Author’s response to reviews

Title: "Blood transfusion in elderly patients with chronic anemia: a qualitative analysis of the general practitioners' attitudes"

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Author’s response to reviews:

Dear Editor,

Thank you for giving us a further opportunity to improve our manuscript submitted to BMC Family Practice. We did our best, guided by your two remaining observations. We believe that these changes have greatly enhanced the readability of the results and the quality of the discussion.

All modifications appear in blue in the corrected manuscript.

1/ Concerning the results:

We rewrite this section with less verbatim and more analysis. 13 citations remain, instead of 30 in the previous draft. We enriched the text with further analysis, whether newly written or taken from the discussion section.

We added:

- in “patient related decision criteria”:

“The cause of anemia did not appear as a determining factor in the decision-making process of transfusion. The poor clinical safety of anemia was considered as the most important factor,…”
“These elements can be found in French or American recommendations20, 21, 22, in fact used without being cited”

“Age seems to have paradoxical effect on GPs attitudes: they tolerate a lower hemoglobin concentration before starting lab tests for older patients, but propose transfusion earlier. In other terms, the presence of a moderate anemia will be trivialized, but in case of worsening they will react faster.”

“More than the slow and insidious complications of chronic anemia, the events of rapid occurrence trigger the process of requesting a transfusion. The presence of cognitive impairments makes the situation more complex. GPs freely mentioned cognitive disorders and their influence on decision making.”

“Institutionalization of the patient was spontaneously associated with severe cognitive disorders and dependence, with a twofold effect: it complicates assessment of the impact of anemia and potentially worsens its effects, through loss of residual autonomy.

When cognitive disorders are severe, or loss of autonomy major, or sometimes just because of a very old age, transfusion may appear futile.”

“So palliative care situations, as cognitive impairment, very old age or loss of autonomy, can lead to opposite decisions: early transfusions because of patients’ frailty, or transfusion avoidance because it is seen invasive and useless.”

- in “attitude to transfusion”

“This excellent image of transfusion seems to be shared with the patients and their families, who retain the immediate effects of this quite simple therapeutic act”

“Compared with the extraordinary efficacy of transfusion, these risks seem insignificant.”

“The impression of lack of competence is easily understandable since there are no precise recommendations in this type of situation. Moreover, the low frequency of confrontation with this situation does not allow learning by experience. But beyond lack of knowledge and experience,”

“So the patient and/or the patient’s family bestow recognition on the GP, who feels at a loss in the more or less long term. The power of medicine therefore seems illusory if the question of disease progression has not been addressed with the patient.”

- in “a lone decision”
"GPs faced with decisions regarding transfusions feel that they are responsible for a weighty decision, as they attribute to transfusion the power to prolong or even to restore life”.

“The other was the only one thinking in terms of a collaborative approach, useful in decision making. It is surprising, in a complex situation where the physician feels uncomfortable and uncertain, that the specialist physician is not contacted either for decision support or for shared responsibility, but rather to confirm the orientation proposed by the general practitioner and to perform the act as a service provider”

“Patient’s family circle finally appears as more influent than specialist in decision making”.

“Interestingly, the patient’s opinion was not explicitly referred to as guiding decision making, and did not seem to be systematically sought”

2/To reinforce the interest of the study for an international audience, we replace the question of blood transfusion in the broader context of general practitioner-specialist relationship.

We added in the introduction:

“This referral process is peculiar, as GPs don’t expect from the specialist they call (hematologist, internist, or geriatrician) a medical advice; they want him to approve and enact their choice. On his side, the specialist can accept or refuse the transfusion, but will usually organize it, often in a day hospital, after a simple phone call, before he can meet the patient.”

This approach conducted us to reworked the discussion, with 3 subsections in the part “Comparison with previous literature”. The 3rd one, “GP-specialist relationship” is newly written, and allow the addition of for new references on that subject.

More precisely, we added:

- the subtitle “deciding in uncertainty”, and, in this part “However, our study has showed that GPs currently don’t know how to integrate geriatric factors in transfusion decision making.”

- the subtitle “shared decision making”, and, in this part, a discussion on family opinion in regard with the literature on this question

“Conversely, the families seem to be actively involved in decision-making. It is possible that the participation of the family is sought to share the responsibility for the decision and/or to avoid a conflict in case of disagreement. However, this opposition between patients and family in shared decision should be taken with caution: a study on admission of elderly patients in intensive care
units demonstrated that physicians who frequently asked patients about their preferences may be more inclined to asked relative for an opinion.41


- under the subtitle, “GP-specialist relationship”:

“GPs who order a blood transfusion are requesting a procedure that they will neither perform nor are trained to perform. Yet, they don’t seek for specialists’ advice. We can suppose that they regard themselves as the best able to make the decision, acting as “specialist” of patient centred comprehensive care. They consider that transfusion decisions don’t rely on a technical knowledge owned by the specialist, but on their comprehensive approach. Motivation of GPs for collaboration with specialist is known to be largely knowledge driven. It could explain that they don’t seek for collaboration, if they can’t acquire new knowledge this way.

We found in the interviews no elements arguing for a lack of approachability of transfusion specialists. In the absence of economic or organizational constraints, transfusion specialists generally seemed to agree to all requests for transfusion (one exception was related to a hemoglobin level >8g), particularly as in the French health care system a blood transfusion is a profitable procedure that takes up little of the specialist’s time.

The interviews did not explicitly address the question of whether the specialist or the GP should explain to the patient the palliative nature of transfusions and involve him in drawing up an advance care plan.44


This development led us to add in the implication part “a closer collaboration between specialists and GPs would enable the drawing up of an advance care plan”
Finally, to maintain the consistency and to limit the length of the manuscript (including abstract and table), we made numerous minor modifications, that all appear in blue.

We hope that this in-depth reworking will allow a publication in BMC family practice.

Best regards,
Dr Aline Corvol