Author’s response to reviews

Title: Active collaboration with primary care providers increases specialist referral in chronic renal disease

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Response to Dr. Levin’s comments:

General:
More sophisticated description of the German health care system. We include the following text in the background section of the manuscript:

“In Germany, about 90% of the populace are covered by the mandatory health insurance system (“Gesetzliche Krankenversicherung”). All physicians who wish to treat these patients are organized in associations, which negotiate a budget with the insurance companies. Depending on the specialty, a typical per capita budget is then assigned per patient for a period of three months. This budget covers consultation fees, and the cost of medication prescribed. If a physician exceeds the total budget thus calculated for his practice, the insurance companies can demand restoration of funds. Typically, a GP’s per patient budget would be much lower than a nephrologist’s. During the time period described here, the nephrologists was allowed to spend about ten times as much per patient than a general practitioner. While this budget strategy is intended as a safeguard against excess prescriptions, it has been criticized by many physicians for inducing sub-optimal treatment as practice owners comply rather with budget demands than with best practice guidelines.”

Major compulsory revisions:
1. ratio of PCP to specialist: We include the following background information: “Dortmund, a town of 589000, has a physician to patient ratio of 141/100000 (German average: 156/100000). There are five nephrological centers, including two hospitals. Currently, 172 general practitioners (“Allgemeinarzte und Praktische Ärzte”), 123 internists (“Ärzte für Innere Medizin”) and 21 urologists are listed in Dortmund. One of the internist practices supervises a dialysis center, but does not provide specialized nephrological consultancy. GPs, internists and urologists were considered primary care providers, as all referrals for treatment of chronic renal failures came from one of these specialties. There were no major fluctuations of physicians numbers between 1997 and 1999, the period for which data was analyzed here.”
b. Description of sessions: As stated in version 1 of the manuscript, this is a retrospective analysis. There was no standardized education program or lecture that was given during the sessions. On entering practice in 1996, K.H. was shocked by the advanced state of renal failure in which patients were referred. A lecture series on basic nephrology, jointly organized by all five nephrological centres of the town, drew no audience—indeed, the lecturers outnumbered the audience! In view of this, K.H. decided that, if the audience did not come to him, he would go to the audience. He participated in the round tables organized regularly by the above defined PCPs. During these occasions, he steered conversations ("subtly introduced into the discussion") so that the burden of end stage renal failure became a topic, and offered to visit individual physicians who were interested to learn more. Thus, he was able to give brief, impromptu lectures during the round table sessions, and individually meet the approximately 250 PCPs who were interested in learning more.

c. See point b.

d. More detailed delineation of intervention: We believe that, with the inclusion of information provided under above points "General" and "1a", as included in the revised manuscript, together with the additional information available under "1b" in this document which shows the prepublication history, will be sufficient.

2. Description of document analysis: The documents were reviewed by T.D.V., who at the time was a final year medical student and since has graduated. We included the following sentence in the “methods” section: “Analysis of patient records was carried out by a final year medical student (TDV).” The inclusion criteria are listed in detail.

3. All patients had agreed that their data would be used for quality analysis. All patients still alive at the time of data collection were informed of the intended use of the information, and we include the following sentence in the “methods” section: “All patients had agreed to have their data used for quality control measures at the time of referral. Specifically informed consent was obtained from all patients still alive at the time of data collection.”. In the “background” section, we have included the following: “In the spirit of the Declaration of
Helsinki, part II.1.: (“In the treatment of the sick persons, the doctor must be free to use a new therapeutic measure, if in the doctor’s judgment it offers hope of saving life, reestablishing health, or alleviating suffering”), K.H. decided to take measures to induce PCPs to refer patients at an earlier stage.”

4. Terms: We have adopted the reviewer’s suggested terms for mild/moderate; moderate; and severe CKD. However, we prefer to retain ECC as this is a measure that is more commonly used in Germany, both by PCPs and nephrologists. For the same reason, we maintained the gradation of ECC below 20 ml/min/1.73sqm, as this is the value recommended for starting to prepare patients for dialysis in Germany (Grabensee, Checkliste Nephrologie, Thieme, Stuttgart 2002).

5. Individual concerns: We cannot find this phrase. If the question refers to the sentence “Individually addressing PCPs’ ignorance and concerns…” within the abstract, then the answer is yes, we did mean budget penalties and loss of patients. We believe that this is adequately explained later on in the full text, and would like the abstract text to remain unchanged. In view of BMC Nephrology’s open access policy, we believe that no essential loss of information will occur.

6. Results: We prefer to separate demographics from diagnosis. As we only demonstrate two results, i.e. the shift from referral in severe CKD to moderate CKD, and the improved (albeit not significantly) better health outcome, we feel that separate sections are inappropriate. Please also note the other reviewer’s comments and our response.

Discussion: We have arranged accordingly, and discussed the relative value of this study with reference to Aronson 2003 and Concato 2000.
Response to Dr. Novak’s comments:

Major compulsory revisions:

1. Significance of results: We agree and have changed accordingly.

2. and 3. We agree with the reviewer as to the problem of small sample size. We have discussed the value of the present study with regards to articles published by Aronson 2003 and Concato 2000 in the revised manuscript. In principle, we feel that the value of the study is the same as that of a case study in that it may incite a prospective, randomized, large scale study. This would need to be carried out by a larger dialysis care provider, who has several centers that draw on a demographically and socio-economically similar population, but are far enough dispersed so that “educated” and “uneducated” PCPs are not mixed. However, in order to meet the suggested recency of training session, such a study would have a very high demand for manpower. In the present study, all education sessions were done by one single nephrologist (K.H.), and it was physically impossible to arrange for the meetings in any shorter time frame. It should be noted that K.H. started to actively contact PCPs only after joint efforts by all five nephrological centers in Dortmund to provide education through lecture series failed due to a lack of attendance.

4. The text was revised accordingly, and figure 2. was eliminated.

5. We have reworded the discussion, but in line with the argument on our perception of the value of the present study, as brought forward above, have maintained a speculative element.

6. We have briefly discussed the point of view brought forward by Traynor et al. in the revised manuscript. However, we would like to stress an important difference: Traynor reports, and defends (Traynor et al. Nephrol Dial Transplant (2004) 19: 1009) that late initiation of dialysis as defined of initiation at ECC below 8.3 ml/min had no detrimental effect on survival. He stresses the point that dialysis should be initiated according to symptoms, rather than lab results. From a practical point of
view, we agree with Traynor in that matter. However, it should be noted that there are no study results available as of now that provide sufficient evidence to make a final decision on the matter; this may change once the results of the IDEAL study (“Pollock C, Collins J, Harris D. IDEAL Study—Initiating Dialysis Early and Late. http://www.nephrology.edu.au/trials/index.htm. 2003.”) are published.

**Minor essential Revisions:**

1. We have included the European recommendation in the manuscript, according to reference # 3: “**Referral** to nephrology should be considered when the GFR is <60 ml/min and is mandatory when the GFR is <30 ml/min”.

2. The word was misspelled, indeed. It should read erythrocyturia, and is defined as red blood cells in the urine at a concentration that does not allow to diagnose with the naked eye (from where on it becomes hematuria).

3. The sentence has been corrected to “and this difference in behavior has decreased, but not been eradicated over time”.

4. The sentence has been altered to “Due to the retrospective design of this study, one cannot analyze…”