Reviewer's report

Title: What is a good health check? An interview study of health check providers' views and practices

Version: 0 Date: 09 Jun 2017

Reviewer: Stacy Carter

Reviewer's report:

Dear authors

Thank you for the opportunity to read your manuscript.

Your research question, at the most abstract level, is a useful and interesting one: I take it to be "what ethical criteria should govern the provision (or non-provision) of health checks"? Secondary to this, I take your more concrete research questions for this paper to be something like "how do Dutch providers of health checks reason about the ethical criteria that should govern these services?" And "How do providers explain their adherence or nonadherence to these criteria in practice?"

I think there are a number of ways that you could strengthen the manuscript.

First, the providers were all Dutch. I get the feeling (but can't be sure at present) that some aspects of the findings reflect the Dutch health care system in particular. There are acronyms I don't recognise, system elements I don't understand (eg independent treatment centre uninsured care) and policy contexts that seem important but aren't explained (e.g. what kinds of health checks are or are not available or allowed?)

I would encourage you to write this as a Dutch study, with appropriate context for readers to understand your findings. This will make it easier for people to make decisions about the transferability of your findings.
Second, and perhaps most important: it is not yet clear to me the scope of your investigation, that is, what does or does not count as a health check. You note in your introduction that there are health checks and there are population screening tests, and you suggest that the criteria governing them are or perhaps should be different. But to my mind you are insufficiently clear about what you consider to be a health check, and what the participants considered to be a health check (i.e., what they thought they were talking about). How are health checks different from screening programs? Are they really comparable to direct to consumer genetic tests as you suggest? Why? What characteristics identify a health check and allow us to distinguish it from, e.g., a diagnostic test or a screening test? At one point participants say tests should only be offered to people at high risk: so what counts as high risk, and how is testing high risk people different from diagnostic testing? One participant talks about preventive research: does this include research as well as clinical contexts? In one of the quotes a participant refers to relief of symptoms - does this mean diagnostic tests are included? In the first paragraph you seem to suggest that the tests offered in population screening programs are like those offered by individual providers, the only difference being who is offering them. Is this so? I disagree with some of the things that you suggest apply to health checks but not population screening (e.g., that informed consent is seen as a path to maximise individual utility, or that there is no consensus on what constitutes a good offer). This is an important conceptual issue and requires greater precision and clarification throughout all sections of the manuscript. NB what the participants took you to be asking about is at least as important as what you take health checks to be. You make a strong claim that you are the first to ask these questions of health care providers, but I don't think this is the case. You may be the first to ask the questions using the 'health check' language, but I think there's been work done asking the same questions with different labelling.

Related to this: a fair amount has been written about the ethics of screening and testing in recent years, including empirical bioethics studies like this one. It would be useful to reflect that literature more closely. You may have missed this literature in part because you are taking an exceptionalist position about "health checks", when in fact they are very like many screening tests.

You present findings at the end of your introduction: they should be presented only in the findings section.

Regarding your methods
You say that saturation was reached long before you stopped interviewing. But your sample was very diverse. How do you interpret this? Do you think they weren't diverse in the ways you expected?

You include data from population screening officers; to my mind this strengthens my earlier claim that health checks and population screening may be less different than you are suggesting.

You discuss a huge number of different tests. These tests have very different characteristics and considerations. I would suggest that you explain in more detail why you think it's meaningful to compare across such disparate interventions (I'm not saying it's not meaningful, just that I think you need to address it).

Were you influenced by a particular methodology for your study design and analysis? Why did you consider the sample of people you spoke to to be the right sample? What guided your analysis?

Another critical issue, which is both epistemic and methodological, is what exactly a study like this one can do in the context of empirical bioethics. Or to put it another way: Why should we care what these practitioners think constitutes a good test? Why are these the right people to ask? This was particularly stark for me e.g. when you presented without commentary talk from the participants that was inconsistent with the evidence (e.g. talk about the necessity of rectal examination for prostate cancer screening, or PSA testing for 30 year olds!!); or presented ethically laden statements without any justification or commentary (e.g. presenting mandatory occupational testing as an exception to the voluntariness criterion; suggesting that people shouldn't be tested unless they are willing and able to change their lifestyle—why, when the health system arguably has a responsibility to support those who find it more difficult to change, and following the path your participants suggest will likely widen the gap between the most and the least well off?) I think some care is required in bridging these participants' account to our thinking about what should happen in health checks.

Findings

Note that the criteria you have developed are not mutually exclusive: some are dependent on others. It would be better to reflect this more directly.
Many suggestions have been made about the criteria that should be applied to evaluate such testing. Very little in the first section of your results adds to that literature. One of the things I take from the existing literature is that it's easy to talk in general terms about criteria for evaluating screening tests (they should do more good than harm, people should have an opportunity to understand before they consent to the test etc.). But these broad criteria can be interpreted in many different ways. The same thin ethically-relevant concept (e.g. benefit or harm) can mean very different things. E.g. 'we should avoid harm' can mean 'we should prevent people from getting cancer at all costs' or 'we should prioritise avoiding overdiagnosis and overtreatment', with opposite consequences for action. And even just approaching these questions from an evidence based practice perspective reveals the complication, uncertainty, and contest over the right answer to questions like 'will this test be likely to benefit more than it harms'?

The first section of your findings seem to me to be quite thin and general. There isn't a lot of richness or diversity in the unpacking of the concepts: the findings operate at the level of motherhood statements rather than deep explication of concepts. You make claims about how the principles outlined by the participants compare with the principles in official documents. But it's not completely clear why you've chosen the documents you've chosen, or what such a comparison might mean, given that the concepts can be interpreted to mean so many different things.

In contrast, the second section of your findings (from the subheading Criteria in Practice) are far more interesting, although still very thin. These are questions that these participants seem well placed to answer: Why do they offer testing in the way that they do? What gets in the way? What are the tensions?

I would suggest, given that the material about evaluative criteria are so thin and not especially new relative to the existing literature, that you summarise these into a very short section at the beginning of the findings, and focus your energy on a deeper analysis of why participants test in the way that they do.
Discussion

I think this is a piece of empirical bioethics work. In my view, you need to confront the ethical implications of the findings more normatively and directly. You ask in passing, for example, "what does it mean to respect autonomous choice if choices are perhaps not (always) made in an informed and rational manner?" and claim "this paper is not the place to discuss this issue", but I disagree: I don't think you can interpret these findings without tackling these issues. I would suggest that you draw out the most important ethical implications of your findings and consider them systematically in your discussion. You mention respect for autonomy a number of times in the discussion, for example, without ever telling the reader what you take it to be.

In summary

I think this manuscript needs work; in particular the methods (particularly sampling and analysis) need more explanation; the findings needs to be deeper and more conceptually rich, and the discussion more normatively nuanced. But the questions you are asking are interesting ones. I wish you all the best with your work.
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Unable to assess

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Yes

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