Reviewer's report

Title: Physicians' communication with patients about adherence to HIV medication in San Francisco and Copenhagen: A qualitative study using Grounded Theory.

Version: 1 Date: 14 August 2006

Reviewer: Rakhi Dandona

Reviewer’s report:

General

This is an interesting manuscript describing a model for physicians’™ communication with patients about adherence to HAART using the Grounded Theory approach. Some more details for methods and results would enhance the usefulness of these data.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. Page 7, para 2 “Certain reasons are stated for not collecting demographic on the patients. Please comment why these data were not collected from the case-files of the patients. Age and sex of the patient may also be variables that might interact to produce the outcome (in this case, discussion on adherence).

2. Page 7, para 3 “Again, could these data not have been retrieved from the case-files with due consent of the patient?

3. Page 8, para 1 “How were comments by the physicians’™ on researcher’s™ noted observations and immediate interpretations used in data analysis later by the researcher?

4. Page 8, para 3 “Currently, this part of methodology is quite generic in nature. It would be useful to describe in more specific manner how data coding was done or concepts were identified/defined. In other words, describe what open coding was used for, how axial coding was used to relate codes (causal conditions/ context/ intervening conditions) for a particular phenomenon, and what/how core category and the related factors/variables were chosen, specifically for the data presented in this paper.

5. Table 1 “
   a. Please also provide percentages with the numbers for the variables shown.
   b. A column showing total (SF and CPH) would be useful to get an idea of the total sample of physicians.
   c. It would be interesting to know if there were any significant differences in the communication patterns based on the sex, specialty (particularly because one-third of the physicians in CPH were under training) and years of HIV ambulatory care.

6. Pages 11-12, Factor 1 “From the manner in which it is described, it appears that the degree of adherence was mainly determined based on the viral load by the physicians (validation of sorts), with situational factors and general perception of physicians about importance of adherence having a little/no role to play. In this background, please clarify why importance of adherence by physicians is considered as a specific variable in this model.

7. Page 12-13, Factor 2 “Perceived awkwardness by physicians could also be related to their previous experience with patients in this regard (as also shown in the example). How was this taken into account in the model? Also, the description suggests that Factor 2 seems to be dependent on the physician’s™ previous experience, communication style, and patient relationship. Please comment.

8. Page 13-14, Factor 3 “It appears that believability was more determined by the validity of claims (based on viral load) and situational factors that are described under Factor 1. The additional point here is communication style of patient when responding to the question on adherence. Therefore, there is some overlap between Factors 1 and 3.

9. Should Factor 3 come before Factor 2 in the sequence of how a physician determines to address
adherence?

10. The three factors described take a physician from Step 1 to Step 4. It would be better to present how each of the three factors influence each step. This could also be done in Table 2. In other words, it is important to know which factor is more decisive for each step or combination of which factors result in what kind of steps (for example - a particular combination of factors may not go beyond step 1).

11. Page 22, para 1 - The differences between SF and CPH physicians do not come out clearly in the results section. These differences could be stated more explicitly.

12. Page 23, para 2 - Recommendations made are reasonable and do come out of the data presented. However, more explicit description (see point 12 above) in results would be needed to categorically make these recommendations.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

13. Page 5, para 2, line 3 - The model presented in this manuscript describes the communication patterns of the physicians regarding treatment adherence with their patients, and includes factors that facilitate the discussion and difficulties that they face. Hence, it might be appropriate to modify the statement regarding the aim of the present analysis accordingly.

14. Page 21, para 3 - Please comment if non-inclusion of patient's observation could also be a limitation for these data.

Discretionary Revisions (which the author can choose to ignore)

15. Page 8, para 2 - Is it possible to give numbers for the most and few physicians referred to in this para?

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:
'I declare that I have no competing interests'