

## PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (<http://bmjopen.bmj.com/site/about/resources/checklist.pdf>) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

### ARTICLE DETAILS

<b>TITLE (PROVISIONAL)</b>	An evaluation of a shared decision-making intervention for dialysis choice at four Danish hospitals: a qualitative study of the patient perspective
<b>AUTHORS</b>	Finderup, Jeanette; Dam Jensen, Jens; Lomborg, Kirsten

### VERSION 1 – REVIEW

<b>REVIEWER</b>	David P S Dickinson Principal consultant Consumation Ltd UK Former director Ask about medicines week UK I carry out paid project work for pharmaceutical companies, and for professional bodies; consisting of communicating health and medicines messages more clearly; user testing and /or consumer research.
<b>REVIEW RETURNED</b>	05-Feb-2019

<b>GENERAL COMMENTS</b>	<p>This crucial topic deserves wider dissemination and the authors deserve praise for taking it on. There is a huge role for publishing a worked-through, practical application of the three-talk model of shared decision making, and what patients feel about it. The patients' feelings, perhaps because of the detailed methodology, seem to come second to the success of the intervention, the PDA, the OPDG, etc. This may come from a concern for reproducibility (or indeed the perception may reflect my own bias). Defining the aims and success measures more specifically (and perhaps more narrowly) will help the reader to establish the focus of the paper. Is it about justifying or validating the intervention, or is it about the benefits to patients of SDM?</p> <p>Unfortunately, I found the proof difficult to follow in parts.</p> <p>The sequence, scale and structure of the study, the pilot and the larger intervention, of which this is a part, was not clear to me. There are figures in Table 1 (eg the intervention sample, n=349) which are not referred to anywhere in the main text. The same is true of terms such as "Kidney School". In the Methods section, data about the intervention as a whole is expressed alongside data about the study and it is difficult to disentangle. Further clarity on demarcation may be needed.</p> <p>The findings are not fully expressed. "My own choice " is not a finding as it stands; the finding is that "all 29 interviewed were of the opinion that this then treatment decision was my own choice".</p>
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	<p>Similarly, the decision process being "circular and iterative" as a finding is not easy to grasp: "circular" is often used as a negative. Both need setting in context - preferably the context of patient benefit.</p> <p>The aim seems to be (for patients) somewhat complex in phrasing: The aim of this study was to evaluate how the SDM-DC intervention influenced patients' experiences of involvement in their choice of dialysis modality. I am not sure that the paper succeeds in that aim. Was it pre-destined to be "their choice of modality?" Or is this ownership of choice a new finding, as reported? Does "how" mean "to what extent", "in what way", or "by what means"?</p> <p>The aim (for the intervention) is to investigate how and why the intervention works. This presupposes that the intervention works. Whereas the implication of the patient aim is to establish whether in fact it works, and if so, by what means – with the benefit of patients' verdicts. Note there are also some contrary suggestions of problems with the intervention - see below.</p> <p>The current form of words may give readers an uneasy feeling that the careful methodology is more important than patients' feelings about the intervention and their decisions. This would not do justice to the excellent research and painstaking evidence-gathering. But exact quotes from service users only feature in a Table at the moment. In fact, the current study does seem to establish that patents reported feeling involved, and it found ways in which that success was reported by patients as a benefit.</p> <p>Some potentially important findings for delivering a better health care service appear to be under-represented or under-discussed (such as importance of a family member, previous experience of zero involvement, dialysis coming as a shock). There seem to be questions raised by the paper that are not fully answered. To what extent do the people interviewed feel that they benefited from the intervention? Some regretted their decision, it seems; the contributions of video and other patients' experiences were sometimes negative. "Some" used the interview process itself to elicit further information - does this suggest a shortfall in the intervention? These findings too may deserve more discussion - and perhaps based on the interview content, rather than shortfalls in method or practice.</p> <p>I am not in a position to judge all the references or statistical questions, but the extent to which the 29 interviewees are seen to represent the intervention sample of 349 ought to be explicitly mentioned. Their eventual choices of treatment modes seems roughly comparable with the intervention group as a whole. Is this worth discussing?</p> <p>The paper handles important topics, and has amassed a lot of data. However, if SDM is to "go mainstream", and its use be more widely reported, the practical benefits and the voices of the patients need to be heard more clearly. Can they choose the "wrong" treatment? What does it mean for such an intervention to "work"? These are difficult questions, and the authors are breaking new ground by tackling them.</p>
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<b>REVIEWER</b>	Glyn Elwyn Dartmouth, USA
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<b>REVIEW RETURNED</b>	18-Apr-2019
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<b>GENERAL COMMENTS</b>	<p>Manuscript ID brmjopen-2019-029090, entitled "A qualitative evaluation of a shared decision-making intervention for dialysis choice."</p> <p>The article has three aims</p> <ol style="list-style-type: none"> <li>1 Patient experience of involvement in choice of dialysis</li> <li>2. How the intervention worked</li> <li>3 Why the intervention worked</li> </ol> <p>But I do not think the work fully accomplishes all these aims.</p> <p>The writing could be improved significantly - and the team would benefit by having a native English writer edit and polish the work to a higher level.</p> <p>Methods has Results. For example, the number of patients interviewed appears in methods. Move to results.</p> <p>Abbreviations appear without explanation - SDM Q9 and DQM.</p> <p>Ideas re analysis appear in in data collection. Move to analysis section. I did not follow the idea of creating a word cloud as part of this analysis. The qualitative analysis section is difficult to follow. Text condensation is not a method that I know. It appears to be more like thematic analysis.</p> <p>The themes are not well titled in my view. For example - "My own decision' seems to suggest full autonomy in making decisions. But the text that follows undermines this and says that relatives and professionals were involved. Perhaps a better title to the theme might be found - e.g. 'Perception of deeper engagement in a decision making process.'</p> <p>My greatest concern was the results did not address the 3 aims well - and are mainly descriptive of themes found in the interviews. The data seems to cover aim 1 more or less and less on aim 2 and 3. I am not sure they asked data on aim 3 - but I could be wrong.</p> <p>The discussion is far too long and seems to have new data that belongs in results.</p> <p>Overall assessment This is good work and rare to find interviews over this time span and on this important topic. I think the paper should be revised to address the aims more directly, to be clearer about the qualitative analysis methods and to pay attention to methods being methods only, results to be more focused on aims, and discussion to be clear of new results. I suggest revision and additional review.</p>
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<b>REVIEWER</b>	Teresa Gavaruzzi University of Padova, Italy
<b>REVIEW RETURNED</b>	18-Apr-2019

<b>GENERAL COMMENTS</b>	This paper describes the experiences reported by 29 patients using
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	<p>a shared decision making intervention about dialysis choice.</p> <p>The paper has potential but it would benefit from some revisions and clarifications.</p> <p>Both in the abstract and in the main text, it is stated that this study aims to investigate how and why the intervention works, but, from what you have stated, the intervention is still under evaluation; therefore you do not know yet whether it “works” (besides needing to specify what “working” means).</p> <p>Please better clarify what options were offered. Sometimes it seems as if the main choice offered was between HD and PD, both from the text and from the quotes from patients, but in table 1 it is specified that the options offered were 4. How were the options presented to participants? Were they offered the choice between HD and PD and then between self vs. assisted options? From a decision science point of view, it is important to specify how the options were presented, as we know that people can be biased by the way options are presented e.g. grouped vs. not. In other dialysis decision aids (e.g. Winterbottom et al. 2016), particular attention has been devoted to presenting information about options not to bias patients’ decision making. It would be helpful if you could provide the overview of the options as supplementary material.</p> <p>Also, could you elaborate on the reasons behind the choice of the two videos, both depicting home dialysis. E.g., was it meant to familiarize patients with less conventional types of dialysis, to promote home-based options, etc. Since there is evidence that patient stories can bias decision making, (Winterbottom et al. 2011), as you also mention in the discussion, I am concerned by the choice of showing only two types of dialysis and not all four. One of the participants was also aware of the influence of videos, as he reported that it changed his decision (p. 10 line 8).</p> <p>Even if the intervention has been previously described, the reader would benefit from a brief but clear description of the intervention (maybe depicted in a schematic representation?). For instance, more details about the three meetings would be helpful. E.g. do each meeting reflect one of the communication skill of the three talk model? E.g. were they all offered to all patients? or if a patient decided at the first/second meeting she would skip the following two/one? Also, a brief description of the three communication skills of the three-talk model would be helpful to readers who are not familiar with that model.</p> <p>Could you clarify why you provided all the tools at the first meeting? Wouldn’t it risk encouraging patients to use the tools independently and discourage them from attending further meetings?</p> <p>When describing the PDA, it is stated that it has been assessed using IPDAS criteria but only some of the criteria met are mentioned. You may want to specify them all, maybe in an appendix or supplementary material.</p> <p>It is stated that the intervention is tailored to individual patients but it is unclear on which basis it is tailored. Was the intervention tailored to patient’s preferred role in shared decision making? It is mentioned that the intervention is tailored to individual patients but it is not clear whether her role preference was taken into account by the renal consultant delivering the intervention.</p>
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	<p>Data collection. Were the 26 patients who did not accept to participate similar to patients who participated? If you have this information, please provide it in a format similar to Table 1.</p> <p>It would be helpful if you could provide the interview guide as a supplementary material and provide more details on how it was modified depending on the answers to the two questionnaires (SDM-Q9 and DQM).</p> <p>Findings and Table 1. Intervention or total sample. You mention that this study is part of a broader research encompassing also the evaluation of the intervention, but it rather odd to see “the intervention sample” in this table. Has the intervention been evaluated already? There is no mention of this in the paper. Please clarify.</p> <p>Findings. Were the findings related to the number of meetings that patients attended and/or to when they made the decision? For example I wonder whether patients finding the OPDG useful in the decision process were mainly those who had not made a decision yet and/or those who attended the third meeting?</p> <p>p.10 line 35 and figure 1. Why was patient [11] included if he did not make a decision at all, having only one option?</p> <p>Discussion. Your findings map very nicely in the 5 phases of dialysis decision making as described by the Canadian study. I wonder how you are planning to use this information. For example, I wonder whether you are planning to adapt/modify your intervention based on your findings.</p> <p>Minor: abstract line 15 in the sentence “the intervention is supposed to be tailored to individual patients” it is unclear why it is “supposed” maybe designed?</p> <p>abstract line 26 please specify the timeframe of these experiences (e.g. after the intervention, after the decision was made)</p> <p>p. 4 line 27 When describing the PDA, it is stated that it has been published at the ohri inventory but in the webpage linked it is written that it is available upon request from the first author.</p> <p>p. 6 line 49 word cloud of most used words of 6 or more characters. Is this limit appropriate not to exclude important words (e.g. for English it would not be appropriate)?</p> <p>p. 7 line 36 Eight patients participated in the interview with their spouse. Were their words also transcribed and analysed?</p> <p>p. 10 “other patient contributed sometimes with somewhat to the decision process” sound odd. You may want to change the word somewhat with something, or check with a native speaker.</p> <p>Table 1. If possible, it would be helpful to have a note stating the percentages of patients choosing the four dialysis types from renal registries or alike.</p> <p>You may want to consider revising the name of the theme “my own choice/decision” to active role in the decision, as it could be clearer.</p>
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	<p>You may want to refer to the OPDG section as values clarification tool, a broader term .</p> <p>References  Winterbottom, A. E., Bekker, H. L., Conner, M., &amp; Mooney, A. F. (2011). Patient stories about their dialysis experience biases others' choices regardless of doctor's advice: an experimental study. <i>Nephrology Dialysis Transplantation</i>, 27(1), 325-331.</p> <p>Winterbottom, A. E., Gavaruzzi, T., Mooney, A., Wilkie, M., Davies, S. J., Crane, D., ... &amp; Bekker, H. L. (2016). Patient acceptability of the Yorkshire Dialysis Decision Aid (YoDDA) booklet: a prospective non-randomized comparison study across 6 predialysis services. <i>Peritoneal Dialysis International</i>, 36(4), 374-381.</p>
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### VERSION 1 – AUTHOR RESPONSE

#### Reviewer 1 comments to author: David P S Dickinson

*This crucial topic deserves wider dissemination and the authors deserve praise for taking it on. There is a huge role for publishing a worked-through, practical application of the three-talk model of shared decision making, and what patients feel about it. The patients' feelings, perhaps because of the detailed methodology, seem to come second to the success of the intervention, the PDA, the OPDG, etc. This may come from a concern for reproducibility (or indeed the perception may reflect my own bias). Defining the aims and success measures more specifically (and perhaps more narrowly) will help the reader to establish the focus of the paper. Is it about justifying or validating the intervention, or is it about the benefits to patients of SDM?*

The aim has been reworded.

*Unfortunately, I found the proof difficult to follow in parts.*

*<b>The sequence, scale and structure</b> of the study, the pilot and the larger intervention, of which this is a part, was not clear to me. There are figures in Table 1 (eg the intervention sample, n=349) which are not referred to anywhere in the main text. The same is true of terms such as "Kidney School". In the Methods section, data about the intervention as a whole is expressed alongside data about the study and it is difficult to disentangle. Further clarity on demarcation may be needed.*

More information has been added about Table 1. Kidney school has been removed from the table. The pilot study is published elsewhere and is only mentioned in the background and in the discussion.

*<b>The findings are not fully expressed</b>. "My own choice" is not a finding as it stands; the finding is that "all 29 interviewed were of the opinion that this treatment decision was my own choice". Similarly, the decision process being "circular and iterative" as a finding is not easy to grasp: "circular" is often used as a negative. Both need setting in context - preferably the context of patient benefit.*

The two findings have been reworded and put into context, and the word 'circular' has been removed.

*<b>The aim</b> seems to be (for patients) somewhat complex in phrasing: *<i>The aim of this study was to evaluate how the SDM-DC intervention influenced patients' experiences of involvement in their choice of dialysis modality</i>. I am not sure that the paper succeeds in that aim. Was it pre-destined to be "<i>their choice of modality</i>?" Or is this ownership of choice a new finding, as reported? Does "<i>how</i>" mean "to what extent", "in what way", or "by what means"?**

In several studies, patients report that the choice is made by the healthcare professionals. Our aim was to involve the patient using an intervention based on shared decision-making with an intention to

make shared decisions. The main finding (that the patients experienced the decision as being their own choice) was a surprise.

*<b>The aim </b>(for the intervention) is <i>to investigate how and why the intervention works</i>. This presupposes that the intervention works. Whereas the implication of the patient aim is to establish <b>whether</b> in fact it works, and <b>if so, by what means</b> – with the benefit of patients’ verdicts. Note there are also some contrary suggestions of problems with the intervention - see below.*

The aim was not to investigate whether the intervention works, but to evaluate the Shared Decision-making and Dialysis Choice (SDM-DC) intervention with regard to patients’ experience and involvement. The aim has been reworded.

*The current form of words may give readers an uneasy feeling that the careful methodology is more important than patients’ feelings about the intervention and their decisions. This would not do justice to the excellent research and painstaking evidence-gathering. But exact quotes from service users only feature in a Table at the moment. In fact, the current study does seem to establish that patients reported feeling involved, and it found ways in which that success was reported by patients as a benefit.*

The methodology section has been shortened. A table was chosen as the method to present quotes to allow as many as possible to be included.

*Some potentially important findings for delivering a better health care service appear to be under-represented or under-discussed (such as importance of a family member, previous experience of zero involvement, dialysis coming as a shock). There seem to be questions raised by the paper that are not fully answered. To what extent do the people interviewed feel that they benefited from the intervention? Some regretted their decision, it seems; the contributions of video and other patients’ experiences were sometimes negative. “Some” used the interview process itself to elicit further information - does this suggest a shortfall in the intervention? These findings too may deserve more discussion - and perhaps based on the interview content, rather than shortfalls in method or practice.*

We chose the focus of the discussion in accordance with the aim of the study. The author guidelines do not ask for ‘implications for practice’. The above-mentioned findings would have been part of ‘implications for practice’.

*I am not in a position to judge all the references or statistical questions, but the extent to which the 29 interviewees are seen to represent the intervention sample of 349 ought to be explicitly mentioned. Their eventual choices of treatment modes seem roughly comparable with the intervention group as a whole. Is this worth discussing?*

More information has been added about the extent to which the 29 interviewees are representative.

*The paper handles important topics, and has amassed a lot of data. However, if SDM is to “go mainstream”, and its use be more widely reported, the practical benefits and the voices of the patients need to be heard more clearly. Can they choose the “wrong” treatment? What does it mean for such an intervention to “work”? These are difficult questions, and the authors are breaking new ground by tackling them.*

Thank you.

## **Reviewer 2 comments to author: Glyn Elwyn**

*The article has three aims*

- 1 Patient experience of involvement in choice of dialysis*
- 2. How the intervention worked*
- 3 Why the intervention worked*

*But I do not think the work fully accomplishes all these aims.*

*The writing could be improved significantly - and the team would benefit by having a native English writer edit and polish the work to a higher level.*

In accordance with all reviewers' comments, we have tried to make the writing clearer. The revised paper has been proofread by a native English writer.

*Methods has Results. For example, the number of patients interviewed appears in methods. Move to results.*

The information on numbers of patients has been moved to the results section.

*Abbreviations appear without explanation - SDM Q9 and DQM.*

Some abbreviations have been removed, and all abbreviations have been checked.

*Ideas re analysis appear in in data collection. Move to analysis section. I did not follow the idea of creating a word cloud as part of this analysis. The qualitative analysis section is difficult to follow. Text condensation is not a method that I know. It appears to be more like thematic analysis.*

The methodology section has been rewritten to make it clearer. Systematic text condensation includes elements of thematic analysis. The method is defined as a systematic thematic cross-case analysis. The core elements are the systematic way the findings are achieved and that the analysis is carried out across cases.

*The themes are not well titled in my view. For example - "My own decision' seems to suggest full autonomy in making decisions. But the text that follows undermines this and says that relatives and professionals were involved. Perhaps a better title to the theme might be found - e.g. 'Perception of deeper engagement in a decision making process.'*

The finding 'my own decision' has been reworded. The patients used these words.

*My greatest concern was the results did not address the 3 aims well - and are mainly descriptive of themes found in the interviews. The data seems to cover aim 1 more or less and less on aim 2 and 3. I am not sure they asked data on aim 3 - but I could be wrong.*

The aim has been reworded, and we have tried to address it more directly.

*The discussion is far too long and seems to have new data that belongs in results.*

The discussion has been shortened.

#### *Overall assessment*

*This is good work and rare to find interviews over this time span and on this important topic. I think the paper should be revised to address the aims more directly, to be clearer about the qualitative analysis methods and to pay attention to methods being methods only, results to be more focused on aims, and discussion to be clear of new results. I suggest revision and additional review.*

#### **Reviewer 3 comments to author: Teresa Gavaruzzi**

*This paper describes the experiences reported by 29 patients using a shared decision making intervention about dialysis choice.*

*The paper has potential but it would benefit from some revisions and clarifications.*

*Both in the abstract and in the main text, it is stated that this study aims to investigate how and why the intervention works, but, from what you have stated, the intervention is still under evaluation; therefore you do not know yet whether it "works" (besides needing to specify what "working" means).*



The word 'works' has been removed from the aim, and the aim has been reworded.

*Please better clarify what options were offered. Sometimes it seems as if the main choice offered was between HD and PD, both from the text and from the quotes from patients, but in table 1 it is specified that the options offered were 4. How were the options presented to participants? Were they offered the choice between HD and PD and then between self vs. assisted options? From a decision science point of view, it is important to specify how the options were presented, as we know that people can be biased by the way options are presented e.g. grouped vs. not. In other dialysis decision aids (e.g. Winterbottom et al. 2016), particular attention has been devoted to presenting information about options not to bias patients' decision making. It would be helpful if you could provide the overview of the options as supplementary material.*

The patient decision aid in English has been added as supplementary material, but the English version has not been face validated by patients, and nor have we carried out a readability test in English. The way we present the options was inspired by the patient decision aid developed by Winterbottom et al.

*Also, could you elaborate on the reasons behind the choice of the two videos, both depicting home dialysis. E.g., was it meant to familiarize patients with less conventional types of dialysis, to promote home-based options, etc. Since there is evidence that patient stories can bias decision making, (Winterbottom et al. 2011), as you also mention in the discussion, I am concerned by the choice of showing only two types of dialysis and not all four. One of the participants was also aware of the influence of videos, as he reported that it changed his decision (p. 10 line 8).*

Some patients and professionals asked specifically for these two videos. If patients wish to see dialysis at the hospital, we can just take them next door to see it. Home haemodialysis and peritoneal dialysis are not so easy to show. We now have four videos, but the additional two videos were not ready in time for the interviews with the 29 patients.

*Even if the intervention has been previously described, the reader would benefit from a brief but clear description of the intervention (maybe depicted in a schematic representation?). For instance, more details about the three meetings would be helpful. E.g. do each meeting reflect one of the communication skills of the three talk model? E.g. were they all offered to all patients? or if a patient decided at the first/second meeting she would skip the following two/one? Also, a brief description of the three communication skills of the three-talk model would be helpful to readers who are not familiar with that model.*

*Could you clarify why you provided all the tools at the first meeting? Wouldn't it risk encouraging patients to use the tools independently and discourage them from attending further meetings? When describing the PDA, it is stated that it has been assessed using IPDAS criteria but only some of the criteria met are mentioned. You may want to specify them all, maybe in an appendix or supplementary material.*

A description of the intervention according to the TIDieR-PJP guidelines has been added to the supplementary material. The various tools were developed and used separately in the alpha- and beta-testing, but it was then found to be useful to bring them together in the patient decision aid. We think patient involvement also means allowing the patient to choose his or her own way of working with the patient decision aid. More detailed information about the IPDAS criteria is published in the developing paper (Finderup et al 2018) and can be found on the OHRI web page.

*It is stated that the intervention is tailored to individual patients but it is unclear on which basis it is tailored. Was the intervention tailored to patient's preferred role in shared decision making? It is mentioned that the intervention is tailored to individual patients but it is not clear whether her role preference was taken into account by the renal consultant delivering the intervention.*

The intervention is delivered by the dialysis coordinator and not the renal consultant. More detail about tailoring has been included in the description of the intervention which has been added to the supplementary material.

*Data collection. Were the 26 patients who did not accept to participate similar to patients who participated? If you have this information, please provide it in a format similar to Table 1.*

We do not have specific information about the patients who did not agree to participate, but we do have information about the whole intervention sample.

*It would be helpful if you could provide the interview guide as a supplementary material and provide more details on how it was modified depending on the answers to the two questionnaires (SDM-Q9 and DQM).*

The interview guide has not been translated into English. More information about the use of SDM-Q9 and DQM has been added.

*Findings and Table 1. Intervention or total sample. You mention that this study is part of a broader research encompassing also the evaluation of the intervention, but it rather odd to see “the intervention sample” in this table. Has the intervention been evaluated already? There is no mention of this in the paper. Please clarify.*

This paper is the qualitative evaluation of the intervention. A quantitative evaluation was conducted later and has been submitted to another journal.

*Findings. Were the findings related to the number of meetings that patients attended and/or to when they made the decision? For example I wonder whether patients finding the OPDG useful in the decision process were mainly those who had not made a decision yet and/or those who attended the third meeting?*

The tailoring of the intervention means that we could address the purpose of the third meeting at the second meeting. Only having one meeting or two meetings does not mean that the patient did not work with the OPDG. All the findings were validated if they were related not only to some specific patient characteristic, like having only one meeting, age, gender etc., but also specific characteristics of the interview situation. We have only mentioned a relationship between these characteristics if we found this.

*p.10 line 35 and figure 1. Why was patient [11] included if he did not make a decision at all, having only one option?*

A study by Robinski et al about dialysis choice suggests a shared decision-making intervention should also be provided for patients with chronic kidney disease who only have one choice available.

*Discussion. Your findings map very nicely in the 5 phases of dialysis decision making as described by the Canadian study. I wonder how you are planning to use this information. For example, I wonder whether you are planning to adapt/modify your intervention based on your findings.*

Yes, we plan to implement these findings in a new version of the patient decision aid, which will be ready for use this autumn. This will also be based on the new version of the three-talk model.

*Minor:*

*abstract line 15 in the sentence “the intervention is supposed to be tailored to individual patients” it is unclear why it is “supposed” maybe designed?*

The sentence has been reworded.

*abstract line 26 please specify the timeframe of these experiences (e.g. after the intervention, after the decision was made)*

The sentence has been reworded.

*p. 4 line 27 When describing the PDA, it is stated that it has been published at the ohri inventory but in the webpage linked it is written that it is available upon request from the first author.*

The sentence has been reworded.

*p. 6 line 49 word cloud of most used words of 6 or more characters. Is this limit appropriate not to exclude important words (e.g. for English it would not be appropriate)?*

No clear description has been found of what is appropriate, and perhaps this will differ between languages and projects.

*p. 7 line 36 Eight patients participated in the interview with their spouse. Were their words also transcribed and analysed?*

No.

*p. 10 “other patient contributed sometimes with somewhat to the decision process” sound odd. You may want to change the word somewhat with something, or check with a native speaker.*

The sentence has been reworded.

*Table 1. If possible, it would be helpful to have a note stating the percentages of patients choosing the four dialysis types from renal registries or alike.*

We do not have information about their decision, but only about the prevalence of patients on different dialysis modalities, and that is not comparable.

*You may want to consider revising the name of the theme “my own choice/decision” to active role in the decision, as it could be clearer.*

The finding has been reworded.

*You may want to refer to the OPDG section as values clarification tool, a broader term.*  
The term 'value clarification tool' has been used.

## VERSION 2 – REVIEW

<b>REVIEWER</b>	D P S Dickinson Consumation Ltd UK No direct conflict in relation to this study I am a paid consultant to pharma companies for medicines information editing and testing
<b>REVIEW RETURNED</b>	22-Jul-2019

<b>GENERAL COMMENTS</b>	<p>Congratulations to the authors on the revisions to this paper since I saw it last. It seems to me that the focus and clarity have been changed on the right directions and that it is much easier for the reader to understand the context and significance of the study, and of the intervention it describes and evaluates.</p> <p>I have a few small points to make where further clarification might be helpful.</p> <p>On page 7, under data analysis, the paper describes text condensation. One sentence reads: “During interviews, the first author performed some primary analysis and noted preliminary themes ... These themes were targeted in subsequent interviews with patients.” This might imply that there were later interviews with the same patients which explored the themes.</p> <p>However, if I understand correctly, each patient was only interviewed</p>
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	<p>once for this study. If that is correct, it might be helpful to say that the preliminary analysis was done “after the first five patient interviews (or whatever the correct number is) the first author performed some primary analysis ...”</p> <p>Design of Table 2. I very much welcome the inclusion of further quotes from patients. I found the design and phrasing of Table 2 slightly confusing. The “category headings” are clearly at a higher level than the “codes”, as they provide the main structure for the findings and discussion. However, they occupy a narrower column in the table, which makes them look less important than the “codes” (which might be thought of as sub-categories). I realise that this is partly to ensure the table is of a manageable length. Perhaps they should not be presented side-by-side, but more like sequential text, with a heading structure that reflects the hierarchy of categories and sub-categories.</p> <p>It may also be worth finding other words for “references” and “sources”, as these have a particular meaning in a research paper which is distracting. “Major quotes” and “mentions” might do the job?</p> <p>Under Findings, in The decision aid contributed to the decision process and elsewhere, the words some, several and most are used. Might it be possible to include numbers for some of these findings? The findings would be still more persuasive if so.</p> <p>In the Discussion, in the first section, there is an interesting observation, that SDM-DC was not perceived as shared decision making, but as people’s own decision making - perhaps almost too successful? But I did not quite follow the next sentence: “Due to the age of the patient group, this finding was surprising when compared with a study of the over-65 age group.” What is surprising? Over half the current study were over 60, and on the face of it, both groups felt involved in decisions, and were more satisfied as a result. I think I may have missed something here!</p> <p>Also in the Discussion, there is a reference to this study “adding more decision needs for this patient population.” This is part of a sentence which is over 3 lines long. I suggest that this point is too important to be included as an afterthought. It deserves a sentence of its own, or indeed a paragraph.</p> <p>Overall, a much crisper presentation of what seems a very useful intervention.</p>
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<b>REVIEWER</b>	Teresa Gavaruzzi University of Padova, Italy
<b>REVIEW RETURNED</b>	12-Jul-2019

<b>GENERAL COMMENTS</b>	<p>The revised version of the manuscript has greatly improved from the previous version.</p> <p>I have few very minor comments:</p> <p>In table 1 it is stated that the interview sample included 0 patients aged above 80 but in the text it is stated that the only patient who did not experience the decision as his own was above 80 (p 10 line 56) and reference to patients above 80 is also on p. 14 line 46.</p> <p>In reply to a previous comment, it was specified that the way in</p>
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	<p>which the options were presented was inspired by the patient decision aid developed by Winterbottom et al. (2016). I would specify it in the text (probably on p. 3 line 37).</p> <p>Even if it has not yet been accepted, I would add the reference to the quantitative evaluation of the intervention (maybe as a working paper, or a conference presentation if you presented it somewhere)</p>
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## VERSION 2 – AUTHOR RESPONSE

### Reviewer 3 comments to author: Teresa Gavaruzzi

*The revised version of the manuscript has greatly improved from the previous version.*

Thank you.

*I have few very minor comments:*

*In table 1 it is stated that the interview sample included 0 patients aged above 80 but in the text it is stated that the only patient who did not experience the decision as his own was above 80 (p 10 line 56) and reference to patients above 80 is also on p. 14 line 46.*

Thank you for identifying this. Typing the numbers into the tables zero patients have been put at patient aged above 80 instead of patient aged below 50. Five patients aged above 80 were interviewed.

*In reply to a previous comment, it was specified that the way in which the options were presented was inspired by the patient decision aid developed by Winterbottom et al. (2016). I would specify it in the text (probably on p. 3 line 37).*

The three decision aids, which have inspired our decision aid, have now been added as references.

*Even if it has not yet been accepted, I would add the reference to the quantitative evaluation of the intervention (maybe as a working paper, or a conference presentation if you presented it somewhere)*

The quantitative evaluation is in review for BMC nephrology. This has been added as reference.

### Reviewer 1 comments to author: David P S Dickinson

*Congratulations to the authors on the revisions to this paper since I saw it last. It seems to me that the focus and clarity have been changed on the right directions and that it is much easier for the reader to understand the context and significance of the study, and of the intervention it describes and evaluates.*

Thank you

*I have a few small points to make where further clarification might be helpful.*

*On page 7, under data analysis, the paper describes text condensation. One sentence reads: "During interviews, the first author performed some primary analysis and noted preliminary themes ... These themes were targeted in subsequent interviews with patients." This might imply that there were later interviews with the same patients which explored the themes.*

*However, if I understand correctly, each patient was only interviewed once for this study. If that is correct, it might be helpful to say that the preliminary analysis was done "after the first five patient interviews (or whatever the correct number is) the first author performed some primary analysis ..."*

For this study patients were only interviewed once. The sentence has been rewritten to make it clearer.

*Design of Table 2. I very much welcome the inclusion of further quotes from patients. I found the design and phrasing of Table 2 slightly confusing. The “category headings” are clearly at a higher level than the “codes”, as they provide the main structure for the findings and discussion. However, they occupy a narrower column in the table, which makes them look less important than the “codes” (which might be thought of as sub-categories). I realise that this is partly to ensure the table is of a manageable length. Perhaps they should not be presented side-by-side, but more like sequential text, with a heading structure that reflects the hierarchy of categories and sub-categories.*

Design of table 2 has been changed according to your recommendations.

*It may also be worth finding other words for “references” and “sources”, as these have a particular meaning in a research paper which is distracting. “Major quotes” and “mentions” might do the job?*

The words 'references' and 'sources' are used in NVivo. Sources indicated numbers of participants where the coding has been identified. References indicated numbers of quotations including this code. 'References' and 'sources' have been changed to 'participants' and 'quotations'.

*Under Findings, in The decision aid contributed to the decision process and elsewhere, the words some, several and most are used. Might it be possible to include numbers for some of these findings? The findings would be still more persuasive if so.*

In according to Sandelowski (2001) and presentations of qualitative data, the exact numbers have not been used, instead expression such as few, some or many have been used just to indicate the recognised patterns. [M. Sandelowski, Focus on Research Methods, Real Qualitative Researchers Do Not Count: The Use of Numbers in Qualitative Research, research in Nursing & Health 24 (2001) 230-240.]

*In the Discussion, in the first section, there is an interesting observation, that SDM-DC was not perceived as shared decision making, but as people’s own decision making - perhaps almost too successful? But I did not quite follow the next sentence: “Due to the age of the patient group, this finding was surprising when compared with a study of the over-65 age group.” What is surprising? Over half the current study were over 60, and on the face of it, both groups felt involved in decisions, and were more satisfied as a result. I think I may have missed something here!*

The sentences have been rewritten to make it clearer.

*Also in the Discussion, there is a reference to this study “adding more decision needs for this patient population.” This is part of a sentence which is over 3 lines long. I suggest that this point is too important to be included as an afterthought. It deserves a sentence of its own, or indeed a paragraph.*

The two new decision needs added by this study has been put in to a sentence of its own.

*Overall, a much crisper presentation of what seems a very useful intervention.*

Thank you.