Author's response to reviews

Title: Patchy 'coherence': using Normalization Process Theory to evaluate a multi-faceted shared decision making implementation programme (MAGIC)

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Version: 3 Date: 6 August 2013

Author's response to reviews:

Tuesday, July 30, 2013

Dear Anne,

Thank you for your letter 24 July, and the valuable suggestions. See below for details of how we have responded. Thank you for your help with this work.

Sincerely,
Glyn

Editor letter: 24 July 2013, 07:46

MS: 1803509409970126

Patchy 'coherence': using Normalization Process Theory to evaluate a multi-faceted shared decision making implementation program (MAGIC)

Amy Lloyd, Natalie Joseph-Williams, Adrian Edwards, Andrew Rix, and Glyn Elwyn

Comment 1

I think more attention needs to be given to the key point made by the previous reviewer. "A point made both here and in the abstract is that 'the implementation of SDM is far more complex than the delivery of patient decision support'. This is a key conclusion - and justified by the data and analysis reported - but at the beginning of the paper I did wonder how these two activities are being conceptualised/defined - perhaps a bit more on this in the introduction would help to demonstrate more strongly why the findings of this study are important (ie in terms of challenging more simplistic conceptualisations).". Could the authors please try and address this more fully in the abstract, introduction and discussion.
Response: We have done this in the three areas as suggested. The most substantive change has been in the Background section – see below, and in track changes in the MS.

Patients are encouraged to think about the available screening, treatment, or management options, and the likely benefits and harms of each so that they can communicate their preferences and collaborate to select the best course of action [2]. Most attempts by researchers to implement SDM have been based on a narrow interpretation of SDM [3], which is that the delivery of decision support tools to patients in the hope that the information acquired would accomplish greater levels of patient-provider collaboration. Over 80 randomized controlled trials, mostly conducted since the early 1990s onwards, have demonstrated that decision support tools lead to patients having greater knowledge, more accurate risk perceptions, greater comfort with decisions, while also reducing the number of patients remaining undecided or choosing major surgery [4]. Yet, debate remains as to whether greater levels of collaboration is generated within clinical encounters. In addition, there are very few demonstrations of successful implementation of decision support tools outside of a research setting [5, 6]. This ‘tool delivery’ interpretation of shared decision making is being challenged REF, and viewed as too myopic.

Comment 2
Make some changes to the abstract
Add to the background of the abstract first sentence the reasons for why Implementation in routine practice is challenging - Clarify what the terms the few areas outside research settings are or delete - Make clear whether the programme from the HFOundation is research or routine practice, Edit it out duplicate words in sentence (e.g. health professionals Mention use of NPT Add details on number of interviews, type of analysis Move interview numbers to methods Is there a contradiction between shared decision making was integrated into routine practice... and final sentence coherence missing Say in what way shared decision making is more complex than the delivery of patient decision support interventions

Response: The abstract has been edited in response to suggestions but we did not move interview numbers to methods – we feel those are results. The new abstract is as below:

Background
Implementing shared decision making into routine practice is proving difficult, despite considerable interest from policy-makers, and is far more complex than merely making decision support interventions available to patients. Few have reported successful implementation beyond research studies. MAking Good Decisions in Collaboration (MAGIC) is a multi-faceted implementation program, commissioned by The Health Foundation (UK), to examine how best to put shared decision making into routine practice. In this paper, we investigate
healthcare professionals' perspectives on implementing shared decision making during the MAGIC program, to examine the work required by to implement shared decision making and to inform future efforts.

Methods
The MAGIC program approached implementation of shared decision making by initiating a range of interventions including: providing workshops; facilitating development of brief decision support tools (Option Grids); initiating a patient activation campaign (“Ask 3 Questions”); gathering feedback using Decision Quality Measures; providing clinical leads meetings, learning events, and feedback sessions; and obtaining executive board level support. At nine and 15 months (May and November 2011), two rounds of semi-structured interviews were conducted with healthcare professionals in three secondary care teams to explore views on the impact of these interventions. Interview data were coded by two reviewers using a framework derived from the Normalization Process Theory.

Results
54 interviews were completed with 31 healthcare professionals. Partial implementation of shared decision making could be explained using the four components of the Normalization Process Theory: coherence, cognitive participation, collective action, and reflexive monitoring. Shared decision making was integrated into routine practice when clinical teams shared coherent views of role and purpose (coherence). Shared decision making was facilitated when teams engaged in developing and delivering interventions (cognitive participation), and when those interventions fit with existing skill sets and organizational priorities (collective action) resulting in demonstrable improvements to practice (reflexive monitoring). The implementation process uncovered diverse and conflicting attitudes towards shared decision making; coherence was often missing.

Conclusions
The study showed that implementation of shared decision making is more complex than the delivery of patient decision support interventions to patients, a portrayal that often goes unquestioned. Normalizing shared decision making requires intensive work to ensure teams have a shared understanding of the purpose of involving patients in decisions, and undergo the attitudinal shifts that many health professionals feel are required when comprehension goes beyond initial interpretations. Divergent views on the value of engaging patients in decisions remain a significant barrier to implementation.

Comment 3
Introduction could still be more tightly written with inclusion of more details of previous research (e.g. long quote in first line does not summarise the point as well as paraphrasing and illuminating comprehensively the key facets of shared decision making.

Response: This has been changed and paraphrased. See MS.
Comment 3
Add time period to when the trials were conducted where etc) Outline the previous attempts to implement SDM and summarise why they have considered to have failed - are there no elements of success reported etc?
What is meant by the simplistic conceptualisations that define SDM?

Response: This has been changed. A citation is given to a systematic review of implementation efforts for SDM is in press at BMC and recently published book. We have explained narrow conceptualization as in the following section:

Most attempts by researchers to implement SDM have been based on a narrow interpretation of SDM [3], which is that the delivery of decision support tools to patients in the hope that the information acquired would accomplish greater levels of patient-provider collaboration. Over 80 randomized controlled trials, mostly conducted since the early 1990s onwards, have demonstrated that decision support tools lead to patients having greater knowledge, more accurate risk perceptions, greater comfort with decisions, while also reducing the number of patients remaining undecided or choosing major surgery [4]. Yet, debate remains as to whether greater levels of collaboration is generated within clinical encounters. In addition, there are very few demonstrations of successful implementation of decision support tools outside of a research setting [5, 6]. This ‘tool delivery’ interpretation of SDM is being challenged [3], and viewed as too myopic.

Comment 3
The term broader approach taken does not make sense unless the previous components of the approaches to implementation are specified and the pros and cons made explicit Why are health professionals experiences relevant and the focus on professionals - what have previous studies of professional experiences of implementation shown ?

Rationale for use of NPT needs further elaboration/explanation.

Response: We think that the explanations in previous sections allow this section to be better understood.

Comment 4
References require checking and editing some lack details of most up to date versions of papers (e-ahead of pub) and volume numbers of many references.

Response: Some articles remain in press – or as epub. We will update all references at submission.

Thank you for your help with this work.
Glyn