Reviewer's report

Title: Helpful ways providers can communicate about persistent medically unexplained physical symptoms

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Reviewer: Christopher Burton

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This is an interesting manuscript representing a second analysis of this dataset (although the first is surprisingly not cited). While I have some sympathy with the conclusions I don't think that as stated they are supported by the data.

I have three major issues and some lesser, specific points

1. It's misleading to talk about communication about MUS when the questions relate to communication about Gulf War Syndrome. It's not that I don't think of GWS as within the Functional Somatic Disorders umbrella (so a "MUS" if we must use that term) but I don't think one can talk of communication about something without actually mentioning it. I found myself wondering how the patients who so valued acknowledgement about their GWS would feel reading a paper about their MUS? The authors have written elsewhere about the importance of concordance between professionals' and patients' explanations so I am surprised to see this here.

2. There is no sense of how long / short the responses to the questions were. This is important as the coding and classification depends on this. It is written in a similar fashion to the analysis and coding of an interview in which (hopefully) the interviewer/analyst is using context (verbal and non-verbal) as well as the actual words to infer meaning. Here however we only have the words and with only the most simple form of classification (by inferred theme, rather than by linguistic analysis). If responses comprised a paragraph or two then I would be happy. But I suspect that for many there was just a single phrase / sentence. Is that really enough to do this analysis? (I wondered why the "it's not curable, they could just treat the symptoms" quote is regarded as a "recommendation for managing" - it smacks more of nihilism to me - but that's the problem of missing context: we just don't know.

3. There is a major logical flaw in that one can only conclude that one form of communication is more often helpful than another if it is clear that both have been received. While we can reasonably assume that those who reported no helpful communication perceived none, the inference in "patients most often find it helpful to be acknowledged…" can only be made if
we know that they have had other information. The way the question was framed precludes that knowledge. And research from the Netherlands and elsewhere suggests that doctors are much more likely to deliver validation than any practical advice - so maybe the practical management stuff was more valuable but wasn't often provided.

Minor issues

1. The introduction includes quite a few old papers and few new ones (including some of the recent work on explanations.)

2. There's some inappropriate handling of an ordinal variable as a continuous one in the average visits section (3.0 results)

3. Numbered headings aren't part of BMC house style - this looks like legacy formatting from an earlier submission

4. The discussion includes a strength that "we were able to examine provider patient communication". That implies observation / examination of a contemporaneous record, not unstructured recall of what was perceived as useful in retrospect. There are recent studies that look directly at provider patient communication around MUS - but this is not one of them.

5. The title is presented as if a quote - but it isn't as far as I can see; rather it seems to be a fusion of quotes or a paraphrase. If quotes are ever appropriate in titles, then they need to be actual quotes from the data.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

No

Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

No
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