Author's response to reviews

Title: Design and Validation of the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI)

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Author's response to reviews: see over
Reviewer's report

Title: Design and Validation of the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI)

Version: 1 Date: 23 September 2004

Reviewer: David Buchanan

Reviewer's report:

General

This study describes the creation and preliminary validation of a new survey assessing health professionals' attitudes toward homeless patients. A survey of this kind does not currently exist in the United States and it represents a contribution to those who study and teach about this topic. The process for creating the survey is sound and appropriate steps were made to eliminate redundant items and those which do not correlate with the overall scale.

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

Abstract:
- Under “Conclusions:”, the statement, “Inter-item and inter-scale correlations supported the overall construct of the HPATHI and its hypothesized subscales” appears to contradict the manuscript’s Discussion. The Discussion states, “the confidence sub-scale … failed to show a satisfactory Cronbach’s alpha coefficient in either of the two separate administrations of the instrument.”

P. 3, Conclusions: Revised and reorganized.
We eliminated the discussion relating to hypothetical subscales because it was confusing.

- In the final sentence of the abstract, “Extreme group comparisons, which suggest that experience with the homeless rather than medical training affects health-care professionals’ attitudes toward the homeless…”, the word affects suggests a causal link between the experience and attitudes. Since this data is cross-sectional the competing hypothesis that people with better attitudes seek out this clinical work can not be excluded, the sentence should be re-worded to reflect this. A prospective study showing that exposure changed attitudes would be needed to confirm the authors hypothesis and would be useful direction for future study with this instrument.

P. 3, Conclusions: Revised and reorganized.
“Affects” has been changed to “could have an effect” and the need for future evaluation has been suggested.

Background:
3rd paragraph, final sentence: the words, “that can only” should be changed to “may” or a similar word unless a reference can be provided.
Methods:
Although the ATHI and ATHQ are both described in the Background section as prior instruments used for similar purposes, there is no discussion of why the authors chose to compare their new instrument to the ATHI and not to the ATHQ. This decision should be clarified.

P. 5, Last line of paragraph: Revised accordingly.
We made it clearer that the ATHI was used because it uses American English.

Phase 2: first paragraph
Describe the response rate for the pilot administration and for the second administration two weeks later. For instance, were all third year students (n?) asked to complete the survey and 72 completed it? Or, are there only 72 students in the class? Or, if only 72 students were asked to complete it, how were the 72 selected? Similarly, for the second administration, a brief description of how the 34 students were “randomly selected” and what the response rate was among those selected would improve this section. These questions relate to the generalizability of the sample used.

P. 7-8, Stages of Development and Validation of the HPATHI, 2nd Paragraph: Revised accordingly.
We described the response rate more clearly. The response rate was 72 out of the 100 students who were in class on a given day. The students responding to the second administration were those who provided contact information and subsequently responded to our request.

Second paragraph: The authors present in the paper two ways of separating the overall scale into sub-scales. One is based on the hypothetical subscales (attitudes, interest, and confidence) and the other is based on the results of the factor analysis. If the hypothetical subscales are to be discussed in the paper, the specific items included in each sub-scale should be included in the text of the paper to assist future work with the HPATHI by other groups. On the other hand, if the authors feel that after the factor analysis, the hypothetical sub-scales are less important, the sub-scales could be eliminated from the paper to reduce confusion. If both are included, the independent contributions of each should be stated in the Discussion section.

P. 7, Top of page: Section revised and reorganized.
We eliminated the discussion relating to hypothetical subscales because it was confusing.

Discussion:
2nd paragraph: final sentence: “…the HPATHI could be used to evaluate the impact of training experiences on students and residents…” This statement should be qualified because the current instrument has not been shown to be responsive to change. Use of this instrument in this way should be framed as a next step in the instruments further validation.

P. 12, Discussion, 2nd Paragraph: Revised accordingly.
We removed the statement from the discussion section and put the reworded phrase in the Conclusion, emphasizing that the instrument could be used in the future to determine if attitudinal changes are affected by training experiences occurring with the homeless.
Conclusions

1st paragraph: “The validation process for the instrument has shown promising results that could offer guidance in the design and implementation of educational activities aimed at fostering improved medical care to the homeless.” This is interesting and suggests that the authors learned lessons from the validation process which gave them insight into the learners or curriculum they teach. If this is true, the lessons should be included in the Discussion section of the paper.

P. 13, Conclusion, 1st Paragraph: Revised accordingly.
The statement was removed because it is not possible to present the data to support this contention at this time.

3rd paragraph: The authors say, “The instrument may also be used to determine attitudinal changes affected by training experiences occurring among the homeless.” This has not been demonstrated by the current study and should be framed as a future direction.

P. 14, top of page: Revised accordingly.
We discuss our plans to test this hypothesis further by administering the survey as a pre/post test to medical students in the homeless track.

“Over the next year, medical students, residents, and practicing physicians will be asked to respond simultaneously to the ATHI and the HPATHI.” This implies to me that in the study presented, the ATHI and HPATHI were not responded to simultaneously. If that is true, the interval should be described in the Methods section.”

P. 14: Revised accordingly.
We clarified the sentence to indicate that testing of the ATHI and the HPATHI is ongoing.

“Additionally, we intend to include participants from other medical schools in the United States and to expand our sample to other health care professionals to improve the instrument’s overall validity.” Minor point: Consider changing the concept of “improving” to “further testing”. The validity would only be improved if it was tested and further revised (and this is not implied currently). If there are no further plans to revise it, the validity would be further tested or demonstrated by using it with other populations, but it would not be improved.

P. 14, last line: Revised accordingly.
“Improve” has been changed to “further test”.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Conclusions
1st paragraph: “The scales identified by the factor…” Change “b” to “by”.

P. 13, Conclusions, 1st Paragraph: Corrected.
3rd paragraph: “over…” changed to “Over…”

P. 14: Paragraph: Corrected.
Changed to “Moreover”.

Table 1: Remove the line drawn after item #23, or explain it in a note at the bottom of the table.

P. 19: Done.
Removed line.

There are two tables labeled “Table 5” and none labeled “Table 4”

P. 22-23: Corrected.
Because of revisions to manuscript, the tables have shifted. The tables have been renumbered and the incorrect label has been changed.

Discretionary Revisions (which the author can choose to ignore)

Methods, 3rd paragraph: Consider changing “all experts in homeless care” to a description of their experience in this area or a description of how the panel was convened.

P. 7, Stages of Development and Validation of the HPATHI, 1st Paragraph: Revised accordingly.
The individuals were identified as experts because they work with the homeless on a regular basis and are members of the National Health Care for the Homeless Coalition.

Tables: Consider removing the 4 items from the final two tables which you do not recommend including in the final instrument. If you choose to continue to include them in the tables, add a note to the final table which lists the deleted items (as you did in the next to last table).

Because of revisions to manuscript, the tables have shifted. The 4 items have been removed from the appropriate table.

What next?: Accept after minor essential revisions

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

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:

None
Reviewer's report

Title: Design and Validation of the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI)

Version: 1 Date: 12 November 2004

Reviewer: Michael Wilkes

Reviewer's report:

General

Abstract: This is a fair and honest summary of the work described.

Summary: The authors seek to develop an instrument to assess attitudes toward the homeless and assess their interest in working with them.

Introduction:

1) The data in the abstract are old (1999) there is far more recent data.

P. 2, 1st Paragraph: No action taken.
There are no data per se in the abstract. Although we have updated the source for the data regarding population size, it is still based on the same data. According to Martha Burt (personal communication 12/01/04), author of the original 199 study and the US authority on homeless enumerations, "we should all update it [the homeless estimates], but that would take another national study. As a result, we can't update it until the feds sponsor some more data collection."

2) The authors could do far better in looking at and describing the current state of knowledge in regards to caring for the homeless (see Gerlberg and others);

P. 4, 1st Paragraph: Updated and revised.
We used a more current source for the statistics on homelessness from the Department of Health and Human Services and provided more extensive references to emphasize the difficulties that homeless people face when accessing health care. We also added a reference from Gelberg. A more extensive review of the literature on health care for the homeless did to appear to be relevant to this validation study.

3) The authors tie their basic premise to humanism, and the attitudes related to caring for the homeless go way beyond humanism. Their is an entire social science literature on this that is not even alluded to;

P. 4-5, 3rd Paragraph: Revised.
We have included background and references on humanism from the social sciences literature.

4) The authors suggest that one flaw in the ATHI is that it is UK specific. This is not the case. Having lived and worked as a medic in both places the issues are very, very similar. While some terms might need adjusting the problem of homelessness is identical and the issues related to care are identical.
As presented in the paper, the ATHI does not address the attitudes of health-care providers nor is it UK specific. The ATHQ is UK specific. We identified several differences in health-care terminology – GP, NHS, and sleep rough – that are not used in the US at all. Further, as presented in the Methods section (P. 7, Stages of Development and Validation of the HPATHI), we used items from both the ATHI and the ATHQ for the first phase of the Delphi panel then added, adjusted, and deleted items based on their feedback.

5) The authors do not make a case (page 5 para 2) for WHY it is important to measure the attitudes of physicians and medical student’s to the homeless.

Medical schools generally require outcome evaluations as part of their curricul. In the case of attitudes toward the homeless, measurement outcomes could provide valuable information about needed changes in current curricula. Despite not having published the results yet, we have had several requests to use the instrument from both national and international organizations and educational institutions (e.g., University of Texas in Houston, as well as Boston, Pittsburgh, and San Diego in the US; Toronto Canada; and St. Thomas, Virgin Islands).

Methods:
1) The methods seems relative standard and straight forward for instument development. (I am not a statiscian so I would advise consultation with someone with these skills)

No action taken since this appears to be an editorial comment.

2) The authors refer to "experts in homeless care" but don't define this term. Who are these experts and what constitutes an expert?

The individuals were identified as experts because they work with the homeless on a regular basis and are members of the National Health Care for the Homeless Clinicians’ Network.

3) In phase two the authors administered the instrument to "a group of medical students enrolled in the clinical years...". The authors have not described their experience with the homeless, their year of training, their gender, what state are they located in, how were they selected, was anyone excluded, etc.

We explained that the students had some experience and interest in working with the homeless at a local clinic, specified that they were third year students, that they are attending medical school in Houston, that it was a convenience sample, and that no students were excluded and those who participated were self-selected. There is no data on gender breakdown.

4) The group who took the instument at Baylor are not exactly a representative sample of students. They are from a Red State with potentially a far different prespective on homelessness than those from other areas.
Students matriculate to Baylor College of Medicine from all over the country, making them a suitably representative sample. Despite our best efforts to reform Texas, it is still a conservative state, as is Georgia, the state from which the ATHI originated. However, Houston has a very comprehensive and active program of health care for the homeless.

RESULTS:

Did they sample non respondents?

We did not sample non-respondents either because they did not provide contact information or because we could not identity the students who did not come to class. We did describe the response rate more clearly. The response rate was 72 out of the 100 students who were in class on a given day. The students responding to the second administration were those who provided contact information and subsequently responded to our request.

Phase 2: How were the 72 third year students selected (were any excluded)? What do we know about the other students not selected.

Students were selected as a convenience sample, no students were excluded, and those who participated were self-selected. We do not have any data on the students who did not participate.

Why did they randomly select 34 students (out of 72)? Why did they not include the entire cohort of 72?

Of the students who provided contact information after the first administration of the instrument, 34 self-selected to complete the second administration. We could not include the entire cohort of 72 students because not all of them provided contact information.

The CA for some subscales (attitudes) are very low

Given the relatively high Pearson CC between HPATHI and ATHI this just confirms that the UK instrument might have done nearly as well.

It is the ATHQ that was developed in the UK, not the ATHI. In this discussion comparing the HPATHI and the ATHI, our purpose was not to validate the ATHI but to use questions from both the ATHI and the ATHQ to help us develop a new instrument.
Discussion:

1) It seems that the conclusion, "individuals who had more extensive experience with the homeless showed more positive attitudes and interest in homeless patients" is obvious. We do not need an tool to show us this. Those of us who live with these patients day to day see this.

P. 12, Discussion, 2nd Paragraph: No action taken.
While this conclusion may be obvious to those of us who work with the homeless on a daily basis, this may not be the case for those providers who are unfamiliar with the health-care needs of the homeless. The fact that a conclusion is obvious does not remove the need to demonstrate its validity; many assumptions are later disproved. In addition, the purpose of the instrument we were testing is to measure the effectiveness of a homeless care curriculum. The instrument needs to be sensitive to attitudinal changes and our validation strategy highlighted a significant difference between the groups.

2) Perhaps these students are self selected? Insisting on more exposure for everyone in order to improve attitudes does not follow from the former observation.

P. 12, Discussion, 2nd Paragraph: No action taken.
Although the students who participated in the survey were self-selected, there were some who had had no experience with underserved populations (please refer to Table 2). In terms of improving attitudes to homeless patients, we believe increasing exposure could be a way to change health professional attitudes. By teaching the principles of humanism during medical training and exposing medical students to underserved patient populations, the students may become more sympathetic toward their patients. If they are less judgmental about their patients' lives, perhaps they will be able to provide more empathic care.

3) The authors talk about limitations. It seems a major limitation is that this instrument has only been tested in one Texas academic institution. It needs far wide field testing before it is ready for publication and use.

P. 13-14, Conclusions, 2nd Paragraph: No action taken.
We acknowledged the fact that the small sample size and one test site were limitations but specified the need for a larger number of participants from other medical specialties. Further, we concluded the paper by stating our intention to include participants from other medical schools in the US and to expand our sample to other health care professionals to further test the instrument's overall validity.

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

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
Discretionary Revisions (which the author can choose to ignore)

What next?: Reject because too small an advance to publish in any journal

Level of interest: Too insignificant to warrant publication in any journal

Quality of written English: Acceptable

Statistical review: Yes

Declaration of competing interests: no competing interests