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

Authors:

Dominique Somme (dominique.somme@chu-rennes.fr)
Arnaud Gautier (arnaud.gautier@inpes.sante.fr)
Stéphanie Pin (stephanie.pin@inpes.sante.fr)
Aline Corvol (aline.corvol@dzne.de)

Version: 4 Date: 24 May 2013

Author's response to reviews: see over
Reviewer: Michael Pentzek

Reviewer’s report:

The authors have done good work, but in my opinion some shortcomings still preclude the article from publication.

**COMMENT:** 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.

>>> I think at least the four items of the AD module including the response options have to be presented in an appendix. If the process of questionnaire development has not been published yet, there should be more details on that.

**ANSWER:** As suggested we added an appendix with the items of the AD module with the response options and we made a reference to the complete questionnaire published as a book in French. We added this sentence p5: “The complete methodology and the whole questionnaire were previously published [8]”

**COMMENT:** The multivariate analyses should be explained in much more detail and more structured: which analyses were made (regression? ANOVA?), with which dependent variable 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.

>>> The logistic regression method is not mentioned in the Methods section. In the Results section, there are important quality parameters on the regression model missing: appropriateness of the regression model according to the Hosmer-Lemeshow test and explained variance according to Nagelkerke R².

**ANSWER:** As suggested we re-wrote the statistical method section concerning multivariate analysis and give the asked quality indicator in the table (we just want to stressed that our
purpose is more on descriptive statistics than predictive model and thus that these parameters are less important in this approach).

The statistical method section concerning multivariate analysis (p9) is now:

“For multivariate analyses, we used a binary logistic regression. In one first logistic regression analysis the dependent variable was to feel insufficiently trained for any 1 or more themes. Secondly, in a series of multivariate analysis, the dependant variable were respectively (all dimensions considered tested independently) : use of diagnostic tests; diagnosis disclosure; referral to a specialist; patients/families orientation towards assistance or home care; awareness of the national AD recommendations; comorbidities management; easy coordination of care; easy management of behavioral disorders. The independent variables were the same for both and were all the available characteristics of the interviewed physician. The results obtained are expressed as odds ratios (OR) [95% confidence interval (CI)]. All statistical analyses were computed with Stata V10.SE software. We used Hosmer Lesmeshow test and R² Nagelkerke as quality indicator of our multivariate analyses.”

**COMMENT:** 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.

>>> I cannot accept this explanation. First, this is an international journal, and not all readers are common with or agree with the French guidelines (btw: are these GP guidelines or specialist guidelines which recommend disclosure and testing?). Second, this is a Family Practice journal, and the family practice perspective has to be included in an article on family physicians. So, I would strongly suggest to critically reflect these „indicators of good quality care” and to include an explicit paragraph on this problem in the Discussion section.

**ANSWER:** As suggested, we strengthened the critical perspectives on disclosure process highlightening the scarcity of Family Physician perspective on this quality indicator (p13). with the paragraph : “The French guidelines for patients with Alzheimer’s disease, addressed to all medical practitioners, including family physicians, considered the diagnosis disclosure as an indicator of the quality of care. It could be debatable considering that most of the literature [17-24] on this subject examines the perspectives of patients or specialists, but very little is known about family physicians’ perspectives.”
Considering the test we considered that the paragraph already written, have a strong critical perspective as we stated: "Other more rapid tests that current guidelines recommend are still not widely disseminated [14]. This finding should also be viewed in the context of the time constraints during office consultations [3, 4]. Thus, more widespread diffusion of the recommended rapid cognition tests (5-word test, verbal fluency test, clock test, 7-minute test, etc...) seems desirable. Acceptance of these tests by primary-care physicians should be a research priority, to finally retain one or several tests the most compatible with their medical practices.”

**Reviewer: Hanna Kaduszkiewicz**

Reviewer's report:

Thank you for the revised version of the manuscript. The paper has noticeably gained clarity.

Major compulsory revisions

**COMMENT :** Methods, statistical analyses: The description of the first multivariate analysis is missing (which corresponds to the results in table 3 ... feeling insufficiently trained). And in the description of the second package of multivariate analyses the feeling of being insufficiently trained should be replaced by "the declared practices or difficulties according to general practitioners’ characteristics" (which corresponds to table 4).

**ANSWER :** As stated in answer to reviewer 1, we re-wrote the statistical method and hope that by this way we gained in clarity.

**COMMENT :** Table 4: I'm still not convinced that it makes sense to use the "level of training score" as an independent variable in the analyses presented in table 4. It still seems a tautology to me that for example the practice of (not) disclosing the diagnosis to patients is associated with the feeling of insufficient training in announcing the diagnosis and/or communicating with the patient.

Further: The score consists of four quite randomly chosen items (communication with the patient, the family, announcing the diagnosis and non-drug treatments). It doesn't help in understanding the practices of the GPs.

Therefore I highly recommend to remove the score from the analyses in table 4.

**ANSWER :** As suggested we completely remove the score from table 4, delete all the paragraphs that were linked with this analysis, in abstract, method, results and discussion and re-wrote a result and a discussion paragraph on table 4 without any mention of the score.
Results: “Most of the GPs’ characteristics did not show any statistical association with clinical practice or difficulties. We only noticed a significant association between male sex and self-sufficiency (less referral to specialist and social services) and self-assessment of their practice (more disclosure and more prone to declare to be aware of national guidelines, and to declare an easy management of comorbidities). The age of the GP also influenced practices: the older GPs tend to declare less disclosure of the diagnosis but more referral to a specialist or social services. The characteristics “GPs having a role as an educator” and “GPs with high patients load” have only a small negative influence on the probability of systematic referral to specialized care. GPs who are involved in educating the public declared more frequently being aware of national guidelines (but without any statistical difference in disclosing the diagnosis), and declared less difficulties in managing behavioral disorders. Finally, GPs participating in a network declared more frequently referring to social services and being aware of national guidelines”

Discussion: “Sociodemographic criteria, like age or sex, affected the GPs’ practices and difficulties, as previously described [3, 18]. In particular, a gender bias in self-estimated competence, with female physicians according themselves lower competence, was previously described [42]. The other found associations are statistically small and quite intuitive (more referral to social services for GPs with an activity in a network involving social services, more declared knowledge of national guideline in GPs declaring having a educating role, less referral in GPs declaring having a certain expertise because of their teaching position or their clinical experience).