BMC Palliative Care

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Title:
Out-of-hours palliative care provided by GP co-operatives: availability, content and effect of transferred information.

Reviewer 1

This is an important paper and the first that I have seen on information transfer for on call physicians for palliative care patients. As they point out the rate of transfer of information to the GP cooperatives was low at 25%. The rate of home visits after a call however was high 53% and was not related to whether transferred information was available. They state that "when information was transferred less patients were referred to a hospital." Although in the strengths and weaknesses section they state that they could not determine whether the relation between less hospital referrals and information transfer is conclusively positive. It would be helpful if they could expand on this as it is such an important component to the paper. Some comments on future research would be helpful. There are some minor spelling mistakes and some duplication which can be easily corrected which I judge to be minor essential revisions.

Response

We appreciate that the reviewer agrees to the importance of our research topic. We followed the suggestion to expand on the relation between information transfer and hospital referrals. We performed a logistic regression analysis with hospital referral as outcome. Results are shown in Table 5.

Reviewer 2

This could be a potentially interesting and useful paper but it needs a greater review of relevant literature, particularly D. Munday and attention to the language and sentence structure. One example on page 5, second paragraph from the

As requested by the reviewer we expanded our review of the literature.
bottom, refers to nursery homes, which should be nursing homes. There is confusion about the use of full stops and commas when presenting percentages etc. which needs clarification and amendment.

On page three, the first line of the last paragraph refers to an article by Shipman et al in the BJGP 2000, which is not in the references. Reference 12 is Burt et al -not Thomas, Burt et al. I wonder why a search of textwords did not include heart failure and COPD - this seems very cancer biased.

The discussion needs a reworking in relating to relevant literature and also the debate about how relevant transferred information might be.

Reviewer 3

1. The questions are reasonably clear but I am not sure the study actually answered the questions particularly whether information transfer actually impacted care provided by the locum.

2. I found the analysis confusing. First retrospective chart audits are always fraught with difficulty. No indication from the authors that the information they sought was part of every encounter. A comparison with non-palliative care patients would answer that question. Perhaps information was only transferred in 25% of other calls as well.

What we mean here are residential care homes. We changed this throughout the text.

This is correct, we added the reference

We compared relevant literature with our research and modified the text about the influence of information transfer (page 7)

Table 4 describes the relation between information transfer and action undertaken by the locum and Table 3 shows that more home visits were paid for patients for whom information was transferred. We added the analysis in Table 5 which also shows the impact of information transfer on referral to hospital.

Our data were derived from Callmanager, a database program that forces the locum to use a strict format. It requires ICPC encoding for every encounter, so the kind of information available for palliative care patients is not different compared with non-
palliative care patients. However, information transfer by the patient’s GP is done exclusively for palliative care patients (and sometimes for patients with severe psychiatric problems).

3. Although a p value is stated as significant, the chance for error because the numbers are so small in the group sent to hospital is great and may not be clinically significant especially since we do not know whether those sent to hospital were sicker in the first place.

4. Indeed, the numbers of calls from palliative patients was quite small and did not include non-cancer patients with other terminal illnessess.

5. The link to “improvement in end of life care” as stated in the last recommendation is really without proof from the study. It may have been very appropriate to send people to hospital.

In the analysis shown in Table 5 we expand on this.

The number of calls from palliative patients did include non-cancer patients, see Table 1.

It is true that there may have been appropriate reasons to send people to hospital, in fact that is very likely. But part of good anticipatory care is to prevent “emergency referrals” during the out-of-hours period. Information transfer is one of the means to do that. Information transfer is also important for all other actions undertaken by the locum, for instance the treatment of symptoms and decisionmaking in end-of-life situations.