

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)	Doctors' understanding of individualisation of drug treatments: A qualitative interview study
AUTHORS	Denford, Sarah; Frost, Julia; Dieppe, Paul; Britten, Nicky

VERSION 1 - REVIEW

REVIEWER	Sarah Tonkin-Crine Research Fellow University of Southampton, UK
REVIEW RETURNED	15-Feb-2013

THE STUDY	The methods section explains that study details were emailed to "practices on the Devon Primary Care Incentive Scheme register". The authors do not say what this is, or which types of doctors are likely to be listed on this register. A reader may assume this register is only of GPs and GP practices however hospital consultants were also recruited for this study. Would it not have been better to have GPs only? These points could be explained in more depth in the paper. It would also be interesting to know whether the participants gave any input on the findings when a summary was sent to them and if so, what impact this had on the results.
------------------	---

REVIEWER	Majid Ali Senior Lecturer Department of Pharmacy (University of Hertfordshire) College Lane Campus Hatfield AL10 9AB UK
REVIEW RETURNED	17-Feb-2013

THE STUDY	The participants are described to some extent e.g. whether they were GP in urban or rural areas or hospital consultants. There is no inclusion or exclusion criteria as such. Although, it would be appropriate to report some more relevant demographic data e.g. age and duration of practice of the participants as the views may be affected by these two factors. This is a qualitative study. Therefore, no statistical methods required.
GENERAL COMMENTS	The amendments required are very minor. I think there would be no need to review the revised manuscript. Abstract:

- Under 'Settings' it's appropriate to say only, 'Primary and secondary care in South West of England'.

Introduction:

- The first paragraph can leave the reader in confusion. What's the difference between 'treatment individualisation' and 'self-management'? Is 'self-management' one of the levels of 'treatment individualisation'?
- Third paragraph mentions about 'evidence based guidelines'. Are there any references to them?

Methods:

- How many doctors were emailed for recruitment? What was the response rate? Of those who responded, were all (or the opportunistically selected ones) interviewed?
- The topic guide was based on literature and clinical experience. Were there any themes in the topic guide? Was it piloted?
- Ethical process and consenting is well defined.
- Data analysis plan at the end of methods section is very rigorous and very well summarised.

Results:

- 20-60 minutes duration is quite a big variation. What was the mean interview time duration?
- Well-structured results section.
- Themes and subthemes with quotes are well selected.

Discussion:

- There is a bit of repetition.
 - Second paragraph, 'Whilst we report that the four hospital consultants appeared to be more willing than general practitioners to individualise treatments.....'
 - Fourth paragraph, 'Only a small number of doctors (mainly from secondary care.....'
- Any difference in opinions of GPs from urban and rural areas?
- Any involvement/contribution of other healthcare professionals (from literature) e.g. pharmacists in treatment/medicine individualisation?

	Overall, it is a very well conducted and reported study with rigorous data analysis. I would recommend the acceptance with minor amendments. I think you have enough data (especially under first of the two themes) to propose a definition of 'treatment individualisation'. Well done!
--	---

REVIEWER	Dr Dianne Bowskill Non Medical Prescribing Lead Quality Lead University of Nottingham School of Nursing Midwifery and Physiotherapy Queens Medical Centre Nottingham NG7 2HA
REVIEW RETURNED	23-Feb-2013

GENERAL COMMENTS	Thank you for undertaking this excellent piece of research. It provides an invaluable insight to the hidden elements of the consultation and raises an important conceptual question of individualisation. The paper is well written, the clearly structured presentation encourages the reader to reflect on practice and to think about how individualisation may influence safe, effective and appropriate prescribing for patients. I look forward to the publication of this paper. I hope you continue to develop findings from this research.
-------------------------	--

REVIEWER	Dr Richard Cooper Lecturer in Public Health SchHARR University of Sheffield
REVIEW RETURNED	04-Mar-2013

THE STUDY	The binary 'yes', 'no' is not helpful here regarding the research question so this qualitative comment hopefully elucidates. I have concerns that this is a difficult area and the study and paper have a difficult task from the start, in trying to gather data from doctors about a topic that the authors also agree is 'often unclear' and 'used to refer to a number of things.' Specifically, the choice of a single word - individualisation - is immediately problematic, if there are concerns about meaning and terminology. I also feel this is such a potentially large topic that, in some respects, overlaps with other areas omitted in the paper, such as pharmacogenetics and also the vast literature on concordance/adherence. In this respect, the paper invites this widening, since it sets out initially that there are 3 processes (diagnosis, prescribing and patient use) which in my view, invites the concordance/adherence issues. What is also mentioned periodically but mainly in passing, is any reference to 'risk' and this is, again, another vast area, but one which I wondered if it may have been relevant. And all this is said without even trying to raise the old debate about medical dominance and the broader policy/cultural changes in recent decades (although I noticed Alan Cribb's policy paper about 'personalised' medicine was helpfully referred to at the end). In summary regarding this aspect, I realise this paper study has
------------------	--

	<p>received NIHR funding and therefore has been subject to methodological scrutiny and is clearly worthy, so I am mindful that I am raising fundamental concerns that others may not share, so hope these are taken in this context.</p> <p>Participant details were limited to description of GPs and hospital consultants, and mention made of gender and in two of the latter, speciality, and of rural or other GP practice. This links to concerns around convenience sampling, in part, and also to lack of transparency in the quotes, from which it is not possible to link to participant details, which would be good.</p>
RESULTS & CONCLUSIONS	<p>Given my initial concern around the definition and synonymous terminology, it follows that the data is potentially threatened if one (I assumed) in interviews asked only about 'individualisation'. Perhaps more transparency and information is simply needed here to indicate to the reader that the interviewer permitted and hinted at this open context. This is a classic qualitative dilemma, in trying to elucidate responses from participants in areas that may be tacit, or pre-reflective, and when simply launching into the 'what is X, or how do you do X' then 'X' may not be immediately known, could require the researcher to explore using other (literature driven) leads.</p> <p>The second question in this section asks if the results are credible and I have indicated yes, notwithstanding the above, since I get a good sense that suitable 'quality' approached to analysis were undertaken. However, see below for some further methodological issues about the coherence of the themes.</p> <p>I answered no to 'well presented' and again the binary categories are unhelpful here. I felt there were many good practices of qualitative writing in terms of quotes and some contextual wording. In other parts however, I felt:</p> <p>a) that the actual themes - and what I understand to be the explanatory, over-arching emergent higher level categories - were limited (to understanding and doing). Of course, a reader has to take it on trust that this is what the data revealed and I realise this paper did not set out from a medical sociology perspective and theoretical orientation and could not use (or benefit?) from such a stance (as Nicky did previously using Habermas's system/lifeworld to good effect for example re medicines). I also felt that the separation of understanding and doing, or 'methods' (which felt an odd phrase) overlapped and particularly that about understanding seemed to contain much that was about enactment, which in my view was inevitable. In this sense, I felt the presentation (and potentially analysis) could have been enhanced. I noticed that in the discussion, there was a return to the 3 processes, and raised the question of how important this typology was, and why it framed the start and end but not results.</p> <p>The clarity of message is in one sense well set out - doctors vary in terms of what they understand and do about this thing that is called 'individualisation'. The concern remains as to what the doctors thought they were being asked to discuss.</p>
GENERAL COMMENTS	<p>My overall thoughts on this paper are that:</p> <p>a) this is a difficult topic to study given the contested and broad nature of the subject.</p> <p>b) as a result, the study had a difficult task in being sure that what was asked of participants was what was understood by the term.</p> <p>c) some methods issues in the use of convenience sampling was not ideal and more details needed of participants at least. This sampling</p>

strategy is fine for hard to reach groups in my view but not ideal when there is a known group like GPs and consultants. Also, some interviews very short, giving concern as to the depth of data collected.

d) the thematic organisation and headings felt quite limited (and potentially overlapped)

e) a main claim (in abstract, results and conclusion) was that descriptions were not consistent with examples, and this required more explication, since it felt very much a view that the researcher imposed upon the data. In principle, not a problem with this, but need more of a defence AND to arguably have more transparency about the researchers (see comment below).

More specific comments:

a) p6 l.3 'our own clinical experience' say more here, in interests of transparency. and perhaps add in this section more about whether the 'individualised treatment' description was fixed or if the other synonyms were used or prompted.

b) p6 l26 very odd that themes are referred to in the analysis process before coding is mentioned.

c) in methods, no mention is made of respondent validation. Epistemologically, an interesting area but did this lead to any contested aspects, or were accounts accepted?

d) p6 l44 -20 minutes to 60 minutes. What was the mean time? Have some worries about 20 minutes interviews. I've used that level on some occasions and can work, but depends of the topic.

e) linked to d), could a comment be given as to how easy the interviews were to conduct - ie a meta-analytic aspect of data in my view, about the researcher's view of whether doctors found it easy to discuss this, or if prompting was needed etc. It is mentioned that 2 could not, but given my concerns above, might more information be helpful here.

f) p7. l15-8 - this issue of descriptions not matching examples was not worded well and came across rather too much as a researcher-imposed view and felt much more was needed here to explain (and defend) this.

g) why are participants given numbers to three digits? As per earlier comment, I would have liked either a table linking number to demography, or pseudonym 'Jane, 30s, GP rural practice.'

h) p7 l34 - use of abbreviations like 'i.e.' is not good writing style (minor point). and p8. l3 too.

i) p 8 l26 'what the patients is prepared to do' sounded rather normative. Also reappears on l52 of same page (although tense now changed to past correctly). Wondered if this could have been explored more.

j) p9 l9014 is good example of where the wider literature is relevant but opens up a vista of different aspects. I agree and recognise that this paper gives a good message in saying the doctors don't really consider much what happens after the consultation, but again feel that this would open up further area to reflect on.

k) 'text book scenarios' - was this researcher phrase or a participant. If latter, then interesting, if former, needs clarifying - does it mean 'simple'? Or is this where the clinical aspects of the researcher are apparent? Fine with this, but need to be transparent in these areas where arguments are being advanced.

l) geriatricians mentioned in the results but not methods, and came as quite a surprise, and reinforced the lack of transparency and convenience sample, especially as there were 2.

m) some interesting references to colleagues and isolation and felt this was an aspect that could have had thematic implications.

n) felt use of 'Q' and 'A' in p9. l54 and next page was unusual and

	<p>suggestive of a structured questionnaire. I realise we ask questions but felt 'A' for answer did not capture the ontological aspects of qualitative work - that there are not answers but responses. Again on p 11 l45-53</p> <p>o) p10 l129-44 is a very long quote but this is on-line so not a word count issue and feel it gave good depth of insight.</p> <p>p) p.10 l51 'convince or persuasion' are fascinating words that evoke the paternalism debate and issues of power - again, old territory but felt this could have been explored. linked to the 'might come round' quote on next page, which again felt so much of that sociological debate.</p> <p>q) 'Dosette' capitals and single 's' but perhaps better to avoid overt brand reference and say monitored dosage systems.</p> <p>r) felt some of the interesting data on side effects could have been captured by reference to surveillance medicine perhaps?</p> <p>s) p13 l 55 - 'lack of consensus' - did you expect there to be? In qualitative work, not sure I'd expect that</p> <p>t) p.14 16-18 - resonant validation and comments referred to here, but not in methods or any details given over impact of this process.</p> <p>u) p15 l32 'dangerous adaptations' ventures into new risk territory here and felt rather normative. Also felt reference to developing 'tools' here and in abstract was not matched to wording or details of this in data/results. What might a 'tool' be? Are you thinking decision-making tools, electronic/paper, guidance document/CPD?</p>
--	---

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

1. Reviewer 1 helpfully points out that “the methods section explains that study details were emailed to "practices on the Devon Primary Care Incentive Scheme register". The authors do not say what this is”

To address this, we have included a sentence stating that “the Primary Care Incentive Scheme register is a register of primary care practices who have applied for support from the Primary Care Research Network for participation in research” (page 6 of the manuscript).

2. The reviewer then suggests that we explain in more detail how we recruited hospital consultants and why we did not limit our sample to GPs.

We anticipated that individualisation would be particularly relevant to doctors who deal with patients with a range of problems; therefore we decided to sample doctors who are generalists, such as general practitioners and geriatricians. We recruited two clinical academics to take part in pilot interviews. Their data were included in the analysis. One pages 5 and 6 we now include the paragraph: “We used opportunity sampling to recruit doctors to the study. We anticipated that individualisation would be particularly relevant to doctors who deal with patients who have a range of problems; therefore we decided to sample doctors who are generalists (such as general practitioners and geriatricians). Two clinical academics (who were also hospital consultants) from within the medical school took part in pilot interviews to help test the procedure and topic guide. We then emailed information about the study to 55 practice managers from practices on the Devon Primary Care Incentive Scheme register (a register of primary care practices who have applied for support from the Primary Care Research Network for participation in research), and asked interested doctors to make contact and arrange a time and place for the interview to take place. Sixteen doctors from 12 primary care practices responded to the email and took part in the interview. Two geriatricians were recruited using snowball sampling.

3. On page 16, we respond to the comment that “It would also be interesting to know whether the

participants gave any input on the findings when a summary was sent to them and if so, what impact this had on the results.”

Respondent validation consisted of discussions with the participants who took part in the pilot interviews. These participants recognised our findings, and agreed that they were plausible. To address this comment, the sentence: “participants who took part in our pilot interviews stated that they could recognise our findings, and agreed that they were plausible” is included on page 16.

Reviewer 2:

4. Reviewer 2 notes that “the participants are described to some extent e.g. whether they were GP in urban or rural areas or hospital consultants. There are no inclusion or exclusion criteria as such. Although, it would be appropriate to report some more relevant demographic data e.g. age and duration of practice of the participants as the views may be affected by these two factors.”

Unfortunately, we did not collect demographic information on any of the participants, such as age or years of practice. We agree that these factors are likely to influence doctors’ understanding and use of methods to achieve individualisation. However, the decision was made not to collect demographic information for ethical reasons. As all participants were recruited from South West Devon, we had concerns that demographic information could lead to the identification of participants or their patients. Participants were asked to discuss sensitive examples of clinical practice with patients; therefore we did not collect any information that could lead to our participants being identified.

Abstract:

5. “Under ‘Settings’ it’s appropriate to say only, ‘Primary and secondary care in South West of England’.”

We have accepted the reviewer’s helpful comment and the sentence now reads “primary and secondary care in South West of England.”

Introduction:

6. “The first paragraph can leave the reader in confusion. What’s the difference between ‘treatment individualisation’ and ‘self-management’? Is ‘self-management’ one of the levels of ‘treatment individualisation’”

To make it clear that individualisation may facilitate self-management; we have changed the opening sentences of the manuscript to read “Self-management is the foundation of chronic disease management. However, self-management is not straight forward. To facilitate self-management, policy makers advocate that treatments are tailored, personalised or individualised to patients’ needs.”

7. “Third paragraph mentions about ‘evidence based guidelines’. Are there any references to them?”

Two references (Haynes 1996 and Hayward, 1995) have been included for the sentence in question on page 4.

Methods:

8. “How many doctors were emailed for recruitment, what was the response rate, of those who responded, were all (or the opportunistically selected ones) interviewed?”

As stated above (point 2), we now provide this information on page 5 of the manuscript.

9. “The topic guide was based on literature and clinical experience. Were there any themes in the topic guide? Was it piloted?”

We have provided more detail on the topics that are included in the guide, and the process of piloting the topic guide. On page 6, we now describe how “open ended questions were used to explore the

following topics (i) understanding of individualisation (ii) examples of individualising treatments (iii) methods used when patients' preferences are incompatible with guideline recommendations (iv) methods used to support patients to use their medication outside consultations (v) methods used to individualise treatments for patients with multiple chronic conditions and (vi) when individualisation is and is not appropriate. Participants were also asked if there was anything else they thought was relevant to individualisation. The topic guide was piloted with two academic clinicians. On the basis of these pilot interviews, the topic guide was modified to make it clear that we are interested in individualised drug (as opposed to other) treatments in patients with chronic (as opposed to acute) conditions. In order to obtain detailed accounts, doctors were encouraged to provide examples whenever possible."

Results:

10. "20-60 minutes duration is quite a big variation. What was the mean interview time duration?" The first paragraph of the results section now states that "the mean duration of interviews was 48 minutes." (Page 7)

Discussion:

11. "There is a bit of repetition. Second paragraph, 'Whilst we report that the four hospital consultants appeared to be more willing than general practitioners to individualise treatments.....'" The repetition has been addressed by removing the sentence "whilst we report that the four hospital consultants appeared to be more willing than general practitioners to individualise treatments after the consultation this is based on a small number of participants."

12. "Any differences of opinion between doctors from urban and rural practices?" While factors such as location and size of practice could influence doctors' opinions, in this study, doctors understanding and methods used to individualise treatments did not appear to be related to whether they were from urban or rural areas. We tentatively suggest that variation in other factors (such as age, experience) may have confounded any relationship between location of practice and doctors' opinions.

Reviewer 3

We would like to thank reviewer 3 for her very positive comments. We agree that this is a very important topic, and one we hope to develop further with our ongoing work.

Reviewer 4

We would like to thank reviewer 4 for his detailed and constructive comments. We agree that individualisation can be considered an umbrella term; used interchangeably to refer to a range of related and overlapping concepts. We explore the huge variation in the use of such terms in another paper we are currently developing. Our intention in this paper was to explore doctors' understanding of individualisation in relation to drug treatment for patients with chronic conditions explicitly.

13. Comment A & B: "a) this is a difficult topic to study given the contested and broad nature of the subject. b) as a result, the study had a difficult task in being sure that what was asked of participants was what was understood by the term." We agree with reviewer 4 that this is a difficult topic to study, and we agree that this study raises a number of issues relating to terminology surrounding individualisation. We are in the process of conducting additional research projects including a review of the concepts surrounding individualisation, and a Cochrane systematic review of the methods used to achieve individualisation. We hope that this qualitative study in combination with our two reviews will help to highlight, and start to address, some of the problems within the existing literature.

Reviewer 4 highlights that individualisation could be used to refer to a wide number of things, and expressed concern that the participants may not understand what they were being asked. Based on our ongoing work and knowledge of the literature, we started with a working definition of individualisation as “a prescribing decision, or a series of decisions, that incorporates patients’ specific needs and experiences and any existing strategies for using their medications with the professionals’ clinical judgement. This usually includes patients monitoring their symptoms and, with the support of the professional, making appropriate product, dose or timing adjustments as necessary.” However, as this study is intended to be exploratory and we did not want to be too prescriptive, and so did not provide doctors with a definition. In response to reviewer 4’s comment, we now include the following paragraph on pages 6 and 7 “To contextualise our study, the interviewer gave the following explanation at the beginning of the interview: “Patients will vary in terms of the number of conditions they have, the amount of medications they take, and the severity of their condition(s). Patients will also have very different lifestyles, priorities, and beliefs about their condition(s) and treatments. We aim to explore the methods used by Healthcare providers to individualise treatments. We are aware that there is little consensus about what individualisation is, little guidance in the literature about how to do it, and that some doctors have developed their own approaches. We are interested in exploring the methods or strategies that are used by healthcare providers to tailor treatments to each individual patient.” The interviewer started interviews by asking participants what they understood individualization to be, and to provide an example of a time during which they had individualized treatment with a patient. To avoid influencing participants’ answers, we did not explicitly define individualisation. However, the interviewer later used prompts to encourage participants to discuss additional situations that could be considered to be amenable to individualisation (as per the topic guide). We anticipated that this would provide a detailed account of doctors’ understanding of individualisation and the methods that they would use to achieve it within their understanding as well as the methods that they used to individualise treatments as others may see it.” Participants did not spontaneously mention risk or pharmacogenetics – in response to the opening questions or the prompts.

14. Comment C. “Some methods issues in the use of convenience sampling was not ideal and more details needed of participants at least. This sampling strategy is fine for hard to reach groups in my view but not ideal when there is a known group like GPs and consultants. Also, some interviews very short, giving concern as to the depth of data collected the methodological issues with the use of convenience sampling.”

The decision to use convenience sampling in this exploratory work was a pragmatic one. It was not possible to provide payment for participation; therefore we had to rely on volunteers. We accept that there are problems with self-selected samples, and acknowledge the limitations in the discussion on page 17. Having said this, as we are interested in best practice, we were not overly concerned with recruiting only those with an interest in the study. The interviews were conducted during doctors’ working hours in the time they had available. In some cases, doctors could spare no longer than half an hour. However, despite the length, the data provided was rich and varied, with explanations and examples of individualisation.

15. Comment D: “The thematic organisation and headings felt quite limited (and potentially overlapped).”

We did consider structuring the results in accordance with the three processes we described in the introduction and discussion. However, we decided that structuring the paper in terms of the doctors’ understanding and the methods that they use to individualise treatments reflects the nature of the data that we actually collected, and the aims of the paper. Reviewer 2 supported this with her comment: “well structured results section.”

16. Comment E: “A main claim (in abstract, results and conclusion) was that descriptions were not consistent with examples, and this required more explication, since it felt very much a view that the

researcher imposed upon the data. In principle, not a problem with this, but need more of a defence AND to arguably have more transparency about the researchers”

The claim that the descriptions are not consistent with the examples was apparent from the doctors’ answer to the question about their understanding of individualisation, and the examples they later provided. We mention it in the paper as we attempt to tease out the dissonance between the rhetoric of individualisation and clinical experience. This dissonance between rhetoric and experience was evident throughout the interviews. For example, some doctors appeared to think that individualised treatment was incorporating the patients’ preferences and world views into treatment decisions. We now include an additional section in the results section (page 15) entitled ‘dissonance between rhetoric and experience.’ In this section, we exemplify the conflict between participants’ understanding and their clinical practice. We later return to the issue in the discussion (page 17).

Specific comments:

17. Comment A: “Our own clinical experience’ say more here, in interests of transparency and perhaps add in this section more about whether the ‘individualised treatment’ description was fixed or if the other synonyms were used or prompted.”

We now include a sentence on page 6 to clarify that our own clinical experience came from two members of the team who have considerable experience working in clinical practice as a nurse and a rheumatologist. As described above (point 13), more detail has been included to inform the reader that participants were initially asked open-ended questions to identify their understanding of individualisation. As the interview progressed, participants were prompted to discuss clinical situations that are related to or associated with individualisation.

18. Comment B: “Very odd that themes are referred to in the analysis process before coding is mentioned”

We have clarified that coding preceded the identification of themes in the data analysis section (pages 7). The section now reads “two researchers independently read transcripts and noted down core codes that were identified. We met regularly to discuss codes and to develop a preliminary list of themes. As analysis progressed, we drew on the existing literature to refine this list and to group related themes together”

19. Comment C: “In methods, no mention is made of respondent validation. Epistemologically, an interesting area but did this lead to any contested aspects, or were accounts accepted?”

As described above (point 3) we now provide more detail about respondent validation.

20. Comment D: “20 minutes to 60 minutes. What was the mean time? Have some worries about 20 minute interviews. I’ve used that level on some occasions and can work, but depends of the topic”

As described above (point 10 and 15), we now specify that the mean duration of interviews was 48 minutes, however, despite the short duration of the interviews, the data was rich and varied.

21. Comment E: “Could a comment be given as to how easy the interviews were to conduct – i.e a meta-analytic aspect of data in my view, about the researcher’s view of whether doctors found it easy to discuss this, or if prompting was needed etc. It is mentioned that 2 could not, but given my concerns above, might more information be helpful here”

To address this comment, we now include the sentence “There was variation in the ease with which doctors spoke about individualisation. There were two doctors who could not articulate their understanding of individualisation, but who were still able to respond to prompts about how they would deal with situations that could be considered to be amenable to individualisation.” (Page 8).

22. Comment F: “This issue of descriptions not matching examples was not worded well and came across rather too much as a researcher-imposed view and felt much more was needed her to explain

(and defend) this.”

As discussed above (point 17) the dissonance between participants’ descriptions and understanding of individualisation is discussed in more detail on page 15.

23. Comment G: “Why are participants given numbers to three digits? As per earlier comment, I would have liked either a table linking number to demography, or pseudonym ‘Jane, 30s, GP rural practice.” Throughout the results section, participant numbers have been replaced with pseudonyms, and whether they were urban or rural general practitioners, clinical academics, or geriatricians. To avoid risking participants’ anonymity, we have not presented (or collected) any demographic details.

24. Comment H: “Use of abbreviations like ‘i.e.’ is not good writing style”
Abbreviations have been removed throughout the manuscript.

25. Comment I: “‘What the patient is prepared to do’ sounded rather normative. Also reappears on 152 of same page (although tense now changed to past correctly). Wondered if this could have been explored more.”

We did not intend the theme “what the patient is prepared to do” to sound normative. What the patients were prepared to do was described by doctors as being unique to each individual patient. We have changed this title to “patients’ willingness to take medication.” We agree that this is an interesting area and could be discussed in relation to a number of areas (the congruence between doctors’ and patients’ views on what patients are prepared to take, how doctors could explore patients views on this issue, etc). However, we think that further consideration of these issues is beyond the scope of this study.

26. Comment J: Reviewer 4 commented that our paper “gives good message in saying the doctors don’t really consider much what happens after the consultation, but again feel that this would open up further area to reflect on.”

To address this comment, we include the following paragraph on page 17 “The lack of consideration of what goes on outside the consultation is particularly interesting and worrying. Pound et al., (2005) have shown that many patients will monitor their symptoms and side effects and make treatment adaptations as necessary – with or without the support of the doctor. Self-management of chronic disease requires patients to take multiple treatments and monitor their health over many years. Therefore, strategies to support patients to modify treatments, and providing safe parameters for them to do so, may actually limit patient driven amendments to treatments without professional support. However, our study highlights the variation in opinions about whether or not patients should be encouraged to adapt treatments after consultations. One doctor felt that patients did not want to adapt their treatments. Another doctor thought that encouraging patients to be aware of side-effects could actually contribute to side effects. Others were concerned that encouraging patients to monitor symptoms could lead to unnecessary stress. Only a small number of doctors (mainly from secondary care) thought that patients should be encouraged to individualise treatments after the consultation. This is an important issue worthy of future study.”

27. Comment K: “‘text book scenarios’ - was this researcher phrase or a participant. If latter, then interesting, if former, needs clarifying - does it mean ‘simple’? Or is this where the clinical aspects of the researcher are apparent? Fine with this, but need to be transparent in these areas where arguments are being advanced.”

Two doctors used the term in reference to situations that are commonly used in text books. To clarify, we have used quotation marks around this phrase.

28. Comment L: “Geriatricians mentioned in the results but not methods, and came as quite a surprise, and reinforced the lack of transparency and convenience sample, especially as there were 2”

As discussed above (point 2) a detailed description of our recruitment strategy is included on pages 5 and 6.

29. Comment M: "Some interesting references to colleagues and isolation and felt this was an aspect that could have had thematic implications."

We agree that doctors' references to colleagues and isolation are interesting and worthy of further study. However, we think that consideration of this issue is beyond the scope of this paper.

30. Comment N: "felt use of 'Q' and 'A' in p9. l54 and next page was unusual and suggestive of a structured questionnaire. I realise we ask questions but felt 'A' for answer did not capture the ontological aspects of qualitative work - that there are not answers but responses"

Throughout the results section, the Q and As have been replaced with (i) interviewer and (r) respondent.

31. "Comment O: ll29-44 is a very long quote but this is on-line so not a word count issue and feel it gave good depth of insight."

We agree with reviewer 4 that the quote on page 10 is long; however, we also agree that its length is justified by the depth of information it provides.

32. Comment P: "'Convince or persuade' are fascinating words that evoke the paternalism debate and issues of power - again, old territory but felt this could have been explored. linked to the 'might come round' quote on next page, which again felt so much of that sociological debate"

Themes discussed in our paper certainly could contribute to the large body of literature about paternalism and patient choice. We agree that data relevant to this argument is evident in our paper, and refer to this issue in the discussion by including the following section on page 17: "Paternalism versus patient choice is an ongoing debate, and widely discussed in the literature(15, 30, 31). In the current paper, the dissonance between the rhetoric of individualisation and doctors' clinical experience appeared to stem largely from this issue, with the data revealing tensions between doctors' desire to treat the patients' social needs, and simultaneously treat their medical needs." However, we think that a more comprehensive discussion of this issue is moving away from the aim of this paper, and could distract the reader from our key message.

33. Comment Q: "'Dosette' capitals and single 's' but perhaps better to avoid overt brand reference and say monitored dosage systems"

The use of the term dosette box has been replaced with monitored dosage systems.

34. Comment R: "I felt some of the interesting data on side effects could have been captured by reference to surveillance medicine."

We chose not to relate our findings to surveillance medicine, although we agree that it could be relevant.

35. Comment S: "'lack of consensus' - did you expect there to be? In qualitative work, not sure I'd expect that"

We agree that achieving consensus of opinion is not the aim of qualitative research. Claims that there was a lack of consensus in doctors' understanding of individualisation have been removed from the paper.

36. Comment T: "Respondent validation and comments referred to here, but not in methods or any details given over impact of this process"

As described above (point 3) we now provide more detail about respondent validation.

37. Comment U: "'Dangerous adaptations' ventures into new risk territory here and felt rather

normative. Also felt reference to developing 'tools' here and in abstract was not matched to wording or details of this in data/results. What might a 'tool' be?"

We used the term "dangerous adaptations" to show that patients may make adaptations that are against medical advice. This term has been changed to "amendments to treatments without professional support." The reference to a 'tool kit' was intended to communicate our longer term aim of developing a practical way of supporting patients and practitioners achieve individualised treatment. We hope that this, and other studies, will lead to the development of a tool kit that can be used to help doctors achieve individualised treatments. We acknowledge that reference to such a long term goal is inappropriate, and have removed the term tool kit from the manuscript.

VERSION 2 – REVIEW

REVIEWER	Dr Richard Cooper Lecture in Public Health SchHARR, University of Sheffield, Sheffield, S1 4DA UK
REVIEW RETURNED	16-Apr-2013

GENERAL COMMENTS	Thank you for responding to the (very) detailed comments I sent. Being mindful of the views of the other reviews, I will not explore some aspects of the context of the paper further, as the reiteration that this is an exploratory study and by its nature limited in scope satisfy me, and I am pleased that the broader debates will be explored later. I feel the paper work well and communicates, as I noted earlier, the interesting message that what doctors say and do vary and adds the topic of 'individualisation' to that burgeoning canon! I remain of the opinion that the study's use of convenience sampling could be a limitation but, again, this is exploratory and if readers view the data in that context, then that is fine. I look forward to reading the broader, more nuanced paper in due course and good luck with the rest of the study/writing.
-------------------------	---