Author's response to reviews

Title: GPs' decisions on drug treatment for patients with high cholesterol values: A think-aloud study

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Comment to reviewer.

Manuscript 9062211163753956. “GPs’ decisions on drug treatment for patients with high cholesterol values: A think-aloud study”.

Third paragraph. “A clearer and more precise statement of the study question….”

A sentence has been added on page 3, second paragraph, beginning with “We will try to highlight the..”

Furthermore, on pages 4-5, the paragraph describing research questions has been largely rewritten in order to make the questions more explicit. The paragraph begins with “Our first set of research question….” We have also deleted the research question concerning clustering of the participants, and consequently the corresponding analyses in the Result section (and Fig 4). This has been done in order to reduce the number of research questions and because the results of the cluster analysis did not add much to the understanding of our results. For the same reasons, we have deleted the test of whether a reference to a rule would be more likely for participants with a Yes-decision than for those with a No-decision. (Paragraph on page 7 beginning with “Our second set of research questions..”). The corresponding section under Results including Figure 5 has accordingly been deleted. The research question concerning decision rules has accordingly been rephrased to “Our question was how frequently such decision rules were in the verbal protocols and their content in relation to practice guidelines for elevated blood lipids.” In the summary of research questions, pages 8-9, a corresponding rephrasing has been made: “Use of rules (their frequency and contents)”.

Fourth paragraph of reviewer’s report, regarding our discussion about disagreement. We have tried to make this a little more distinct by changing the research question. Our original expression “.. the extent to which specified information about a patient…leads to
disagreement ..” has been exchanged (end of first paragraph page 5) by the more specific “.. which kinds of specified information about a patient… are the most likely to lead to disagreement..”. The new expression is also more congruent with our hypothesis that certain kinds of information would lead to disagreement more likely than other would.

The second area of revision (paragraphs 6 and 7 of reviewer’s comments). The disagreement refers mainly to specified values on a variable, e.g. the presence of smoking. With the few cases used it seems difficult to evaluate the influence of a variable for a certain doctor, e.g. in the sense this is conceptualised in CJA. Partly for the same reason (few cases) the disagreement had to be determined by comparisons between doctors. To exemplify with smoking once again, we had only one smoker among the patient cases, which makes it difficult to demonstrate disagreement or lack of consistency for a certain doctor in his or her evaluation of (the presence of) smoking. The limitation of the results in this respect has been stressed by adding the following sentence to the manuscript (page 23): “For example, the opposing evaluations of the same patient data could only be demonstrated between doctors due to the low number of patient cases. “

Other questions about the methods:

a) How to control for the large amount of unmodelled information in the cases. We believe that you are referring to the 10 out of the original 21 information categories that were not analysed further. Most of these information categories were only evaluated once or twice in a positive or negative direction and none of them more than four times. We believe that it would be difficult to get any meaningful data from such small numbers. We have not made any change in the manuscript on this point.
b) The validity of the cluster analysis. We agree that the cluster analysis is merely
descriptive and that we have not validated the cluster solution against any other data.
As mentioned above, we suggest that the cluster analysis be deleted.

c) “How do you know that some of the difference in directionality wasn’t unimportant
because the variable had very little weight in the decision?” We can get some support
for the validity of our discussion about disagreement from the comparison between
subgroups with Yes and No decisions for the different patient cases separately. For
example, as is shown in Figure 3, participants who decided not to prescribe a drug for
this patient with coronary heart disease seemed to emphasise his overweight and
possibly used it as an argument not to prescribe. In order not to lengthen the article,
we have not made any additions to the manuscript.

d) The correspondence between the weights with our methodology and the results from
the CJA study. There are of course many methodological difficulties in comparing the
results from the two studies, mainly due to the constraints imposed by the few patient
cases in the think aloud study. The cholesterol level was most important
according to our definition of this concept in the TA study and second in importance
in our CJA study (mean regression weight across doctors). One interesting observation
is that smoking was the second most often evaluated information category in the TA
study but it had a significant regression weight for only two of the 38 participants in
the CJA study. This may point to interesting differences between the two methods.
However, comparing the methods did not belong to our research questions in the
present article and would probably lengthen the manuscript substantially.
Final comment, the Conclusion section. The section has been rewritten, shortened, and has been restricted to the methodological aspects. The following sentence has been added to the Conclusion section of the Abstract: “The method promised to be useful for understanding why doctors differ in their decisions on the same patient descriptions and why rules from the guidelines are not followed strictly.” The sentence beginning with “The results also ..” has been deleted in order to keep the Abstract short.