PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Case stories in general practice: A focus group study
AUTHORS	Abildsnes, Eirik ; Flottorp, Signe; Stensland, Per

VERSION 1 - REVIEW

REVIEWER	Armson, Heather University of Calgary
REVIEW RETURNED	29-May-2012

GENERAL COMMENTS	**"Introduction** Case stories have a longstanding traditions in medicine. Doctors share case stories when referring patients to hospital from primary health care, at morning reports in hospital, and when discussing interesting or difficult cases. [1 2] Case stories include everyday practice, dramatic "war stories" and anecdotes of uncommon practice[3]. The stories aim to provide a professional audience with succinct and sufficient information –sufficient for what?. [3] Doctors adopt the medical storyline (what is a medical storyline?) early in their career. During case presentations students, interns and residents improve knowledge based on clinical experience, and learn the medical language, professional principles, traditions and values. [4]Their supervisors evaluate their presentations based on relevance, conciseness and mastery of the medical language. [5] Patients adjust their illness narratives to the listening doctor, (does this have any relevance to the topic?) [6] doctors adjust their retelling and interpretations into case stories suitable for a professional audience. [7] Peer groups of general practitioners share professional competence, experience and social role (not sure what the intent of this sentence is). Socially shared knowledge has an interactive nature. It is formed and maintained through dialogical thinking and communication, and affects what is being talked about and the manner by which content is framed. [8] It influences how group members speak about others, such as patients, other professionals or health authorities. Dialogues involve tension and intentions, and dealing with ~~the~~ this implicit shared knowledge within a group is an important social skill. [9] The distribution of this competence within a group may affect group dynamics, and the outcome of group discussions. Communication is affected by fear of losing face, indirect communication and hidden agendas. While group members talk to each other, they may simultaneously carry out internal dialogues with themselves or others (you cannot carry out an internal dialogue with others- does

this mean something else). [8]

Research on the development of doctors' communication patterns emphasizes that medical education, internship and residency influence doctors' identities in ways that affect communication with patients. [10] Case-based teaching is used along with problem-based teaching in medical education, and is well suited for small-group teaching. [11] Problem-based teaching focuses on a particular clinical problem, while case-based teaching focuses on a particular patient presenting with a clinical problem. In general practice case-based learning in organized peer groups is widely used. [12-15] Permanent small-group activities have become an important part of CME in many countries, and if well functioning can serve as supportive networks to share knowledge and clinical experience. [16-19]

The primary aim of the research project was to study general practitioners' experience with lifestyle counselling. While conducting focus group sessions among general practitioners, [20] we observed interesting interactions within the groups …"
What is the research question?
In the methods section:

- Please define terms: partners (are these practicing physicians).
- What was the purpose of the learning groups, how were they structured and how often do they usually meet.
- I am very confused as to the number and types of participants and the locations of the practices of the participants. The fourth sentence " Two groups of interns (17 participants), one group of residents (eight participants) and two groups of partners (13 participants) attended " suggests that there are 38 participants in the study but the next paragraph references 50 physicians.
- Are the interns and residents working exclusively out in the community? Where did the eighteen physicians working in rural practice come from and the 16 working more than 10 years —in the previous section there were only 13 practicing physicians??

- "We considered audiotape recordings as an acceptable basis to study verbal interaction."— a very awkward sentence.
- "fictive names"
- "Some of the participants referred condensed case histories…" I don't think referred is the correct word here…presented? Need more discussion of what a condensed case history involved compared to the other stories---did they only present objective data??

In the discussion:

- I struggled with the discussion as a whole because of the lack of a cohesive theoretical perspective. The authors use many references but they do not pull them together in a way

	that would permit the reader to contextualize the individual components. The authors do not seem to take the results and the literature they quote to the 'next level' by suggesting how the diverse components fit together. At the end of the discussion section the reader is left with a 'so what' sensation and no sense of what the authors think the next steps might be. • I think this whole section should be in the methods or in section of the discussion on the limitations of the study: "The presence of the researchers in the focus groups may have influenced what group members chose to tell. [24] To reduce this influence, the conductor chose a withdrawn position, and seldom interrupted the group discussions. Being a peer may elicit information that would not be told to a researcher with a different background, [25] but may also cause blindness to aspects of the discussions that a researcher with different background would see. This was compensated to some extent by the presence of an observer with another professional background. The group members knew each other quite well, and we conducted the group sessions in a scheduledmeeting." • Limitations of the study are presented before the study findings • "In focus groups the audience may supply the speaker by verbal interruption, exclamations, supportive or confronting utterances, and by non-verbal communication. .."does this mean interact with the speaker? • "Moments of 'split floor' and polyphonic discussions occur, as well as moments in which nobody wants to 'take the floor'. [26] In this study we observed 'split floor' and polyphonic discussions, but never moments when nobody 'took the floor'. " All three of these components of discussion need to be defined. • "Professional back stage communication is included in the hidden curriculum of medical education, supports each group member and strengthens group affiliation. " The second half of this sentence does not fit—do you need to take out "included in the hidden curriculum of medical education." • "While people talk to each other, they simultaneously carry out internal dialogues with themselves or others to position themselves in the discussion. " –same comment as above on the internal dialogue with others—does this just require rewording? • "Some participants told about their own struggle with lifestyle" issues • The discussion almost exclusively references physicians and yet well over half of the participants are interns and residents. I would expect there might be differences in the dialogue of interns and residents compared to practicing physicians?

REVIEWER	Reventlow, Susanne The Research Unit for General Practice, Department of Public Health, Copenhagen University
REVIEW RETURNED	29-May-2012

THE STUDY	The method section or in the introduction the authors could place descriptions of the concept used. See my comments later.
GENERAL COMMENTS	Generally the manuscript is well written and easy to read and I consider the subject of the paper very important. We need more knowledge from research about how doctors learn, reflect on their experiences and develop their clinical skills – here attending group sessions. I have a few comments to the study, which I hope the authors will consider in order to develop the paper a little more. The study design is considered appropriate to answer the research question, and so are also the methods. Having six groups with 50 physicians constitute a good basis for the analysis. However, I miss some more descriptions of the central concept used, e.g. narrative and case stories – is it the same? The authors use systematic text condensation and an editing analysis style and focused in their analysis on interaction and process in the presentation and discussion of the case stories. I think this might be appropriate, but I wonder if a more structural analysis inspired by narrative analysis could have strengthen the analysis focusing on interaction and processes, language and different positions taken by the participants? I think the findings concern the interaction among the participants, but I first had difficulties to understand the order of how the results are presented, I think it is clear for me, but I think the authors could make it more clear by changing the headings or explain how they will present the results? The discussion contributes with some interesting considerations concerning how groups share social knowledge and communication. Finaly, I declare that there is no competing or conflicts of interests. Susanne Reventlow

VERSION 1 – AUTHOR RESPONSE

Reviewer 1, Heather Armson:

We appreciate a very careful and critical reading of our paper.

There are some very awkward language issues in this paper that impact on understanding. Please see below:

Introduction

Case stories have a longstanding traditions in medicine. Doctors share case stories when referring patients to hospital from primary health care, at morning reports in hospital, and when discussing interesting or difficult cases. 1 2 Case stories include everyday practice, dramatic "war stories" and anecdotes of uncommon practice3. The stories aim to provide a professional audience with succinct

and sufficient information –sufficient for what?. 3 Doctors adopt the medical storyline (what is a medical storyline?) early in their career. During case presentations students, interns and residents improve knowledge based on clinical experience, and learn the medical language, professional principles, traditions and values. 4Their supervisors evaluate their presentations based on relevance, conciseness and mastery of the medical language. 5 Patients adjust their illness narratives to the listening doctor, (does this have any relevance to the topic?) 6 doctors adjust their retelling and interpretations into case stories suitable for a professional audience. 7

Peer groups of general practitioners share professional competence, experience and social role (not sure what the intent of this sentence is). Socially shared knowledge has an interactive nature. It is formed and maintained through dialogical thinking and communication, and affects what is being talked about and the manner by which content is framed. 8 It influences how group members speak about others, such as patients, other professionals or health authorities. Dialogues involve tension and intentions, and dealing with ~~the~~ this implicit shared knowledge within a group is an important social skill. 9 The distribution of this competence within a group may affect group dynamics, and the outcome of group discussions. Communication is affected by fear of losing face, indirect communication and hidden agendas. While group members talk to each other, they may simultaneously carry out internal dialogues with themselves or others (you cannot carry out an internal dialogue with others- does this mean something else). 8

Research on the development of doctors' communication patterns emphasizes that medical education, internship and residency influence doctors' identities in ways that affect communication with patients. 10 Case-based teaching is used along with problem-based teaching in medical education, and is well suited for small-group teaching. 11 Problem-based teaching focuses on a particular clinical problem, while case-based teaching focuses on a particular patient presenting with a clinical problem. In general practice case-based learning in organized peer groups is widely used. 12-15 Permanent small-group activities have become an important part of CME in many countries, and if well functioning can serve as supportive networks to share knowledge and clinical experience. 16-19

The primary aim of the research project was to study general practitioners' experience with lifestyle counselling. While conducting focus group sessions among general practitioners, 20 we observed interactions within the groups …"

We will thank the reviewer for her remarks about language. We have followed the proposals to improve the language.

In the introduction, we have changed the manuscript according to the reviewer's comments. We disagree about her comments about internal dialogues, but accept that the concept of internal dialogues with others is not immediately comprehensible to the reader without exploring the topic in detail. We hope the changes we have made in the introduction and discussion section make sense. Reference 7 provides exhaustive information about internal dialogues.

What is the research question?

At the end of the introduction section we have tried to make the aim of the study clearer:

The aim of this paper is to explore and describe how peer groups of general practitioners interact when they share and discuss case stories.

The corresponding research question would be: How do general practitioners interact when they share and discuss case stories? If the editor wishes, we may use the research question instead of describing the aim of the study.

In the methods section:

• Please define terms: partners (are these practicing physicians).

• What was the purpose of the learning groups, how were they structured and how often do they usually meet.

In the beginning of the methods section we have inserted a paragraph to describe the different peer groups and the context of the meetings. We have also included additional information about the participants that the reviewer calls for.

• I am very confused as to the number and types of participants and the locations of the practices of the participants. The fourth sentence " Two groups of interns (17 participants), one group of residents (eight participants) and two groups of partners (13 participants) attended " suggests that there are 38 participants in the study but the next paragraph references 50 physicians.

The reviewer has left out the sentence that makes the number of participants 50. We have changed the text to make this even clearer.

• Are the interns and residents working exclusively out in the community? Where did the eighteen physicians working in rural practice come from and the 16 working more than 10 years —in the previous section there were only 13 practicing physicians??

We have included the information the reviewer asks for in the beginning of the methods section.

• "We considered audiotape recordings as an acceptable basis to study verbal interaction."— a very awkward sentence.

We have changed this sentence.

• "fictive names"

We have changed this: fictitious names

• "Some of the participants referred condensed case histories…" I don't think referred is the correct word here…presented? Need more discussion of what a condensed

We have changed this sentence to meet the reviewer's remarks.

. I struggled with the discussion as a whole because of the lack of a cohesive theoretical perspective. The authors use many references but they do not pull them together in a way that would permit the reader to contextualize the individual components. The authors do not seem to take the results and the literature they quote to the 'next level' by suggesting how the diverse components fit together. At the end of the discussion section the reader is left with a 'so what' sensation and no sense of what the authors think the next steps might be.

We have tried to improve the last part of discussion section with respect to these comments.

. I think this whole section should be in the methods or in section of the discussion on the limitations of the study: "The presence of the researchers in the focus groups may have influenced what group members chose to tell. 24 To reduce this influence, the conductor chose a withdrawn position, and seldom interrupted the group discussions. Being a peer may elicit information that would not be told to a researcher with a different background, 25 but may also cause blindness to aspects of the discussions that a researcher with different background would see. This was compensated to

some extent by the presence of an observer with another professional background. The group members knew each other quite well, and we conducted the group sessions in a scheduled meeting."

. *Limitations of the study are presented before the study findings*

We believe we have followed author's instructions and put this paragraph in the discussion section, after having provided a short summary of the main findings. In the revised paper we have inserted subheadings to make this even clearer.

. *"In focus groups the audience may supply the speaker by verbal interruption, exclamations, supportive or confronting utterances, and by non-verbal communication. .."does this mean interact with the speaker?*

Yes, and we have changed the text to make this clearer.

. *"Moments of 'split floor' and polyphonic discussions occur, as well as moments in which nobody wants to 'take the floor'. 26 In this study we observed 'split floor' and polyphonic discussions, but never moments when nobody 'took the floor'. " All three of these components of discussion need to be defined.*

We have explained the use of 'split floor', 'take the floor' and 'polyphonic voices' as the reviewer has suggested.

. *"Professional back stage communication is included in the hidden curriculum of medical education, supports each group member and strengthens group affiliation." The second half of this sentence does not fit-do you need to take out "included in the hidden curriculum of medical education."*

We believe the 'hidden curriculum' is an important concept to understand how doctors and students learn. We have removed the second half of the sentence as the reviewer has proposed.

. *"While people talk to each other, they simultaneously carry out internal dialogues with themselves or others to position themselves in the discussion." - same comment as above on the internal dialogue with others-does this just require rewording?*

As discussed above, we accept that the concept of internal dialogues with others is not immediately comprehensible to the reader without exploring the topic in detail, and have changed the text.

. *"Some participants told about their own struggle with lifestyle" issues*

We are not sure about what the reviewer means by this remark.

. *The discussion almost exclusively references physicians and yet well over half of the participants are interns and residents. I would expect there might be differences in the dialogue of interns and residents compared to practicing physicians?*

We agree, but we believe that the study design is not adequate to compare the groups in a valid manner.

<u>Reviewer 2, Susanne Reventlow:</u>

The method section or in the introduction the authors could place descriptions of the concept used. See my comments later.

Generally the manuscript is well written and easy to read and I consider the subject of the paper very important. We need more knowledge from research about how doctors learn, reflect on their experiences and develop their clinical skills – here attending group sessions. I have a few comments to the study, which I hope the authors will consider in order to develop the paper a little more.

The study design is considered appropriate to answer the research question, and so are also the methods. Having six groups with 50 physicians constitute a good basis for the analysis. However, I miss some more descriptions of the central concept used, e.g. narrative and case stories – is it the same?

The reviewer calls for a description of the concepts used, e.g. narrative and case story. We have intended to use the concept 'case story' throughout the paper, as this is a concept that every doctor is familiar with. A description of a traditional case story is given in the introduction. We have searched the manuscript and a few places removed the concept 'narrative'. In most cases the two concepts may be used interchangeably. Narratives can be defined as stories with a teller, a listener, a time course, a plot, and a point (Charon, R. 2006. Narrative medicine: Honoring the Stories of Illness, Oxford University Press). Most case stories fulfill this definition, but narrative is a wider concept. In this paper, we intend to consistently use the concept 'case story', and have made some changes as a response to the reviewer's remarks.

The authors use systematic text condensation and an editing analysis style and focused in their analysis on interaction and process in the presentation and discussion of the case stories. I think this might be appropriate, but I wonder if a more structural analysis inspired by narrative analysis could have strengthen the analysis focusing on interaction and processes, language and different positions taken by the participants?

The reviewer states that systematic text condensation and an editing analysis style is appropriate, but also suggests that a more structural analysis inspired by narrative analysis could have been appropriate and maybe better. We agree that a narrative analysis also would have been an appropriate method in analysis, but have chosen to use systematic text condensation in this study.

I think the findings concern the interaction among the participants, but I first had difficulties to understand the order of how the results are presented, I think it is clear for me, but I think the authors could make it more clear by changing the headings or explain how they will present the results?

In the result section, we have made some changes of subheadings and the text intending to make the presentation clearer.

The discussion contributes with some interesting considerations concerning how groups share social knowledge and communication.

We appreciate that the reviewer consider the topic of this paper important, and that she finds that the discussion contributes with interesting considerations about social knowledge and communication.

We hope that the changes we have made have improved our manuscript, and that the paper may be of interest to the readers of BMJ Open.

Yours sincerely

Eirik Abildsnes

VERSION 2 – REVIEW

REVIEWER	Heather Armson MD MCE CCFP FCFP Associate Professor Department of Family Medicine University of Calgary I have no conflicts of interest to report.
REVIEW RETURNED	11-Jul-2012

GENERAL COMMENTS	The revised paper is much stronger and includes a clear, concise description of the methods and results both discussed within the context of the appropriate literature. The paper is an important contribution to the field as there are few examples in the literature of this type of detailed assessment of the content and process of physician interactions.