Author’s response to reviews

Title: Association between quality of care and empathy and burnout in primary care

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Author’s response to reviews:

Distinguished Editor Dr. Sandman,

First of all, thank you for the possibility of reviewing our article on empathy and quality of care. We try to respond to the reviewers in all recommendations done. We hope to respond to all the notes and improvements proposed by your team of reviewers.

Reviewer reports:

Atsushi Asai (Reviewer 1): Comments to the Author

1. The paper touches on an important and interesting theme concerning association between quality of care and empathy and burnout in primary care. The question posed by the authors is new and well defined. The methods are appropriate and well described. The title and abstract accurately convey what has been found. However, I have some major concerns that can and should be addressed prior to publication.

Thank you very much. This article is the result of a work that wants to show the importance of the empathy and burnout of professionals in the quality of care in primary care.
2. First of all, although I am not an expert of statistics, I am afraid that multiple logistic regression analysis is necessary to draw any conclusions or suggestions from this survey. I am also not sure if it is appropriate to classify scores into three categories. It is also the case for multiple use of Chi-square. In addition, it is uncertain whether or not selected independent variables (age, sex, profession, and place of work) are adequate for statistical analysis.

Thank you for your reflection, which we also share with our statistical team. Taking into account that the sample is 220 patients, if we performed a logistic regression, adjusting for other variables would not have the statistical power necessary to assess the effect between our quality indicator and the degree of burnout / empathy.

We have decided to classify the results of empathy and burnout into 3 categories, as other previous studies had done. As for empathy, it allows us to establish the scores around the 125 points described by Hojat, and their standard deviations (2 above for high empathy and 2 below for low empathy). As for burnout, we performed this classification because this is established by the manual to evaluate Burnout based on the questionnaire of Cristina Maslach.

We decided to add the independent variables to assess if they could have an effect on quality of care outcomes, although we did not find significant differences.

3. Second, the research design used was a cross-sectional survey and I wonder if it is possible to discuss specific cause-effect relationship among 3 factors. More and different interpretations might be possible regarding the association in question.

Since this is an observational study, there is no established cause-and-effect relationship. However, because it is a study of empathy, burnout and quality of care, we believe that it was easier to think that the degree of empathy and burnout causes the alteration in the quality of care, rather than the other way around. That is to say that the quality of care causes a certain degree of empathy and burnout. Obviously other interpretations can be made but that is what we agreed the research team.

4. Third, empathy is one of very important topics in both medical ethics and medical education. I think that the authors should extensively discuss 1) intrinsic value of empathy from the ethical point of view regardless of association with QSI or burnout, 2) its instrumental value, and 3) real possibility to make people more empathic through education.
We think this comment is very appropriate, and that is why we have included two sections in the text.

In page 5:

“Empathic skills, and the ability to understand patients' feelings and concerns, are basic to proper health care. With the empathic perspective, we can promote the patient's autonomy, favoring his benefit and avoiding maleficence, all of them fundamental principles of ethics.”

In page 6:

“This is why we believe that favoring the empathy of professionals, promoting communicative skills, mindfulnes programs and educational projects from the earliest years of medical education has an intrinsic value in improving the physician-patient relationship (not just ethics) but also of quality of care”.

5. Although JSPE has been suggested to be used as a common tool to evaluate individual empathy level, more detailed description about the measure should be added so that the audience who have no knowledge about the scale can understand the significance of this research more deeply.

We strongly agree. We have included more information in the methodology section in page 3.

The JSPE is the most widely used scale for assessing empathy in health professionals. An scale that measures physician empathic orientation and behavior. The average empathy score is considered to lie around 125 points and we followed previous strategies of classifying empathy levels as high for mean scores plus 2 SDs and as low for mean scores minus 2 SDs.

6. Fourth, the authors wrote, "Practitioners with low empathy had higher QSI scores than those with high empathy (672.8 vs. 654.4) while those with high burnout had lower scores than those with low burnout (702 vs. 671)". This means that practitioners with high burnout had lower QSI scores that those with low burnout and I am not sure how to interpret this result because the main result suggested that higher QSI scores tended to be observed for practitioners with high burnout.
This was an error of writing in the Abstract that we have corrected. In the results section, it is correctly described:

Practitioners with low empathy scored higher than those with high empathy (672.8 vs. 654.4), while those with high burnout scored higher than those with low burnout (702 vs. 671.8).

7. In text 27-34, the authors tried to interpret the association between level of activity and empathy and mentioned that more empathic practitioners spend more time talking to their patients than entering information and codes into the system. I am not sure if the authors really draw this conclusion from their results.

Actually, in our study we have observed that the more empathic professionals register less, and perform a lower activity based on the computer program of primary care. Our team has assumed that probably the most empathic professionals spend a lot of the time of the consultation to talk with patients, and are not so pending to perform computer records, and therefore show less activity. We have adjusted the one written on page 6.

“The fact that practitioners with medium levels of empathy spent the most time entering patient information and scored highest on the QSI suggests that probably more empathic practitioners prior to spend more time talking to their patients than entering information and codes into the system.”

8. Finally, it would be desirable for the authors to describe characteristics of patient-health care worker relationship in Spain from medical ethics standpoints. Different cultures could have different relationship among stakeholders in the clinical setting and practitioner's empathy could influence their relationship in different ways.

We think your comment is very appropriate, that is why we have introduced a section in the introduction, which hopefully reflects the spirit of your comment.

“In Spain, the patient medical relationship has presented a similar evolution to that of the rest of Europe. The existence of a public system that guarantees universal access for all citizens, allows all the people of our country to have a reference family doctor who can consult without
limitation, and who manages most health problems. Access to hospital care is reserved for serious pathology and unless emergencies must be performed by prescription of a family doctor. The increased technification of the health system has facilitated the connection between different levels of care, but the multitude of data available from the patients can limit the clinical interview and base the patient doctor relationship in an analysis of tests and results.”

Dario Sacchini (Reviewer 2): The paper is interesting and really surprising.

As highlighted by authors, we need wider studies, maybe with different tools, for gathering further data.

Thank you very much for your comment. We hope that this study could lead to other teams to continue our investigation.