Author’s response to reviews

Title: "I can't bend it and it hurts like mad": Direct observation of gout consultations in routine primary health care

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Author’s response to reviews:

Dr Emma Healey
BMC Family Practice

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Dear Dr Healey

Re: "I can't bend it and it hurts like mad": Direct observation of gout consultations in routine primary health care, reference: FAMP-D-16-00232

Thank you for collating the reviewers’ responses to our manuscript. We are grateful for the time and thought that has gone into making the comments and the suggestions for improving the manuscript.

We have responded to each comment individually below and highlighted the changes that we have made within the text of the revised manuscript.
Reviewer 1

This paper addresses an important clinical issue - the talk related to gout in primary care consultations. The management of gout in primary care is known to be suboptimal and a number of stereotypes surround gout - the talk about gout in consultations might well be helpful in unpicking these issues and identifying how care could improve. It utilises a bank of video recorded consultations with appropriate approval for secondary analysis. It is not clear whether this is an unselected sample or not. The paper is well written and analysis well described.

The sampling issue raised by the reviewer is addressed under “Additional points” – see below.

In my view, the major weakness of this paper is the depth of the qualitative analysis with not enough discussion of implications for practice or situating the findings in the context of what is known about gout or other consultation studies. The background and aim of the paper could also be strengthened.

Please note: all new references added have been highlighted in the reference list.

A number of additional references have been included in the Background section to provide greater context around what is known about gout and other consultation studies.

The study’s aim has been strengthened by explicitly identifying (i) where this study fits in relation to previous qualitative work, (ii) what it adds to previous studies and (iii) how the findings could help improve patient care.

The Discussion section has been strengthened by the addition of references to more clearly locate our findings in the gout and other broader consultation study literature. A greater emphasis is now placed on the implications for practice.

The authors report 2 themes - on relating to the importance of gout and one related to communication (talking vs listening). The first theme relating to importance, has 2 subthemes - one relating to gout as an incidental finding and one relating to impact of the condition. The first describes how gout discussion is either incidental or as a presenting complaint. This has been identified before in my own consultation study, and other work (Paskins et al Ann Fam Med 2016). The nature of the 'incidental' consultations could be expanded, with further description of the consultations studied - this would help to contextualise the results - perhaps a table? (see example in reference above)

Studies by Paskins et al. and Salisbury et al. have now been included in both the Background and Discussion sections.
A new table has been added (Table 5) to provide contextual background information about the consultations comprising our dataset.

What is missing from the discussion relating to the subtheme relating to impact is a narrative about how gout is conceptualised. The language used (as in the quote in the title) by the patient in the context of a presenting complaint is powerful - why is this? Does the GP acknowledge the distress? Are symptoms validated or legitimised? Does it appear as if the patient has to fight hard to have gout acknowledged? There is an important background qualitative literature here which alludes to the stigma of gout which might be helpful - see Chandratre et al 2016. Liddle et al 2015, Richardson et al 2015.

The difference in conceptualisation of gout by patients and practitioners is now included in the Discussion section and located in both the gout and more general consultation literature. The importance of stigma surrounding a gout diagnosis is now mentioned in the Background section and discussed in the Discussion.

In talking vs listening - the 2nd theme - at a superficial level you could apply this theme to any consultation analysis. What is different here? The author's suggest diet is one area where there was more talking vs listening. This is interesting and could be developed further

The evidence that diet reduces urate levels is weak at best and weaker still to say it prevents attacks. The authors have assumed the knowledge as given by the participants they are studying. Why do clinicians focus on diet? Is it where they feel most confident? Does it take onus off them and put in onto the patient? How do patients react if doctors clinicians revert to diet.

Greater discussion around ‘telling’ versus ‘listening’ is now included in the Discussion section with a cross-reference to a published paper by the author team specifically around gout medicines. As this paper was still under review at the time of submission we were unable to refer to it in the original version of this manuscript.

Background information on lifestyle management and diet has been expanded, now making reference to the evidence base for recommendations in national guidelines. The important issue of the balance of information provided to patients about lifestyle management versus management with medicines is also introduced here (and picked up in the Discussion section).

We know from existing literature that some primary care practitioners place a higher priority on lifestyle advice (Humphrey et al.; newly published and added to the text). We suggest that this may result from a lack of confidence in treating gout and/or lack of familiarity with treatment guidelines. In reality, this remains an unanswered question.
Why are doctors / clinicians 'talking' more than listening? Is it contextual - i.e. lifestyle advise administered in the context of a brief consultation cannot be expected to be more than giving of information? How does the nature of talk where there is listening vs talking compare to study of other conditions? How does it relate to the context of these consultations? The finding that clinicians did not elicit expectations is much more important in the consultations where patients raised gout as a discussion topic than where doctors raised as a condition to review.

We report in the manuscript Discussion section that the ‘telling’ approach appears contextual in terms of the content of the conversation (lifestyle versus medicines). We now further note that this is irrespective of whether the patient was currently symptomatic and that this tendency was also seen in the larger set of diabetes-related consultations.

The Conclusion in the abstract (and paper) is weak, What are the implications for practice? One obvious example I can see is the gap between patient focus on pain and clinician focus on disease control. Actually these are one and the same but the explanation may be missing. The Conclusion in both the main body of the text and Abstract has been revised to include three implications for practice.

Additional points

Reflexivity - What is the background of CM?

The background of CM (a pharmacist and experienced qualitative researcher) is now included in Table 3, point 3.

Line 42 (abstract) - technically it is the inflammatory response to the deposition of monosodium urate crystals

This oversight has been corrected to read:

“Gout is recognised as the most common form of inflammatory arthritis and occurs as a response to the deposition of monosodium urate crystals in the joints.”
Pg 4 line 12 - 'a number of factors contribute to health outcomes’ - vague sentence - can it be reworded? I think this is symptomatic of a bigger problem with the background and aim where a stronger case needs to be made for this study.

A number of additional references have been included in the Background section to provide greater context around what is known about gout and the study’s aim strengthened. As part of this revision the specified sentence has been removed from the text.

Line 20 - the authors imply there is a strong evidence base that certain foods trigger gout. This is not the case. Neither is there a particularly strong evidence base for lifestyle management. This section needs reworking.

Background information on lifestyle management and diet has been expanded, now making reference to the evidence base for recommendations in national guidelines. The important issue of the balance of information provided to patients about lifestyle management versus management with medicines is also introduced here (and picked up in the Discussion section).

Table 1 Can the authors add something about the inclusion/exclusion criteria for these studies - or is this an unselected sample?

Additional information about the base studies included in the ARCH database has been added to Table 1.

Also need to describe how the original coding took place (describe how the database was populated - in which the author's searched for key term gout)

The ‘Identification of gout consultations’ sub-section of the Methods has been expanded to include this information.

Page 10, line 5 - sentence starting 'Furthermore…'It is unclear to me where this perception arises from. Is it from the authors?

This perception arises anecdotally from the authors’ informal discussions with practising clinicians. The word anecdotally has been added to the sentence for clarification.
Reviewer 2

This is a great study and a clearly written paper. My suggestions relate mainly to the explanations provided about data analysis.

Literature

I appreciate that the lack of more recent qualitative publications may be a result of the time lag between literature searching/writing and the submission and review process. Given the relatively small body of literature in this area, the background and discussion sections would be strengthened by drawing on additional qualitative gout publications from 2014-2016. The paper should also include some references/theory to support the approach taken to data analysis.

A number of additional references (highlighted in the reference list) have been included in the Background and Discussion sections to provide greater context around what is known about gout from more recent qualitative studies.

The text in the Data analysis subsection of the Methods is explicit that our aim is to “… report on the emerging range of issues and communication styles without pre-conceived assumptions”

We have included three new citations (reference numbers 28-30) that support the qualitative inductive approach used.

Analysis

The analysis clearly benefits from the involvement of a multidisciplinary team with different perspectives and approaches. I would have preferred table 3 to include more information around the specifics of what these different perspectives fed into the analytical process e.g. how was the interpretation amended or enhanced at the 3rd and 4th stages? Can some examples be included in this table?

Three specific examples are now included in Table 3, point 4.

I would imagine that there were more than two main themes developed from the analysis, and if so, can these be mentioned along with some explanation that this paper focuses on two? It would be helpful to include a thematic map or list to show what the full range of other themes/sub-themes were to provide context, even if these are not the focus of this paper. In addition, why is the theme named 'listening and talking', whereas in the data and discussion it seems to be more specifically about 'listening and telling' rather than 'talking'?
It has now been made explicit at the beginning of the Results section that this paper focuses on two key themes derived from the analysis. The content of Table 4 has also been expanded to include other themes identified from the data and provides a cross-reference to a second paper derived from this dataset. (As this paper was still under review at the time of submission we were unable to refer to it in the original version of this manuscript)

We thank the reviewer for highlighting this oversight which has been corrected to listening and telling throughout the manuscript.

The paper is enhanced by the fact that non-verbal 'video' data is included and incorporated into the findings, but the links between the 'text' data and 'visual' data are less prominent in the wider discussion and conclusions sections E.g. How did these non-verbal behaviours contribute and/or exacerbate/ameliorate/contrast with the verbal communication, and how does this all tie in with the conclusions?

It has been made more explicit in the text that the theme of ‘The impact of gout on patients was derived from not only a review of the conversation that took place but also from the demeanour of the patients as they talked, and that insights gained from a review of the body language in play between the parties was an important part of defining the ‘Telling versus listening theme’.

The paper does not discuss clearly how the 'video' e.g. visual aspects of data were incorporated into the analysis. The table describes 'coding' data, but not how this was achieved for non-text data. A brief summary of this should be included.

Information on coding of the non-verbal data is now included in Table 3, point 1.

Limitations

The strengths and limitations section is clearly written and summarises most of the key issues. However, an additional limitation is the potential differences between those who did not consent to being videoed (and are therefore not part of the study) and those who were happy to be recorded. Can something along these lines be added?

We thank the reviewer for this useful observation; this issue is now explicitly addressed by the addition of the following text to the Discussion section:

“A potential limitation of the study is that differences may exist between patients who did not consent to being videoed and therefore not included in the database used for study and those who were happy to be recorded and therefore included.”