Author’s response to reviews

Title: “Living a normal life”: a qualitative study of patients’ views of medication withdrawal in rheumatoid arthritis

Authors:

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Author's response to reviews:

Reviewer 1 (Dr. Heidi Lempp) comments

Comment 1: “Title: In my view it would be helpful, to clarify whether the paper's focus is tapering, reducing, cessation, or withdrawing the medication, as all of these verbs are mentioned, and I was not always clear what the main focus has been. The keywords do not help either. Is tapering not the main focus or tapering and withdrawing?”

Response 1: The main focus of this paper is on DMARD withdrawal, and patients were asked to express their views regarding stopping (as opposed to reducing or tapering the dose) of their arthritis medications in the semi-structured interviews. Nevertheless, the manuscript does cover issues and themes that would also be important and relevant to consider when reducing/tapering DMARD regimens. Dr. Lempp raises an issue here of relevance to manuscript publication in that there sometimes ambiguity in the terms used to describe a lowering of DMARD therapy, including dose reduction, dose spacing, DMARD minimisation, DMARD tapering, withdrawal and cessation. The lack of an agreed consensus term makes the selection of keywords difficult, and we have opted to use a wide range of keywords to increase the likelihood that the manuscript will be found through online search engines.

We have opted for the term ‘withdrawal’ in our manuscript, which we have used to replace other terms in this resubmission. We have also included an additional 2 sentences in the limitations section of the discussion (lines 379-383) to highlight this further.

Comment 2: “Abstract (and main body): I suggest to state the word normal life as "normal life" through the manuscript, as the concept is a contentious one.”
Response 2: This has been replaced as suggested throughout the manuscript.

Comment 3: “commonly the word 'chronic' is now replaced by long-term, or long-life because the term 'chronic' tends to accentuate therapeutic pessimism, the authors may want to consider the replacement.”

Response 3: ‘Chronic’ replaced with ‘long-term’ as suggested, except for in the first sentence of the background where we wish to emphasise that therapeutic pessimism in RA is now outdated.

Comment 4: “As the focus is on patients as stated in the title, may I suggest to put the challenges of the patients first re DMARDS and medication and then the clinicians ones?”

Response 4: Text re-ordered as suggested (background, 2nd and 3rd paragraph order reversed)

Comment 5: “I also suggest to insert the definition of normalisation in long-term conditions, currently on p16/line 329-334 in the background section, so the reader knows straight away what the authors referring to. It seems a bit late in the Discussion section in my view?

Response 5: The definition of normalisation has been moved from the discussion to the background (2nd paragraph) as suggested.

Comment 6: “pl explain data saturation and provide relevant references, as this is an important and delicate concept in qual research. You had 13 patients for the study, it was not clear to me why? Did you have a range of number of patients in mind, which is normally the case in qual research and then terminate recruitment when data saturation has been reached, can you pl explain? Was this your recruitment process?”

Response 6: Reference to data saturation, and justification of the sample size with reference to the study protocol have been added to the first methods paragraph (lines 102-105)

Comment 7: “There has been no explanation how the interview schedule has been developed, from the literature, and/or from experiential knowledge? This is crucial for an academic publication. Also not all the questions in the interview schedule were open ones, in my”

Response 7: This study was conducted as a pilot study to gather data surrounding patients’ perceptions of benefits, risks and concerns of DMARD therapy, and their views on DMARD
withdrawal, prior to the design of a clinical trial of DMARD withdrawal. As such the interview schedule was pragmatically directed towards these key areas as reflected by the interview schedule questions, which were used as prompts to initiate discussion. However, patients were encouraged to discuss more widely the issues relevant to their own personal circumstances and experiences. The above points have been further expanded by addition to the 2nd paragraph of the methods section (lines 117-127).

Comment 8: “There is very little info about the data analysis. I am not convinced that Grounded Theory approach has been used (there was not reference for example), the interview process is different when applying Ground Theory from what has been described, it looked to me as the authors have taken an a phenomenological approach?”

Response 8: We have discussed our methodology as a team. While there are aspects of Grounded theory in our analysis (e.g. using techniques such as constant comparison and deviant case analysis), we accept that there are also aspects qualitative content analysis and for this reason have referenced this in the text (lines 131-132).

Comment 9: “The authors explained how the key themes were identified and then agreed in the research team. Why was no computer software programme used, e.g. NVivo for example, which is common practietc. This is also common practice, can the authors pl explain why ?”

Response 9: The study was conducted as a Masters student project under a very limited budget, and unfortunately without access to qualitative research software of funds to cover the necessary license cost.

Comment 10: “Why was no pilot study conducted, also very common in qual research, to establish with patients whether the patients are relevant, the timing of the interview etc.”

Response 9: As discussed above, this study was itself a pilot study to inform the design of a future clinical trial. Due to the constraints of limited time and resources to complete the project within an Masters student project placement, and time pressure from the fixed start date of the imminent clinical trial, there was unfortunately insufficient time to conduct a further pilot study. Were this to have been possible we accept that this may have improved the quality of the study, and have added this to the limitations paragraph in the discussion section of the manuscript (lines 388-391).
Comment 11: “How was the data validated? There are a number of strategies that are normally applied for qual data, to demonstrate rigorous and robust data analysis. Some strategies were briefly mentioned, e.g. deviant accounts and only one single counting was stated (9/13; p.14/280), no consistency throughout the result section. In my view single counting is one important validation strategy. Others are a pilot study, asking an experienced qual researcher to cross-check the initial codes, and others. Given that study included 13 participants, single counting would make a difference to demonstrate the strength of the findings. Stating 'some', 'some participants', or 'many' is not rigorous enough in my view.

Response 11: As detailed in the methods section, the initial qualitative theme codes were reviewed and agreed by KB and BT – the latter is a senior experienced qualitative researcher with an MD in qualitative rheumatological research and who has supervised qualitative researcher students at both Masters and Doctoral levels. An additional subsection within the methods (‘Rigor and accuracy of the qualitative study’) has now been added (see response 23 below). Unfortunately we did not have sufficient resources or time to complete an additional pilot study within the constraints of this Masters student project. Dr. Lempp highlights that single counting would help to reinforce the strength of the findings, and this is now included at ten points in the results section (lines 166, 175, 183, 213, 228, 237, 261, 280, 292, 293).

Comment 12: “The word 'arthritis' was frequently stated, e.g. p.10/line 194; p.16/line 316/318, p. 18/line 364/367. Two points here: the diagnosis of 'arthritis' does not exist, and patients do not like this phrase, as Rheumatoid Arthritis reflects the degree of impact on patients lives more comprehensively than 'arthritis'.”

Response 12: As suggested, the term ‘arthritis’ has been replaced with rheumatoid arthritis (RA) throughout the manuscript.

Comment 13: “p.11/214-219; pl add more accounts in the section so that the reader is convinced about your data.”

Response 13: Additional accounts have been added as requested (lines 229-235).

Comment 14: “p. 11/ 224-229: pl add more accounts that demonstrate the different strategies patients apply.”

Response 14: Apologies for the confusion here – this paragraph was intended to be a summary of the prior ‘disadvantages of DMARD therapy’ section, rather than a description of additional
results. The paragraph has been reworded with reference to the quotations above to avoid confusion (lines 243-249).

Comment 15: “p.15/line 292-294: pl add in [ ] what is meant by 'it', I presume you mean RA?”
Response 15: The patient is indeed referring to RA, and this has been added in brackets as suggested (line 304).

Comment 16: “I agree, being interviewed by a clinician is commonly not helpful with patients, as they tend to be less open or critical in their accounts. Pl provide a reference after the statement, as this is an important limitation in the study.”
Response 16: Reference has been added (line 388).

Reviewer 2 (Erika Mosor)

Comment 17: “Please describe the study design in the methods of the abstract (page 2, line 32)”
Response 17: Sentence reworded to highlight that this is a qualitative interview study (line 32).

Comment 18: “Also indicate the age and gender of participants in the results of the abstract (page 2, line 37)”
Response 18: Median (range) age and sex have been added (line 37).

Comment 19: “I would suggest to avoid writing "many" patients in the result part (with an N of 13). "some" patients would be also fine.”
Response 19: ‘Many’ changed to ‘some’ as suggested (line 38).

Comment 20: “Instead of "views of DMARD", "views on DMARD" (line 34).”
Response 20: ‘of’ changed to ‘on’ as suggested (line 34).

Comment 22: Thank you for the suggested references, which have been added to the introduction (lines 78 and 82).

Comment 23: “Methods Study design: Please describe the study design at the very beginning of the method part (page 5, line 87) and use sub-headers like: Study design, Participants, Ethical considerations, Data collection, Data analysis and maybe Rigor and accuracy of the qualitative study, to better structure the methods section.”

Response 23: The methods section has been restructured under the suggested headings.

Comment 24: “I would suggest to add the name of the Ethical Committee and the number of the ethical approval also here and to add that all participants gave oral and written informed consent.”

Response 24: The ethical statements in the declarations section at the end of the manuscript have been duplicated in the methods section as recommended (lines 149-154).

Comment 25: “On page 5, line 98, the authors wrote: "Semi-structured patient interviews (see supplementary material available online) were conducted by the same researcher (KB) in a private rheumatology outpatient consulting room". Please mention the development of an interview schedule here.

Response 25: There is overlap of this with comment 7 above, and we hope our response and amendments to the manuscript above address this comment.

Comment 26: “The duration of the interviews seems to be rather short for an in-depth exploration of the theme. This should be mentioned in the limitations.”

Response 26: This has been added to the limitations section (lines 377-378).
Comment 27: “It is not clear for the reader what the competences of those conducting the interviews (described on page 6, line 106 and 107) mean.”

Response 27: Additional information regarding the competences of the researchers has been added (lines 138-142).

Comment 29: “The qualitative analysis steps should be explained in more detail. Give examples from the original data, how the higher and lower--level themes were built from initial coding.”

Response 29: The development of the qualitative themes during data analysis have now been presented as additional Supplementary Material.

Comment 30: “Regarding the methodological orientation, the analysis of the data seems to follow more a qualitative content analysis than a grounded theory methodology. Especially, when looking at the results depicted in table 2 and 3, the analysis of the data was very much focused on extracting categories from the answers of the questions that had been asked.”

Response 30: This overlaps with comment 8 above and is addressed there.

Comment 31: “Which strategies were used to improve and verify the trustworthiness of the qualitative data, like debriefing, checking the transcripts against the audio files,…? Please specify. You should also mention that this study adhere to the Consolidated criteria for reporting qualitative studies (COREQ) and refer to the supplemental material in the manuscript.”

Response 31: An additional section ‘rigor and accuracy of the qualitative study’ has been added to the methods section to address these points (lines 137-147).

Comment 32: “Results: I would suggest to also add the median age and gender of participants, as well as the time frame when the study was conducted in the results section.”

Response 32: The median age of participants is detailed in Table 1. Data on the sex of participants has now been added to table 1. The time-frame of the study has been added to the first sentence of the results section (line 158).
Comment 33: “I would suggest to reduce the original quotes to those of the patients only and to abstain from parentheses, word repetitions and under-lining, where it is not necessary, to ensure that the reader can better read the quote and grasp the meaning.”

Response 33: The quotations had been reproduced with the original conversation notation of the transcripts. We appreciate this has potential to dilute the impact of the quotations, and agree that some of the notations (e.g. for pauses, word emphasis etc.) may be unfamiliar to some readers without experience of this style. We have therefore removed the parentheses, word repetitions and underlining as suggested. The interviewer text has been removed from the majority of quotes as recommended, but has been left in where it is essential to understand the context of the patient quotation.

Comment 34: “You might reduce the lines between the text and the quote, as the quotes are indented and written in italics.”

Response 34: The blank line before each patient quotation has been removed as suggested.

Comment 35: “Maybe in bracket after the quote: (No. x, female, age 72, RA for 11 years).

Response 35: The patient identifier has been moved from the start to the end of the quotation as requested.

Comment 36: “Is it my son? (page 10, line 201)”

Response 36: The patient is indeed referring to her son, but with the colloquial use of ‘me’ instead of ‘my’ common in the North East region of the UK. To avoid confusion for non-native English speakers, ‘me’ has been changed to ‘my’ as this does not affect the meaning of the quotation (line 216).

Comment 37: “Instead of their health care, it is her healthcare (page 11, line 218)”

Response 37: ‘their’ has been changed to ‘her’ as suggested (line 238).

Comment 38: “In my opinion is better to write e.g. 9 out of 13 participants, as you did on page 14, line 280, than to write "many" (e.g. page 12, line 239).”
Response 38: This overlaps with comment 11 above, and single counting has now been included at several points within the manuscript (see response 11).

Comment 39: “Table 1: Maybe adapt the table according to the APA6th guidelines or similar, and perhaps: Write Demographic/clinical data and Total in the header of the columns. Also add Number of women (%) - this is important!!! Median age in years (IQR) - this is already in. Also add Age in years min/max (which also might be of interest) in addition to the clinical data.”
Response 39: The header of the first column of Table 1 has been changed to ‘Demographic / clinical data’ as suggested. However, a heading of ‘Total’ for the second column would not be correct for many of the rows, which indicate median values and proportions rather than counts. Number of women and age range have been added to the table as suggested.

Comment 40: “Tables 2-4 need to be adapted. Maybe rephrase the concepts, to better point out what you mean (e.g. Uncertainty after DMARDS withdrawal, or Getting rid of unnecessary medication,…).”
Response 40: The theme descriptors (first column of table 4) have been reworded to give greater clarity to their meaning.

Comment 41: “Please discuss whether it would make sense to summarize all of the results of the analysis in over-arching themes (higher-level concepts) and responding lower-level themes in one table - focusing more on the research question and the title of your work: patients’ views of medication withdrawal in rheumatoid arthritis.”
Response 41: The additional supplementary material now presented regarding the development of themes addresses this comment.

Comment 42: “I do not know your data, but the advantages of taking DMARDS could perhaps fit to "DMARDS as a weapon to fight the disease"?”
Response 42: The ‘weapon to fight disease’ theme specifically related to the quotation regarding lack of control over disease if DMARDs are withdrawn, and so we feel relates to the withdrawal of DMARD section better than the advantages of DMARDs section – the reworded descriptor of this theme now provides more clarity in this regard.
Comment 43: “Perhaps mention the frame work (facilitating or hindering "normal life") within the first sentences in the discussion section. It is an important finding!”

Response 43: The order of the first and second paragraphs in the discussion section have been reversed to address this comment.

Comment 44: “In the discussion (page 17, line 357) you also pointed out that previous disease experiences and social circumstances were important additional factors that can crucially influence patients' views of DMARD withdrawal. This is very interesting. Please make sure that the reader finds these concepts/themes named in the same way throughout the paper (text and table).”

Response 44: The rewording of theme headings in Table 4 (see response 40) addresses this comment, and explicit mention of ‘social circumstances’ in the text of the results section has been added (line 311).

Comment 45: “Discussion: Please change or explain "unselected" patients? (page 17, line 352)”

Response 45: The word ‘unselected’ has been removed (line 354).