Reviewer's report

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

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Reviewer: Bart Van den Eynden

Reviewer's report:

1. General considerations

• Firstly we are convinced this is undoubted 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 came pass true.

• But there are also some major negative aspects in my mind:
  o It might be possible (and the literature reference list indicates this) that this research takes part in a larger whole (f.e. 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 emphasis 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.

  o 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!

  o 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)!

  o 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!

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?

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 the authors: 3 GP’s did not wanted to participate, 2 GP’s were absent and 2 GP’s discontinued the course: this accounts 7 GP’s not participating . 5 is not equal to 7? Can this be explained?

ii. Table 1: working percentage of FTE: range intervention group: 0.08-1.00 en control group: 0.03-1.00. Is it reasonable to include physicians with 0.08 FTE and 0.03 working FTE (as doctor? Or as GP?) ?

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"