Reviewer’s report

Title: Treating childhood intermittent distance exotropia: a qualitative study of decision making

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Reviewer: Anna Horwood

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Major Compulsory revisions

This is an interesting and well-written paper in the under-explored area of decision making in strabismus using a qualitative method, which should be applauded. As qualitative methods are relatively rarely published in the field, my main concerns are around explanation of technical terms and discussing limitations of the study and the conclusions drawn - most of which can be addressed by qualifications in the Discussion.

Methods:

1. What was the composition of the study advisory group? It would be helpful to have some more detail about the topic guide. As bullying was a recurring theme throughout the paper I particularly wanted to know if the word “bullying” was introduced as a specific topic suggestion, or did it emerge spontaneously from a more general “social interaction/ appearance” theme? i.e. which also discussed topics like cosmetic appearance, poor body image, avoiding eye contact, self-consciousness and people mistaking where someone is fixing. Parents may be concerned with bullying and cosmetic appearance as separate issues. Patients returning for treatment in adulthood find the latter problems more of an issue – did they also influence parents?

2. Some readers may not be familiar with the methods of carrying out semi-structured interviews and may not understand terms like “topic guide”, “data saturation” “NVivo used as a data management tool”, “constant comparative method”. A brief description of what the Control Preference Scale is designed to address would be helpful.

3. Was there any effort made to stratify the parent sample selection according to child age, size of deviation, control score, surgical / non-surgical, length of attendance, prior successful or unsuccessful treatment, socio-economic status, ethnicity (all of which affect decisions) – or was it an opportunistic sample? If it was, I would at least like to see some more detail of the spread of some or all of these factors, if they were collected, in Table 1. If not, they should be mentioned as possible confounders.

Results and points arising that should be discussed:

4. Line 158 Making treatment decisions. It was not clear whether at all centres the division of decision-making and explanation giving between professionals
was similar, and what is was? i.e. did the patients routinely see an ophthalmologist as a new case, annually or just for surgical discussions? This is particularly important for non-UK readers where work practices may be very different.

5. Were they only booked to see the surgeon once the common preliminary “we’ve been monitoring for sufficient time, carried out any non-surgical treatments (presumably unsuccessfully), so we should probably discuss surgery?” conversation had taken place with the orthoptist? If so the decision-making by the parents may be very different when talking about surgeons and orthoptists. They may have been mulling over surgery in discussion with the orthoptists over for many years, and only been booked to see the ophthalmologist once they had already decided they were prepared for surgery, so were now further down their decision making journey – perhaps everyone involved at this later stage expects the balances of power in the decision to be different from earlier on?

6. Was the word “doctor” used in the Control Preference Scale - as opposed to something more team-related? Did they (or some) interpret “doctor” as whichever professional they were seeing or only the ophthalmologist? If they rarely see an ophthalmologist because they are being monitored, is it the interaction with the orthoptist which are they using to answer this question?

7. Parental perception may well have differed according to what role they felt the orthoptists had, and Table 3 does not help us. Did they see the orthoptists' representing the whole team approach, or as technician /gatekeepers to access to a more authoritative surgeon opinion (in which case parents might have shown orthoptist/surgeon differences in who they would like to make decisions).

8. The paper sometimes seems to suggest there is a difference in opinion between orthoptists and surgeons which may not exist e.g. “orthoptists are more likely to suggest conservative treatments”(line 59 and 567). It is more likely to be that the surgeons and orthoptists are just involved at somewhat different stages in the case management and so the conversations (but not the overall approach to management) are likely to be different.

9. There also appears to a very clear difference between the groups in terms of what was being discussed in the interviews. The professionals seem to have been discussing children with X(T) in general, while parents would only have been discussing their specific, and so more limited, experience. They may even never have been exposed to the whole range of treatment choices because some may have been clearly inappropriate. The design of the study would have been stronger if the professional interviews had also related to a specific case. Ideally, that should have been the same case for professional and parent, but I can see that would have been very difficult. I do not underestimate the huge effort involved in this study, so while not invalidating the study, it is a limitation.

10. Line 502 I was confused by the sentence “from clinician descriptions, shared decision making is not widely practiced”, when the largest number of each professional group reported shared decision making and 95% reported that there was either an equal relationship or weighting of decision making was towards
parental opinion after discussion. This sentence suggests that parents are not given autonomy, while the figures in Table 2 (and 3) suggest the opposite.

11. Tables Not sure which table the asterisked foot note applies to?
The tables describe 9 surgeons, but the Results report 8

Discretionary Revisions
1. A clear theme from the clinicians was the difficulty in dealing with uncertainty, variability and lack of evidence while conveying information and advice. Was there any evidence that parents were aware of this uncertainty, and thus the difficulty that the professionals themselves have in making decisions on any one visit; and did it result in loss of confidence?

2. Line 551 An outcome from the study suggests that uncertainty and variability are a common problem, so finding parents “in the same situation” to talk to might be impossible, or even counterproductive.

3. Abstract. In general the abstract is excellent. In the conclusion the authors suggest “written information”, but in the next sentence and main Discussion later they discuss some problems with written information and also suggest other information sources. I suggest “written information” is replaced by “other sources of information available for use at home” or something similar. And also mention national /professional websites e.g. squintclinic.com, AAPOS

4. The fact that only one sub-group of the data reached saturation suggests that the rest did not. What effect might this have?

Minor essential revisions
1. Fonts and font sizes have been used for text and quotations, but this is not consistent throughout the text.

2. Line 69 change to “monocular eyelid closure”

3. Line 314 should be “It can give a child…….”?

4. Line 332 should be Control Preference Scale?

5. Line Please briefly describe what an option grid is.

Level of interest: An article of importance in its field

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