

## **Author's response to reviews**

**Title:** An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary health care: A grounded theory study

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# UNSW



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Dr Anne Sales  
The Implementation Science Editorial Team

**Re: Revision of Manuscript: MS: 1090623202839413**  
**Re: An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary health care: A grounded theory study**

Dear Dr Sale,

Thank you for the useful reviews and your comments on the manuscript. We have attempted to address each of the reviewer's comments (as detailed in the table below). In particular, we have expanded on the review of the literature to more clearly articulate how this piece of work fits with an extends previous research and theory in this area. We have also modified the title in line with your suggestions.

A copy of the revised manuscript has been uploaded. If you have any further queries please do not hesitate to contact me.

Yours Sincerely

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## **Referee Report 1:**

<b>Comments / Revisions</b>	<b>Author Response</b>
<b><i>Major Compulsory Revisions</i></b>	
1. The methods used were appropriate however it should be noted that the participants were self selected and as such are likely to be highly motivated – the model will only reflect these views.	<p>The fact the interviewees agreed to take part in an interview and hence may be more motivated than those who refused to be interviewed has been acknowledged in the last paragraph of the discussion, (starting p24).</p> <p>However, it is noted in the methods (under Data sources and Collection Procedures, paragraph 1, starting p 7) that a concerted effort was also made to identify and approach those who felt less positive about the project and risk factor management in general to take part in an interview</p>
2. It was also not made clear from the outset what type of clinicians participated but it appears that the vast majority were nurses (plus some aboriginal health workers and allied health practitioners) this needs to be made clearer earlier in the manuscript as a lot of the background literature refers to general practitioners/primary care physicians.	We have attempted to make this clearer earlier in the manuscript. The types of clinicians is now included in the methods section of the abstract. The literature in the background section now highlights the lack of studies outside of general practice. The methods section ‘ study context’ now also explains upfront that the study focuses on non GP PHC providers.
3. The authors should include some recognition of the fact that baseline and follow-up interviewers were different people and the implications this has for the analysis.	<p>The majority of participants (18 out of 30) included in the interview sample were interviewed on two occasions</p> <p>Thus most interviews included in the study (36 out of 48) were with the same participant on two occasions. Twelve participants included in the study were only interviewed on one occasion (either at baseline or post intervention), these participants were selected on the basis of purposeful or theoretical sampling.</p> <p>We have attempted to make this clearer in the methods (under Data sources and Collection Procedures, paragraph 1, starting p 7) and results section (paragraph 1, page 11).</p>
4. Again authors should give provide greater recognition of the limitation of their sample (e.g. no males) and lack of generalisability of their results to other health care settings.	This has been acknowledged in the last paragraph of the discussion, starting p 24).
<b><i>Minor Essential Revisions</i></b>	
5. Box 1 was repetitive of the text and should be deleted.	Box 1 has been deleted.
6. References to software should be cited.	References to software have been cited (p 10).
<b><i>Discretionary Revisions</i></b>	
Personally I would prefer consistency in the use of supporting quotes (either in the text or boxes/tables but not both).	The reason for showing the quotes in Table 3 is to allow the reader to relate the quotes to the description of the different role expectations and intentions of clinicians. Quotes relating to the different intervention strategies used by clinicians are shown in Box 3 to allow the reader to quickly compare the types of strategies used. These could be incorporated in the text but this would add length to the paper and we believe would reduce the visibility of the findings. We will await the response of the editor re this issue.

<p>The results of the interviews as presented here reflect much of the findings from other qualitative work although the authors have attempted to offer something new in the form of a model. It would be interesting if the authors could discuss how their model fits with findings from quantitative work in this area (see Lock, C.A., Kaner, E.F.S. 2004. Implementation of brief alcohol interventions by nurses in primary care: Do non-clinical factors influence practice? Family Practice, 21(3), 270-275 and Kaner, E.F.S., Heather, N., Brodie, J., Lock, C.A., McAvoy, B. 2001. Patient and practitioner characteristics predict brief alcohol intervention in primary care. British Journal of General Practice, 51(471), 822-827).</p>	<p>Two additional paragraphs have been added to the discussion (paragraph 2-3, page 20-21 comparing the model with existing literature and highlighting how the model offers new insights.</p>
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## **Referee Report 2:**

<b>Comments / Revisions</b>	<b>Authors Response</b>
<b><i>Major Compulsory Revisions</i></b>	
<p>Further detail in the Methods section is necessary regarding the context of the sampling frame.</p>	<p>Further details of the context of the sampling frame has been added in paragraph 1, page 7 under ‘ Methods- Data Sources and Collection Procedures.</p>
<p>1. In the “Study Setting and Context” section, the authors note that the “community health teams were selected...through expressions of interest.” The authors should include how this interest was ascertained. In other words, what selection criteria were used?</p>	<p>An additional paragraph has been added (page 6, paragraph 3) to describe in more detail how teams were selected.</p>
<p>2. What accounts for the different sample sizes across teams?</p>	<p>Allied health practitioners and child and family nurses from team two were over-represented in the interview sample. This reflected the purposeful and theoretical sample techniques that aimed to include a diverse range of clinician types and those with varying levels of attitudes and practices related to the management of lifestyle risk factors.</p> <p>The characteristics of all clinicians is now provided in Table 2 (p 36) as a direct comparison with the characteristics of those clinicians included in the interview sample. A discussion of the representativeness of the interview sample is now provided in the text (p11, under results, first paragraph).</p>
<p>3. Is there a particular reason why no men were interviewed? How many men were part of the teams? It may be helpful to add demographics of the full composition of the teams so readers can know if the interviewees are different in any particular way.</p>	<p>There were only 3 males working across the three teams at the time the baseline interview were conducted (2 in team three and 1 in team 1) and only 1 male at the time the post intervention interviews were conducted.</p> <p>The characteristics of all clinicians is now provided in Table 2 (p 36) as a direct comparison with the characteristics of those clinicians included in the interview sample. A discussion of the representativeness of the interview sample is now provided in the text (p11, under results, first paragraph).</p>

<p>4. While there is sufficient detail with regard to the overall analytic process, it would be helpful to add details regarding how the research team divided interpretive activities.</p>	<p>Details regarding how the research team divided interpretive activities is provided in the last paragraph of the methods section title ‘Data Analysis and Model Development ‘ starting on page 10.</p>
<p>Comments pertaining to the Discussion: 5. While the authors do a nice job of drawing out the implications from the results, there are some components that seem less feasible. For example, on pg. 21, the authors note that perhaps a “fundamental shift in their beliefs about the determinants of lifestyle behaviors...” is needed. Another view on this issue would be that in resource depleted contexts, clinicians “rationally prioritize” their efforts based on their experience in judging how to best maximize their counseling. In other words, much of the focus here relates to deficiencies that stand to be modified rather than viewing clinicians as highly adaptive to their settings and the ability to accurately read patient cues.</p>	<p>We have re-written the paragraphs on the implications of the findings in an effort to make more specific recommendations for improving practices (see paragraphs 6-8 on page 22-24 of the discussion).</p>
<p>6. I wonder if the authors were able to review their findings with members of the participating teams? If so, did they find concordance regarding the reported approaches?</p>	<p>A conscious decision was made not to use member checking, a process of cross checking findings and conclusions with participants. As the purpose of the analysis was to code all responses and organise into a new higher order theoretical model, it was not expected that participants would be able to recognise their individual contributions or concerns. It was therefore not appropriate to seek ‘validation’ from individual participants. Instead, a number of other techniques were used to ensure interpretations were grounded in the data. These included the use of constant comparisons, memo writing, extensive use of participant quotes and discussing coding frameworks and preliminary theoretical ideas with two other members of the research team (MH and LK) for the purpose of gaining other perspectives and challenging assumptions rather than to reach agreement.</p> <p>This justification has been added to the last paragraph of the methods section titled ‘Data Analysis and Model Development ‘ starting on page 10.</p>
<p>7. It was noted that the lead author (RL) kept a journal and that these observations were included in the analysis. It would be interesting to learn how these observations were integrated.</p>	<p>These observations were coded in the same way as other qualitative interview data in stage 2 of analysis (as described in 2nd paragraph under ‘data analysis and model development, page 8)</p>
<p>8. While the model seems to imply that Commitment is a dynamic process, the manuscript does not emphasize this view. Health care priorities are in flux and clinicians are responsive to a diverse range of personal, patient, clinic and community factors. This issue relates to the compelling literature on “competing demands” and the reality that clinicians can not possibly address all the presenting and preventive counseling needs of their patients so they make decisions. Greater attention to one set of issues comes at the expense of others. I wonder how the authors see this tradeoff.</p>	<p>The model suggests that in face of competing demands that clinicians rationlise their approach to addressing lifestyle issues. This involves making judgements about the extent to which addressing lifestyle issues is considered a legitimate, do-able and worthwhile component of the role.</p> <p>The first paragraph of the discussion (p 20) has been rewritten to more clearly articulate this view.</p>

<p>Fit with other literature on this topic:  9. An overarching concern pertains to the question of what this research study adds to the broad literature on factors that influence counseling for lifestyle risk management. I agree with the need to align interventional strategies to enhance these clinical efforts by paying close attention to clinician beliefs and attitudes (affective dimensions). However, I'm not sure if the findings here represent new perspectives on these issues nor whether (or how) the implications drawn from the study could be implemented. Indeed, there is research in the primary care literature that the authors have overlooked that has reached similar conclusions (see journals such as the Annals of Family Medicine and the Journal of the American Board of Family Medicine). For example, prior research has specifically identified how clinicians modify definitions of success (p. 20) as a justification to continue preventive counseling efforts as well as the use of "opportunistic approaches" (p.17) and views about self efficacy/autonomy (p. 14). I would encourage the authors to undertake a closer literature review to see how these issues have been previously addressed and use their findings to build our understandings in these areas accordingly.</p>	<p>We have re-written the paragraphs on the implications of the findings in an effort to make more specific recommendations for improving practices (see paragraphs 6-8 on page 22-24 of the discussion).</p> <p>Two additional paragraphs have been added to the discussion (paragraph 2-3, page 20-21 comparing the model with existing literature and highlighting how the model offers new insights).</p>
<b><i>Discretionary Revisions</i></b>	
<p>1. On page 7, it might be helpful to have demographics by each team.</p>	<p>The characteristics of clinicians from across the three teams is now provided in Table 2 (p36). A break down of these characteristics by team adds little new information for the reader.</p>