

MSc Thesis – Tommaso D’Ovidio  
McMaster University – Health Sciences, Health Research Methodology

PUBLIC DELIBERATION FOR HEALTH SYSTEM DECISION-MAKING: AN  
EVALUATIVE CASE STUDY OF MCMASTER HEALTH FORUM’S CITIZEN  
PANELS

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DECISION-MAKING: AN EVALUATIVE CASE STUDY  
OF MCMASTER HEALTH FORUM’S CITIZEN PANELS

By

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A Thesis

Submitted to the School of Graduate Studies

In Partial Fulfillment of the Requirements

For the Degree

Master of Science

McMaster University

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MASTER OF SCIENCE (2016)  
Health Sciences – Health Research Methodology

McMaster University  
Hamilton, Ontario

TITLE: Public Deliberation for Health System Decision-  
Making: An Evaluative Case Study of the McMaster  
Health Forum’s Citizen Panels

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NUMBER OF PAGES: 32

## **Abstract**

**Background:** Public deliberation can be used in a number of decision-making processes to make the health system more responsive to public values, and to help inform and refine health system policy decisions. This study evaluates how the McMaster Health Forum implements the key elements of public deliberation and identifies both areas of strength and potential areas for improvement.

**Methods:** An evaluative case study approach was used. Data were collected from three sources: quantitative and open-ended responses to questionnaires from 19 panels (200 respondents); panel summaries from 13 panels; and transcripts of 2 panel deliberations. Thematic analysis was used to assess four key elements of deliberation: the representativeness of participants, the information supports provided to them, the procedural criteria used, and the focus on explicit reasoning in coming to conclusions.

**Results:** Participants felt that the McMaster Health Forum recruited a representative sample of participants based on gender and diversity of opinion. However, participants noted that the panels could be improved by striving for more age and ethnocultural diversity while also including health professionals or policymakers. Participants mostly occupied the role of a ‘consumer’ of health services. They viewed the information presented in citizen briefs as credible but had questions about the brief-development process. Procedurally, the panels fostered openness without impeding consensus and facilitators fostered mutual respect among participants. Finally, the groups incorporated values, showed an ability to come to a deeper understanding of policy options and harnessed the diverse experiences of their fellow participants as they reasoned.

**Discussion:** This case study is part of a larger evaluation process that assesses all of the McMaster Health Forum citizen panels which aim to elicit citizens’ values and preferences about health system issues in Canada. The framework used to assess the public deliberation process can be used to evaluate other processes in the future.

## **Keywords**

Public deliberation, citizen panel, decision-making, health policy

## **Background**

Over the last decade, healthcare has moved towards public deliberation as a means to bring people's opinions and values into health policy processes (Degeling et al, 2015; Street et al., 2014). Public deliberation elicits citizen's values and preferences that can in turn inform decisions about ethical or values-based dilemmas, priority-setting processes, resource allocation decisions, and the development of policy recommendations or tools (Abelson, 2009; Baum et al, 2009; Gutmann & Thompson, 2004; Lehoux et al, 2009; Mitton et al, 2009; Willis et al, 2010). In a rapidly transforming health system with changing citizen roles and responsibilities, deliberation can be a critical tool for developing and improving policies to meet the needs of the public while taking into account the tradeoffs entrenched in the process.

In an attempt to harness these advantages, many public deliberation initiatives have been implemented by government agencies and health policy researchers (Degeling et al, 2015; Street et al, 2014). A key consideration in the implementation of these initiatives is evaluating their outcomes (e.g., changes in knowledge and/or attitudes; impact on individual and/or policy decisions) or elements of the process itself (Abelson et al, 2003; Abelson & Gauvin, 2006; Fishkin & Farrar, 2005; Timotijevic & Raats, 2007). Process evaluations focus on the practical aspects of deliberation, (Abelson & Gauvin, 2006) and can provide vital data about how the deliberation was implemented and what problems were experienced (OECD, 2005).

Current evaluation research highlights four key elements of deliberation: 1) the representativeness of the participants; 2) the information supports provided to them; 3) the procedural criteria used; 4) the focus on explicit reasoning in coming to conclusions

(Abelson et al, 2013; Burkhalter et al, 2002; Gastil & Black 2008). In a recent mapping exercise, Abelson and colleagues (2013) found that the majority of studies that focus their evaluation efforts on deliberative theory came close to achieving these elements, albeit with varying degrees of success. The authors note that the variation in operationalization is most likely due to the limitations of current deliberation definitions, the limited attention paid to them, or both. The following paragraphs delineate the four elements of the deliberation process and highlight gaps in the evaluation literature.

Convening a ‘public’ that is representative is critical to the success of a deliberation exercise (Boivin et al, 2014; Lehoux et al, 2012; Martin, 2008). Yet, the literature has not presented consistent definitions of representativeness (Boivin et al, 2014). Researchers often conflate the representativeness of demographic perspectives, such as young or old (as measured through recruitment), with representativeness of participant opinions expressed during deliberation, such as lay person versus service user (as determined through opinions expressed during deliberation) (Abelson et al, 2013). Exacerbating this problem is the fact that researchers frequently fail to report whether they had directed participants to arrive at conclusions based on personal preference or community interest (Degeling et al, 2015). The lack of such reporting may reveal an implicit assumption that merely convening a public comprised of citizens will ensure that democratic legitimacy emerges when this is not necessarily the case (Lehoux et al, 2012; Martin, 2008).

The efforts to use information supports has become a critical part of deliberation, in part as a means to enhance the credibility of the process (Abelson et al 2003; Abelson et al, 2007; Abelson & Gauvin, 2006; De Vries et al, 2010; Stromer-Galley, 2007; Thompson, 2008). Some scholars have identified criteria to guide the preparation of information

supports (Abelson et al, 2013). However, these efforts have not been supported by rigorous evaluation to determine how information is best presented.

Public deliberation initiatives generally aim to meet certain procedural criteria. (Pratchett, 1999; Smith & Wales, 1999). Evaluations of deliberation tend to assess criteria such as: 1) Was there equal participation? 2) Did the facilitator help move the discussion forward and keep participants on task? 3) Was mutual respect and concern for others emphasized throughout deliberations (Abelson et al, 2003)?

An essential premise of public deliberation is that persons “reason together” but may still hold different points of view as they arrive at a collectively reasoned position (De Vries, 2010; Rowe & Frewer, 2005; Timotijevic & Raats, 2007). However, as deliberation scholars have noted, the literature has not been precise in its description of the key underpinnings of value-based reasoning or how they are to be carried out (Abelson et al, 2013). In some instances, deliberation participants are prompted with a values framework before they debate the merits of one option over the other. Other times, values emerge organically during the reasoning process. Deliberation initiatives have also noted how values and knowledge independently and co-operatively influence reasoning (Lehoux et al, 2009).

### ***Context for and focus of the evaluation***

The McMaster Health Forum’s citizen panel program started in 2013 and, to date, over 20 panels have been convened to address health-system issues in Canada. The panels engage members of the public and encourage them to share their views in the context of a structured deliberative method (Table 1). For each panel, a sample of 10-16 citizens are recruited, with sample aiming to include those affected by health-system issue being addressed in the panel,

or who could be affected by future decisions regarding the issue. The panels are informed by a plain-language ‘citizen brief’ that provides information about an issue, options to address it and key implementation considerations. Panel deliberations take place over one day sessions and are facilitated by members of the research team.

This study was carried out as part of the formative evaluation process for the McMaster Health Forum’s citizen panels. How the principles of deliberation should be implemented in practice is not universally agreed upon and few empirical studies have shed light on the quality of the deliberative discourse (Carman et al, 2015; De Vries et al, 2010). Given this, our goal was to provide insight about the key elements of one approach to public deliberation that is rooted in the literature, and to identify both areas of strength and potential areas for improvement.

## **Methods**

### ***Research design***

Evaluative case study methodology was used to assess public deliberation at the McMaster Health Forum (Yin, 2014). The single case (i.e., unit of analysis) in this study was defined as the McMaster Health Forum’s citizen panels process. The process refers to the recruitment of participants, information supports given to the participants and the deliberation that occurs among participants (Table 1). Since the majority of panels were conducted at the McMaster Health Forum, using the same structure and the same recruitment strategy, the panels were not designated as embedded cases or separate cases in



a multiple case study (Yin, 2014). The only aspect of initiative that changed from panel to panel was the health system issue being addressed.

### ***Data sources***

Three data sources were used to evaluate the citizen panel process: responses to questionnaires comprising quantitative ratings of specific design features (1=not helpful at all, 7=extremely helpful) and open-ended responses to questions, for both the citizen briefs (prior to participating in the panels) and the citizen panels (immediately following the panels) ( $n=19$ ); panel summaries describing the key findings from the citizen panels ( $n=13$ ), which were prepared by Forum staff; and transcripts of audio-recorded panel deliberations ( $n=2$ ). Data collection was performed by members of the research team before the principal author (TD) began evaluating the process. TD did not provide input in the creation of the questionnaires or the panel summaries. Ethics approval was obtained before the initial implementation of the McMaster Health Forum citizen panel program in 2013 by McMaster University HiREB (Hamilton, Ontario).

### ***Sampling***

All available and completed questionnaire sets ( $n=19$ ) and panel summaries ( $n=13$ ) were included in the analysis. A typical case sampling approach (Patton, 1990) was employed to select two citizen panels for in-depth analysis: i) a citizen panel on improving access to palliative care in Ontario; and ii) a citizen panel on addressing nutritional risk among older adults in Ontario. The purpose of this qualitative profile of two typical cases is

to illustrate a standard set of case characteristics. These two panels were selected because they were conducted using the Forum’s standard approach.

### *Analytical framework*

The analytical framework used to evaluate the citizen panel process addressed representativeness, information supports, procedural criteria, and reasoning (Table 2). These elements were derived from four taxonomies used in the literature to evaluate public deliberation process and quality as previously discussed. Table 2 provides a mapping of these elements to the existing literature from which they were derived. The elements are explained below. Abelson et al’s (2003) framework identifies four key components, three of which were relevant to the evaluation of the citizen panel process: representation, the information used in the process, and the structure of the process or procedures. A decade later, Abelson et al (2013) examined how the core features of public deliberation were articulated and put into practice through: representation, representativeness and diversity; information provision; and value-based reasoning. De Vries et al (2010) emphasized how measures such as: equal participation, respect and reasoning can help determine the quality of a public deliberation initiative. Two years later De Vries et al (2012) modified this framework and broke down the evaluation into components: information (i.e., understanding and application of information), process (i.e., facilitation, equal participation, participant engagement, and respect), and reasoning.

Representativeness: Participant data (e.g., demographic), participants’ views about representativeness (i.e., diversity of demographic perspectives and participant opinions) and

how participant roles were assigned and occupied were used to determine how representative the citizen panels were and if the right ‘public’ was engaged. The recruitment strategy was assessed through an analysis of participants’ demographic data. These data helped determine if the panels were successful in engaging a diverse range of participant perspectives and were triangulated with participants’ views about representativeness, as characterized by their quantitative and qualitative questionnaire responses. Participants’ qualitative responses from the questionnaire about the panel were also used to assess the diversity of participant opinions. Finally, panel summaries and transcripts were used to identify whether participant roles were assigned and how these roles were occupied during deliberation. Roles were defined as the lens through which participants engaged in deliberation (Krinks et al, 2015). The literature describes three basic constructions of the public, they are: citizens (lay people, the *pure* public), consumers (patients, service users, the *affected* public) and advocates (experts and interest groups, acting as the *partisan* public) (Degeling et al, 2015).

Information supports: Several elements can influence how successful the educational material was in informing the participants. Information should be credible, trustworthy and accurate (Abelson et al, 2003; Abelson & Gauvin, 2006; Door Gold et al, 2012). Participants identified in the questionnaire the characteristics of the information material that they thought were beneficial and should be retained in future briefs, as well as areas for improvement. The adequacy of information materials was assessed using the quantitative and open-ended responses to the questionnaire about the citizen brief.

Procedural criteria: Evaluation of the deliberative process in particular focused on criteria related to the process (Abelson et al, 2003; De Vries et al, 2010; Door Gold et al, 2012) such as: 1) did the deliberation aim for consensus? 2) was there a concern for equal participation? 3) did the facilitator keep the discussion moving forward, keep participants on task, encourage participation and elicit viewpoints from all participants? 4) was mutual respect and concern for others emphasized through deliberations? 5) were participants able to communicate freely by challenging or building on others’ ideas or accepting or rejecting others’ positions? 6) was ample time provided for discussion? Note that the process criteria do not have clear boundaries between them. For example, respect embodies another sense of “equality” (i.e., the participants act as equals in deliberation). Moreover, true engagement will often involve a certain degree of respect among participants. The adequacy of the citizen panel deliberation was also assessed using the open-ended responses to the questionnaire about the panel and triangulated with the transcripts of the two panels.

Reasoning: Though value-based reasoning is challenging to specify and decipher from accounts of public deliberation, some studies provide descriptions about how it is carried out. These works posit that values-based reasoning involves the complementary activities of values expression, information exchange, knowledge acquisition, questioning and debate (Abelson et al, 2013; Lehoux et al, 2009). To negotiate this complex process through our analysis, we identified values using Niemeyer et al’s (2007) list of common values that are expressed in deliberation, assessed how participants demonstrated their knowledge and applied information when they corrected one another and/or made key distinctions important to policy (De Vries et al, 2012), and noted clear demonstration of language

indicating acknowledgment of others’ points of view, counterarguments, challenges and justification (Abelson et al, 2003; Dorr Goold et al, 2012). Questionnaires, panel summaries and panel transcripts were used to evaluate how individual participants and the group reasoned as they came to policy conclusions.

### ***Data management and analysis***

Quantitative questionnaire data was managed and analyzed in Microsoft Excel. All qualitative data were handled in QSR NVivo 11 including the qualitative questionnaire responses, panel summaries and audio recordings. Before the two sampled audio recordings were uploaded onto NVivo 11, they were transcribed using Nuance Dragon Scribe software. A ‘denaturalized’ transcript was produced in which grammatical errors were corrected and sounds or words that did not contribute to the primary message were removed in order to capture the fundamental meaning behind the statements (Oliver et al, 2005).

Qualitative data analysis was approached in phases according to Feredey & Muir-Cochrane’s (2006) method for demonstrating rigour in thematic analysis. The elements of the deliberative process outlined in the analytical framework were addressed one at a time. All questionnaire responses relevant to elements and sub-questions in the analytical framework were included in the analysis as well as all panel summary and transcript data. Themes corresponding to each element were defined and described in the codebook for easy reference and in order to maintain consistency. Finally, coded themes were refined through constant comparison techniques (Tuckett, 2005). This process involved validating and triangulating themes across multiple data sources in a recursive manner (Braun & Clarke, 2006).

The qualitative nature of thematic analysis makes peer checking of inter-coder reliability difficult, and has engendered skepticism in the literature about its value. Instead, the principal author maintained a personal research journal documenting research decisions and thought processes as a practical way of improving rigour (Barbour, 2001).

## **Results**

### ***Representativeness***

Overall, the participants had a positive view about the representativeness of the citizen panels and scored this item an average of 6.3 out of 7 (SD = 1.2). Participants identified strengths of the panels as well as potential areas for improvement through comments about the diversity of demographic perspectives and opinions. The roles of citizen and consumer were occupied during the panels as participants deliberated.

### ***Diversity of demographic perspectives***

Demographic data (Table 3) and questionnaire responses showed that the panels were mostly representative but the perspectives of some key populations may have been under-recruited. Several participants offered their thoughts about the lack of age and ethnocultural diversity (Table 4). One participant felt that it might be beneficial to “include some younger people, to get their views.” When speaking about the responsiveness of the health system, another participant stated:

“Young people are going to be dealing with how the system needs to change to support all these people becoming seniors. It would be good to get more young people's input on their expectations.”

Several participants also felt that “more cultures should be represented.” In a panel about Improving Care and Support for Unpaid Caregivers in Ontario, one participant stated:

“No visible minority representation which for this topic is important due to culture and languages is important.”

Generally, these views are substantiated by the demographic data. Some of the perspective imbalances can be attributed to the recruiting tool. Those registered for the AskingCanadians™ panel are mostly middle to older aged, Canadian adults.

Though they were not included in the panels, some participants suggested “it would’ve been nice to hear the perspectives of professionals who have expertise in this field.” One participant also noted that by including a policymaker, the panel members might develop a more thorough understanding of the decision-making process and what it might take to overcome a health system challenge.

#### *Diversity of opinions*

Some participants noted the value of having a diversity of opinions on the panels. One participant noted that it was “enlightening to hear others’ experiences,” and another participant stated “that everyone [was] unique and the personal experience was educational and eye opening.” The fact that each participant had “gone through something” and had stories to tell from their prior interactions with the health system was an influential characteristic of the deliberations.

#### *Participant roles*

Participants mostly occupied the roles of citizen and consumer during the citizen panels. However, they were not assigned to these roles explicitly. As demonstrated in both

the palliative care and nutrition panel transcripts, the facilitators asked participants to give some introductory information and describe why they chose to participate. As participants introduced themselves, many participants took on the identity of a patient or caregiver. Over the course of the deliberation event, the large majority of participants inhabited the role of consumer when documenting their experiences. When discussing palliative care, one participant stated:

“My mom is aging and I’ve watched my in-law pass from cancer, so it’s about trying to get myself in better health as I get older.”

In this quotation, the participant shows a progression of identities from family member of affected patient to being a patient themselves. It is also interesting to note that roles often changed throughout the discourse. One participant spoke about his experience as a stroke victim in the introduction to the group. Then, changed his lens in response to a question about how to define palliative care: “that’s the general consensus.” This type of dynamic role occupation was common in the panels.

### ***Information supports***

When asked about how helpful the citizen brief was in informing the citizen panels, participants scored this item an average of 6.5 out of 7 (SD=0.880). Participants had comments about its comprehensiveness, its credibility, the quality of the research evidence, and the brief development and review process.

### ***Comprehensiveness***

Many participants called (in the open-ended responses part of the questionnaire) for the briefs to provide a more comprehensive description of the health system issue. Some



participants thought that comparisons between jurisdictions would be helpful to present the full scope of the problem and potential solutions:

“The brief could describe how other provinces and countries have, are or are planning to deal with the issue. The brief could show how similar or differently the issue manifests itself in other jurisdictions.”

Cost was another theme that emerged during analysis as a potential source of data. Some participants called for “some considerations of relative costs of option” to make a more informed judgment about the policy options proposed, including the feasibility and potential tradeoffs regarding the allocation of scarce resources.

### *Credibility*

A few participants commented about the credibility of the information presented in the citizen briefs. The credibility of the information materials was generally deemed to be adequate as one participant noted:

“No improvement. It's great to have the research to show what does not work. You do not believe a certain thing will help, and the research was supplied to prove it. Less chance of wasted efforts on going with a plan that's proven ineffective.”

This comment illustrates that the participant believed that the options presented were trustworthy. In a panel on palliative care one participant said that the brief “[presented] the most recent evidence that has [proven], successful outcomes when implementing a strategy for talking about end of life care.”

### *Quality of research evidence*

When asked about how helpful it was to include the quality of how research was conducted, participants scored this item an average of 5.8 out of 7 (SD=1.22). A few

participants valued how up-to-date the information was and how the research team outlined the ‘quality’ of the evidence. However, others suggested that this was not necessary:

“Skip the ‘low quality review’ and just say what you want to say without quantifying it - perhaps have an appendix where people can pursue the rest if they wish.”

### *Citizen brief development*

Some participants raised questions in their questionnaire responses about who chooses the information, where it comes from and what the development process looks like. When asked about this process in the questionnaires, participants scored it an average of 5.5 out of 7 (SD=1.38). One participant asked “Who picked these options? Are they the best?” Another asked if it were possible to explain how the three options were chosen as the option to discuss. It was also unclear to participants what the contributions of the reviewers were. One participant questioned: “Who decides their quality?” Transparency emerged as a constant theme from these statements. A transparent process adds credibility to the information supports and improves the legitimacy of the process.

### *Procedural criteria*

The third element of the framework evaluated was the procedural criteria through features that appeared in the data sources such as: consensus, equal participation, facilitation, mutual respect, participant engagement, and participant comments about the structure of the citizen panels.

### *Consensus*

Consensus is not an explicit goal of the McMaster Health Forum citizen panels. Rather, the aim is to find both common ground and differences of opinion. To help quantify

what this objective might look like in practice, one participant suggested a target percentage: “if you can achieve a 75% agreement in a diverse panel that is achievement of a goal.” As noted in the representativeness analysis, participants had diverse opinions on a topic, yet they “were able to find common ground on many points.” Overall, participants valued how “the citizen panel aimed to find both common ground and difference for opinions” and scored the item an average score of 6.7 out of 7 (SD=0.53).

### *Equal participation*

Some participants noted that there was room for improvement in terms of equal participation but that generally “everyone who had a chance to give his or her opinion.” Simply recording the number of times each participant talks does not account for the quality of the contribution. Offering an opinion, however, denotes a deeper level of reasoning. Contrarily, some participants noted that there “were times that were too many voices” but the participant conceded this observation as a reality of the process. One participant noted that:

“The ground rules should be stronger to prevent the same people always talking and get equal airtime. (When we run studies we use that phrase "equal airtime").”

This comments speaks to the expectations set prior to the deliberation sessions about how participants should engage with the group.

### *Facilitation*

Upon analyzing the data it became clear that good facilitation is a matter of subtle but clear direction of the conversation. One participant noted that: “the moderator gave us

leeway to venture past the original guidelines to further explore other ideas.” Here is an illustrative exchange between a participant and facilitator:

P: “Some people are more shy than others and aren’t quick to jump in.”

F: “We’ll help with that and make sure that everyone has an equal opportunity to contribute but if you can keep that in mind yourselves.”

The facilitator encouraged reluctant participants to speak while reminding all participants that this responsibility also falls on them.

### *Mutual respect*

It is also the facilitator’s duty to encourage respect and this is demonstrated through this quotation:

F: “I encourage you to just think about the following as you listen to each other: that you will be respectful of each other. Each of us has something to say. There aren't right or wrong answers. This is about sharing your opinions review even your values about this topic area.”

Mutual respect between participants makes constructive interaction possible even with those whom one potentially disagrees (Guttman & Thompson, 2004). In this example above, the facilitator acknowledges that deliberation will involve tradeoffs and a discussion of values but that it is important to remain open to the views of others. Overall, the participants scored the facilitators’ ability to assist discussion highly at an average of 6.9 out of 7 (SD=0.37).

### *Participant engagement*

A reliable sign of engagement is the acknowledgement of one another’s deliberative contributions. In the questionnaires, a few participants noted that “people did not try to overpower the views of others.” They reinforced each other’s positions. In other instances, participants asked each other questions in order to achieve a better understanding:

P1: “What’s dictionary definition of palliative care?”

P2: “What’s the difference between palliative care and hospice?”

P3: “It says here that palliative care is a type of specialized care. In terms of quality of life...it includes four components: pain management, symptom management, social, emotional, spiritual and psychological support.”

This interaction between participants demonstrates the process of knowledge acquisition.

The second participant verifies the question and moves the conversation to a deeper understanding of the terms. The third participant then refers to the citizen brief as an evidence source to clarify the definition.

### *Citizen panel structure*

The procedures used in the citizen panels at the Forum differ from other deliberative methods in several key aspects and participants highlighted these differences in their questionnaire responses. One participant noted that “it would’ve been nice to have a larger group of people to discuss the problem.” Another suggested that a 20-citizen group might be ideal. Many participants also proposed extending the citizen panels so that they take place “over 2 or 3 days,” and “potentially looking at having [a] longer time frame for more in depth discussion.” Indeed, collective decisions are difficult to finalize quickly according to one respondent: “this is not an overnight consensus, it should last more than one day.”

### ***Reasoning***

Participants incorporated a discussion of their values, knowledge about the policy option, and the diverse views of their fellow panel members as they reasoned in coming to decisions about the policy options to address the health system issue (Table 4). This excerpt

from a complex cancer care surgery panel summary demonstrates how diverse views, values and knowledge came together in the process of collective decision-making:

Participants debated whether [this] option allowed greater patient choice...improving the delivery of complex cancer surgeries where they are now being provided (including in low-volume hospitals) would allow greater patient choice... ideally, patients should be able to choose among all possible treatment options. Many participants disagreed with this opinion. They argued that investing efforts to improve the delivery of complex cancer surgeries in low-volume hospitals may broaden the treatment options available locally, but at the expense of patients having to choose among sub-optimal treatment options. One participant went further... improving the delivery of complex cancer surgeries in low-volume hospitals could actually remove the possibility of patients choosing the optimal treatment option: undergoing complex cancer surgery in a regional surgical centre of excellence where there is a concentration of expertise and the potential for the best possible health outcomes.”

Participants were asked to consider what values might be influencing their views about quality improvement initiatives in low-volume hospitals. In this example, participants wrestled with individualism and access to care. Localizing services in low-volume hospitals allows for more patient choice, however this comes at a potential cost in quality.

Participants engaged in exchanges, corrected one another and sorted through the information presented in coming to a common and correct understanding of the issues at hand, a debate that was borne out of a diversity of opinion. Further, evidence of participant understanding is found in the ability to make distinctions important to health-system policy. In the example above, one participant confirms that concentrating care in centres of excellence can contribute to more positive health outcomes. However, in coming to these conclusions, only a few participants referenced the research evidence from the information supports directly to demonstrate how it influenced their positions.

## **Discussion**

### *Principal findings*

The McMaster Health Forum implements many of the core elements theorized for ‘good’ public deliberation processes. At the same time, comments from the participants highlight some potential areas for improvement. Participants were generally satisfied with the representativeness of the panels. The responses from participants allude to the fact that a diversity of demographic perspectives and opinions can lead to a fuller, more informed discourse. Some participants suggested including health professionals and policymakers, thus shifting away from a consultative approach to a participatory approach in which panels facilitate a two-way information exchange and increase mutual learning between non-expert and expert (Boivin et al, 2014; Lehoux et al, 2014). The information supports were generally viewed favourably by participants, albeit with some questions about comparable jurisdictions and costs. A few participants made positive comments about the credibility of the information presented in the brief, but some participants wanted to know who chose the information and what the review process entailed and who was involved. Presenting this information to participants would enhance the transparency of the brief development process. Many participants had positive things to say about procedures such as the openness of the discussion, panel facilitation, equal participation and engagement. Some even suggested adding more participants and extending the length of the sessions. Finally, through the analysis it was clear that the McMaster Health Forum facilitates values-based reasoning by encouraging participants to consider the values related to the issue, the types of evidence and knowledge informing debate and their fellow participants’ diverse perspectives and opinions.

*Strengths and weaknesses of the study*

This study had two major strengths. First, multiple data sources were used to analyze the case, which helps to ensure insights drawn could be confirmed (or disconfirmed) and that there were opportunities to triangulate results as they emerged. Second, the use an analytical framework, informed by relevant concepts and theory, helped to ensure that there was consistency throughout the analysis and that the account of the public deliberation initiative was detailed, comprehensive and cohesive.

This study also had two major limitations. The first was that the lead author (TD), was not involved in the development of the items in the questionnaires. Therefore, the goals of this evaluation do not necessarily match up with the goals of those who originally designed the items. Secondly, of the over 20 panels completed, only 2 were sampled for transcription analysis of representativeness, the procedural criteria and reasoning. Therefore, it is possible that additional themes were missed or that themes emerging from these transcripts would not be found in others.

*Findings in relation to other studies*

The findings highlight the difference in the way that participant roles are defined between the McMaster Health Forum and other approaches in the literature. The Forum was not explicit about assigning the role of citizen or consumer to the participants during deliberation, however both of these roles were occupied during deliberation. The rationale for involving citizens rather than consumers is to introduce a fresh and objective perspective that is supposed to be apolitical (Degeling et al, 2015). The role prescribed for citizens is to draw on some broader notion of the public good (Charles & DeMaio, 1993). In this way,



citizens are expected to contribute legitimacy to policy discussions, and, potentially, greater consistency with democratic principles (Street et al, 2014). Some would argue that this is the most desirable methodology and result from public deliberation (Martin, 2008). In contrast, consumers with diverse, practical experiences may voice different priorities and alternate courses of action that have the potential to improve decision-making and health system functioning in ways that may not otherwise emerge (Krinks et al, 2015). The aim of deliberations such as those held by the McMaster Health Forum’s citizen panels is both to produce decisions that better reflect democratic principles, and to generate and refine a discrete set of positions. As such, the unique experiences of regular citizens as well as patients, caregivers and other consumer groups are invaluable in making judgments about policy options and defining the roles in this way helps demonstrate this link.

This evaluation acknowledges the work of other public deliberation scholars in describing reasoning as a multifaceted process. Because values and knowledge are different but interrelated ways of reasoning, public deliberation initiatives and evaluations need to emphasize a process that encourages both (Lehoux et al, 2009). This paper recognizes that participants act on their own values and knowledge and the McMaster Health Forum’s citizen panels encourage ways of reasoning that harness a participant’s desire to express their values and practically evaluate the expected intervention effects. Convening panels with a broad set of perspectives and opinions also set the foundation for effective reasoning. Evans and Plows (2007) suggest that deliberations with diverse participants help to increase the quality of decision-making because a greater scope of knowledge claims and opinions better inform policy and show participants’ heterogeneous stances toward the same policy problem.

*Meaning of the study*

There is a paucity of rigorous studies evaluating different methods of public deliberation and much work remains to be done in establishing general principles for evaluation criteria (Abelson et al, 2003; Cox et al, 2009). The substantive contributions of this study are the insights from an empirical evaluation of the implementation of a deliberative program and a framework for assessing the key elements of the public deliberation process. As deliberative methods become a more commonly used approach for incorporating citizen perspectives into decision-making, there will be an increased need to study these exercises with a robust yet simple framework.

*Unanswered questions and future research*

By focusing on four key elements of the process, this study sheds light on the implementation of deliberative methods, however, there is also a need to determine the effectiveness of alternative deliberation methods. There are two areas for future inquiry related to effectiveness. First, there is a need to study the impact of public deliberation methods on participants. The McMaster Health Forum has collected information about the ways in which participants’ knowledge and attitudes are affected by deliberation and future studies can evaluate this data. Secondly, future research can assess impact that representative, informed and reason-based public deliberation has on the decisions made by policymakers and, ultimately, its impact on policy.

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Table 1. Description of the McMaster Health Forum citizen panel process

Phase	Description
Planning process	Steering committee comprised of three to five policymakers, stakeholders and researchers - The committee meets by teleconference every two to four weeks to provide input on the terms of reference for the plain-language brief (citizen brief), drafts of the citizen brief, the plan for the overall approach (i.e., the composition of the panels, recruitment and selection process, agenda, and supporting documentation for the citizen panel), and drafts of the panel summary.
Pre-consultations	Twenty-to-thirty minute telephone conversations with 10-20 key informants (i.e., policymakers, stakeholders, and researchers) to inform the design of the panels and supporting materials - Key informants are identified by the steering committee, informed by a stakeholder-mapping exercise. The key informants contribute to the refinement of the terms of reference in three ways: 1) provide input on the issues covered in the terms of reference; 2) suggest sources of data and/or evidence about the issues covered in the terms of reference; and 3) suggest potential sources of invitees if the desired characteristics are rare (e.g., lived experience with a rare condition).
Recruitment	Panels composed of approximately 10-16 citizens who have been or are likely to be affected by a pressing health issue or by future decisions regarding the issue and registered with the AskingCanadians™ panel - The panel may be composed of “healthy” volunteers, volunteers with lived experiences with the issue (e.g., patients / services users, family members and caregivers) or both. The recruitment and selection strategy for each panel is tailored to the nature of the issue and the desired ‘level’ of deliberation (e.g., local, provincial or national).
Citizen briefs and panels	One to two weeks before each panel, the citizen brief – consisting of a description of a health-system problem, policy options for addressing it, and implementation considerations – is circulated to panel participants. Participants are convened for a one-day meeting to deliberate about the health-system issue. Mornings are spent discussing the problem and afternoons are used to deliberate about policy options and implementation considerations.
Disseminating materials	Inputs to and findings from each panel – the citizen brief, the panel summary and a topic overview summarizing the issue and the findings – are posted on the McMaster Health Forum’s website ( <a href="http://www.mcmasterhealthforum.org">www.mcmasterhealthforum.org</a> ) and disseminated electronically to all panel participants, steering committee members, and key policymakers and stakeholders.

Table 2. Analytical framework for evaluating the citizen panel process

Public deliberation element	Questions asked	Data sources used
Representativeness of the participants	<ul style="list-style-type: none"> <li>- Did the citizen panels achieve diversity of demographic perspectives and diversity of opinions?</li> <li>- Was the right 'public' engaged in the public deliberation (i.e., citizen, consumer, advocate)?</li> </ul>	Questionnaires, panel summaries, panel audio transcripts
Information supports provided to participants	<ul style="list-style-type: none"> <li>- Were the information supports accessible, accurate, comprehensive, credible, trustworthy, independent, readable and sufficient?</li> <li>- Who chooses the information and what does the selection process look like?</li> </ul>	Questionnaires
Procedural criteria used	- Did the public deliberation foster equal participation, strong facilitation, legitimacy, mutual respect and participant engagement?	Questionnaires, panel audio transcripts
Focus on explicit reasoning in coming to conclusions	<ul style="list-style-type: none"> <li>- How were values expressed?</li> <li>- How was knowledge applied?</li> <li>- Did participants debate and challenge one another in coming to conclusions?</li> </ul>	Panel summaries, panel audio transcripts



Table 3. Demographic data for all panels ( $n=19$ )

Characteristics	<i>n</i>	%
<b>Age (n = 199)</b>		
18-24	8	4%
25-44	28	14%
45-64	91	46%
65+	72	36%
<b>Gender (n = 197)</b>		
Women	101	51%
Men	96	49%
<b>Ethnic background (n = 188)</b>		
Canadian (excluding next row)	129	69%
First Nations, Inuit, Metis	9	5%
European	24	13%
Asian	9	5%
South-Asian	7	4%
West-Indian/Caribbean	2	1%
African	0	0%
Other	8	4%
<b>Education level (n = 195)</b>		
No schooling	0	0%
Elementary school	8	4%
High school	36	18%
Community college	47	24%
Technical school	17	9%
Bachelor's degree/post-graduate training /professional degree	72	37%
Post-graduate training	15	8%
<b>Work status (n = 192)</b>		
Self-employed	16	8%
Full-time	57	30%
Part-time	14	7%
Unemployed	5	3%
Retired	81	42%
Student	3	2%
Homemakers	3	2%
Disabled	13	7%
<b>Income level (n = 198)</b>		
Less than \$20,000	29	15%
Between \$20 - \$40,000	52	26%
Between \$40 - \$60,000	44	22%
Between \$60 - \$80,000	25	13%
More than \$80,000	25	13%
Prefer not to answer	23	12%

Table 4. Key findings derived from evaluations of the citizen panel process

Public deliberation elements	How element was implemented	Strengths	Potential areas for improvement
Representativeness of the participants	<ul style="list-style-type: none"> <li>Recruited affected members of the public through the AskingCanadians™ panel</li> </ul>	<ul style="list-style-type: none"> <li>Gender parity was achieved</li> <li>Unique opinions related to personal experiences</li> <li>Participants occupied the role of consumer</li> </ul>	<ul style="list-style-type: none"> <li>Strive for greater age and ethnocultural diversity</li> <li>Include health professionals and/or policymakers</li> <li>Explicitly assign roles to participants</li> </ul>
Information supports provided to participants	<ul style="list-style-type: none"> <li>Citizen brief, which was distributed to participants before attending the panel deliberations, described the health-system problem, policy options for addressing it, and implementation considerations</li> </ul>	<ul style="list-style-type: none"> <li>Information was credible and trustworthy</li> </ul>	<ul style="list-style-type: none"> <li>Include more information about comparator jurisdictions and costs</li> <li>Enhance transparency about the citizen brief development</li> </ul>
Procedural criteria used	<ul style="list-style-type: none"> <li>Panels included a facilitator and aimed to identify both common ground and difference of opinions</li> </ul>	<ul style="list-style-type: none"> <li>Openness of discussion</li> <li>Facilitators encouraged deeper exploration of ideas and supported mutual respect</li> <li>Participants reinforced each other's positions</li> </ul>	<ul style="list-style-type: none"> <li>Include clearer expectations in terms of consensus and participation opportunities</li> <li>Increase citizen panel size</li> <li>Lengthen citizen panel sessions</li> </ul>
Focus on explicit reasoning in	<ul style="list-style-type: none"> <li>Participants were asked to offer their views about the policy options to address the health-system issue</li> </ul>	<ul style="list-style-type: none"> <li>Participants were prompted to consider how and which values influenced their positions</li> </ul>	<ul style="list-style-type: none"> <li>Encourage participants to consider how and</li> </ul>

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coming to  
conclusions

- Participants showed willingness to embrace their diversity and challenge one another by exchanging knowledge in coming to a deeper understanding how the policy options could address the health-system issues

which research  
evidence influenced  
their positions

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