Author's response to reviews

Title: Applying strategies from libertarian paternalism to decision making for prostate specific antigen (PSA) screening

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Author's response to reviews: see over
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Jack Cochrane  
BMC-series Journals  
BioMed Central  
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Dear Mr. Cochrane,

We are pleased to resubmit our manuscript entitled: “Applying strategies from libertarian paternalism to decision making for prostate specific antigen (PSA) screening”, for consideration for publication in *BMC Cancer*.

In this revised article, we have addressed the helpful comments provided by the referees. We have included in this letter a point-by-point response to the concerns of the referees. We hope that we have satisfactorily responded to the concerns.

We appreciate your consideration of our work and look forward to hearing from you soon.

Sincerely,

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Reviewer 1 report:

Minor Essential Revisions.

On Figure 2, Figure A will be made more clearly like Figure 1.

This comment does not apply to our paper, as we have no figures.

Reviewer 2 report:

Major compulsory revisions:

1. Discussion, existing decision-making approaches, second paragraph: ‘Several studies show that a significantly lower proportion of patients choose PSA testing among those who were given…’. What do the authors want to imply with it? That more IDM is performed? That men are better informed and therefore decide not to undergo PSA screening?

Thank you for this comment. In this text, we are simply stating results of studies that show reduced election of PSA tested when decision aids are used in both informed and shared decision making. Patients who receive decision aids are more likely to be better informed about benefits and harms of PSA testing.

2. Discussion, existing decision-making approaches, third paragraph (proponents of the IDM and SDM approaches argue): in this paragraph the authors mention as a disadvantage the fact that ‘by increasing involvement of patients in the clinical decision-making process, IDM/SDM places more of the responsibility and pressure for a complex decision on the patient’. In my opinion this does not change by adding LP to the process, as patients have to sign a form for the decision they make in order to minimize potential, future claims.

The default decision in libertarian paternalism, which is in line with the medical principle of first do no harm, removes some of the burden of decision making. The default decision is made for the patients if they cannot or will not decide on their own and would be included on the consent form to be signed; it is different from IDM or SDM.

3. Discussion, libertarian paternalist strategies for PSA screening, default decision: are men not biased by the default option that is chosen (as the default option reflects the best interest of the patient)?

The default decision is simply the suggested option intended to minimize harm, according to the current level of evidence. Men still have the freedom to make their own decision about screening. If viewed as a “bias”, it should be viewed as a less harmful one than existing health care provider and health care system biases based on current incentives, with the added benefit of being more overt.

4. Discussion, libertarian paternalist strategies for PSA screening, framing: ‘In practice, framing has been shown to influence personal choice when deciding on medical procedures’. Please add reasons. Was it indeed the loss-aversion and
positive framing? Any known percentages that can be added?

We added the results of a study of patients choosing between equally efficacious treatments where the benefit for one was presented in relative terms (57% chose) and another was presented in absolute terms (15% chose).

5. Discussion, libertarian paternalist strategies for PSA screening, strategies in practice: ‘Adding a system default decision that minimizes harm would help reduce overdiagnosis and overtreatment’. Is there any proof that can found this statement? Otherwise the authors are not able to so convincingly state such a thing. If no proof is available, please replace ‘would’ by ’might’.

We replaced “would” with “may”.

6. Overall comment: I find the idea of incorporating LP a good one, as indeed, men (or more generally humans) do not act rationally. However, I see some obstacles that have to be beard before such a strategy could be implemented. First of all, how to choose the default option? Several major American Guidelines all have different views on PSA screening. Will it be possible to design a default option that all medical specialists will agree on? Or should a default option be designed per state perhaps? Another issue would regard the set of information materials that is provided to men who consider PSA screening? Which information is included and what will be highlighted? How will implementation problems be solved as extra steps are added to the process? Overall, I see the potential of the strategy, however, I feel that the authors are a bit too enthusiastic and only highlight the advantages of the proposed strategy. In my view a paragraph on possible downsides or barriers should be added.

We have added a paragraph on page 15 (paragraph 2) that discusses some of the issues/barriers for implementation of this approach that the reviewer has raised. We also state on page 14 (paragraph 2) that the current state of evidence should be used when deciding on the default decision and framing to use in decision aids and that in the absence of a clear consensus, the option that minimizes harm should be emphasized.

Minor essential revisions:

7. Please adjust in the background section the sentence on ‘In 2010, approximately 217.730 men will die…..to reduce prostate cancer mortality’. Past tense should be used.

We made this change in the text.

8. Add the reference on the Göteborg randomized trial, published in 2010 in Lancet Oncology (Hugosson et al).

We added this reference.

9. Discussion, existing decision-making approaches, second sentence: please
move the word ‘what’ # ‘provider telling the patient what to do…’.

We made this change in the text.

10. Discussion, challenges to decision-making, first paragraph: please add references to found you statements.

This first paragraph introduces the ideas that are discussed in this section and the references for supporting evidence come in the following paragraph. However, we added some references to this paragraph.

11. Discussion, challenges to decision-making, third paragraph: concerning the 1996 survey that is mentioned; does it provide the most recent evidence on this matter?

No, it does not. We also cite a 1998 survey and a 2009 survey that address this issue of differences in the information that is provided to patients from health care providers and the information that patients would like to know.

Reviewer 3 report:

Overall, this is a strong piece. The authors present a methodical and convincing argument for using a libertarian paternalism approach to PSA screening for prostate cancer. I agree with their analysis of the deficiencies of the “shared decision making” paradigm, and they do a good job of outlining the essentials of LP approach before applying it to prostate cancer screening.

Thank you.

Major compulsory revisions

1. The authors should replace reference #4 with direct references to the 3 major guidelines on PSA screening: the US Preventive Services Task Force (2008), the American Urological Association (2009), and the American Cancer Society (2010). Not mentioning the USPSTF, which is considered to be the most evidence-based of the three, is a major omission.

This is an excellent suggestion. We have added these additional references to the major guidelines as suggested and cite them on page 4.

Discretionary revisions

2. Pages 9-12 go over examples of the default decision, framing, and timing. This is necessary information, but it could be condensed quite a bit and the non-clinical examples (e.g. company retirement savings plan) eliminated.

We agree that this is necessary information and believe the non-clinical examples make the paper accessible for a broad public health audience. Most of the examples are in public health. The retirement
savings example is a classic one in the libertarian paternalism literature. However, we can reduce the length of the text in this section if this is preferred by the journal editor(s).

3. The authors are unnecessarily defensive on p. 14 about their default choice of no PSA screening. Most of us have heard of primum non nocere.

We proactively address a potential counter argument to our approach here. We removed the definition of primum non nocere.

4. Although this is perhaps beyond the scope of this paper, it would be useful for the authors to briefly comment on the practicality of implementing this approach in primary care practices, especially requiring the patient to wait 1-2 weeks before choosing PSA screening. I can't think of an analogous test or procedure where we do this for patients.

We agree that the topic is beyond the scope of this paper. We changed the waiting time to be 1 week.