PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Integrating Patient Values and Preferences in Health Care: A Systematic Review of Qualitative Evidence
AUTHORS	Tringale, Michael; Stephen, Genla; Boylan, Anne-Marie; Heneghan, Carl

VERSION 1 – REVIEW

REVIEWER	Clary, Heidi M Munger Wake Forest School of Medicine
REVIEW RETURNED	15-Sep-2022

GENERAL COMMENTS	The authors present an impactful and rigorously completed systematic review of an important and neglected topic. This work has significant potential to benefit patient care delivery and bring increased attention to the value of qualitative research to impact clinical practice. I do have a few suggestions to enhance the paper: The description of the thematic analysis could benefit from additional information, for example I would like to know how many coders were involved in the coding process and the expertise that the coder(s) have in thematic analysis. Are there limitations in the methodology regarding the number of coders who participated in analysis, particularly if only one coder was used? Consider adding to the limitations section if so. It would be interesting to consider whether the themes may vary somewhat depending upon specific noncommunicable disease group for which clinicians are caring. Should this be an area of future research, or is there any potential for considering whether some of the themes were more common in particular disease groups or care setting types? Consider modifying the text accordingly. I'd be interested in a little more justification for why the particular disease groups were chosen besides being common, and whether the authors think this information may be relevant to care of other chronic diseases vs. whether less common chronic diseases require separate study and potentially a separate, independent study. Consider whether to organize the results section with text and then a series of tables having the representative quotes broken down by themes.

REVIEWER	Manja, Veena University of California Davis
REVIEW RETURNED	16-Sep-2022

GENERAL COMMENTS	Please clarify discrepancies in Methods: Appraisal of quality – Page 9 and 10: The authors note that they considered the credibility, dependability, transferability, and confirmability of qualitative findings utilizing the JBI checklist. However, the JBI checklist does not have questions addressing the confirmability and transferability of findings. (reference 25 - Please reference appropriately – book references should note chapter/page where the referenced material mentioned). Questions 1-5 and 10 of the JBI checklist assess methodological congruence, 6 and 7 note the researchers background 8 refers to participant voices and 9 assesses ethical aspects. Please reconcile. Does this discrepancy influence the overall confidence in included records? Extraction, Synthesis and Analysis – was this a purely an inductive process? The description is somewhat unclear. How were codes and nodes different? Results: Characteristics of included studies – include references for each included characteristic. Taxonomy of themes – there is much overlap between the themes. Many of the sub themes under communication can be ascribed to concern, similarly many sub-themes under concern can fit under communication. Competence sub-themes mainly related to including communication and concerns in the decision making. All the sub themes under competence can fit under concern or communication. Similarly there is a lack of congruence in the overlay of the primary themes noted in this study on the EBM triad. The overall value of this study comes from integrating published literature on incorporating patient value and preferences in patient care. The data do not completely support the categorization of themes and the framework developed by the authors.

VERSION 1 – AUTHOR RESPONSE

Response to Reviewer 1 (Dr. Heidi M. Munger)

Editor's Comments	Authors' Reply	Update to Manuscript (shown in red below, and marked in the manuscript)

The description of the thematic analysis could benefit from additional information, for example I would like to know how many coders were involved in the coding process and the expertise that the coder(s) have in thematic analysis.	Updated with additional information.	Updated text in the Methods: Extraction, synthesis and analysis section as follows – "One author with experience in qualitative methods and coding conducted line-by-line coding using NVivo computer software allowing for simultaneous coding and an initial synthesis of the information. Using an inductive approach, extraction began with reading and re-reading records to become familiar with the content followed by handcoding of all records. This enabled the development of a preliminary coding scheme for organizing and managing data in NVivo, wherein the author continued to inductively and iteratively code the data. Codes were collated, analyzed, grouped, and categorized into a number of increasingly narrow sets of codes based on statements and ideas across data. Themes, developed from the codes, were further synthesized based on patterns and similarities in their meaning to arrive at a final set of primary themes that could be used as a basis for a meaningful summary and interpretation. Themes were only considered if there were two or more codes underlying the theme."
Are there limitations in the methodology regarding the number of coders who participated in analysis, particularly if only one coder was used? Consider adding to the limitations section if so.	Updated.	Added in the Discussion: Strengths and limitations section – "One author conducted the initial coding and further developed themes in discussion with other authors. All authors contributed to the review, analysis, and interpretation of findings."

It would be interesting to consider whether the themes may vary somewhat depending upon specific noncommunicable disease group for which clinicians are caring. Should this be an area of future research, or is there any potential for considering whether some of the themes were more common in particular disease groups or care setting types? Consider modifying the text accordingly.	Updated	Added in the Discussion: Future research section – "Future research could consider whether the themes described in this review vary, or are more common, among specific noncommunicable disease groups, HCP types, or care settings."
I'd be interested in a little more justification for why the particular disease groups were chosen besides being common…	These particular disease groups were chosen to narrow the study scope to include the most common chronic diseases among adults, conditions which require ongoing therapeutic relationships involving more frequent HCP-patient interaction.	Modified text in the Introduction section as follows – "These are often managed in primary and secondary care settings and require ongoing therapeutic relationships involving more frequent HCPpatient interaction which makes values integration even more important."
…and whether the authors think this information may be relevant to care of other chronic diseases vs. whether less common chronic diseases require separate study and potentially a separate, independent study.	Many of the approaches described from the data and the resulting themes may be applicable to clinical care for other chronic diseases, but separate independent studies are encouraged. The text has been updated accordingly.	Added text to the Discussion: Future research section – "Many of the approaches described from the data and resulting themes may be applicable to clinical care for other chronic diseases, but separate independent studies are encouraged."

Consider whether to organize the results section with text and then a series of tables having the representative quotes broken down by themes.	Thank you for this suggestion, we are willing to discuss this with the editor, but quotes and extracted verbatims alongside text/results is a customary method for systematic reviews of qualitative evidence and consistent with JBI methods.	No changes.

Response to Reviewer 2 (Dr. Veena Manja)

Editor's Comments	**Authors' Reply**	**Update to Manuscript (shown in red below, and marked in the manuscript)**
Please clarify discrepancies in Methods: Appraisal of quality – Page 9 and 10: The authors note that they considered the credibility, dependability, transferability, and confirmability of qualitative findings utilizing the JBI checklist. However, the JBI checklist does not have questions addressing the confirmability and transferability of findings. Questions 1-5 and 10 of the JBI checklist assess methodological congruence, 6 and 7 note the researchers background 8 refers to participant voices and 9 assesses ethical aspects. Please reconcile.	This study was originally reported as a 15,000 word dissertation for an MSc degree and several references were made in that report regarding the importance of establishing the credibility, dependability, transferability, and confirmability of data in qualitative reviews. This was incorrectly attributed to the JBI checklist in the original version of this manuscript, and the discrepancy has now been reconciled with updated text.	Updated text in Abstract: Data extraction and synthesis section – "The JBI Critical Appraisal Checklist for Qualitative Research was used to assess methodological quality and assess overall confidence and trustworthiness of included records." Also updated text in Abstract: Results section – "Confidence in the quality of included records was deemed high." Also updated text in Methods: Appraisal of quality section as follows – "The objectivity of qualitative research can be strengthened through the use of quality methods. This review utilized the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research, a validated tool to help determine the methodological quality of included records in systematic reviews (supplemental appendix C)."Also

		updated text in Results: Methodological quality of included records section – “Confidence in the quality of included records was deemed high.
Does this discrepancy influence the overall confidence in included records?	This does not influence the overall confidence in included records.	No changes
Reference 25 – Please reference appropriately – book references should note chapter/page where the referenced material mentioned.	Updated with complete citation.	Reference 25 updated as follows – “Lincoln YS, Guba EG. Naturalistic inquiry. Beverly Hills; London: Sage 1985:Chapter 11, p.293.”

Extraction, Synthesis and Analysis – was this a purely an inductive process? The description is somewhat unclear.	This was an inductive process. Text has been updated to reflect this and to provide a clearer description.	Updated text in the Methods: Extraction, synthesis and analysis section as follows – "Using an inductive approach, extraction began with reading and re-reading records to become familiar with the content followed by handcoding of all records. This enabled the development of a preliminary coding scheme for organizing and managing data in NVivo, wherein the author continued to inductively and iteratively code the data. Codes were collated, analyzed, grouped, and categorized into a number of increasingly narrow sets of codes based on statements and ideas across data. Themes, developed from the codes, were further synthesized based on patterns and similarities in their meaning to arrive at a final set of primary themes that could be used as a basis for a meaningful summary and interpretation. Themes were only considered if there were two or more codes underlying the theme."
How were codes and nodes different?	NVivo uniquely uses the terms "code(s)" and "node(s)" interchangeably. This manuscript has now been updated to only use the term "code(s)" for clarity.	"Node(s)" updated to "code(s)" throughout.
Results: Characteristics of included studies – include references for each included characteristic.	Updated.	Updated text in Results: Characteristics of included records section as follows – Reference(s) now provided for each characteristic described. (See marked edits in manuscript)

Taxonomy of themes – there is much overlap between the themes. Many of the sub themes under communication can be ascribed to concern, similarly many subthemes under concern can fit under communication. Competence sub-themes mainly related to including communication and concerns in the decision making. All the sub themes under competence can fit under concern or communication.	Thank you for your helpful perspective on the question of taxonomy of themes developed in this review. Authors acknowledge that some of these themes and subthemes may seem to overlap, owing to the complex and multidimensional nature of clinical care and the multiple skills and approaches required to provide patient-centered values integration to any one patient. Whereas much of the previous research on this topic indeed attributes many of these behaviors/approaches to "communication," the authors of this manuscript feel strongly that the valuable and unique contribution of this study is the perspective of these behaviors/approaches in the context of patient values integration. We feel confident in the overall taxonomy developed which attempts to disaggregate specific behaviors/approaches from simply "communication" and further orient them in more nuanced and useful groupings such as "concern," "competence," and "congruence," as well, allowing for a more useful examination. However, authors do agree that "Listening" is better located under the "Communication" theme, and the manuscript has been updated to reflect this.	"Listening" relocated under the "Communication" theme and text has been updated to reflect this. (See marked edits in manuscript).

Similarly there is a lack of congruence in the overlay of the primary themes noted in this study on the EBM triad.	Thank you for your feedback and insight on Figure 3 illustrating the "overlay" of primary themes with the EBM triad. Authors agree that this illustration could benefit from a redesign for clarity of meaning.	Figure 3 redesigned (see below on p. 7 of this document).
The overall value of this study comes from integrating published literature on incorporating patient value and preferences in patient care. The data do not completely support the categorization of themes and the framework developed by the authors.	Authors agree that the overall value of this study comes from integrating published literature on incorporating patient value and preferences in patient care. Authors respectfully disagree that data do not support the development of the themes presented, and feel confident that this review reflects the published literature on values integration and that the newly developed framework is strongly supported by the available data.	No other updates, other than already indicated above.

REVISED FIGURE 3:

Figure 3 – The EBM Triad and Primary Themes of Approaches to Values Integration