Reviewer's report

Title: How do family physicians and patients communicate about cardiovascular risk? Prevalence and determinants of different risk communication formats

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Reviewer: Lidewij Henneman

Reviewer's report:

This is a study using “real” consultations to address the topic of communication of cardiovascular risk to patients. Although very few practitioners agreed to participate, the study shows some interesting findings.

• Major Compulsory Revisions

Title:
The title suggests that the study also addresses patient communication about risks, whereas it is only the GP’s use of risk communication formats that are studied. Consider to re-phrase.

Is prevalence the right word in this context? (In medical context one might think of something else). Better to use frequency?

Abstract:
Change “patient understanding” to “subjective patient understanding” (also in the rest of the article).

The results section in the abstract could benefit from actual numbers (not only presenting percentages). E.g. In 73% of X consultations, etc.

Introduction:
The question is well defined, however, the introduction might benefit from more (theoretical) background information: How do patients currently perceive the CVD/CVRF risk (underestimation/overestimation?)? Why is it important that patients understand their risk? Or rather: What is effective communication?

The introduction as given here is not limited to cardiovascular risk. Risk formats may however have different effects depending on the height of the risk (higher or lower that 1%), also the context (positive, negative framing) and also the purpose of communication (persuasive, informed decision making) may differ. The introduction does not make a difference between different areas of risk communication.

Is there evidence that effective communication of CVRF leads to better understanding of risk and improved outcomes? (see e.g. review Waldron Pat Ed Couns, 2010).

Perhaps the authors could give some (brief) information on standard care in
Swiss with regard to CVRF counselling (context). How are patients generally counselled by CVRF? Is it a separate preventive counselling session or part of a usual consultation (i.e. opportunistic). Are GP’s in Suisse paid for these counselling activities? What are the recommendations of the medical association with regard to risk communication (format)? Are the visual coloured tables (visual format) used by physicians in the study also in the guidelines?

Perhaps the authors could elaborate somewhat more on individual characteristics in the introduction (numeracy, intelligence etc.) (line 11, including references, e.g Reyna Psychol Bull 2009), since they also address determinants in their study. Also this sentence (patient characteristics- providers varies) is complex to read (make two sentences).

Perhaps refer to “shared decision making” already in the introduction.

Methods
If no information was given to patients and GPs about the exact purpose of the study, what did they tell them since they were “provided with information about the aims of the study” (page 5 line 4)?

How many GPs withdrew after being told about the exact purpose of study?

How was awareness (estimate) of the risk of developing CVD exactly measured, was it risk as feeling (how likely do you think it is) or was it a numerical risk estimate (what do you think your risk is), or recall (what has been told?)?

How did the GPs’ measure of patient’s estimation of risk and anxiety compare to the patients estimate?

Discussion:
With regard to the association between gender and the use of verbal formats: what do the authors think of the reason behind this main finding of the study?

How do the authors know that a high proportion of patients understood the risk (page 11, line 4). Understanding was a subjective measure.

The authors explain that one reason for the high extent of verbal qualifiers was that they are not aware of the numerical facts. Not aware or are they (individual risks) simply not available?

Verbal communication to express opinion? (page 13, 5). It has been show that verbal communication may induce different meaning to patients. Not favourable; although verbal qualifiers, according to physicians themselves, might also be used to reassure or influence behaviour (persuade). (see also Henneman, Marteau, Timmermans Pat Ed Couns 2008 different reasons that counsellors themselves mention when using verbal terms- although different context i.e. genetic counselling; where non-directiveness is considered more important).

Figures:
Fig 1: GP gender or patient gender? The label says there are 32 female doctors
and 45 male doctors? Is the label correct?

Fig 2: what is meant by “p=0.001 vs verbal” etc.?

• Minor Essential Revisions
First line relatives= first degree relatives.
List of abbrevations: add IQR, API, RF
The reference list needs closer look (some references are twice in list).
Error Ref Alaszewski: oabout= about

• Discretionary Revisions

Abstract:
In the abstract the aim of looking also at determinants of communication format is not given; it only addresses the frequency.

Perhaps describe setting in methods section.
“visual” is probably not clear to everyone (give example in brackets or add e.g. “graphs”)
Also in the introduction it would be helpful to explain what is meant by “visual formats” line 5.

Introduction:
Ref. 5 is about patients preferences, and not about understanding as the authors suggest.
CVD is not only a major issue in “public health” but also in Medicine. Or do the authors mean e.g. health of the public?
An interesting article, though in another context (breast cancer counseling) is the study by Pieterse et al (Gen in Med 2006), also recording of real consultation.
Did the GPs also use different time horizons (life time, 10-years time)? How did they frame their message (positive, negative framing?). Did the authors look at that?

Results
Although 2.9% of GPs were willing to participate it was actually only 1.9% of GPs that participated (participation rate).

Methods:
The methods section, as well as the results section, would benefit from more headings (e.g. measures); if journal allows.
Did the authors consider multilevel analyses? (different practices).
It would be better if the results on agreement between researchers (raters) were
given in methods section. It is rather odd to find them in results section between the other results.

Results:
How did the raters know what visual adds were exactly used? (since these were audio-taped)

Discussion:
In the discussion it was explained that numerical and visual formats were used in minor degree and mostly combined with each other. Explain that numerical formats were combined with verbal qualifiers and visual aids with numerical format.

The sentence: "Restrictions on the use...part of the graphic" is difficult to understand, Rephrase. What is also true for numerical format? (next sentence)

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being published

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:
'I declare that I have no competing interests'