Author's response to reviews

Title: Professional centred shared decision making: patient decision aids in practice

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

We would like to take this opportunity to thank the reviewers for their useful and constructive comments. We believe this is a much better paper for these comments.

Reviewer: Bridget Young

1. The authors state that a distinctive aspect of their study is its focus on a broad spectrum of professionals. Nevertheless the focus is entirely on SDM in primary care. It would be helpful if this was more clearly reflected throughout the paper, especially in the title and the conclusions. Only about one third of participants were non GPs and again this needs to be more clearly acknowledged throughout. It would be helpful if the authors could comment on whether the GPs tended to dominate the focus group discussions, or what steps were taken to avoid this. Finally, the professional background of speakers should be indicated when quotes are presented as this would allow the reader to judge how far non GPs are represented in the “representative quotes” cited.

We have added (general) to title and made it clear that study was in general practice. Note that we have put ‘general’ in parentheses so as not to lose the double meaning of practice in the title: that it is both locative (in terms of where the study takes place) and practical (in terms of the implications of the study for the application of SDM in primary care). We have made explicit throughout that study occurs in routine general practice and have reworded the last section of the background to better reflect participant participation in the study. Moreover, in the new section on limitations of study results (as requested by the second reviewer) we have emphasised that the study was a baseline for further research, and noted the limited range of participants recruited to the study. We acknowledge that 1/3 of the participants were not GPs and there is a paucity of representative quotes from non-GPs. We have addressed this concern in two ways; first by making clear in the methods that the focus groups discussions were, in general, dominated by GPs; but second in revisiting the data to consider how non-GPs were included or excluded in the focus group, and their views on SDM and patient decision aids. We have added further quotes and comments on this in the analysis. Profession and gender added to representative quotes as requested.

2. In the discussion the authors state that they have identified two orientations to SDM “patient-centred and HCP centred”, but it seems very unlikely that this is the first time these orientations have been discerned and it is important to acknowledge this. Perhaps some key references in this field are missing (e.g. Charles C, Gafni A and Whelan T. Shared decision making in the medical encounter… Social Science & Medicine 1997: 681-92)?
We are aware of the Charles et al paper, and respectfully disagree on this point. The two orientations we identify are towards the particular notion of shared decision making as one involving a ‘philosophically’ different relationship between practitioner and patient. Charles et al usefully identify a range of decision making possibilities in healthcare of which SDM is regarded as a new methodological approach. However as we further discuss in this section, there are other authors such as O’Flynn and Brittain and Elwyn (who we acknowledge here) who see the shift as more than a new model for decision making behaviours – but as one that involves a change in the ‘professional identities’ that have traditionally underscored patient/client relations. It is not clear from our reading of the Charles et al paper that this is their understanding or that they have identified different orientations to SDM (though they have described different orientations to decision making). We have clarified this in the discussion.

Minor Essential revisions

There are a large number of grammatical errors throughout, particularly in the use of apostrophes. These need careful correction. The expression is slightly awkward in places, particularly in the discussion

We have edited the manuscript for grammatical errors and awkwardness of phrasing.

*The final sentence in paragraph 2, page 12 is unclear.*

We have reworded this sentence to clarify our meaning

*It is unclear what is meant by the term “SDM language” - see page 13.*

We have reworded all references to SDM language.

*There are too many acronyms, particularly in the introduction.*

We have removed acronyms from the introduction, and replaced all reference to HCPs with ‘practitioners’. Only SDM (shared decision making) is repeated as the ‘key’ acronym throughout the paper. Have added SDM to key words to make clear what the acronym refers to.

Discretionary Revisions (which the author can choose to ignore)

1. *The discussion raises some important questions, but an important question is largely sidestepped: whose interests are served by a shift of responsibility (as well as authority) from professional to patient that SDM represents? This is raised by several of the participants particularly quote 3.6, but also 3.4 and 3.5. The authors refer to there being “powerful rhetorics at play” (p6) and to professional identities (p12), but it would be worth some effort in deconstructing these concepts. Indeed, is it “only” a question of rhetorics?*
Professionals are not just facilitators of SDM, they have moral obligations to care for patients who are often very vulnerable. This means being responsible for ensuring patients receive proper care. What about patients’ expectations that doctors will always act in their best interests and their needs to be cared for when they are vulnerable? This, of course, raises fundamental questions about SDM and the challenge it presents to the largely unwritten emotional, social and ethical contract between professionals and their patients. Admittedly, a full consideration of this is beyond the scope of the paper, nevertheless, the issues are very pertinent and some acknowledgement of them seems warranted.

We thank the reviewer for these comments and agree entirely that the challenge SDM presents requires further discussion, but also agree that it is beyond the scope of this paper. At the same time we agree that the three quotes you raise usefully demonstrate that for these healthcare professionals, SDM does represent a shift in responsibility and changed relationship – even as it challenges their ‘traditional’ professional identities. We have added a sentence to this effect.

2. The authors might consider tempering the implications and conclusions they draw pending further work on these issues.

Agreed and revised conclusions.
Reviewer 2. France Legare

1. Is the question posed by the authors new and well defined?
Yes, the specific question that is being addressed by this publication is somehow new and well defined (To explore health care practitioner’s perceptions and use of patient decision aids (PDAs) in routine clinical practice before PDAs are being introduced in routine clinical practice). However, the objective of this study is located in the “background” section of the abstract. I would recommend that the authors copy-paste their clearly stated objective at the end of the “introduction” section.

We have moved the objective to the introduction section as requested.

2. Are the methods appropriate and well described, and are sufficient details provided to replicate the work? This is a qualitative study in which health care practitioners were asked to reflect on PDAs. They were also asked on how PDAs could be implemented in their practice. After a two week period for reflection participants were invited to take part in focus groups to discuss with individuals in charge of this study. The context/setting is not sufficiently described. I would like the authors to provide more details about the context in which their study took place. Although I understand that the authors have removed all patient/personal identifiers so the participants can not be identified, it would be helpful to have a better understanding of the clinical practice and to some extent of the general socio-political context in which this study was conducted.

We have added further detail on how practices were recruited and the process of self-selection from within each practice. We have added a sentence to the background section describing the study in relation to our other work. We note that the information the reviewer notes as missing (full discussion of methods, ethics etc) was present in an earlier draft and only removed in order to reach the word limit. We have reinstated this discussion but with due regard to maintaining the word limit.

In the “methods” section, the authors referred to a “framework approach.” I would like the authors to be clear about this approach.

We have added further clarification of the framework approach.

I would also like the authors to add their thematic framework in an appendix.

We have added the thematic framework as requested

The sampling strategy is not completely described, or is not fully justified. It appears to me that this study might have been included in a larger study of implementation of PDAs in clinical practice. However, this is not clear.

We have added further clarification that this was a baseline study prior to a broader implementation study and have identified the context that led to this research
I would like if the authors could be more specific about this. I would also like the authors to give details of the recruitment strategy (e.g. snowball, purposeful, etc.). How many participants were asked to participate and how many accepted? Does the sample include the full range of relevant, possible cases/settings?

We have added further clarification that practices approached built on relationships established in our earlier study, and participation was on the basis of self-selection. We could go into more depth on this, but as it was a baseline study in which we were examining themes, we did not wish to claim the study as generalisable. We have tempered the implications of the study to reflect its exploratory nature.

Did participants sign an informed consent form? Was there an ethic committee approval? The data collection procedures are not clearly described. In other words, who conducted the focus groups?

We have added this information

How many participants attended each focus group? It is not clear if there were any verification procedures to help establish credibility/trustworthiness of the study (e.g., prolonged engagement in the field, triangulation, peer review or debriefing, negative case analysis, member checks, external audits/inter-rater reliability, etc.) I would like the authors to reflect on this. If no verification procedures were used, this should be discussed in a “limitations of the study results” section. In summary, the “methods” section needs to be enriched.

We have addressed these questions as requested and enriched the methods section.

3. Are the data sound and well controlled?
I would like the authors to provide some details on the participants. For example, age range, gender, number of years in practice, etc.

A table has been provided with a breakdown of the participants in each focus group, however we do not have the complete data you request – particularly number of years in practice. We did not anticipate this would be needed in a baseline study as the purpose was to generate themes prior to a more detailed implementation study.

I appreciate the fact that the authors provide sufficient representative quotes to support their interpretation and conclusions. However, there is a tension between the quotes from individuals and the results that are expressed as reflecting the practice level. I would like the authors to explain in more details if they considered their analysis of the verbatim at the group level or at the individual level. For example, I notice that Table 1 presents representative quotes from one group, FG1. In contrast, Table 2 presents representative quotes from multiple groups, FG2, 3 and 5. It would have been helpful if representative quotes had been presented by main theme. For example, it is not clear if each Table is presenting quotes under one main theme or not. A title for each Table should be used. On the
other hand, if each Table does contain specific quotes for one main theme, then perhaps, fewer quotes can be used. In summary, I believe the “results” section could be improved.

We hope we have resolved all these concerns by first, giving titles to the tables and second, noting that the representative quotes are from the most representative focus groups (i.e. a group level analysis) that demonstrate the practitioner centred SDM approach or patient centred SDM approach.

4. Does the manuscript adhere to the relevant standards for reporting and data deposition? Overall, yes.

5. Are the discussion and conclusions well balanced and adequately supported by the data? The authors wrote: “Several recent studies have sought to address the apparent lacuna in understanding HCPs views on PDAs in clinical practice [9, 13, 14, 23]. Findings of these studies tend to be conceptualised around ideas of ‘barriers’ and ‘facilitators’ to operationalising SDM [14, 21]. In these views issues of time and lack of applicability for particular consultations are routinely represented as roadblocks to the successful implementation of SDM. We do not dispute the importance of these observations in helping to explain many of the difficulties HCPs associate with introducing PDAs into practice, or in helping develop solutions to some of the practical barriers and the identification of training needs of HCPs. However, the expectation that SDM occurs only within the consultation setting and between GPs and patients limits opportunities for introducing SDM in practice based settings. Moreover, such accounts do not take into consideration variations between institutions and individuals in how SDM is experienced or that SDM language does not in itself guarantee that SDM is being adopted.” I agree with the authors but it is not clear to me how their study addresses the important question of “variations between institutions and individuals in how SDM is experienced…” As mentioned above, the authors should provide a better account on how they have analysed the verbatim: at the group level or at the individual level? The authors need to add a “limitation of study results” section. As above The authors need also to be explicit about the likely impact of their own personal characteristics and position in the health care system on the data obtained. We have included a statement in methods section that details the epistemological background of researchers.

6. Do the title and abstract accurately convey what has been found? Yes. I like the title. This is an excellent eye-catcher.
7. Is the writing acceptable? OK

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. Rewrite the methods section
We have added further detail and explanation of the methods and standpoint.

2. Add more details about the context of this study

We have added contextual details related to the developmental nature of the study.

3. Add more details about participants

We have added details available to us.

4. Improve the presentation of the quotes

Tables are now labelled and quotes include further information about the participant.

5. Improve the “results” section

We have addressed all the comments relating to the results section and improved the language.

6. Add title to Tables

Titles added

7. Add “limitation of study results” section.

We have included a limitations section at the beginning of the discussion

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Discretionary Revisions (which the author can choose to ignore)

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

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

Declaration of competing interests:
I have published studies in this field. One of my publication in this field has been peer reviewed by one of the author, Dr RG Thomson (see ref. 21 in the submitted version 1).