Author’s response to reviews

Title: Unstated factors in orthopaedic decision-making: a qualitative study

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Author’s response to reviews: see over
Response to reviewers

We thank the reviewers and the associate editor for their careful reading of our manuscript and the insightful comments. We have addressed the comments as outlined below, which we hope improves the manuscript. We have also made minor typographical and small edits throughout the text to enable us to make these changes without dramatically lengthening the manuscript. We have also changed the author order with agreement from the authors that the order now better reflects level or input. The page numbers listed here refer to the version showing ‘track changes’.

With regards,

Rachael Gooberman-Hill

Reviewer 1

Major revisions

We thank the reviewer for her positive words about our study design, methods and data.

The reviewer asks that we deepen our analysis of the complexity of decision-making and address in more detail the differences between clinicians and patients’ decision-making processes. For instance, she suggests that we explore the possibility that for patients the consultation may be an information gathering event, whereas this is less the case for clinicians who may have already made much of the decision prior to the consultation. The reviewer also suggests that we explore the question of mismatch between patients and clinicians perspectives in more detail and address satisfaction. In addition the reviewer asks if we can enhance the framing of results in the light of the ‘extensive evidence on patient decision-making and processes’.

We find this an extremely helpful comment, and we have worked on these issues to improve the manuscript. Specifically we have expanded the section entitled ‘the complexity of decision-making’ to include data about the process of decisions, and how this sometimes entailed a decision prior to the consultation, and the potential for patients to be ‘surprised’ by the outcome of their consultation. We have also improved the discussion of shared-decision making in the Discussion by redrafting the paragraphs that relate to the literature on decision-making while staying focused on the key messages from this paper. We have added citation of Cox et al (2007) – an important reference from the primary care literature which indicates that physicians underestimate the degree to which patients would like to be
involved about treatment decisions (Abstract, Results, pages 24-27; Discussion, pages 28-31).

Minor revisions

The reviewer asks if we can explain the term ‘Extended Scope Practitioner’ (ESP) in more detail for those not familiar with the term.

- We have added a definition of Extended Scope Practitioner where it is first used (Methods, page 8).

Reviewer 2

Major revisions

The reviewer asks that we clarify how the study decided that six physicians and 26 patients was enough for data saturation.

- We have added a discussion of how we stopped sampling with this number of participants because we had achieved saturation, such that gathering additional data was not sparking any additional theoretical insights (Charmaz 2006) (Methods, page 11-12)

The reviewer asks if the patients were provided with compensation for participation.

- We have added a statement that the participants gave their time ‘free of charge’ (Methods, page 9 and Abstract)

The reviewer asks about family life as an example of lifestyle factors.

- We have added an example of family life into the results section along with a quote from Mrs Lee in which she says that the surgeon asked her about her family/living situation (Results, page 17).

The reviewer asks about the inclusion of the quote from Mr Brown describing surgeon A as ‘a bit quick’

- This quote was included to indicate that patients preferred to have the chance to ask questions, and we have added an introduction accordingly (Results, page 22).

The reviewer queries the final sentence in the results section, in which we say that the patients are more likely to refer to the explicit than the implicit factors.

- We have altered this paragraph to reflect the changes made to this section in response to Reviewer 1 and altered some wording in the abstract and Discussion to reflect this. (Abstract; Results, page 27; Discussion pages 31-32).
The reviewer asks whether there were any observed mismatches between actual and reported behaviour.

- The clinicians provided reflective accounts of their own practice in the post-consultation interviews, for instance Surgeon A was well aware that he tended paternalism. We have added a sentence saying that this matched with the observed behaviour, and include both patients’ and researchers’ observations here. (Results, page 18, Discussion, page 31).

Minor revisions

The reviewer asks that we include age and years of experience of the clinicians, why there was no Surgeon C and about the age of Mrs Lloyd.

- We appreciate that including age and years of experience would be normal practice with a larger sample, but with such a small sample we have not included the age and years of experience of the clinicians as this has the potential to lead to their identification. It might also lead to the identification of the patients too as they are ‘matched’ with their clinicians. We have added two sentences to this effect (Methods, page xxx; Discussion, page xxxx). There is no surgeon C because the pseudonyms were assigned prior to consent and data collection, out of the seven clinicians approached, six took part, Mr C is one who did not participate.

- Thank you for noticing that the age of Mr Lloyd on the table does not match that of the text. We have cross-checked with our original data and corrected this. He was 87 at the time of data collection and we have corrected the table accordingly.

The reviewer has identified a possible problem with clarity in our presentation of Mr Morris’s comments about surgeon A although his consultation was with ESP 2.

- We are have added a sentence before this quote to make it clearer that patients expressed confidence in surgeons even if they had not met them because their consultations were with ESPs who would not themselves conduct the surgery. In the case of Mr Morris it then become clear that although Mr Morris was listed for surgery by ESP 2 she is talking about her confidence in Surgeon A (Results, page 19).

Minor discretionary revisions

The reviewer asks about the possibility of including topic guides for physicians.

- We agree that more information about the interview topics would be useful. Therefore we have added more detail about the questions asked to the clinicians in the Methods section (Methods, page 10).

Reviewer 3

Minor essential revisions

The reviewer asks if we can specify the city.
• We are sorry but we are unable to do this as it may lead to the identification of the participants. We made a specific undertaking to participating clinicians and funders that we would not name the city in any publications or presentations arising from the study.

The reviewer asks if we can specify how many clinicians were potentially eligible.

• We have added some additional information in the description of the approach to clinicians to state that seven clinicians were identified as potentially eligible and were approached to take part (Methods, page 8).

The reviewer asks about any additional inclusion/exclusion criteria for clinicians.

• There were no additional inclusion or exclusion criteria other than those already listed cited in the manuscript.

The reviewer asks if we can include additional information about the interviews.

• We have added additional information about the interview questions (see also our response to Reviewer 2, above), interview length and use of open-ended questions and probing. We are sorry that these were not included previously for the sake of brevity and agree that they are important for readers (Methods, pages 9-10).

The reviewer asks if there were any other additional inclusion/exclusion criteria for patients.

• The only other inclusion criterion is that potential participants were due to see participating clinicians. Therefore, for clarity in the Methods section we have added that the study approached patients who were due to see participating clinicians “about the possibility of a joint replacement operation” (Methods, page 8).

The reviewer asks how many potential participants were identified from NHS clinic lists.

• To make this clearer, in the Methods section we have moved ‘Seventy-seven’ to feature earlier in the paragraph about recruitment of patients (Methods, page 8).

The reviewer asks at what point the in-depth interview with the clinician was done.

• We have added into the methods section that the in-depth interviews were conducted at various times in the study, but always once at least one consultation had been observed (Methods, page 10).

The reviewer asks about the clinicians’ characteristics and the length of time of the clinical consultations.

• We have added the length of the consultations but we are unable to include the detail for each clinician as it would compromise their anonymity (See response to Reviewer 2, above). (Methods, page 9)

The reviewer asks if a consensus was reached on all coding.
• We have added more detail in the methods section about the independent coding process and the ongoing refinement of codes as the analysis progressed. We hope that this provides more clarity on how analysis was conducted (Methods, page 11).

The question is raised about discordant data over multiple points and asks how we dealt with this.

• The value of conducting interviews with patients after consultation was that they had had time to reflect on their appointment and to express how they felt about it. This is an issue that we deal with in the section about communication when patients describe in the post-consultation interviews that they felt somewhat rushed or did not raise their questions. We have added a description about patients’ ‘surprise’ about the outcome of the consultations to the Results section. We have also added into the Discussion that the ability to collect this kind of data was a strength of the study (Results, page 24; Discussion, page 28, 29, 31).

The reviewer asks our view about data saturation and whether we stopped data collection when no new themes emerged or when the same themes were reoccurring.

• We stopped data collection when no new themes were arising from the data and the themes were fully ‘saturated’ with material – employing Kathy Charmaz’s definition of data saturation (Methods, page 11-12).

The reviewer suggests that we temper some statements about patients’ beliefs and behaviour.

• To address this we have changed: ‘Our study indicated that patients modify their behaviour’ to read ‘Our study indicates that some patients modify their behaviour’ and elsewhere we have made similar edits to soften the portrayal of the results (Results, page 24-27, Discussion, page 28).

The reviewer asks if we can state how limited ethnic representation might have affected the findings.

• We have added a sentence to the discussion of the study’s limitations, explaining why further study incorporating and exploring ethnic variation is important to understand possible reasons for inequitable provision of surgery (Discussion, page 30).

The reviewer asks that we discuss any affect that the timing of in-depth interviews with patients up to 3 weeks after consultation might have had on their reflections about their appointments.

• In the discussion of strengths and limitations we have added that the length of time between consultation and interview gave patients the opportunity to reflect on the decision that was made and the process that took place in their appointments (Discussion, page 31).

Major Compulsory Revisions

The reviewer asks for clarification about the independent coding of the transcripts.
• We have lengthened the description of the coding process to explain in more detail the independent coding, including detail of the number of transcripts that were independently coded (Methods, page 11-12).

The reviewer asks the extent to which all the observations were incorporated into the analysis.

• To make this clearer we have added more discussion about the inclusion of the observational material and data analysis. (Methods, page 12, Discussion page 31).

The reviewer queries the presentation of the data and its relationship to the analysis.

• To address this we have added more detailed description of the analysis process. The transcribed interviews and audio-recordings were analysed together which provided a unified set of codes relating to the encounters and decision-making processes. Notes were used to enhance interpretation and to inform questions asked in interviews. Data were also analysed as complete cases so that patients’ and clinicians views were compared and contrasted, and tables were produced (Methods. Page 11-12).

The reviewer asks that we address any potential biases that we may have brought to this work.

• We welcome the suggestion that we add in a reflexive component, which we think is often lacking in qualitative research papers, sometimes due to space constraints. To address this issue but without lengthening the manuscript too greatly, we have added a brief description of the background of the research team and explained that this informed the study design (Methods, page 9).