PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Factors influencing trust in doctors – a community segmentation strategy for quality improvement in health care.
AUTHORS	Gopichandran, Vijayaprasad; Chetlapalli, Satish Kumar

VERSION 1 - REVIEW

REVIEWER	Ramanathan, Mala Sree Chitra Tirunal Institute for Medical Science and Technology, Achutha Menon Centre for Health Science Studies
REVIEW RETURNED	26-Oct-2013

GENERAL COMMENTS	Page 2. Abstract. line 38/39. ...quality of care should read - ...perceived quality of care. Page 6. line 22. The authors mention that this is a multistage random sample. But it not so based on their description. It is random up to the last cluster. But at the last stage, the sampling seems to be convenience sampling to select 50 persons. Unless these 50 eligible respondents (line 29) were selected randomly, the sampling strategy cannot be described as multi-stage random sampling. At best, it can say it used multi-stage sampling strategy to identify 625 participants. Page 8. Table 1. Characteristics of the study participants. The authors could include a column that gives the population characteristics of Tamilnadu state. This will help to describe the extent of representativeness or deviations from it in the sample. Page 13. line 26/27. The authors say - this is typically the mainstream section of society with good access to resources and services. The word 'mainstream' is loosely used. The authors can consider replacing it with a less stronger word. To argue that this group that consists of younger individuals with higher levels of education is problematic. If the researcher adds the % urban to the figure 1 in the boxes on personal trust/objectively assessed trust, it may show that these segments are strongly urban, though not enough to be statistically significant. But this is something that the authors can verified as rural groups load onto emotionally assessed trust strongly. Page 17. Line 15/16. The authors mean 'perceived quality of care' when they say, 'quality of care'. It needs to be stated at each point and therefore the authors should say ' perceived quality of care' instead of 'quality of care'. This is a very well written paper. The only problem is in the description of the sampling strategy. This will affect the generalisability of the findings. It is for this reason that I suggest including in table 1 a profile of TN population using the recent census or any other authentic sources as it will help in an understanding the extent to which the sample represents TN at least in terms of general socio-economic characteristics.

REVIEWER	McKinstry, Brian University of Edinburgh, centre for population Health Sciences
REVIEW RETURNED	01-Nov-2013

GENERAL COMMENTS	I thought this was a novel and interesting study. In particular in the way the authors try to ascribe attitudes to trust to different sections of society. The response rate is not clear as it is not stated how many people were approached and the characteristics of those who may have turned down interviews. It would be useful to know who did the interviews. Could that have influenced some of the responses? I wondered if people understood all the questions. For example it is hard to believe that someone would have trust in a doctor who discriminated against them for reasons of religion, caste, language etc…. yet it seems that 38% of people were not bothered by that prospect! I am not sure if you can say "This study clearly demonstrates that with resource deprivation, the factors that influence trust in doctors tend to be in terms of emotional assessment rather than quality of care. " behavioural competence would be better. I am not sure you can say that training in behaviours ASSOCIATED with trust will improve trust. Several trialists have attempted this with variable effects. Thom DH. Training physicians to increase patient trust. Journal of Evaluation in Clinical Practice 2000;6(6):245-53. Thom DH, Tirado MD, Woon TL, McBride MR. Development and evaluation of a cultural competency training curriculum. BMC Medical Education 2006;6:38. Tulsky JA, Arnold RM, Alexander SC, Olsen MK, Jeffreys AS, Rodriguez KL, et al. Enhancing communication between oncologists and patients with a computer-based training program. Annals of Internal Medicine 2011;155:593-601. I am not an expert statistician and feel it would be helpful for the paper to be checked by someone more expert.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Mala Ramanathan

Comment 1: Page 2. Abstract. line 38/39. ...quality of care should read - ...perceived quality of care.
Response: We agree
Action: Page 2 line 25

Comment 2: Page 6. line 22. The authors mention that this is a multistage random sample. But it not so based on their description. It is random up to the last cluster. But at the last stage, the sampling seems to be convenience sampling to select 50 persons. Unless these 50 eligible respondents (line 29) were selected randomly, the sampling strategy cannot be described as multi-stage random sampling. At best, it can say it used multi-stage sampling strategy to identify 625 participants.
Response: The last stage of the cluster is not randomly selected. But we believe that in the matter under study there is a role for strong intra-cluster homogeneity due to the fact that the clusters are usually served by the same doctor and they share a lot of common opinions and experiences, especially in the cultural setting given here. So in this sampling we are more interested in the inter-cluster variability. That was the reason for not making the last stage of the sampling random.
Action: We have changed the phrase "multistage random sampling method" to "multistage sampling

strategy" as suggested by the reviewer. We have added a note explaining the non random selection in the last stage on page 6 lines 13 – 18.

Comment 3: Page 8. Table 1. Characteristics of the study participants. The authors could include a column that gives the population characteristics of Tamilnadu state. This will help to describe the extent of representativeness or deviations from it in the sample.
Response: We think this is a very good suggestion.
Action: Page 8 – Table 1 has been modified. References have been added.

Comment 4: Page 13. line 26/27. The authors say - this is typically the mainstream section of society with good access to resources and services. The word 'mainstream' is loosely used. The authors can consider replacing it with a less stronger word. To argue that this group that consists of younger individuals with higher levels of education is problematic. If the researcher adds the % urban to the figure 1 in the boxes on personal trust/objectively assessed trust, it may show that these segments are strongly urban, though not enough to be statistically significant. But this is something that the authors can verified as rural groups load onto emotionally assessed trust strongly.
Response: We agree that 'mainstream' may be a stronger word. So we would like to reword it as 'upper social stratum'. We did the verification of urban percentages in the personal trust and objectively assessed trust groups. The percentages were not dominantly urban. But in personal trust there seems to be a higher proportion of urban.
Action: Page 14 lines 10-12. Figure 1 has been changed

Comment 5: Page 17. Line 15/16. The authors mean 'perceived quality of care' when they say, 'quality of care'. It needs to be stated at each point and therefore the authors should say ' perceived quality of care' instead of 'quality of care'.
Action: This change has been incorporated in Page 16 line no. 16 and Page 18 line 12

Reviewer: Brian McKinstry

Comment 1: I thought this was a novel and interesting study. In particular in the way the authors try to ascribe attitudes to trust to different sections of society.
Response: Thank you for the warm complements.

Comment 2: The response rate is not clear as it is not stated how many people were approached and the characteristics of those who may have turned down interviews.
Response: We agree that this is important.
Action: We have included this in Page 6. Lines 13-20.

Comment 3: It would be useful to know who did the interviews. Could that have influenced some of the responses?
Response: We agree this is an important point. The interviews were conducted by the first author along with three trained field investigators. The first author is a physician, but his qualification was not explicitly revealed to the participants to avoid bias.
Action: Page 7. Lines 7-10

Comment 4: I wondered if people understood all the questions. For example it is hard to believe that someone would have trust in a doctor who discriminated against them for reasons of religion, caste, language etc.… yet it seems that 38% of people were not bothered by that prospect!
Response: We think this is not an issue of understanding of the questions. This is more of an issue of what was the most important in the agenda for the respondents. For some of the respondents, especially in rural areas, the trust was implicit and largely driven only by emotional factors. In such conditions they could have responded to the non-discrimination question without giving it much

consideration as they did not even feel it was a matter of importance.
Action Taken: We have included an explanation for this in the discussion of the “Emotional Trust” section. Page 15 lines 7-8.

Comment 5: I am not sure if you can say “This study clearly demonstrates that with resource deprivation, the factors that influence trust in doctors tend to be in terms of emotional assessment rather than quality of care. “ behavioural competence would be better.
Response:We agree.
Action taken: Page 16, Line no. 16

Comment 6: I am not sure you can say that training in behaviours ASSOCIATED with trust will improve trust. Several trialists have attempted this with variable effects.
Response: We agree. we have mentioned the Cochrane review which has shown that there is no strong evidence to support the effectiveness of such trainings.
Action: We have removed the referred statement. Page 18 line 1-2.