Author's response to reviews

Title: Identifying context factors explaining physician's low performance on communication assessment: an explorative study in general practice

Authors:

Geurt TJM Essers (g.essers@elg.umcn.nl)
Sandra van Dulmen (S.vanDulmen@nivel.nl)
Chris van Weel (C.vanWeel@elg.umcn.nl)
Cees van der Vleuten (C.vanderVleuten@maastrichtuniversity.nl)
Anneke Kramer (a.kramer@elg.umcn.nl)

Version: 3 Date: 13 October 2011

Author's response to reviews: see over
Reviewer's report
Title: Identifying context factors explaining physician’s communication behaviour: an explorative study in general practice
Version: 2 Date: 8 August 2011
Reviewer: Marcel Reinders
Reviewer's report:

Major compulsory revisions
1. The authors have analyzed 17 consultations of GPs in order to identify contextual factors of communication skills. This seems to be a very interesting area for research and made me very eager to know what these factors are and how to handle these. The first two paragraphs of the Background however seem to discuss the problem of transferring that what is learned in the vocational training to daily practice, which is of course also very relevant, but is not the subject here. Therefore I would suggest starting the Background with the third paragraph “in the past few years …”, which sounds very relevant to me.

Re: This suggestion is taken up and the paragraph has been changed accordingly. The text of the first paragraph is now (p. 3): Communication is a key competence for health care professionals. In the past few years, several researchers have pointed out that context factors on different levels influence communication in health care [1-4]. Context factors range from a micro-level (patient and doctor characteristics) to meso- and macro-levels (organizational and societal features). According to Durning et al. [5] “context (1) comprises interacting factors that add to the meaning of something that exists or occurs in an environment, and (2) allows for change in that meaning as information is added over time.” This definition points to the wide variability within consultations and the dynamic environment in which communication has to take place. In the assessment of communication skills, these factors have been mentioned as possibly interacting in the communication process, but so far no empirical analysis of how to take these factors into account has been made [6].

Re: We have made some changes in the Background section, but have decided not to take up the reviewer’s suggestion to start with the third paragraph. We have tried to change the section according to the suggestion, but it did not work out the way it was intended.

To start off the article by a statement on what we came up with, does not do justice to the process and logic of the study. We started off from the problem of low scores on GP and GP registrar communication performances. The original sequence of paragraphs depicts best the logic of the steps we took. This logic also takes the reader by the hand, from the problem we encountered to the things we went looking for to clarify why this problem exists.

However, the reviewer’s comments led us to slightly change the title of the manuscript, into:

Identifying context factors explaining physician’s low performance in communication assessment. An explorative study in general practice.

We also made changes in the second paragraph. The text now reads:
Various explanations have been given for the low scores on communication skills. Firstly, it has been contended that the transfer is hampered by the separation of training and practice [15,16]. There is evidence that communication training programmes, that are aligned to daily practice, have
resulted in more and long term positive effects [17,18]. Secondly, a number of authors have pointed at the generic nature of communication guidelines and instruments that are used to assess professionals’ performance. The assumption that communication skills are generic and can be assessed as such may be unjustified [19-22]. As a consequence, however, all consultations are treated as if they were the same, whereas, in daily practice, GPs constantly need to adjust their approach to the individual person presenting with a specific problem.

This also applies to the Abstract/Background, in which there seems to lack a logical step from sentence 2 to sentence 3 “although communication skills …”. Unless the authors want to make a point that communication do yield much improvement to communication skills, and it is just because we are observing with the wrong materials, that we are measuring otherwise, I tend to struggle with this opening paragraph.

Re: The opening paragraph in the Abstract has been changed in order to satisfy the reviewer’s comment. The text “Communication skills training programmes, generally, yield limited improvement. Although communication skills are mostly treated as generic skills, the context of daily practice may require different skills or specific ways of handling these generic skills” has been deleted and replaced by: “Communication is a key competence for health care professionals. Analysis of registrar and GP performance in daily practice suggests a suboptimal application of communication skills. The influence of context factors could reveal why GP communication performance levels, on average, do not appear adequate. The context of daily practice may require different skills or specific ways of handling these skills, whereas communication skills are mostly treated as generic. So far no empirical analysis of these context factors has been made. Our aim was to identify context factors that could be related to GP communication.”

2. The presentation of the results could be improved by structuring with subheadings. Now each paragraph ends with the conclusions of the discussion group, which represents the procedure in time sequence, but is difficult to follow.

Re: The Results section already is structured into subheadings (doctor-related, patient-related, and consultation-related factors, and the interaction between these factors). Because of the qualitative nature of the study, the results need some elaboration on the way they were reached. A few changes have been made in order to systematically follow and clarify the steps that were taken: observation – relation to recommendation – conclusion. This led to changes in the first paragraph on page 9: “Also specific aspects of the presented problem were inferred as consultation-related factors. In dealing with complaints that were easily solved (e.g. removing cerumen or a suture), we saw the GP not going into emotions. We inferred that, as these complaints usually have little emotional impact, there is no need for the GP to discuss emotions. Also problems needing urgent help were considered a context factor, as they usually lead to direct action. In one consultation we observed a patient probably having suffered a TIA, for which the GP took action without exploring patients request for help. On the other hand, with a patient who presented problems in coping with her divorce, and problems with her son, we saw the GP expressing much empathy and
discussing patients feelings, but also losing the structure in the consultation. From this we considered psychosocial problems to be a context factor too.”

Please check that all items in Table 3 are also discussed in the Results (which is not the case now).

Re: We added some text to accommodate this comment. Page 6, last sentence of first paragraph under ‘Doctor-related context factors’: “We considered the GP’s knowledge of the patient and knowledge of the way the patient communicates to be influential context factors.”

Under ‘Patient-related context factors’ on page 8, a fourth paragraph was added: “Furthermore, we observed consultations in which the GP and the patient discussed the management of a health problem, but no history taking was seen. From this we concluded that the health problem was known to both of them. And from the observation of a patient who started to roll up his sleeve for his blood pressure check-up, without any prior instructions from the GP, we inferred that he must have been familiar with the procedure. Thus, we considered the patient’s familiarity with the PE a context factor as well.”

3. Please explain if saturation was reached and how. My first impression was that observing a sample of 17 consultations was probably not much, but elaborating on how saturation was achieved, might be helpful to convince the reader. Unfortunately, a lengthy paragraph in the Discussion mentioned that indeed there might be more factors to be found, if more samples were taken. Please explain, whether the achieved saturation is likely or not. I would suggest to look at the existing literature, and compare if items were still missing that others may have found indeed.

Re: We state that saturation was reached after 17 consultations, because we did not find any new context factor in the last five consultations. In the literature on qualitative research, saturation is reached if, in 5 consecutive cases, no new information is found (Glaser & Strauss, 1967). A number of 15-20 observations is seen as being enough to reach saturation (ref. Marshall, MN. Sampling for qualitative research. Family Practice 1996; 13: 522-525; Guest et al. How many interviews are enough? An experiment with data saturation and variability. Field Methods 2006; 18: 59-82). The number of 17 consultations we found, seems to fall within acceptable limits for saturation to be reached.

In the Discussion section (p. 12), we added a paragraph with the following text: “We reached saturation after 17 consultations, because we did not find any new context factor in the last 5 consultations we observed, which is used as a criterion. Also in other explorative, qualitative research, the number of 17 consultations seems to fall within acceptable limits for saturation to be reached.”

However, we do not pretend to have found all possible context factors influencing communication in GP consultations. On theoretical grounds, more context factors can be discerned. Some of these can only be found through other research methods (e.g. Veldhuijzen et al.). Our aim was to find an explanation for low scores by looking for context factors influencing communication behaviour through observing videotaped GP consultations. The method we used can be seen as a limitation of our study. We have mentioned this in the revised version accordingly. On p.11: “In this study we identified context factors acting on a micro-level, but we did not continue our
analysis to context factors acting at meso- or macro-levels (organizational, demographical, political), that may have played a role [1]. (...) In the method we used we only focused on the micro-level. "And on p. 16: "The method that we used is a limitation of this study as it allowed us to find context factors at a micro-level, but not at other levels. Different methods may reveal more context factors."

4. At numerous occasions, the authors refer to what is (page 4): criteria from formal training, recommended skills, generic communication standards, criteria taught; state of the art (abstract),....... I am afraid that from these remarks the readers are given a false idea that these criteria really exists, while in reality communication might not be captured in uniform criteria. So, probably there is no gold standard with which deviations can be found (conclusion). Otherwise, if the authors do have a clear idea of what this standard is, please explain.

Re: We do not mean to say that there is a gold standard. Yet, in the study by Hobma et al. (2004), standards are set for ‘adequate communication’ by general practitioners. Furthermore, recommendations can be derived from the goals of communication training programmes and can be seen as the ‘state of the art’ communication, although it is never indicated when to apply the skills and when not. We have decided to only use the word ‘recommendation’ in the revised article, if appropriate, in the same definition as Veldhuijzen (2007) does: "all documents containing (more or less) evidence based recommendations for doctor patient communication, even when another designation is used in the document itself." The text has been changed into (p. 4): "If it is true that the context is a determining factor for the actual communication GPs display, this will lead to deviations from recommendations on communication, as captured in assessment instruments [21]."

5. The authors have focused on low scores on the Maas-Global instrument, which they used to discuss whether these were real flaws or that these could be justified by contextual factors. This looks very relevant to me, but as it is, it also seems like a validation study of the MAAS-Global Instrument to me. Although in the Discussion page 13 this is mentioned (‘update of the MAAS’), in the Background’ section this could be brought forward already as well.

Re: We pondered to mention the question of validity, but decided not to as the MAAS-Global is put forward as an example of a way of thinking about assessing communication. We just used it as a frame of reference for observing communication. We did not mean to question the MAAS-Global instrument. Furthermore, this study is not a validation study, although it can become a reason for a validation study. Therefore, it does not seem appropriate to mention it in the Background section. No changes have been made there, but in order to legitimize the remarks in the Discussion section, we changed the last paragraph in the Results (p. 9): “Finally, the number of persons present influenced the communication process. In these cases we saw the GP strive to divide their attention to those present and to involve everyone in the consultation process according to their role. This communication behaviour is not mentioned in the MAAS-Global.”

6. Could the authors suggest in the Discussion section what the precise consequences of the relevant contextual factors are for the vocational training of the GPs, because this seems to be lacking.
Re: We changed the last paragraph in the Discussion section to satisfy this comment: “Our findings may have implications for communication programmes in the GP specialty training. From what we found, it seems that the way generic communication assessment instruments are used does not suffice to justly assess communication performance in general practice. Moreover, training programmes should be organized around different types of consultations and take into account that patients can be treated by other providers and know what is coming. The focus should be on the flexibility and creativity with which future GPs handle their communication skills.” (p.12).

Discretionary revisions
Re: We deleted in the abstract “presenting highly prevalent health problems in primary care” (p.2), and used the word ‘consultations’ instead of ‘visits’ (p.2).

8. Page 3. Last paragraph: ‘From this we hypothesize…’. To me it is not clear how the authors come to this hypothesis.
Re: We deleted this sentence and changed it into (p.4, first paragraph): “If it is true that the context is a determining factor for the actual communication GPs display, this will lead to deviations from the recommendations on communication, as captured in assessment instruments”.

Re: This sentence has been deleted.

10. Page 4. last sentence: This sentence is a bit awkward; when (if), whether…. 
Re: The sentence has been altered and now is (p.4): “And, if this occurs, whether it can be explained or justified by a particular context factor”.

11. Page 5. first sentence: Reality of GPs: what does that mean?
Re: This sentence has been deleted.

12. Page 5. first sentence: I am not sure if ‘daily practice’ can be used as ‘daily general practice’.
Re: As we focused our study specifically on general practice, we refer to ‘daily general practice consultations’ in this sentence.

Re: It means that the MAAS-Global, as a framework for observing medical communication, is widely used in the Netherlands. In addition, the MAAS-Global has been developed in accordance with the larger framework of the Calgary-Cambridge Guide for communication, that is used in many countries (see p. 2 of the MAAS-Global Manual).
However, we deleted the sentence as it was. The text is now: “We used the MAAS-Global as the generic communication skills framework for our observations. The MAAS-Global is a validated observation and assessment instrument, that serves as a guideline for patient-centred medical communication [23]. It is
widely used in undergraduate medical and GP specialty training in the Netherlands” (p.5)

14. Page 6. line 3: I am not sure if the Maas Global is used to guide patient centered communication, but the authors of course may be right here.
Re: The MAAS-Global is at least intended to do so. In addition to the above mentioned reference, one of the authors has written some short articles a few years ago (2005-2006) in the Dutch Journal of General Practitioners (Huisarts en Wetenschap) to explain in what way the content of the items on communication skills in the MAAS-Global is based on the literature on doctor patient communication. Although a specific referral to patient centredness is lacking, in the MAAS-Global Manual various references to literature incorporating patient centred communication are given (Bensing, Silverman, de Haes). No changes have been made.

15. Page 6. first paragraph: I am not sure if the readers all know what behaviour indicators are, when we are talking of communication skills. Please explain what behavior indicators are.
Re: By ‘behaviour indicators’ we mean the concrete doctor behaviour that can be regarded as an indication for the communication skill that is intended in the item. For clarity purposes, we have changed the sentence into (p.5): “Each item has three or four sub-items referring to criterion behaviour”. The words ‘criterion’ and ‘behaviour’ are mentioned as such in the MAAS-Global Manual.

16. Page 7. Results, first sentence. I guess deviations in communication skills are actually low scores on the MAAS, please say so.
Re: The sentence has been changed into: “We found 19 context factors in GP consultations that could be related to low scores on the MAAS-Global.” (p.6).

17. Page 7. Doctor related factors: First sentence; ….or referring… is awkward.
Re: We recognize the problem and have adjusted the sentence into: “In 14 of the 17 consultations we observed the patient and GP discussing the patient’s social and/or family circumstances (e.g. a patient who had recently had to move to a smaller house; a patient who has a partner with a serious health condition), or referring to prior contacts (e.g. a consultation with a child that was very taciturn and difficult to engage).” (p.6).

18. Page 7. third paragraph: a related factor is a related contextual factor I suppose.
Re: For clarity we changed it into ‘a related context factor’ in this sentence.

19. Page7 last sentence: I guess this is a bit obvious isn’t it, but if it was not always observed, what could be the explanation for that?, otherwise delete.
Re: The sentence has been deleted.

20. Page 8. A First sentence… this sentence opens a bit awkward, perhaps it should be rewritten.
Re: The first two sentences have been rewritten and changed into: “We observed patients who, at the beginning of the consultation, unsolicited, detailed and clearly, stated their health problem and related needs, preferences and expectations. The GP’s response in these cases was restricted to a few
additional clarifications or a very short history taking prior to proceeding to the physical examination (PE).” (p.7).

21. Page 9. Second paragraph: These consultations….The latter? No (see new text); and, excuse me for not knowing, what are single consultations? 
Re: Although there is no accepted definition of ‘single consultation’, we used the term to indicate what is described in the MAAS-Global Manual (p.3) as ‘the consultation that is relatively complete and uncomplicated, such as when the patient presents just one complaint and the consultation comprises all phases’. The text now reads: “The former mostly were part of a chronic disease protocol (e.g. hypertension), to which the GP in one case explicitly referred. Here, the initiative came from the GP, whereupon the patient mostly agreed to attend, not necessarily having a problem. These consultations differed essentially from single consultations, first consultations in a series, and other follow-up consultations, in which the patient presented with a problem and the GP had to explore and find out what the patient required.”

22. Page 10. Third paragraph: Together synergistically, I am not sure if that isn’t double.
Re: Although both formulations exist, it looks like a pleonasm. Consequently, ‘together’ has been deleted. It now reads: “Sometimes two or three context factors seemed to work synergistically.” (p.9).

23. Page 13. Last sentence: From this… Future research and further research should probably be combined.
Re: The sentence has been changed into: “Future research could be directed at finding consensus on the ways communication patterns should adapt to context factors, and should focus on how to take the presence or absence of context factors into account in the assessment of GP communication behaviour.” (p.12).

24. Page 14, third paragraph: This could have made a difference… this sentence is difficult to comprehend. Please clarify.
Re: It has been changed into: “The behaviour stemming from different ethnic or cultural backgrounds can also be considered ‘specific patient behaviour’ to which the doctor needs to respond”. (p.13).

25. Discussion: Patient related contextual factors are found, that have great effect on communication skills of GPs. If this is the case, this opens up a very interesting area for discussion. Maybe the physician is not solely responsible for the quality of the communicative aspects of the consultation, but the patient is responsible too. Would this not be something for a paragraph in the Discussion section?
Re: We recognize that the patient has a vital role in the doctor-patient interaction. We consider patient behaviour therefore an essential context factor that the doctor needs to deal with. The question of responsibility, however interesting, is not one we would like to address in the Discussion paragraph. It would enter a totally new point, that needs some elaborating before any point can be made. Therefore, we chose not to discuss it.
Minor essential revisions

26. Page 2 (and throughout the manuscript): The authors seem to use communication skills, communication performance and communication behaviour all for one meaning, which is not the same to my opinion. The authors better refrain to one definition.

Re: The reviewer is right in saying that these are different things. We scrutinized the article and minimized using the term ‘communication behaviour’, aiming to use the appropriate term wherever possible. However, across different sources, there is not ‘one definition’ of these concepts that is universally accepted and used.

27. Page 3 Background/second paragraph: ‘firstly, it has been…’ seems to give no explanation, but simply repeats the problem definition.

Re: The sentence has been deleted. Instead, a sentence on the problem of transfer was added to the third paragraph: “The influence of context factors could reveal why GP communication performance levels do not appear adequate, and moreover, could also provide an explanation for the limited effects of communication skills training for GP registrars, as they may play a vital role in allowing transfer to take place.”

28. Page 3: Background/second paragraph: ‘secondly, the transfer is…’. Perhaps the authors claim here that communication skills can be taught at school and then transferred in practice. Maybe the reality is that GP residents predominantly acquire communication skills by learning by doing, and the institutes just ought to provide theoretical frameworks like patient-centeredness, shared-decision making, bad news telling etc.

Re: We agree with the reviewer that the institutes need to provide the theoretical frameworks, but they also offer training programmes in which various communication skills can be practiced. These skills need to be transferred into practice. We wonder to what extent the context of general practice allows for this transfer to happen. This is what we added (see Re: 27).

29. Page 4: First and second paragraph: In the past few years… has been made [28]. Perhaps the authors could discuss all referred studies together and be more concise.

Re: The references have been changed accordingly and the paragraph now starts with: “In the past few years, several researchers have pointed out that context factors on different levels influence communication in health care [22-25].” (followed by text in Re:27).

30. Page 5. Methods: Each with a different…. Probably it would be useful to start here with the number of observers and the number of observed videotaped consultations.

Re: The text of the paragraph has been changed into: “Three researchers, each with different backgrounds (GP, communication researcher, and communication trainer), independently observed and analyzed the same set of videotaped real-life GP consultations. For this, a purposive set of consultations (N=17) was selected from a database of videotaped consultations of Dutch GPs”.

31. Page 5. Methods, first paragraph. In the Dutch….“I do not think this adds
much to the methods section.

Re: In the Dutch context, having a patient list as a GP is an important context factor on a macro level. However, realizing that this is so, we transferred the remark to the Discussion section.

32. Page 5. The study regulation: Perhaps the authors can take this section out and put it in one sentence after the main manuscript.

Re: This section was transferred to the end of the manuscript. It now reads: "The fact that in the Dutch health care system the GP has a fixed patient list and acts as a gatekeeper for specialist care is a societal context factor that may have contributed to the identification of doctor-related factors like ‘doctor knows the patient and his social context’, and the patient-related context factor ‘patient is also treated by other provider’." (p.11).

33. Page 5. Last paragraph: Problems (samples?) were selected… I don’t know how this fits in, together with criteria 1:) a broad range.

Re: We changed the paragraph, now better clarifying how we selected the consultations (p.): “Selection criteria for the sample were: 1) a broad range of complaints or problems presented (different ICP codes having a high prevalence in general practice), and 2) a variety of GPs, with an even distribution of male and female GPs. By including a broad range of health problems representative for general practice, we aimed to increase the chance to detect as many different context factors as possible, including the content of the problem." The sentence ‘Problems were selected that have a high prevalence in general practice’ has been deleted.

34. Page 6. last sentence: after analyzing…. Perhaps the authors should clarify why 8 consultations were seen and then sets of three, I guess there must be a well planned idea behind it.

Re: In the literature on assessment of communication, a number of 8 consultations is mentioned to rule out context-specific aspects. Therefore we expected that we at least needed to observe 8 consultations. From there on, we chose a number of three consultations for practical reasons (less time consuming) and because we did not expect to reach saturation before we had analyzed at least 15 consultations. The paragraph has been changed into: “We started analyzing and discussing eight consultations in this manner, as this number is mentioned to control for case-specific aspects. Subsequently, for practical reasons, we observed sets of three new consultations until no new context factors were identified.”.

35. Page 8. How can the observers conclude that physicians were older and more experienced, just by observing what they looked like?

Re: The physician’s looks are indeed an easily observed characteristic, but not sufficient to also infer experience. This inference was made by the way the physicians handled the patient and their complaints: there seemed to be more calmness and rest in the consultation. The consultations seemed to go smoother, quicker sometimes, and be more concise and compact. The more experienced doctors seem to know what they are asking for, and use fewer questions – out of knowing the disease scenarios. This also lead to a more loose structure of the consultation (which we mentioned).
Recently, an article has been published in which communication pattern characteristics of experienced GPs are revealed using Conversation Analysis. We deleted the word ‘older’ and have changed the paragraph into: “Moreover, the more experienced GPs seemed to know what they were asking for, used fewer questions, applied the skill ‘Structuring’ more loosely, and without losing key information performed adequately on a medical level.” In the Strengths and limitations section (second paragraph), we referred to the above mentioned study in order to satisfy this comment (p.13): “Secondly, other ways of analyzing communication behaviour can reveal very adequate communication patterns in experienced GPs that were not seen before [34].”.

36. Page 9. Consultation related factors, First sentence (awkward): what is a marked difference in a qualitative study?
Re: The word ‘marked’ has been deleted. The sentence has been changed into: “We observed a difference between follow-up and preventive consultations - initiated by the GP – on the one hand, and on the other hand consultations, in which the initiative to attend mainly lay with the patient.” (p.8).

37. Page 10/11 Discussion: After a very nice and clearly written opening paragraph, the rest of the discussion seems to be very long with several overlaps.
Re: The Discussion has been rewritten (except for the opening paragraph). (see text changes in Re: 38 – 41)

38. Page 11, second and third paragraph: I would suggest here to use one or two sentences for goals and context factor, and then one or two sentences for what the authors added or confirmed to that.
Re: This paragraph has been changed into: “Our empirical findings confirm the factors theoretically influencing the communication process, as presented in the conceptual model by Feldman-Stewart [3] for example. In this model, the communication process is directed by the goals each of the participants have. Several authors have pointed to the relevance of each of the participants goals for the communication process in the consultation [4,30]. One recent study found that specific goals indeed modulate the GP’s application of communication skills in daily practice [31]. We consider this a support for our findings, as goals themselves may be a derivative of specific context factors. To unravel the relationship between context, goals and communication behaviour, different research methods are required.”

39. Page 11. Last sentence: Although the initiative…. This is confusing to me. Should the doctor yes or no explore all emotions etc if it comes down to ‘easy stuff’?
Re: We changed the sentences to make it more clear what we mean: context factors may explain the absence of certain behaviour, but there is no gold rule for ‘should do’ or ‘should not do’ that is applicable in all cases. It now reads: “Although the initiative for the consultation lies with the doctor, it does not discharge the GP from exploring questions that the patient may have. Similarly, it may be logical not to go into emotions in the case of an easily solved problem. Nevertheless, the GP needs to stay attentive of emotions that may arise despite the simplicity of the complaint.”
40. Page 12. Second paragraph. I would suggest leaving out this whole paragraph, which is mostly about contextual factors the researchers did not look upon. If the authors do like to report on this matter, I am afraid that it would not contribute to the rigorousness of the study.

Re: We deleted this paragraph.

41. Page 12. Last sentence; page 13 first two sentences. The former also applies to the clinical practice guidelines etc. I am afraid this is beyond the scope of the study.

Re: The sentences have been changed into: “For instance, the identification of preventive and follow-up consultations as a context factor, may reflect the use of clinical practice guidelines that can be considered a context factor on a macro-level.”.

42. Page 14. Limitations. The authors seem to be ambiguous about whether saturation is reached or not. If more contextual factors might be revealed, please check some more consultations. Otherwise mention the method as itself as a limitation. Perhaps even a systematic review could provide more evidence on contextual factors.

Re: The method itself is a limitation in this study. Other methods may provide different results. In the new paragraph on Strengths and limitations (p.13) the text now reads: “However, the method that we used can be considered a limitation of this study as it allowed us to find context factors at a micro-level, but not at other levels. We inferred context factors from low item scores on the MAAS-Global. Implicitly, this may suggest that a) only low scores are context-dependent, and b) high MAAS-Global scores represent a gold standard for communication. These implications are not intended.”.

43. Page 14. Conclusions….. yet displayed adequate overall professional performance. I guess this conclusion is pretty strong, considering the fact that 3 observers scored 17 consultations of unknown GPs. I expect that the inter-observer variability that usually comes with this kind of scoring does not allow for strong conclusions like this.

Re: The word ‘overall’ has been deleted.

44. Page 15. Conclusions, Last sentence. Future research … Perhaps this sentence belongs to the Discussion rather than that it is a conclusion.

Re: As this had already been said in the Discussion, the sentence has been deleted.

The article has been reviewed and language corrections have been made.

Level of interest: An article of importance in its field
Quality of written English: Needs some language corrections before being published
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:
I declare that I have no competing interests