Author's response to reviews

Title: Patient-provider communication about gestational weight gain among nulliparous women: A qualitative study of the views of obstetricians and first-time pregnant women

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Author's response to reviews: see over
15 November 2013

Peter O’Donovan, PhD
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Dear Dr. O’Donovan,

We are pleased to submit a revised version of our manuscript, “Patient-provider communication about gestational weight gain: A qualitative study of the views of obstetricians and pregnant women.” The reviewers’ comments and concerns were very helpful, and we consider the manuscript to be strengthened from incorporating their suggestions. In this letter, we would like to outline our responses to the reviews.

Author Response To Reviewers:

Reviewer's report

Title: Patient-provider communication about gestational weight gain: A qualitative study of the views of obstetricians and pregnant women

Version: 1 Date: 28 August 2013

Reviewer: Tammy Chang

Reviewer’s report:

Thank you for the opportunity to review this interesting work. This is a small, single center qualitative study of obstetricians and patients from the same clinic focusing on gestational weight gain. Their main findings are that there are differences in what information the OB and patient perceives is being provided as well as variation among patients in regard to communication style. The authors conclude that more direct communication between OB and patient is needed on this topic including patients’ preferred communicative style.

Overall, I found this paper to be interesting, though containing major issues around the analysis, presentation of results, and conclusions.

Discretionary Revisions:
Page 2: In the results section of the abstract, you do not explicitly mention your major themes. This is not required, but it may help to orient the reader later in the paper. “We found 4 major themes…”

We agree that including the themes in the abstract helps to orient the reader. We have made this change.

Page 9/10: It really adds a lot that you listed some pt identifying information after the quotes for patients—really nice. I wonder if you can do that with the OBs without putting their identities at risk. Ie- OBs BMI, gender, age, etc.
We agree that providing identifiers gives important context to the reader. We are concerned, however, that because the total pool of eligible obstetricians was small (10), identifiers could be used to actually identify participants, or at the very least, to substantially narrow the possibilities. For example, only one physician would fit the category of 0-10 years since graduation from medical school, and only two graduated more than 20 years ago. While narrow ranges would too easily identify participants, broad ranges would not offer useful context. However, because the numbers of male and female participants were fairly even (3 men and 4 women), this information is unlikely to provide enough context to identify the speaker. Thus, we have added obstetrician sex to each quote.

**Minor Essential Revisions:**

*Page 1-2 (Title and Abstract):* Because your study is of only nulliparous women, it would be a way to highlight a strength of your paper by putting that into your title and mentioning that in your abstract. For example “Patient-provider communication about gestational weight gain among nulliparous women: A qualitative study of OBs and first-time pregnant women.” I.e. You are adding to the knowledge of how first-time moms feel about GWG. Many of your findings from patients are likely the result of them being first time moms.

We agree that limiting the sample to nulliparous women is an innovative aspect of our study and something that we wish to highlight. We have made the recommended change to the title. This information was also retained in the abstract (methods section).

*Page 8: The theme of general discussions about GWG seems very broad and almost the aim of the entire interview- I wonder if there is a more nuanced way to code these discussions.*

Thank you for this perspective. We had intended to communicate that that first theme is about communication about body weight per se, in contrast to the second theme, communication about nutrition and physical activity, which is tangentially about weight. At the beginning of the results section, where we name the four themes, we have revised the first theme to: “communication about the amount and pace of GWG.” We hope this makes more apparent how that theme is distinct from the others.

*Page 9: All quotes are set in block format except one OB quote on page 9- probably bc it is imbedded within a sentence. Would be more consistent to have all quotes presented the same way.*

We have altered this sentence so the quote falls at the end and can more easily be included in block form as the others are.

*Page 9 and 13: You allude to a “reactive” approach by OBs that is well documented in REF # 26 and 28- this would help relate your findings to other similar work done in the US.*

Thank you for suggesting this connection. We have added references to these studies in the second paragraph of the discussion and agree that this helps to relate our project to other similar work in the United States.

**Major compulsory Revisions:**

*Page 2: In the background section, I feel that you could set up a much stronger argument for why this study is necessary then what you have written about the IOM, especially since it was updated over 4 years ago. You could say something about the rampant excess wt gain that occurs in the US, lack of*
resources for pt and OBs, etc etc. Your argument is stronger in the introduction—perhaps pull one of those statements.

We have rewritten the background section of the abstract as recommended to strengthen the significance of the work.

Page 6: In the concluding statement of the Introduction, you aim to “describe how obstetricians communicate about GWG” but later in the results, the “HOW” is not directly addressed, mostly the “WHAT”. Because you mention “style” in your abstract, it may make sense to describe the OBs styles.

We appreciate this distinction. We intended to focus this manuscript on the what, so we have revised the wording in the concluding statement of the introduction to specify what rather than how. In revising the results section of the abstract, we also removed mention of OB “style.”

Page 7: Your results section is difficult to following because you alternate between OB and patient findings. It appears you asked both questions in the same content area (Table 2) but different questions. It would be customary to analyze and code OBs and patients separately and report the results separately. It’s possible to report them together as you have based on content area, but an introductory statement about how you analyzed the two types of participants (separately or together) and how you are going to report them (separately or together) would help to orient the reader.

We appreciate this feedback and opportunity to improve the clarity of the manuscript. We coded the OB and patient responses separately, and, when we saw that corresponding codes emerged in analysis, decided to present results as integrated to make apparent the similarities and differences in OBs’ and patients’ perspectives. We have added language to the methods and results sections to make this clear to readers.

Page 10: The title here appears to be reversed—should probably read: “The Content of Advice” first since it is a major theme, then “Nutrition and Physical Activity” OR you could also just list the theme as you did on page 8 (#2) to stay consistent.

We reversed this subtitle to read: “The Content of Advice: Nutrition and Physical Activity.”

Page 15: The bulk of this page discussion biases should be put into the limitations section.

We agree that the potential for desirability bias and recall bias are limitations of the study and we have added those concepts to the limitations section. This comment highlighted the need to add clarification to this paragraph; we intend for this section to add context to our finding that patient and provider accounts differ, as well as to offer possible explanations for the differences. Thus, we rearranged the paragraph to clarify this.

Page 16: One of your major recommendations is to ask patients about what “tracks” of communication they would prefer. Most patients do not think this way and would likely have a difficult time choosing. It may differ from scenario to scenario within the same patient. “Provider-driven” does not sound like something many American women would subscribe to. Many times providers do not have enough time to do much of this counseling and it is done by nurses or assistants. I feel that more realistic recommendations are required for this paper to add to the current body of literature. Perhaps instead of additional research on public health—this study might support more research on the disparity between what OBs perceive they are doing and what patients perceive they are receiving from OBs.
Thank you for offering this perspective. We have reworked the conclusions incorporating this feedback.

*Table 1/3:*

*It is customary for the first table of the study to be of the study participant characteristics. Including the 2009 IOM guidelines does not add to your study as it could easily be referenced.*

We recognize that the first table often describes study participant characteristics. However, removing the table of IOM guidelines would not fully address this, because of the placement of Table 2 (interview questions and example patient responses) and the new Table 3 (see response to your last comment below). Thus, we have left the table placement as is. Regarding removing the IOM guidelines altogether, because of the disciplinary diversity of the readership of *BMC Pregnancy and Childbirth*, we think this table adds value and context for readers who may not be familiar with the guidelines. Readers will need the recommended ranges to make sense of the patient quote identifiers that include how many pounds women have gained so far in pregnancy.

*The characteristics of the other participants of your study: the OBs is completely missing!*

As noted above, the practice is small enough (10 OBs were eligible to participate) that the 7 who were included could be identified too easily if we include characteristics. We have added OB gender to the quote tags but believe that if we add additional information beyond the description of the sample in aggregate, we risk compromising participants’ identities.

*Table 2:*

*This table only provides examples from one type of study participant (patients). I would recommend two tables- one of major themes and quotes from OBs and one from patients. At the very least, include OB quotes, but it would make your table very cumbersome.*

Thank you for this suggestion. We have added a table (Table 3) with OB quotes.

**Reviewer’s report**

Title: Patient-provider communication about gestational weight gain: A qualitative study of the views of obstetricians and pregnant women

Version: 1 Date: 7 July 2013

**Reviewer: Edwin van Teijlingen**

Reviewer’s report:

'Patient-provider communication about gestational weight gain: A qualitative study of the views of obstetricians and pregnant women'

Elizabeth A Duthie, Elaine M Drew and Kathryn E Flynn

*Interesting small study on the doctor-patient relationship (a concept which in itself is not addressed, or at least not set in the wider literature on the topic) and women weight gain in pregnancy, where by the pregnant woman is the ‘patient’ and the obstetricians the ‘doctor’. There is no notion in the paper...*
that the word ‘patient’ is seen as problematic by some as it implies that ‘pregnancy & birth’ are an illness that turn a woman into a patient.

We are sympathetic to the notion that the medicalization of pregnancy and childbirth is a topic worth exploring and that the status of pregnant women as “patients” should be subject to examination. We appreciate the scholarship of others in this area, such as Robbie Davis Floyd and Deborah Lupton, but we are concerned that the scope of this project does not allow for adequate discussion here and including only a brief mention of this subject may distract from our aims. While it is a small sample, we note that none of our respondents (i.e. neither pregnant women nor obstetricians), indicated any qualms about the medicalization of pregnancy, or about the “doctoring” role obstetricians assume relative to the “patient” role women assume. For these reasons, we have not addressed this body of literature here.

The researchers don’t really seem to have employed Grounded Theory as claimed in the paper. It reads as if the paper has been analysed using a thorough thematic analysis, I think the authors have employed an approach which they can claim has been influenced by Grounded Theory, but I don’t think they can claim it is Grounded Theory, or a version of Grounded Theory. Grounded Theory would typically include ‘theoretical sampling’, not ‘opportunistic sampling’, ‘paying attention to disconfirming cases’ AND ‘developing a theoretical explanation. The authors really used only one of the four key elements of Grounded Theory in their approach in terms of their inductive analysis. I would suggest that the authors describe their analysis as ‘thematic’ (see for example 28. Forrest Keenan, K. et al. (2005) The analysis of qualitative research data in family planning and reproductive health care, Journal of Family Planning & Reproductive Health Care 31(1): 40-43).

We appreciate this comment and agree that the methods employed in this manuscript may be better described as thematic analysis. We have made appropriate changes in the abstract and the methods section to correct this.

The authors address a key issue in the medical sociology literature, namely the doctor-patient relationship, but there no real reference to any of this literature. I found a good summary for the key views at: http://ethics.missouri.edu/Provider-Patient.aspx also see: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496871/

Other useful papers might be:

We have added some key citations from the larger literature on communication within the doctor-patient relationship to the background section in order to situate our study within this broader context.

The other major comment is that there is only one single reference in the whole Methods section, I would have expected references to: the sampling process, the inclusion criteria, for example why ‘select
only women age 18 and over'; references (and a mention) to mixed-methods research as the authors also used a survey; perhaps a reference to questionnaire design; open coding; axial coding; etc.

We are hesitant to label our project "mixed methods" because other than reporting basic frequencies, we do not have any quantitative results. The survey was intended to provide background information in which we could situate participants’ responses; we have added this information to the Data Collection paragraph within the Methods section. We have also added an additional reference to describe the analytic methods used.

**Minor comments**

**Page 4** the following sentence should refer to US: “The Institute of Medicine (IOM) in the United States of America....”

**Page 4** “last sentence second paragraph “...[17], some of whom seek ..”

**Page 9** the abbreviation BMI is used without giving its full meaning on first use, similarly on page 12 OB which has not been defined

**First sentence page 14** “Our single-center study explored patient-provider communication about GWG with diverse obstetricians and patients who were in their third trimester of their first pregnancy.” can be removed as it seems repetition.

**Page 15** “the majority of studies show ..” should read: “the majority of studies shows ..”

Thank you for catching these errors. We have corrected them in the manuscript revision.

The authors have taken an odd approach to identifiers, for the women we get great detail, including weight gain, gestation etc., for the obstetricians there is nothing, despite the fact the we know their gender, years since graduation and year with clinic (page 8). Why is there no identifier for the doctors, even though it is not precise e.g. years since grad 0-5; 6-10; 11 and over to maintain anonymity?

As you suggest, our reasoning for leaving out identifiers for doctors was concern for anonymity. We also address this point in response to comments from Reviewer 1 above. We have added OB sex to the quotes to add context without jeopardizing confidentiality.

**Page 15** Under limitations the authors should add that obstetricians were ‘self-selected’ as many/several were invited by email (page 6) and ‘only’ seven participated.

We agree and have added this to the limitations section in the discussion.

**References: From the journal’s web pages: Examples of the BMC Pregnancy and Childbirth reference style**

**Article within a journal**
Also journal title needs to be abbreviated in ref .14, ref 24 and 26
Ref 25 not sure what “(Larchmt)” means.

Thank you for catching these errors. We have corrected and double-checked all references in the revised version to make sure they conform to BMC Pregnancy and Childbirth style.