Reviewer's report

Title: Preferences, predictions and patient enablement: a pilot study

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Reviewer: Margaret Maxwell

Reviewer's report:

This paper makes an interesting contribution to the assessment of quality in primary care consultations. The authors identify a lack of research into patient expectations and their fulfilment and their relationship to perceived outcomes. They also make a call for researching ‘expectation’ as two distinct concepts and make some interesting observations regarding the distinction of such concepts. Although here I think they are making more of a point regarding poorly constructed questions/questionnaires.

The 2 main aims of the study are clear and the general methods and analysis appear robust (although some methodological problems may exist as outlined below).

Major compulsory revisions

There are some potential problems with their method of identifying preferences and predictions and the assumptions they make regarding what constitutes ‘patient expectations’ which have implications for whether they have truly tested out the association between preferences/expectations and enablement as an outcome.

The full range of preferences and predictions are not described. This may be important. Whilst Howie et al emphasised that quality outcome measures might better reflect what is important to patients, it was also understood that ‘enablement’ would reflect patient judgements of doctors that go beyond technical aspects of care such as scripts, tests, referrals. Current primary care is largely concerned with managing chronic illness, and alongside delivering clinical care GPs also have to understand and help patients cope with day to day living with their illnesses. Were such preferences and predictions (for empathy and understanding) included? These more holistic elements of the consultation explain the correlation between the PEI and empathy/consultation skills, and why some people may be less satisfied (if expected tests were not conducted) but may still also be enabled.

The authors used medical and nursing clinicians to identify common outcome types. Why were patient not used to derive this list? By using clinicians they may have limited the scope to the technical aspects of care. The rationale for this should be described and this should also be acknowledged as a limitation.

Were options for social referral – which might help with housing, finance or social isolation problems included? These were certainly within the spirit of
‘enabling’ consultations as would even the simple discussion of such problems within a consultation regardless of whether a person or profession was subsequently identified as a referral option. Did the list include the provision of health promotion advice? Again, the rationale for the list should be clearly explained and limitations acknowledged.

The list represents persons or professions that might be involved in the patients care. Presumably most patients would not express a preference or expectation for more than one or two of these – might this increase the chance of their being disagreements and reduce the chance of preferences being met? And if patients expressed multiple preferences, what is the real likelihood of these being met?

The Discussion points to a potential limitation in the PEI in that it scores for improvements in patient understanding and capacity and is therefore only applicable to those who have ‘room to improve’ in this regard. This may apply in cases where the appointment is a routine check up (the only scenario we are presented with) – but in cases where a ‘health literate’ patient has asked to see a GP it is presumably because something requires attention (diagnosis, change of treatment, new referral etc.). This is always likely to require further explanation of what is happening and why. It is probably a false assumption that patients reach a level of understanding that can never be improved (most GPs also improve their knowledge on a daily basis!). In addition, there are also other questions within the PEI that relate to coping with their life and illness. Regardless of their knowledge/health literacy, many patients will still struggle with life changes that illness brings and it is the understanding (and sometimes actions) of the GP which can help them cope better. Again this reflects ‘enablement’ as more than giving out prescriptions or making referrals. Such questions will likely apply to all patients, and especially the chronic care management ones. The current discussion may be misleading and itself based on false assumptions.

Whilst the authors have made an attempt to explore the relationship between patient expectations and outcomes, they may also have to acknowledge that their own methods may be flawed before they can make any strong conclusions regarding enablement. It may be that their list of preferences/expectations is broader than initially described – but if not then this is problematic and must be acknowledged.

Discretionary revisions:

The study could easily have included a ‘satisfaction’ measure which may have added to their exploration of ‘desire’ and ‘prediction’ on satisfaction as distinct from enablement. The authors might discuss this.

Previous studies have also shown that process variables such as consultation length impact on enablement and it may have been beneficial for this pilot to include such a measure to see if this impacted on whether preferences were met. Did the authors consider this?

The authors call for further investigation into presentation, caseload type and
context. They could discuss the previous work already undertaken using PEI in this way (e.g. their Ref No.4).

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

Non-financial competing interests:
I am one of the original authors of the PEI.