Author's response to reviews

Title: Effectiveness of the ACA training programme on general practitioner-patient communication in palliative care; a controlled trial

Authors:

Willemjan Slort (slortentan@planet.nl)
Annette H Blankenstein (ah.blankenstein@vumc.nl)
Bart PM Schweitzer (schweitz@telfort.nl)
Dirk L Knol (d.knol@vumc.nl)
Luc Deliens (l.deliens@vumc.nl)
Neil K Aaronson (n.aaronson@nki.nl)
Henriëtte E van der Horst (he.vanderhorst@vumc.nl)

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Author's response to reviews: see over
To: the Editor of *BMC Family Practice*

Amsterdam, March 10, 2013

Dear Editor and referees,

On behalf of the authors, I am pleased to submit the revision of our manuscript **MS: 189105698847740** - Effectiveness of the ACA (Availability, Current issues, and Anticipating) training programme on GP-patient communication in palliative care; a controlled trial.

We thank you for your helpful comments on our manuscript. To our opinion, the article has been improved after addressing your concerns in a revised manuscript. In the attached document we respond to each of your concerns and show the changes in the text of the article.

We do hope that you will consider this revised version of our paper for publication in your journal.

With kind regards,

Willemjan Slort, M.D.
EMGO+ Institute for Health and Care Research
Department of General Practice & Elderly Care Medicine
VU University Medical Center
Van der Boechorststraat 7, kamer D-552, 1081 BT Amsterdam, The Netherlands
Mail: slortentan@planet.nl; w.slort@vumc.nl
Tel: +31 6 53 17 04 17
Reviewer's report

Title: Effectiveness of the ACA training programme on general practitioner-patient communication in palliative care; a controlled trial

Version: 1 Date: 13 January 2013

Reviewer: Bart Van den Eynden

Reviewer's report:

1. General considerations

• Firstly we are convinced this is undoubtedly a valuable research project: the question if educational programmes are increasing substantially good communication between GP’s and palliative patients is important! The authors themselves are stressing that this is the first study on effectiveness of a communication training programme specifically targeted at GP-patient communication in palliative care. The results could have consequences for education about palliative care of GP’s and for the working field of primary care and of palliative care.

• Positively is also that the authors are reporting about a research project with ‘negative’ results: the hypothesis that the ACA-educational programme will make the communication of practising GP’s about palliative care more effective, did not come pass true.

• But there are also some major negative aspects in my mind:
It might be possible (and the literature reference list indicates this) that this research takes part in a larger whole (e.g., PhD-thesis) but it remains a pity that the study seems to focus only on quantitative aspects of communications. The abstract is still more misleading: it emphasizes almost only on the effect of the number (13) of issues discussed by GP’s during the 15 minutes during consultation, before and after the ACA training programme.

**Answer 1.**

*Before we performed the trial reported in this manuscript, we had obtained qualitative information by performing focus group, interview, and questionnaire-studies, and a literature review (of 15 qualitative and 7 quantitative studies) to find facilitators and barriers for GP–patient communication in palliative care with the aim to develop a training programme that enables GPs to improve their palliative care communication skills.*

*The study reported in this paper is a trial which, as all trials do, uses quantitative outcome measures, to evaluate both quality (how, and which issues) and quantity (number of issues discussed) of GP-patient communication.*

*We discussed the outcomes of our trial many times during the project. Because we considered this an important and difficult aspect of the study, we organized an expert meeting to discuss which outcomes would be the best measures of the overall quality of the GP-patient communication in this project. We concluded to measure both how the GP communicated with the patient and what he discussed with him. These outcomes fit in well with the content of the ACA training programme on how to communicate with the patient (availability items) and what to discuss (the current and anticipated issues). Both ‘how’ and ‘what’ were measured quantitatively.*
We have changed some parts of the article:

Abstract, previous version:

Methods

……... To evaluate the effect of the programme a quantitative content analysis (RIAS) was performed of one videotaped 15-minute consultation of each GP with a simulated palliative care patient conducted at baseline, and one at 12 months follow-up, using linear mixed models and logistic regression models.

Results

The 62 intervention and 64 control GPs raised on average eight of the 13 ACA issues during a consultation. The ACA training programme had no effect on the number of issues discussed by GPs or the quality of their communicative behaviour.

Abstract, revised version:

Methods

……... Both how the GP communicated with the patient (‘availability’) and the number of current and anticipated issues the GP discussed with the patient were measured quantitatively. We used linear mixed models and logistic regression models to evaluate between-group differences over time.

Results

……... We found no effect of the ACA training programme on how the GPs communicated with the patient or on the number of issues discussed by GPs with the patient. The total number of issues discussed by the GPs was eight out of 13 before and after the training in both groups.

In the Methods section we added:
Outcome measures were determined in discussion with a panel of experts in palliative care research. The decision was taken to measure both how the GP communicated with the patient and what he discussed with him. These outcomes fit in well with the content of the ACA training programme on how to communicate with the patient (availability items) and what to discuss (the current and anticipated issues). Both ‘how’ and ‘what’ were measured quantitatively.

But there is more to say about that: this study simulates a laboratory situation, I mean by that that not even experienced palliative care specialists will try or be able, to discuss 13 or more of the issues of the ACA. This would mean 1,15 minute per issue: how can a caregiver do this in a qualitative way? Taking care as a GP means most of the time going the whole end-of-life process together with the patient, at his rhythm, not trying to speak about as much as possible issues!

Answer 2.

This relevant aspect was also discussed many times in our project group. We have added a summary of our discussions to the discussion section of the paper:

Although we developed an evidence based intervention and used sound methods to evaluate its effectiveness, we found no effect on how and what the GP discussed with the simulated palliative care patient. Besides a possible ceiling effect in this group of GPs with more than average interest in palliative care, we considered also other possible explanations for these ‘negative’ results. The intervention might not have been effective or the outcome measures might not have been sensitive to
change over time. Although the ACA checklist provides a concise summary of the essential factors for GP-patient communication in palliative care, all separate items (‘how’) and issues (‘what’) are not new, especially not for experienced GPs. Our quantitative content analysis (RIAS) of the consultations might not be sensitive enough in assessing overall quality of the GP’s communication with the patient. Although we discussed extensively the best outcomes for this intervention, in retrospect we doubt whether the number of issues discussed by the GP is an appropriate indicator of quality of communication. It might be that the GP discussed the same number of issues at baseline and at follow-up, but discussed these issues in a better way at follow-up. However, we also failed to detect a significant effect on the “how” of GP-patient communication. Although we included the several actors who role-played a patient with advanced stage cancer in our analyses as a covariate, this factor might have influenced our results more than we could identify.

Risking to simplify it still more, I will nevertheless mention the classical metaphor: “the ‘beauty of a rose can’t be measured just by means of the number of weight of the different leafs of the flower, neither by measuring the intensity of the colour, nor by estimating the milligrams of perfume substances present etc…”. Does the treatment of less/more ACA issues says so much about the quality of the palliative care consultation by a GP (or by any physician)!

Answer 3.

See our answer 2.
So the whole question, that is not even raised, is about the quality of the content and the way the different ACA issues are mentioned, anticipated, treated ... by the GP’s, even when the quality of their general communicative behaviour is suitable!

To resume this important part of my critical thoughts, GP’s are family doctors, following many of their palliative and terminal patients for many years, knowing many aspects of their life history, their family, their context...Is an artificial situation with simulation patients measuring the number of issues doctor are mentioning during one single consultation, a good method to get an idea about the effectiveness and efficiency of a palliative care consultation, and finally about the impact of an educational programme as ACA.

I would suggest that the authors add a frame where this issues are treated and what their position is about them!

Answer 4.
(See also our answers 1 and 2.)

This study is an effectiveness study in the sense that real GPs who had self-selected to attend a training course on palliative care, were trained in the naturalistic environment of that training to apply the ACA model in their communication with palliative care patients. Effects of training courses can be measured on four levels, according to Miller’s pyramid: ‘knows’, ‘knows how’, ‘shows’, and ‘does’. Until now, training effects in palliative care have been evaluated on ‘knows’ or ‘knows how’ level (see our systematic review). We measured the effects on the ‘shows’ level. We agree with the referee that the ‘does’ level would be preferable, but recording real-
patient GP-patient visits in palliative care is very difficult: not all GPs would provide palliative care to patients at baseline and at follow up; we expected that many GPs would fail to produce proper recordings of their consultations at the patients’ homes; and the consultations with different patients (different personal characteristics, different diseases, different stages of their diseases) would be less comparable than the standardized consultations with our trained actors.

We have added the following text on these issues to the paragraph strengths and limitations:

As a trial with videotaped consultations of GPs with real palliative care patients was not deemed to be feasible, we used trained actors to simulate patients with advanced stage cancer. Our study was based on the four levels of competence according to the pyramid model of Miller; 1. knows (knowledge), i.e. recall of basic facts, principles, and theories; 2. knows how (applied knowledge), i.e. ability to solve problems, make decisions, and describe procedures; 3. shows how (performance), i.e. demonstration of skills in a controlled setting; and 4. does (action), i.e. behaviour in real practice. We focused our effectiveness evaluation on the third level.[24]

Moreover, we measured one 15-minute consultation, while in daily practice, Dutch GPs visit their palliative care patients frequently at home and thus discussion of relevant issues is spread over several visits.

2. Some detailed issues:

a. It is a controlled study, not a randomised controlled study: the authors write in their article that the study group and the control group are regionally chosen
because of ‘practical reasons’. What are these practical reasons? Could this reasons not be a source of bias? Wouldn’t be have done more efforts in order to make it an RCT?

Answer 5.

Although randomizing at GP level would have been preferable, there were a number of practical considerations that led us to carry out assignment to the experimental or control condition at the level of a Palliative Care Peer Group Training Course. In the paragraph ‘setting and participants’ (of the methods section) we have added the following information about the reasons for assigning the several groups to the intervention or control condition:

All GPs enrolled in the four PCPT courses in 2006 and 2007 were invited to take part in the study. As our intervention was added to an existing training course, we had to assign whole training groups to either the intervention or the control condition. Because we wanted to start with an intervention group in 2006, and to prevent contamination between groups, GPs enrolled in the PCPT courses conducted in Eindhoven (2006) and Rotterdam (2007) were assigned to the intervention condition in which the ACA training programme was integrated into the PCPT course. GPs who enrolled in the PCPT courses in Amsterdam (both 2007) were assigned to the control condition in which the ACA training programme component was not included.

b. A specific detail:

i. Figure 1: intervention group: baseline: 60 videos / follow up after training: 55 – this means. So 60 minus 55= 5 video’s less than at baseline. The explanation of
Answer 6.

*We included 62 GPs in the intervention and 64 GPs in the control group.*

Unfortunately, 2 of the 62 baseline videotaped consultations of the intervention GPs were lost. Therefore, 60 videos (from 62 intervention GPs) were available at baseline, and 55 (from 62 intervention GPs) at follow-up.

*We added n=62 and n=64 to the title of Tables 2 and 3.*

Answer 7.

*We have checked the surprising low FTEs and found that we reported these FTEs incorrectly. We have corrected the FTEs and adapted Table 1 as follows:*

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
<th>Control</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTE (median, range)</td>
<td>.80 (.50-1.00)</td>
<td>.75 (.40-1.00)</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Kind regards

Bart Van den Eynden

**Level of interest:** An article whose findings are important to those with closely
related research interests

**Quality of written English:** Acceptable

**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' below"
Reviewer's report

Title: Effectiveness of the ACA training programme on general practitioner-patient communication in palliative care; a controlled trial

Version: 1 Date: 11 February 2013

Reviewer: Paul Van Royen

Reviewer's report:

This is a nice and well developed article –it addresses a relevant problem communication in palliative care.

1. Is the question posed by the authors well defined?

The question posed by the authors is defined as follows: ‘if GPs exposed to a training programme in GP-patient communication in palliative care, would raise more issues and become more skilled in their communication with palliative patients’ Some elements of this question remain unclear such as the issues raised- does this correlate with a better GP-patient communication and with a better palliative care. The quality of the communication is defined by the scores on the six items and the verbal dominance. This last item would rather be a indicator of a patient-centred communication. It is necessary that the authors explain these aspects and their interrelationship in the introduction of the article.

Answer 8.

The aim of our study was to improve palliative care for incurable patients in general practice, by improving GP-patient communication in palliative care. Literature suggests that it is rather difficult for GPs to communicate effectively with their patients, especially in palliative care, as it also concerns psychosocial and emotional
issues. If the GP does not identify all patient’s problems, the GP will not take subsequent actions. As a consequence, quality of life of the palliative care patient will not be as high as possible.

In the introduction we added:

If a health care professional does not communicate as well as he could, some, if not many, of the problems that patients are facing might not be identified. Consequently, it is likely that the health care professional will not be able to take the appropriate actions, and the patient’s quality of life may be unnecessarily impaired.

2. Are the methods appropriate and well described?

It concerns a controlled trial.

The authors should motivate why they took 0.5 SD (only 1 extra issue discussed by the GP). Is this a relevant difference in this context- and why?

The risk of bias should be discussed more in depth. All other details of the methodology are sufficiently described.

Answer 9.

We have chosen a difference of 0.5 SD as relevant more on statistical than on conceptual / theoretical grounds.

About the risk of bias we added in the paragraph strengths and limitations: As we had to assign participating GPs to either the intervention or the control condition without randomization, we carefully compared both groups and included significant between-group differences on background characteristics as covariates in the
3. **Are the data sound?**

This article reports about a relevant problem. Is this study really an effectiveness study – regarding the feasibility for implementation and the non-naturalistic setting. Since there is little known about the effectiveness of training GPs in specific elements of communication in palliative care, wouldn’t an efficacy study more appropriate?

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**Answer 10.**

*See our answer nr. 4 above*

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4. **Does the manuscript adhere to the relevant standards for reporting and data deposition?**

Yes, it is clearly written and

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5. **Are the discussion and conclusions well balanced and adequately supported by the data?**

The discussion is supported by the data. It is very worthwhile that a study with a negative result is reported.

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6. **Are limitations of the work clearly stated?**

Because of no randomization, there is a risk of bias, this should be discussed more in depth.
7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
Yes

8. Do the title and abstract accurately convey what has been found?
Why use an abbreviation as ACA in the title – it is not clear in this way

Answer 12.

We used the first letters of the three categories availability, current issues and anticipating (ACA) as an acronym for the training programme. We have added the meaning of ACA between brackets in the title.

9. Is the writing acceptable?
Yes

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:
I have no competing interest.