Author's response to reviews

Title: Barriers to the implementation of preconception care guidelines as perceived by general practitioners: A qualitative study

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Author's response to reviews: see over
Dear Dr Gagliardi,

Thank you for your agreeing to review our manuscript. After reviewing your feedback, we have now revised our manuscript to incorporate the comments from the reviewers. We have outlined below a detailed response to each comment, including a description of the changes that have been made to our manuscript.

We look forward to hearing from you soon.

Yours sincerely,

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Response to reviewers’ comments

Reviewer: Ann McKillop

1. In the methods section, the intention is stated that opinions were sought that reflected diverse practice settings. The description of participants included high and low SES, male/female and rural (5 practices or do you mean 5 GPs?). The total number of practices is not provided so that the number of urban practices cannot be deduced.

Thank you for your comment. We have now revised the manuscript (page 6, Methods section, paragraph 1) to indicate that the GPs from the low and high SES postcodes were also from urban practices.

2. The schedule of questions provided in Table 1 totals 27 under 12 domains. This seems a large number for a focus group to consider within 90 minutes. Did all focus groups respond to all questions?

No, not all questions were asked during the focus group interviews. The facilitator chose which questions to ask from the list of questions outlined in Table 2 and the line of questioning was modified according to whether barriers and enablers were elicited for each domain. We have modified the manuscript (page 6, Methods section, paragraph 2) to include this information.

3. Content analysis was applied to the data and found to be suitable for just 4 of the 12 domains. Does this mean there were no data that could be assigned to any of the remaining 8 domains and if so what does this mean for the validity of the 12 domain framework?

The barriers and enablers to the uptake of preconception care were primarily elicited in four domains: beliefs about capabilities; motivations and goals; environmental context and resources; and memory, attention, and decision making. This reflects the fact that these four domains were the most relevant to behaviour change when determining interventions for the uptake and delivery of preconception care guidelines. The Theoretical Domains Framework is a tool that can identify which of the 12 domains are likely to be the best explanations of implementation problems. We have modified the text in the manuscript (page 6, Methods section, paragraph 2) to make this clearer.

In response to your comment, we have clarified in the revised manuscript that there were domains that were not relevant and these have now been included in the manuscript (page 7, Results section, paragraph 1).

4. In the background and discussion sections, there is no reference to the importance of a culture of effectiveness including team-based solutions to barriers rather than the focus of the article on the behaviours of individual clinicians. It would be useful to discuss the tension between individual vs collective approaches to solution-finding in general practice settings.

Thank you for your comment. We acknowledge that there are other alternatives to overcoming the barriers to the uptake of preconception care that are not reliant on individual clinicians. In our previous publication (Mazza et al. 2010), we investigated women’s perceptions on the barriers and enablers to the uptake of PCC. In this study, we found that promotional materials and letters of invitation from GPs were perceived by patients as potentially useful in facilitating the uptake of PCC. Practice nurses could also play a more active role in seeking out patients for PCC, especially those who are perceived as high risk. These points have now been included in our revised manuscript (page 15, Conclusion section, paragraph 1).
1. While the results are unsurprising, the use of the theoretical domains framework is interesting, as this could be the basis for a general approach to barrier analysis and implementation intervention design. However, there was no discussion of whether any of the data did not fit into existing categories.

In response to the previous reviewer, we have clarified in the revised manuscript that there were domains from the theoretical domain framework that were not relevant to our study. We have included these domains in the revised manuscript (page 7, Results section, paragraph 1).

2. In the Results section under the subheading Motivation and goals they talk about other competing preventative care interests getting in the way of doing PCC. The preventative care examples they give that get in the way include chlamydia screening, pap smears and discussing alcohol and smoking are actually part of preconception care as well.

Thank you for your comment. While chlamydia screening, pap smears, and discussing alcohol and smoking might be components of a PCC consultation, they can also constitute a separate consultation that is not related to PCC. Women may present to GPs because of these preventive care issues, but they are not necessarily interested in accessing PCC. This results in GPs often having to raise PCC issues opportunistically at the end of a consultation for an unrelated issue.

3. The time constraint example could have been further explored to see if this is really just a prioritization issue, that GPs don’t think this is an important issue (either because it’s so rare or because that folic acid doesn’t really work).

Thank you for your comment. Based on the responses from the GPs, it was very clear that prioritisation and time constraints were two separate issues. Many thought that it was important to discuss PCC with women of reproductive age, but time constraints were proving to be a barrier to the delivery of PCC. We believe we have discussed this sufficiently in our manuscript.

4. Lastly, the fact that women don’t present for preconception care, and those that are at the highest risk are the least likely to come makes the idea that GPs can make a difference in this problem improbable. Approaches like practice facilitation by nurses focused on preventive care and proactive outreach to high-risk groups (along with a bit of opportunistic counseling) and mass media seem much more promising. It would be interesting to note if GPs themselves noted that these approaches might be more effective than the counseling they are not keen to provide.

In response to the previous reviewer, we acknowledge that other approaches may be more effective in ensuring that PCC is delivered to women of reproductive age. Consequently, we have included a statement in the revised manuscript (page 15, Conclusion section, paragraph 1).

5. The potential for this to be a more general approach to barrier analysis could have been explored in the intro or discussion, and describe what other clinical areas have been studied in this way.

Thank you for your comment. We have expanded our statement in the Background section (page 5, paragraph 1) on the use of theoretical domains for barrier analysis in other health care settings by providing some details on previous studies that have used this method. We have also referenced two recent articles to support this statement further.