Author's response to reviews

Title: Communicating with differences and tension: Treatment provision experiences of primary care doctors treating patients with overactive bladder in Hong Kong

Authors:

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Version: 5 Date: 2 September 2015

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

Thank you very much for your and reviewers’ valuable comments on my submitted manuscript “Communicating with differences and tension: The treatment provision experiences of primary care doctors to patients with overactive bladder in Hong Kong” to your Journal BMC Family Practice. Also, thank you very much for giving me an opportunity to revise my manuscript for your Journal. I have revised the manuscript according to the reviewers’ comments. Please kindly find below for my responses to these comments.

Responses to the Editor

1. Giving greater information about methodology (eg. Explaining theoretical framework, justifying sampling) and an extended discussion of the study limitations.
   - Response: The methodology part is now revised. Study limitations are also indicated in the limitations section. (line 103 – 197)

2. Focusing the discussion by avoiding repetition.
   - Response: The whole paper has been gone through to remove repetitions.

3. Attending to linguistic inconsistencies and English language.
   - Response: Professional English editing has been conducted in this revised version.

Responses to Dr Adrian Wagg

1. The conclusion, which I might relabel discussion, introduces the concept of lack of trust and tension and a mismatch of expectations which doesn’t appear elsewhere – this perhaps needs to be justified in the results section somehow
   - Response: Actually, lack of trust, tension, and mismatch in expectations did appear in the results section even in the first version. (line 292-356) In theme 2 “differences in treatment expectation between the sampled doctors and their patients” in the results section for example, I mentioned these three issues. In the second paragraph of the discussion section, I elaborated further about these issues basing on the cultural stereotype on private doctors in Hong Kong. Therefore, I wrap these issues up in the conclusion part.

2. The definition of OAB is not correct – urgency incontinence is not required to make a diagnosis; reference 4 appears to be misplaced here.
   - Response: I have deleted reference 4 by Easton, and have revised the definition of OAB to “Urinary urgency accompanied by frequency, with or without urgency urinary incontinence, and with the absence of urinary tract infection or other obvious pathology”, using the definition by Haylen et al. 2010 instead. (line 57-58)
3. The sentence structure regarding the AUA guidelines needs rewriting “recommends in a new guideline...” in fact the use of English does require some revision and tightening up throughout
   - Response: This sentence has been revised according to the reviewer’s suggestion. (line 65)
   Also, the whole manuscript has received professional English editing.
4. Doctor shopping may need explanation to those unfamiliar with the term
   - Response: The explanation about doctor shopping is added. (line 71-72)
5. I’m afraid the meaning of this sentence is unclear to me... Illness experiences often subject to
   the interaction between health care providers and patients, hence both the health care
   providers and patients are the key players in accounting the whole treatment experience
   - Response: This sentence is now rewritten to make the meaning clear.
6. How was the sample size arrived at – was this a purposive sample, was snowballing used, what
   theoretical framing was employed to understand the schema. Was sampling merely continued
   until no new themes arose?
   - Response: These are explained in the data collection paragraph, and this section moves
   earlier as the first section in methods part. Sampling of the participants was done by
   purposive sampling, based on the referral of OAB patients who had been interviewed for
   another earlier study. The sample size to achieve data saturation ranges from 12 to 17
   interviews according to the literature, and this study had 30 interviews to reach a higher
   confidence of data. This is added in the data collection part. (line 118-133)
7. Ah – here is the methodological framework – perhaps this should be amalgamated with the first
   paragraph
   - Response: The paragraphs of data collection are now moved to the first section of methods.
   This makes the sampling size and method to come in earlier.(line 109 – 171)
8. Was the identification of relevant doctors by OAB patients subject to bias? Were either more
   negative or positive treatment experiences likely to be identified, and therefore their doctors
   with them? How representative of the “usual” experience do the authors feel the obtained
   sample was?
   - Response: The sampling of the participants was based on the referral of OAB patients who
   had been interviewed for another earlier study. (line 118-129) These OAB patients were
   asked about their first contacted treatment providers in private practice for their bladder
   conditions. This ensured the sampled participants had the experience in providing
   treatment to OAB patients, and minimized the likelihood of inaccurate sampling of other
   primary care doctors who had treated those patients with similar bladder symptoms but not
   yet confirmed with OAB diagnosis. Although this may make the sampling to appear to have
   bias when compare with random sampling (since the patients who did the referral all had
   unpleasant experience as noted in my earlier paper), this did not result in much bias in the
   result, since the fieldwork on OAB patients during these years has been indicating that their
   treatment experiences are all negative. The doctors sampled for this study, in other words,
   all treated the OAB patients with negative treatment experiences. This paper is a qualitative
   study investigating the treatment provision experiences among primary care doctors to OAB
   patients in Hong Kong; although qualitative study is not good at making generalization, so it
   will be difficult to conclude that all the primary care providers who had provided treatment
to OAB patients in Hong Kong had experienced the same things as this paper shows, the higher number of the sampling as taken in this study than the literature documented number of sampling ensured data confidence, which suggests the experiences of the sampled doctors as representative.

9. Purely a stylistic preference but one prefers papers written in the third person.
   - Response: A third person voice is now adopted in the writing.

10. Was there another researcher involved in reviewing the transcripts and identifying the themes?
    It would be unusual for a single researcher to do this – even twice
    - Response: This study is a single-researcher study, except the interviews were transcribed by student assistants. As the data collection and analysis was conducted by a single researcher, coding and recoding of the transcripts were performed to establish reliability and confirmability, and to ensure that the codings and categories were free of ambiguity, overlaps, and lack of clarity. Recoding was conducted one month after the first coding as cross-checking to enhance the validity and reliability of the data and findings; also, the recoding with a fresh eye ensured the elimination of subjectivity and bias. (line 173-197)

11. In the section titled participants - there are quite a few results – this should be moved to the appropriate section.
    - Response: The section of participants is now moved to the results section. Just as the reviewer commented, this participants section contains some results, though these results cannot be grouped under themes. Therefore, this new arrangement can serve as an introductory paragraph to the core results. (line 212-241)

12. The author should explain the term “a dawdling rise”?
    - Response: “dawdling rise” is replaced with another word now. (line 229)

13. The presentation of themes is comprehensive and easy to read, the section on ketamine may be less generalizable. The illustration of the multiple “barriers” and the impact of the potentially embarrassing condition is extremely useful particularly as this was expressed by the treating physician; again, I am unsure as to how culturally specific some of these data may be.
    - Response: This manuscript investigates the situation among primary care providers who have treated the patients with OAB in Hong Kong. Although qualitative studies are not good at making generalization, this study can still provide an in-depth understanding of the issue with a high data confidence given the higher than literature documented sampling size. This paper is Hong Kong-specific, and it is rather difficult to conclude that other primary care providers in other places and/or countries will have the very similar experiences when providing treatment to patients with OAB. However, given the paucity of overseas literature on this issue, this paper serves to provide an initial understanding on this issue in other places and/or countries. (line 244-249)

14. There’s a great opportunity to assess the impact of an educational intervention for recognition and treatment of OAB in primary care in order to address treatment and breaking down the barriers of taboo on the part of the physician.
    - Response: With the support of literature, I have added my comment about the potential of educational intervention in the primary care setting in the final paragraph of the discussion section – It is suggested that greater emphasis should be put on teaching the medical
students about the importance of humility by means of narrative and role modeling in the medical training. This may help to improve not only the treatment experiences of patients, but also warrant a more positive experience among doctors in their treatment provision processes. However, the awareness of humility and the willingness to admit their limitations in the treatment of OAB may be a big challenge for doctors in the Chinese communities, since doctors in Chinese cultures have been getting used to the higher social hierarchy and deference, and thus the sense of arrogance among doctors appears to be inevitable. Moreover, this also involves the change of the stereotypes and expectations on doctors among the general public, which can be difficult to change. Therefore, to enable primary care doctors serving as gatekeepers in OAB care according to the new guideline of American Urological Association, it is thus important to enhance their knowledge about OAB in their continuing medical education, so that they are empowered in the long-term care provision to patients with OAB, and at the same time, they are able to preserve their professional dignity without breaking the taboo of admitting their limitations. Introducing empathetic communication skills and addressing the special psychological needs of patients suffering from OAB in the undergraduate, postgraduate, and continuing medical education may also warrant better experiences of both patients and doctors. These skills are particularly important for primary care doctors, since they are the first contact point of patients, with the aim to provide continuous and comprehensive care. (Line 537-553)

15. The identification of the need for physicians to “save face” and not admit a lack of knowledge may serve as a factor in exacerbating tensions – perhaps this could be explored?
   - Response: With the support of literature, I further explore this point as suggested by the reviewer in the second paragraph of the discussion section. (line 409-422)

16. The authors might address the things that they think need to be done and the sequence in which they think things should be addressed in order to improve the situation – this might be a useful addition to the discussion, rather than the simple narrative description.
   - Response: This is now mentioned in the final paragraph of the discussion section – that in the medical training, greater emphasis should be put on teaching the medical students about the importance of humility by means of narrative and role modeling. This may help to improve not only the treatment experiences of patients, but also warrant a more positive experience among doctors in their treatment provision processes. Also, to enable primary care doctors serving as gatekeepers in OAB care according to the new guideline of American Urological Association, it is thus important to enhance their knowledge about OAB in their continuing medical education, so that they are empowered in the care provision to patients with OAB, and at the same time, they are able to preserve their professional dignity without breaking the taboo of admitting their limitations. Introducing empathetic communication skills and addressing the special psychological needs of patients suffering from OAB in the undergraduate, postgraduate, and continuing medical education may also warrant better experiences of both patients and doctors. These skills are particularly important for primary care doctors, since they are the first contact point of patients, with the aim to provide continuous and comprehensive care. (line 537-553)
17. The weakness of the paper is in the single researcher analysing the data – this may have been solved by obtaining a second opinion
- Response: the limitations of this paper raised by a single researcher are now indicated in the limitations part within the discussion section – All the research procedures including study conception and design, data collection, data analysis, and the writing of this article were conducted by a single researcher. Although data collection conducted by a single researcher ensured interview quality and consistency, rendering crosschecking of the whole study with other researchers was impossible. To overcome the limitations raised by a single researcher, second round data analysis of recoding was performed one month after the first coding, which enabled the crosschecking of analysed data. (line 190-197; line 559-565)

Responses to Dr John Yaphe

1. These issues relate mainly to linguistic problems and the paper would benefit from careful editing by a native English speaker.
- Response: Professional English editing has been received for this manuscript.

2. The interviews were conducted in Cantonese, which is the native language of the researcher and her subjects. The transcripts of the interviews were translated into English and the analysis was done on the translation. Though the researcher did the interviews and the analysis (and presumably the translation) this introduces several filters and this needs to be clarified for the reader. What biases might this introduce? I imagine that an article written in Cantonese for local doctors using actual quotes from the doctors might have different impact on the reader.
- Response: This is now clarified in the data analysis part - Interviews were transcribed verbatim by student assistants, and the sampled doctors were asked to read over the transcribed interviews to ensure accuracy. The transcribed interviews were then translated into English by the researcher, and back translation was conducted by another student assistant who is competent in English and Chinese to ensure the translated interview transcripts did not distort the original interviews. The back translation procedure also served as cross-checking of the first-line translation and minimized the translation bias that might be raised by researcher’s bias. (line 173-180)

3. The use of the term “gap”, which is a key concept in this study, appears to be inappropriate. I would prefer the word “differences” as in differences in knowledge, expectations of treatment, or communication styles. While a gap is something that can be bridged or shortened (as in geographical or even dental usage), these differences need to be discussed and explored by doctors and patients in order to find common ground.
- Response: “Gap” in Chinese usage also means “difference”. When I used “gap” in the previous version of this manuscript, I also meant to say there was significant differences between the sampled doctors and their patients with OAB, making the doctors’ treatment experiences difficult. I have used “difference” to replace “gap” now wherever appropriate.
4. The methods section contains a fascinating description of the process of care of patients with OAB given by this group of doctors (lines 214-227). I would move this to the results section, which follows immediately.
   - Response: The whole section of participants is now moved to the results section. Just as the reviewer commented, this new arrangement can serve as an introductory paragraph to the core results, which were about the treatment provision experiences of the participants. (line 212-241)

5. I find the use of the term participants to be confusing at several points in the results and discussion. It would be sufficient to say “doctors who participated in this study” early on and call them “the doctors” after that, as distinct from “their patients” who were participants in an earlier study.
   - Response: To avoid confusion with the patients who were the participants in my earlier paper, now I use “sampled doctors” instead of “participants” in this manuscript.

6. There are several linguistic corrections that need to be made throughout the paper especially with regard to the use of prepositions. As these are too numerous to list here, I will leave this to the technical editor.
   - Response: Professional English editing has been conducted in this revised version.

7. In the discussion I would like to hear the author’s opinion on ways to overcome the deficiencies in care and sources of doctor and patient dissatisfaction that she identified. What approaches in undergraduate, postgraduate and continuing medical education would she suggest?
   - Response: In the final paragraph of the discussion section, I raise a possible approach to overcome the current situation – according to literature, it is suggested that greater emphasis should be put on teaching the medical students about the importance of humility by means of narrative and role modeling in the medical training. This may help to improve not only the treatment experiences of patients, but also warrant a more positive experience among doctors in their treatment provision processes. However, the awareness of humility and the willingness to admit their limitations in the treatment of OAB may be a big challenge for doctors in the Chinese communities, since doctors in Chinese cultures have been getting used to the higher social hierarchy and deference, and thus the sense of arrogance among doctors appears to be inevitable. Moreover, this also involves the change of the stereotypes and expectations on doctors among the general public, which can be difficult to change. Therefore, to enable primary care doctors serving as gatekeepers in OAB care according to the new guideline of American Urological Association, it is thus important to enhance their knowledge about OAB in their continuing medical education, so that they are empowered in the care provision to patients with OAB, and at the same time, they are able to preserve their professional dignity without breaking the taboo of admitting their limitations. Introducing empathetic communication skills with and addressing the special psychological needs of patients suffering from perceived sensitive diseases in the undergraduate, postgraduate, and continuing medical education may also warrant better experiences of both patients and doctors. These skills are particularly important for primary care doctors, since they are the first contact point of patients, with the aim to provide continuous and comprehensive care. (line 537-553)
8. A summary table comparing doctors' and patients' explanatory models, expectations of investigations, expectations of treatment, expectations of outcomes, and preferred communication style would also be helpful.
   - Response: Table 1 is now added for these information at the end of text. (line 584-585)

Responses to Dr Martine Granek-Catarivas

1. But the paper requires extensive English editing and shortening
   - Response: Professional English editing is received for this manuscript.

2. There are some repetitions between the introduction of each of the themes and the relevant citations chosen. They should only complement each other and not repeat each other.
   - Response: The results section is now edited to remove repetitions.

3. Shortening the Discussion: The discussion could easily be cut by half! It is very lengthy, very repetitive within itself and repetitive of the comments and introductions of the themes already reported in the results. The discussion should only briefly refer to the themes that have been lengthily explicated in the results, and just elaborate and summarize them in the context of primary care in HK and the Chinese culture.
   - Response: The discussion section is now edited to remove repetitions. (line 383-553)

4. Discussing the limitations of a methodology is always valorizing the research paper. In this research, all the interviews were conducted by the same researcher. It is recommended to have an external interviewer and 2-3 data researchers performing the data analysis and interpretation. I suggest discussing the limitation of having only one research person doing the study conception and design, the design of the interview question guide, the data collection, data analysis, data interpretation, and the writing of the manuscript.
   - Response: The limitations of this paper raised by a single researcher are now indicated in the data analysis section and the limitations part within the discussion section – All the research procedures including study conception and design, data collection, data analysis, and the writing of this article were conducted by a single researcher. Although data collection conducted by a single researcher ensured interview quality and consistency, rendering crosschecking of the whole study with other researchers was impossible. To overcome the limitations raised by a single researcher, second round data analysis of recoding was performed one month after the first coding, which enabled the crosschecking of analysed data. (line 190-197; line 559-565)

5. All the interviews were conducted by the same researcher. There should be an additional sentence specifying how many researchers did participate in the transcription, the translation and the data analysis, as well as the coding and the re-coding.
   - Response: This is indicated in the data analysis section - Quick data analysis was conducted by the researcher during the interviews to determine what was known and what needed to be explored further. Interviews were transcribed verbatim by two student assistants, and the sampled doctors were asked to read over the transcribed interviews to ensure accuracy. The transcribed interviews were then translated into English by the researcher, and back
Thank you very much for your kind consideration of my manuscript, and also thank for your and reviewers’ valuable comments. All these comments enable me to further improve my manuscript. I sincerely hope that my revised manuscript and the responses to reviewers’ comments can meet the standard of your Journal. As your Journal enjoys a high reputation in the field of study in family medicine and family practice, I feel honorable that my manuscript can be considered to be published in your Journal.

I am looking forward to hearing from your Journal in the near future!