PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Development and validation of a socio-culturally competent trust in physicians scale for a developing country setting
AUTHORS	Gopichandran, Vijayaprasad; Wouters, Edwin; Chetlapalli, Satish Kumar

VERSION 1 - REVIEW

REVIEWER	Joselina Barbosa Medical School, University of Porto, Portugal
REVIEW RETURNED	16-Jan-2015

GENERAL COMMENTS	Introduction Often repeats the same idea. Description of validated scales very extensive Methods Study setting - very extensive Subsection "Validation of a pre-existing scale of trust in physicians in the setting location" This is not methods. This justifies the need to develop a new scale study. Should be in Introduction. Is missing setting (relevant dates, periods of recruitment, follow up, data collection) Results Standardize decimal places in tables and text. The Cronbach's alpha of the scale item 22 was 0.92. But, Cronbach's alpha if item deleted was always higher than 0.92 (Table 2).

REVIEWER	Brian McKinstry University of Edinburgh UK
REVIEW RETURNED	24-Mar-2015

GENERAL COMMENTS	This is an important area. As the authors mention, to date there has been no measure of trust developed for developing countries. As they suggest it is possible that trust measures may vary from culture to culture. However it is important to remember that the positive associations with Trust mentioned in the introduction are just that… associations. For example it is not known if increasing trust increases self-efficacy and not that more self-efficacious patients are more inclined to trust doctors. They fall into the trap of ascribing a direction to this. The authors provide a comprehensive description of the study

	setting and demonstrated that the most commonly used measure of Trust was not as reliable as expected in a S Indian setting. They go on to describe the development of a new questionnaire, initially through focus groups for content and comprehension and then with a much larger group to determine its psychometric properties. They carried this out in a comprehensive fashion. I was not clear how they obtained the lists of people who reported regular primary care attendance, or to what extent this sample reflects the population as a whole (in terms of age sex, education literacy etc). It would be helpful to have some idea of this. They had an excellent response rate. Although the researcher says s/he did not say s/he was a doctor this may still have had an impact on the responses or his/her attitude to responses. I was unsure about the relevance of some of the items. E.g. “There are no side effects to the medicine prescribed by the doctor”. This is clearly not true and I would have thought ‘ my doctor will tell me about any side effect I might have with my medicine’ would be better. Likewise some of the items about crowded clinics, or access at different times may not really be anything to do with trust. ‘Whatever illness I have, I will go only to this doctor’ I would have thought was too extreme and ‘prefer to go’ might have been better I realise I may be looking at this through a Western lens and these issues are more understandable to a S Indian audience, but it was interesting that the item to total correlation of some of these was lower and some were subsequently removed from the questionnaire. Also it was a surprise to me that honesty… so important in the west… was not considered important in country where corruption scandals dominate the news. I was not convinced by the explanation given by the authors. Perhaps they might wish to expand on this

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

1. Introduction often repeats the same idea. Description of validated scales very extensive

Response: We agree with the reviewer that the description of the previous scales is very elaborate. However, we believe that a detailed description of previously validated scales will substantiate the fact that most of the scales have been developed in the Western context. Since this paper is focused on scale development, we feel that this is essential.

2. Study setting - very extensive

Response: We agree that the study setting description is extensive. The main justification for a unique trust scale for a developing country setting lies in a thorough description of the context of health care in these settings. We have mentioned in the introduction that trust tends to be contextual and therefore there is a need for a unique scale for trust in developing countries. This elaborate description of the context is the backbone for developing the justification for this unique scale. It also creates a sound platform for discussing the study findings later on based on this context.

3. Subsection "Validation of a pre-existing scale of trust in physicians in the setting location"

This is not methods. This justifies the need to develop a new scale study. Should be in Introduction.

Response: We agree with the reviewer. We have included this section in Page 5-6 in the Introduction section.

4. Is missing setting (relevant dates, periods of recruitment, follow up, data collection)

Response: We agree that relevant dates are important. Since it is a cross sectional study there was no follow up. We have included the dates of the study in the “Measurement” section on page 9.

5. Standardize decimal places in tables and text.
Response: We agree that this is an important comment. We have made the decimal places in the tables and text standardized.

6. The Cronbach's alpha of the scale item 22 was 0.92. But, Cronbach's alpha if item deleted was always higher than 0.92 (Table 2).
Response: We thank the reviewer for the keen observation. There was a typographical error. The Cronbach’s Alpha of the 22 item scale was 0.928 and not 0.92 as typed earlier. The Cronbach’s Alpha if item deleted is always lower than the Cronbach’s Alpha. We have changed the Cronbach’s Alpha to 0.928 in all the places where it is reported.

Reviewer 2:

1. This is an important area. As the authors mention, to date there has been no measure of trust developed for developing countries. As they suggest it is possible that trust measures may vary from culture to culture.
Response: Thank you for this comment. We are glad that the reviewer agrees with our assessment that this is one of the first scales of trust in physicians from a developing country setting.

2. However it is important to remember that the positive associations with Trust mentioned in the introduction are just that… associations. For example it is not known if increasing trust increases self-efficacy and not that more self-efficacious patients are more inclined to trust doctors. They fall into the trap of ascribing a direction to this.
Response: This is a very valid point. We agree with the reviewer. We have modified the language of this paragraph. Page 4 paragraph 2 – we have modified the language. We have added a statement which mentions that these associations need not necessarily be causal in nature.

3. The authors provide a comprehensive description of the study setting and demonstrated that the most commonly used measure of Trust was not as reliable as expected in a S Indian setting. They go on to describe the development of a new questionnaire, initially through focus groups for content and comprehension and then with a much larger group to determine its psychometric properties. They carried this out in a comprehensive fashion.
Response: Thank you for this comment. Yes, we have tried to describe the comprehensive process involved in the scale development.

4. I was not clear how they obtained the lists of people who reported regular primary care attendance,
Response: We did not obtain a list of people who reported regular primary care attendance. When we approached the respondent, the first screening question was whether they had a primary care physician / facility. If they said yes, then they were included. This has now been explained clearly in Page 9, paragraph 2

5. or to what extent this sample reflects the population as a whole (in terms of age sex, education literacy etc). It would be helpful to have some idea of this.
Response: The extent to which the sample represents the population as a whole is shown in Table 1. A note has been added on the representativeness of the sample in the first paragraphs under “Results” section – page 11 and 12.

6. They had an excellent response rate. Although the researcher says s/he did not say s/he was a doctor this may still have had an impact on the responses or his/her attitude to responses.

Response: This is a very important observation. We agree that the attitude of the researcher towards the responses could be influenced by the fact that he is a physician. It is also possible that the responses themselves were different because of the non-verbal signals of communication between the researcher and the participant. The former bias is unlikely to have influenced the objectivity of the quantitative research as the researcher only noted down the responses given by the participant without any interpretations or reactions at the point of the interview. However the latter is a definite limitation that needs to be kept in mind while interpreting the findings. We have included an explanatory note in the methodology section explaining that though there is a chance of the responses influencing the researcher, by standardizing the questionnaire administration process and limiting the scope for reactions and interpretations at the point of interview, this was overcome. However there is a likelihood of the responses themselves being influenced by the attitudes and non-verbal signals of the physician-researcher.

7. I was unsure about the relevance of some of the items. E.g. “There are no side effects to the medicine prescribed by the doctor”. This is clearly not true and I would have thought ‘ my doctor will tell me about any side effect I might have with my medicine’ would be better.
Response: As previously discussed in the introduction section, the research was conducted in a resource limited setting with low levels of health awareness. Prescribing medicines which did not have much side effects was reported as a strong indicator of “perceived competence” of the physician in the previous qualitative study. Though from the view point of a physician this item may be impossible and meaningless, it is a vital dimension of competence assessment in the study setting. We have included a description of this in page no. 21 second paragraph under Discussion

8. Likewise some of the items about crowded clinics, or access at different times may not really be anything to do with trust.
Response: We understand the concern of the reviewer. However, from our qualitative research in the same area we concluded that there are several important surrogate indicators of trust. A crowded clinic is an indicator for a popular physician. Therefore it is viewed in this community as an indicator of confidence in the physician. Moreover the dimension of “assurance of treatment” or “dependability” implying that they can access the physician at any time of the day came out as very significant in a resource poor setting without universal access. We have included a description of this in page no. 21 second paragraph under Discussion

9. ‘Whatever illness I have, I will go only to this doctor’ I would have thought was too extreme and ‘prefer to go’ might have been better
Response: We agree with the reviewer that the statement is rather strongly worded. We have kept it intentionally that way because there is a strong emotional component attached to that statement. It came out strongly during the qualitative exploration. We have included a description of this in page no. 21 second paragraph under Discussion

10. I realise I may be looking at this through a Western lens and these issues are more understandable to a S Indian audience, but it was interesting that the item to total correlation of some of these was lower and some were subsequently removed from the questionnaire.
Response: We agree with the reviewer’s observation. Some of the items were indeed not correlated with the total score of trust and so were removed from the scale, especially the crowded clinic statement. We may try phrasing these statements in a softer manner in future explorations. We have included a description of this in page no. 21 second paragraph under Discussion

11. Also it was a surprise to me that honesty… so important in the west… was not considered important in country where corruption scandals dominate the news. I was not convinced by the explanation given by the authors. Perhaps they might wish to expand on this
Response: We agree with the reviewer and thank the reviewer for this important comment. We think

that the honesty dimension is built inside the dimension of respect, loyalty and assurance of treatment. We also think there is a need to develop an honesty subscale and explore this dimension in greater detail in the future. We have included a note explaining this in page 23.