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)	Too complex and time-consuming to fit in! Physicians' experiences of elderly patients and their participation in medical decision making: a grounded theory study
AUTHORS	Anne W Ekdahl, Ingrid Hellström, Lars Andersson and Maria Friedrichsen

VERSION 1 - REVIEW

REVIEWER	I have no competing interests. Elizabeth Murray, Reader in Primary Care, University College London, UK.
REVIEW RETURNED	12/03/2012

THE STUDY	This is a well conducted qualitative study, exploring physician views of barriers to shared decision making for elderly patients admitted to acute hospital wards. The conduct of the study, including the analytical procedures, appears to be excellent. There are no statistical methods to be described and this is appropriate. A "not applicable" button would have been useful here. The quality of the written English is good, but not good enough for publication. This would be easily remediable by working with an editor.
RESULTS & CONCLUSIONS	The method for deriving the results from the data was exemplary - but despite this I have real problems with the results. The authors posit a core underlying category "lacking in time", which they suggest underlies both "being challenged" and "being a small part of the health care production machine". My experience from similar work is that shortage of time is usually presented as a socially acceptable reason for much more complex, and often less socially acceptable, reasons for physicians not living up to their stated ideals. I think I see similar findings emerging from these data too - for example, on page 10, under "having a feeling of incompetence", these doctors are clearly stating that they suffer from a lack of knowledge and skills. This is a training issue, not a lack of time. The data presented on page 11 seems to me to reflect a conflict between these doctors ways of measuring professional achievement ("good statistics") and core values of humanity and care, leading to the chilling remark about elderly patients being "totally worthless". Overall, from these and other examples in the results section, I think these data have been shoe-horned into addressing a question on participation in decision making, when they actually reveal a much deeper problem with elderly care in acute hospital wards. This includes some of the factors referred to in the paper, such as

	routines geared toward younger patients with acute illnesses, a widespread lack of consideration of elderly patients' needs, with a concomittant lack of training in how to meet these needs. There also seems to be a lack of will to address these problems in the system.
GENERAL COMMENTS	The introduction rather overstates the case for shared decision making. The references cited suggest that although almost all patients wish to be informed about the treatment options, many do not wish to actively participate in the decision-making process. The data also suggest that this preference changes over time and with different situations (i.e. is a state rather than a trait). Finally, the data to support the thesis that active participation leads to improved health outcomes is weak. Despite all this, I support the authors' contention that shared decision making is a goal to be pursued, and agree that exploring physician views about barriers to this, especially in the care of elderly patients, does need further research.

REVIEWER	Åke Rundgren Associat professor Dept of Geriatrics K-huset, plan 6 I can not see any conflicts of intersts concerning the present papaer
REVIEW RETURNED	16/03/2012

GENERAL COMMENTS	*To the editor and the authors* The objective of this study is to explore physicians' thoughts and considerations of participation in medical decision making by hospitalized elderly patients**.** The care for the elderly with multiple illnesses shows many malfunctions. The traditional disease-oriented approach, focusing on usually one diagnoses and treatment of this is not suited for many frail elderly and there is a need for a change to a more situation-based approach with a holistic perspective. Here the hospital physicians play a vital role and it is thus important to understand their feelings and motives when dealing with the elderly inpatients. This interesting and important paper gives us a perspective in this field. In this qualitative study physicians reveal their thoughts and opinions why it is so difficult in most cases to give an adequate medical care to elderly patients with multimorbidity. The methods used for the study seem to be relevant and adequate and the conclusions well founded. Twenty-nine physicians working in three hospitals from the same geographical area in Sweden were interviewed in smaller groups. The physician's age and years of experience had a reasonable mix. They represented four different specialties but the number from each specialty was not mentioned and how their views might differ according to their speciality. It was also not stated how many sessions and for how long each session lasted. Two categories were identified that described the physicians' thoughts on participation in medical decision making of elderly patients with multimorbidity. One category was "being challenged," i.e. meeting the challenge to take care of elderly patients with multimorbidity in all its complexity. Another category was "being a small part of the health care production machine," with its bureaucratic routines and remuneration systems that do not favor elderly patients with multimorbidity. Both categories were leading to the core category "lacking in time" and blaming the routines in the hospital care system which do not reward more complex elderly

	patients with multimorbidity. Among the interviewed physicians elderly patients with multimorbidity gave rise to frustration by giving the physicians a feeling of professional inadequacy, due to lack of competence, holistic views, appropriate routines, time, and proper remuneration systems for treating these patients. The lack of competence in geriatric and gerontological knowledge seems to be an important obstacle for the majority of physicians (except for the geriatricians). It had been interesting if this could be more elucidated in the discussion, because among other things geriatric medicine is such a small part of the curriculum in medical schools. Most of the physicians thoughts on elderly patients with multimorbidity are process related i.e. they are talking about lack of time, unfit premises, lack of beds etc. However, some of the physicians expressed more emotional feelings of frustration about not being able to give priority to these patients, while others expressed that elderly patients were not ill enough to be in hospital, taking beds and time from the “really ill” patients (bed blockers) and thus not according to their views welcome in a hospital. It would have been of interest to know a little more about the emotional side of the physicians and exploring if there were signs of ageism in the opinions covered by blaming lack of time for being uninterested. It seems to me that this subject should be expanded and that this paper is a very good start.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Elizabeth Murray, Reader in Primary Care, University College London, UK.
I have no competing interests.

This is a well conducted qualitative study, exploring physician views of barriers to shared decision making for elderly patients admitted to acute hospital wards. The conduct of the study, including the analytical procedures, appears to be excellent.

There are no statistical methods to be described and this is appropriate. A "not applicable" button would have been useful here.

Response: Agree

The quality of the written English is good, but not good enough for publication. This would be easily remediable by working with an editor.

Response: Please see acknowledgements

The method for deriving the results from the data was exemplary - but despite this I have real problems with the results. The authors posit a core underlying category "lacking in time", which they suggest underlies both "being challenged" and "being a small part of the health care production machine".

My experience from similar work is that shortage of time is usually presented as a socially acceptable reason for much more complex, and often less socially acceptable, reasons for physicians not living up to their stated ideals. I think I see similar findings emerging from these data too - for example, on page 10, under "having a feeling of incompetence", these doctors are clearly stating that they suffer

from a lack of knowledge and skills. This is a training issue, not a lack of time. The data presented on page 11 seems to me to reflect a conflict between these doctors' ways of measuring professional achievement ("good statistics") and core values of humanity and care, leading to the chilling remark about elderly patients being "totally worthless".

Response: I do absolutely see your point! The doctors talked about lacking in time– but that could have been interpreted on a more abstract level as you suggest. But "having a feeling of incompetence", including a lack of knowledge and skills also means that they do not prioritize to learn, i.e. they do not take the time needed to learn about it.

Overall, from these and other examples in the results section, I think these data have been shoe-horned into addressing a question on participation in decision making, when they actually reveal a much deeper problem with elderly care in acute hospital wards. This includes some of the factors referred to in the paper, such as routines geared toward younger patients with acute illnesses, a widespread lack of consideration of elderly patients' needs, with a concomittant lack of training in how to meet these needs. There also seems to be a lack of will to address these problems in the system.

Response: You have a very good point again. Our focus from the beginning and our questions during the interviews were participation in decision-making – but the doctors expressed so much more about problems taking care of elderly in acute wards trying to explain why they reasoned the way they did. We have also tried to be close to what they have said and not interpret too deeply. Being a geriatrician myself I from the beginning wanted to address to non-geriatricians, and I am just very happy that you have paid attention to the area. I think I am raising the problems pointed out by you in both the discussion, the overall theory, conclusion and the title of the manuscript and I am going to write more about this subject in my thesis (due to be defended in October)

The introduction rather overstates the case for shared decision making. The references cited suggest that although almost all patients wish to be informed about the treatment options, many do not wish to actively participate in the decision-making process. The data also suggest that this preference changes over time and with different situations (i.e. is a state rather than a trait). Finally, the data to support the thesis that active participation leads to improved health outcomes is weak. Despite all this, I support the authors' contention that shared decision making is a goal to be pursued, and agree that exploring physician views about barriers to this, especially in the care of elderly patients, does need further research.

Response: You are right – there is a lot written about participation in medical decision making and perhaps the chosen references were not enlightening the subject good enough. I do agree that many patients do not want to participate but in an overview from 2010 (Tariman JD, Berry DL, Cochrane B, Doorenbos A, Schepp K. Preferred and actual participation roles during health care decision making in persons with cancer: a systematic review. Annals of Oncology 2010;21(6):1145-1151) it does look like it is a bigger problem with too little rather than to much participation which we also showed in our previous article (Ekdahl A, Andersson L, Wirehn A-B, Friedrichsen M. Are elderly people with co-morbidities involved adequately in medical decision making when hospitalised? A cross-sectional survey. BMC Geriatrics 2011;11(1):46. I have made minor changes in the introduction (underlined and bold) and have added the new reference (Tariman).

Thank you very much for your thought-provoking comments.

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Sweden

I cannot see any conflicts of interests concerning the present paper

The objective of this study is to explore physicians' thoughts and considerations of participation in medical decision-making by hospitalized elderly patients. The care for the elderly with multiple illnesses shows many malfunctions. The traditional disease-oriented approach, focusing on usually one diagnoses and treatment of this is not suited for many frail elderly and there is a need for a change to a more situation-based approach with a holistic perspective. Here the hospital physicians play a vital role and it is thus important to understand their feelings and motives when dealing with the elderly inpatients.
This interesting and important paper gives us a perspective in this field. In this qualitative study physicians reveal their thoughts and opinions why it is so difficult in most cases to give an adequate medical care to elderly patients with multimorbidity.
The methods used for the study seem to be relevant and adequate and the conclusions well founded. Twenty-nine physicians working in three hospitals from the same geographical area in Sweden were interviewed in smaller groups. The physician's age and years of experience had a reasonable mix. They represented four different specialties but the number from each specialty was not mentioned and how their views might differ according to their speciality. It was also not stated how many sessions and for how long each session lasted.

Response: There happened to be exactly 6 doctors in each interview (we anticipated for between 5-8) and each session took almost exactly an hour – the geriatricians around 15 minutes more.
We did not describe differences apart from competence – but as a matter of fact also the geriatricians found that geriatric patients were a challenge with their many diseases. The difference between geriatricians and other specialities were more their acceptance (of course) of the challenge of the geriatric patients. There were generally no differences between the specialities in any other category or subcategory which we perhaps should have written out, but on the other hand this in not really part of the qualitative method.

I have added information you asked for in the method.

Two categories were identified that described the physicians' thoughts on participation in medical decision making of elderly patients with multimorbidity. One category was "being challenged," i.e. meeting the challenge to take care of elderly patients with multimorbidity in all its complexity. Another category was "being a small part of the health care production machine," with its bureaucratic routines and remuneration systems that do not favor elderly patients with multimorbidity. Both categories were leading to the core category "lacking in time" and blaming the routines in the hospital care system which do not reward more complex elderly patients with multimorbidity.
Among the interviewed physicians elderly patients with multimorbidity gave rise to frustration by giving the physicians a feeling of professional inadequacy, due to lack of competence, holistic views, appropriate routines, time, and proper remuneration systems for treating these patients.
The lack of competence in geriatric and gerontological knowledge seems to be an important obstacle for the majority of physicians (except for the geriatricians). It had been interesting if this could be more elucidated in the discussion, because among other things geriatric medicine is such a small part of the curriculum in medical schools.
Most of the physicians thoughts on elderly patients with multimorbidity are process related i. e. they are talking about lack of time, unfit premises, lack of beds etc. However, some of the physicians expressed more emotional feelings of frustration about not being able to give priority to these patients,

while others expressed that elderly patients were not ill enough to be in hospital, taking beds and time from the “really ill” patients (bed blockers) and thus not according to their views welcome in a hospital. It would have been of interest to know a little more about the emotional side of the physicians and exploring if there were signs of ageism in the opinions covered by blaming lack of time for being uninterested.
It seems to me that this subject should be expanded and that this paper is a very good start.

Response: We were discussing adding the concept of ageism in the discussion earlier and after your comments we have added this in the discussion. I also agree that It would have been very interesting to study the doctors' emotions more in detail and enlighten this in coming studies.
Thank you a lot for your comments and for taking your time and effort with this article!

Anne Ekdahl
Geriatrician, Norrköping
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VERSION 2 – REVIEW

REVIEWER	Åke Rundgren Associat professor Dept of Geriatrics K-huset, plan 6 Mölndals sjukhus I cannot see any conflicts of interests concerning the present paper
REVIEW RETURNED	26/04/2012

The reviewer completed the checklist but made no further comments.