Author's response to reviews

Title: Family doctors’ problems and motivating factors in management of depression

Authors:

Pille Oopik (pille.oopik@ut.ee)
Anu Aluoja (anu.aluoja@klinikum.ee)
Ruth Kalda (ruth.kalda@ut.ee)
Heidi-Ingrid Maaroos (heidi-ingrid.maaroos@ut.ee)

Version: 4 Date: 19 June 2006

Author's response to reviews:

Dears Alex J Pemberton,

Thank you very much for your reply.

We would like to re-submit for editorial consideration our revised manuscript entitled: "Family doctors' problems and motivating factors in management of depression" by Pille Oopik, Anu Aluoja, Ruth Kalda, Heidi-Ingrid Maaroos.

We thank the reviewers for the critical remarks and valuable advice. We have extensively revised the manuscript according to the comments provided by the reviewers.

Authors’ response to reviewers.

Title: Family doctors' problems and motivating factors in management of depression

Authors:

Pille Oopik: pille.oopik@ut.ee
Anu Aluoja: anu.aluoja@klinikum.ee
Ruth Kalda: ruth.kalda@ut.ee
Heidi-Ingrid Maaroos: heidi-ingrid.maaroos@ut.ee

Version 1

Date 13.06.2006

We would like to re-submit for your consideration our revised manuscript entitled: "Family doctors' problems and motivating factors in management of depression" by Pille Oopik, Anu Aluoja, Ruth Kalda, Heidi-Ingrid Maaroos.

We thank you for the critical remarks and valuable advice. We have extensively revised the manuscript according to the comments provided by you.

Reviewer's report

Title: Family doctors' problems and motivating factors in management of depression Version: 1 Date: 21 May 2006
Reviewer: Jane Gunn

Reviewer's report:

General

This paper reports a survey of 500 Estonian family doctors on their views about caring for people experiencing depression. The authors report a low to fair response rate for surveys of health professionals of 41%. The paper addresses an issue of importance to primary care as primary care practitioners are the main providers of depression care in many countries in the world. The paper contains a number of grammatical errors that require careful editing. Overall the paper reports fairly limited descriptive data about how Estonian family doctors view their role in depression care, the analysis presented is very basic and there is very little discussion about how the findings compare and contrast with the published literature in this field.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

The authors should state their key hypotheses and justify the choice of method (survey). Identifying barriers and facilitators often leads researchers to use qualitative interview methods. Why did the authors choose the survey method?

We wanted to know the opinion of as many FDs as possible. Use of a qualitative interview in the case of such a large number of subjects would have too time and finance consuming. Also this would have involved engagement of additional interviewers. As these prerequisites were not fulfilled, it was only possible to conduct an opinion study with a questionnaire.

It is not clear how the reported study links to the PREDICT study mentioned on page 3, Background.

This was the background study for the PREDICT project to find out readiness of FD to take part of this. We selected participants in this study from among the FDs who gave their consent.

Provide information about the context of the study. Include information about Estonian family practice as the structure and the training. Is there a family practice post-graduate training course? Is it compulsory? What level of training in mental health is there in the family practice training course? Provide enough information for a reader from another country to understand how similar, or different, Estonian Family practitioners are from their own family practitioners.

We accepted the suggestion and included the description of Estonian Family Medicine in to the Discussion, page 8, line 6-10. We added a reference were a more detailed answers to your question can be found in Croa Med J 2004;45:563-566 Maaroos HI. Family Medicine as a Model of Transition from Academic Medicine to Academic Health Care: Estonian's Experience.

The sample size calculations should be included in the methods section.

We have not calculated the sample size because the study was planned as background study for the PREDICT.

Please state how the questionnaire was devised. Was it mailed out? How many postings? State clearly exactly what you did so that the reader could repeat your study if required. Consider including the questionnaire as an attached file.

The questionnaire was devised by the authors of this study in consideration of the purpose of the study. We agree the suggestion and included the description of what we did and how we delivered questionnaires into the Methods. After correcting the Method section the questions are better described and were believe there is no need for including the questionnaire as an attached file.

Comment clearly on the data handling, coding, cleaning and checking. Was double-entry used? What
amount of double-coding did you use? Who did these tasks? What packages did you use to undertake these tasks?

We accepted the suggestion and included the description in the Methods.

It appears that the survey consisted of items with pre-categorized responses for the doctors to select and some which allowed a free text response. Please include the details about the types of questions used, how they were developed and how they were analyzed? Have you presented all the results you had available? If not, what have you left out and why?

We accepted the suggestion and included the description into the Methods. We have presented all the available results.

Page 8 states response rate to be 51%. I calculate the response rate to be 41% based on figures given on page 4 and 5.

Thank you for the remark, the number was indeed incorrect; the correct number would be 41%.

Page 8, line 19-20. The study does not report the patient perspective. This should be revised.

We agree, with the reviewer, we have not presented our idea clearly. We have tried to revise the text so that it would be understandable that we report FD’s opinions.

Page 9, line 17 aE” 22 go beyond the data presented in the paper and should be revised.

We have revised and improved page 9

The discussion should tackle in a more systematic way how the findings compare and contrast with the published literature in this field.

We were following up the discussion.

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Table 1 and 2 could be combined.

We can not combine Tables 1 and 2. Not all data were similar, but we changed the Tables 2, 3 and 4.

Table 3 aE” the headings of the cells do not make sense.

Thank you for the remark about Table 3. It is changed.

Quality of written English: Not suitable for publication unless extensively edited

Language editor has made additional corrections.

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Reviewer's report

Title: Family doctors' problems and motivating factors in management of depression Version: 1 Date: 31 March 2006

Reviewer: Stephen Newman

Reviewer's report:

General

The paper is well written and includes interesting findings, especially those from the "content analysis." The clarity of the paper will be improved once Tables 2, 3 and 4 have been reformatted.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. It is stated that open-ended questions were analyzed using "content analysis." A brief description of this method should be included, as well as one or more references.

   Thank you for the remark about "content analysis". It was not correct, and we changed it into "thematic analysis". Also we described the method and included two references.

2. Tables 2, 3 and 4 are presented in a confusing manner. In Table 2, there should be three main columns with headings such as: Total, Location, Sex. Under Location, there should be a subheading: Rural, Urban. Under Sex, the subheadings are: Male, Female. In Table 3, there should be three main rows with headings such as: Total, Location, Type of practice. The subheadings should be indented. Similar remarks apply to Table 4.

   Thank you for the very good remark about the Tables 2, 3 and 4. We changed all Tables.

3. The p-values from the chi-squared analysis should be added as footnotes to the revised Tables 2, 3 and 4, with a phrase explaining what is being compared with what.

   We added footnotes to the revised Tables 2, 3 and 4 with a phrase explaining what is being compared with what.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

1. On page 5 there is the statement "There were no differences between the characteristics of the FDs
practicing and the respondents in the study (table 2)." This is too strong an assertion, as Table 2 considers only urban-rural location and sex.

Thank you for the remark about the statement on page 5 "There were no differences between the characteristics of the FDs practicing and the respondents in the study (table 2)." We changed it as follows: "There were no differences between the characteristics of the sex and location of the practicing FDs and the respondents in this study (Table 2)".

2. Average age, which is mentioned in the Discussion, should be added to Table 2.

We agree with your remark "Average age, which is mentioned in the Discussion, should be added to Table 2." We corrected this shortcoming with the previous answer (in fact, we did not know the age of the FDs to whom the questionnaires were sent).

3. The numbers of subjects, 115 and 90, discussed on page 7 do not correspond precisely with Table 4

We corrected Table 4.

4. In Table 3, I think the headings should be "Is it your daily work?" "Are you ready to deal with it?" and "Do you deal with depression?"

Thank you for the remark about the headings in Table 3. We used the headings as proposed.

5. In the Discussion, it is remarked that "51% of the practicing FDs agreed to take part." But, 500 were invited and 205 agreed, which is 41%.

Thank you for the remark, the number was indeed incorrect; the correct number would be 41%.

Discretionary Revisions (which the author can choose to ignore)

As the survey questionnaire consisted of only 10 questions, perhaps the authors could include it as an Appendix.

Regarding the suggestion to include used questionnaire as an appendix we are sure that after correcting the Method section the questions are now well described and there is no need for inclusion of questionnaire.

Authors` response to reviewers.

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Reviewer's report
Title: Family doctors' problems and motivating factors in management of depression
Version: 1 Date: 27 April 2006 Reviewer: Daniel W O'Connor

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. Is the question posed by the authors new and well defined?

The study is very simple. The authors presented a brief questionnaire about depression to Estonian family doctors (FDs), of whom 41% responded. This response rate is reasonable. Their questions concerned doctors' knowledge of depression, their willingness to treat depressed patients and their views regarding treatment.

FDs' responses were fairly predictable. They wished to treat depressed patients but were constrained by time, patients' attitudes and a lack of access to specialist services.

The questions, while not new, are still of interest. FDs are the first point of contact for many depressed people throughout the world and it's good to be reminded of doctors' own perceptions of their role.

We agree, FDs are the first point of contact for many depressed people throughout the world. But this situation is new for Estonian FDs. For elaborate we included this description on the Discussion section.

The questions put to FDs by the authors were so narrow, however, that we learn little of enduring value. The authors imply that depression is primarily a medical problem that should be treated with antidepressant medication. The problem, the authors suggest, is that patients do not always share that viewpoint and are reluctant to take pills. I agree with the patients here. Pills are always the answer. Biological treatments work best for major depression and have little more impact than placebos on milder depression.

The depression is not only a medical problem that should be treated with antidepressant medication. We have detailed the motivation factors for the FDs to deal with depressive patients and included the description into the Results page 7, line 4-6 and line 9-11.

The reality is that depression lies on a spectrum from human unhappiness, frustration and grief at one end of the spectrum to profound melancholia at the other. The paper glosses over this distinction. FDs are not necessarily the best agents to tackle personal, marital, family and occupational distress. They cannot be all things to all people. Their training is mostly medical in nature and their time is limited.

We agree with you and included the description into Discussion.

For mildly depressed people, an encouraging comment may be all that is required. Antidepressant
medications can certainly help patients with more severe and persistent depressive conditions and FDs can play a crucial role here. They can also help greatly by diverting patients with obvious psychiatric conditions from endless, pointless and risky medical investigations. Some patients are so unwell that they must be referred to psychologists or psychiatrists.

FDs mentioned lack of cooperation with psychiatrists and psychologists.

The authors gloss over the complexity of these issues and I am not sure that FDs who read this paper will learn much from it. Most FDs said that they needed more training. This statement by itself is not very helpful.

2. Are the methods appropriate and well described, and are sufficient details provided to replicate the work?

The methods and findings are very clear. They are just not very interesting. The paper would be strengthened by a brief outline of FD and psychiatric services in Estonia. How many FDs are there? Are they free? What is the average length of consultation? What training do FDs have in psychological and psychiatric assessment and treatment? What specialist mental services are provided? What antidepressant medications are available?

Every patient is free to choose their FD, for secondary care is the visit fee. In Estonian study of consultations allowed that the average consultation lasted 9.0 min. Psychiatric care is concentrated into three major cities and most psychological service is not covered by health insurance. We accepted the suggestion and included the description of Estonian Family Medicine in the Discussion.