Author's response to reviews

Title: Deconstructing patient centred communication and uncovering shared decision making: an observational study

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PDF covering letter
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Reviewer: Dr. Nicky Britten

1a. Measures: We agree that the measures we have used had limitations. We have now included box 1 to describe the items and underlying indicators in detail, as the reviewer suggested. This shows that these items cover a wide range of specific aspects, but that the scores per item are at a global level. An advantage of using the MAAS data was that we avoided an ‘intention bias’ which may be related to measures for PCC or SDM. We have rewritten the paragraph on the measures in the methods section to explain better why we made this choice. (‘For the purpose of …’). Limited time and money were of course additional reasons not to use more than one measurement instrument.

1b. Reliability: We have included in the discussion section, par. 1: ‘These findings should be interpreted in the context of the limitations of the measurement instruments.’ And par 2: ‘However, more reliable scales would provide better possibilities to identify significant associations with other factors.’ We hope this emphasises the point sufficiently.

2. Explorative study: we have added this to the methods section of the abstract.

3. Aims in abstract: we have added this.

4. Women patients: The hypothesis refers to women patients (unfortunately we had too few women doctors to test hypotheses related to patient-doctor dyads). We have replaced reference 6.

5. Sampling of GPs and patients: We did not record in detail reasons and numbers of refusals, but we have added some information in the methods section (first paragraph).

6. Age of patients unknown: this figure is similar to other studies, but we have no suggestions for its interpretations (e.g. are these mainly older patients? Younger patients?)

7. Statistical power: This is a good point. The number of GPs and patients was based on a power calculation for the larger study, a randomised trial. We have calculated retrospectively which differences could be detected approximately, given the actual numbers and added this calculation to the section on data-analysis. We included this in the section on the data-analysis: ‘Given the 60 GPs and 10 patients per GP (these numbers were based on a power calculation for the larger study), the actual standard deviations and intraclustercorrelations found, and alpha=0.08 and power=0.80, this study had the power the detect differences between equally-sized groups of 0.3 points on the SDM scale and 0.4 points on the PCC scale.’

8. Paradigm of PCC: This paradigm may be labelled as a biopsychosocial or holistic approach.
Reviewer: Dr. Peter Bower

1a. Measurement methods: We have changed the sentence on the availability of measurement methods in the discussion, and we now only claim the relevant measures for SDM were not available at the time of the study. The Stewart measure for patient-centredness was of course available at that time. We had practical reasons (resource limitations) for choosing the MAAS (a relatively short instrument), as well as methodological reasons which have been included in the methods section as a response to point 1 of the first reviewer.

1b. Reliability: We agree that the dimensions may need to be further differentiated and we have included this in the discussion section, par. 2: ‘However, the low reliability suggests that the dimensions can be further differentiated.’ Each consultation was scored by one rater. The evidence for the reliability of this procedure is provided by a study of Ram et al., who showed that the generalizability coefficient per GP (with 12 patients per GP) is 0.79 if there is one rater and 0.85 if there are two raters per consultation. So using one rater instead of two reduces the reliability only a little bit. The generalizability coefficients in his study reflect the reliability of the measures, taking into account the number of items, raters and consultations per GP. Two remarks should be made:

- His instrument included the 12 items on communication as well as 4 items on medical skills, which we did not use. If only the 12 items on communication are used (as we did), the reliability coefficients are somewhat higher, so that we only needed 10 patients per GP (Ram, personal communication).
- We did not calculate reliability coefficients per GP, but reliability coefficients per consultation (Cronbach’s alpha, which is a specific type of generalizability coefficient). Since these reliability coefficients per patient are not affected by the number of consultations per GP (only by the number of items and raters), these are usually higher than the reliability coefficients per GP.


2. Choice of measures: We have omitted the sentence refered to by the reviewer. The reasons for choosing the MAAS have been described in this paragraph as a response to remarks 1 of both reviewers.

Minor points
1. Figure 1: We leave it up to the editors to include or exclude this figure. We think it illustrates nicely the difference of clustering within GPs between the two measures.

2. Hypothesis 1: The hypothesis mentions a ‘moderate’ correlation, but we have indeed not quantified this. Most correlations in social science research are low. To our knowledge, $r=0.20-0.25$ is usually considered a weak correlation, based on (old) studies with observers who interpreted plots that reflected different sizes of correlations. A correlations of 0.35-0.40 would refute the hypothesis. As we cannot change the hypothesis posthoc, we have added in par. 1 of the discussion between brackets that the correlation between PCC and SDM was weak but existent.

3. Hypothesis 2: Again, we cannot change the hypothesis posthoc, but we agree with the reviewer. We have tried the underlying rationale for this hypothesis better by adding that the PCC competencies apply to all consultations, while the SDM competencies should be applied more flexibly. When SDM is relevant and when not, is a topic for debate which is difficult to summarize shortly and probably outside the brief of this paper.

4. Other factors tested: We did not have a priori expectations regarding these factors, but we thought it would be interesting to show their association with PCC and SDM. Perhaps it is most straightforward to omit this information, which we would accept, but we felt presenting this information adds something to the paper.
5. Representativeness: We responded to these remarks partly in point 5. Unfortunately, no information about refusers is available.

6. New measures: We have added two references (nr 15 and 16)

7. Paradigm: We agree that the older descriptions of evidence-based medicine suggest that only knowledge determines decisions, but newer descriptions do in fact include patient preferences as well.

8. Re-writing: We have rewritten these two sections.

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