Author's response to reviews

Title: Implementing A Pilot Leadership Course for Internal Medicine Residents: Design Considerations, Participant Impressions, and Lessons Learned

Authors:
Daniel M Blumenthal (dblumenthal1@partners.org)
Ken Bernard (kbernard@partners.org)
Traci N Fraser (tnfraser@partners.org)
Jordan Bohnen (jbohnen@partners.org)
Jessica Zeidman (jzeidman@partners.org)
Valerie E Stone (vstone@mah.harvard.edu)

Version: 3
Date: 29 October 2014

Author's response to reviews: see over
October 29, 2014
Jamiu O. Busari, MD
Associate Editor
BMC Medical Education

Dear Dr. Busari:

Enclosed please find a revised version of our manuscript entitled “Implementing A Pilot Leadership Course for Internal Medicine Residents: Design Considerations, Participant Impressions, and Lessons Learned.” (MS # 8341942481367119). We appreciate the thoughtful reviews from the two external peer reviewers, and have made significant edits in response. We have included below a point by point response to each of the reviewers’ questions and recommendations.

Also attached are two versions of our manuscript: one with modifications with changes tracked and a “scrubbed” version in which all of these changes have been accepted. Please note that the page and line references below correspond to the version with changes tracked, and not the “scrubbed” version.

Please do not hesitate to contact me if you have any questions or concerns about this revised version of our manuscript.

Thank you again for considering this manuscript for publication in BMC Medical Education. We look forward to hearing back from you soon.

Warmest regards,

Warmest regards,

Daniel M. Blumenthal, MD, MBA
Massachusetts General Hospital
Department of Internal Medicine
Division of Cardiology, GRB 800
Boston, MA 02114
Dblumenthal1@partners.org
Response to Dr. Ka’s Reviewer 1) Recommended Revisions:

I) Minor Essential Revisions

Reviewer comment: Minor Essential Revisions: Table on supplement outlining your program-hours assigned do not match your text (perhaps should say approx. 3 hours) but also do not add up to the times listed for individual sessions.

Author response: Thank you for this very helpful, and specific, feedback. In Appendix Table 1, we have updated and revised the times listed for entire course sessions, and specific components of each session, to be sure that the total time allotted for each session equals the sum of the times for each of the activities planned in that session. We have also amended the abstract (p. 2, line 8) and text (p. 8, line 1) to note that the sessions ranged from two-three hours in length.

II) Discretionary Revisions:

Reviewer comment: “I note that you covered team leadership at the end of the series… Did you teach them in this course or in other parts of the curriculum how to facilitate small groups-I ask because I see that you have members facilitating each time. Were they taught to do so and if not, could that have affected the success of your small group sessions. Can you also clarify if the small groups stay the same so that they can form, storm, etc….”

Author response: These are excellent points. We have added a sentence to the discussion to acknowledge that we didn’t train participants to lead small group sessions, that this lack of training could have affected the success of these groups, and that some of the criticisms of the small group sessions could reflect ineffective facilitation (p. 15, lines 14-17). We have also added a sentence to the methods (p. 8, lines 16-17) to clarify that participants could not switch out of their assigned group.

Reviewer comment: “Your focus is on clinical leadership-I understand your focus in terms of patient care outcomes…what about leadership in others domains of a physician? You may want to comment that you are focusing on this aspect only and the larger context of leadership development or perhaps the transition of the KSA gained in your course to other areas outside of clinical” medicine.

Author response: This is another excellent point, and we agree. The final paragraph of our introduction defines the scope and aims of the leadership development course, and
the purpose of the paper: “The LDC’s goals were to 1) Help residents to develop basic leadership skills that are directly applicable to their clinical work; 2) Promote residents’ personal and professional development; and 3) Build longer-term interest in leadership and management. The aims of this paper are three-fold: First, we describe the methods used to develop, implement, and evaluate this pilot leadership course; second, we present initial post-course feedback from participants; and third, we highlight lessons from our experience that may inform efforts to create similar training interventions in other residency programs and across specialties.”

We believe that this paragraph clearly defines the scope and aims of the course and manuscript, and have therefore decided not to make any additional revisions in response to this comment.

Reviewer comment: “You have other interesting features such as using peers as ‘teachers’ within this program-fairly unique that you may want to comment about as well.

Author response: This comment is very insightful. However, we did not ask participants to comment on, or evaluate the use peers as ‘teachers,’ and would prefer not to comment on this unique aspect of the course in the absence of any data to help inform these remarks.

Response to Dr. Dath’s (Reviewer 2) Recommended Revisions:

I) Major Revisions:

Reviewer comment: “page 3, second sentence “clinical leadership skills…” is conjecture stated with high confidence: X is ‘vital’ to Y. Later, you state that leadership skills are not trained, and that clinicians therefore never develop ‘basic’ leadership skills. The totality of this paragraph is tantamount to stating that much of the medical care in the US is not of high quality and is not cost effective. That is quite a whallop. Yet, you have not proven this train of thought in any way. This statement should be re-written, softened, or stated as an hypothesis, theory, or question instead of stated as fact.”

Author response: This is an excellent observation. We have rewritten lines 5-11 on p. 3 to soften our assertions, and to emphasize that doctors currently learn clinical leadership skills through “ad-hoc,” on-the-job learning, as opposed to through formal leadership development programs.

Reviewer Comment: page 10: Data analysis. “You have small numbers. You compare the two right-most outcomes on your agreement scale with the mid-point. However, a stronger measure would be to compare <agreement> with <neutrality or disagreement>. Given your results, I do not expect the outcomes to change anyways.”
Author response: Thank you for raising a very important question about our statistical methods. After thoroughly considering your suggestion for revising our statistical analyses, we would like to respectfully disagree with your recommendation. Our reasoning is as follows: We actually compared the mean of the numerical value of all likert scale responses (on five point scale) to a given question to the number three, which corresponds to a likert scale response of “neither agree nor disagree.” In doing so, we were asking the following question: Is the mean of the participants’ responses statistically different from the response “neither agree nor disagree” (which suggests ambivalence, as opposed to moderate or strong disagreement). It is actually more difficult to meet statistical significance using this method than using the method recommended by the reviewer for two reasons: 1) The mean of all likert responses includes all responses, not just those who agree somewhat or strongly (i.e. “4’s” and “5’s” on a 5 point likert scale). Thus, just a few “disagreement” responses to any given question (scores of 1 or 2 on the likert scale) can significantly shift the mean towards 3. Thus, by including all responses, we are giving our respondents the best possible chance to show us that they don’t agree with a given question stem. 2) The mean of responses of people who are neutral (likert scale score of 3), disagree somewhat (likert score of 2), or disagree strongly (likert score of 1) can never be greater than 3. The further the mean of these responses is from 3, the more likely we will be to find a significant difference between this mean, and the mean of the responses of those who agreed with the question stem (i.e. the mean of all individuals who chose 4 or 5 on the likert scale). Thus, by comparing the mean of our responses to 3, we are again biasing our analyses towards the null hypothesis (that there is no difference between the mean of the participants’ responses and the number 3). For these reasons, we have elected not to revise our statistical methods or rerun any analyses. Moreover, as the reviewer astutely pointed out, and for the reasons outlined above, we are certain that running the analysis suggested by the reviewer would not change our findings (and might actually strengthen them by lowering our p values even further).

The reviewer’s comment does raise another important question: Is our explanation of our statistical methods unclear? We have therefore reviewed the methods section closely, and have made some revisions that we hope will help readers to understand our statistical methods (p. 10, line 20).

Reviewer Comment: “page 11: results. Your results are provided in table form and reiterated in text form in the results section. Use the text to summarize only and shorten the reader’s work.”

Author response: This is another very helpful recommendation. We have removed almost all of the direct numerical comparisons of responses and p-values for our survey questions from the text. The results section now includes a more concise summary of the survey responses.
Reviewer Comment: “You mention the 4 Kirkpatrick levels of assessing the residents to evaluate the course. This is misleading as you only truly assessed K1,2 and hope to assess K 3,4 later. It is like an IOU study—not good technique.”

Author response: This is an excellent point. We have removed our one reference to Kirkpatrick level 3-4 outcomes (p. 9, lines 20-22), and our description of ongoing course evaluations (p. 11, lines 9-16 and Appendix 4).

II) Minor revisions:

Reviewer Comment: Page 8, line 12: “rewrite ‘four-five’ as four to five; similarly, correct line 18

Author response: Thank you. We have made these changes to the manuscript.

Reviewer Comment: Page 19: “Promote leadreship… ‘repair the word ‘Leadership.’”

Author response: Thank you. We have amended the manuscript accordingly.

Other Changes

1) Per your request, we have added to the manuscript a sentence about informed consent for survey completion. This sentence (p. 10, lines 14-15) reads as follows: “participants were told that completion of a survey implied informed consent to use this information for research purposes.”

2) We have moved our statement about IRB exemption to lines 16-17 on p. 10. This sentence makes clear that our study was evaluated and deemed exempt by our institution’s Institutional Review Board (IRB).