Author's response to reviews

Title: Preferences for Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD): A discrete choice experiment

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Author's response to reviews:

We made major revisions on the paper.

Dr. Terry Flynn

The article has failed to acknowledge any of the main DCE literature (particularly key methodological issues that pertain to this study) published in recent years. Major contributions are acknowledged; See Page 8

The foldover method (to produce ‘right-hand side’ profile from ‘left-hand side’ one) is appropriate. However, it appears from the first paragraph of page 11 that the authors may not have obtained an Orthogonal Main Effects Plan (OMEP) in 8 to start with, but generated these 8 profiles randomly. Therefore they should input their entire design into the Street web-based design generator (http://crsu.science.uts.edu.au/choice/choice.html) so that they may quote the efficiency of their design (which will be 100% or close to it, IF they used an OMEP but otherwise might be MUCH lower) and that all main effects can be estimated independently of each other (or not).

"The eight basic scenarios to be fold over were generated automatically as an orthogonal design using the software SPEED. The design demonstrated uncorrelated main effects and an efficiency of 100% [18]."

The design was put into the web based design generator and demonstrated uncorrelated main effects and efficiency of 100%

Dr. Peter Wehmeier

The study does not really seem to be about “preferences in the drug treatment” that is being assessed, but about the properties that patients and parents would expect an “ideal” drug treatment to have. No actual preference was assessed in
this study.

"Discrete choice models have recently gained importance in the study of innovative health technologies and of non-market goods in the health care sector [13,14, 15]. A key feature of these models is the specification of utilities associated with the alternatives in terms of choice characteristics and individual preferences [16].

Discrete Choice Experiments offer strategies for eliciting preferences to value health and health care [13]. The term patient preferences still lacks a consistent definition; despite these differences in definition, there appears to be convergence in the view that patient preferences are statements made by individuals regarding their needs, values and expectations and the relative importance of treatment properties. Therefore these preferences refer to the individual evaluation of dimensions of health outcomes."

See Page 8 and 9

Unfortunately, no limitations were stated or discussed. This is a major gap that would have to be addressed.

Limitations are discussed; see Page 15

"There are a few limitations to this study that need to be pointed out. First, for practicability DCE needs to be performed with preferably the least number of parameter and pairs. The level of complexity of our study turned out to manageable for the participants. Second, there is the difficulty that the questionnaire was widely spread (paper and pencil version and online version). The number of patients who got into contact with the questionnaire is unknown – therefore, response rates cannot be calculated. The intense usage of the paper version shows that offering the paper copy is important and useful – at least in this patient population. Third, the study participants are probably more committed and well informed than the average of ADHS patient, because most of the respondents were therapy-experienced and members of patient advocacy groups. We do not know if this selection could have potentially biased the preference assessments."

The authors do provide a few references relating to work on which they are building. Unfortunately no papers on ADHD medication preference or reasons for choice of ADHD medication are cited. A couple of such references would be welcome in the discussion of the findings.

New References are cited and discussed