Reviewer's report

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

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Reviewer: Rolf Wahlstrom

Reviewer's report:

Comments to the authors
The authors have responded in a comprehensive way to the comments from me and the other reviewer. It is now possible to understand in full how the study was conducted and to be more precise and, hopefully, constructive in commenting. In my view, there are still major issues that need to be further clarified.

Major compulsory revisions

Background and aim

It is commendable that the authors have shortened the background to what is essential for the study content. However, it may now be too short to position the focus of the research into the quite narrow field where it, according to my assessment, belongs. Three essential key concepts are used, but not fully elaborated: interactions, communications, relationships. Is it the same or different? The authors write: “Research has shown that communication, as an interactional process involving both doctors and patients, is key to understanding the quality of care patients receive.” They don't refer to Pendleton (reference #4) in this particular statement, but to understand what the study is about it is useful to refer to how Pendleton described the areas of activity during a consultation: a. Opening the consultation; b. Nature and history of problem; c. Aetiology of problem; d. Patient’s ideas and beliefs; e. Patient’s expectations; f. Patient’s concerns; g. Effects of problem; h. Continuing problems; i. At risk factors; j. Action taken; k. Sharing understanding; l. Involving in management; m. Closing the consultation.

This puts the aim of the research into a much broader perspective. The authors state their aim as exploring “… whether doctor-patient communications differ across rural and [urban; my addition] family clinics”, and further that they “… illustrate subtle but important differences in doctor-patient interactions in rural and urban clinics”. In my view, the authors are far away from exploring “communications” and even more “interactions” in the comprehensive way that is illustrated by the activities according to Pendleton (and many others, e.g., Byrne and Long, reference #8). What they have done is to look at the ways of talking exhibited during the consultations, the conversation styles. This is important as one part of the interaction between doctor and patients, but if it is not at all related to activities that should be covered during a consultation it becomes superficial. It would be interesting if the authors could analyse their material in
relation to this perspective by mapping the consultations according to Pendleton or some other framework for content of the consultation, and explore how it fits to the respective conversation styles.

There is another problem with the aim: the authors want to explore how communications differ between urban and rural clinics, and they even state that they have found important differences. As we now have information about the full design of the study, according to my judgement, it is not possible to answer that research question by observing only two doctors in each of the settings. Therefore, my recommendation is that the authors describe their exploration as a first attempt, a pilot, to get information whether this is a field of research that could be valuable to further understand elements of doctor-patient interaction.

Methods

1. The authors state that the selection of doctors for the study was made with the purpose to get “information-rich cases”. However, in their response letter they inform that there were only two rural doctors in the sample of 42 doctors, and they were thus selected. Maybe they happened to be such “information-rich cases”, but the description of the selection process is misleading.

2. The authors state that “several themes emerged from the observation data until saturation was reached and nothing new emerged”. This may be true for the number of consultations in the respective settings, but I am not convinced that observations of 3-4 more doctors in each site wouldn’t give additional themes.

3. The description of the analytical process is now clarified, showing that the authors have mainly used an inductive approach, with some deductive elements.

4. The description of the observations should be further clarified. The expression that the purpose of the observations was to “capture a detailed description of their day-to-day activities” seems to be inaccurate. What has been reported from the observations relates to the doctors’ communication style and the reasons for patients to seek a consultation, not other aspects of the “day-to-day activities”.

Results

The description of the conduct of the observations gives rise to the following questions:

1. The observations were performed by the second author, a female professor in sociology. It is stated that she had “no preconceived notions of what to observe”, but an “intent to explore and describe experiences and meanings of practicing medicine across different specialties and in different settings”. It has to be justified and discussed whether it is possible for a professor in sociology (or anyone) to observe doctor-patient interactions without preconceived notions. And also why this should be an advantage.

2. Furthermore whether it is possible to “explore and describe the experiences and meanings of practicing medicine” by observing that practice. I think quite strong arguments support that it is not possible.

3. There is another confusing element in this sentence: “across different specialties”? This must be a mistake, the observed doctors have the same
specialty.

Discussion

Limitations: This is a qualitative study but the discussion does not concern aspect of trustworthiness usually discussed in qualitative papers: credibility, dependability and transferability. There are elements of comments about these issues in the limitation section, but it should be much expanded, in my view.

1. It is not enough to just mention that the small sample raises “concerns about generalizability”, it should be elaborated on what concerns (my recommendation is to use the concept of ‘transferability’).

2. In the same way the comment that data in observational research are “restricted to that which the particular field researcher” draws attention to and make notes of. How does it impact on the findings and how should the findings be viewed with this in mind?

3. And what are the advantages of this kind of observations, “with no preconceived notions”, compared to observations made by someone familiar with the context?

4. Other issues that could be brought up are, for example: a) whether all observations supported the described themes or whether there were examples of contradictory observations; b) how researchers interacted in the analysis and resolved conflicts; c) whether there was any presentation of the field-notes or other preliminary material to the participants for comments.

Conclusions

This section is now coherent with the presentation of findings.

1. However, it seems that new findings are presented in the next to last sentence about the time used by urban doctors in “purely instrumental” compared to “blended appointments”. I cannot find this result in the Results section (I may have missed it).

2. The very last sentence is an interpretation that in my mind goes beyond what has been studied. The authors have not studied the extent and degree to which the doctors had been able to build “trusting, personal relationships” with their patients. It is not enough to just state (Results, last paragraph, 2nd sentence) that it “is evident that there is an immense amount of trust and caring in these relationships …”. However, it can be assumed that one reason for the doctors to use more socio-emotional communication could be to build such relationships in the long term. If the statement is somewhat modified, like “Thus, it does not appear that using socioemotional communication with the ambition to build trusting, personal relationships with patients … resulted in lengthening the time of patient appointments”.

Abstract

The abstract must be revised in accordance with other changes made.

Minor essential revisions
Methods

1. The length of experience in practice is stated for the rural, but not for the urban doctors. This information is essential as the doctors’ ways of practising medicine may be related to their length of work experience.

2. It is explained that “a doctoral candidate” performed the coding of the observational material (and probably also the interview material although not stated explicitly). If this anonymous coder is the first author, it should be mentioned. If it is not, the interaction with the authors should be described more in detail.

References

The following should be corrected:

1. Insert space before page numbers: Ref #2,3,5,6,13
2. Delete & sign: Ref #4
3. Delete full stop after initial: Ref #3,16,19
4. Spelling of name: Ref #12 (Dordrecht)
5. Page numbers in plain text (not bod): Ref #13
6. Colon in plain text (not italics): Ref #20
7. Full stop at the end of reference: Ref #16
8. Alignment of colon in bold (after volume): Ref #6,11,14,15,17,19,20,21
9. Alignment of full stop in bold (after title): Ref #1,7,10,17,19,21,24

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.