Reviewer's report

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

Version: 1 Date: 4 June 2010

Reviewer: Roni Evans

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This paper is very relevant given the increased focus on shared decision-making between practitioners and their patients. As health care decision making processes are influenced by opinions, beliefs and preferences a qualitative approach is definitely appropriate.

Overall, the methods are appropriate and ethics/human subjects issues have been addressed. Some revisions are needed however to improve the quality of the reporting of this very interesting study. The researchers identified some of the challenges of shared decision making related to joint replacement. Because of the difficulties in ascertaining the extent to which all observations were included and how discordant views were accounted for, it is difficult to say whether or not the conclusions are adequately supported by the data. I believe this, along with other items, can be remedied.

Specifically, I believe the following revisions are warranted.

Minor Essential Revisions
1. Specify city
2. Unclear how many clinicians were potentially eligible
3. Were there additional inclusion/exclusion criteria for clinicians to be eligible other than being a specialist in hip and/or knee surgery?
4. Some additional information regarding the interview questions would be helpful. What made the in-depth interviews “in-depth”, versus brief? Were more questions posed? What were they? Were there more probes utilized? How long did the interviews take?
5. Were there additional inclusion/exclusion criteria for patients other than gender, age, hip and knee OA? For example, I’m imagining that they had to be a candidate for hip and/or knee surgery? But maybe not...
6. How many potential participants were identified from NHS clinic lists?
7. At what point was the in-depth interview of the clinician done?
8. Characteristics of the clinicians (e.g. how long they had been in practice, how many TJR’s they had performed, age, gender, etc.) would be helpful in establishing context. Also, if possible, it would be helpful to note the length of time of the clinical consultations.
9. Was consensus reached on all coding?
10. Regarding the number of data collection points (which the authors cite as a strength, and can be, if it is clear how discordant data over multiple points has been addressed). It has been my experience that subjects sometimes contradict themselves or change their views over time…did this occur? How was it dealt with?

11. While the authors acknowledge the sample size is relatively small, what was their impression regarding whether or not saturation was reached? Did they continue to see new themes emerge, or did they reach a point where the same themes were reoccurring (saturation)?

12. I would also suggest that the authors temper some of the statements; for instance, instead of saying “Our study indicates that patients modify their behavior in order to better match the style of a clinician” perhaps change to “Our study suggests that some/many patients….”. I believe such statements would be more balanced.

13. The authors have addressed some of the study’s limitations including limited ethnic representation. It would be helpful if they stated how this might have affected their results and conclusions.

14. Another potential limitation not addressed is that some in-depth audio recordings with patients could occur up to 3 weeks after the consultation. It is possible that time may affect their reflections on their outpatient appointment.

Major Compulsory Revisions

1. It is unclear to me whether two individuals independently coded ALL transcripts. It is mentioned that this was done for a “sample” of transcripts—how many? Also, how were the code lists compared? Using kappa statistics? Another method?

2. It is difficult to ascertain the extent to which the researchers incorporated all the observations into their analyses. I understand that there are different schools of thought regarding this, however, this is where I believe some mixed methods could be helpful (e.g. citing how many of the participants or consultations displayed or cited certain thematic factors). Further, I do not see any evidence that non-confirming cases were searched for, nor presentation of cases that differ from the researchers’ theories. This raises the possibility of a biased presentation of the results.

3. There is something troubling me about the presentation of the data. Did the researchers consider the consultation to be a “case” in which there is one patient, and one clinician, and these were analyzed as a unit? Or did they deal with the patients and clinicians independently? I believe this affects how the data is presented, and should be explicitly stated in the methods. Also, from what I can see, the presentation of the results mixes the views of the patients’ with the perceptions of the clinician, and then at times observation of the encounter. While this paints what appears to be a complete picture, it becomes difficult to assess whether or not the data truly supports the researchers’ emerging theories. Perhaps the results would be more completely presented by presenting the views
of the clinicians, then those of the patients, and then weaving the two together?
4. I believe it necessary that the authors’ address any potential biases that they may have brought to the work; could their professional roles in any way impact their perspectives, and perhaps have impacted how they analyzed the data? Identified themes? Affected their theory development?

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.