Author's response to reviews

Title: Instrumental and Socioemotional Communications in Doctor-Patient Interactions in Urban and Rural Clinics

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Author's response to reviews: see over
AUTHORS’ RESPONSE TO REVIEWERS’ COMMENTS
November 7 2012

Reviewer’s report
Title: Instrumental and Socioemotional Communications in Doctor-Patient Interactions in Urban and Rural Clinics
Version: 2 Date: 30 April 2012
Reviewer: Nicole NE Ernstmann

The following aspects should be addressed in a major compulsory revision of the manuscript:

Background:

1) The section is well written and coherent. However, there should be an explicit research question and study aim at the end of the section to allow the reader to put the following methods sections in context.

Authors’ Response: We have explicitly stated the aim of the study at the end of the introduction as follows: “This paper explores whether doctor-patient communications differ across urban and rural family clinics”.

Methods:

2) Many details are missing in the methods section. The authors should report study methods according to the consolidated criteria for reporting qualitative research (COREQ) (International Journal for Quality in Health Care; Volume 19, Number 6: pp. 349–357).

Authors’ Response: We have revised our methods section accordingly.

3) Table 1 presents study results and should be placed in the results section.

Authors’ Response: We have moved the references to Table 1 to the results section.

Results:

4) All results should be presented anonymously.

Authors’ Response: This was explicitly stated on page 8 of the original draft (i.e., “Their names have been changed to protect the anonymity of the participants”). We have made this point even more explicit by stating: “In order to protect the anonymity of the participants, pseudonyms have been used. The two urban doctors have been re-named as Dr. Jim Barrett and Dr. Mary Cummings, and the two rural doctors have been re-named as Dr. Alan Jones and Dr. Colleen Walker.” In addition, we remind the reader that they the names used are pseudonyms when they are first used following this statement.

5) Where are the results of the 42 interviews presented?

Authors’ Response: We have clarified how we strategically selected the subsample of 4 doctors from the larger sample of 42 for this paper. In this paper, we have only presented the results for two rural and two urban family doctors.
Discussion:
6) In the limitations section, the effect of the observer knowing the hypotheses (about the expected frequency of each communication style in the rural vs. urban setting) should be discussed. This is a major limitation.

Authors’ Response: The observer did not know anticipate the communication styles of each of the doctors prior to conducting observations. These themes emerged from the data from a third party analysis (i.e. the coauthor) and then were support by a subsequent revisiting of the literature. We have added a couple of sentences explaining the purpose of the observations in response to your concerns in the methods section.

Reviewer's report
Title: Instrumental and Socioemotional Communications in Doctor-Patient Interactions in Urban and Rural Clinics
Version: 2 Date: 11 September 2012
Reviewer: Rolf Wahlstrom

Major Compulsory Revisions
Methods
1. A major problem is that there seems to be two studies that are interlinked – one comprising 42 doctors and one with only four doctors. The main issue is that there is only very brief information about the first study, where 42 doctors were observed and interviewed. It is not made clear why the reader doesn’t get any more detailed information about the results of these observations and interviews.

Authors’ Response: We have clarified our sampling strategy of strategically selecting four doctors from the entire study sample of 42 doctors in the methods section. The current paper is based on a subsample of four of these 42 doctors. These four doctors were chosen for two reasons 1) there were very few rural doctors included in the sample, all of which have been included in the subsample and 2) the two urban doctor who were selected practice medicine in very similar practice settings compared to the rural doctors. They were purposefully selected to represent typical, information-rich cases that allow us to examine the communication patterns of rural and urban doctors and their patients in detail.

2. Even more problematic is that there is no information on why the four doctors were selected for the study presented in the article. On what grounds were they selected? What had been found that gave the rationale for continuing the study with these ‘in-depth’ interviews and observations? Or were the interviews the ones that had already been performed? And the same with the observations?

Authors’ Response: See response to Comment 1 above. In addition, the design of the study is described in greater detail in the methods section where we explain that we first interviewed physicians and then carried out observations in a job shadow of those same physicians.
3. This leads to the obvious question about the research design. It is stated that a grounded theory approach was utilised, but this is not clearly shown in the article. Which theory has been developed, grounded in the empirical material? To me it seems that the researchers had their theory well developed when they started the study as shown in the Introduction, and that they rather apply this framework on their analyses of the data. This is of course fully respectable, but should then be named for what it is.

**Authors’ Response:** The authors began with the data and then moved to the literature. Within a grounded theory perspective “all is data” (see Glaser, 2001) including previous literature and findings. The themes regarding the differences in communication patterns emerged from the observation and interview data. We then reviewed the literature on doctor-patient interaction and found the labels of socioemotional and instrumental communication captured the styles we observed in the observation and interview data. We have summarized and clarified this process in the “Data Analysis” section.

Table 1: The table s problematic. There is no definition of “strictly instrumental”, which makes it difficult to understand how the percentages were estimated. Percentages of what? Total number of uttered communication units? It looks strange that the examples of instrumental communication for rural doctors should only amount to 4 and 15%, respectively, compared to 50 and 63% for the two urban doctors (the latter is imprecisely referred to as “more than half of the appointments ...”; “more than half” is literally anything between 50 and 100 percent). The quote might indicate that the percentage refers to whole consultations, which would make it questionable as the number of appointments is between 13 and 23. It is recommended not to use percentages if the observations are of these low numbers. Why were 13 observations deemed to be enough for one of the doctors, while the other three were observed during 18-23 visits?

**Authors’ Response:** Following your suggestion, we have removed any references to percentages from Table 1 and instead simply describe the actual number of strictly instrumental communications in the text. In addition, we have explained in the text that the four physicians were observed for approximately 3½ to almost 5 hours – it depended on the length of time that the doctors were working for either their morning or afternoon set of appointments. As a result, the researchers had no control over the number of visits that were observed during the physicians’ regular work hours.

**Background**

1. Too long. The reference to literature on social environment is not necessary or should be kept to a minimum.

**Authors’ Response:** We have shortened this background section as you suggest.

2. The text on doctor-patient interaction is basically good, but I miss reference to the well-known work by Pendleton. I’m also surprised that McWhinney is not mentioned in the context of patient-centredness, given that the article comes from Canadian researchers.
**Author’s Response:** We have added Pendleton and McWhinney as references in our discussion of doctor-patient interactions. Thank you for directing us to their work.

3. The presented framework for the doctor-patient interaction is descriptively linear and not very useful for the aim of the study (compare Pendleton)  
**Authors Response:** We discuss one of the limitations of our study a limitation based on Pendleton’s work on the cycle of care. We acknowledge that we have only observed one interaction site out of many potential ones. Additionally, we have substantially revised the background and have removed many of the references to the linearity of the doctor-patient appointments.

**Results**  
1. The presentation is mainly clear. However, there are some potential contradictions related to the views of the rural doctors, as the interpretation can be understood as describing the female as more in the same category as the urban doctors.  
**Authors’ Response:** We believe the sentence referring to Colleen focusing more on her administrative duties attached to her position is what lead to this confusion. This physician also had an administrative role in rural medicine in addition to her family practice, and we did not go into too much detail to describe this in the text so that she could not be identified and we could protect her anonymity. We have revised this sentence and hopefully it does not lead to the confusion reported above.

3. There is a general problem in the way the results are presented. It can be seen as describing the character of four individual doctors, which is not that interesting for the international reader. This gives an impression that the analysis is still on a rather superficial level. In my assessment, it is needed to give a much more comprehensive presentation, which is derived from the empirical material preferably with more quotations.  
**Authors’ Response:** We have moved the descriptions of the practice settings to the methods section to provide context for the readers, particularly to set out the features of these Canadian family clinics in rural and urban setting. The description is necessary in terms of ensuring that each site is comparable to the others. In order to draw any conclusions, the sites of care and the doctors themselves, have to have similar practices and experiences. In essence, by providing these descriptions, we have attempted to demonstrate some measure (albeit imperfect) of control aside from the variable we wish to manipulate (urban vs. rural). We reviewed the interview transcripts again, and do not see that there are any additional quotations that could be added to strengthen our presentation. Rather, the combination of the observations and interviews together, as we have presented them, tell the story.

**Discussion**  
1. Limitations: Much more must be written about limitations. In my assessment, it is an important limitation that there are only four doctors in the study as
presented. No rationale is given for this and no information is given on data saturation.

**Authors’ Response:** We have expanded on the limitations at the end of the discussion section. We have also explained the strategic selection of these four physicians in our methods section.

2. The comments about impact of consultation time are quite superficial. The consultation time at each visit is only one parameter in the interaction between doctor and patient. Others are how often the patient visits the clinic and whether there are other contacts by phone or mail or otherwise. This finding is only interesting and necessary to discuss if there is reason to believe that the outcome is similar, or at least that outcomes of consultations in the rural and urban context are of similar value for the patient in terms of health improvement.

**Authors’ Response:** This is a good point. We did not have access to patient histories as the focus of this study was on physicians not the patients. We have noted this in our discussion of the limitations of this study.

3. Parts of section 5 and the whole sections 6 and 7 are general comments on community ties and on what characterizes and determines urban and rural health, respectively. These comments are more like speculations referring to the literature and only loosely linked to the results. In my assessment, these parts should be deleted or at least drastically reduced. This is not the place for sharing justifications for other studies.

**Authors’ Response:** We have edited down this section considerably.

**Conclusions**
The conclusions must be revised.

1. The first part is an unnecessary repetition of results focusing the length of the consultation. As indicated above, this is not a particularly “interesting finding” in itself as we don’t know what it actually means in terms of health outcomes.

**Authors’ Response:** We have reframed this paragraph to explain how it is interesting that it does not take more time to build socio-emotional ties with one’s patients while also garnering instrumental information through the interaction.

2. The comment on how the urban interactions “tend to follow the basic script documented by conversation analysts”, should be presented somewhere else in the Discussion.

**Authors’ Response:** This phrase is no longer in the conclusions.

3. The second part is a comment on the literature on the relationship between socioemotional communication and patient outcomes, and should as such not be part of the conclusions at all.
Authors’ Response: It is a suggestion for future research and returns the readers to the rationale for examining doctor-patient interactions stated at the beginning of the paper in that they may ultimately affect patient outcomes.

4. The next to last sentence is not well connected to the previous discussion as the authors here seems to take the stand that it is already documented that socioemotional communication is one determinant of poorer health in rural areas, although it is not known to what extent.
Authors’ Response: We have revised the last two sentences accordingly.

5. The final sentence points to the importance of “better understanding the different types of doctor-patient communications” in order to explain variations in health care and health outcomes between urban and rural settings. But wasn’t the aim of the study to contribute to this understanding? What more do we need to know about these “types”? Or are there also other types, which have not been explored in this study?
Authors’ Response: The aim of this study was to examine differences between doctor-patient communications, however, future research is needed to explicitly study the connections between communication, patient outcomes, and the urban/rural divide.

Abstract
The abstract must be revised in accordance with other changes made.
Authors’ Response: We have revised the abstract accordingly.

Minor Essential Revisions

1. I find the following two sentences (last sentences in paragraph #4 in the Discussion) quite strange. I think they need to be thoroughly revised, as it is not clear what is actually referring to what. The sentences relate to urban interactions: “Again, these conversations, while personal and emotionally supportive, are not to the same extent as those observed in the rural clinics. These interactions tend to be more instrumental and task oriented than those in the rural clinics where most of the conversation in the urban is focused on the patients’ health concerns.”
Authors’ Response: We have revised these sentences.

2. Discussion, section 7, line 8: change to “affected”.
Authors’ Response: We have made this change accordingly.

3. In the section starting “When asked about the most satisfying thing about his work …”, the fifth sentence is confusing. It states that “Similar to all of the doctors already mentioned, the rural doctors found spending time ...”. Who are all these doctors? The two urban doctors?
Authors’ Response: We have revised this sentence so that it more clearly stated.
4. Methods, first section, 6th sentence (starting “The interviews consisted of ...): This sentence ends with “etc.” I strongly recommend the authors to either spell out what this “etc” means or delete it. It is not for the reader to fill in such information.

**Authors’ Response:** We have revised this sentence accordingly.

6. Last section in Methods: change to “casual” (communication).

**Authors’ Response:** We have changed “causal” communication to “casual”.

7. Past tense should be used in most of the text, especially presentation of results.

**Authors’ Response:** We have revised the document so that the past tense is used throughout.