Author’s response to reviews

Title: Feasibility Study of Multidisciplinary Oncology Rounds by Videoconference for Surgeons in Remote Locales

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RE: Edits to *Feasibility Study of Multidisciplinary Oncology Rounds by Videoconference for Surgeons in Remote Locales*

BioMed Central Editors:

Many thanks for considering our manuscript for publication in BMC Medical Informatics and Decision Making. Below is a description of the edits we have made, organized according to the reviewers’ suggestions.

We hope that you find our responses acceptable and agree to publish our manuscript in your journal.

Best regards,

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**REVIEWER 1**

**Compulsory Revisions**

1. **Please clarify whether this study was submitted for ethics review.**

   This feasibility study was part of a larger study that was accepted by the University of Toronto’s Health Sciences Ethics Review Committee. Mention of ethics review is now mentioned in the manuscript within the Methods section, last sentence of first paragraph (page 4).

2. **Please clarify the choice of the 3 focus group members, how they were selected, and how representative they would be in reflecting the educational needs of their peers.**

   The last sentence of paragraph 2 in the Methods section (page 4) has been revised as follows to elaborate on the selection of the three individuals who were interviewed by telephone:

   *Indirect needs assessment was carried out using three strategies. First, responses to a previously conducted survey of provincial surgeons were examined. In that survey surgeons were asked to specify their clinical and information needs in relation to the care of cancer patients. Second, the*
Royal College of Physicians and Surgeons of Canada WebDiary database was analyzed to identify the cancer-related self-directed learning projects most often undertaken by Ontario general surgeons using this online portfolio (18). Third, open-ended unstructured telephone interviews were conducted with three cancer surgeons from different regions of Ontario. One of these interviews involved a surgeon residing in Ottawa. He was interviewed for his expertise and knowledge in the concepts of knowledge transfer, organizational learning and surgeon education. The purpose of this interview was to discuss the organization and format of the pilot study rounds and how to best evaluate them. The two remaining interviews involved a surgeon from North Western Ontario (Fort Francis) and a surgeon from North Eastern Ontario (Sault Ste Marie). As regional liaisons to the Surgical Oncology program, these individuals were selected to discuss the usefulness and format of videoconference multidisciplinary oncology rounds. As general surgeons practising in remote regions of Ontario their feedback was representative of the surgeons targeted by this feasibility study.

3. Did the authors go back to the individuals who indicated that they would change their practice behaviour and see if in fact this has occurred? Or were there objective measurements taken to reflect this behavioural change? If so, it would be important to include to assert that the VC rounds are having a real impact in behavioural change.

The Surgical Oncology program is no longer structured such that ongoing evaluation of this intervention can be explored. However, the reviewers comments are addressed within the Discussion section as follows (see page bottom of page 9 to page 11). The Discussion section explains why more thorough evaluation to assess behaviour change is so difficult.

It should be noted that this feasibility study was part of a larger study that did not take place due to an insufficient number of consenting participants. The larger study planned to conduct pre- and post-videoconference series surveys to examine self-directed learning attitudes and behaviour based upon Oddi’s validated self-directed learning inventory; dialogue analysis of videotaped videoconference rounds to examine instances of self-reflection, community building and informal learning according to Wenger’s communities of practice framework; and follow-up semi-structured, grounded interviews with participants to assess impact on behaviour and practice.

Our inability to more thoroughly assess the impact of participation in videoconference multidisciplinary oncology rounds revealed a variety of factors that challenge valid evaluation of remote collegial interaction that are also mentioned in the medical literature on videoconferencing applications.

This is followed by text which appeared in the submitted manuscript but has been re-arranged to better flow with the newly added text.

4. The authors assert that this program builds tacit knowledge. What evidence is there, with the exception of the satisfaction surveys, to show that tacit knowledge has been built or captured?
Paragraph 2 in the Background section (page 3) notes that, in general, “communities of practice” enable the exchange of tacit knowledge. We hoped that by implementing videoconference rounds we would foster the development of a “community of practice” similar to “tumour boards” such that we could potentially assess self-reflection, community building and informal learning in a future study. Without further investigations beyond this pilot study we could not evaluate whether tacit knowledge was transferred or used.

Although we have not formally evaluated the impact of videoconference oncology rounds on the behaviour of general surgeons we have highlighted a number of challenges in doing so (need for frameworks and alternative methods more suited to the phase of the program being evaluated).

Description of these challenges is valuable information to those who are interested in conducting further research on this topic and for those undertaking telemedicine projects. These contributions to the literature are included in the Discussion and in the Conclusions: “However further research is required to develop frameworks and suitable, phase-specific methods by which to evaluate the impact of telehealth initiatives.”

**Discretionary Revisions**

1. **Please clarify how the focus group questions were formulated, and whether they were based on the 1998 and Royal College surveys. It would have been nice to also attach a copy of the survey questions with the manuscript.**

Instead of a focus group we conducted interviews by telephone with three individuals at an early conceptual stage of the study so the interviews were unstructured/grounded (no framework was provided to guide the discussion). Instead, the interviewees were asked for their opinion on the usefulness and format of videoconference oncology rounds and they were free to expand on their views.

As requested by the reviewer, the reason these individuals were chosen and the purpose of the interviews is now described in the Methods section of the manuscript (page 4) as discussed above in Compulsory Revision #2.

2. **Please discuss how the videoconferencing program content was designed: evidence-based, put together by an individual or a committee, peer evaluated, consideration of techniques of videoconferencing incorporated into the course design?**

The Methods section has been amended with the following text:

Page 4, second sentence

_In the absence of a “how-to” manual on medical videoconferencing the series was designed according to information provided by a variety of stakeholders who were consulted during the development of this program._
Several weeks prior to each session the presenting surgical oncologist was asked to develop a patient scenario that involved cancer surgery, presented treatment decision-making challenges, and would foster multidisciplinary discussion. The multidisciplinary panel (radiation oncologist and medical oncologist) were asked to review and edit the patient scenario.

Already included in the manuscript on the top of page 8 was the following, to indicate that participants were provided with evidence-based information:
The TORO coordinator recorded and summarized the discussion at each session, later incorporating citations for relevant published trials or guidelines. The summary was distributed to the oncology panelists for review and edited according to their feedback. The discussion summary was distributed with the patient scenario for the subsequent sessions by fax and by posting to the project website.

REVIEWER 2

Discretionary Revisions

1. The conclusions drawn extend beyond the intent of the study. The study focused on assessing the feasibility of using videoconferencing for interactive and multidisciplinary oncology rounds, which was very well demonstrated through the study with interesting results. The focus of the study was not on investigating telehealth evaluation frameworks which is included as a peripheral item in the discussion and then added to the conclusion. This ‘extension’ is unnecessary since the remaining material is of sufficiently high quality and stands alone.

AND
…the discussion strays from the focus of assessing the feasibility of videoconferenced oncology rounds to a new topic of telehealth evaluation frameworks.

AND
Final sentence of Conclusion…unnecessary if previous comments are accepted.

In responding to the comments made by Reviewer 1 and expanding the Discussion section we have elaborated on why we did not carry out a rigorous evaluation and in so doing have better justified why we discussed the need for evaluation frameworks. Better evaluations of telemedicine applications are not possible without the development of valid evaluation frameworks to suggest what measures to assess in order to claim that the intervention offers a benefit to either providers or patients.
2. Evaluation, p8, 1st para. This paragraph seems a little misleading when reviewing the results. Recommend changing from “…nearly 43%…” to read “…and 30% to 43%…”.

AND

Oncologists were more satisfied than general surgeons overall (88.3% versus 75%) but more general surgeons than oncologists reported that information revealed was not accessible elsewhere, that discussion provided useful tips for practice, and that discussion caused reflection on practice. Further, only general surgeons but no oncologists indicated the sessions would change their current practice.”

Both these recommended edits were added (see last paragraph on page 8).

3. Inclusion of decimal medians for such discrete data as ‘number of participants’ and ‘evaluations submitted’ seems inappropriate.

The median reported values in Table 1 were removed.