Author's response to reviews


Authors:

Shedra A Snipes (sas84@psu.edu)
Sherrill L. Sellers (sellersl@muohio.edu)
Adebola O Odunlami (aodunlam@hsph.harvard.edu)
Lisa A Cooper (lisa.cooper@jhmi.edu)
Julie C Fields (julie.fields86@gmail.com)
Vence L Bonham (bonhamv@mail.nih.gov)

Version: 2 Date: 11 June 2011

Author's response to reviews: see over
RESPONSES TO REVIEWER COMMENTS


Authors: Shedra A. Snipes (sas84@psu.edu)
Sherrill L. Sellers (sellersl@muohio.edu)
Adebola O. Odunlami (aodunlam@hsph.harvard.edu)
Lisa A. Cooper (lisa.cooper@jhmi.edu)
Julie C. Fields (julie.fields86@gmail.com)
Vence L. Bonham (bonhamv@mail.nih.gov)

Response to Reviewers: This letter documents our changes, and responds to each reviewer’s concerns and recommendations. Reviewer comments are included here along with our responses. The reviewer comments are in bold italic text and our responses are in normal text.

General Comments: We sincerely thank the reviewers for their detailed and thoughtful comments regarding our manuscript, “Is Race Medically Relevant? A Qualitative Study of Physicians’ Attitudes about the Role of Race in Treatment Decision-Making?”. Our paper is vastly improved as a result of the reviewers’ thoughtful feedback, and we have made changes to our original submission based on their recommendations.

In response to the reviewers’ overall comments, we have made the following changes: 1) Key themes that came up around the ways that race is important (or not) to physicians are included in the results section of the abstract, as well as in the results section of the manuscript. 2) The discussion includes interpretation of our findings in context of how race is used as a proxy for epidemiologic base rates (consistent with Bayesian approaches). These interpretations are explored more thoroughly compared to the original submission. 3) We cite the paper, Lutfey, Karen E., Stephen M. Campbell, Megan R. Renfrew, Lisa D. Marceau, Martin Roland, and John B. McKinlay. 2008. “How are patient characteristics relevant for physicians’ clinical decision making in diabetes?: An analysis of qualitative results from a cross-national factorial experiment.” Social Science and Medicine 67(9): 1391-99. 4) Methodological issues regarding number of mentions of a code, variance according to how talkative physicians are, and the issue of falsification or use of negative cases are addressed. 5) Additional study limitations are included in the conclusions section about the lack of statistical methods to confirm true differences between black and white physicians’ views regarding the relevance of race.

REVIEWER 1

The paper is well-written, poses a coherent research question that is clearly situated in relevant literature, and uses appropriate data to address the questions. The role of patient race in clinical decision making is known to make conflicting contributions to variations in medical practice, sometimes seen as predictive of disease risk and other times as a source of bias and prejudice, intentional or otherwise (i.e. in service of minimizing uncertainty). I think the paper would be strengthened significantly by a serious discussion of how race is supposed to be used in the context of Bayesian decision making models. Some of the data point to the use of race as a proxy for epidemiologic base rates (consistent with Bayesian approaches) and other times as a proxy for behavioral, cultural, and SES related factors. These interpretations and uses could be explored more thoroughly.

- We thank Reviewer 1 for the suggestion to enhance our manuscript by including discussion regarding the use of race in the context of Bayesian decision making models. Accordingly, we added text
regarding Bayesian decision-making models in the context of our findings. Our additional text can be found on page 18, first paragraph, starting with the third sentence. It reads as follows:

“This finding has important implications, since probability-based models suggest that race should be used as a primary proxy for establishing that any given patient of a particular racial or ethnic group will experience a health problem. For example, since African Americans in the United States suffer from increased risk of hypertension and diabetes (National Center for Health Statistics, 2008; reference number 18), disorders outlined in our clinical vignette, some reasoning suggests that population-based probability of disease should accompany the decision-making process. However, we found that white physicians in our study did not rely on race as a determinant for treatment decision-making. Other studies agree with this, finding that among a largely white physician population, doctors rarely mentioned race and ethnicity to determine clinical assessments (Lutfey, 2008; reference number 19). Moreover, while black physicians indicated using race as a proxy for disease risk, black physicians held nuanced and complex views about the appropriate context in which race should be used (e.g. to determine appropriate medication and to understand social determinants of health linked with stress and health disparities).”

The following paper does something similar—the physician sample is not stratified by physician race, but the vignettes are and this allows for comparison of how race is conceptualized among the largely white physician population and how it compares with discussions of social, cognitive, motivational assumptions relevant to diabetes care. Lutfey, Karen E., Stephen M. Campbell, Megan R. Renfrew, Lisa D. Marceau, Martin Roland, and John B. McKinlay. 2008. “How are patient characteristics relevant for physicians’ clinical decision making in diabetes?: An analysis of qualitative results from a cross-national factorial experiment.” Social Science and Medicine 67(9): 1391-99.

• We thank the reviewer for pointing out the Lutfey et. al (2008) manuscript, and it’s relevance to our findings. The Lutfey et. al. (2008) manuscript is cited, and added to our numbered list of references. The citation can be found on page 18 of our manuscript. It is reference number 19.

In terms of limitations, it would be appropriate to address the potential issue that the number of mentions of a code will vary according to how talkative physicians are in a focus group, which can confound results. How did the authors protect against a possible inflation of reports about race due to particular individuals in a focus group?

• We understand the reviewer’s concern regarding addressing the potential issue regarding the number of mentions of a code, and variation according to how talkative physicians are – all of which can confound results. To address this, we added the following language, which can be found in the last paragraph on page 19 beginning with the second sentence:

“Although multiple responses from the same individual were only counted once, it is possible that the number of mentions of particular codes regarding the use of race reflect how talkative physicians were in some focus groups versus others. However, when we assess differences in the coding across all focus groups, there are marked thematic differences between black and white physicians. All five focus groups among black physicians contained discussion about the importance of race for medical decision-making, regardless of length of discussion. Conversely, all focus groups among white physicians indicated that race is not especially medically relevant.”

The authors are right to note that they are not addressing implicit bias, nor can they directly assess whether white physicians are less willing to talk about race in the focus groups, and this is a strength of the paper. Within that context, however, it seems urgent that they be more specific about how race is used, how it’s a proxy, and be prepared to comment somehow on which usages are appropriate in a Bayesian context (and relatedly in terms of statistical discrimination and the use of group averages).
Both reviewers pointed out that our manuscript could be strengthened with the addition of specific language and context regarding the use of race by physicians. We added such language throughout our manuscript, including the abstract and results section. In the abstract, the revised text reads:

“Forty self-identified black and 50 self-identified white physicians participated in the study. All physicians – regardless of their own race – believed that medical history, family history, and weight were important for making treatment decisions for the patient. However, Black and White physicians reported differences in their views about the relevance of race. Several black physicians indicated that patient race is a central factor for choosing treatment options such as aggressive therapies, patient medication and understanding disease risk. Moreover, many black physicians considered patient race important to understand the patient’s views, such as alternative medicine preferences and cultural beliefs about illness. However, few white physicians explicitly indicated that the patient’s race was important over-and-above medical history. Instead, white physicians reported that the patient should be treated aggressively regardless of race.”

Our results begin by providing the reader with a summary of focus group findings. The summary has been edited to better reflect the ways in which physicians discuss race and its use (or not) for decision-making. The changes can be found in the final paragraph of page 10, and extend to the first paragraph of page 11. It reads:

“We found three main themes. Overall, we found that both black and white physicians held similar views that the patient’s medical information is (e.g. past medical history, family history) the most important factor for treatment decision-making. However, black and white physicians’ views about the medical relevance of race differ, and are presented as separate themes. Among white physicians, patient race was viewed as relatively unimportant for treatment decisions. Instead, white physicians believed that the hypothetical patient should be treated aggressively regardless of her race. Conversely, black physicians in the study believed that race is important for clinical decision-making, provides useful information for choosing medication, understanding disease risk, and is associated with social determinants (socioeconomic factors and cultural beliefs about illness) for the patients’ health. Results are also explained in detail below.”

Additional language addressing the use of race by physicians is also addressed in the subsections of the results. The subsection titles are:

**Theme 1.** Black and White Physicians Hold Similar Beliefs that Medical Information is the Most Important Factor for Medical Decision-Making

**Theme 2.** White Physicians Reported That Patient Race is Not Important for Treatment Decision-Making, and That Medical History Should Drive Decision-Making

**Theme 3.** Black Physicians Reported That Patient Race is Medically Relevant, and Can Be Useful in Treatment Decisions

Examples of how physicians view the relevance of race for treatment decisions are provided in narrative quotes. Two examples are provided below:

“I’m not sure that it’s [race is] relevant in this woman’s case…because of all the medical issues that you’ve described, she’s going to need to be treated aggressively.” (White physician, Philadelphia Focus Group)

“I think it’s very significant to know what her race is because it will make some decisions…about what paths I’m going to use to treat her…” and “I mean [race] is important to choosing the medication.” (Black physician, Atlanta Focus Group)
There is little discussion of falsification or the use of negative cases, which is always appropriate in a qualitative data analysis.

- We thank Reviewer 1 for helping us to clarify the rigor of our qualitative analysis regarding negative cases. Our approach has been added to the methods section. Our edits can be found starting with the last sentence on page 9, and extends through the first paragraph of page 10. It reads:

  “Our analysis also involved paying careful attention to negative cases (e.g., race not important), which were addressed by examination and reexamination of every case discussion around the medical relevance of race. Negative cases were resolved by the vignette core research team through comparison of all code differences to see whether the emergent themes were applicable to the majority of cases. Once negative cases were noted, we reexamined our codebook adding codes for negative cases. For example, codes were created for discussion around when race is not considered medically relevant. Recoding of negative cases was conducted by the analysis team until properly coded. This iterative process continued until it was determined that there were no negative or unresolved cases.”

REVIEWER 2

While the findings were very interesting, there was an emphasis throughout the paper on comparing black and white physicians. While this is useful and important, it seems somewhat limiting to focus primarily on these differences rather than on the attitudes themselves. To make this point clearer, in the abstract for example, the only results mentioned are that black and white physicians both focused on medical and family history being important as well as weight, and that black physicians felt that race was important while white physicians tended not to. It would be helpful to see in the abstract some mention of the key themes that came up around the ways that race was seen as important (or not). Also, in the results section, it would be helpful to see a list of these key themes.

- We thank both reviewers for pointing out that our manuscript could be strengthened with the addition of specific language and context regarding the use of race by physicians. However, reviewer 2 specifically asked us to address focusing on attitudes in general instead of by physician race. We address reviewer 2’s recommendation by explaining the overall findings regarding the use of medical history. Then, we explore differences by physician race. We chose this approach because beliefs about the relevance of race for treatment decision-making differ significantly between black and white physicians. Thus, we found it appropriate to present the data separately. We addressed the concerns of Reviewer 1 and Reviewer 2 together by editing language throughout our manuscript, including the abstract and results section. This response is noted above, and is repeated here.

In the abstract, the revised text reads:

  “Forty self-identified black and 50 self-identified white physicians participated in the study. All physicians – regardless of their own race – believed that medical history, family history, and weight were important for making treatment decisions for the patient. However, Black and White physicians reported differences in their views about the relevance of race. Several black physicians indicated that patient race is a central factor for choosing treatment options such as aggressive therapies, patient medication and understanding disease risk. Moreover, many black physicians considered patient race important to understand the patient’s views, such as alternative medicine preferences and cultural beliefs about illness. However, few white physicians explicitly indicated that the patient’s race was important over-and-above medical history. Instead, white physicians reported that the patient should be treated aggressively regardless of race.”
• Our results begin by providing the reader with a summary of focus group findings. The summary has been edited to better reflect the ways in which physicians discuss race and its use (or not) for decision-making. The changes can be found in the final paragraph of page 10, and extend to the first paragraph of page 11. It reads:
  “We found three main themes. Overall, we found that both black and white physicians held similar views that the patient’s medical information is (e.g. past medical history, family history) the most important factor for treatment decision-making. However, black and white physicians’ views about the medical relevance of race differ, and are presented as separate themes. Among white physicians, patient race was viewed as relatively unimportant for treatment decisions. Instead, white physicians believed that the hypothetical patient should be treated aggressively regardless of her race. Conversely, black physicians in the study believed that race is important for clinical decision-making, provides useful information for choosing medication, understanding disease risk, and is associated with social determinants (socioeconomic factors and cultural beliefs about illness) for the patients’ health. Results are also explained in detail below.”

• Additional language addressing the use of race by physicians is also addressed in the subsections of the results. The subsection titles are:
  Theme 1. Black and White Physicians Hold Similar Beliefs that Medical Information is the Most Important Factor for Medical Decision-Making

  Theme 2. White Physicians Reported That Patient Race is Not Important for Treatment Decision-Making, and That Medical History Should Drive Decision-Making

  Theme 3. Black Physicians Reported That Patient Race is Medically Relevant, and Can Be Useful in Treatment Decisions

• Examples of how physicians view the relevance of race for treatment decisions are provided in narrative quotes. Two examples are provided below:
  “I’m not sure that it’s [race is] relevant in this woman’s case…because of all the medical issues that you’ve described, she’s going to need to be treated aggressively.” (White physician, Philadelphia Focus Group)

  “I think it’s very significant to know what her race is because it will make some decisions…about what paths I’m going to use to treat her…” and “I mean [race] is important to choosing the medication.” (Black physician, Atlanta Focus Group)

In the limitation section, it would be important also to mention that the study focused on just one case vignette related to chronic disease management – an adult female patient with poorly controlled hypertension, hyperlipidemia, and diabetes. The value assigned to patient race by physicians in this setting may or may not be different in this case than in other types of clinical cases/settings.

• We thank Reviewer 2 for this recommendation. We have added to our limitations section that the value assigned to patient race by physicians in this setting may be different in other types of cases or settings. The revised text is located in the second paragraph of page 22. It reads:
  “Also, our exploration of clinicians’ intended use of race used a clinical vignette with self-report of intent rather than observation of actual clinician behavior. It is important to note that our clinical vignette focused on a hypothetical patient with Type 2 diabetes and untreated hypertension, who was also a current smoker. Thus, physicians’ responses about the relevance of
race for this patient’s treatment may not represent physicians’ responses for other types of clinical cases or illnesses.”

Also, it is mentioned that focus group studies are limited in sample size, but it should be explicitly stated that statistical methods were not used to compare results between groups, so the findings should only be viewed as hypothesis generating, not as true differences (unless you choose to apply some quantitative statistical methods, which some qualitative studies do).

- Again, we are grateful to the reviewer for this recommendation. Accordingly, we have added to our limitations section that our results do not reflect statistical differences. The revised text is located in the first paragraph of page 22. It reads:
  “Moreover, our results are exploratory in nature and quantitative methods were not used to compare differences between groups. These design and sampling strategies may reduce the external validity of our study.”

The language throughout the paper should reflect this as well. For example, in the abstract, the authors state that “black physicians were much more likely than white physicians to consider…” This statement is not valid without statistical methods as it is written. I would recommend softening this claim or simply using the actual numbers – 35 black physicians made statements supporting…and 10 white physicians…). Whichever approach is used should be continue throughout the paper.

- The advice of reviewer 2 to soften our language is well taken. We made the recommended changes in the abstract, and throughout the document.