Author's response to reviews

Title: Clinical inertia in general practice: a matter of debate. A qualitative study with 114 general practitioners in Belgium

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Author's response to reviews: see over
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Dear Editor,

First of all, we would like to thank you and the reviewers for the comments received, as well as for the invitation to submit a revised version of our manuscript.

Please find herewith our responses to the 3 reviewers’ questions and comments. We have discussed the comments and amended our manuscript accordingly.

Yours sincerely,

On behalf of co-authors:
Isabelle Aujoulat

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<th>Reviewer 1 – M. Nelson</th>
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Application of clinical guidelines in the real world is somewhat problematic because there are practitioner, patient and system variables at play and as clinicians we only have direct control over the first. However we must be wary of dissonance reduction, explaining away our actions when at odds with the evidence that our patient is likely to benefit from therapeutic intervention or intensification. The statement “appropriate inaction as a result of good clinical reasoning” may encompass this concept. Thus the concept of ‘true CI’ is questionable.

I think therapeutic inertia is a superior term to clinical inertia as the former refers to drug therapy and the latter to drug and lifestyle interventions, e.g. appropriate response to a high BP reading is to question compliance to existing drugs and reinforce the importance of taking the tablets prescribed rather than adding another agent. What we should be dealing with is a high risk compliant patient with uncontrolled blood pressure. They have a clear and unambiguous need for increased drug therapy. Prioritisation in polypharmacy is justified as cardiovascular disease is the common adverse outcome for most common diseases, e.g. diabetes and chronic kidney disease.

Thank you for this extensive comment, which summarises well the important questions raised by the term clinical inertia.

We have now deleted the term “true” which we had used in several occasions to distinguish clinical inertia from appropriate inaction. We use it now only in one paragraph, in the introduction section, as we cite an author who has used this term (Reach, 2011)

Regarding the comment about the use of the term therapeutic inertia rather than clinical inertia, we opted for the term “clinical inertia” because it points to the process of changing a therapy, whereas “therapeutic inertia” points more to the failure to achieve a desired
therapeutic outcome (target). Allen et al. (2009)\(^1\) propose to use the term clinical inertia rather than therapeutic inertia, because it has been defined first, has been used more widely, and has more precise foundations.

The paragraph in our introduction section (p.4, l. 53-57) is now as follows:

As shown in our recent literature review [12], actual CI is therefore difficult to observe and distinguish from appropriate inaction. It should not be evidenced without a careful investigation of a practitioner’s reasoning underlying their decisions. Moreover, in order to help anticipate the risk of CI in practice, it is necessary to understand which modifiable and non-modifiable factors underlie CI.

Moreover, we wish to add the first sentence of the reviewer’s comments to our discussion, p. 13, l. 287-189:

Application of clinical guidelines in the real world is somewhat problematic because there are practitioner, patient and system variables at play. However, clinicians only have direct control over the first.

Comment/Question 2:

1. How representative are members of the Société Scientifique de Médecine Générale of the general practitioners in Walloon and Flemish speaking GPs? While sampling is less important in qualitative studies it still should be representative. This needs further explanation for international readers.
2. Table 1. How do these characteristics compare with the Belgian general practice population as a whole?

The answers to these questions have been added in the following paragraph:

All participants were members of the same scientific society (Société Scientifique de Médecine Générale - SSMG). Over 40% of all GPs in the French speaking part of Belgium are members of SSMG, thus ensuring truthworthiness of our study. (…) Although representativeness is not an issue in qualitative research, it is worth stressing that the male/female ratio among the participants in our sample (58.9/41.2) was the same than the male/female ratio among the members of SSMG (59/41).

Comment/question 3:

1. “When my patient is a 75 year-old woman with a blood pressure as high as 15” do you mean a woman with a BP of 150(mmHg)/15 kPa?

Indeed, a woman with a BP of 150(mmHg). This has now been changed in the text.

Reviewer 2 – Jack William

Comment/question 1:

2. Are the methods appropriate and well described? – Yes, but in lines 96-99 the authors state for the first time that there were 5 focus groups followed by the steering committee meeting and then 3 more focus groups. The abstract section on methods notes there were 8 group meetings of 114 GPs and the same is said in the paragraph on methods, lines 66-67.

I would suggest that the lines in the abstract and section on methods should reflect the methods stated in lines 96-99. Further, it would be interesting to note if issues addressed in the last three groups differed significantly from those discussed in the first 5 groups.

Thank you for making us aware of this need for clarification. As suggested, the information about the two series of focus groups has been moved to an earlier paragraph in the methods section. We haven’t changed the abstract however, as the information provided here is not a different information, but rather a precision of how the 8 groups were managed.

The issues addressed in the last three groups did not differ significantly from those discussed in the first 5 groups. That’s why the data collection was stopped after 8 groups. We have made this clearer in paragraph p. 5, l. 76-79, where we raise the question of saturation.

Our sample involved a total of 114 GPs in 8 group interviews, between October and December 2012. After the 5 first focus groups, a meeting of the steering committee (co-authors) was organised in order to refine the emerging themes and discuss implications for practice. After 3 more focus groups, as no new themes emerged, descriptive saturation of data was reached.

Comment/question 2:

3. Are the data sound? – Yes, I think so. This is a sound qualitative study. I did wonder if the responses varied for GPs with long practice experience compared to younger GPs with significantly less experience. Also, were there notable variations in responses by gender?

All our groups counted GPs with different lengths of practice experience. It is not within the scope of the analysis of focus group discussions to compare what members within a same group said or did not say. Yet, we did notice that gender or age did not seem to play a role regarding how clinical inertia was perceived or experienced. More than age or gender, a significant factor of influence might be whether the GP works alone or with colleagues in a group setting. Indeed, group practice was stressed in several groups as a protective factor against clinical inertia.

Comment/question 3:

The reviewer recommends that we make note of our article published in Advances in Medical Education and Practice. We had already cited our publication, but have now made a more explicit note about it. Thank you for this acknowledgement of our own work.
1. Methods section, lines 63-66: Please clarify what you mean here. What encounters and regular meetings are you referring to?

This paragraph has now been re-written as follows:

Please see p. 4, l. 64-74:
All participants were members of the same scientific society (Société Scientifique de Médecine Générale - SSMG). Over 40% of all GPs in the French speaking part of Belgium are members of SSMG, thus ensuring truthworthiness of our study. As part of their vocational training, members of SSMG from a same geographical area meet regularly around topics of interest to their practice. We used the opportunity of these existing practice-sharing encounters to conduct our interviews. In accordance with the local group coordinators, the GPs were informed beforehand of the topic of the discussion through a letter co-signed by the first author (IA) and the medical coordinator of SSMG. The practitioners who accepted to participate in our study were asked to inform the coordinator of their group that they would participate.

2. Could you provide us with some verification that this type of research does not require explicit verbal or written consent in Belgium? We may need a letter from the Ethics Committee of the Institution the lead author is affiliated to to verify this.

Please find attached the full response which we received from our local ethics committee, and which was already sent to the journal.

We have now completed the paragraph on ethics, and moved it at the end of the methods section. In doing so, we have also addressed the two following requests for clarification, about being respectful of the GPs’ experiences, and sending to each GP a synthesis of their group discussion.

Please see p.6-7, 118-130

Our study did not involve any patients nor patients’ relatives, nor did it require that patient data be shared with the researchers. Our study does therefore not fall within the scope of the Belgian Law of 7 May 2004 on Human experiments, and did therefore not require the approval of an ethics committee, nor that informed consent forms be signed by the participants.

Ethical considerations were present however at all stages of the project: Every GP was personally informed of the study and invited to knowingly join (or not) the focus group interview several weeks before the encounter; the interview process was conducted with a non-judgmental attitude and was very respectful of the GPs’ perceptions and self-reported experiences regarding the phenomenon of CI in their own practice; last but not least, every GP within a group was sent a synthesis of the discussion within that group, and was thus given the possibility to comment personally, either by e-mail or over the phone, on the synthesis of their interview.
3. What was the topic of discussion? How was it introduced to the group? What was the group discussion questions?

The answers to these questions were present further down in the same paragraph. We left it as it was.

Please see p. 6, l. 86-91:
*The first author would introduce the topic with a brief review of the literature on IC. The group discussion would then be moderated by the second researcher (PJ), and observed by IA. The research interviews were guided by two categories of open-ended questions consistent with the objectives of the study: (i) GPs’ beliefs regarding the risk of CI in their own practice, (ii) factors associated with CI.*

4. (we received feedback from 6 participants...) From how many groups? E.g did they all come from one group? Would be useful to have the breakdown. What was the content of the feedback? How did you use it in the analysis?

This information has now been added to the text, p. 6, l. 99-106:
*We received feedback from six (6) participants, representing 5 different groups. Three (3) participants thanked the researchers for the discussion and the follow-up, and formally validated the synthesis. Two participants explained how the ideas shared during the focus group were further discussed within their groups, one stressing that it had made him personally more aware of the risk of CI in his own practice. The last participant informed the researchers of a TV programme relevant to the topic of CI. The participants’ comments did not add much to our analysis in terms of thematic contents, but confirmed the relevance of addressing the sensitive issue of CI with GPs.*

5. (... until saturation of the data was reached). Plse spell out what you mean by this. Although commonly used, it is worth being more specific about what it means in the context of your study.

We have now specified that descriptive saturation was achieved, meaning that no new themes were emerging, p. 6, l. 115-117
*The study was stopped after 8 groups, as no new themes were emerging, meaning that descriptive saturation was achieved.*

6. Could you say something here or in the Strengths and limitations on the issue of Researcher characteristics and reflexiveness. - to enable reviewers and readers to to understand how the background of the researchers/their perspectives/assumptions influenced data collection and interpretation ( See any guidelines on reporting qualitative research)

The issue of reflexivity is now addressed at the end of the discussion, in the strengths and limitations section. Please see, p. 14, l. 298-307:
*Regarding the researchers’ characteristics that might have influenced the study, whereas one researcher (first author) is very experienced in conducting qualitative research in the field of health care and clinical communication, the other researcher (second author) is a research nurse with extensive clinical experience and thorough knowledge of evidence-based practice.*
A strength of the study therefore lies in their complementarity to conduct the study. Moreover, none of them is a medical doctor. Although it might be argued that professions other than physicians are not given enough credence by physicians in other circumstances, we believe that this was a strength for our study, as we approached the physicians without a priori representations of how they should be dealing with the risk of CI in their practice.

Specific comments from the executive editor:

1) Please clearly state in the Methods section of your manuscript that ethical approval for your study was not required according to Belgian ethical guidelines.
2) Please state in the Methods section whether informed consent for participation in the study was obtained from participants.

Response to comments 1 & 2: As already indicated, the paragraph regarding ethical issues has been rewritten, in order to make it more clear that ethical approval and formal consent are not required for this type of study according to Belgian ethical guidelines. Your request has made me however more aware of this issue, and I think I will deal with it differently in future studies.

3) Please use authors initials only in the Authors’ contributions section.

The authors’ initials were changed to either first or second author where relevant. I hope this is satisfactory.

IA – 11/11/2014