PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Incentivised case finding for depression in patients with chronic heart disease and diabetes in primary care: an ethnographic study
AUTHORS	Alderson, Sarah; Russell, Amy; McLintock, Kate; Potrata, Barbara; House, AO; Foy, Robbie

VERSION 1 - REVIEW

REVIEWER	Carolyn Chew-Graham Research Institute, Primary Care and Health Sciences, Keele University. I examined Sarah Alderson's PhD, of which this work was a part.
REVIEW RETURNED	06-Apr-2014

GENERAL COMMENTS	ABSTRACT What does ‘contrastive’ approach mean? Inconsistent use of ‘screening’ or ‘case-finding’ Strengths & Limitations: How can authors assure us that the 12 practices where ethnography was undertaken were ‘typical’? Perhaps this sentence needs re-phrasing. INTRODUCTION: The authors need to explain the difference between case finding and screening and be consistent, using one term only. States that there is no literature on patient views on depression incentives – but could cite: Dowrick, C., Leydon, G. M., McBride, A., Howe, A., Burgess, H., Clarke, P., Maisey, S., & Kendrick, T. (2009). Patients’ and doctors’ views on depression severity questionnaires incentivised in UK quality and outcomes framework: Qualitative study. British Medical Journal, 338, b663. METHODS: Line 39 page 6 - could the authors give some examples of ‘clinical events’ that they were looking for in patient records. Explanation of the word 'contrastive' approach to analysis should be explained and referenced. RESULTS: Each of the six sub-headings is very short suggesting a descriptive ‘analysis’ backed up with minimal illustrative data.

	Page 7&8 It is not clear that the data presented illustrates that 'case finding exacerbates the discordance between patient and professional agendas' – the PN is trying to measure blood pressure, not asking the case-finding questions. This extract does illustrate how data gathering in the consultation may mean that patient cues are not picked up. There is a sub-heading about 'professional beliefs' – the data is from observation in consultations and field note; I am not convinced that you can extrapolate beliefs from such data. Page 10 'interviewed patients articulated the belief…..' No data is given to illustrate this statement. There was insufficient discussion of the last three 'themes'. I would suggest that the authors re-look at their data and consider presenting three, more powerful themes, that tell a more coherent story, underpinned by a theoretical framework which seems lacking in the current analysis. DISCUSSION The authors claim that case-finding 'appeared to augment the discordance between patients and professionals'. I do not feel that the authors have presented convincing evidence to support this claim. The authors describe professionals' beliefs, but they have extrapolated this from observations; they present no data from interviews with professionals to support their claims. The authors suggest that their findings help explain the lack of benefit of case finding when implemented outside of collaborative care models. More explanation of this point is needed. The suggestion that practices need more 'guidance' is a rather simplistic conclusion of a complex and interesting study. Please be consistent in the revised paper in use of terms case finding or screening.

REVIEWER	Chris Burton University of Aberdeen UK
REVIEW RETURNED	30-Apr-2014

GENERAL COMMENTS	The question about this paper is whether it represents a sufficient advance in knowledge. My feeling is that it doesn't - which is a shame because it is elegant and well conducted. If you felt there was sufficient originality there, then it's a minor revisions only. Overall this is a well written manuscript. It reports an ethnographic study examining screening for depression in patients with long term conditions in primary care. It is the first study to my knowledge to match this method to this condition / context and appears to have been well conducted. However this topic has been explored by

	others (the authors cite Coventry 2011 but not Maxwell 2012 or Barley) and while this study confirms findings from those studies, there are few new findings. Having said that, it is the strongest evidence yet that the principle of interrupting the flow of clinical conversation to ask out-of-context questions about sensitive issues is as daft in practice as it looks when I write it down. I have a few minor comments about the text P8 line 10 on – these quotes and comments really aren't about depression / depression screening. The nurse over-rules emotional talk in order to check blood pressure. P4 Line 3 (Intro) do we really believe that 1/3 of all patients with CHD have depression – including all those stable, one episode 5 years ago and living a normal life? I know everyone quotes these kind of figures but it's hard to reconcile with real life experience (unless you take a very inclusive approach to depression). I note that only one of 65 screened patients received any treatment! It may be better to think in terms of relative proportion (say twice as common) which allows one to adjust for other factors. P14 line 40 "Those who screen positive" is a rather inelegant phrase in this context.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

ABSTRACT
What does 'contrastive' approach mean?
The word contrastive has been taken out of the abstract and more information regarding our data collection has been added.
Inconsistent use of 'screening' or 'case-finding'
Thank you for pointing out our inconsistency. We have updated the text to case-finding where appropriate.

Strengths & Limitations:
How can authors assure us that the 12 practices where ethnography was undertaken were 'typical'? Perhaps this sentence needs re-phrasing.
We have re-phrased this sentence to 'broadly representative' and explained why we feel the practices are representative in our main body of text.

INTRODUCTION:
The authors need to explain the difference between case finding and screening and be consistent, using one term only.
We are now consistent in the use of the term 'case-finding' and have explained the difference between the two.

States that there is no literature on patient views on depression incentives – but could cite:
Dowrick, C., Leydon, G. M., McBride, A., Howe, A., Burgess, H., Clarke, P., Maisey, S., & Kendrick, T. (2009). Patients' and doctors' views on depression severity questionnaires incentivised in UK quality and outcomes framework: Qualitative study. British Medical Journal, 338, b663.
Thank you for pointing out this reference. We have added this to our text.

METHODS:
Line 39 page 6 - could the authors give some examples of 'clinical events' that they were looking for

in patient records.
We have listed the clinical events we reviewed patient records for in our methods.

Explanation of the word 'contrastive' approach to analysis should be explained and referenced.
The description of our thematic analysis has been reworded and the word contrastive has been removed and the explanation simplified.

RESULTS:

Each of the six sub-headings is very short suggesting a descriptive ‘analysis’ backed up with minimal illustrative data.
We have expanded our results to include more detail about the individual themes identified and increased the illustrative data to back this up.

Page 7&8 It is not clear that the data presented illustrates that ‘case finding exacerbates the discordance between patient and professional agendas’ – the PN is trying to measure blood pressure, not asking the case-finding questions. This extract does illustrate how data gathering in the consultation may mean that patient cues are not picked up.
We have continued to include this quote to illustrate how the use of tick-boxes in consultations means that emotional cues are ignored and a missed opportunity for case-finding. We have added further explanation a to why this is relevant to our results.

There is a sub-heading about ‘professional beliefs’ – the data is from observation in consultations and field note; I am not convinced that you can extrapolate beliefs from such data.
The data includes unstructured interviews from health care professionals where they describe their views and beliefs regarding case-finding. Our methods have been re-worded to ensure that it is clear we interviewed professionals as well as patients and illustrative quotes have been given.

Page 10
‘interviewed patients articulated the belief…..’ No data is given to illustrate this statement.
A quote from an interviewed patient has been added to support this statement.

There was insufficient discussion of the last three ‘themes’. I would suggest that the authors re-look at their data and consider presenting three, more powerful themes, that tell a more coherent story, underpinned by a theoretical framework which seems lacking in the current analysis.
We have presented further data that supports these three themes. With this study we are not trying to make a conceptual framework for depression case-finding we’re showing how these themes create barriers to the ideal way case-finding should take place. To support this we have added a diagram illustrating an ideal process for depression case-finding and how the barriers we have identified influence this.

DISCUSSION
The authors claim that case-finding ‘appeared to augment the discordance between patients and professionals’. I do not feel that the authors have presented convincing evidence to support this claim.
We have added further data and analysis to support our claims in the results.

The authors describe professionals’ beliefs, but they have extrapolated this from observations; they present no data from interviews with professionals to support their claims.
We have made our methods clearer to illustrate that professionals were interviewed for beliefs and opinions about depression case-finding.

The authors suggest that their findings help explain the lack of benefit of case finding when

implemented outside of collaborative care models. More explanation of this point is needed.
Thank you for pointing out that this was not clear. We have added more explanation as to how the barriers identified in this study might be reduced if a collaborative care model existed for patients with co-morbid depression.

The suggestion that practices need more 'guidance' is a rather simplistic conclusion of a complex and interesting study.
We have expanded our recommendations on guidance and related this back to our results.

Please be consistent in the revised paper in use of terms case finding or screening.
We have updated our text to case-finding.

Reviewer: 2

The question about this paper is whether it represents a sufficient advance in knowledge. My feeling is that it doesn't - which is a shame because it is elegant and well conducted.
Thank you for this comment. We have updated our text to explain why this paper is the first to provide evidence that introducing a deceptively simple intervention in primary care consultations for depression has many barriers that prevent implementation.

If you felt there was sufficient originality there, then it's a minor revisions only.

Overall this is a well written manuscript. It reports an ethnographic study examining screening for depression in patients with long term conditions in primary care. It is the first study to my knowledge to match this method to this condition / context and appears to have been well conducted. However this topic has been explored by others (the authors cite Coventry 2011 but not Maxwell 2012 or Barley) and while this study confirms findings from those studies, there are few new findings. Having said that, it is the strongest evidence yet that the principle of interrupting the flow of clinical conversation to ask out-of-context questions about sensitive issues is as daft in practice as it looks when I write it down.
Our results explain why the introduction of depression case-finding has not worked as intended and we have updated our discussion to include how this can be improved for future policy interventions.

I have a few minor comments about the text
P8 line 10 on – these quotes and comments really aren't about depression / depression screening. The nurse over-rules emotional talk in order to check blood pressure.
As we mentioned above, this quote illustrates the missed opportunity for case-finding and discussion regarding emotional issues and coping in preference to obtaining other tick-box targets and our text now explains why this missed cue was important.

P4 Line 3 (Intro) do we really believe that 1/3 of all patients with CHD have depression – including all those stable, one episode 5 years ago and living a normal life? I know everyone quotes these kind of figures but it's hard to reconcile with real life experience (unless you take a very inclusive approach to depression). I note that only one of 65 screened patients received any treatment! It may be better to think in terms of relative proportion (say twice as common) which allows one to adjust for other factors.
Our introduction has been updated to include the greater risk of depression in this cohort of patients rather than incidence and prevalence.

P14 line 40 "Those who screen positive" is a rather inelegant phrase in this context.
We agreed and have changed the text to "Patients identified through case-finding".

VERSION 2 – REVIEW

REVIEWER	Carolyn Chew-Graham Research Institute, Primary Care & Health Sciences, Keele University UK
REVIEW RETURNED	05-Jul-2014

GENERAL COMMENTS	The authors have responded to most of the previous concerns and comments. I think the paper would benefit from a careful read to ensure that the narrative is completely clear, and that the data supports the narrative. There are some specific comments below: line 22 page 4 - my understanding is that it is the 'Quality and Outcomes Framework'. lines16-18 page 5 - need to explain why case- finding was withdrawn from QOF for the benefit of the non-GP reader; and was it 2012 or 2013? page 9 line 14 -'Difficulties arose in the consultation when the patient mentioned something that was perceived to be important but unrelated to the review.' This sentence is unclear and needs re-phrasing. page 14 lines 39-40 'Competing practice priorities and inconsistent lines of communication around the management of potential cases of depression' - this seems to be two separate issues and i find it confusing; the field notes (lines 50-2) do not help. page 16 line 16 'It appeared to augment discordance between professionals and patients.' is a strange phrase - was there discordance already?? page 20 lines 21-2 the authors finish with: 'If case-finding is to be recommended for other patient groups, practice teams need clearer guidance on the pathway for people with likely depression which can be accommodated within available systems and resources.' As case finding for depression is no longer in QOF, this is an odd place to end. I suggest that the authors revise the final paragraph.

REVIEWER	Christopher Burton University of Aberdeen
REVIEW RETURNED	11-Jul-2014

GENERAL COMMENTS	The authors have clearly worked to address earlier review concerns and I think the paper reads better as a result. I have a few residual concerns 1. While many instances of screening have been replaced by case-finding, others persist. Within quotes or field notes, that is fine but there are still instances in the text. Similarly "with positive result on case-finding" is longer that "screen-positive" but would be more accurate

	2.Last sentence of Abstract / conclusion could be clearer .. "needs to operate within " or "activate" pathways might be better 3. While the authors have included Leydon et al in the introduction I think it is important to add that they found that patients valued the questionnaires even though GPs didn't think they were necessary 4. The statement in Discussion paragraph 2 that the only evidence that case finding was difficult to implement is not true. Coventry (cited) and Maxwell 2012 (not) both addressed this.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name Carolyn Chew-Graham
Institution and Country Research Institute, Primary Care & Health Sciences, Keele University UK
Please state any competing interests or state 'None declared': None declared

The authors have responded to most of the previous concerns and comments.
I think the paper would benefit from a careful read to ensure that the narrative is completely clear, and that the data supports the narrative.

There are some specific comments below:
line 22 page 4 - my understanding is that it is the 'Quality and Outcomes Framework'.
We have added the 'and'.

lines16-18 page 5 - need to explain why case- finding was withdrawn from QOF for the benefit of the non-GP reader; and was it 2012 or 2013?
Changed to 2013 and added 'due to lack of evidence of patient benefit'.

page 9 line 14 -'Difficulties arose in the consultation when the patient mentioned something that was perceived to be important but unrelated to the review.' This sentence is unclear and needs re-phrasing.
We have rewritten this sentence.

page 14 lines 39-40
'Competing practice priorities and inconsistent lines of communication around the management of potential cases of depression' - this seems to be two separate issues and i find it confusing; the field notes (lines 50-2) do not help.
We have shortened this theme title to make it clearer.

page 16 line 16 'It appeared to augment discordance between professionals and patients.' is a strange phrase - was there discordance already??
We have changed augment to 'cause' to make this clearer.

page 20 lines 21-2 the authors finish with: 'If case-finding is to be recommended for other patient groups, practice teams need clearer guidance on the pathway for people with likely depression which can be accommodated within available systems and resources.'
As case finding for depression is no longer in QOF, this is an odd place to end. I suggest that the authors revise the final paragraph.
We have taken out the part that mentions case-finding as we think the rest of the sentence is still a relevant conclusion to finish on.

Reviewer: 2
Reviewer Name Christopher Burton
Institution and Country University of Aberdeen

Please state any competing interests or state ‘None declared’: None declared

The authors have clearly worked to address earlier review concerns and I think the paper reads better as a result.
Thank you!

I have a few residual concerns
1. While many instances of screening have been replaced by case-finding, others persist. Within quotes or field notes, that is fine but there are still instances in the text. Similarly "with positive result on case-finding" is longer that "screen-positive" but would be more accurate
We have changed all references to screening except where they appear in field notes or quotes.

2.Last sentence of Abstract / conclusion could be clearer .. "needs to operate within " or "activate" pathways might be better
Changed to ‘within’.

3. While the authors have included Leydon et al in the introduction I think it is important to add that they found that patients valued the questionnaires even though GPs didn't think they were necessary
Added to introduction.

4. The statement in Discussion paragraph 2 that the only evidence that case finding was difficult to implement is not true. Coventry (cited) and Maxwell 2012 (not) both addressed this.
We have added these two references and amended the sentence, but we feel this study highlights more problems from observing in practice so we have left this part in.