Author's response to reviews

Title: Looking behind the scenes. - A qualitative perspective on barriers to evidence-based practice in patient counseling and advocacy in Germany.

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Author's response to reviews: see over
Revision

Looking behind the scenes. – A qualitative perspective on barriers to evidence-based practice in patient counseling and advocacy in Germany.

Reviewer’s report and author’s response:

BACKGROUND

1. The background literature needs to be revised significantly and reported in light of existing research on EBP and EBM facilitators and barriers. For example, the terms most commonly used are “individual and organizational” barriers and facilitators. It is unclear why the authors chose to use cognitive and attitudinal as different categories of factors when these are all related to the individual (even though they represent different elements of the individual). Also, the authors refer to personal barriers as “gender, motivation and experience”; again these are all related to the individual. These distinctions need to be made more explicit.

Response to comment 1: Thank you for your recommendations. We addressed this issue in the background section and propose the following:

“Scientific work on the mechanisms of knowledge translation and the barriers and facilitators for EBP and behavior change demonstrates that there are various factors, which can hinder or facilitate the application of EBP in health care occurring on the individual as well as institutional level [8]. Attempts to contextualize these multi-faceted factors yielded several models and frameworks for the application of EBP in health care [9-12]. Individual health care professional related barriers and facilitators identified across these models include demographic characteristics (age, gender, motivation, experience), EBP knowledge (cognition, awareness) and skills as well as attitudes towards EBP (ratio, emotions, self-confidence, authority concerns, rigidity of professional boundaries). Institutional factors encompass environmental barriers / facilitators in the organization (e.g. resources, time, peer influence, institutional culture) [8-13]. In this regard, individual EBP barriers of health care professionals include a lack of knowledge in and limited awareness of EBM concepts, a rather negative attitude towards EBM methods and EBP strategies and a lack of self-confidence to perform EBP due to a self-perceived lack of competency and limited sense of authority or responsibility. Examples of institutional barriers include a lack of organizational structures and a lack of human, material and financial resources [8, 10, 13, 14].”

2. The only paper cited is reference 8, a systematic review that is almost 8 years old. There are numerous publications from different disciplines that have been published since 2007 that would greatly strengthen the background.

Response to comment 2: We addressed this issue by adding numerous new articles. Please see our response to comment 1.

Study objective:

1. “Efficacy” and “acceptance” are different concepts, they imply different things in EBM research, and should be separated and explained and not divided by a
Response to comment 1: We decided to revise this phrase and tailor it more to the actual aim of the article. We propose the following:

“To address this knowledge gap, we performed a qualitative study on the perceived barriers and facilitators of EBP in the daily vocational practice of PCs and PAs working in counseling and advocacy facilities in Germany.”

2. The authors indicate that the objective was to “map important determinants”; map onto what? The use of this term is not clear and suggests that they will be analyzed according to some more deductive process or compared to a framework.

Response to comment 2: We decided to rephrase this term and propose the following:

“Our main objective was to identify important determinants influencing the implementation and application of EBP in the counseling and advocacy setting.”

METHODS

There are a number of important issues that need to be clarified in the methods:

1. What is the difference between standard and narrative interviews? Add a reference and explain the difference.

Response to comment 1: There was a typo in this passage. The term is structured and not standard. We revised this part and added a reference. We propose the following:

“Semi-structured interviews combine the advantages of structured and narrative interviews, allowing a well-ordered data collection without limiting the narrative space [15].”

2. It is unclear how the literature review helped shape the interview protocol; explain how and give an example?

Response to comment 2: We decided to revise this part by detailing the purpose of the review and propose the following:

“The semi-structured interview guide was developed on the basis of the information gained from a systematic literature review on barriers/facilitators of knowledge translation and EBP among health care professionals, particularly considering frameworks and models contextualizing factors of EBP from the individual and organizational perspective. Three comprehensive models/frameworks for knowledge translation and EBP barriers were identified [9, 10, 13] and served as a basis to develop a list of barrier types reported in the literature. To incorporate the interview guide we determined the interview purpose, created a list of EBP barrier/facilitator types identified in the systematic review and performed a preamble oriented pyramid discussion with an interdisciplinary team (physician, nurse scientist, sociologist).”
3. The following statement is unclear: “To incorporate the interview guideline we determined the interview purpose and collected information on sensitive issues by performing a preamble oriented pyramid discussion with an interdisciplinary team (physician, nurse scientist, sociologist) [9].” What does this entail exactly? What is a pyramid discussion?

Response to comment 3: We decided to describe the development process of the guide in more detail with a special emphasis on the pyramid discussion method. We propose the following:

“To incorporate the interview guide we determined the interview purpose, created a list of EBP barrier/facilitator types identified in the systematic review and performed a preamble oriented pyramid discussion with an interdisciplinary team (physician, nurse scientist, sociologist). A pyramid discussion is a method that involves raters making choices from a list of items within a given theme or subject [16, 17]. In our case, the pyramid discussion was applied to determine the barrier/facilitator types of EBP relevant for the interview guide and to decide on the content and format of the questions in the guide. Members of the interdisciplinary team of physicians, nurse scientists, and sociologists rated a list of EBP barrier/facilitator types individually, then in pairs, then fours and finally, the whole team took part in a discussion of the ratings.”

4. There is no mention of individual and group interviews on page 3, yet later in the paper, the authors indicate they used group discussions/interviews: the reason for using both individual and group interviews needs to be mentioned earlier.

Response to comment 4: We decided to mention the type of interviews earlier at the beginning of the methods part. Furthermore, we decided to mention the reason for the group interview under the section “sample” as this is typically done when giving information on the sample used. We propose the following:

At the beginning of the “Methods” part: “We carried out a qualitative study performing semi-structured face-to-face expert interviews and one group interview with patient counselors and patient advocates.”

In the section titled “Sample”: “Overall, 9 face to face interviews and one group interview were performed. The latter facilitated the exchange of perceived EBP barriers/facilitators between all nine participants and was performed after all face-to-face interviews were completed. Interviews were continued until category saturation was complete (nine interviews).”

5. In the sampling section the authors need to explain what “were identified by expert recommendations” means”. Why were potential participants selected or identified in this manner? How is this the best possible method for finding the participants most likely to provide the data needed to answer the question? And why does salaried vs. non-salaried matter?
Response to comment 5: We decided to explain the sampling strategy in more detail and removed the information salaried vs. non-salaried. We propose the following:

“The convenience sample was chosen from a key target group of PAs and PCs who were identified via expert recommendations and by contacting relevant institutions. Interview participants were identified from the most relevant institutions for counseling, and advocacy in Germany (see appendix 1). To identify relevant institutions we contacted four counseling and four advocacy experts from academia and public health organizations asking for the most relevant institutions performing patient counseling and advocacy in Germany. These institutions were then contacted via telephone and email. Respondents were classified as PAs if they were not directly involved in counseling individual patients but were active in committee work on various levels of the healthcare system. Respondents were classified as PCs if they were directly involved in counseling individual patients in counseling institutions, self-help groups or patient associations. Thirty people were classified as PRs or PCs and invited to participate in the semi-structured interviews.”

6. In the ethical recommendations the authors mention questionnaires? Is this the interview protocol? If yes, best to call it that, and not a questionnaire, which implies a survey type measure.

Response to comment 6: We decided to rephrase the term questionnaire and propose the following:

“Our research involved only semi-structured interview-guides and de-identified interviews.”

ANALYSIS:

1. The following statement is not clear: “In this study a paradigm was developed for hindering factors of evidence based practice in patient counseling and advocacy in the German health care context.

Response to comment 1: To make clear what we mean we decided to describe the development of the paradigm in more detail and referred to the figure 1, which depicts the paradigm. We hope that it is clearer now. The method to develop a paradigm is part of the Grounded Theory analysis of qualitative data. For more information on the method please read (Hastings et al. Developing a paradigm model of youth leadership development and community engagement: A Grounded Theory in Journal of Agricultural Education 52:1 pp.19-29)

We propose the following:

“Based on the recommendations of Strauss and Corbin the qualitative data was used to develop a paradigm that contextualizes the interrelations between hindering and facilitating factors for EBP and the attitude towards the utilization of EBP among patient counselors and advocates in the German health care context. To develop the paradigm, interview statements were divided into several meaning-carrying units and categorized according to different content domains. This was followed by the interpretation of the content domains in regard to their impact on the attitudes of PAs
and PCs towards to the utilization of EBP in their daily work, finally yielding the paradigm presented in figure 1.”

2. Why were result only included in case of agreement? This brings to question the validity of the findings. Rigorous qualitative analysis requires reaching agreement through discussion, member checking and bringing in a third researcher if needed for discussion and consensus building.

Response to comment 2: The sentence was not appropriately describing our methodological steps. Therefore, we decided to rephrase this sentence and propose the following:
“Results were included after reaching agreement through discussion between both researchers regarding the interpretation of the data.”

DISCUSSION

1. On page 10 lines 268 the word developed a paradigm that describes the current role of EBM: Again, why use the word paradigm and how is this a paradigm?

Response to comment 1: As described in the methods and results part our study aimed to perform a qualitative study using Grounded Theory and develop a paradigm to contextualize the impact of barriers and facilitators of EBP on the attitude of PRs and PRs towards EBP. The paradigm is presented in figure 1. The method to develop a paradigm is part of the Grounded Theory analysis of qualitative data. For more information on the method please read (Hastings et al. Developing a paradigm model of youth leadership development and community engagement: A Grounded Theory in Journal of Agricultural Education 52:1 pp.19-29). We decided to revise this section by detailing the information in the paradigm and propose the following:

“This qualitative study aimed to identify and contextualize determinants that influence the application of EBP in patient counseling and advocacy in the German health care context. For this purpose, we carried out semi-structured interviews with nine PCs and PRs, performed a thorough analysis of the qualitative data using the Grounded Theory method and developed a paradigm that describes the effects of barriers and facilitators of EBP on the attitude of PCs and PRs towards the perceived relevance of EBP for patient advocacy and counseling.”

2. The authors discuss the findings, in particular the acceptance of new procedures according to what they refer to as “medical education theory”; this is an inaccurate term as medical education is not a theory, it is a context in which we work and conduct research. This needs to be revised and then explained. For example, the authors could suggest theories that allow us to better understand the utilization of new practices? There are numerous such theories in EBP and knowledge translation research. Most importantly, the authors need to revise the discussion and interpret their results in light of the extensive body of research on EBM and knowledge translation. They have not drawn from any of the seminal literature in this field in the discussion, and this is most striking in lines 362-369.
Respond to comment 2: We decided to revise the discussion part of the manuscript by focusing more on the discussion of our findings in light of the existing literature on the barriers and facilitators of EBP. Therefore, we decided to remove the part mentioned in the comment. For more details, please look at the revised discussion part.

LIMITATIONS:
1. On line 349 the authors suggest a follow up quantitative study; It is unclear why this is necessary and how it would add to the current study.

Response to comment 1: Since there is no other study dealing with barriers and facilitators of EBP among PCs and PRs in Germany and internationally, we proposed further studies investigating this topic. We decided to revise this part and propose the following:

“Our study has some limitations that need to be discussed. First, we used a rather small convenient sample in order to perform more in depth interviews that allow for multi-level analysis. In this regard, a further qualitative study with a larger group of PCs and PRs would be useful to verify our findings.”

2. On lines 353-354, the authors indicate that “EbM programs a sample without prior experiences could have provided different results” Why do they consider this a limitation?

Response to comment 2: Our aim in this study was to determine barriers and facilitators of EBP. We propose that PAs and PRs without any experience in EBP would have rated more or other barriers than PRs and PCs with existing experiences. To make our point clear we revised this part and propose the following:

“Although this approach provided novel insights in the evaluation of currently offered EBP programs a sample without any prior experiences in EBP could have reported greater difficulties in EBP knowledge.”

Minor Essential Revisions
1. The words EBM and evidence-based practices are used interchangeably; either explain why or be consistent; they are not one in the same.

Response to comment 1: We decided to define both terms in the Background to make clear what we mean with EBP and EBM. We propose the following:

“In the last two decades the concept of evidence based medicine (EBM) has developed into a gold standard for health services planning and delivery[1]. EBM aims to facilitate the provision of optimal patient care by offering health care decision-making strategies that combine information on the current best medical evidence, cost effectiveness and patient preferences. The implementation of EBM in health care delivery requires evidence based practice (EBP) among health care professionals denoted as the integration of research evidence, clinical expertise and
patient values in the daily work processes[2]. To apply EBP successfully health care professionals have to acquire certain skills in obtaining, critically appraising and rapidly incorporating scientific evidence into clinical practice [3]."

2. Evidence-based medicine is typically abbreviated as EBM.
Response to comment 2: We revised the abbreviation in the overall manuscript.

3. There are several grammar and punctuation errors in lines 190-194. Line 194 “some of which may result in contradictory information” contrary to what?
Response to comment 3: We revised these errors and the inconsistency and propose the following:

“As a result PAs indicate to follow the physicians opinion instead of stating the own professional position on EBP. Further, PAs and PCs have a partly critical view on EBM questioning its reliability. This view is based on the opinion that EBP is strongly affected by emerging research findings and new guidelines sometimes leading to frequent practice changes that contradict the usual procedures leading to uncertainty.”

4. Line 212 “effect measures” and “evidence grades”, do the authors mean effect sizes and levels of evidence?
Response to comment 4: We revised these terms and followed the recommended ones.

5. Lines 226-228, this sentence is not clear; Needs to be explained. Line 229: what is a low threshold approach? Describe or cite the literature if this is a common term.
Response to comment 5: We revised this part. We replaced the term “low threshold” by the term “easily accessible” and propose the following:

“In this regard, PCs and PAs describe their expectations in regard to the design and scope of EBM training programs. For the respondents a needs-based EBM training should be easily accessible, cover a period of 1 to 2 days, include funding and require both personal class attendance and completion of online courses (Table 2).”

6. Lines 247-259: correct errors in grammar and punctuation. “Despite of [remove the word OF] the attitudinal and cognitional [should be cognitive] barriers towards the application of EbM among PCs and PAs, respondents state that there are some factors, which could facilitate EbM application in [missing word]” THE future
Response to comment 6: We revised this part.

7. Line 273: EBM is a process, one used to make clinical decisions; it is not an instrument.
Response to comment 7: We revised this part and propose the following:

“This means that PCs and PAs do not perceive EBP as a tool that supports their role as patient advocates and leads to an increased appreciation for their contributions to patient care.”

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being Published

Statistical review: No, the manuscript does not need to be seen by a statistician.