Author's response to reviews

Title: Characteristics of communication guidelines that facilitate or impede guideline use: a focus group study

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Author's response to reviews:

Dear editor,

Thank you for the opportunity to revise our manuscript for publication. We first respond to your recommendations and to the comment (both referees) on our guideline perspective. We would prefer to publish in BMC Medicine rather than in BMC Medical Informatics and Decision Making. We motivate this separately. Finally we will respond to the referees concerns (see part 2) point by point.

1: Expand the literature review to include relevant / recent references
We considerably expanded our literature review, focusing on educational aspects of doctor patient communication.

2: Refine the conclusions drawn with regards to the sample size used.
Qualitative research is an appropriate method to answer our research questions [1-3]. Moreover, our sample is larger than usual in qualitative research. Therefore we consider our results as valid. Still, we refined our conclusions by adding suggestions for further research.

3: Add a limitations section
We expanded our "strengths and weaknesses" section and added a subheading.

4: The guideline perspective
We started from an educational perspective, but we went over to implementation theory and a guideline perspective, because this is better suited for evaluating recommendations (see 6.1). We therefore retained our guideline perspective. Besides, clinicians are used to guidelines in their daily work and readers of BMC medicine even might have more trouble in understanding an educational perspective. Still, we have broadened our literature review to describe also the central issues from the educational perspective.

5. Is the manuscript suited for med. informatics and decision making?
This journal focuses on 'information management, systems and technology in healthcare and the study of medical decision making'. Our study focuses on doctor patient communication and not on evidence based medicine. Therefore we do not think our manuscript is suited for this journal. Good doctor patient communication is at the core of good diagnosing, treating and counselling patients. The medical profession has greatly benefited from the view of behavioural scientists, but adherence to communication guidelines is low [4-7]. Therefore, doctors should take responsibility in defining what good communication is about and in exploring what is needed to adhere to communication guidelines. We think that our paper is relevant for physicians in general, inviting them to reflect on their reasons to use or neglect the communication guidelines they have been taught. We therefore consider our paper as particularly suited to publication in BMC Medicine.

6. Reactions on Reviewer 1 (Jozien Bensing)

6.1. There already is a wealth of research on didactic methods in communication training. Therefore we focussed on the quality of the educational content, i.e on recommendations with impact on communicative behaviour (performance). We searched for different theoretical perspectives, and after careful consideration we decided to use the guideline perspective. Clinical guidelines are evidence-based statements with the
purpose 'to make explicit recommendations with a definite intent to influence what clinicians do'.[8] This matched our research subject: educational content used to influence communicative behaviour by listing recommendations. Although the term 'guideline' is, as the referee mentions, uncommon in communication literature, it is used to describe texts that list recommendations for good communication.[9] Moreover, using the guideline perspective, enabled us to evaluate the quality of the recommendations with the AGREE assessment instrument. It turned out that in the guideline development little attention has been paid to user centeredness and feasibility, the main reason to start our study.[9] All together, we decided to maintain our innovative guideline perspective. Still, we broadened our literature review and included central issues from the educational perspective.

6.2. The issues of skills, competencies and performance are related to the first comment. We agree that in medical education, especially in undergraduate courses, training of isolated communication skills is important. However, in vocational training (our domain) the focus shifts from skills to competencies, with specific attention to the performance of trainees in daily practice. In everyday practice not all tools are used for every medical problems. Trainees should learn how to choose the right communication strategy. We do agree that this philosophy is not yet common in medical schools, although it was pointed out by some authors before. Only one of the guidelines in our study had variable contexts, the others described only one line of action. To our opinion, this issue is strongly related to "feasibility and user centeredness" of recommendations, i.e. practice based guidelines.

6.3. Involving patients in the development of new communication guidelines is very important indeed. We have added the remark that patients should be involved in developing guidelines for doctor patient communication to our discussion.

7. Reviewer 2 (Margaret Holmes-Rovner)

7.1. + 7.8 + 7.9 We validated our sample by creating sufficient variation to make it likely that all existing opinions are included[10]. We included different types of users and users of different universities. In the GP-trainees groups, we varied the year of training and explicitly invited trainees with strong positive or negative opinions. Additionally we took a large sample of ten focus groups were most studies consist of 5 groups or less. Within health care research qualitative methods are considered especially useful for exploring reasons for non-adherence and developing ideas to enhance adherence.[1-3] Focus groups are useful for exploring people's experiences and stating suggestions based solely on focus group studies is accepted. [1-3, 11-13]

7.2 See point 3.

7.3 We expanded the information on the impact of interventions that promote good communication.

7.4 Apparently, our text was unclear on this issue. We agree with the comment. We added a reflection on the research on didactics and rephrased some sentences to clarify our point.

7.5 The referee might have interpreted the sentence 'However, doctors' adherence to guidelines generally varies and can be quite low sometimes.' as a reflection on communication guidelines instead of on guidelines in general. We have made textual changes to improve clarity.

7.6 A good literature review indeed facilitates the development of evidence-based guidelines. On top of this, the consensus procedure for formulating recommendations is crucial.[14]

7.7 We evaluated the main guidelines, defined as text containing recommendations for doctor patient communication, which were most frequently used in GP communication training of each medical school (see method section).

7.10 Although social scientists tended to be most positive and GP-trainees to be most critical, there was no category of opinions that was mentioned by only one of the groups, or that was not mentioned by one of the groups. We have added this information to our results section.

7.11 We added this information in appendix 1.

7.12 We changed this in numbered focus groups, since the exact location of the medical schools is not relevant.

7.13 We added the interview scheme in appendix 2. The analysis was guided by the research questions
and interview topics. The ways in which guidelines were used by participants was an unprovoked theme (see results).

7.14 Yes, this analysis can be repeated. We did not determine inter-rater reliability. Instead we tried to maximize variation in the analyses by choosing analysts with different backgrounds. The final code set was formed by discussing the differences in textual interpretation and coding between first and second analysts.

7.15 Goal-directed communication guidelines are not mentioned in the conclusions section (p 24). Our main conclusion is that communication guidelines are considered useful, but that their feasibility is strongly impaired by lack of flexibility and applicability to practice routines. We based this conclusion on two findings: 1. When participants explained why they did not adhere to communication guidelines, or adhered to them only partially, they specifically mentioned that different situations need different communication, and that the guidelines are inefficient because they only offer the option to apply all recommendations. 2. Most suggestions for improvements of communication guidelines were about developing a more flexible guideline. We gave these findings more emphasis in the text (section). We suggest that the development of flexible guidelines with a supporting structure should be considered. There are several ways in which this can be achieved. Further research is needed to determine the best way to develop flexible communication guidelines. Developing goal-oriented communication guidelines is an option we favour, both in the light of literature ref!, and in the light of our results.

7.16 We removed these recommendations,

References

Part 2: feedback

To facilitate a clear reaction we have added a numbering to the reaction of the editor and the reaction of referee 2.

Editor:
We would be grateful if you could address the comments in a revised manuscript and provide a cover letter giving a point-by-point response to the concerns. Specifically, we would advise an expansion of the literature review to include relevant and recent references (1), and also a refinement of the conclusions drawn with regards to the sample size used (2). We ask referees to indicate the level of interest of
manuscripts they review. A ‘Limitations’ section would be of particular help with this aspect (3).

As one of the referees, Margaret Holmes-Rovner, felt the manuscript may be better suited to publication in BMC Medical Informatics and Decision Making it is possible that we will recommend publication in this subject specific journal, once the reviewers’ criticisms have been addressed. However, we would encourage you to give your reasons why you believe your revised manuscript is particularly suited to publication in BMC Medicine.

Reviewer: Jozien Bensing

Reviewer’s report:
General
This manuscript describes the results of 10 focus groups (seven mixed groups of experienced GPs, communication trainers and trainees, and three groups of trainees only) on the usefulness and limitations of communication guidelines. The methodology and results are clearly described. These show that more help than hindrance was experienced from the communication guidelines, which are used in Dutch medical schools. The results are largely recognizable (they do ring a bell) and interesting for communication teachers and trainers. The recommendations to use a more target-oriented approach (instead of focussing on general communication skills) is certainly helpful in a teaching setting.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
1. In fact, this article is not about guidelines but about teaching models. Using the term guidelines in this context is somewhat misleading. I have read the three articles which were cited to make the statement that doctors do not adhere to communication guidelines. However, the concept of guidelines was not used in any of these articles. These articles were mainly about the limited effect of communication training (which can be due to several factors) and not about adherence to guidelines. Guidelines are a set of (evidence-based or consensus-based) advices how to act in circumscribed situations. Guidelines can be used in teaching or in training, but are mainly developed to support practicing doctors in their day-to-day work (like in diabetes care).

I strongly suggest to change the word communication guidelines into teaching model all over the manuscript. And to put this study in the context of the medical education literature, rather than the guideline literature. In the Discussion, a plea could be made for developing communication guidelines to support physicians in different situations (patients, diseases, stages), as this would solve most of the problems mentioned throughout the article. They could even stat, that, ideally, all medical-technical guidelines should be complemented by focussed communication guidelines. That would be a relevant and interesting statement, based on the results of this study.

2. Related to the first problem, I think that the authors mingle the issues of skills, competencies and performance. In medical education several skills must be taught in order to give physicians an adequate toolkit. In everyday practice not all tools are used for every medical problems or in every situation. So, apart from teaching all kind of communication skills, a second educational goal should be: teaching doctors how to choose the right communication strategy, depending on the situation at hand. I do agree with the authors that this philosophy is not yet common in medical schools, although it was pointed out by some authors before. But, again, this has little to do with adherence to communication guidelines.

3. I was a bit surprised that no patients were involved in the focus groups. As the study is about doctor-patient communication, it would have been natural to ask the other party (the patient) what their view on this issue is. This could help to broaden the inner-directed view on what is good communication. I would consider this as a procedural flaw.

Notwithstanding these critical remarks, I think that this manuscript contains a lot of interesting information, both for teachers in medical schools and in guideline developers.

Reviewer: Margaret Holmes-Rovner
Reviewer’s report:
General
The revised manuscript, characteristics of communication guidelines addresses an important and understudied area of research, the question of whether the standard approach to teaching communication skills to health professionals follows what is known about applicability to practice settings in the guidelines literature. The authors take a novel approach to the problem, using the guidelines literature as a template for assessing communication skills teaching as it is done in Dutch medical schools. In doing so, the authors challenge what appears to be standard Dutch medical school teaching, but has not been subjected to the test of applicability to routine practice settings, as seen through the lens of practice guideline implementation. However, there are significant gaps in the authors review of the background literature and in their reporting of their methods. While the results are interesting, the authors do not reflect that these are the opinions of 10 small groups of trainers and practitioners (characteristics not described). The authors imply (p 23) that their focus group results represent the broader universe of practitioners and trainers and students and that communication skills training should be changed based on their results. This seems a strong claim for a small data set, which is likely to maintain biases the authors have not described. (1)

There is no limitations statement included in the report. (2)

Background: Teaching communication skills is basically an intervention. There is a large literature about the teaching of communication skills. There are several reviews of the literature. MA Stewart has recently published one. In addition, there is a Cochrane review of randomized trials. See Lewin et al, 2005 issue of the Cochrane Library, issue 4, Interventions for providers to promote a patient-centered approach in clinical consultations. That review is largely focused on trials and controlled before/after designs. However, it also lists all the vast literature reviewed to identify the trials. It would enhance the article if the authors reported what the impact of such interventions is, and therefore, why medical schools teach them. (3) The review of the literature would reveal that many of the trials combine skills and disease-specific content. The introduction says (p 4) that implementation has focused on changing practitioners attitudes or the organization of health care. Apparently the authors overlooked the literature on changing skills and behavior of practitioners. (4)

The lack of attention to the prior literature is an interesting oversight, since the authors report that their participants are concerned about lack of evidence of the effectiveness of communication skills training. The authors are less critical of the guidelines literature, although many reviews show that guidelines for technical changes have had implementation difficulties. (5)

Interestingly, the focus group results (p 19) suggest that evidence-based rather than consensus-based guidelines should be developed. Since neither the participants nor the authors report on a review of the evidence, this result suggests that a thorough and balanced literature review could help address the problem identified. (6)

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Background: Please describe conceptual framework: What is a guideline? The authors indicate that four medical schools use the same communication guideline and three use a different guideline each (p 7). Do they refer to a course? A set of published guidelines? Reference 25 is not available, and the description on page 7 doesn't say what they mean. Is this similar to communication guidelines in other medical schools in other countries? What is being evaluated in the focus groups? (7)

Methods and data: Focus groups are useful for identifying issues in need of investigation. However, they are known to produce premature consensus, due to participants tendencies to agree with each other in a group setting. This is not accounted for in their discussion of the methods or results. (8)

There are several items missing from the report of the methods that need to be provided: --The participants are not described (age, gender, years in practice, academic rank, etc). A table is needed, and some indication of how these differed among focus groups. How representative are they of some constituent group for guidelines? (9)

--Remarks and opinions of novices are not differentiated from experts (even though they have three separate focus groups of trainees). If there are no differences, they should say so. They say in the text that only trainees used the whole model, but the table does not reflect this information, nor show a distribution of implementation rates reported. The authors report that there was lively discussion. However, they do not report differences or similarities between practitioner perspectives and trainer perspectives. The data report does not provide a context for interpreting their opinions. (10)
--Guideline sources are not identified. These could be listed, even though the authors have submitted another publication elsewhere. (11)

--Comments quoted from individuals are identified by the initials of the medical school with which they are affiliated. However, nowhere are those initials spelled out to show where they come from. If this is important, it should be more transparent. (12)

--The coding process is not described except in terms of the software nodes. This does not show what content was looked for. They also do not include a moderators guide or some other record of what questions were asked. This should be provided in an appendix. Even if the questions were open-ended, it is important to know what the participants were responding to. What scope of content was reviewed? How were the responses coded with respect to that content? What unanticipated, or unprovoked themes emerged? (13)

--The authors report that to maximize richness of interpretation (p 6) three different researchers performed independent analyses. What was the inter-rater reliability of the final coding? How did their different/same interpretations contribute to the formation of codes? Could this analysis be repeated by someone who was given the dataset? (14)

The main conclusion of the article (p 23) is that goal-directed communication guidelines should be developed. However, table 2 does not contain that conclusion. Table 2, and the accompanying remarks in the text appear to focus largely on who controls the communication, and how the structure of the consultation helps practitioners maintain a grip. While the data provide a useful recitation of what this group of participants finds impeding, and to a lesser degree facilitating, about (undefined) communication, the authors do not make a convincing case that the list of assumptive flaws leads to a goal-directed approach. (15)

Finally, the authors recommendations for applied professional ethics and knowledge about best practices are not well defined, or the case made for how these are contradicted by skills (p 23). (16)