PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (see an example) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below. Some articles will have been accepted based in part or entirely on reviews undertaken for other BMJ Group journals. These will be reproduced where possible.

ARTICLE DETAILS

TITLE (PROVISIONAL)	**Improvement in the quality of doctor-patient communication between 1982 and 2001: an observational study on hypertension care as perceived by patients and professionals**
AUTHORS	Butalid, Ligaya; Verhaak, Peter; Tromp, Fred; Bensing, Jozien

VERSION 1 - REVIEW

REVIEWER	***Professor Ian Watt*** University of York Department of Health Sciences/Hull York Medical School Heslington York YO10 5DD
REVIEW RETURNED	20-Jun-2011

THE STUDY	This is an interesting paper which provides an analysis of whether doctor/patient communication has improved in recent years. In general the methods are well described, however, further detail would be helpful in one or two areas. Firstly, how were the 103 consultations on hypertension selected from the 1982-84 cohort (or do they represent all the hypertension consultations in the cohort)? Secondly, how were the 12 GP observers selected? It should also be clarified in the paper that the 108 videotaped consultations in the 2000-2001 cohort were undertaken by a 108 GPs (ie. 1 hypertension consultation per GP).
RESULTS & CONCLUSIONS	My main concern with the paper relates to the discussion section. The authors state that their findings indicate that clinical guidelines do not necessarily jeopardise individual attention for the patient. This maybe the case but I feel the authors maybe overstating this on the basis of this particular paper. Their study is based on consultations for hypertension, the vast majority of which were repeat visits. To my mind this gives rise to a number of concerns. Firstly, I am uncertain the extent to which follow-up hypertension consultations generate scope for patients to voice psycho-social concerns compared to other conditions hence hypertension may not represent the best exemplar condition through which to assess GPs skills in providing psycho-social care. I also think that evidence based guidance on the treatment of hypertension was available to GPs in the 1980s, as well as more recently, and therefore I would avoid unduly simplistic interpretations of the role of task orientated care in a quality of communication. As a further point, I would welcome clarification on how much scope there was for GP observers to judge medical technical quality in relation to hypertension treatment guidelines when dealing mainly with follow-ups. In summary therefore, I feel that the paper whilst interesting should express caution in the external validity of the findings given the consultations are based largely on hypertension follow-up consultations.

REVIEWER	***John Skelton*** Professor, Clinical Communication College of Medical and Dental Sciences University of Birmingham Edgbaston BIRMINGHAM B15 2TT UK No competing interests
REVIEW RETURNED	23-Jun-2011

THE STUDY	There is a comparison between how one group of doctors assessed a set of videos in the 1980s, and how a contemporary group of doctors assessed them. The research design is a clever idea, and creates an interesting way of executing this kind of diachronic study. However, given the (necessary) subjectivity of the judgments, it is much less clear that doctors at both periods were looking for, or assessing, the same thing. Did doctors in the 1980s mean the same thing by "interpersonal", for example. This kind of term tends to be bound up in the sociopolitical dialogue of its times. This difficulty - indeed, the general difficulty of dealing with subjective judgments - needs to be more fully addressed in the Discussion. This is one reason why I feel the conclusions are overstated, and why I think eg the claim for "improvement" - foregrounded by the use of the word in the title - is overstated. The other is, of course, that the study reports changing perceptions rather than changing facts. In addition, I would like a little more information about how one is to distinguish "psychosocial" from "interpersonal" (an obvious weakness of the study is that to some extent the authors must extrapolate from written report how these terms were originally interpreted, a point which also needs drawing out). And, in the case of the patients, how both are to be distinguished from "clarity", which prima facie is simply a part of successful interpersonal interaction under many circumstances.
GENERAL COMMENTS	See above. This is an intriguing study, with a great deal to recommend it. It is painstaking and workmanlike, and well put-together - but also of real interest. It looks as if it forms part of a PhD thesis, and if this is so, the first author is to be commended. I think the real meaning of the findings is considerably more ambiguous than is suggested, and would encourage the authors to pull their conclusions back somewhat. But this is a study I enjoyed reading.

VERSION 1 – AUTHOR RESPONSE

Dear Mr. Sands,

Thank you for the opportunity to revise and re-submit our paper. We were pleased to read that both reviewers found the study interesting and we are grateful for the thoughtful comments of the reviewers that helped us to improve the paper and clarify critical issues. Below we have indicated how we have changed our paper in response to the reviewers' comments. As you have requested, we also confirmed in the contributorship statement that all authors approved the final submitted version of the manuscript.

Both reviewers commented that the conclusions drawn in the paper are overstated. We agree with the reviewers that the findings might be more ambiguous than we have suggested in the Discussion

section of the paper and therefore we made some changes and added more nuances in our conclusion statements (p9-11). The abstract and article summary have also been adjusted to the changes.

* The vast majority of repeat visits in the sample indeed require some caution in generalizing our findings. In response to reviewer #1 (Professor Ian Watt), we added this issue as one of the limitations of our study. However, we also believe that it is important to judge the psychosocial quality of hypertension consultations, as psychosocial factors do play an important role in hypertension (Steptoe, 2000), but are often and easily overlooked (Roter et al., 1992). Repeat visits might provide a good opportunity to pay attention to psychosocial issues, because doctors are already familiar with the patient and his/her psychosocial background, while patients who are already familiar with the GP might find it easier to voice their concerns in repeat visits.

* Reviewer #1 mentioned that the change in perceived quality cannot fully be addressed to the implementation of clinical guidelines, since these guidelines were already available in the 1980s. To avoid overstatements we have removed this conclusion and adjusted the texts in the Introduction section that referred to a possible relation of the implementation of clinical guidelines and changed perceived quality.

* We are aware of the changing context between the two periods as reviewer #2 (Professor John Skelton) pointed out. Although we cannot avoid the effect of time and context, we can guarantee identical procedures and instructions to the two groups of GP observers, since one of the authors (J.M. Bensing) was involved in both studies and supervised the quality assessments by the peer GPs. Moreover, the written quality assessment protocol which was used in the first study was available for the second study.

* Reviewer #2 also pointed out that the study reports changing perceptions rather than changing facts. We fully agree with the reviewer on this issue and we also recognized that the Discussion section was not always clear on this. Therefore, we paid extra attention to the wording and avoided the claim for 'improvement' (also in the title).

Furthermore, the reviewers requested clarification on some methodological issues.

Reviewer #1 (Professor Ian Watt)
* How were the 103 consultations on hypertension selected from the 1982-1984 cohort?
The selected 103 consultations with hypertensive patients were all hypertensive patients from a larger sample (n = 1569) of videotaped GP consultations, which were recorded for a PhD-project, supervised by the last author (J.M. Bensing). This is the 1982-1984 cohort. In the revision of the paper, clarification on this issue is provided in the paragraph 'videotaped consultations' in the Methods section (p5) and some additional references are provided in which the data collection is described in more detail (Bensing, 1991; Bensing & Dronkers, 1992).

* How were the 12 GP observers selected?
The GP observers were recruited from the Dutch National Register of General Practitioners, which is kept by NIVEL. A random selection was made of all GPs working in a radius of < 20 kilometres from Utrecht, where the database is kept. Exclusion criterion was: being videotaped in the same project. Clarification of the selection of GP observers is provided in the paragraph 'peer assessment by general practitioners (GP observers)' in the methods section (p6).

* Clarify in paper that the 108 consultations in the second cohort were undertaken by 108 GPs.
Clarification on this issue is provided in the paragraph 'videotaped consultations' in the Methods section (p5).

Reviewer #2 (Professor John Skelton)
* How is one to distinguish 'psychosocial' from 'interpersonal' quality?
For the assessment of psychosocial quality, the GP observers and patient observers were asked to pay attention to the degree to which the GP was receptive to any non-somatic aspects related to hypertension. These could for example refer to stress-related factors in the origin of hypertension and the psychosocial problems caused by hypertension or its treatment. In contrast, assessment of the interpersonal quality referred exclusively to the way in which the GP succeeded to build an open and secure relationship with the patient.
We noticed that patient observers easily related to psychosomatic aspects of hypertension, such as stress, and were well able to distinguish the psychosocial dimension from the interpersonal dimension of quality, but also from the clarity of any medical explanations given by the GP.
We provided a more detailed explanation on these two quality dimensions in the paragraphs 'peer assessment by general practitioners (GP observers)' and 'patient assessment by patient observers with hypertension' in the Methods section (p6-7).

We hope to have given sufficient reply to the comments by the reviewers and the editors.

VERSION 2 - REVIEW

REVIEWER	***John Skelton***
REVIEW RETURNED	01-Jul-2011

GENERAL COMMENTS	Very interesting! and happy with changes

REVIEWER	***Ian Watt***
REVIEW RETURNED	13-Jul-2011

THE STUDY	It is stated that in the 2000/1 dataset one hypertension consultation was selected from each of the 108 participating GPs. No detail was given on what guided this selection (eg. was it a random selection, convenience selection).