Author’s response to reviews

Title: Mixed feelings: General practitioners’ attitudes towards eHealth for stress urinary incontinence - a qualitative study

Authors:

Lotte Firet (lotte.firet@radboudumc.nl; lottefiret@hotmail.com)
Chrissy de Bree (chrissydebre@gmail.com)
Carmen Verhoeks (carmenverhoeks1991@hotmail.com)
Doreth Teunissen (Doreth.Teunissen@radboudumc.nl)
Antoine Lagro-Janssen (Toine.Lagro@radboudumc.nl)

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Author’s response to reviews:

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Dear Dr. Tovah Honor Aronin,

Thank you very much for reviewing our paper ‘Mixed feelings: General practitioners’ attitudes towards eHealth for stress urinary incontinence – a qualitative study’ and giving us the opportunity to revise it.

We appreciate the careful reading and the constructive questions of the editor and the reviewers. Within this point-to-point letter we have addressed all comments that were mentioned by the editor and the reviewers and we amended our manuscript accordingly.

We await your reply with interest and we hope for a positive decision on publication in the BMC Family Practice.

Yours sincerely, on behalf of my co-authors,

Lotte Firet, MSc
General practitioner in training, PhD student
Lotte.firet@radboudumc.nl
Radboud university medical center
Department of Primary and Community Care
PO Box 9101, 6500 HB Nijmegen
the Netherlands
Tel: +31 24 36 68036

1. Technical comments

Editor Comments:

1.1. To be certain of anonymity, please amend the identifiers with the quotes. Please remove sex or age, or provide age as a range if essential to include.

Thank you for indicating this privacy aspect. We believe that sex is relevant to mention as stress urinary incontinence is a women’s issue which can be viewed differently by male or female general practitioners. We changed age into age category according to the ones we already used in table 1 (≤ 45 years or > 45 years).

A sentence was added in the analysis section of the Methods:

“To illustrate the main results, quotes are displayed with identifier number, sex and age category”

1.2. Ethical approval and consent to participate: Please provide a link or reference for the Non-WMO research of webpage of Central Committee on Research Involving Human Subjects
By the time we developed this study no ethical approval was needed for studies with health care professionals as subjects. Nevertheless, we asked approval from the research ethics committee of the Radboud university medical center, Nijmegen for this study as it was part of our broader research project: ‘An e-Health Intervention for Dutch Women with Stress Urinary Incontinence: an Implementation Study’. The committee gave their positive reply in November 2016. Within the text this has been changed into:

“This study was approved as part of a broader project on eHealth for stress urinary incontinence (file number 2016-2721). The research ethics committee of the Radboud university medical center, Nijmegen, replied positive on this request in November 2016.”

1.3. COREQ guidelines: Can you please include a completed COREQ checklist as an additional file when submitting your revised manuscript.

See appendix 2 for a completed COREQ checklist. Within our method section we already mentioned most aspects of the COREQ guideline. This together with the COREQ checklist improves the evaluation of the methodological aspects of our study.

2. Reviewer reports

Janny Dekker (Reviewer 1): This is a well executed qualitative study on a relevant topic for family practice. The manuscript can gain in meaning through a number of changes or adaptations.

General comments

2.1. The authors focus on stress urinary incontinence but do not make any remark about the two other main types of incontinence: urgency incontinence and mixed urinary incontinence. If an e-health application is to be used as a stand-alone intervention, than a diagnostic module should be incorporated into the application.

We agree with the reviewer that it is important to embed a diagnostic procedure within an eHealth application. However, within this study we aimed to gain insights into the GP’s attitudes on eHealth and the diagnostic procedure did not emerge as an important theme. For further comments see 2.16.
2.2. And data are necessary on the reliability of self-diagnosis on the type of incontinence.

There is evidence that shows that women can accurately diagnose themselves with the use of a questionnaire. See reference 33 and 34.

We changed reference 34 because the former citation included two studies: Farrell et al (reference 33) and Hess et al (which is now reference 34).


2.3. How specific was the description of the e-Health intervention about which the GPs had to give their opinion? The way in which an e-Health intervention is delivered, and the content of it, might influence the effectiveness and acceptability. This should be addressed in the manuscript.

We agree that the description of eHealth has not been specified within the manuscript. Prior to the interview, the participating GPs received a letter with detailed information about the type of eHealth application that will be studied for women with stress urinary incontinence. Also prior to the start of the interview the concept was explained again by the interviewer. The design and content of this application were based on the one that had been studied by Sjöström et al. (reference 18 in the manuscript). GPs were informed that the eHealth application was based on Swedish research, which showed that eHealth is effective in treatment of women with SUI. The eHealth application was described as an internet module that consists of an eight-step pelvic floor muscle training. Furthermore, information was provided about different aspects of SUI.

We rewrote the following text in the abstract, background and methods:

“Therefore this study aims to get insight into the GPs’ attitudes towards an internet-based, eHealth, intervention for women with SUI.”
“GPs were informed that there is evidence that eHealth could be an effective treatment modality for women with SUI [18]. They were also told that the eHealth application was defined as an eight-step internet-based training with PFMT and information about different aspects of SUI.”

2.4. BACKGROUND.

As said in the general comments, a description of the different types of incontinence is missing. The statements on stress incontinence are true for all types of incontinence (embarrassment, fear of being smelt). Stress incontinence is relatively common in younger women, and with ageing mixed type incontinence and urgency incontinence become more frequent. This should be mentioned. The e-Health intervention that is the subject of the study, is meant only for stress urinary incontinence.

Indeed, the consequences of stress urinary incontinence and the barriers in help-seeking behaviour are applicable to all types of urinary incontinence. We therefore changed the word “SUI” into “urinary incontinence”. However, we choose not to describe the other types of urinary incontinence in detail because the eHealth intervention that we mention is specifically aimed for women with stress urinary incontinence. By changing the first sentences on the background section we think that we meet your demand for mentioning the other types of urinary incontinence.

“Urinary incontinence is a common condition in women and has a major impact on quality of life. Stress urinary incontinence (SUI) is the most prevalent subtype of incontinence which is defined as the complaint of involuntary urinary leakage on effort or exertion, or on sneezing or coughing [1].”

2.5. The trials that have done so far on the effectiveness of an e-Health intervention were internet-based (ref 18) or used a mobile phone App (ref 17). Ref 19 is a small (n=34) observational study with a web-based intervention. So, the evidence on the effectiveness of e-Health interventions is not yet overwhelming and the form and content of the studied interventions were very different. This should be acknowledged in the manuscript.
Two Swedish studies (ref 17 and 18) indeed used different eHealth modalities, but the strength of those studies is that they used the same outcome measurements which facilitates the comparison of the results. The sample size calculations were well performed according to the standard procedures of a randomized controlled trial. We agree with the reviewer that ref 19 is a study with a small sample size.

We changed this part of the background section by adding the following sentences:

“Two randomized controlled trials and one observational feasibility study have been conducted in this area [17,18,19]. A Swedish trial with an internet-based intervention with PFMT showed that 70% of women experienced improvement of SUI[18]. During the intervention, there was no face-to-face contact, but a urotherapist sent reminders via e-mail and was available for questions if needed. Most women appreciated this contact because it motivated them, and they felt supported without being exposed [20]. The two other studies used a mobile phone application, as this differed from an internet-based application the results of these three studies cannot be simply added up."

2.6. Before we can implement an e-Health interventions successfully (page 5 line 8), we not only need to know the GPs attitudes, but we also need more evidence on the effectiveness and potential harms (wrong diagnosis by the patients for instance) and of course we need to know the patient's perspective.

We completely agree with the reviewer that more is needed before an eHealth interventions could be implemented successfully, especially the patient’s perspective is needed. We consider the GP to be one of the stakeholders who could become involved in this eHealth intervention. From implementation science we know that it is important to explore the stakeholder’s perspective for them to become engaged in the innovation (reference 22). Therefore, within this study we studied the GP’s perspective on the topic.

We rewrote the last paragraph of the background section:
“Thus, the GP could become involved when eHealth for SUI would be implemented within the health care system. To implement an eHealth intervention successfully, the stakeholders’ attitudes need to be explored [21,22]. Therefore this study aims to get insight into the GPs’ attitudes towards an eHealth intervention for women with SUI.”

METHODS

This is a well-executed qualitative study. The design is appropriate for the research questions.

A few remarks:

2.7. 'An e-Health intervention' was discussed with the GPs. This must be specified: Web-based? App-based? Content? Stand-alone or after a diagnosis by the GP or pelvic physiotherapist? As I understand from the results, the GPs were asked for their opinion about an e-Health intervention with pelvic floor muscle exercises as content. Is that right?

See previous comments number 2.3. The definition of ‘stand-alone intervention’ was comparable with the one used by Sjöström et al (ref 18), meaning no face-to-face contact but having a researcher who checks the diagnosis after a women filled in a questionnaire. During the intervention women can contact the researcher for support or questions via e-mail. We choose not to describe the diagnostic procedure into detail during the interview on purpose because we were interested in the unprejudiced perspective of the GP. We explicitly asked the GPs their opinion about support during eHealth as we knew from previous research that women appreciate personal support during an eHealth intervention (ref 23).

2.8. Study design: this is a qualitative study. Please mention this in the methods.

Thank you, we amended this in the subsection ‘study design’:

“Within this qualitative study semi-structured interviews were carried out among GPs...”

2.9. Specialised GP à GP with special interest
We changed this phrase into: “Each GP from this expert group...”

2.10. 'The interviewer had no relationship with the participants' sounds a bit strange.

We agree that the word relationship sounds ambiguous, we chose it as it derives from the COREQ checklist. We changed it into the following sentence:

“The interviewer and the GP did not know each other before the study started.”

RESULTS

2.11. The study tries to answer two questions: one is about the GP routines regarding the treatment of women with SUI, the other is about the attitudes of GPs towards an e-Health intervention. In the results, mainly the second has been worked out and this is also represented in the title. Delete the second aim?

The reason for asking the GPs about their routine practice was to start a conversation which showed us that pelvic floor muscle training indeed is the treatment of first choice for all participating GPs. From the literature on implementation science we know that it is important that stakeholders see the added value of an innovative method (ref 22). By starting the interview with exploring the GP’s current practice we aimed to explore if ehealth would add value to their routine practice. We think the reviewer suggested to delete the first aim, which was to explore the GP’s routine treatment for women with SUI, instead of the second aim. We agree to delete the first aim since the exploration of the routine practice was only used as a tool to start a conversation and to let the GPs create their attitudes on the topic.

We removed the first aim in the abstract and method sections.
2.12. The second theme has a strange title: ‘mixed feelings’. Do the authors mean that the opinion of the GPs on a supportive role in addition to an e-Health intervention varied between the participants?

We are glad that the reviewer made this comment because ‘mixed feelings’ was not explained well in the text. The GPs themselves had mixed feelings about eHealth; ideally they regard eHealth as a stand-alone intervention, but currently they think it would not work out well. According to the GPs the lack of personal support would be an issue.

We tried to clarify the explanation of ‘mixed feelings’ by rewriting the first sentence of this section:

“GPs had mixed feelings about personal support during an eHealth intervention because on the one hand they preferred eHealth as self-sufficient tool, but on the other hand they were concerned that currently the effect of the training could not do without personal support.”

2.13. And what is meant by a ‘stand-alone intervention’? No contact at all with the GP? Also not in the diagnostic phase of urinary incontinence? The quote on page 10 from GP9 suggests that the e-Health intervention the GPS were asked about, only included the training of the pelvic floor muscles, not the diagnosis.

See comment number 2.7. The quote showed that this GP anticipated that a correct diagnosis is important before women start the eHealth intervention. This was not a topic that was addressed by the interviewer, but she came up with this concern herself.

2.14. What is meant by the sentence 'GPs highly appreciated following their patient's progress by updates about their status' (page 9 line 56-57)? Is this meant in general or only for urinary incontinence?

We meant that regarding stress urinary incontinence GPs prefer to know about the woman’s progress once the GP have referred her to the physiotherapist.
2.15. In the remarks about age, it is unclear whether the GPs confined themselves to patients with stress urinary incontinence, since older women more often have mixed or urgency urinary incontinence. And for younger women, the opinions differed: GPs though they could profit more from e-Health, but on the other hand GPs were more inclined to refer young women to a therapist or specialist. Did they think e-Health could prevent such a referral?

In the information letter to the GP and in the interview the researcher made clear that we discussed stress urinary incontinence and not the other subtypes. Younger women were perceived as more digitally competent compared to older women. Furthermore, GP were more prone to refer a young women to a physiotherapist or to a specialist. The GPs did not mention anything about the prevention of a referral after following eHealth.

DISCUSSION

2.16. The discussion starts with a clear summary of the findings on the study. The subsequent section, about the disadvantages, suffers from lack of information about the intervention the GPs had to reflect upon: did it include a diagnostic module or only PFMT? Maybe the two disadvantages that were mentioned by the GP, that is, lack of a diagnostic procedure and lack of monitoring and support can be separated more.

See comment 2.3 and 2.7 about the intervention the GPs had to reflect upon. The absence of a diagnostic procedure did not emerge as an important theme. Nevertheless, a few anticipating GPs mentioned their concerns about the absence of a diagnostic procedure when the interviewer asked them about disadvantages of eHealth, or about attitudes on support during an eHealth intervention.

To make a clear distinction between the two disadvantages we rewrote the following sentence:

“GPs also mentioned disadvantages of eHealth as a stand-alone intervention which are related to the diagnostic procedure and to the monitoring of the intervention.”
2.17. The authors acknowledge in line 36-38 on page 13 that eHealth is a broad concept. This study is not clear about the concept the GPs were talking about. This should be addressed in the discussion, as it may have influenced the answers of the GPs.

A description of the intervention was provided twice before the interview (see 2.3 and 2.7). Nevertheless, it could have happened that GPs had different eHealth concepts in mind.

We added the following sentence:

“Furthermore, we could not prevent response bias as we questioned GPs on a conceptual eHealth intervention [18], although we explained that it was based on the one used in the Swedish study.”

2.18. And in line 49-51 on page 13 the GPs are accused of being reluctant with using eHealth, based on misperceptions rather than on evidence. As stated above, the evidence on eHealth applications for urinary incontinence is not yet abundant, so maybe it is better to says that GPs are, justly, waiting for more evidence. We have to do more research in this area, and also in older women with urgency or mixed incontinence.

We appreciated your recommendation for putting more nuance in this paragraph. We also believe that because the studies on eHealth for SUI are not conducted in the Netherlands, our GPs are not yet familiar with the concept.

We kept the word misperceptions with respect to regular care for SUI because we used it previously when we described the misperceptions about age and treatment for women with SUI.

The paragraph was rewritten accordingly:

“The GPs in our study express reluctance with using eHealth as stand-alone intervention which shows that they are either not familiar with the current evidence on the topic, or that they found that the studies are not convincing. The GPs in our study also mentioned that before they would
use or recommend eHealth they need to be sure that it is evidence-based. Trust in eHealth could increase with education that addresses both the GPs’ misperceptions in regular care for SUI, and the existing evidence on potential future eHealth therapy, also in the elderly [18,28,36]. Before eHealth can operate as a stand-alone therapy, also research on an eHealth intervention in Dutch women with SUI might be necessary for these Dutch GPs to gain trust in its self-reliant aspects of eHealth.”

2.19. Therefore, the sentences in the CONCLUSIONS that GPs should be corrected in their misperceptions and that they need to trust the stand-alone eHealth, do not do justice to the concern of the GPs about the possible disadvantages and lack of evidence on eHealth urinary incontinence. This should be reformulated.

According to the previous comment (2.18) we changed our conclusion. We changed the last two sentences of the conclusion.

“These perceived shortcomings are in contrast with the literature on eHealth for SUI. Training should inform GPs about these new treatment possibilities for SUI and should focus on common misunderstandings about regular care for these women. Also more evidence or awareness is needed to convince the GPs on the added value of eHealth.”

3. Reviewer 2 (Reviewer 2):

REVIEWER COMMENTS FROM REPORT: This is largely a descriptive study with opinions rather than hard evidence. The study design, sample size, is too small to deduct if these findings can be translated to other population groups. The authors have used the words ‘many, few, several’ too frequently in the discussion and it is unclear if this can be replaced by percentages instead given the small sample size. It will also be interesting to see if the age of the GPs themselves had anything to do with the results of the survey. However as a tool for policy implementation, it may be useful in the national scenario.

REQUESTED REVISIONS:

The authors can replace the words ‘few, many’ etc used repetitively in the discussion.
We would like to thank the reviewer for his/her comments on our manuscript. The focus of this study was not to study which ideas are most prevalent when it comes to eHealth for SUI, but to gain in-depth insights into the GP’s attitudes on this topic. This is the reason why we chose a qualitative study design. Studying the umbrella of ideas is one of the characteristics of qualitative research. The aim of a qualitative study is not to generalise the results for a certain population, but to study the variety of opinions within one group. Therefore we think by using percentages that we would undermine the essence of qualitative research. Instead, we chose the words ‘few, several, many, most or all’ to add nuance to the attitudes that were expressed by the GPs. Therefore, we would like to keep these words in our result section. The reviewer kindly requested to replace the repetitive use of these words in the discussion. As we only used them twice in the discussion we are not sure if we understood the reviewer correctly. Furthermore, we agree that it would be interesting to study whether the GP’s age was related to their attitudes towards eHealth. In our study we did not ask the GPs to reflect on this topic, and given our qualitative study design we could not provide an answer on this research question. Lastly, we agree with the reviewer that the results of this study may be useful as a tool for policy implementation in the national scenario.