Author’s response to reviews

Title: The PSA testing dilemma: GPs’ reports of consultations with asymptomatic men. A qualitative study.

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Author’s response to reviews: see over
Dear Dr Le Good

MS: 1527972874132118  The PSA testing dilemma: GPs’ reports of consultations with asymptomatic men. A qualitative study.

Thank you for your provisional acceptance of our paper. We have addressed the reviewers’ comments and our point-by-point responses are below.

We have also addressed the formatting changes requested as follows:

  i.  the abstract has been incorporated in the pdf version of the manuscript (page 2)
  ii. the sections are now in the following order: Abstract; Background; Methods; Results (re-named from Findings); Discussion; Conclusions (new section added); Competing interests; Authors’ contributions; Acknowledgements; References; Box 1 (incorporated from a previously separate file) and Table 1 (incorporated from a previously separate file).

Responses to John Oliffe

1.  The research questions[s] are not explicitly stated and inclusion of these details, linked to the purpose of the article would strengthen the readability and focus.

To clarify the aims of the study we have added the underlined text to the existing statement: “Our study sought to understand GPs’ interactions with men who consult them without having any of the symptoms associated with the disease (asymptomatic men) and to identify the degree to which the PCRMP guidance was reflected in the consultations”.

2.  The qualitative methods are a little thin in detail. However, this may be related to the preferences of the journal rather than any author related issues. The authors might like to consider if an interpretive descriptive approach would best detail how they conducted the analysis.

We feel that the description given of the recruitment, data collection and analysis is sufficient for the reader to assess the value of these stages of the research process. Our understanding of interpretive description is that it provides a set of strategies by which knowledge about human health and illness experience can be developed, and was itself developed to overcome restrictions imposed on nursing research by
traditional qualitative research methods. Our decision to use the framework approach for our analysis was determined both by the development of this method for use in applied research, and the pre-existing coding framework we had developed from our knowledge of the PCRMP guidance. It is a highly systematic, comprehensive approach driven by the accounts of the research participants. While we appreciate the value the analytic approach within interpretive description for many situations, we do not feel it accurately describes the principles underlying our analysis and we see no merit in retrospectively re-describing our work in this way.

3. The authors might like to consider further development of their commentaries around the participant quotes that are provided.

Our aim in presenting the data in the way we have was to describe the main themes that arose from the transcripts, using the participant quotes to illuminate the themes. We feel our descriptions do justice to our analysis and we have used the discussion for the opportunity to elaborate on the implications of the findings.

4. I suggest that the authors revisit (discussion and conclusion section) to more explicitly convey the implications of the findings. I wondered about the possibility of discussing the following:

i. the emergence of active surveillance, and what that might mean for GPs and ii. the current understandings about PSA velocity guiding the need for TRUS-Bx and Tx[s].

We acknowledge that these, together with even more recent advances, are important issues for consideration following receipt of a raised PSA result, and therefore would be an important component of any discussion aimed at promoting informed decision making re PSA testing. However, as these issues are not included in the current PCRMP information pack, nor were they reported to have been raised by any of the GPs, we feel that it would not be appropriate to include them in the discussion. The focus of our paper is the reported consultation between the GP and their patient, and our interest is in the minimal reference by GPs to any of the treatment / follow up options, not the specifics of each possible choice and the implications these may have in the future for the GP. The revision of the PCRMP pack will include advances in techniques, and they will be important factors to be aware of in any future evaluation of GPs’ discussions with patients prior to PSA testing.

iii) the impact of not having a PSA policy – eg. does this jeopardise the uptake of your guidelines? Moreover, does it leave the GP between a rock and a hard place?

We were not entirely certain of the point being made, but are making an assumption that the reviewer is referring to the impact of there not being a screening programme in the UK at present, rather than there not being a PSA policy (which is that ‘any man who wishes to have a PSA test should have access to the test, provided he has been given full information regarding the possible benefits and limitations associated with receiving a test’). We feel that regardless of whether there is an established
PSA screening programme or not, the role of the GP (or another health professional) will always be (as with any screening test) to provide information to their patients about the benefits and drawbacks to undergoing the screening offered, to facilitate the process of informed choice. The current PCRMP guidance was established specifically to take account of the lack of evidence of effectiveness of PSA screening in reducing mortality. It therefore does not follow that the lack of a screening programme could affect the use of the guidance.

iv) will PSA screening change with the RCT results due out in 2008?

Two large-scale randomised screening trials from the Europe and the USA, aimed at assessing whether screening reduces prostate cancer mortality are anticipated to provide definitive results by 2008. If these trials demonstrate a mortality reduction, the UK National Screening Committee will consider all the evidence of benefits vs harms and decide whether or not to recommend the introduction of a national screening programme. It is likely there will be a policy change. In the event of a screening programme being introduced, the role of the GP will be as it is at present, to provide men with full and balanced information on the benefits and harms to facilitate an informed decision about whether or not to undergo screening. This is the process that operates in other screening programmes in the UK. The 3rd paragraph of the discussion now includes a consideration of the potential implications of evidence of mortality reduction through PSA screening.

Minor Essential Revisions: I suggest another draft to do justice to this important study – and eradicate some of the moments that border on prolix.

These are not major revisions per se. However, I strongly encourage the authors to re-visit from an editorial perspective to further advance the readability, and re-write the conclusion to provide a more sophisticated outline of the implications of the study findings

Several changes have been made to the style of presentation within the discussion to take into account the reviewer’s concerns about readability. We appreciate there are different ways to relate the findings from research to both practice and to future studies, and we valued the suggestions of the reviewer in the potential changes that could be made to the discussion. We carefully considered these suggestions and incorporated the one (described above in point 4 iv.) that we felt added to our existing clear description of the implications of our work, and which related to the aims of the study.

Responses to Suzanne Steginga
It is noted that a relatively small proportion of the GPs in the sampling frame were actually interviewed, and this will have introduced some bias into the data. Some discussion of this would be helpful.

We acknowledge that the number of interviews conducted was determined by the time frame of the study, not by the point of data saturation. This potentially may have limited the range of consultations that were described to us. We have addressed this by adding a sentence to the strengths and limitations section of the discussion.
We hope that our responses and the changes made to the paper have successfully addressed the concerns of the reviewers.

We very much look forward to hearing from you

With best wishes
Alison Clements