Author's response to reviews

Title: General practitioner's clinical practices, difficulties and educational needs to manage Alzheimer's disease in France: analysis of national telephone-inquiry data

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Author's response to reviews: see over
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Dear Dr Hanna Kaduszki ewicz,

We would like to thank the Reviewers and the Editorial Board members of BMC Family Practice for reviewing our manuscript (MS: 5737414298442295) now entitled, General practitioner’s clinical practices, difficulties and educational needs to manage Alzheimer’s disease in France: analysis of national telephone-inquiry data, by D. Somme, A. Gautier, S. Pihl and A. Corvol. Their comments led us to revise the manuscript extensively and, hopefully, improve its clarity and message.

Please find below our detailed responses to the Reviewers.

Reviewer 1

We appreciate the Reviewer’s interest and careful methodological assessment that has helped us specify and improve the methodology reported.

1) collected primarily by pharmaceutical companies’ representatives… unusual way of recruitment; has to be explained

A private database was chosen because its daily updating is more reliable than those of other French GPs' public databases, like ADELI or SNIR national files, as now explained in the text (page 5, paragraph 2 of “Modalities of respondent selection”)

2) GPs participating fully in the inquiry were compensated. Which compensation? Paid by whom?

GPs completing the 25-min inquiry received 30€ from the polling institute INPES. This sum corresponds to 1.5 x the nationally standardized consultation fee. A sentence has been inserted in the text (page 6, last sentence before “Inquiry duration”).

3) Health Barometer is not explained; what other modules were asked beside the dementia module? This is important for the appraisal of possible context effects within the questionnaire/between the items.

We explained “Health Barometer”, by adding (page 5, first paragraph): “Many different topics were broached in this inquiry, e.g., screening for viral hepatitis, HIV or cancers, vaccination practices, addiction management and therapeutic patient education.”
4) with the AD module questions being posed only to about half the GPs selected randomly. “Please give a flowchart with the number of GPs selected FOR THE AD MODULE as the base population (not all selected GPs) and the numbers of these GPs who responded/not responded (with reasons). It must be possible to calculate a response rate for those who were a priori selected for the AD module.

Unfortunately, it is not possible to provide a flowchart with the number of GPs selected for the AD module as the base population, because GPs were assigned to the different modules only after they had accepted to participate in the inquiry. To improve clarity, we reversed the order of Tables 1 and 2, reporting the comparisons between our population sample and national databases first for demographic characteristics, and then the GPs’ characteristics according to their AD patient-load second, respectively. Pertinently, AD module respondents did not differ from those of the entire GP population.

5) This questionnaire was created by a working group composed of experts in public health, specialists (neurologists, geriatricians), representatives of family associations and institutions. There is no expertise in general practice included in the construction of a questionnaire about general practice? This is a major methodological shortcoming, as members of the later target population have to be included.

GPs contributed to building the questionnaire; they read the final version and all their comments were considered to correct the first draft. Their participation has been reported in the text (page 7, first sentence of “The AD module”).

6) The items of the questionnaire as well as its development are not reported in adequate detail. Why and how were these questions selected? Please report the questions and response categories (if given) as well as the items’ underlying theoretical constructs. How were the questions pretested/piloted?

We chose to not translate the whole questionnaire because we do not think that all the questions are necessary to understand our purpose. The questionnaire was pretested on voluntary GPs and modified, based on their remarks, by excluding, rewriting or clarifying poorly understood questions. However, it seems difficult to detail the entire process of questionnaire construction in this article.

7) Confusion arises regarding two paragraphs: a) identifying their attitudes, difficulties and educational needs to manage AD and b) The second and third theme referred to the doctor’s attitudes either in his/her clinical practice (e.g., the use of tests and the frequency of disclosing the diagnosis to the patient and his/her entourage) or in his/her relationship with patients or in the management of different aspects of AD (e.g., comorbidities, coordination of care, information about available social assistance and the management of behavioral disorders). The
fourth and last item was the GP’s self-perception of his/her level of training concerning certain aspects of managing AD patients: communication with the patient, communication with the family, announcing the diagnosis and non-drug treatments of the disease. A table would be very helpful which clearly explains the connection of construct and item, including the following columns: Construct (i.e. attitudes, difficulties, educational needs), theme (e.g. test use), question, response options. Furthermore, it is not clear what attitudes are measured, as the examples in the text are not intuitive and refer more to practice than attitude (e.g. “use of tests and the frequency of disclosing the diagnosis to the patient and his/her entourage” are practice, not attitude). There is confusion in the text as the terms “items” and “themes” are intermixed.

It seems that the concept of attitude, as we had used it, was ambiguous and misleading. To clarify our construct, we decided to use the expression “declared clinical practices”, that is clearly different from difficulties, knowledge and self-estimated training needs. Therefore, the confusing terms in “the AD module” have been changed (page 7–8, paragraph 2 of “The AD module”): The first item concerned professional activities: the number of AD patients among the GP’s clientele. The second referred to the doctor’s clinical practices (e.g. the use of tests and the frequency of disclosing the diagnosis to the patient and his/her entourage). The third concerned his/her difficulties in relationship with patients or in the management of different aspects of AD (e.g., comorbidities, coordination of care, information about available social assistance and the management of behavioral disorders). The fourth and last item was the GP’s self-perception of his/her level of training.

8) The multivariate analyses should be explained in much more detail and more structured: which analyses were made (regression? ANOVA?), with which dependent variables and which independent variables? Tables 3 and 4 should include declarations of the multivariate analysis method and of course p values for single variables.

The multivariate analysis method is a logistic regression (page 8–9, paragraph 3 of “Statistical analyses”). We changed the notes to Tables 3 and 4, and specified dependent and independent variables as well as p values.

9) In the text it is said that frequent disclosure of the diagnosis and test use are indicators of good quality care. This is debatable. Please cite evidence for that! And also cite general practice literature contributing to this debate.

We considered diagnosis disclosure to the patient and use of clinical tests for AD diagnosis as indicators of good quality care, because these practices are recommended in French national guidelines. We agree with the Reviewer that this is debatable. However, we think that this discussion is beyond the scope of our article.

Reviewer 2
We thank the Reviewer for her accurate evaluation and valuable suggestions. They led us to an in-depth revision of our manuscript. We deleted the ambiguous concept of "attitudes" replacing it with the more concrete term of "declared clinical practices". We also deleted the term "education score" and replaced it with "self-estimated training needs". We have revised the paper as follows.

We changed the title to: General practitioner's clinical practices, difficulties and educational needs to manage Alzheimer's disease in France: analysis of national telephone-inquiry data.

1) Abstract, conclusions: I do not agree with the conclusion that the results (not the results but the survey?) "identified and prioritized the educational needs of French GPs", because the pre-set statements of the survey regarding education were restricted to communication and noncure treatments.

We changed the Abstract conclusion as follows: Our study identified "gaps in French GP training concerning Alzheimer disease diagnosis practices and diagnosis announcement. GPs seemed aware of their educational needs and described difficulties in managing behavioral disorders. Our findings enabled the definition of policy priorities to provide training and disseminate information.

2) "Table 1: An important information from this table is not described in the text. To my view it is the fact that GPs with no AD patients tend to be young, female, have small practices with a small patient load, more partial fee reimbursement, more alternative medicine techniques and working fewer days in office. This can be discussed against the background of the feminization of medicine and the trend within GP to narrow the spectrum of treated patients."

In response to the Reviewer's comment concerning the newly numbered Table 2 (previously Table 1) (characteristics of interviewed GPs), we emphasized in the text (page 10, end of the first paragraph) that, Physicians not included because they declared no AD patients were more often women, with a lower patient load and part-time activity, more often practicing alternative medicine, and more of them received only partial fee reimbursement.

According to the comment concerning the table 4, we added in the text (page 10, paragraph "Declared practices of the interviewed GPs"): Male and younger GPs declared more often that they "usually" or "always" disclosed the diagnosis to the patient (Table 4).

3) "I doubt that "use of tests, disclosing the diagnosis to the patient, knowledge of the national recommendations, referrals..." are pure attitude indicators. They have very much to do with
Concerning the Results, we agree with the Reviewer’s view that the term “education score” was misleading. We replaced it with “self-perceived training.” Thus, we think that analyzing associations between self-perceived training and objective indicators of good quality practice, as declared, such as the use of diagnostic tests, diagnosis announcement or knowledge of the national guidelines is meaningful. The text has been modified as follows (page 11, head of the last paragraph): Association between GPs’ characteristics and their declared practices, difficulties and self-perceived training needs.

The influence of GPs’ characteristics on their declared practices, their knowledge of the national recommendations and their difficulties, was studied through a multivariate analyses, whose results are reported in Table 4. A significant association was found between GPs’ self-estimated training score and the probability of declaring the use of diagnostic tests, disclosing the diagnosis to the patient, claiming to be aware of the national recommendations, and having easily managed comorbidities, the coordination of assistance and behavioral disorders. For each of these items, the higher the score (i.e., the more the GP feels adequately trained to assure these roles), the greater the probability of responding yes is high. Inversely, the score was apparently not associated with systematic referral to a specialist or to medical-social resources.

4) Table 4: In this table there is important information, but the description of the results focuses on the educational score only. As mentioned above the educational score should be deleted and the other results highlighted, e.g.– Disclosing the diagnosis is associated with male and younger GPs,– Systematic referral to a specialist is associated with older GPs, and with GPs with a high patient load. GPs, who teach medical students less often refer to specialists etc. Are all the single analyses controlled for all other GP characteristics? So that we know that it is really the older GPs irrespective of their gender who tend not to disclose? Also, please delete the headlines “Clinical practice attitudes” or “Health system attitudes”, because they don’t match the activities summarized below, e.g. being aware of national guidelines will be partially due to attitudes, but also to education. Still table 4: “involved in educating the public”: 0767 should be corrected.

We indicated dependent and independent variables in Tables 3 and 4, and deleted “Clinical practice attitude” and “Health system attitudes” headings from Table 4.

5) Page 13: “The representative sample questioned in our study, not based on voluntary participation, probably explains that difference.” I may view the participation in your study was voluntary, too. Maybe the fact that the other physicians [reference 13] participated in a public health network explains the difference.
In response to the Reviewer’s suggestion, we deleted the comment on “voluntary participation”, and explained in the Discussion (page 12-13, last lines of the page 12 and first ones of the page 13): That all the approached doctors were GPs in France who were asked participate but could refuse to do so, as opposed to being volunteers who spontaneously proposed their participation, probably explains that difference in the representativeness of the sample questioned.

We clarified the Discussion, about referral rate (page 14, end of the second paragraph of “Orient at i on for assistance and awareness of national recommendations”): This particular organization, with neurologists in private practice, led experts to qualify our system as competitive [34] and, in their opinion, could make GPs reluctant to refer their patients. Thus, the high-observed referral rate could in fact indicate a low degree of competition concerning dementia patients.

The lack of GPs’ information on available social services, judged in other contexts as the major impedence to their good use [4], does not seem, for our study, to explain the insufficient referral to these services. Some GPs considered them selves sufficiently informed but still had trouble organizing medical-social-assistance services."

6) Page 16: “W e are not aware of another study exploring the aspects on which we focused.”
There are more studies. Please see as an example: Kaduszkiewicz H, Wiese B, van den Bussche H. Self-reported competence, attitude and approach of physicians towards patients with dementia in ambulatory care: results of a postal survey. BMC Heal t h Serv Res. 2008 Mar 6; 8: 54. doi: 10.1186/1472-6963-8-54. Here you also find a theoretical framework which you could use to arrange your results.

We thank the Reviewer for suggesting this relevant article. We took those results into account in the Discussion (page 16, second paragraph): These results confirm that GPs seem to be aware of their level of competence and educational needs for AD management, as shown in a German study [41]. Our univariate analysis showed, as did Kaduszkiewicz et al’s study, that the feeling of being insufficiently trained was associated with less use of diagnostic tests. It was also associated, in our study, with a lower rate of AD-diagnosis disclosure and poorer awareness of the national recommendations, but not with referral practices.

7) In the Discussion I miss a reflection of socially desired answers and of the known gender bias in self-perception of being insufficiently trained.

To respond to the Reviewer’s remark, we added comments on gender bias in self-estimated competence and the social desirability response bias in the Discussion (page 16, end of the second paragraph). In particular, a gender bias in self-estimated competence, with lower competence estimates by female physicians, has previously been described [42]. The observed correlation between self-perceived training needs and declared clinical practices
can also be questioned, as these practices were not directly observed but only reported by the GPs. Some of them may have overestimated their training and declared better practices because of a social desirability response bias [43]. Only direct examination of GPs's knowledge and practices, which is beyond the scope of our study, could eliminate such a bias. However, this bias could only lead to an overestimation of good practices and an underestimation of educational needs, and, thus, would not change our conclusions concerning educational needs.

Minor Compulsory revisions:

Page 6: “Every phone number was called 20 times, and the interviewer let it ring 5 times.” I was surprised about letting the telephone ring 5 times. This seems fairly short to me. In my view 1 minute or 10 times are needed to give the other person the chance to answer the phone.

Concerning the phoning procedure, we hope that the number of calls (20) compensated for the short waiting time (5 rings). We cannot change what was done, and it seems important to describe our methods precisely, to allow criticism.

Page 7: „The questionnaire was created by... representatives of family associations... ” Do you mean family physicians/GPs? Were GPs involved in creating the questionnaire?

GPs were involved in the elaboration of the questionnaire, and this point has been corrected.

I would be happy to see a list of the original survey questions referring to the management of Alzheimer's disease (in English) in an appendix.

Please accept our apologies but in the time and budget constraints we did not have the opportunity to translate in English the AD module of the questionnaire. Despite the interest of this document to embrace the whole process of the research background, we think that it was not essential for the understanding of our purpose.

We hope we have replied adequately to the Reviewers’ concerns. We appreciate the opportunity to more clearly express ourselves in the manuscript and to provide a more rigorous report on our work. We look forward to hearing from you.

Yours Sincerely,
Dr. Dominique Somme