Author's response to reviews

Title: On the other side of the stethoscope: Results of a Delphi process to identify patient behaviors that could enhance communication in medical encounters

Authors:

Jaya K Rao (jayarao@unc.edu)
Lynda A Anderson (lala0@cdc.gov)
Bhuvana Sukumar (bhuvana.sukumar@macrointernational.com)
Danielle A Beauchesne (Danielle.A.Beauchesne@macrointernational.com)
Terry Stein (terry.stein@kp.org)
Richard M Frankel (rfrankel@iupui.edu)

Version: 3 Date: 13 October 2009

Author's response to reviews: see over
October 12, 2009

Melissa Norton, MD
Editor in Chief
BMC Health Services Research

Re: Manuscript #1493763479281874

Dear Dr. Norton,

We are delighted by your interest in our manuscript entitled, “On the other side of the stethoscope: Results of a Delphi process to identify patient behaviors that impact communication in medical encounters.” My co-authors and I have carefully reviewed and discussed the comments of the 2 peer-reviewers. In this letter, we describe our response to the reviewers’ comments and indicate where we have made changes to the manuscript.

**Reviewer #1 (Karen Cleaver)**

*Minor essential revisions*

1) Please provide more information on the sample. For example, were only internists involved? The description of the sample should be less US-centric. Define “health care scientist” and “physician assistant” as these terms may not be understood by an international readership.

In the first paragraph of the results, we now describe the characteristics of the experts who were invited to participate in the project, and those who agreed to participate, or declined or did not respond to the invitation. In the second paragraph of the results, we describe the experts who did not respond to the first round of rating (which precluded further involvement). For the non-physician experts with doctoral degrees (i.e., health scientists), we describe their training background (i.e., psychology, public health, etc.). Finally, we include a definition of the term, “physician assistant” in the first paragraph of the results.

2) It is difficult to track the number of participants across the different rounds and their backgrounds. Please provide the background for the 18 participants who responded to the initial round and how they differed from the 23 who initially agreed to participate.

As stated in our response to #1, we now provide information on the backgrounds of the experts’ throughout the entire Delphi process. In compiling the information necessary to address this comment, we found that 17 experts responded to round 1 (not 18, as reported in the original version). The current version contains the correct number of participants (and background) for all rounds.
In the original version of the paper, we provided the response rate to rounds 2, 3 and 4 as the final sentence of paragraph 2 in the results section. In the revised version, the response rate is included with the paragraphs describing the rating information for each round (last sentence of paragraphs 4, 5, and 6). Round 2 had a 100% response rate. Rounds 3 and 4 had 94% response rate (1 non-respondent each), and we provide information on the 2 people (both internists) who did not respond to these rounds.

b) It would be helpful to highlight Table 3 as the definitive table that lists the consensus behaviors and the original behaviors. Table 2 does not have column 5 as indicated in the text.

Table 3 is now “Table 4” due to another suggestion from this reviewer (see response to the next item), and we now highlight this as the definitive table. This statement is at the end of the last paragraph of the results section. Regarding the second comment, we have included the column headers when referring to information in Table 2 (now ‘Table 3’). Column 5 of Table 3 provides the “final results” after 3 rounds of rating.

**Discretionary suggestions for revision**

1) It would be helpful to include a Table that describes the original Four Habits Model.

We appreciate this suggestion and added a Table which describes the original Four Habits Model (new Table 1). Because the original model also includes non-verbal communication behaviors, and our project focused on verbal communication only, the panel members were provided with a slightly modified version of the Model that included physician verbal communication behaviors. This statement is made in the methods section (page 7, paragraph 1, sentence 3).

2) The title could be modified to indicate that the study identifies patient behaviors that could “positively enhance” communication in medical encounters. The term “impact” can also indicate an adverse effect.

We agree with the reviewer and made this change. The revised title is: “On the other side of the stethoscope: Results of a Delphi process to identify patient behaviors that could enhance communication in medical encounters.”

3) Consider adding an explicit research question to the introduction. Table 2 is in landscape form and should be changed to portrait.

We added the research question to the introduction (last paragraph, sentence 3). The format of Table 2 (now Table 3) was changed from landscape to portrait.

4) The consensus behaviors assume an articulate, confident patient, with patients and physicians sharing the same values with respect to the patient’s health. The authors should explore the extent to which the original Four Habits Model and the consensus
behaviors is applicable to other types of patients (i.e., patients who are unable or unwilling to participate in the encounter or behave in the “preferred way” such as pediatric or psychiatric patients). Similarly, issues with respect to gender and the physician-patient interaction have not been addressed in the discussion—the authors may want to consider whether the Four Habits Model addresses issues in relation to physician gender and patient gender.

There may be a misunderstanding about the Four Habits Model and its generalizability to various situations. The original Four Habits Model describes a basic set of physician communication behaviors for the clinical encounter. The underlying evidence for the model came from studies conducted in primary care with adult patients and expert opinion, such the Kalamazoo consensus statement. Thus, the original Four Habits Model and, by extension, the patient behaviors derived from our consensus process may not be applicable to settings such as psychiatric clinic or pediatric clinic and also may not reflect the potential differences in communication style due to the gender or ethnic background of physicians and/or patients. We discuss this issue as a potential limitation, and encourage further work to adapt the original Model and our additions to these particular situations (Discussion, page 15, paragraph 1, “Third, it is important to note…”).

5) The limitations are identified but not highlighted as such. The failure to include patients is a significant limitation.

The paper now includes a sentence that clearly introduces the discussion about the study’s limitations (Discussion, page 14, paragraph 2, sentence 1). Regarding the second comment, we had several reasons for choosing to focus on professionals first, which we did not clearly explain in the original version. Our goal was to identify measurable communication behaviors for an overarching framework. We believed that experts would be familiar with this literature and could help to generate a list of patient behaviors efficiently. We also believed that having this list was a necessary step for guiding our subsequent work with patients. We agree with the reviewer that the model should be validated with patients as the next step. Among the potential populations to include in this process are patients with different demographic characteristics, those who are vulnerable (e.g., limited health literacy), and patients with varying degrees of comorbidity. Conducting an extensive series of validation studies with patients was beyond the scope of our resources but is something we plan to pursue. We more completely describe our rationale for focusing on professionals and provide suggestions for future work with patients in the last 2 paragraphs of the discussion (pages 15 and 16).
Reviewer #2 (Trisha Greenhalgh)

1) The outcome of a Delphi method depends heavily on the make-up of the expert panel, and this study did not include patients, which is a limitation.

   In the revised version, we have provided more information on the background of the (see response to reviewer 1, essential revision, item #1) and addressed the comment about not including patients (see response to reviewer 1, discretionary comment #5).

2) The experts selected were all known to the research team, and the evidence which they were sent included the Four Habits model. There is a much wider literature from critical sociology (e.g. the work of Eliott Mishler on the Voice of Medicine versus the Voice of the Lifeworld) which suggests that ‘what gets said’ in the consultation can’t be taken at face value because of complex and often dramatic power imbalances between physician and patient (and more broadly, between the ‘system’ and the individual). The work presented is entirely coherent within its paradigm, but it rests on the assumption that the main task in improving communication is to identify “good habits” and ensure that docs and patients both adopt such habits. This for me is sociologically naïve, especially when considering consultations with ‘hard-to-reach’ (disempowered, socially excluded) groups. I’d like the discussion to engage a bit more with the more radical critiques of the “habits” literature and consider what different recommendations might have been made had the “expert panel” included the likes of Mishler as well as people who were already signed up to the key assumptions of the model that was distributed. At the very least I suggest that omission of the claim to having developed a “holistic model” of communication should be a condition for acceptance of the paper.

   We addressed some of these points (i.e., background of the expert panel, vulnerable populations) in our response to reviewer 1’s comments (essential revision 1 & 2; discretionary comment 5). However, we would like to respond to 3 other issues raised by the reviewer and provide clarification.

The first statement implies that our research team knew all of the experts, and that was not the case. The experts were selected based on their involvement in communication research or education. We did not personally know several participants, but were familiar with their work. The comments also give the impression that the experts have an ‘ivory tower’ view of communication, and that the group included only physicians. All of the experts have spent many years trying to enhance the patients’ experience of health care, and it should be noted that the panel was not comprised of only physicians. Indeed, 7 behavioral scientists participated in this process. The fact that the group eliminated some behaviors as impractical for the typical patient attests to their interest in the patient’s perspective. We include this information in the text of the discussion (page 15, paragraph 2).
Dr. Greenhalgh’s comments also mention the work of Eliott Mishler in the context of power imbalances between patients and physicians. It has been our observation that much of the recent emphasis in communication research has been on improving physicians’ communication skills. Indeed, during the review process for our 2007 literature review of patient and physician communication interventions, one reviewer for a communication journal said that s/he “didn’t understand the need for examining patient interventions since intervening on physicians has a greater impact and is more cost-effective.” Therefore, in essence, we agree with Dr. Greenhalgh that physicians have been dominating the conversation in patient-physician communication research. This consensus process is our attempt to bring the patient’s “voice” to patient-physician communication. To that end, we have made a number of revisions to provide a more balanced view of the Four Habits Model, and our goal of adding the patient’s voice to this model. Changes were made to the abstract (introduction, conclusion), the introduction (final paragraph) and conclusion.

Finally, we removed the reference to “holistic” model of communication (abstract, conclusion of original) and now refer to an “overarching” model of communication.

3) The reviewer believes that it is conventional not to express as percentages, proportions where the denominator is substantially lower than 100. For example, (the reviewer) would prefer 10 out of 20 instead of 50% throughout the paper.

We are not aware of this convention. Because we made decisions for each round of rating based on percentages (e.g., 70% agreement to retain), we thought it was important to provide this information rather than having readers calculate the percentages for themselves. The raw numbers (x of y) and percentages are provided in Table 3 (rating data by round), as was the case in the original version of the paper. In addition, we now include information on what some of the percentages mean in terms of the number of experts (i.e., 70% of 17 experts meant 12 or more votes). This information is provided in the results (see paragraphs related to rounds 2, 3, 4, pages 10-11).

We thank both reviewers for their comments and suggestions. We believe that the revisions have significantly improved the paper’s content. The paper has been formatted to confirm to the Journal’s guidelines. If there are any questions or concerns regarding this paper, please do not hesitate to contact me. We appreciate your consideration of this revised manuscript and look forward to hearing from you.

Sincerely,

/s/
Jaya K. Rao, MD, MHS (corresponding author)
UNC Eshelman School of Pharmacy
2202 Kerr Hall, CB 7573
Chapel Hill, NC 27517 [919-962-4334 (P); 919-966-8486 (F); jayarao@unc.edu]