Reviewer’s report

Title: Should patients be activated to request evidence-based medicine? : a qualitative study of providers’ responses to the VA Project to Implement Diuretics (VAPID)

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Reviewer: Aanand Naik

Reviewer’s report:

I appreciate the opportunity to review this qualitative study. My comments to the authors are dividing into the following categories and numbered accordingly.

I. Major Compulsory Revisions

1) The objective of the authors was to understand the effectiveness, barriers to, and acceptability of the intervention, as well as the suitability/acceptability of patient-activation for more widespread guideline implementation. These study questions were not well framed because the introduction did little to set-up the study question. The first paragraph contains some extraneous background and relied on mostly old references. While the problem of uncontrolled hypertension remains, it is a much more targeted and nuanced problem nowadays in VA. The article by Eve Kerr in Ann Intern Med (May 2008) and the accompanying editorial by Phillips and Twomby provide a much more current framework.

2) The third paragraph of the introduction does describe potential uses of qualitative methods following a clinical trial. However, this description is not specific to the VAPID study. Why do the interventionalists believe they need a qualitative description of the trial’s success? What aspects of the primary study results are poorly understood or need additional clarification?

3) The methods lack significant clarity.

a) How were the questions in the interview guide developed and refined? Did it evolve with subsequent interviews? If so, how? How do the individual questions map to the study aims?

b) What was the sampling strategy for recruitment?

c) It is difficult to follow the difference between the process of developing a coding system and the process of applying the coding system. Was a standardized qualitative method use for these processes?

d) How many interviews comprised “the first set”? What was the degree of agreement (Kappa score or %agreement) of the initial coding? What was the process of reaching consensus? More detail is needed regarding the differences in coding for the remaining transcripts. Doesn’t seem appropriate that only one coder was involved. There is mention of “a sample of these transcripts” being coded by two others…how many? What was the agreement with the primary
coder? How were differences adjudicated?

e) How did the code key and coding system evolve? And how was re-coding
performed? How was thematic saturation determined in this context?

4) Need more descriptive information of the study sample (i.e., a table 1),
including any information about non-responders.

5) The discussion is well-balanced and supported by the data. However, I felt
that it did not do an adequate job of explaining the findings, rather it was more
just a restatement of the results. For qualitative papers, the discussion sections
needs to put the results into some larger context. What was striking to me is that
the intervention seemed to do little more than act as an availability heuristic.
There was not much complexity to it at all. The findings that the incentive and
telephone prompt did little is not surprising if one takes into account the simplicity
of the providers’ comments. The providers’ concerns about the incentives is a
distraction to the main point of the paper. Furthermore, it seems to me that the
intervention was not a patient-activation intervention but rather a
"patient-requests" intervention, again an availability heuristic generator. Rich
Kravitz has written eloquently about the power of patient requests (Kravitz et al.
HSR 2002 and Kravitz Med Care 2002) and that work could provide further
context for this study's findings.

6) An important limitation that is left out is social acceptability bias. The
recruitment strategy, the inability to blind participants, and the questions in the
interview guide cannot avoid this limitation. It probably curbed the interviewer's
ability to ask more probing question about why the patient requests were so
powerful despite the fact that providers claimed to know about the appropriate
guidelines and evidence-based actions.

II. Minor Essential Revisions

7) The second paragraph of the introduction could do a better job of a) defining
“patient-activation” and b) describing the elements of patient activation that
comprised the VAPID intervention, and c) relating those elements to the general
conceptual model of patient-activation. This would better set-up the aims, results,
and discussion on this topic.

8) In the results section, the quotes on “influence on prescribing behavior beyond
the intervention” do not appear very novel. There are many prior qualitative and
quantitative studies on this topic. The same is true about the “sources that inform
prescribing behavior” section.

9) The findings about aligning priorities would benefit from a discussion of the
literature on “concordance.” Reference #50 by Pollack is an example but the
discussion really doesn’t pick up on this broader literature.

10) An addition, the recent work by Kevin Volpp (NEJM 2009) on the power of
patient-directed financial incentives would be helpful in putting into context the
results on incentives in the current paper.
III. Discretionary Revisions

11) Descriptive differences between physicians versus PA/NP would be interesting to know.

12) The overall description of the results is good. One minor point is that sometimes it was difficult to separate quotes from themes or authors' comments; therefore it would be helpful to indent, use italics, or other methods to distinguish the quotes.

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 declare that I have no competing interests