Article details: 2017-0160	
Title	The influence of patient-clinician ethnocultural and language concordance on continuity and quality of care: a cross-sectional analysis
Authors	Sina Waibel PhD MPH, Sabrina T. Wong PhD RN, Alan Katz MBChB MSc, Jean-Frederic Levesque PhD MD, Raji Nibber RN, Jeannie Haggerty PhD
Reviewer 1	Louanne Keenan
Institution	Division of Community Engagement, University of Alberta, Edmonton, Alta.
General comments (author response in bold)	The suggestions that are provided in the attachment are mostly related to the size of the Chinese and Punjabi populations in comparison with the "presumed English or French" populations. The use of percentages instead of actual numbers in the body of the article make it difficult to determine the value of the data. The significance is only evident because the OR numbers were in bold, but the actual statistical information was missing. Response: We have added clarification in the tables that bolded ORs are statistically significant, $p<0.05$. We calculated 95% confidence intervals which are informative of the precision of the ORs. It is difficult to draw accurate conclusions about how the data was analyzed when the reader is not given the initial population sizes, the statistical calculations, or how the researchers did their statistical analysis. Response: We provided a data analysis section in Methods; we state: "We conducted a series of logistic regression models were generated to examine the relationships between respondents' patient-clinician ethnocultural and language concordance and patient's ethnocultural group and: 1) continuity of care and 2) patient ratings of overall quality of care and empowerment." We discuss how the data were analysed, including the statistical program we used (RStudio). We have added a column in Table 2 that provides information on the total sample. Why did you call your Discussion section "Interpretation"? **We have revised to call this Discussion. The journal may want this changed back.** Are there any other papers written about the data other than the article about the BC data? There have been no other manuscripts written using these data. The manuscript you refer to here used a different dataset, though collected using the same methods and survey questionnaire. Attachment: Abstract It is strange to start the Results section with "except for" **This has been removed.** The introduction of Indigenous participants seems to come out of the blue; this population was not mentioned during the Introduction or Methods sections. **We have added to introduction and the methods section that patients self-identified their ethnocultural background including Indigenous.** Do you need to specify that participants were foreign-born? **In the results, first paragraph, we do state that though most participants were born in Canada (72%), these were mostly from the presumed European descent group. Chinese and South Asian groups had much higher numbers who were foreign born (see Table 2).** Present a summary of results for outcome measure "empowerment" as this was not mentioned in Results, and then is included in Interpretation with no context. **Our results suggest that empowerment was not associated with ethnocultural or language concordance. Given the limited word count, and other suggestions we needed to address, we keep the focus on the outcome that concordance was associated with, quality of care.** Were clients not asked about their background? Why is it "presumed" European descent? **We have revised throughout to state, European descent. As you point out, there is no need for the word presumed.** Introduction -any updated statistics on foreign-born Canadian population from 2016 census data? **The statistics and introduction have been revised** -participants in the current study do not appear to have been recruited for their "foreign-born" status, as is mentioned in the Abstract. What about Canadian-born individuals from this particular cultural groups? Not sure if you are directly equating language targeted with ethnicity/where the individual was born? **We have revised the introduction to increase clarity. We were interested in Canadians who are ethnoculturally and linguistically diverse.** -p. 3 line 20- people of non-European descent? **This has been revised as suggested** -p. 3 line 31- are all of these factors similar/equivalent in determining strength of concordance? **We have revised to provide the examples of only ethnicity and language to increase clarity and focus of the manuscript. You ask a good question, though, beyond the scope of this manuscript.** -p. 3 line 36- patients' satisfaction with overall care received? **This has been revised as suggested** -In paragraph one, you focus on strategies to overcome issues with concordance based on linguistic factors. What about the other three factors? Is there a literature on strategies here? If not, important to say so, and perhaps offer some options in the Discussion section **We have revised to suggest an example of issues with linguistic barriers. We have put a sentence in the discussion about the fact that more work needs to be done in the area of concordance, not just on ethnocultural and language but also on sex and age and important shared similarities between patient and clinician.**

Method
In the Introduction you focus on the literature for an Indigenous population; however, no mention of recruiting members of this group?
This is a secondary analysis of a cross-sectional survey that used random digit dialling. The survey was designed to examine patient experiences across three ethnic and language group (English, Chinese, Punjabi, French). It did not look to specifically recruit Indigenous people. When we created the ethnocultural background variable for this study, we recognized that an important number of the respondents self-reported Indigenous. Given that few studies on this topic look at the Indigenous population, we considered important to look at them separately.

P.9 line 10- were participants only recruited from metropolitan areas? Were certain area codes targeted? Very interested in this detail as likely to have more individuals in Winnipeg of Indigenous descent vs. in Vancouver?
In the methods, 2nd paragraph, we have added information on our random digit dialling methods. We were specifically trying to reach people who spoke Chinese and Punjabi. We know that most of our Indigenous participants came from Quebec (48.7%) and Manitoba (35.0%) followed by British Columbia (16.2%).

P. 9 line 22- no self-reported cognitive impairment? Physician diagnosis? Please specify
Cognitive impairment was assessed using four questions and a validated scoring method. This information was added in the paper in the data collection procedures section.

P. 9 lines 34-35- you now introduce an Indigenous group as part of your sample, not sure what language you were looking for with these individuals? Why are they not mentioned earlier in the Methods (e.g., p.9 line 5)
This was a secondary analysis. The original primary study objective was to gather patients' experiences in primary care across those who spoke English, French, Chinese and Punjabi. Thus, we were not "looking for" any particular ethnocultural group. The Indigenous group was not specifically recruited in the sampling process.

P. 9 to 10- the method for recording empowerment scores- is this based on the literature?
Why group "good" in with "fair" and "poor" (this was not done for self-rated health status)?
What was distribution of the data? Could you use a median split instead to create a dichotomous variable?
Empowerment was a patient reported impact of care, one of our outcome variables. For ease of interpretation, we conduct a series of logistic regressions. Therefore we had to dichotomize the empowerment score. Our method of where to dichotomize these variables is based past work using similar Likert scales.

P. 10 line 49- all models were adjusted for other patient experiences of care?
Yes, all models were adjusted for other patient experiences of care. A word was missing in this sentence, which was corrected.

Results
Any participants who began but did not complete phone survey? Any difference in completers vs. non-completers? There were actually more participants than what you report here, as in the data analysis section above you report that 28 were excluded. Perhaps best to describe 1) number contacted; 2) number excluded due to lack of connection to one of the four ethnocultural groups; 3) number who completed survey (flow chart?)
The random digit dialled survey was completed by a survey research company. We did not require, as part of their contract that they collect data on non-completers. For future studies we will ensure this information is collected. We have added a sentence to the limitations section.

P.11 line 15 answers my earlier question about studying foreign-born Canadians. If the majority of your participants were born in Canada, why are foreign-born Canadians the focus of your Introduction? Should you not comment instead on Canadian-born patients of the healthcare system who may speak other languages that English?
The second sentence of the introduction speaks to the fact that in Canada, much of the growth comes from immigrants. The focus of this study is on those who speak languages other than English or French—they are likely residents but immigrants to Canada. We have added a recent reference about the evolution of language in Canada, regardless of where they were born. In the results section we state, "Almost three quarters (72%) of participants were born in Canada, though there were much smaller percentages in the Chinese (5%) and South Asian (4%) groups."

Please provide subheadings and describe concordance separately first by your two factors of interest
We understand this to mean adding subheadings in the results section. We have made these revisions.

P.12 lines 34, 35- individuals of Chinese and Punjabi descent
We have kept the language consistent to be Chinese descent and South Asian descent. Punjabi is the language.

Interpretation
-In the Introduction, you talk about two other factors of concordance; age and sex. These are not discussed further. Either bring these factors into the discussion or explain in Introduction why the focus is on 2/4 factors that you describe, especially since the majority of participants not foreign-born.
We have revised the introduction to focus on ethnicity and language. We have added a sentence in the discussion that suggests more work is needed to examine concordance by age/sex in these ethnocultural groups. As stated above, while the majority of participants are not foreign-born most of those making up the Chinese and South Asian groups are foreign born.

-This section about how yours is the first such-work in Canada could be moved up to Introduction to provide background/importance of this work
We have a sentence in the introduction stating that no work has examined the relationship between concordance and continuity, etc.

-Is this past work in the US based on individuals born in the US or foreign-born?
The past work in the US is based on US born African Americans and mostly foreign-born Hispanics.

	-p. 13 line 12… this study adds what? **We have clarified this sentence.** -p.13 line 51- maybe reword as "in particular it is necessary to examine true differences…" **We have clarified this sentence** -p.14 line 1- please provide a "limitations" sub-heading **This sub-heading was added** -p.14 line 8- what additional items could have contributed? What is your evidence for this? **This has been revised.** -No mention at all in Interpretation section of the results for the Indigenous population. Given the current Canadian climate, would be particularly interesting to speak to issues with healthcare provision for this population. Where were they located? Rural or urban areas? Are they seeing physicians from their own cultural group or going to large cities for service? (if you do not have answers to these questions could pursue these as "future directions") **There were a total of 117 participants who identified as Indigenous. We do not have any of the data to answer your questions. However, you do point out that a separate, short piece would be of interest. We will further pursue this in the future.** -There is very little mention in this section about empowerment. Does this relate to selfefficacy? Does it differ by age group? Please provide more details about these data **This paper focuses on concordance and its relationship to continuity of care and patient reported impacts of care. Since there is no relationship between concordance and empowerment, we did not feel it warranted any statements in the discussion. We did add a sentence in the concluding paragraph about empowerment and quality of care. You also provide another idea for further analyses which we will pursue in the future.** Table 3- no need to repeat information in the title of this table, keep to patient experiences and patient-reported impacts **The title was revised.** -for this table, simply provide the percentages rather than counts and percentages **We carefully considered your feedback. However, in order to keep the tables consistent (tables 2 and 3), we kept both counts and percentages.** -interesting that in the note section you provide information about missing data. How were thee data treated in the models? Was any participant with missing data in any of the cells excluded? Need to discuss this more in Results. How many participants had a complete data set? You did mention missing sociodemographic data in the Methods section but need to address entire data set **We added more information about the missing data of the entire data set and how we treated them in the regression models to the methods section (data analysis).** -did not see specialist could be added as a "NA" row **We carefully considered this feedback. We believe it would be confusing to a reader to add this information to the already information dense table.**
Reviewer 2	Leah Douglas, MSW, PhD, RCSW
Institution	School of Social Work & Human Services, University of the Fraser Valley, Abbotsford, BC
General comments (author response in bold)	Dear authors, Thank you for the opportunity to review this interesting and relevant paper. I hope my comments are useful in strengthening or clarifying your report. My questions and comments follow. Some are minor editing points and others more conceptual; none prevent publication of your research report. In the abstract results section, you refer to Chinese and Punjabi. Do you mean Chinese speakers, or Chinese people, or…? Response: We created an "ethnocultural background" variable based on the patients' selected country of origin. We congregated the patients into four ethnocultural groups: European descent, Chinese, South Asian and Indigenous. Those four groups were used for analysis. In the introduction first sentence, do you mean "in 2011" not "by 2011"? The second implies the current year is prior to 2011. **This sentence has been revised.** In the introduction re. Indigenous populations in Canada, you don't mention the numerous distinct languages or what percentage of First Nations people speak a language other than English or French. This seems incomplete given the preceding information and focus of the paragraph, and would be useful context for the reader. **We have added a sentence to the first paragraph in the introduction to address this feedback.** Is there information available about the current ethnocultural make up and language capacities of physicians in Canada? If so, this data would help the reader understand if the profession is reflective of the population. **We searched for data in different Canadian databases (CIHI, CMA) and only found information of the country of MD graduation. This information was added to the first paragraph of the manuscript.** You state that concordance is a "shared identity", and "a characteristic", but I believe this is too narrow - people assess their similarity with others based on multiple factors, not one single characteristic. Acknowledging this is important. I would invite you to further consider how intersectionality (including the perception of socio-economic status or privilege, sexual orientation, etc.) might influence patients' perceptions of concordance with their physician. Near the end of the paper, you note that "that the patient-clinician relationship is strengthened when patients perceive a shared identity and commonalities with their clinician, such as personal beliefs, values, communication (8) and shared experiences." This context provided near the beginning of the paper would assist the reader in framing concordance. **A sentence was added to the concordance paragraph in the introduction. A paragraph in the discussion was added**

	to address this feedback. The limitations of random digit dialing (or phone surveys in general) should be clearly stated. Many people with health risks, and some who may be some of the most vulnerable, may be excluded (including those who are institutionalized, in prison, alcohol or drug treatment, living in areas without access to cell phones, or living in extreme poverty, etc.). **Two sentences were added to the limitation section.** How were some groups presumed to be of European descent? **This has now been changed throughout to European descent.** In the interpretation, implications for Indigenous people are markedly absent. Earlier you note that, "Except for Indigenous participants (48%), around two-thirds of respondents reported ethnocultural or language concordance", but no mention is made of why this is, or the (numerous, important) implications. **A paragraph was added in the discussion to reflect on the fact that even in discordant (ethnocultural and language) relationships, other similarities (e.g. interpersonal communication) are important. The implications for Indigenous people are beyond the scope of this paper. Your feedback is important and will be taken up in a different manuscript, with Indigenous partners to assist with the interpretation of what this means.**
Reviewer 3	Kate Dupuis
Institution	Department of Psychology, University of Toronto Mississauga, Mississauga, Ont.
General comments (author response in bold)	The topic of this paper is very intriguing; examining how features of healthcare providers and their patients interact to inform the provision of care is highly relevant to an ethnically diverse and geographically complex country such as Canada. However, there are some major points of clarification and data reinterpretation that are recommended. In particular, the Introduction of the paper suggests that the focus of the paper will be on foreign-born individuals, while the data show that the majority of participants were born in Canada, and there does not appear to be any further discussion of the influence of place of birth on the results. Response: In the first paragraph of the results section, we state: "Almost three quarters (72%) of participants were born in Canada, though there were much smaller percentages in the Chinese (5%) and Punjabi South Asian (4%) groups." Paragraph 3 in the discussion has been revised to respond to this feedback. In addition, although it appears that individuals from an Indigenous background will be of interest to the authors, very little information is provided about this group. Finally, the Introduction states there are four important factors to concordance, but the paper does not touch upon sex and age in any detailed way. Are there cultural differences in how sex influences concordance? What about the influence of a rapidly aging population on concordance based on age? If the average age of a physician in Canada is 50 years, and your sample went down to 19 years of age, how do younger patients perceive patient-client care? Repositioning the article in the Introduction will help inform the description of the results and the interpretation of your findings. **The introduction has been substantially revised to clarify the focus of the paper. The discussion has also been revised to suggest there are other characteristics (e.g. age and sex, etc) that need to be taken into account in future work.** STROBE Statement—checklist of items for observational studies Title Recommendation: To be consistent with the purpose of the study, the title should include the commonly used term (continuity of care) and the broader category of "impact of care": The influence of ethnocultural and language concordance between patients and primary care clinicians on continuity of care and impact of care: a cross-sectional analysis in three Canadian provinces **We included continuity and patient reported impacts of care in the title.** Introduction Background/rationale: The statement on P. 4 (line) "No work has examined the relationship between concordance, continuity of care or patient empowerment" cannot be correct because this is a secondary analysis and the questions were already set in the initial data collection. **The original primary study objective was to assess the reliability and validity of the items and scales used to measure patients' experiences in primary care. For this secondary analysis, we elaborated additional research questions, which are the ones that we address in this paper. We would also like to mention that there have been no other manuscripts written using the same data. The published article that we refer to in the manuscript (Wong et al. 2014) used a different dataset, though employed the same methods and survey questionnaire.** Methods Study design (p. 4, first paragraph of the Method section) There is inconsistency in the wording of the questions from the original source of the questionnaire in the reference 17, which is provided at the end of the following statement: "The development and validation of the questionnaire is reported elsewhere (17)." **The sentence was revised to reflect that the development and use of the questionnaire is reported elsewhere.** Considering that there were computer-assisted telephone interview, the script was standard and not open to interpretation or alteration by the researchers for the secondary analysis. **That is correct, and we discuss the fact that conducting these analyses are secondary as a limitation.** Setting (p. 4, first paragraph of the Method section) The period of recruitment is not included, nor the relevant dates at the different locations. **The recruitment period is now added.** Participants Cross-sectional study— (p. 4, last paragraph + p. 5, data collection procedure) The following also affects the readers understanding of the Bias: It may be worth adding in the information from the previous study about the 2 approaches to randomly selecting telephone numbers: 1) Oversampling oversampled telephone numbers in census dissemination areas where there was a high likelihood of

	speaking Chinese or Punjabi at home; and 2) oversampling Chinese and South Asian households where the listed surname for the telephone number matched the list of Chinese or South Asian surnames maintained by ASDE, which maintains the Canada Survey Sampler. **As suggested, this information has been added.** Variables The following is an awkward sentence: "Language concordance was defined as: the language most comfortably spoken by the patient being used always or usually the same as during the healthcare visit." (p. 5) **This sentence has been changed to: "Language concordance was defined as: the language most comfortably spoken by the patient is the same as the one that is also being used during the healthcare visit."** Data sources/measurement P. 6 (~ line 50-52): "All models were adjusted other patient experiences of care (first contact accessibility, interpersonal communication). This is a confusing sentence. **A word was missing in this sentence, which was corrected.** The Measures did not include what was in the previous study concerning the measure of consumer confidence, even though confidence is a major consideration the introduction section. In the original study, the dependent variable of interest was patients' reports of their confidence in PHC: "On a scale of 0–10, where 0 means no confidence at all and 10 means total confidence, how much confidence do you have in the ability to get the primary health care services you need?" **Correct, we did not use confidence as a measure in this manuscript. We deleted a sentence about confidence in the introduction section.** Study size: Explain how the study size was arrived at: The development of questionnaire is reported elsewhere, see reference 17). However, this was just for the BC portion of the study, not an explanation of the other provinces that were included in this study, which accounts for the difference in the study population from 1211 participants in the BC study and 3156 in this "secondary analysis". **The sample size calculation is not meaningful to this secondary analysis. The sample size calculation was done for a different purpose. However, we do provide 95% confidence intervals so that a reader would be able to ascertain whether a type I error was made (e.g. not having sufficient sample size).** Quantitative variables: (pp. 5-6, measures + Table 1) Were the individuals that spoke an Indigenous language given the opportunity to have their survey in their Indigenous language? **No, the original study was not designed to have interviewers be available in any language except English, Chinese (Mandarin or Cantonese), Punjabi, or French. The survey was designed to examine patient experiences across three ethnic and language group (English, Chinese, Punjabi, French). It did not look to specifically recruit Indigenous people, thus we did not develop and validate a questionnaire in an Indigenous language. When we created the ethnocultural background variable for this study, we recognized that an important number of the respondents self-reported Indigenous. Given that few studies on this topic look at the Indigenous population, we considered important to look at them separately.** Statistical methods: Describe all statistical methods, examine subgroups and interactions; and missing data **More information on the abovementioned statistical methods was added in the data analysis section.** The last paragraph on p.7 does not use actual figures, but rather used words like "most" or less precise amounts ("almost 1 in 4; Three-quarters). Since this is a quantitative study with numerical data, the authors could use actual data, not estimations. **As suggested, we changed some of the words that we used to numerical data, or added them to the text.** Cross-sectional study Concerning the method for selecting individuals that did not speak English or French and only spoke Mandarin, Cantonese or Punjabi (the 5 choices for the set telephone questionnaires): there could still be ethno-cultural discordance with newcomers that could speak English or French, but they may have been included in the wrong category. Also, there could be fear on the part of those who only spoke a foreign language to answer a survey on the phone. **We might not have been totally clear in the previous version of the manuscript how we created the ethnocultural variable. The patient's ethnocultural background was self-reported and was independent from his or her language spoken during data collection. We now explain this better in the methods section.** **We agree that there are a number of limitations when using telephone questionnaires, e.g. the use of telephone surveys is limited to those who have a telephone and chose to answer their phone. Random digit dialling methods will exclude those not living in the community. We now highlight a few more limitations when using telephone questionnaires in the limitations section.** Results Participants (a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analyzed (p. 7, first paragraph; this is a secondary analysis of the data and all the response data (e.g. nonparticipation) is reported elsewhere, please see reference 17) Response: We report non-response and cooperation rates. We do not have specific information on confirmed eligible, etc. Information was added to the limitations section that there could have been bias added given that there are people whom we could not reach (e.g. did not have a landline) or those who refused to answer the survey. The socio-demographic characteristics by concordance group are deceiving because they are percentages of the total population for each group. The issue is that there are "Almost three quarters (72%) of participants were born in Canada, though there were much smaller percentages in the Chinese (5%) and Punjabi (4%) groups." It is much easier for the reader to determine the value of the statements when the actual numbers are provided, not a percentage of a number that is never revealed. **The focus of this manuscript is on the language and ethnic concordance. It is likely our own biases that make us think the socio-demographic characteristics are deceiving. We are used to quick sound bites of information and need more time to process complex information. Table two does show that the number of those with**

	ethnic/language concordance drops to 63% when examined by "born in Canada". **In a previous version of the manuscript we showed the socio-demographic characteristics by ethnocultural groups; however we then changed it to concordance group given the focus of the paper. Information presented in both tables is relevant, but to adjust to the table limitation of the journal we decided to show actual number and percentages of socio-demographic characteristics by concordance group in the table and give the most relevant information of socio-demographic characteristics by ethnocultural group in the text.** There is not information that indicates the actual number of people that identified as Chinese, Punjabi, Indigenous, English, French, which would have been easy to determine by reporting how many in each of these categories was provided the survey in each of the 5 languages (Mandarin, Cantonese, Punjabi, English and French). Using the percentages in table 2, Punjabi speaking participants seems to be approx. 350 individuals and the Chinese population seems to be between 310 and 326. In comparison with the 2358 that are presumed to be of European decent because they answered the phone in English or French, it is difficult to make accurate predictions about these populations. **We have added a column in Table 2 that provides information on the total sample, including the total sample of each ethnocultural group.** (b) Give reasons for non-participation at each stage There are no reasons provided for the individuals that were phoned and did not want to participate, or who did not answer all the questions. **Reasons for non-response are provided in the results section.** Terms such as "Around two-thirds" is not scientific terminology: "Except for Indigenous participants (48%), around two-thirds of respondents reported ethnocultural or language concordance." **This sentence has been changed to: "Except for Indigenous participants (48%), over 64% of respondents reported ethnocultural or language concordance."** The following percentage does not make sense: "The percentage of those reporting both ethnocultural and language concordance decreases to 54% for both Chinese and Punjabi compared to those of presumed European descent (63%)." **This sentence was changed to: "The percentages of those reporting both ethnocultural and language concordance decreased to 54% for both Chinese and South Asian, and to 63% for participants with European descent."** There is no significance to the statistical findings, only percentages in what appears to be very small numbers in the Chinese, Punjabi and Indigenous categories. **This is correct. The manuscript focuses on concordance, not ethnicity. The analysis of the sociodemographic characteristics of participants was purely descriptive in nature and not analytical. We consider that the participation of 329 Chinese, 352 South Asian and 117 Indigenous in the survey is a relatively high number and sufficient to identify significant differences and associations in the models that we employed.** The question that is quoted in this study in Table 1 for the Relationship Continuity is as follows: "Thinking of the past 12 months, when you went to see your regular doctor, how often were you taken care of by the same doctor? (Always, usually, sometimes, rarely, never"; "How would you rate your regular doctor's knowledge of your entire medical history? (Excellent, very good, good, fair, poor) In the original questionnaire the questions were different: 1) "How long have you been seeing this same doctor or going to the same place? (0–3, 4–9 months, 1 year (10–18 months), 2, 3–5, 6 years or more) **All of the three questions were part of the survey but they measure different aspects of relational continuity. The two questions that we used refer to "concentrated care with regular provider" (also called "consistency of care" in the literature) and "accumulated knowledge". The last question analyses longitudinal care. All of them relate to relational continuity but we picked the first two because they are representative of the dimensions as used in the framework by Reid et al., which is the one that we applied in this study.** The Interpersonal question in Table 1 was, "How often did your regular doctor seem informed and up-to date about the care you received from any specialist doctors? (Always, usually, sometimes, rarely, never) However, in the original study the questions were as follows: 1) In the past 12 months how often did your doctor speak too fast?" 2) "How often did your doctor use words that were hard to understand? (never, rarely, sometimes, usually, always; scale reversed so higher score is better)" 3) How often did doctors explain your test results such as blood tests, X-rays or cancer screening tests? 4)" How often did doctors clearly explain the results of your physical examination? (never, rarely, sometimes, usually, always)" Even though there was reference to the issues such as the doctor speaking too fast, and the tests not being explained to the patient, these were not included in the Table 1. Why is there a discrepancy? **The question that we used measures information transfer across care levels, which is consistent with Reid et al.'s framework to analyse informational continuity. The three other questions mentioned above do not analyse information transfer across care levels but interpersonal communication. We were specifically examining continuity of care in this manuscript.** Discussion (called Interpretation) The limitations and lack of generalizability were present in the final interpretation. There were a lot of references to the previous studies. The limitations were explained. Minimal generalizability because of the small population sizes for the Chinese and Punjabi populations. Why was the Aboriginal population ignored? **We have added a paragraph in the discussion section. Importantly, no interpretation of the Indigenous findings can be appropriately interpreted without further work. As noted in a response to a different reviewer, we will be working on a specific Indigenous manuscript once we have the right team members in place in order to honor their reported experiences with the appropriate interpretation.**

	Interpretation: With the small populations of Chinese and Punjabi participants, it is not clear that this study "adds by further substantiating that the patient-clinician relationship is strengthened when patients perceive a shared identity and commonalities with their clinician, such as personal beliefs, values, communication (8) and shared experiences. (p. 9) **This study is the first in Canada and has the largest sample size to examine patient-clinician concordance. We suggest our results can add to a growing body of work about the importance of continuity of care. The sample size of Chinese and Punjabi participants was sufficient to calculate logistic regression and OR, as evidenced by the 95% CIs.**