PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (see an example) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below. Some articles will have been accepted based in part or entirely on reviews undertaken for other BMJ Group journals. These will be reproduced where possible.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Staff's perception of abuse in health care: a Swedish qualitative study.
AUTHORS	Swahnberg, Katarina ; Wijma, Barbro

VERSION 1 - REVIEW

REVIEWER	Loveday Penn-Kekana Centre for Health Policy School of Public Health Uniiversity of the Witwatersrand P.O.Box 2000 Johannesburg Gauteng South Africa
REVIEW RETURNED	15-May-2012

THE STUDY	Some of the questions are not relevant for this paper. If they are not relevant I have ticked yes. I felt that it was too few interivews to really know what impact it had had on the staff. And this wasn't acknowledged. I thought that the key messages adn the limitations section was weak. I felt that the article relied too much on work done in Sweden and that there is a literature on the way that staff treat patients, patient provider communication, the need for culturally appropriate nursing/medical care , as well as abuse of patients taht wasn't quoted. Although generally the quality of the written english was very good there were a couple of the translated quotes where i was a bit unsure of a couple of words that had been used and wasn't sure if it was a translation issue or the provider had used that word. For example the use of the word "fixated" on page 10 line 27
RESULTS & CONCLUSIONS	I think that 10 interviews is probably not enough to evaluate impact.
GENERAL COMMENTS	This article is interesting and tackles an important topic.It is well written. However if feel that it would be strengthened if it talked to other literature outside of Sweden on the topic. Although the author has published extensively on the Norvold Abuse Questionnaire it has not been widely used elsewhere and i was not familiar with what it actually measures and what was actually happening in the faclities in Sweden. I also think that it is important to engage in debate about whether it

	is the nature of the particular forum play intervention that brought about change and if so why - or whether any intervention that draws attention to the topic would have been useful. For example health care workers for change is one that has been used by Fonn S and others.

REVIEWER	Sharareh Akhavan, PhD Senior lecturer University of Malardalen- Public health- Sweden
REVIEW RETURNED	16-May-2012

GENERAL COMMENTS	1-Although I keep wavering about this thought, I'm not sure that interviewing 14(or 10?) staff members is grounds to be able to conclude that "staff showed a greater willingness not only to acknowledge AHC but also to take on the responsibility to act in order to stop or prevent AHC". I am a qualitative researcher so my issue is not at all with the approach, I think I'm reacting to the strength and breadth of the assertion based on a limited group. I think you have to be careful what you conclude. 2-A major question I'd like to see addressed is how what the staff said is different than previous research. What can we learn from this study that adds to the literature in general or that specifically supports why it was important to do this study with this group in Sweden? So, is there something about the particular context in Sweden that would require adaptation or input from this study? I'm not saying that you need to get rid of your entire analysis of themes but I just wonder if there is something unique, different, that you can emphasize a little more. 3-The aim of the study is not clear. In abstract: "The study aim was to apprehend changes in the attitude of health care staff to abuse in health care (AHC) after an intervention, based on 'Forum Play'". In page 4: "Our aim was to evaluate the intervention by means of a design allowing the findings from pre intervention to be compared to those from post intervention qualitative interviews". What was the aim of the study? Clear, short and well-formulate? 4- In the abstract: 10 staff members who participated In Material and procedure page 6: Eligible for the present study were those 14 informants Additionally, It is useful to mention even in abstract that the participants are from the original sample and this study is a follow-up How many participate in this follow-up study? 5- The part about the Intervention should be shortened and moved to introduction. 5- What kind of interviews did the authors conduct? Individual semi-structured interviews? Why? rather than another qualitative method, e.g. focus groups? While I don't disagree with their choice, readers cannot evaluate the adequacy of their methods unless the authors

	briefly explain their rationale. 6- Additional context would be helpful in evaluating the quality of this study. Could the authors be more specific about the clinic they selected? 7- It can also be helpful to know more about the staff that declined to participate. What was the reason? 8- It's not clear that 14 (or 10?) interviews are adequate to attain thematic saturation. Typically, qualitative studies of this nature include between 25-35 interviews, and 20-25 are often the minimal number required to attain saturation. If the authors attained thematic saturation with a fewer informants, it would be important to explain why they felt this was the case. 9- Additional information is needed on the composition of the interview and the analytic teams. The former may influence interviewee responses. The latter are likely to introduce some degree of bias into the analytical process. Typically, a team approach is used to ensure that the analysis is conducted by a group of individuals with diverse but complimentary personal and professional backgrounds, in order to balance individual biases. At a minimum, a brief description of the analytic team members would be useful. 10- It is extremely important to explain the research questions, how and/or why these particular questions were selected, as the results are dependent upon the questions asked. 11- Data seem sound, but the paper should include a table of the process (from coeds to new substantive codes and so on). 12- It was not clear exactly who read the transcripts? Did they do so independently? Need to clarify that. 13- There was no discussion of how or whether they discussed and/or came to agreement on their coding of the transcripts and whether they used criteria for inclusion of a coding category in the final results. That should be added. 14- In the beginning of the Results: A summary of categories and core category is needed 15- Follow-up interviews is a better word to use than post interviews 16- In title the word "perception" is used but in the aim it is "attitude".

	I think the authors should be consequent and use one concept. 17- It could be a very good idea to use headings in the discussion in order to structure it. 18- Table 1 is mentioned is introduction. Do the authors use this definition in the interviews? How and in which way the table and the definition are related to this follow-up study? 19- What are the numbers in Table 2 under categories? e.g. Relative 7 ?

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Some of the questions are not relevant for this paper. If they are not relevant I have ticked yes.

I felt that it was too few interivews to really know what impact it had had on the staff. And this wasn't acknowledged.
I thought that the key messages adn the limitations section was weak.

Author's response
The following paragraph has been added to a section now called limitations, in the discussion:

"One of the study limitations is that it is based on few interviews; only ten out of 21 informants took part in the follow up study. In spite of this drawback we could establish that no new substantive codes emerged after the fourth interview. Early saturation indicates that there were more similarities than differences in staff's experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that yet another interview could have added new information."

I felt that the article relied too much on work done in Sweden and that there is a literature on the way that staff treat patients, patient provider communication, the need for culturally appropriate nursing/medical care , as well as abuse of patients taht wasn't quoted.

Author's response
More references have been added to the Introduction.

Although generally the quality of the written english was very good there were a couple of the translated quotes where i was a bit unsure of a couple of words that had been used and wasn't sure if it was a translation issue or the provider had used that word. For example the use of the word "fixated" on page 10 line 27

Author's response
…"they held her tightly" is a more accurate translation, and we have changed accordingly in the text.

I think that 10 interviews is probably not enough to evaluate impact.

Author's response

Thank you for pointing this out. We would like to avoid the expression “evaluate impact” and focus on “apprehending staff's perception”. The manuscript is rewritten accordingly.

This article is interesting and tackles an important topic.It is well written. However if feel that it would be strengthened if it talked to other literature outside of Sweden on the topic. Although the author has published extensively on the Norvold Abuse Questionnaire it has not been widely used elsewhere and i was not familiar with what it actually measures and what was actually happening in the faclities in Sweden.

Author’s response
To give a complete picture of what is actually happening in the facilities in Sweden is a real challenge. With our quantitative and qualitative studies we have described what AHC can look like.
In the introduction we have now tried to outline what AHC is not and how we have operationalized the concept in NorAQ.

“Negative encounters in health care has been described as medical errors [1], communication failures or medical mishaps [2], patient dissatisfaction [3], sexual misconduct [4] etc.
Many of these negative encounters have to be investigated but what if there was no medical error or misconduct committed but the patient still felt abused?
Abuse in health care (AHC) covers a phenomenon different from e.g. medical errors and patient satisfaction even if there might be overlapping cases. [5]
AHC has been investigated in the Nordic countries. It is a rather new concept that has been operationalized in The NorVold Abuse Questionnaire (NorAQ) (Table 1). [6-10] Based on NorAQ the prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent. [11] AHC is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [8, 12-14] “

I also think that it is important to engage in debate about whether it is the nature of the particular forum play intervention that brought about change and if so why - or whether any intervention that draws attention to the topic would have been useful. For example health care workers for change is one that has been used by Fonn S and others.

Author’s response
This is an interesting question.
The following paragraph has been added to the discussion:

“However, it cannot be ruled out that any intervention against AHC that merely drew attention to the topic would have been useful. Therefore it would be interesting to compare different strategies to counteract AHC in future studies.”
We refer to the work by Fonn S and others in the introduction:
“There is a long tradition of interventions that addresses the interpersonal component of quality of care. [18] Role play is one technique used for this purpose. [19, 20] What makes this study different is our focus on AHC.”

Reviewer: 2

BMJ Open

Review – “A Summoning Stone in the Shoe”: staff's perception of abuse in health care a qualitative study 1-Although I keep wavering about this thought, I’m not sure that interviewing 14(or 10?) staff members is grounds to be able to conclude that “staff showed a greater willingness not only to acknowledge AHC but also to take on the responsibility to act in order to stop or prevent AHC”. I am a qualitative researcher so my issue is not at all with the approach, I think I’m reacting to the strength and breadth of the assertion based on a limited group. I think you have to be careful what you conclude.

Author’s response
The conclusion now reads as follows:
“In this follow-up study staff’s perception of AHC were closer to the patient’s perspective. Compared to the pre intervention interviews staff showed a greater willingness not only to acknowledge AHC, but also to take on a responsibility to act in order to stop or prevent AHC. Explanations for this stance could be that Forum Play had showed staff that there were possibilities to act, and that the taboo status of AHC had been broken at the clinic.”

The number of informants available for this study was limited due to the study design.
As mentioned in the method section saturation was reached early.
“No new substantive codes emerged after the fourth interview. All interviews were analysed to stabilise the categories and reach saturation.”

The small sample size is now discussed under the heading Limitations in the discussion.

The limitation of a small study sample is now addressed as follows in the discussion:
“One of the study limitations is that it is based on few interviews; only ten out of 21 informants took part in the follow up study. In spite of this drawback we could establish that no new substantive codes emerged after the fourth interview. Early saturation indicates that there were more similarities than differences in staff’s experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that a seventh interview could have added new information. “

2-A major question I’d like to see addressed is how what the staff said is different than previous research. What can we learn from this study that adds to the literature in general or that specifically supports why it was important to do this study with this group in Sweden? So, is there something about the particular context in Sweden that would require adaptation or input from this study? I’m not saying that you need to get rid of your entire analysis of themes but I just wonder if there is something unique, different, that you can emphasize a little more.

Author’s response
We appreciate this challenging comment.
The uniqueness in our research is probably that we have gone all the way from descriptive prevalence studies to actually trying out an intervention to counteract AHC.
However, there is no reason to believe that AHC is a Swedish phenomenon.

A sentence about the rationale behind the study has been added to the Introduction:
“High prevalence of AHC, creating long-lasting suffering among patients and little awareness about the problem among staff forced us to design and test an intervention against AHC. The intervention was based on theories from ethics, sociology, cognitive theories and pedagogy [19-24].”

3-The aim of the study is not clear.

In abstract: “The study aim was to apprehend changes in the attitude of health care staff to abuse in health care (AHC) after an intervention, based on ‘Forum Play’”.
In page 4: “Our aim was to evaluate the intervention by means of a design allowing the findings from pre intervention to be compared to those from post intervention qualitative interviews”.
What was the aim of the study? Clear, short and well-formulate?

Author’s response
The study aim now reads: “The study aim was to apprehend staff's perception of AHC after an intervention based on ‘Forum Play’, and make comparisons to pre intervention interviews and interviews with male and female patients.” in both the abstract and the main text.

4- In the abstract: 10 staff members who participated In Material and procedure page 6: Eligible for the present study were those 14 informants Additionally, It is useful to mention even in abstract that the participants are from the original sample and this study is a follow-up How many participate in this follow-up study?

Author’s response
The following information has been added to the abstract:
“In a pre-intervention study 21 staff members were interviewed. Eligible for the follow up study were 14 informants who had participated in the intervention. Four declined participation leaving ten informants for this study.”

5- The part about the Intervention should be shortened and moved to introduction.

Author’s response
The part about the intervention concerning Forum play in general has been moved to the introduction and the example has been omitted. The more specific part about the workshops was left in the methods section.

5- What kind of interviews did the authors conduct? Individual semi-structured interviews?
Why? rather than another qualitative method, e.g. focus groups? While I don’t disagree with their choice, readers cannot evaluate the adequacy of their methods unless the authors briefly explain their rationale.

Author’s response
The following two sentences have been added to the methods section:

“The two authors conducted ten individual semi-structured interviews:….”

“Individual interviews were preferred due to the sensitive nature of the topic that might evoke feelings of guilt and shame.”

6- Additional context would be helpful in evaluating the quality of this study. Could the authors be more specific about the clinic they selected?

Author’s response
The following sentence has been added to the methods section:

“During the period January 2008 - January 2009, all staff members at the study clinic, a women’s clinic at a county hospital in the south of Sweden (N=136), were invited to participate in Forum Play workshops led by professional Forum Play leaders.”

7- It can also be helpful to know more about the staff that declined to participate. What was the reason?

Author’s response
We do not have this kind of information. For ethical reasons we are not allowed to collect information from those who decline participation.

8- It’s not clear that 14 (or 10?) interviews are adequate to attain thematic saturation. Typically, qualitative studies of this nature include between 25-35 interviews, and 20-25 are often the minimal number required to attain saturation. If the authors attained thematic saturation with a fewer informants, it would be important to explain why they felt this was the case.

Author’s response
The number of informants available for this study was limited due to the study design.
As mentioned in the method section saturation was reached early.
“No new substantive codes emerged after the fourth interview. All interviews were analysed to stabilise the categories and reach saturation.”

The limitation of a small study sample is now addressed as follows in the discussion:
“One of the study limitations is that it is based on few interviews; only ten out of 21 informants took part in the follow up study. In spite of this drawback we could establish that no new substantive codes emerged after the fourth interview. Early saturation indicates that there were more similarities than differences in staff’s experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that a seventh interview could have added new information. “

9- Additional information is needed on the composition of the interview and the analytic teams. The former may influence interviewee responses. The latter are likely to introduce some degree of bias into the analytical process. Typically, a team approach is used to ensure that the analysis is conducted by a group of individuals with diverse but complimentary personal and professional backgrounds, in order to balance individual biases. At a minimum, a brief description of the analytic team members would be useful.

Author’s response
The following sentence has been added to the method section:
“In order to balance individual biases the transcripts were read and analyzed by both authors, a physician and a nurse with different amount of experiences in research and clinical work.”

10- It is extremely important to explain the research questions, how and/or why these particular questions were selected, as the results are dependent upon the questions asked.

Author’s response
In this follow-up study it was important to us to use the original questions only altered to suit the “after

intervention” situation. Our main question is described as follows:

“The analysis presented in this study is based on answers to open-ended questions similar to those in the pre-intervention study. The main question used for comparing results was: “When I say abuse in health care, what is the first thing that comes to your mind?”

11- Data seem sound, but the paper should include a table of the process (from coeds to new substantive codes and so on).

Author’s response
We are sorry but this would be difficult since the analysis was not conducted by means of tables.

12- It was not clear exactly who read the transcripts? Did they do so independently? Need to clarify that.

Author’s response
The following sentence has been added to the method section:
“In order to balance individual biases the transcripts were read and analyzed by both authors, a physician and a nurse with different amount of experiences in research and clinical work.”

13- There was no discussion of how or whether they discussed and/or came to agreement on their coding of the transcripts and whether they used criteria for inclusion of a coding category in the final results. That should be added.

Author’s response
We are not sure what “criteria for inclusion of a coding category” means, but concerning agreement the following sentence has been added to the method section:
“The authors reached agreement on their coding through discussion.”

14- In the beginning of the Results: A summary of categories and core category is needed

Author’s response
The result section now has the following introduction:
“The core category, ‘a summoning stone in the shoe’, was constructed of five categories: ‘Dehumanising the patient ’, ‘Unacceptable: you are bound to act!’, ‘Ubiquitous’, ‘Unintentional’ and ‘Relative’. Each category is described separately below. The interaction between the categories are described under the headline “core category” at the end of the result section.

15- Follow-up interviews is a better word to use than post interviews

Author’s response
We agree and have changed the text accordingly.

16- In title the word “perception” is used but in the aim it is “attitude”. I think the authors should be consequent and use one concept.

Author's response
Thank you for pointing this out we choose to use the word perception throughout the manuscript.

17- It could be a very good idea to use headings in the discussion in order to structure it.

Author's response
Headings have been added to the discussion.

18- Table 1 is mentioned is introduction. Do the authors use this definition in the interviews? How and in which way the table and the definition are related to this follow-up study?

Author's response
Table 1 is related to the background of this study. We have tried to make this more clear in the Introduction now:

"Negative encounters in health care has been described as medical errors [1], communication failures or medical mishaps [2], patient dissatisfaction [3], sexual misconduct [4] etc.
Many of these negative encounters have to be investigated but what if there was no medical error or misconduct committed but the patient still felt abused?
Abuse in health care (AHC) covers a phenomenon different from e.g. medical errors and patient satisfaction even if there might be overlapping cases. [5]
AHC has been investigated in the Nordic countries. It is a rather new concept that has been operationalized in The NorVold Abuse Questionnaire (NorAQ) (Table 1). [6-10] Based on NorAQ the prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent. [11] AHC is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [8, 12-14] "

"High prevalence of AHC, creating long-lasting suffering among patients and little awareness about the problem among staff forced us to design and test an intervention against AHC. The intervention was based on theories from ethics, sociology, cognitive theories and pedagogy [19-24]."

19- What are the numbers in Table 2 under categories? e.g. Relative 7 ?

Author's response
"Figures represent the number of interviews represented in each category." (added text in a note).

Editor-in-Chief's Comments:

- Please define what they mean by "abuse" in the abstract and methods, not just in table 1.

Author's response
Our suggestion is that we add the following section to the Introduction:
"Negative encounters in health care has been described as medical errors [1], communication failures or medical mishaps [2], patient dissatisfaction [3], sexual misconduct [4] etc.
Many of these negative encounters have to be investigated but what if there was no medical error or

misconduct committed but the patient still felt abused?
Abuse in health care (AHC) covers a phenomenon different from e.g. medical errors and patient satisfaction even if there might be overlapping cases. [5]
AHC has been investigated in the Nordic countries. It is a rather new concept that has been operationalized in The NorVold Abuse Questionnaire (NorAQ) (Table 1). [6-10] Based on NorAQ the prevalence in female gynaecology patients in the Nordic countries ranged between 13-28 per cent. [11] AHC is prevalent in Sweden; 14-20 per cent in female and 8 per cent in male clinical and population based samples have had such experiences. [8, 12-14] “

High prevalence of AHC, creating long-lasting suffering among patients and little awareness about the problem among staff forced us to design and test an intervention against AHC. The intervention was based on theories from ethics, sociology, cognitive theories and pedagogy [19-24].

The following sentence has been added to the Abstract:
“AHC can be described as a failing encounter from the patient’s perspective.”
- In doing so, please also confirm that mean "blackmail"? Would "bullying" be a better translation into English?

Author’s response
"blackmail" is the translation that we have used in previous studies.

- Please delete "“A Summoning Stone in the Shoe" from the title but retain the informative description of the study question and design. This phrase in the current title won't mean much to most native English speakers.

Author’s response
The title has been changed accordingly and now reads:

“Staff's perception of abuse in health care: a Swedish qualitative study”

VERSION 2 – REVIEW

REVIEWER	Loveday Penn-Kekana Researcher Centre for Health Policy School of Public Health University of the Witwatersrand.
REVIEW RETURNED	03-Jul-2012

THE STUDY	Were all the 17 workshops the same? Or were you meant to attend all of them? Did that impact on people's attitudes? The key limitation of this research is correctly stated as the fact that only 10 of the 21 informants took part in the follow up study. The fact that the interviews that were carried out reached satuaration is interesting - but it does not account for the fact that the people who declined to participate in the follow up interviews might have had very different views to those who did participate.
RESULTS & CONCLUSIONS	I felt that the results could have been presented in a clearer way. At the moment I felt that the results were listed and not described with too much reliance on direct quotes for some of the topics.

VERSION 2 – AUTHOR RESPONSE

Reviewer(s)' Comments to Author:

Were all the 17 workshops the same? Or were you meant to attend all of them? Did that impact on people's attitudes?

Author's response
Our guess is that the more workshops one attends the greater impact on people´s attitudes, but we have not investigated that.
The following paragraph has been altered to make these questions clearer:
"Participation was voluntary and there was no limit to the number of workshops a staff member could participate in. Seventy-four participants took part in at least one of the seventeen half-day workshops that were held (74/136=54%).
During the workshops, staff re-enacted (role-played) situations that they had experienced or heard of when patients had felt abused in health care. The situations were different from one workshop to another, but typically included a bystander who was not intervening but felt that he or she ought to do something…"

The key limitation of this research is correctly stated as the fact that only 10 of the 21 informants took part in the follow up study. The fact that the interviews that were carried out reached satuaration is interesting - but it does not account for the fact that the people who declined to participate in the follow up interviews might have had very different views to those who did participate.

Author's response
This should be stated in the limitation paragraph and the following lines have been added:

"Early saturation indicates that there were more similarities than differences in staff's experiences of AHC. Six more interviews were conducted to fill up categories and assure saturation, but it cannot be ruled out that yet another interview could have added new information or that people who declined to participate in the follow up interviews might have had very different views to those who did participate.
"

I felt that the results could have been presented in a clearer way. At the moment I felt that the results were listed and not described with too much reliance on direct quotes for some of the topics.

Author's response
This is true and also the authors' choice. We use quotes as illustrations not proof. A sentence has been added to the introduction in the result section.

"Each category is described separately below. The interactions between the categories are described under the headline "core category" at the end of the result section. Quotes are used to illustrate our findings."