Author's response to reviews

Title: A theoretical framework to describe communication processes during medical disability assessment interviews

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Author’s response to reviews:

7 September 2009
RE: 2137508507274921 – A theoretical framework to describe communication processes during medical disability assessment interviews

Thank you for reading the manuscript and for the helpful suggestions for revision. We have revised the manuscript and point-by-point addressed the reviewers’ concerns.

Response to comments of reviewer James Talmage

Review’s report, major compulsory revisions

(1) In Table 1, the line dividing "Preparation before ..." from "During Assessment ...") is in the wrong place. The 6th row "Barriers/Support" belongs in "During assessment ..." and not in "Preparation ...":

Barriers/Support of the insurance physician and the claimant indeed play an important role during the interview and especially the Barrier/Support described as ‘other people who are present’ and ‘missing files’ will not be noticeable until the interview starts. We have therefore acted upon the reviewers suggestion by adding a row “Barriers/Support” to the action phase in Table 1 (p. 40-41).
(2) In Table 1, the column for "Claimant" has an empty cell for the row "Social influence". There are social influences that affect Claimants as well as Physicians. Reference Ernest Volinn, SPINE 2005; Volume 30, Number 6: pp 697–704 PhD,*Back Pain Claim Rates in Japan and the United States: Framing the Puzzle.

Thank you for this interesting literature suggestion on claims for back pain in a individualistic versus collectivistic culture. We agree that social influences (as well as self-efficacy) also influence the claimant. Therefore, we have added the suggested reference to the cell concerning Social influence with the description “Influence of other people” in Table 1, both for the claimant and the social insurance physician. Moreover, we have added a reference for Self-efficacy of the claimant (p. 40-41).

Reviewer’s report, minor essential revisions

(1) This is an important article that should be of interest to those with a PhD in Psychology, who probably are already familiar with many of the terms used, but which also should be of interest to, and read by, occupational physicians, insurance physicians, governmental disability insurance system administrators, private disability insurance executives, disability advocate attorneys, and legislators. Many of these individuals, like this physician reviewer, will not know the definitions of many of the terms used in this paper. In addition, this appears to have been written by individuals for whom English is not their primary language. The paper has many grammatical errors and odd ways of phrasing things that make this a difficult paper to read. Many of the above categories of individuals who would profit from reading this may start the article, and give up half way through it. Most American universities teach Technical Writing in the English department. I suggest an individual trained as a technical writer be recruited to help rewrite the paper. Such a person would not know the subject matter, and would need to be in dialog with the authors, but would help rewrite this so that terms are defined at a level easily understood by those without a PhD in Psychology, and the grammer/syntax would be improved.

We agree with the reviewer. To clarify the terms used in the paper, we have added or clarified definitions of the following terms to the manuscript:

- Proactive communication (p.6): taking initiative and anticipating the claimant;
- Behavioural theory (p.7): a theory according to which behaviour is learned instead of being innate;
- Attitudes (p.8): external evaluations, for example of another person, action or idea;
- Intentions to behaviour (p.8): the willingness to adopt a certain behaviour;
- Self-efficacy (p.8): the confidence and ability to be able to act adequately in a given situation;
- Social influence: (p.8): the influence of social norms and beliefs of relevant others on a person’s actions;
- Skills (p.8): the capacity to adopt certain behaviour;
- Barriers (p.8): potential obstructions that could prevent the occurrence of certain behaviour;
- Patient-centred behaviour (p.11): behaviour that puts the patient and his/her concerns, perspective and information needs first;
- Physician-centred behaviour (p.11): behaviour that puts the physician’s perspective and information needs first;
- Instrumental relationships (p.11): concern aspects of the relationship between the social insurance physician and the claimant that explicitly serve a goal (information-giving and information-seeking);
- Affect-oriented relationships (p.11): concern collaborative, affective, social-emotional aspects of the relationship between the social insurance physician and the claimant (positive and negative social talk);
- Transference (p.15): the claimant expresses feelings, wishes and experiences towards the physician that are actually felt towards other people who are of were important in the claimants life;
- Counter transference (p.15): reactions from the physician to the claimant;
- Ecological approach (p.15): an approach that states that behaviour results from multiple sources which interact, including the person himself/herself, other persons, and the context, including the situation and environment;
- Helping Alliance (p.18): considering the psychotherapeutic relationship as a means by which a health professional can engage with the patient;
- Content skills (p.21): refer to the physician’s basic medical knowledge, including the content of the questions asked, the information that is given, and the answers that are received;
- Process skills (p.21): concern the way in which questions are asked, how to explain things, how to listen, and how to build up a relationship with the claimant;
- Perceptual skills (p.21): concern the content and awareness of the physician’s own thoughts and feelings.
- Psychological distancing and avoiding (p.26): mentally creating distance between oneself and the environment;
- Locus of control (p.29): a personality trait indicating the degree to which gains are thought to result from one’s own efforts or considered to be random events according to the claimant.

We agree with the reviewer that this increases comprehensibility and readability, and others than psychologists should now be more able to understand the manuscript.

To address the second concern, we have presented the manuscript for approval to a native speaker of English. To address the reviewers concerns about grammatical errors and odd ways of phrasing, we have adjusted the grammar/syntax in the manuscript according to her feedback.

(2) On page 7 the TPB is introduced as an option, chosen as the option, and then used throughout the rest of the paper, but the TPB is not defined. Please define the elements of this model. The other models briefly considered and not chosen are also not defined, but since they are not the focus of the article, this omission may be acceptable.

The TPB and its elements are now defined in the revised manuscript on page 8: “The TPB is based on three types of beliefs: (1) beliefs about and evaluations of the likely results of behaviour, which lead to positive and negative attitudes towards behaviour; (2) beliefs about and evaluations of norms and expectations of others, which lead to compliance with or rejection of these subjective norms; and (3) beliefs about behaviour-facilitating or behaviour-impeding factors and their strength, which lead to perceived behavioural control. The combination of attitudes (defined as rather consistent evaluations of behaviour), subjective norms and perceived behavioural control (also referred to as self-efficacy) leads to behavioural intentions, which then lead to behaviour”.

We chose not to define the other models because this would make the paper too lengthy as was pointed out by the second reviewer (i.e. major remark 1). Moreover, as
this reviewer states, these are not the focus of the article. For clarity, we have nevertheless given a short definition of each of the models in this reply. If the editor thinks it desirable, these descriptions could be added to the manuscript on page 8.

- Social Cognitive Theory (SCT): The SCT was developed by Bandura (1977) and had its roots in the Social Learning Theory, which states that people learn their behaviours and attitudes by observing and imitating others. Bandura added self-efficacy (i.e. confidence in the ability to perform desired behaviour) as an important predictor of actual behaviour. According to the SCT, self-efficacy determines if behaviour is initiated and the degree of self-efficacy indicates the degree of actual control a person has over a situation.

- Theory of Reasoned Action (TRA): In the 1970s and 1980s Fishbein and Ajzen brought about the theoretical association between attitudes and behaviour in literature by proposing the TRA. According to the TRA, attitudes about behaviour are not directly related to performing that behaviour. The strength of the intention to perform the behaviour, or in other words: motivation, determines the likelihood that the matching behaviour is performed. Furthermore, subjective norms (i.e. expectations from relevant others) are suggested to determine the intention, together with the attitude about the behaviour. In the 1980s, Ajzen extended the TRA to the Theory of Planned Behaviour.

- ASE-model: The ASE-model states that attitudes (A) about behaviour, subjective norms (S) and self-efficacy (E) combined and possibly interacting, result in intentions. Together with actual skills, intentions realise behaviour. Not only skills, but a lack of skills is also incorporated in the theory. This lack of skills is labelled barriers.

**Reviewer’s report discretionary revision**

(1) *On page 5 under "Objectives" it would help the reader see the big picture, before the discussion of the details begins, if under "Objectives" the conclusions from the first 3 sentences under "Implications for Future Research" on page 29 were stated.*

We agree with the reviewer’s comment. The sentences have been added in the Objectives section (p. 5).
Reviewer’s follow-up email

(1) I wish to pass along the attached article that is a reference that could be cited to verify their statement on the bottom of page 19 that “other people” present during an insurance exam can change the exam of be “barriers”. Reference: Robert Barth, The Guides Newsletter 2007, July/August, *Observation Comprises the Credibility of an Evaluation.

Thank you for this article presenting interesting social psychological findings regarding effects of observing evaluations. We have now referred to it in the manuscript (p. 21), as was suggested.

Response to comments of reviewer Peter Donceel

Review’s report, major remarks

(1) The article is too long and especially the long introduction section can be shortened to increase the readability.

We have shortened the Introduction section by omitting text in the Background section and the Behaviour model section. All together, the introduction is now over one page shorter.

(2) Insurance medicine is a very broad field and the article deals with only one specific aspect: the disability assessment interview in a social security context. The title is correct in this respect, but throughout the article it is suggested that the model is applicable to all communication settings in insurance medicine. I doubt that this is the case for e.g. private insurance contacts, health care insurance, medical expertise for courts, counselling with regard to insurance problems .... In many cases the term ‘insurance medicine’ is better replaced by ‘social insurance medicine’ or ‘social security medicine’. Instead of using ‘insurance physician’ it is more appropriate to refer to the ‘social insurance physician’.

We agree with the reviewer that the model is conceptualised for a specific setting: disability assessment interviews in a social security context, and the suggested terms would better fit this context. We have therefore made the suggested changes by
replacing the term ‘insurance physician’ by ‘social insurance physician’ and the term ‘insurance medicine’ by ‘social insurance medicine’ throughout the manuscript.

(3) The text is written with the very specific situation of the Dutch social insurance legislation in mind. Sometimes the Dutch situation is presented as the general situation of any social insurance physician, but evidently this is not case due to heterogeneity of social security legislation and organisation. Some examples of such statements, which should be avoided or specified:

We thank the reviewer for pointing these statements out to us. The reviewer’s point is well made and the suggested changes are made (see below).

(3a) Page 10: ‘the primary task of the insurance physician is to assess the claimants capacity for work….’: in many countries professional reintegration is an equally important task.

We meant to point out that within the disability assessment process, the physician’s primary task is to assess. We have changed the statement in the manuscript accordingly, in line with reviewer’s opinion: “Within the assessment, the social insurance physician’s main task is to assess the claimant’s work capacity in relation to the medical disabilities, and not to cure or care for the claimant.” (p. 11).

(3b) Page 11: ‘insurance physicians normally meet claimants once’ is not true for many social security settings where repetitive interviews take place especially in the first months of work incapacity.

We have specified the statement both times we make it, recognising that only in some instances the meeting is a one time event: “Social insurance physicians generally work under substantial time-restrictions, and in some cases they only meet the claimant once” (p. 12).

(3c) Page 23: registration of insurance physicians is a typical feature of the Dutch social insurance physicians but not of all social insurance physicians.

Because this personal characteristics is not of major importance to the theoretical framework, we chose to omit the statement from page 23. Consequently, we have also deleted “Registration as an insurance physician” from the bottom row of Table 1. We
hope to have satisfactorily addressed the concerns of the reviewer by making these changes.

Reviewer’s report, minor remark

(1) *I do not understand why insurance medicine is described as a ‘specific area of occupational medicine’ (page 4). Occupational medicine and insurance medicine are two separate domains of social medicine.*

Due to the reviewers comment we realise the statement is not true in an international perspective, although both occupational physicians and social insurance physicians mainly have non-curative tasks. We have omitted the statement from the manuscript.

Should our reply to the reviewers’ comments be unclear or if new concerns arise, please let us know. We would be happy to provide further explanations.

Sincerely,

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