PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Stakeholder experiences with general practice pharmacist services: a qualitative study
AUTHORS	Tan, Edwin; Stewart, Kay; Elliott, Rohan; George, Johnson

VERSION 1 - REVIEW

REVIEWER	Carmel Hughes Professor of Primary Care Pharmacy School of Pharmacy Queen's University Belfast I have no competing interests
REVIEW RETURNED	18-May-2013

THE STUDY	Statistical analysis not appropriate for this type of study.
REPORTING & ETHICS	No checklist used
GENERAL COMMENTS	BMJ Open review Abstract: The first mention of the Pharmacists in Practice study appears under 'Participants'. This probably needs to be stated earlier, perhaps under 'Design' to highlight that this study was part of a larger study. Under Method, the authors state that they analysed the data thematically, but then in the Results, they state that the findings were explained using theoretical frameworks. I would have thought that the latter would have been used as part of the analysis and that it would be more appropriate to report this under Method. Page 4. Under Strengths and Limitations, the authors state that the study involved a private general practice and community health clinic. I assume that this is viewed as a strength, but I am not sure why? In relation to recruitment, the authors explain that they have recruited a number of participants, but why is this seen as a particular strength? The number of patients recruited may be seen as more noteworthy. Background: No comment. Sets the scene well. However, it would be helpful to have a well-articulated aim for the study, lining the background to the Method. Method: For non-Australian readers, what is the difference between the two GP sites? Why was the quality assurance activity focused on osteoporosis? Why did the select different methods for data collection e.g. interviews with patients rather than focus groups? And why via

	telephone? Page 7, line 14. The authors state the focus groups took place at the end of the PIPS study. Why this timing? Did the staff include GPs? Why did they opt for focus groups? Page 7, line 25. I was also not clear what the narrative reports were. A little more detail in this needs to be provided. Page 7. Data analysis. As stated earlier, this section may need to include the theoretical frameworks that were mentioned in the Abstract. Was data saturation obtained? Results It would have been helpful to have had a summary table of the characteristics of participants, especially the practice staff. Very little information is provided about them. Was anyone approached who refused to take part? In the Results section in the abstract, it was stated that the findings were explained using theoretical frameworks. This does not come through at all in the results as currently presented. Discussion I have already highlighted some comments about the strengths and limitations of this study. Why would one private site and one community health centre be viewed as a strength? Page 21, line 11-12-I was not sure what security and medicolegality referred to. Page 21, line 16. What is meant by a consultant pharmacist? And if these pharmacists are not co-located, how might this have reassured the GPs in this study? Page 21, line 29-31. The authors state that the patients in another study had a range of views before and after seeing a pharmacist. Does this mean that their views changed before and after? Page 21. In the second para on this page (starting at line 35/36), there are a number of comments made about attributes and challenges having been raised in previous studies, and other studies having found potential negative effects. None of these comments are supported by references. Page 21, line 55. At this point, theoretical frameworks are mentioned. This needs to be included in the method as they would have been used to have organise the data. There is often a fine line between results and interpretation within qualitative work, but I feel that the frameworks mentioned would have been part of the analytical strategy. A diagram at the end of the results showing how the data maps on to these frameworks would have been useful. This will then lead more logically into the discussion. Page 22, line 36. The authors start with sentence with ‘According to Rogers [25-27}..’ creating the impression that refs 25-27 were all authored by Rogers. This only applied to ref. 25. Page 22, line 49-51. I was not sure how the authors concluded that referral of patients to the pharmacist would be seen as a complex intervention? Overall, the paper is quite Australian-centric. What are the key message for practitioners and policy makers elsewhere? I was not sure what was entirely novel about it. These kinds of findings have been reported before, so how does this study move us on? There is a study from Spain which has found similar results. See Rubio-Valera et al. Factors affecting collaboration between general practitioners and community pharmacists : a qualitative study BMC Health Services Research 2012; 12: 188

REVIEWER	Dr Lisa Nissen Professor (Head), School of Clinical Sciences Queensland University of Technology
REVIEW RETURNED	03-Jun-2013

THE STUDY	The research question isn't explicit - its implied in the final part of the background lit r/v. There is no "aim" perse. The rest is inferred from the methodology. The inclusion / exclusion criteria for participants would be useful e.g. age, english language capacity etc. as I would think that this could be relevant with the community clinic patient population??? Not clear on the sample groups, i.e. the patients, yes purposive sampling for "therapeutic" and "demographic" but what in particular is important in this set of patients that you are seeing? How many are you selecting (i.e. is it a % of the total patients in the trial e.g. 10% etc - and this isn't a comment about "power" as its not relevant for this type of study but more to better understand the decisions around who and what is the purposive group?) - how many from each clinic for example?? There was no clear picture of the types of seeding questions presented to the groups in the interviews or the focus groups? The "topic" guide - what was the key to this ....? No stats required for this type of study. reference 14 - the authors own work, accepted but not available in e-print or similar yet? not certain this is appropriate. Is there other, published conference abstract or similar that could be used instead?
RESULTS & CONCLUSIONS	Who were the participants - would have been useful to have more information on the participants. What types of medical conditions, medications etc., more information on the GPs (e.g. ages, sex, years of practice). How many patients from each clinical site? I am not certain that the results as present provide the best outlook for the data collected. Extensively there are 3 groups - patients, practice staff and study pharmacists. It would have been useful to see the results separately before they were grouped into the consolidated "themes". I would think that there are possible differences between the individual perspectives that might draw out some interesting commentary for this study - in contrast to others in the Australian setting examining the "concept" of the GP pharmacist theoretically. The premise of this study was that the "actual" exposure to the practice of the pharmacist would provide a unique insight into the situation, however with the consolidated output it is unclear that this is evident.
REPORTING & ETHICS	As mentioned above I believe that there needs to be a clearer statement around the inclusion and exclusion criteria for the people involved in the study, particularly language ability for example and consenting process?
GENERAL COMMENTS	Overall would be useful to have a clearer extrapolation of the results for each cohort before the consolidation to the overall themes. as presented difficult to see how this study points to any particular differences than those seen by others who looks at the "idea" of the GP pharmacist. Also, would perhaps have seen a comment on the $ related to the model as in the literature this too was something that others have bough up as the "theory" pointed to this as a barrier, but

	I was surprised that even though the HMR model was used as part of the pilot, that this would not have come up as something for discussion. Also with regard to "other studies" - there is not much interrogation of the findings of other studies as such - quite a lot of comment is "like other studies" ..... since the premise was that this study has be benefit of real observation, it would be good to tease out some of the same / different observations in the results vs. what others have found if the premise is that there would be some benefit in "seeing the model in practice" as such.

REVIEWER	Barbara Farrell B.Sc.Phm., Pharm.D., FCSHP Clinical and Research Coordinator, Pharmacy Department, Bruyere Continuing Care Scientist, Bruyere Research Institute and CT Lamont Centre Assistant Professor, Department of Family Medicine, University of Ottawa Adjunct Assistant Professor, School of Pharmacy, University of Waterloo
REVIEW RETURNED	17-Jun-2013

THE STUDY	Thank-you for the opportunity to review this paper. I enjoyed reading it. A few comments below: Participant description: additional information about the participants (patients and practice staff) and response rates would be valuable Represenativenes: Without knowing the types of patients approached (conditions, types of medication-related problems), it's hard to know if they represent the usual patients seen by the pharmacists. Did any patients decline participating in an interview? I did appreciate the phrase 'reflecting a range of demographic and therapeutic characteristics' and would defer to the editor if this description is felt to be sufficient. In terms of the practice staff, it would be helpful to know the response rate, who didn't participate in the focus groups, and perhaps why (essentially, how many approached and any differences between who agreed to participate and who did not). Methods: The addition of response rate information (as above) would be useful. I would find it interesting to have access to the interview and focus group topic guides (especially since these may have focused responses in a way that the analysis might have been more deductive than inductive). I felt that I would have liked to seen a more detailed description of the methods for the analysis. This is probably my major comment. Given the literature on the topic, the authors might have had some codes in mind when starting the analysis and it would be helpful to know if any directed or deductive coding were done (and if so, did the coders use a template of some sort?) or if only an inductive approach was used. Currently, the description indicates that emergent (ie. inductive) coding only was done. If the coders read independently, then compared their coding, was an interrater reliability determined (easy enough in NVivo)? Or, did they meet and

	discuss themes and coding as they moved through the data? How were the coding and themes brought forward for discussion at meetings of rest of the authors? Did the other authors review portions of the data and coding? Or were NVivo printouts of themes/codes and selected quotes presented? Did the whole group approve a coding process according to early themes found or were only 'near-final' results presented to them? How many meetings were required? Was it an iterative process? Or, was all data collected then analyzed together? How were the themes across the data sources consolidated? Were matrices used? And, finally, what criteria were used to select quotes? Outcome measure: The organisation of the results is very clear. However, I think the major themes could be introduced in a way that links the research question with the outcomes more clearly. Instead of simply stating that five major themes emerged, the wording could be improved by illustrating how these themes address the research question. For example, "Five major themes that illustrate the experiences of..... emerged" Article focus: consider leaving out the word "practice" in front of the word "pharmacist" since it is already clear that the pharmacists are working in general practice clinics Abstract: I am not sure it's necessary to include the sentence "Pharmacist services were perceived to provide benefits for patients and staff" since this is described in the sentence about the five major themes. The other sentences provide examples of, or additional information about each theme but this one does not.
RESULTS & CONCLUSIONS	Credibility: The credibility of the results would be improved with a more detailed explanation of the methods and analysis approach (as described above) Presentation: While I really enjoyed the quotes (as they do a good job of 'telling the story' and they represent multiple perspectives), there are alot and the authors might consider eliminating those that are not as key. For example, I did not get as much out of the following quotes: "I think people are comfortable...", "Having someone on site...", "I loved being part of a team.." etc. In the section on "Integration and Professional Relationships", I found there was a mix of positive and negative in no particular order (text and quotes). I wonder if this would read more smoothly to have the 'positive' quotes follow the 'positive' text and the 'negative' quotes follow the 'negative' text. Then, the approaches to overcoming the negative, and what happened with time naturally follow. On page 14, second last paragraph, the sentence that starts with "Additionally, most negative..." should likely use the term 'did' rather than 'would'. On page 19, I think the quotes would flow better if they followed the relevant statement right away. For example the sentence "Some patients found attending appointments burdensome" is not followed by the quote relevant to it, but rather two quotes more relevant to the previous sentence.

	Strengths and limitations: Why is it a strength to have used two different types of clinics? I am not sure what you mean by saying that a limitation is that the clinics and patients were finite. page 21 (last sentence of second paragraph) - probably do not need the words "in our study" at the end of the sentence. Final paragraph of discussion: I am not sure where 'strong leadership and shared goals" comes from. Seems like new info compared to what is described in the results. Conclusion: In the final sentence, 'lack of time' or 'limited time' is more accurate than stating only 'time'. Contributors: RE and JG are listed as contributing to study concept and design etc, but in the methods section, their involvement in the data analysis phase is described. Please clarify how they were involved in data analysis.
REPORTING & ETHICS	CONSORT not applicable (not an RCT)
GENERAL COMMENTS	This is a very well written first submission. It would be improved with a more detailed description of the methods that will improve the credibility/trustiworthiness of the results. Some small suggestions for improving the presentation of the results and discussion are included.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1: Carmel Hughes

Abstract:
*The first mention of the Pharmacists in Practice study appears under ‘Participants’. This probably needs to be stated earlier, perhaps under ‘Design’ to highlight that this study was part of a larger study.

The following phrase has been added to the Abstract at the end of the Objective: ‘…within the Pharmacists in Practice Study (PIPS) “

*Under Method, the authors state that they analysed the data thematically, but then in the Results, they state that the findings were explained using theoretical frameworks. I would have thought that the latter would have been used as part of the analysis and that it would be more appropriate to report this under Method.

The data were analysed thematically and theoretical frameworks were then used to explain the findings. The following phrase has been added to the Method: ‘…and theoretical frameworks used to explain the findings.’

*Page 4. Under Strengths and Limitations, the authors state that the study involved a private general practice and community health clinic. I assume that this is viewed as a strength, but I am not sure why? In relation to recruitment, the authors explain that they have recruited a number of participants, but why is this seen as a particular strength? The number of patients recruited may be seen as more noteworthy.

Privately-run general practice clinics and community health centres are the two main models of primary care practice in Australia. Including both types of clinics is a strength because it showed this model of practice is feasible in the different settings. By including a range of different stakeholders, we added richness to the data by exploring different perspectives of the service.

*Background:
No comment. Sets the scene well. However, it would be helpful to have a well-articulated aim for the study, lining the background to the Method.

This has been changed in the manuscript to: “This paper describes a qualitative evaluation of the PIPS, the aim of which was to explore general practice staff, pharmacist and patient experiences with pharmacist services provided in Australian general practice clinics.” The last sentence of this section has been deleted, as it is now incorporated in the aim.

*Method:
For non-Australian readers, what is the difference between the two GP sites?

As described above, privately-run general practice clinics and community health centres are the two main models of primary care practice in Australia. In private general practice clinics, GPs are paid on a fee-for-service basis, which comprises a government fee and usually a patient co-payment. Community health centres offer a range of primary healthcare services to local residents, with a focus on health promotion and disease prevention and management. GPs are predominantly salaried and generate income for the clinic through government billing. Fees are charged for services according to the client's ability to pay. This information has been added to the Methods.
Why was the quality assurance activity focused on osteoporosis?
This was a topic that was deemed relevant to the clinics after discussion with staff. Osteoporosis is undertreated in general practice globally and is a national health priority in Australia. The following has been added at the end of the relevant paragraph on page 6: “Quality assurance activities included a drug use evaluation program addressing osteoporosis pharmacotherapy, a topic selected in consultation with clinic staff.”

*Why did they select different methods for data collection e.g. interviews with patients rather than focus groups? And why via telephone?

The following information has been added to the ‘Recruitment and data collection’ section of the manuscript:

Under ‘Patients’:
“…Individual interviews were used because discussions could involve personal or sensitive information about the patient’s health or medicines. These were conducted via telephone for participant convenience. A topic guide was used to facilitate discussion (Supplementary file 1). Recruitment continued until data saturation was reached.”

Under ‘Practice staff’
“…Focus groups were chosen in order to gain a multidisciplinary perspective by stimulation of group discussion, as well as being logistically convenient for participants.”

Under ‘Pharmacists’
“…Periodic narrative reports were used as they enabled prospective capture of pharmacists’ experiences and issues they encountered during the establishment of the service, rather than relying on recall at the end of the study, thus allowing the researchers to observe the pharmacists’ progression and development throughout the study.”

*Page 7, line 14. The authors state the focus groups took place at the end of the PIPS study. Why this timing? Did the staff include GPs? Why did they opt for focus groups?

Focus groups were conducted at the end of the PIPS study as we wished to evaluate how participants felt about the pharmacist services i.e. get their feedback (as indicated in the aim). The staff focus groups did involve GPs and the composition of focus groups is mentioned in the results.

As above, the manuscript now reads: “Focus groups were chosen in order to gain a wider multidisciplinary perspective by stimulation of group discussion, as well as being logistically convenient for participants.”

*Page 7, line 25. I was also not clear what the narrative reports were. A little more detail in this needs to be provided.

The narrative report templates have now been included as a supplementary file to add clarity. The manuscript also now reads: “Periodic narrative reports were used as they enabled prospective capture of pharmacists’ experiences and issues encountered during the establishment of the service, rather than relying on recall at the end of the study, thus allowing the researchers to observe the pharmacists’ progression and development throughout the study.”

*Page 7. Data analysis. As stated earlier, this section may need to include the theoretical frameworks that were mentioned in the Abstract. Was data saturation obtained?

The use of theoretical frameworks has been clarified above. The following sentence (as in the Abstract) has been added: “Following thematic analysis, theoretical frameworks were used to explain the findings.”

Data saturation for the patient groups was obtained. Under Recruitment and Data collection: Patients, the manuscript now reads: “Recruitment continued until data saturation was reached.”

Regarding staff and pharmacists, we had a fixed number of potential participants to draw from. Most of the clinic staff at both sites participated.

*Results
It would have been helpful to have had a summary table of the characteristics of participants, especially the practice staff. Very little information is provided about them. Was anyone approached who refused to take part?

Extra demographic information for practice staff, including age and years of experience has now been included. All staff who had interacted with the pharmacist and were working on the day of the focus group participated. Only a few staff members were not present on the day and thus could not participate. Nobody refused to take part.

The manuscript now reads: “Of the practice staff participants, eight were female, the mean age was 50.9 years (range 37 to 64) and the median duration of general practice work experience was 27 years (range 3 to 33). All practice staff who had worked with the practice pharmacist and were working on the day of the focus group participated. One practice manager from the private practice was unavailable, whilst a nurse and GP from the community health centre were not available. No staff refused to participate. “

*In the Results section in the abstract, it was stated that the findings were explained using theoretical frameworks. This does not come through at all in the results as currently presented.

The application of the theoretical frameworks to the findings has now been moved to the results section.

*Discussion
I have already highlighted some comments about the strengths and limitations of this study. Why would one private site and one community health centre be viewed as a strength?

As answered previously

*Page 21, line 11-12-I was not sure what security and medicolegality referred to.

Security and medicolegality refer to the medicolegal issues regarding scope of practice and responsibility/liability of practitioners.

*Page 21, line 16. What is meant by a consultant pharmacist? And if these pharmacists are not co-located, how might this have reassured the GPs in this study?

The following sentence has been added: “Consultant pharmacists are independent pharmacists accredited to undertake professional pharmacy services, including home medicines reviews, but are not co-located in GP clinics.”

The manuscript already explains that “…many Australian GPs, including those in our study, have experience working with consultant pharmacists and were comfortable that the practice pharmacist would not cross ethical and legal boundaries.”

*Page 21, line 29-31. The authors state that the patients in another study had a range of views before and after seeing a pharmacist. Does this mean that their views changed before and after?

Not necessarily - there was a range of positive and negative views both prior to the clinic (e.g. some participants welcomed the review whilst others were suspicious) and after (e.g. some would like a yearly review whilst others felt they did not gain much from it). The diversity of views is similar to our findings. The wording has been changed to “…both before and after...” for clarity.

*Page 21. In the second para on this page (starting at line 35/36), there are a number of comments made about attributes and challenges having been raised in previous studies, and other studies having found potential negative effects. None of these comments are supported by references.

The manuscript has now been altered to place references 14 and 15 next to these sentences.

*Page 21, line 55. At this point, theoretical frameworks are mentioned. This needs to be included in the method as they would have been used to have organise the data. There is often a fine line between results and interpretation within qualitative work, but I feel that the frameworks mentioned would have been part of the analytical strategy. A diagram at the end of the results showing how the data maps on to these frameworks would have been useful. This will then lead more logically into the discussion.

Please see previous answer to this. A diagram for the D’Amour model, with our results, has been added as a supplementary file.

*Page 22, line 36. The authors start with sentence with ‘According to Rogers [25-27}..’ creating the impression that refs 25-27 were all authored by Rogers. This only applied to ref. 25.

The manuscript has been altered so that only Rogers is referenced.

*Page 22, line 49-51. I was not sure how the authors concluded that referral of patients to the pharmacist would be seen as a complex intervention?

It was mentioned that referral processes were at times complicated/not streamlined, especially when staff were getting used to referring to the pharmacist. But this was more of a 'study constraint' and wasn't included explicitly in the results. The manuscript has been amended by the addition of "…the study process…" for clarity

*Overall, the paper is quite Australian-centric. What are the key message for practitioners and policy makers elsewhere? I was not sure what was entirely novel about it. These kinds of findings have been reported before, so how does this study move us on? There is a study from Spain which has found similar results. See Rubio-Valera et al. Factors affecting collaboration between general practitioners and community pharmacists : a qualitative study BMC Health Services Research 2012; 12: 188

The study was conducted in Australia where this role is currently novel in concept, and uncommon in practice. The findings from this study are applicable to countries where primary health care reform is taking place and pharmacists are beginning to have a greater role within primary care teams, especially with regards to integration into GP practices.

Although there have been trials of practice pharmacists embedded in GP clinics, there is a scarcity of qualitative studies exploring actual participant experiences with this particular role. This study contributes to the understanding of this particular model of health service delivery, not only from an Australian perspective, but globally as well.

The study by Rubio-Valera et al to which the reviewer is making reference involved community pharmacists and GPs. Our study is investigating participant experiences with a pharmacist within the medical practice (who is a pharmacist accredited to undertake medication reviews and not affiliated with a community pharmacy) actually co-located within a GP clinic. This is an important difference.

*Reviewer 2: Lisa Nissen

*The research question isn't explicit - its implied in the final part of the background lit r/v. There is no "aim" perse. The rest is inferred from the methodology.

This has been changed in the manuscript to: "This paper describes a qualitative evaluation of the PIPS, the aim of which was to explore general practice staff, pharmacist and patient experiences with pharmacist services provided in general practice clinics."

*The inclusion / exclusion criteria for participants would be useful e.g. age, english language capacity etc. as I would think that this could be relevant with the community clinic patient population???

Any patient who participated in the PIPS study could take part in an interview. The overall inclusion/exclusion criteria for the patients who participated in the study included those with the propensity for medication misadventure (e.g. polypharmacy, recent discharge from hospital). These patients could be referred by the GP, regardless of age or English language capacity (interpreters were available where needed). This information is included in the PIPS protocol.

*Not clear on the sample groups, i.e. the patients, yes purposive sampling for "therapeutic" and "demographic" but what in particular is important in this set of patients that you are seeing? How many are you selecting (i.e. is it a % of the total patients in the trial e.g. 10% etc - and this isn't a

comment about "power" as its not relevant for this type of study but more to better understand the decisions around who and what is the purposive group?) - how many from each clinic for example??

We endeavoured to sample a range of patients that were reflective of those who had consultations. We did not have a fixed number of patients in mind, rather we sampled patients until data saturation was reached (this was equivalent to 20% of those in the trial). The manuscript now reads: "Recruitment continued until data saturation was reached."

*There was no clear picture of the types of seeding questions presented to the groups in the interviews or the focus groups? The "topic" guide - what was the key to this ....?

To add clarity, we have now included the topic guides (for interviews, focus groups and narrative reports) as supplementary files 1, 2 and 3, and referred to them in the text.

*No stats required for this type of study.

*reference 14 - the authors own work, accepted but not available in e-print or similar yet? not certain this is appropriate. Is there other, published conference abstract or similar that could be used instead?

This paper has since been published and the reference has been updated to reflect this.

*Who were the participants - would have been useful to have more information on the participants. What types of medical conditions, medications etc., more information on the GPs (e.g. ages, sex, years of practice). How many patients from each clinical site?

Patients were 'typical' of general practice with a range of chronic diseases. The following has been added to the manuscript: "Patients had a range of medical conditions (e.g. asthma, depression, diabetes, hypertension, osteoporosis)"
Although we have information regarding patient medications, we feel that this information will not add much to the discussion and is difficult to present concisely.
The manuscript now reads: "Twelve patients were recruited from the private practice and six from the community health centre. This corresponded to roughly 20% of participants from each site."

Additional GP demographics have been added to the manuscript in response to a previous reviewer.

*I am not certain that the results as present provide the best outlook for the data collected. Extensively there are 3 groups - patients, practice staff and study pharmacists. It would have been useful to see the results separately before they were grouped into the consolidated "themes". I would think that there are possible differences between the individual perspectives that might draw out some interesting commentary for this study - in contrast to others in the Australian setting examining the "concept" of the GP pharmacist theoretically. The premise of this study was that the "actual" exposure to the practice of the pharmacist would provide a unique insight into the situation, however with the consolidated output it is unclear that this is evident.
There was discussion amongst the authors regarding whether or not to separately analyse and discuss the findings from each stakeholder group. In the end, we decided to analyse the data across all stakeholder groups collectively. One of the primary reasons for the simultaneous analysis of the various stakeholder groups was the limited numbers of each type of participant as we were restricted to two study sites. Additionally, we decided to group data from the three groups to demonstrate the similarities/differences in their views. Presenting the data from each group separately would make the paper disjointed and not allow comparison/contrasting of views of the three groups.

*Overall would be useful to have a clearer extrapolation of the results for each cohort before the

consolidation to the overall themes. As presented difficult to see how this study points to any particular differences than those seen by others who looks at the "idea" of the GP pharmacist. Also, would perhaps have seen a comment on the $ related to the model as in the literature this too was something that others have brought up as the "theory" pointed to this as a barrier, but I was surprised that even though the HMR model was used as part of the pilot, that this would not have come up as something for discussion.

The issue of funding was not raised during the focus groups/interviews. In this study, we were primarily interested in staff experiences with the services, rather than funding models or sustainability of services per se. This could be an area of future research where policy makers are also part of the discussion.
The following has been added to the discussion of the manuscript: “Future research should investigate the feasibility, sustainability and financial viability of general practice pharmacist roles and evaluate the impact on patient outcomes in larger controlled studies.“

*Also with regard to "other studies" - there is not much interrogation of the findings of other studies as such - quite a lot of comment is "like other studies" ..... since the premise was that this study has be benefit of real observation, it would be good to tease out some of the same / different observations in the results vs. what others have found if the premise is that there would be some benefit in "seeing the model in practice" as such.

As mentioned, our study confirmed some of the findings from other studies that assessed the practice pharmacist from a ‘theoretical’ point of view. However, the additional findings of our study have now been highlighted in the manuscript:

“Compared with other studies, the practice pharmacists in this study highlighted some additional benefits of working in this role. This included the ability to work with a diverse range of staff, including nursing and allied health, emphasising the interdisciplinary nature of the role; that interprofessional communication could occur prior to consultations, resulting in improved delivery of services; and the way the pharmacists now viewed patients more holistically and felt integrated into their overall management.”

*Reviewer 3: Barb Farrell

*Participant description: additional information about the participants (patients and practice staff) and response rates would be valuable

This point has been addressed in the manuscript and was raised by an earlier reviewer.

*Representativeness:
Without knowing the types of patients approached (conditions, types of medication-related problems), it's hard to know if they represent the usual patients seen by the pharmacists. Did any patients decline participating in an interview? I did appreciate the phrase 'reflecting a range of demographic and therapeutic characteristics' and would defer to the editor if this description is felt to be sufficient.

We have now included additional information about the patient participants. The manuscript now reads:
“Participants had a range of chronic medical conditions (e.g. asthma, depression, diabetes, hypertension, osteoporosis).“

Only a couple of patients declined to participate in an interview when contacted. Recruitment continued until saturation was reached. (This point has been added to the manuscript in response to an earlier reviewer’s comment.)

*In terms of the practice staff, it would be helpful to know the response rate, who didn't participate in the focus groups, and perhaps why (essentially, how many approached and any differences between who agreed to participate and who did not).

The manuscript now reads: “All practice staff who had worked with the practice pharmacist and were working on the day of the focus group participated. One practice manager from the private practice was unavailable, whilst a nurse and GP from the community health centre were not available. No staff refused to participate in the focus groups.”

*Methods:
The addition of response rate information (as above) would be useful.

Regarding patients, the manuscript now reads: “Twelve patients were recruited from the private practice and six from the community health centre. This corresponded to roughly 20% of participants from each site.”

*I would find it interesting to have access to the interview and focus group topic guides (especially since these may have focused responses in a way that the analysis might have been more deductive than inductive).

See response to previous reviewer.

*I felt that I would have liked to seen a more detailed description of the methods for the analysis. This is probably my major comment. Given the literature on the topic, the authors might have had some codes in mind when starting the analysis and it would be helpful to know if any directed or deductive coding were done (and if so, did the coders use a template of some sort?) or if only an inductive approach was used. Currently, the description indicates that emergent (ie. inductive) coding only was done.

Although we had some ideas from the literature, which helped guide the development of the interview guides (as mentioned in the manuscript), we did not use a framework or template to facilitate the coding process. Coding was thus largely inductive as we wished to immerse ourselves in the data and see what themes emerged.

*If the coders read independently, then compared their coding, was an interrater reliability determined (easy enough in NVivo)? Or, did they meet and discuss themes and coding as they moved through the data?

Interrater reliability was not determined. Rather, meeting and discussion occurred once the coders had coded the data independently and elicited some initial themes. The coders then met to discuss these and reach consensus.

*How were the coding and themes brought forward for discussion at meetings of rest of the authors? Did the other authors review portions of the data and coding? Or were NVivo printouts of themes/codes and selected quotes presented? Did the whole group approve a coding process according to early themes found or were only 'near-final' results presented to them? How many meetings were required?

Once ET & KS had a general idea of the codes and themes, these were presented to the rest of the team for discussion along with supportive quotes. All team members also had access to the transcripts. A structured coding process was not approved by the whole group, rather ‘near-final’ results were presented to the rest of the team. Approximately four meetings (two between ET and KS

and two with the whole group) were undertaken.

*Was it an iterative process? Or, was all data collected then analyzed together?

All data were collected, entered and analysed together.

*How were the themes across the data sources consolidated? Were matrices used? And, finally, what criteria were used to select quotes?

All data were entered into NVivo and analysed across all sources. Matrices were not used. Quotes that were eloquent and representative of the theme and stakeholder type were selected. Diversity of quotes was sought, including positive and negative view points from the perspectives of different groups for each of the themes/concepts.

The manuscript for the data analysis section now reads:
“Transcripts were verified against audio recordings by one investigator (ET). Data management was facilitated using NVivo® 9.0 (QSR, Melbourne). Interview transcripts, recordings, narrative reports and field notes were entered into the software. All data were collected, entered and then analysed together. Two investigators (ET, KS) read the transcripts and independently analysed the data inductively, and coded the data for emergent themes.[19] The initial coding and emerging themes were then discussed between ET & KS to reach a general consensus. Results were then presented at meetings involving all authors, where discrepancies were resolved and themes finalised. Following thematic analysis, theoretical frameworks were used to explain the findings. Illustrative quotes that represent a range of stakeholders and points of view were selected for reporting.”

*Outcome measure:
The organisation of the results is very clear. However, I think the major themes could be introduced in a way that links the research question with the outcomes more clearly. Instead of simply stating that five major themes emerged, the wording could be improved by illustrating how these themes address the research question. For example, "Five major themes that illustrate the experiences of..... emerged"

The manuscript now reads: “Five major themes that illustrate the experiences of the participants emerged…”

*Article focus: consider leaving out the word "practice" in front of the word "pharmacist" since it is already clear that the pharmacists are working in general practice clinics

“Practice” has been included to avoid any confusion with community pharmacist.

*Abstract: I am not sure it's necessary to include the sentence "Pharmacist services were perceived to provide benefits for patients and staff" since this is described in the sentence about the five major themes. The other sentences provide examples of, or additional information about each theme but this one does not.

This sentence has now been removed and the manuscript reflects this.

*Credibility:
The credibility of the results would be improved with a more detailed explanation of the methods and analysis approach (as described above)

This has been answered previously as above.

*Presentation:
While I really enjoyed the quotes (as they do a good job of 'telling the story' and they represent multiple perspectives), there are a lot and the authors might consider eliminating those that are not as key. For example, I did not get as much out of the following quotes: "I think people are comfortable...", "Having someone on site...", "I loved being part of a team.." etc.

These quotes have been included because they express the feelings of the participants.

*In the section on "Integration and Professional Relationships", I found there was a mix of positive and negative in no particular order (text and quotes). I wonder if this would read more smoothly to have the 'positive' quotes follow the 'positive' text and the 'negative' quotes follow the 'negative' text. Then, the approaches to overcoming the negative, and what happened with time naturally follow.

The manuscript has now been altered to reflect this suggestion.

*On page 14, second last paragraph, the sentence that starts with "Additionally, most negative..." should likely use the term 'did' rather than 'would'.

The manuscript now reads: “Additionally, most negative receptivity disappeared once patients experienced the benefits of the practice pharmacist services.”

*On page 19, I think the quotes would flow better if they followed the relevant statement right away. For example the sentence "Some patients found attending appointments burdensome" is not followed by the quote relevant to it, but rather two quotes more relevant to the previous sentence.

The manuscript has now been altered to reflect this suggestion.

*Strengths and limitations:
Why is it a strength to have used two different types of clinics? I am not sure what you mean by saying that a limitation is that the clinics and patients were finite.

See response to earlier reviewer regarding the two types of site.

We could only sample participants from the two clinics who had experienced working with a practice pharmacist – thus there was a finite pool to draw from, especially regarding staff/pharmacist participants (patient participants were sampled until data saturation was reached). This may limit the generalizability of the results.

*page 21 (last sentence of second paragraph) - probably do not need the words "in our study" at the end of the sentence.

The manuscript has now been altered to reflect this suggestion.

*Final paragraph of discussion:
I am not sure where 'strong leadership and shared goals" comes from. Seems like new info compared to what is described in the results.

Strong leadership and shared goals, were demonstrated by the participants (especially by practice managers and head GPs) during the study, but these were not explicitly mentioned by the participants during the discussion. The supportive nature of staff in general, however, was raised as a facilitating factor and is mentioned in the results. The shared goal of providing optimal patient care was also evident.
The manuscript now reads: “Supportive staff, shared goals and the creation of benefits for patients

and staff are imperative."

*Conclusion:
In the final sentence, 'lack of time' or 'limited time' is more accurate than stating only 'time'.

The manuscript now reads: "Patients and staff benefited from these services; however, logistical challenges posed a barrier."

*Contributors:
RE and JG are listed as contributing to study concept and design etc, but in the methods section, their involvement in the data analysis phase is described. Please clarify how they were involved in data analysis.

Although RE and JG were involved during the final stages of analysis (when finalising themes), they did not actively participate in the coding or interpretation of the data. They have now been recognised as contributing to the analysis.

*This is a very well written first submission. It would be improved with a more detailed description of the methods that will improve the credibility/trustiworthiness of the results. Some small suggestions for improving the presentation of the results and discussion are included.

VERSION 2 – REVIEW

REVIEWER	Prof Lisa Nissen Head, School of Clinical Sciences Queensland University of Technology
REVIEW RETURNED	31-Jul-2013

THE STUDY	The revisions to the paper are appropriate and address previous concerns with sections of the paper.
RESULTS & CONCLUSIONS	Yes, as per previous comment the authors have addressed the concerns raised previously
GENERAL COMMENTS	I feel the authors have revised the paper to a sufficient standard within the limitations of the study itself which they have acknowledged.