Author's response to reviews

Title: Clinical decision-making: physicians preferences and experiences.

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Author's response to reviews: see over
Response to reviewers comments Feb 07

Thank you for giving us the opportunity to respond to the reviewers comments. We detail below how we have responded.

Reviewer 1: A. Siriwardena

Major Compulsory Revisions.

1. **Reviewer:** There are some omissions in the introduction. As well as determining and teaching the competencies for shared decision making, doctors are also being assessed on these competencies.

   **Response:** This omission has been rectified, and the relevant sentence in the introduction amended as follows. The reference cited by the reviewer has also been included.

   “In pursuit of this goal, there have been efforts to determine the competencies needed for shared decision-making in clinical practice {Elwyn, 2000 67 /id; Towle, 1999 85 /id}, along with attempts to teach and assess these competencies in medical students, doctors in training, and senior clinicians {Keefe, 2002 379 /id; Godolphin, 2001 43 /id; Elwyn, 1999 87 /id; Brown, 2002 1 /id; Siriwardena, 2006 411 /id} “.

2. **Reviewer:** Patients often support and require shared decision making even when doctors are reluctant. The preferences and behaviour of the doctors in their consulting style may not be reflected in the perception of patients, i.e. beliefs of doctors and their patients about the style of that doctors are exhibiting may be discordant.

   **Response:** We agree with this, and have included this (and the relevant reference) in the discussion, under methodological issues, to underline our statements about these being self-reported data with no objective confirmation.

   “It has been shown that patients and doctors may have discordant reports of the style of decision-making in any given consultation {Saba, 2006 410 /id} “.

3. **Reviewer:** Also the aim relating to “experience” of physicians may need to be changed to “expressed behaviour” or explained more clearly to differentiate this from physicians’ perceived experience as patients when they themselves visit the doctor.

   **Response:** The methods section makes it clear that the questions related to interactions where the respondent was the physician. We felt that “expressed” style was a confusing term, and wondered how many readers would understand it. In view of this, and as we agree that it is important not to intimate that the style of decision-making reported by respondents was in any way objectively confirmed,
we have re-written the various sections about “experienced” style as “perceived” style. We think this adequately addresses the referees concerns. As this involves a great many sentences and parts of the paper, they are not reproduced here.

4. **Reviewer:** In the discussion (main findings) the first sentence should be changed “..to explore physician perceptions of their preferred and expressed role in clinical decision-making” since we do not know what their actual role is.

   **Response:** As we think “perceived role” is clearer than “expressed role”, we have changed the first sentence to read as follows:

   “These are the first data from a large nationally representative sample of physicians to explore physician perceptions of their preferred and perceived role in clinical decision-making”.

5. **Reviewer:** Similarly “Their preference is by far the strongest predictor of the role the respondents stated they actually played”.

   **Response:** This has been changed to:

   “Their preference is by far the strongest predictor of the role they perceive themselves as playing in clinical decision-making, with 87% of respondents perceiving themselves as practicing their preferred role”

6. **Reviewer:** the main problem with the analysis is the issue of social desirability bias….. In the context of this, the authors need to tone down the conclusions of this study.

   **Response:** We have amended the conclusions in the abstract and the main text in line with this comment, and the similar one from Reviewer 2 (Kevin Eva).

   **Abstract conclusions:**
   “Physicians tend to perceive themselves as practicing their preferred role in clinical decision-making. The direction of the association cannot be inferred from these data; however, we suggest that interventions aimed at promoting shared decision-making need to target physicians as well as patients.”

   **Main discussion: Implications.**
   “Shared decision-making requires a commitment from both parties (patient and doctor). These data confirm the importance of engaging both the physician and the patient in initiatives to promote shared decision-making. Interventions to enhance shared decision-making should address physician concerns about adequate time during consultations and try to assure that patients have adequate access to health information outside the consultation”.

**Minor and Discretionary Revisions:** None requested by this reviewer.
Reviewer 2: K Eva.

Major Compulsory Revisions.

1. **Reviewer:** The primary conclusion that physicians control the type of interactions engaged is not a conclusion that can be drawn from this work.

   **Response:** We have rewritten the conclusions (see also point 6 above).

2. **Reviewer:** The discussion regarding not having data at the individual patient level might be strengthened by explicit mention of the fact that none of the physicians in the sample are likely to engage in one form of relationship 100% of the time.

   **Response:** We have added a sentence to the discussion, explicitly stating this point.

   "It is not likely that any of the physicians sampled used only one decision-making style in all consultations”.

3. **Reviewer:** I was confused by the data reported on page 10 / table 1. On page 10 it is noted that 1,040 respondents answered the question about experiences, and that 73% shared decision-making. In table 1, however, only 320 respondents are included in the “experience” columns and the proportion of them who experienced shared decision-making was only 133/320 (42%). Which is correct?

   **Response:** We are confused by this comment. We agree that on page 10 we report that 1,040 respondents answered the question about experiences (now called perceived role), and that 73% shared decision-making. We are not sure where the figures the referee refers to of 133 and 320 come from. They are not in table 1. Table 1 has 4 columns: the first refers to the numbers of physicians reporting a preference for each of the three styles; the subsequent 3 columns report percentages of doctors experiencing (or perceiving themselves as practicing) the three styles for each style preferred. The first column adds up to 1,040 as reported in the text (as only those doctors who provided data on both preference and experience can be included in this table). If you multiply the proportions listed in the Shared decision-making column by the corresponding row Ns (.21 x 142, .91 x 780, and .21 x 118), sum the three products and divide that sum by 1,040 (the total N for the table), the obtained proportion approximates what is reported in the text on page 10 (accommodating for rounding error). In the subsequent 3 columns, each row equals 100%. We have also checked the other tables, but these only have odds ratios, not raw data, so cannot be the source of this comment.

4. **Reviewer:** More generally I think most of page 10 and table 3 can be deleted – the relationship between experiences and preferences is so strong that page 10 and table 3 can be considered redundant reports of page 9 and table 2.

   **Response:** We disagree with this request, but will of course be guided by the editor. The whole point of our paper is that there is a strong relationship between
experiences and preferences – and if we remove half of the data, this point becomes lost.

**Minor Essential Revisions.**

1. **Reviewer:** More should be said regarding what procedure was used to “weight” the data.

   **Response:** We have said more about the procedures used to weight the data. The paragraph on weighting now reads as follows:

   "**Weighting**
   Data were weighted to match the national population of physicians on the MMS database who spend 20 or more hours per week on direct patient care. Factors used in the weighting were data from the MMS database: specialty, year of graduation from medical school, geographic region (East, South, Midwest, West), whether hospital or office-based, and whether trained in the U.S. or overseas."

2. The spelling of Fisher has been corrected.

3. We have clarified that we used the term “overwhelming” in a statistical sense.

4. A reference to Box 1 has been inserted into the text.

   “Finally, because shared decision-making requires time for discussion and deliberation (Box 1) [Charles, 1997 100/id], we described physicians’ views about the availability of time in patient visits (consultations)” (p5).

We trust these revisions satisfactorily meet the reviewers concerns. Please let us know if further revisions are needed.

Yours sincerely

Dr Elizabeth Murray (for all authors).