Author's response to reviews

Title: Patient and health professional views on rehabilitation practices and outcomes following total hip and knee arthroplasty for osteoarthritis: a focus group study

Authors:

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Author's response to reviews: see over
Dear Ms. Rajabi,

RE: MS: 21244146157303066 - Patient and health professional views on rehabilitation practices and outcomes following total hip and knee arthroplasty for osteoarthritis: a focus group study.

We thank you and the reviewers' for the helpful comments and suggestions for improving the readability and potential impact of the above named manuscript. We have made the suggested revisions to the manuscript and provide detailed responses below to the concerns raised by the reviewers. Additionally, we have paid careful attention to the journal’s formatting requirements and the qualitative research reporting standards outlined in the RATS guideline.

We appreciate your further consideration of our manuscript and welcome any additional comments and suggestions.

Kind regards,

Marie Westby, BSc.(PT), PhD Candidate

Response to Reviewers, Manuscript #2124146157303066

Reviewer #1

Thank you for your helpful comments. We respond to each in turn below:

1. Major concern. The surgeon (n = 9) and physician (n = 5) samples are too small to know that saturation occurred, especially when participants are from different countries. When numbers are so small, percentages (Table 2) are misleading. Deleting this part of the study should be considered. Of somewhat lesser concern, but still of concern, is claiming minority representation as a strength of the study based on 1 African American and 1 First Nation participant, particularly when inclusion was via interview versus focus group.

Authors’ Response: We have clarified the limitations due to small numbers of respondents and the challenge to recruit minority patients. Rather than omitting physician data, and in recognition of their own comment that they have a lesser role in rehabilitation care following TJA for osteoarthritis (vs inflammatory disease or significant co-morbidity), we chose to retain their
perspectives as a useful comparators to the health professional and patient groups. To reduce misleading information, percentages have been replaced by numerical values in Tables 1 and 2.

2. Design. Pages 7-10, Several aspects of the study design need to be clarified:
   a) Page 6 indicates "...as appropriate for each of the other sites. The sites need to be better described so that comments like -- "larger communities" (Page 28) have meaning for the reader. How many? Where were they?

   b) Of the 11 focus groups, how many were held for each stakeholder group?
   How many in Canadian? in the US? This information needs to be brought together in the text rather than dispersed throughout. What was the size of the focus groups (mean, range)? What was the role of WM and CB in the focus groups? In this regard, clarify the comment - "Analysis occurred concurrently with data collection...." Given the purposive sampling procedures and the advantages stated on Page 6 for using focus groups, the inclusion of one-on-one face interviews or telephone interviews seems contradictory. How was the "response form" modified for these participants?

Authors’ Response: The above elements of the study design have been clarified. Please refer to the first paragraph under Results, page 8 for additional information on focus group locations and group sizes.

On page 7, line 5 we have added that the lead author was one of the focus group moderators. The specific roles of MW and CB are outlined in the Author’s contributions, page 29 and the process of thematic analysis using the constant comparison approach outlined in Figure 1.

The response form was not modified for the individuals who were individually interviewed. They used the same response form and, for those interviewed by phone, sent it by mail or fax upon completion of the interview.

Discretionary Revisions
1) It is not clear why delay in IRB review resulted in only 1 US site.

Authors Response: Despite waiting 2 years, approval was never obtained at two additional American sites. We are cautious about explaining this in detail in a publication so as not to criticize individuals’ best efforts to participate in this study.

2) Subthemes-within group analysis. I understand that the study's focus is on themes versus subthemes. However, the section on subthemes is particularly weak and different information is provided about each group of stakeholders and subthemes. For example, we learn that 5 focus groups were held with patient participants; but this comment is not made in regard to the other stakeholder groups. What about the other 6 focus groups? Given the overall length of the paper, you might consider deleting this section.

Authors’ Response: In the process of streamlining the manuscript we have emphasized the main themes and limited description of the sub-themes; they serve, in essence, to explain the content of each main theme. We hope the Results are explained more clearly and concisely in this
version. The number of focus groups and interviews for each stakeholder group are now noted at the end of Tables 3-6.

3. Data analysis. In terms of data analysis (Page 9), subthemes were developed with stakeholder groups and key themes across stakeholder groups. Given this procedure, I expected to be able to identify the presence of a subtheme label of "Communication is key" in each of the stakeholder subthemes. Please clarify why "The communication is key" occurs as a subtheme only for surgeons. Or, perhaps this can be clarified in the data analysis section, Page 9.

Authors’ Response: Different themes arose for different stakeholder groups based on the content of their focus groups/interviews and were given labels unique to that group. “Communication is key” arose for the surgeons as a subtheme because this is was a dominant discussion point, yet elements of communication were also present in various subthemes for other stakeholder groups. For example, communication is found within the patient subtheme regarding kinds of support and the AHP subtheme titled “We all need to be on the same page”. Subthemes are grounded in the transcripts/data obtained, and verified by independent peer review. As the focus of this revised manuscript is now on the main (final) themes across groups, rather than within-group sub-themes, we have clarified the data analysis section.

4. To improve the study’s potential for impact, I suggest that the authors explicitly address the contribution that this study makes to knowledge. As written, the discussion section seems to proceed, almost in a theme-by-theme fashion, to reinforce the congruence between this study and prior studies. What does this study contribute uniquely that was not previously known? Or, is it merely confirmatory?

Authors’ Response: The Discussion has been revised to more clearly identify the unique contributions this study makes to the current literature. In particular, see “strengths of the study” on page 25.

5. Various editorial suggestions.

Authors’ Response: Editorial corrections have been made.

Reviewer #2

Thank you for your helpful comments. We respond to each in turn below:

1. Overall comments
... the paper is a bit lengthy and the result section needs reorganisation to make it easier to grasp. Also the reference list is far too long.

Authors’ Response: We have tried to be more concise while still addressing comments asking for clarification. The Results section has been reorganized, 8 references have been deleted and the overall manuscript length has been reduced by 11 pages.
2. Title, abstract and key-words
…in the abstract result section, the first 3 sentences describing the study population should be moved to the method section, since this is a qualitative study. The conclusion could be clearer about in what way the patients’ views differed from health professionals’. Keywords?

Authors’ Response: In line with traditional manuscript and abstract formatting, we chose to describe the participant demographics under results. The word limit for the abstract precludes more detailed description of how patient and health professional views differed. We would be happy to provide a list of key words at the Editor’s request. This is not currently requested as part of the submission to BMC Health Services Research.

3. Introduction and literature-review
Given the length of the manuscript the introduction is rather brief. In this section I would like to see a short description of how the US and the Canadian health system differ, to set the context of the study and make the results more interesting for international readers. I would also like to see some comparison with rehabilitation after other longstanding illnesses demanding elective surgery. Furthermore, the 2 paragraphs staring with “Focus groups…” (before the purpose) should be moved to the method section.

Authors’ Response: We kept the Introduction brief in part to allow for sharing of findings, which tend to be lengthy when sharing quotations and differing perspectives. We agree a statement comparing US and Canadian health care systems would help establish the context and have added this to the Background, page 5. The rationale for focus groups was intended to support the purpose, but has been reduced in the introduction and relevant portions moved to the Methods.

4. Methods
… the authors need to argue for their choice of sampling techniques. … If the authors consider this to be a qualitative content analysis, they should state that. Or is it a generic qualitative analysis? Or maybe grounded theory? It is not obvious to me. I would like to see examples of coding. This can be done including a table.

Authors Response: The sampling technique has been justified and content analysis explained. Figure 1 outlines the analytical process. Given the length of the manuscript, we’ve not provided coding examples, but can certainly add another table at the Editor’s request.

5. Results
The results are interesting, and they are well illustrated by quotes. However, the result section is not easy to follow. The first part of the result section “Eleven focus groups …” which is describing the sample should be moved to the method section. Instead the results should start by stating the key themes and their subthemes. Comparisons between groups could be described after that. It is unclear to me how the subthemes relate to each other, and a figure could provide much help. Remove the voluminous tables 3, 4 (table 4 occur twice!) and 6. Make clear which themes and subthemes that overlaps between groups, and which do not.

Authors’ Response: The error in table numbering has been corrected. Respectfully, we disagree that the number of groups and participant characteristics belong in the Method, because the
Method describes the plan for the research and the Results describes who participated and what they said. However, we understand your perspective on streamlining the Results and have made this more concise; see also the response to Reviewer #1, item 3, where we aimed to clarify the description of themes vs subthemes.

6. Discussion and conclusions
The discussion section is adequate. On p. 29 the sentences describing “unacceptably high levels of post-operative pain…” to ref [48] could be included in the introduction. If you discuss the findings from a theoretical framework, it would strengthen the study (for instance, patient empowerment theories or coping theories). Strengths and weaknesses of the study are well discussed. Clinical implications are great.

Authors Response: The Discussion has been revised to link the findings to self-efficacy theory (see page 22) and patient-centred practice (see page 26).