Title: Why are eligible patients not prescribed aspirin in primary care? A qualitative study indicating measures for improvement.

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Version: 2 Date: 9 Jun 2003

PDF covering letter
Dear Sir/Madam,

Further to your email of Monday 12/05/03 12:25, I am pleased to resubmit an amended version of our article. We feel that we have addressed all of the points raised regarding our paper.

Below are specific responses to each point raised.

**Reviewer:** Paul Shekelle

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<th>Revision suggestion</th>
<th>Authors’ response</th>
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<td>1. “One weakness of the methods is that it appears only a single person identified themes. I believe the standard in this field is to have themes identified independently by two or more persons and subsequent consensus resolution of any differences. Using a single reviewer increases the chance that the reviewer's own bias may have inadvertently entered into the coding of the results.”</td>
<td>The text has been clarified to reflect the nature of the analysis conducted. The method section now reads “Transcripts were analysed for major themes through an iterative process of comparison and evaluation. Each were revisited and revised as further data was gathered. DS led on analysis and met with MF and JB regularly to discuss shared transcripts. Emergent themes were examined and raised in subsequent interviews with practitioners.”</td>
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<td>2. “…The authors proposed decision analysis as one potential means of (overcoming prescribing barriers). I am not as enthusiastic as they are about for decision analysis, at least as it is normally conceived, as an active process on the part of the GP and or patient, …. If GPs cannot spend the one minute necessary to think and prescribe aspirin in the existing consultation, then it is difficult for me to imagine how they are going to engage the patient in a process of decision analysis …. I am more enthusiastic about computerized office systems that contain within them embedded decision support that can both more appropriately recognize eligible patients by capturing some of the individual patient specific circumstances the authors note, and then provide an alert or reminder to the provider.”</td>
<td>We believe that we share the reviewer’s view entirely and that our proposed idea was misunderstood. We do not propose ‘pure decision analysis’ for the consultation because, as stated by the reviewer, this is too time consuming for primary care. However we propose decision analysis is used to calculate the content of a decision support system. The system can then provide the GP with prescribing evidence for different patient profiles instantly in a consultation. This mirrors what the reviewer goes on to argue the case for. To clarify we have amended our ‘discussion’ text accordingly as detailed below. “….Decision analytical modelling is one potential means of addressing this. Decision analysis is a means of synthesising current evidence and models could be pre-calculated for a number of patient profiles commonly presenting in primary care. The results could then be incorporated into a support system for GPs to access in a consultation.”</td>
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<td>3. “…I am not as negative as the authors about the value of aggregated prescribing data in helping to inform and potentially improve practice…”</td>
<td>We have softened our text to emphasise that we are merely highlighting a need for caution in the interpretation of aggregated aspirin prescribing data because of the reported reluctance of some patients to accept aspirin as an informed choice despite GP recommendations. Our discussion now reads, “…If we accept that informed patients can choose not to receive therapy, then care is required when using aggregated aspirin prescribing data as a measure of optimum prescribing. In the absence of individual details, it is not possible to be sure whether low levels of prescribing reflect appropriate or inappropriate use of aspirin in specific patients. Individual circumstances for each decision and patient choice are key determinants of whether or not patients receive...”</td>
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treatment and in a healthcare system that encourages concordance between the GP and the patient, such a measure may be an unreliable indicator of prescribing quality. If the new GP contract is implemented there may be the facility to record in prescribing data the patients who make informed decisions not to accept a medical recommendation. Current aggregated data however must nevertheless be interpreted with caution.”

Reviewer: Paramjit S Gill

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<td>1. The background needs to place implementation in the context of the general literature on challenges of implementing evidence into clinical practice. [1] 1. Effective Health Care Bulletin. Getting Evidence into Practice. 1999, Volume 5 number 1 or <a href="http://www.york.ac.uk/inst/crd/ehc51warn.htm">http://www.york.ac.uk/inst/crd/ehc51warn.htm</a>.</td>
<td>The background has been updated and the reference has been incorporated. This now reads: “The gap between evidence and practice has increasingly been the focus of research. Several reasons have been cited to explain why some general practitioners do not implement evidence based guidelines. These include difficulties in reconciling generic evidence and trial data to individual patients, concerns that decisions may jeopardise the doctor-patient relationship, poor adherence to practice protocols and the absence of computerised systems [8-11]. It is not known whether these reasons cited for other therapeutic areas can explain the decision not to prescribe aspirin in eligible patients. The first stage of a process to improve the implementation of the evidence is therefore to identify the reasons for behaviour and the factors likely to influence any change. [12]”</td>
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<td>2. A convenience sample was used and needs to be justified</td>
<td>We have clarified our sampling to reflect that we recruited from an established network of GPs associated with our Department. The method section now reads: “After approval from the local research ethics committee, fifteen GPs from nine practices in the West Midlands region agreed to take part in the study. The practices were part of a research network established by the Department of Medicines Management, Keele University, and varied in size, type of location and catchment area. All forty-five GPs from the network were invited to participate.”</td>
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<td>3. Also why were only 15 participants chosen and this needs to be linked to theoretical saturation?</td>
<td>Re: Study sample - See response above – point 2 - we invited 45 GPs to participate, 15 agreed. Theoretical saturation was achieved and the text has been amended to read: “As this was a qualitative study, respondents do not constitute a representative sample, but their accounts illustrate a range of experiences and views on prescribing aspirin for patients in general practice. Respondents varied in age, sex and length of time that they had been qualified as a GP. Table 1 shows the characteristics of the interviewees. The&quot;</td>
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4. How did the interviewer introduce this area with the participants? Were they asked to recall cases they had managed in the past year or longer? Were they asked to keep a log of cases for a period before the interview?

Practitioners were asked at the outset whether they found prescribing aspirin in the secondary prevention of stroke difficult. This was to elicit initial reactions. The interview then discussed published evidence suggesting suboptimal prescribing. Practitioners were then asked to give examples when they had encountered difficulty or uncertainty and reflect upon whether the decision is easy or difficult and the need for more information or assistance. Themes arising from other interviews were often discussed. The methods section now reads: “…The schedule comprised questions exploring: initial reactions to whether there are difficulties in prescribing aspirin; opinions of published evidence suggesting suboptimal prescribing; the ease of implementing national guidelines; examples of GPs' own prescribing uncertainty or difficulties.”

5. Where did the interviews take place and how long were they?

The method section now reads “All interviews lasted between 25 and 35 minutes and were conducted by DS in GP practices.”

6. In view of volume and complexity of transcripts, were any software packages used for the analysis of the transcripts?

No specialist qualitative software was used in the analysis. The volume of data was such that it was not difficult to manage manually. We do not feel that this had any detrimental effect upon the quality of our analysis.

7. In terms of validation, who was involved in the analysis as it seems DS was the only one involved with constructing the themes? If so, the implications of this needs stating in the discussion? Were any field notes taken?

See above - revision 1 (Shekelle) explanation.

Also, the method section states that interviews were transcribed verbatim and were shared and analysed by 3 of the authors.

8. In the methods section, the authors state that respondents varied by ethnic group and this is not indicated in table 1.

We have deleted the reference to ethnicity from the paper. Ethnicity was not recorded as part of the short demographic questionnaire. However, the interviews comprised a mix of ethnic groups.

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**BMC email comment:**

“In addition to addressing the reviewers’ points, could we also ask you to explain a part of your abstract more clearly: the sentence begins ‘As part of a larger study of decision making and the use of evidence…’. Can you state what the larger study is and also whether it has given rise to any other papers, published or submitted?”

**Authors’ response**

The abstract now reads “…This was the first stage of a study exploring the need for and means of improving levels of appropriate aspirin prescribing.”

No other papers have been published. We are in the process of drafting a second paper to submit to the BMJ regarding the value of decision analysis in enhancing the evidence base for primary care in such cases. The emphasis of this paper and the data however are completely different our submission here. We do not intend to write any papers in any way paralleling the issues of this paper.”
If you have any further questions or points regarding our paper, please do not hesitate to contact us.

We look forward to your response

Yours sincerely,

Dr Duncan Short