A comparison of consumers from 1997-8 and 2005” for consideration of publication in *BMC Complementary and Alternative Medicine*.

I have further improved the manuscript in line with the reviewers comments. As suggested, the rationale on page 4 has been removed, as have the discussion of the findings related to shifts in herbalism and biofeedback on page 9. The explanation for changes in the use of reflexology has also been moved from page 15 to page 13 as recommended. Finally, the term “client” has been removed from page 6 and the typo on page 12 has been corrected. I have also reviewed the formatting checklist and made changes where necessary to ensure that the manuscript conforms to the guidelines.

I hope that these revisions are satisfactory and that acceptance can now be confirmed.

Yours Sincerely,

Fuschia M. Sirois, PhD, BSc.
Reviewer 1: Marja Verhoef

Major issues

• To address the issue of whether the results reported in this secondary analysis are “new and informative enough”, an explanatory paragraph has been added to the beginning of the methods section. While this reviewer is correct in stating that the endorsement pattern for some of the motivations at each time point has been reported previously, only 3 of the 6 motivations were examined in the 2002 paper, and only 2 of the 6 in the 2008 paper. Moreover, a comparison of these motivations across the eight years of the two studies has not been conducted. I agree that there are several important methodological issues in this study (which I have attempted to address in response to other reviewers’ comments, and with some additional analyses). However, weighing these issues against the possibility of getting even a glimpse of how CAM motivations may have shifted over time I believe that the current study is unique enough in its focus to make a contribution to the CAM literature.

• A more detailed discussion of the implications of the findings from the current study has also been added to the discussion section to further address the important issues raised by this reviewer. A general statement regarding the implications has also been added to the end of the background section, along with a supporting reference to a recent editorial on the value of CAM consumption survey research.

Minor issues

• The conclusions statement in the abstract (and the discussion) has been re-stated to reflect a more cautious interpretation of the results.

• The typo in the abstract has also been addressed – thank you
Reviewer 2: Lynda Balneaves

Methods

- Additional information describing the differences in the geographical locations of the sampling sites has been added. Population data, physician per 100,000 ratios, and additional information about how the offices/clinics were sampled has been added, as well as a speculative comment regarding the distribution of CAM offices in both times and locations. Thank you for this very helpful suggestion.

- Details regarding the specific types of conventional medicine and CAM offices that the surveys were distributed to is now included in Figure 1.

- The reason for the format change between the two samplings (i.e., to permit an analysis of other the factors associated with the motivations for the primary study) has been noted in the methods section at the end of the paragraph describing the CAM motivations measure.

- More information regarding the criteria for classifying participants into CAM consumers and non-consumers groups has also been provided in the analyses section – my apologies for not making this more explicit.

- Given the focus of the study – use of CAM providers – the list of CAM therapies provided was relatively short with space to add in any “other” therapies. While all therapies considered CAM are listed in Figure 2 and its footnote, I have now also added a listing of the main provider-based CAM that were on the CAM checklist to assess CAM use to further guide the reader. This list appears in the methods section describing this measure.

- An explanation of how the “other” CAM therapies/practices that participants listed were screened for inclusion is now included in the analyses section, as suggested.

- A breakdown of the CAM and conventional medicine office/clinics that refused to participate in the studies is now included in Figure 1, and the title of this figure has also been changed to “Sampling frame” in line with this reviewer’s suggestion.

Results

- The term “significant” has been added to the reporting of the CAM use differences in the results section on page 9 to clarify. In Psychology, when reporting the results of the relations between variables it is usually understood that a test of significance was conducted; therefore simply stating there are relationships or differences between variables implies that they are significant. My apologies if this was not made explicit enough.

Discussion

- A speculative discussion of the possible reasons for the differences in the types of CAM tried between the two time points has been added. Relating these differences to changes in provincial coverage is an excellent suggestion which may help explain these findings.

- Comments regarding the possible explanation for the longer use of CAM in the 2005 sample compared to the 1997-8 sample have been added to the discussion on page 11.

- To address the issue regarding the change in the response format from the 1997-8 to the 2005 study, several changes have been made.

- First, a second recoding of the 2005 responses has been done in which “mildly agree” responses have been coded as “disagree” to deal with any possible acquiescence bias that may have inflated the level of agreement found in the 2005 sample. Both this more
conservative recoding and the original standard dichotomization are now reported in Table 3, and explained in the analyses section. Although this recoding lowered the percent agreeing in 2005, significant differences were still noted for 5 of the six CAM motives, and the discussion, abstract, and conclusions have been adjusted accordingly.

- Second, a discussion of how the 2005 results may be affected by this response bias has been included in the analyses and the discussion. I have also noted that the balancing of the items between positively and negatively valenced items is one other way in which the “yea-saying” bias may have been minimized, and a well-known psychometrician has been referenced to support this proposition.

- Finally, empirical evidence corroborating the validity of transitioning from a dichotomous to a six-point Likert response format has been included in the discussion. The findings from the study of an attitude scale which explicitly examined the equivalence of each response format further supports the idea that the validity of the differences observed between the two time points in the current study is not substantially compromised by the change in response format.

- Although I agree that the response format change is the most substantial methodological issue in this paper, I believe that the conservative recoding, empirical evidence presented, and highlighting of other issues related to response set theory have addressed this issue in such a way that the reader can now make a more informed judgment about the extent of this limitation and its effect on the findings. Finding that the recoding resulted in roughly the same proportion of people endorsing the CAM reason regarding the ineffectiveness of conventional medicine further suggests that the issue of a possible response bias has been minimized by this solution.

Minor Revisions

- Commas have been added to the first paragraph as suggested.
Reviewer 3: Aslak Steinsbekk

Major Revisions

- In response to the concerns expressed by this and the other reviewers’ concerns regarding the change in response format and the implications for the validity of the results, an additional recoding has been conducted and the results presented in Table 3. Please see the response to Reviewer 2 for further details and steps taken to support the argument that the comparison between the two time points is indeed valid.

- Details regarding how the recoding for both the standard and the conservative recoding were conducted are now outlined in the analyses section as requested.

- Clarification regarding the type of CAM consumers (all provider-based CAM use) has been added to the results section. The focus of this study was the use of provider-based CAM, and everyone who is included at both time points had consulted one or more CAM providers. Details regarding self-care CAM practices that had been used are given for descriptive purposes in Figure 2, and are essentially CAM practices that were used in addition to consulting CAM practitioners. Accordingly, there are no CAM consumers who only used CAM self-care, and there is no mixing of self-care only and CAM practitioner clients.

- Using a logistic regression to examine what factors distinguish the two samples would be appropriate if the main focus of the study was to determine how the two samples differed. However, the main focus of this study is not how the samples differ so much as how the motivations and use of CAM may have changed over time. Differences between the two samples are presented to establish how similar the two samples are with respect to demographics and other factors so that any differences noted between the CAM motivations can be more confidently attributed to shifts in public attitudes towards CAM rather than to differences in the sample characteristics per se. This is especially important given that the two samples were obtained from different locations within the province.

- Details regarding the types of CAM and conventional offices sampled from are now presented in Figure 2 in response to the comments made by Reviewers 2 and 3. A discussion of the differences between the two time points with regards to the offices sampled from has been included in the discussion.

- The discussion of the differences in the motivations between the two time points has been revised and now focuses more on the shift among the top three reasons. The updated analysis of the differences between the two time points should address the issue of the absolute differences which are now relatively lower.

- An explanation of what is meant by CAM used to supplement versus replace conventional medicine has been added to the Methods and Results sections, and also reworded for Table 2 to help clarify.

Minor Revisions

- “Number of” has been to the description of the acute and chronic health condition variables in Table 1 as suggested.