Reviewer's report

Title: The nexus of evidence, context, and patient preferences in primary care: postal survey of Canadian family physicians

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Reviewer: John Epling

Level of interest: A paper whose findings are important to those with closely related research interests

Advice on publication: Accept after discretionary revisions

The authors are to be commended for addressing an aspect of evidence-based medicine that is overlooked in the excitement to evangelize - that of the application of evidence-based medicine to the real world of clinical decision-making in a primary care office.

Discretionary Revisions
1. Though the written clinical scenario methodology has been used elsewhere to report on physicians' decision-making, it still would be helpful for the authors to clarify to what extent performance on a written scenario reflects actual practice. The authors illustrate a discrepancy between self-reported value attached to evidence-based medicine and actual performance in a scenario exercise. To discuss the link between scenario performance and actual clinical performance would complete that circle (or at least acknowledge its incompleteness).

2. The authors report that there is a new focus on evidence-based decision making that takes into account patient values and the clinical setting - referencing an article by Haynes, et al. In fact, the second version of "How to Practice and Teach Evidence-Based Medicine" (Sackett, et al. from the Evidence-Based Medicine Working Group) reports a new definition of evidence-based practice: "...the integration of best research evidence with clinical expertise and patient values...." (contrast this to the previous version - "...the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients..."). It may be that in the scenarios written by the authors, the wording represents a predictable change in weight given to patient values in the integration that is part of the new definition. Yes, this is definitely decision-making that is contrary to established evidence, but it still may fit the (new) definition of EBM.

3. The authors thoroughly explore and discuss the limitation of their survey's response rate in terms of the collected demographic information. However, there may be other factors that make non-respondents different from respondents - especially in the domain of clinical decision-making. Is there a deficiency of "reflective practice" in those who don't return surveys, and so might they be less likely to examine their practice for the evidence-base? Some discussion of these other possibilities would be nice.

4. Each of scenario items one through three contain some sort of questioning from the patient ("wonders about" through "demands") about the target intervention. How would these scenarios have changed with no request from the patient? It may be that the physicians' enthusiasm for EBM is reflected in the decisions made in the absence of the patients' prompting - colorectal cancer
screening for those over 50, etc. Some rewording of the discussions and conclusions is probably necessary to account for the fact that these stylized vignettes cannot capture the breadth and complexity of clinical decision-making. It is not merely that physicians say one thing and do another - but that they may genuinely desire to use evidence, but find that patients’ values and beliefs trump the research evidence.

Compulsory Revisions
1. None. In general, the paper (including the statistics) was easy to read and presented well.

Competing interests:

None declared.