Author's response to reviews

Title: The views of general practitioners and practice nurses towards the barriers and facilitators of proactive, Internet-based chlamydia screening for reaching young heterosexual men

Authors:

Karen Lorimer (karen.lorimer@gcu.ac.uk)
Susan Martin (susan.martin@glasgow.ac.uk)
Lisa McDaid (lisa.mcdaid@glasgow.ac.uk)

Version: 3
Date: 12 June 2014

Author's response to reviews: see over
Dear Editors and Reviewers,

RE: MS: 1236462604125621

‘Screening experiences and the views of general practitioners and practice nurses towards the barriers and facilitators of proactive, Internet-based chlamydia screening.’ Karen Lorimer, Susan Martin and Lisa McDaid

(Now changed to: ‘The views of general practitioners and practice nurses towards the barriers and facilitators of proactive, Internet-based chlamydia screening for reaching young heterosexual men’)

We return the revised manuscript having made almost all recommended changes suggested by the reviewers. Most reviewers picked up on similar issues, so our changes attempted to take this into account by rewriting text to suit all reviewer comments. We are pleased that the comments largely pertain to increasing clarity on particular points rather than questioning the scientific merit, credibility or importance of the work.

Below we provide a point-by-point account of each reviewer comment and our response. To aid reviewers we have used red text in the revised manuscript to indicate addition or change. Please note that line numbers now do not now correspond to original reviewer comments, as additional text has shifted the overall alignment.

We firmly believe we have added further clarity and thank all reviewers for their time, and helpful comments. We believe this is a much-improved manuscript, with interest to the journal’s readership.

Should we be required to make any further changes we would be happy to do so.

Please do not hesitate in getting in touch.

Regards,

Dr Karen Lorimer (on behalf of all authors)
Comment 1 - The concept of the term 'screening experience' is not clear at the outset of the paper. It would be helpful to describe this at the beginning, and why this links in to the design of the internet screening.

The experiences that GPs and PNs had of screening men and women were explored within interviews as a way to provide context to their views towards the proposed Internet-based approach. Given the issues to emerge we chose to flag these and place ‘screening experiences’ in the title. However, we don’t feel particularly strongly about this so we’ve amended the title.

- We changed the title by removing ‘screening experiences’.

Comment 2 – part 1 – it is not very apparent what the internet-approach might be. We have now added in more detail about this.

Comment 2 – part 2 – why seek the views of GPs and PNs?
We provided this information across lines 130-132.

- However, we have added a further sentence to our explanation (now lines 132-136), plus a reference (now reference 22) to work raising concerns among GPs about changes to workload from a new approach that may drive patients towards primary health care.

Comment 3 - What was the rationale for selecting 2 central regions (Edinburgh and Glasgow)? This is not clear to the reader.

- On p7 we now provide information on this decision, which was partly pragmatic due to the concentration of services across these two areas of the country.

Comment 4 - It is not clear from the methods whether only one health professional was interviewed at each practice, or whether several could be interviewed at one practice.
Yes, we only sought one interview at each included practice.

- We inserted a short sentence – line 160 - to make this clearer.

Comment 5 - The methods suggest that practices were purposefully selected for high and low deprivation, and for low and high proportion of males 16-24 registered. What did the authors consider to be 'low' deprivation or 'high deprivation'? And what proportion of registered males were considered to be high/low? (See later comment re results)

The SIMD was fully explained across lines 163-171, including 1 being high deprivation and 5 being low deprivation. So a high deprivation practice was SIMD 1 and a low deprivation practice was SIMD 5. We wanted to ensure we did not just recruit 3 or
4, but to also have SIMD1 and 5 practices to get a possible range of experiences and views influenced by those experiences.

It turned out that whilst we may have wanted to recruit GPs and PNs from practices with ‘high’ or ‘low’ percentages of young men registered, in fact there were only a few at these extremes. We took the average of 13% as a benchmark and considered practices with <10% as low and >45% as high, to capture these extremes.

- We inserted more text to explain this on page 8.

Comment 6 - Who undertook the interviews? Was it just one researcher, or a team?
- We added four words to page 9 to state that the first author, Karen Lorimer, conducted the interviews.

Comment 7- How were the data analysed? Was each interview analysed independently using the coding framework by each researcher, then results compared? Or did members of the team analyse a proportion of the interviews?
- Two sentences were added to page 9 to further illuminate the team process.

Comment 8 - If interviewees were purposefully selected from the practices as stated in the methods, it is unclear why the practices are from a range of areas of deprivation (not just low/high), and why the proportion of registered 16-24 yr males is similar between practices. This should be clarified in the discussion section.
We stated we wanted a plurality of voices and experiences (page 7), which may have been influenced by working at a ‘high’ or ‘low’ deprivation practice or by having few or many young men registered at the practice. We attempted to include practices drawn from across deprivation areas, including low and high not just 3 or 4.
- We have attempted to clarify this in our text on page 7

Comment 9 - It is unclear how the experience of GPs and PNs in a practice setting is relevant to an internet approach. Much of the results section reported on why GPs/PNs think they may screen more women, or feel more comfortable raising sexual health as a topic, but this is not related to the discussion or conclusion.
We have now further explained why we chose to interview GPs and PNs as part of developing an Internet screening approach. We have added to the discussion on page 6.

REVIEWER 2: Elaine O’Connell Francischetto

This question is clearly posed however (as I also mention later) neither the discussion nor conclusion clearly reflect on this and do not clearly state how this work will inform the subsequent design of an Internet-based approach to chlamydia
screening. In particular it is not completely clear how these health professional interviews will inform the design of the study. More information on this would be beneficial.

A clearer rationale for why they have interviewed GPs and PN in addition to young men would also be useful (how will they inform the design of RCT?).

- We expanded on this in view of Reviewer 1 comment 2. See page 6 for addition text.

It would be useful to have some context on the internet based chlamydia screening intervention. It is also not clear what information the GPs and PN were given regarding the intervention prior to the interview or the exact process they were giving their views on. Describing the information that participants were given and the intervention would benefit the reader.

- We have now included a figure (Figure 1) to illustrate the process as we explained it to the GPs and PNs.
- We added text to page 8 to refer to Figure 1.

More information on how they developed and what informed the design of the semi-structured topic guide.

We now provide this on p8.

The analysis methods would benefit from added information on how they ensured reliability and how discrepancies were resolved.

We added some additional text to page 9 to more fully illuminate this.

Occasionally it is stated that both GPs and PNs both mentioned an issue but quotes are only presented for the GP, for example the first paragraph of “Experiences of screening women and men for chlamydia” there are 2 quotes from GPs and none from PNs.

- We added a quote from a PN and reduced the GP quotes from 2 to 1, on page 11.

Some really interesting points are lacking supporting quotes which would benefit and be of interest to the reader. For example where you discuss: GPs reassessing their perception of men’s low attendance (lines 251-255), unsolicited questions (lines 320-323), higher screening when payments are offered (lines 327-329), normalising screening (lines 399-406).

- We added a quote for the ‘reassessing’ point
- We already provided a quote for the ‘unsolicited questions’ (by GP10), but we moved the GP quote from p12 to p14 to be within that section, thus now providing two quotes for this
- We added a quote to page 17 to evidence ‘normalisation’

Where you discuss GP describing their reluctance to initiate conversations around sexual health with men, but state that very few PNs offered such accounts (Line
286-300). This is unclear – did they offer opposing accounts in that they were happy to initiate conversations around sexual health with men or did very few not even mention it? You may want to rephrase or add another quote to reflect what you mean.
We added some text to explain what we mean on page 13.

The authors want may want to specify if they considered any guidelines, such as the BMC RATS Guidelines? **Discretionary**

This discussion and conclusion need to reflect the stated intent of the study more and state how these findings will inform/impact the design of the intervention and the next steps of the research. As you have stated that understanding the views of GPs and PNs is vital to the future design of a randomised controlled trial, but how they have done so not completely clear. It may be useful to summarise the results that have informed the RCT.

- We have added further text to the bottom of page 19 and to page 20 to expand on this point.

It may be useful to know if the authors have also considered how the findings relate to the following paper: **discretionary**


- We have now included this reference within context.

There is a lack of information on the limitations inherent within qualitative research and how the interviewer could have influenced the findings.

- We have now flagged the interviewer status, but as a positive not necessarily a limitation, on page 19.

This work would benefit from a clearer link between work they are building and the on-going research.
- We now have text indicating the findings we will take into our intervention development (page 20).
Yes the abstract does convey what has been found, but the conclusion lacks information on how this has informed the design of RCT, this should be made clearer in the conclusions.

- We have now flagged the key issues the future RCT should take account of.

The writing is acceptable however the use of terms in not always consistent (for example the use of numerous terms which are all used to refer to the GPs and Nurses: interviewees, respondents and participants). Use of consistent terminology would be preferable.

- We have now only used the term participants.

Reviewer 3:

Stick with the use of the same terms throughout i.e. you have used the words respondents, interviewees and participants all to describe GPs and PNs.

- We have now referred to participants throughout

Either describe the interviews as ‘short’ or ‘brief’

- We went with short

Given the study is about proactive internet screening of young men I think this needs to be reflected in the title. I suggest: Screening experiences and the views of general practitioners and practice nurses towards the barriers and facilitators of proactive, Internet-based chlamydia screening targeting young men.

- We revised the title to: The views of general practitioners and practice nurses towards the barriers and facilitators of proactive, Internet-based chlamydia screening for reaching young heterosexual men

Line 33: The word in-depth should be removed from the start of the sentence – these interviews are not in-depth qualitative interviews and you have described them elsewhere as ‘brief’ or ‘short’. I would advise that you simply state that ‘short semi-structured’ telephone interviews were undertaken.

- We removed the word in-depth.

Line 41: insert ‘female’ before ‘patients’ to reinforce that it is female patients you are referring to here.

- We inserted ‘female’

Line 43-45: I would rephrase this sentence as it’s not clear what are the facilitators and what are the barriers: Consider -
‘Respondents reported ease of access and convenience as potential facilitators of an internet based approach. Anonymity and confidentiality were identified as being both potential barriers and facilitators to the success of an internet approach to screening’.

- We have now amended this sentence.

**Line 53: Word ‘ensuring’ should be ‘ensure’**
- Changed to ensure

**Line 130: I am not clear from this sentence (and the Methods section) whether you asked GPs and PNs about the potential use of registers to contact men for chlamydia screening. I make this comment a bit later, but I would like further detail and clarification around how you may have proposed (even roughly?) that proactive internet based screening may work….For a semi structured interview schedule your description of your interview topics is rather brief and undetailed.**

- We now provide more information on page 8 and 9

**Line 159: I would like to see this whole paragraph moved up to follow on after the end of the first sentence in Line 143. ‘…registered with the practice’. It makes more sense to provide further explanation here.**
- We made no changes.

**Line 146: I would remove the word ‘but’ from after ‘short’ – not necessary. Just say ‘short, focused semi-structured telephone interviews…’ and I would be inclined to either reference (sounds straight from a text book) or reword the remainder of the sentence ‘…in order to generate comprehensive explanations of the specific phenomena under consideration and include a plurality of voices and experiences’**

- Word ‘but’ is removed.
- The text was written by the first author and has not been changed.

**Line 173-178: I think you need to swap these two sentences around. So start with ‘A semi structured topic guide was designed to guide participants through topic areas [remove word ‘these’] with the use of ….’ And follow on then with ‘Topics included: screening experiences….’**

- Due to other reviewer comments we have significantly re-worded this section so we can now not make the suggested sentence change.

You have listed three quite broad topic areas only here – given you have stressed that you have used a focused semi structured interview schedule I would like to see more detail on the interview topics covered. Also did you collect GP demographics? If so, could you please detail and note how many questions/items were collected.

- We have not indicated the 7 key areas in the interview schedule.
I would also like some further explanation, as I mentioned earlier, around how you explained or described to GPs (or didn’t) how proactive internet based screening might work. I think the reader needs a clearer picture of what GPs and PN’s were informed about prior to the interview taking place. i.e. it seems that you mentioned or the GPs assumed there would be a register...

- Lines 187-188 explain this (in addition to a Figure now included).

Data analysis
Line 180-197: Could you provide a little further explanation around how you decided you had reached saturation point – it’s not enough to just say that interviews ceased after you reached saturation point (line 154). Your aim was to do 20 interviews but you stopped at 18 – why? Did you analyse interviews as you were going along and decide as a team that no new themes/issues were arising from the data? Did you make any changes to the interview schedule along the way to address further issues/questions that arose from the data as you went along?

- We added additional text to clarify on page 7 the process and our decision on data saturation, which was determined to occur when the same comments were being offered to questions with no new data emerging.

Line 245 The word ‘then’ should be ‘than’.

- This has now been changed.

Lines 251-255: I would like to see a quote here to illustrate this point and possibly a little more clarity on this point i.e. once GPs were asked to reflect on the frequency of young men’s visits they realized that they saw young male patients more often than they thought... Did any GPs then reflect that they had more opportunities to offer screening than they thought?

- Quote supplied.

Line 286 – I would remove the last part of the sentence about PN’s as it isn’t further explained until the following page. I would just start with ‘Many GPs voiced their reluctance to initiate .... describing such encounters as ‘difficult’...’

- We’ve now changed this.

Line 323 – Consider rewording – awkward working – ‘Most PN’s did not raise these issues due to the infrequency with which they interacted with men in their practice’.

- Changed to Fewer nurses offered such comments, perhaps reflecting their infrequent contact with young men.

Line 303-306: Again I found this sentence awkward. Consider rewording to something like: ‘While GPs commonly talked about their embarrassment and
discomfort in raising the issue of screening, GPs in high depravity areas were more likely to report that chlamydia screening was not a high priority for many of their young male patients who had more pressing health issues'.

- We’ve simplified this now on page 13. Such embarrassment and discomfort was not always a key factor in failing to raise the issue of screening with men, particularly for those based at practices in areas of higher deprivation, who did not think that chlamydia was a high priority for their patients.

Lines 320 – 329 – I think this point around financial incentives for GPs and increased chlamydia screening needs to be highlighted better (add some quotes) and referred to in your discussion.

- We have streamlined this section so that all ‘financial’ data are grouped together. We have also now included this finding in our discussion and tied it to our thinking for our future intervention work (page 20).

In your discussion you discuss barriers and facilitators related to young people and internet based screening however you don’t really discuss the GP barriers you have identified – i.e. embarrassment and discomfort, financial incentives, lack of time and resources etc. There have been numerous studies which have identified these barriers. Given you conclude that a multi-faceted approach will be required to increase screening to a sufficient level to reduce chlamydia prevalence, I think it is important that you refer back to these GPs barriers, noting that these barriers will also need to be tackled as part of a multi-faceted approach. I think it’s an interesting and important point that GPs said they were uneasy with unsolicited health care interventions and yet offered them if they were part of the practices contractual issues or financial incentives. It was also interesting that once financial incentives were removed some GPs reported less concern/screening levels decreased

- We’ve now added this to page 22

Line 371 Reword so that reader can see more clearly that confidentiality/anonymity was considered both a facilitator and barrier to internet based screening. So possibly: ‘While GPs highlighted the importance of anonymity and confidentiality they also raised concerns around the type of data that would be accessed from registers for this approach...’ Again this is where I would like to have had some explanation/clarification earlier on about a ‘register’ and what GPs were told about how internet based screening might work.

- This section has been re-written in light of other reviewer comments on this issue. See page 20.

Leave the limitations until later.
We have retained the limitations up-front because this enables the reader to read our findings in the context of these important caveats.
Include strengths.
  • We have now expanded this on p19

Further discussion at the end to account for GPs and PN’s barriers to screening.
  • We have now included this in the discussion.
REVIEWER 4: Lindsey Kettinger

(Table) The table displays ‘Participant and practice demographics’, which is descriptive of the sample population of healthcare providers selected for the study, but very little is mentioned in the discussion as to how this relates to the primary outcome measures of the study. The authors go into detail (Methods, second paragraph) regarding the “deprivation score” of the practice sites of the interviewed providers; however, there is no clear correlation between deprivation score and the providers’ view on internet-based Chlamydia screening among young men. How are the responses from the providers in clinics with a deprivation score of 1 different than those from clinics with a deprivation score of 5? Perhaps this correlation can be better outlined in the discussion section.

We do not have ‘primary outcome measures’, and did not seek to find ‘correlations’, instead this qualitative work sought to explore the views of GPs and PNs to a proposed Internet-based approach to chlamydia screening. As appropriate for qualitative research, we identified themes and presented these as key findings. We stated clearly, in the data analysis section, that where there are differences in views we will flag them throughout the text, and this is what we have done, including even stating where there were no differences in views where you perhaps might expect them. For example, the issue of financial incentives seemed not to be in any way patterned at practices with low or high deprivation, nor by the gender of the participant, but was bound with views towards workloads and culture of patient-led consultations, which was found across the data.

- We have expanded on the SIMD quintiles in light of other reviewer comments, so we hope the changes are in keeping with what this comment was seeking.

The author states (Data analysis) that a major limitation to the study is that all PN’s interviewed were female; yet states that overall, there were few differences in views between GPs (50:50 male to female ratio) and PNs. This is confusing, as there is no clear relationship to gender and views of internet screening outlined in the article. How does provider gender influence primary outcomes?

We did not explore gender differences in the views of PNs but did for GPs, as we had both male and female GPs in the study. We state that few differences were evident between male and female views (GPs). We inserted the text: Female-only PNs meant we were unable to explore gender-based differences in the views raised - lines 479-480 to be clear about the point raised.

(Barriers and facilitators, Design and recruitment facilitators) The author has the subtitle “Design and recruitment facilitators” yet in the fourth paragraph potential
scrutiny relating to infidelity by male partners is discussed; this seems more like a barrier than a facilitator to screening young men. Further, the practical issues for internet screening are discussed in the third paragraph – is this a facilitator or barrier?

- The letter appearing through the mail – unsolicited – is tied to the design and recruitment aspect of the proposed approach; however, we mentioned that one participant was unsure about this given it might lead to conflict between partners who may assume infidelity. This was to be clear about the variety, and weight, of views (17 had no issue with this but one raised it). We added text (page 17) to be clear that unless dealt with these could become barriers but if dealt with carefully would be a facilitator.

Discretionary titles change suggestion

- We have now changed the title to ‘The views of general practitioners and practice nurses towards the barriers and facilitators of proactive, Internet-based chlamydia screening for reaching young heterosexual men’