Author’s response to reviews

Title: Recruiting General Practitioners for palliative care research in primary care: real-life barriers explained

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Author’s response to reviews:

Answer to reviewer 1:
Thank you for your suggestion. It is interesting to see that in France many barriers for palliative care research are the same like in Belgium.

Answer to reviewer 2:

Abstract:
The numbers in the abstract are in Table 3, which belongs to the Results section. Thank you for highlighting this. I suppose you did not find the Tables, because in this pre-publication format they were very far away below the text in separate files. I have been re-reading the submission guidelines and I found I can just insert the tables in the main manuscript, so that is what I have done – this makes it easier for you.
Mentioning ‘high interest’ in the abstract without more explanation: I changed the abstract a bit, in the results section is mentioned that many contacted GPs showed high interest in the project.

Introduction:
I tried my best to make the introduction shorter without losing too many interesting references of predecessors in the field. I moved the lines 77-87 to the methods section. I agree with the idea of average number of deaths per year per GP – easier to imagine than the previous abstract number of percentages. Because GPs’ practice sizes differ considerable per country, I had to include the average GP practice size in Belgium as well.
Methods:

Thank you for the suggestion of a project summary in the methods section. I included a summary of the project.
I think it still has value to describe the recruitment activities in full and not only in Table 1.
Already in the first version of this article, I made Table 1 as a summary of the performed recruitment activities, including how many GPs were present on them, but I felt the content of the recruitment activities can easily be misunderstood if not explained in more detail.

Results:

Table 3 was already in the first version showing the numbers you ask for; I included the number of included patients on it.
I deleted some numbers in the text, as you suggested.

Discussion:

I included the hospital-based strategy in the discussion.
In Belgium, this is possible as AJ showed, but any recruitment for research will stay to be difficult because of very specific characteristics of the Belgian health care system: freedom of choice for patients to which doctor they want to go, even when they want to go straight to any university hospitalist, they are also free to look for a second opinion and switch health care provider, most doctors work on a fee for service basis. All these elements lead to patients with high expectations and healthcare providers who want to please their patients, ‘otherwise patients might leave the practice/hospital’. Reaching quality indicators doesn’t bring more money for doctors, that is why many Belgian doctors are not so interested in evidence-based medicine, not even in taking time for their patients, so far they do what their patients want them to do. Many patients have a ‘normally attending’ GP (often single-handed) and some “spare” GPs in the neighbourhood in case the normally attending GP is on holiday, sick or not willing to do what the patient wants on that very moment. I added some more information on these aspects in the ‘Sample and setting’ part.
The participating GPs have had training, thank you for highlighting this, because I forgot to explain this (it was too evident for me). I added this aspect throughout the text.

In general:

Thanks to your comments. I have rewritten and restructured the manuscript, and I have deleted some parts as well. Even though I included a project summary and more context details, I reduced the word count of the text from Background to Conclusions from 5098 words in the first draft to now 4686 words (both without Tables and their legends).
I hope it is more interesting to read now.

Answer to reviewer 3:

Thank you for showing me these parts to be improved. I tried to reformulate all these parts more clearly. After reformulating, I still changed many aspects of the manuscript.
Answer to reviewer 4:

I included a project summary with the explanation what was expected from GPs (in the beginning of the Methods section) and comments on the efforts required to participate as a GP (in the beginning of the Discussion section).

I totally agree with changing the focus to needs rather than prognosis, that is also what we told our participating GPs. But we still need a simple screening tool ‘to start somewhere’, to have a population selected who is at-risk for having palliative care needs. As White et al wrote, the prognostic accuracy of the SQ is not even so good (White N, Kupeli N, Vickerstaff V, Stone P. How accurate is the 'Surprise Question' at identifying patients at the end of life? A systematic review and meta-analysis. BMC medicine. 2017;15(1):139).

I hope that the now included project summary makes clear that identification of patients happened with the SQ/SPICT and that when this trigger is present, then an assessment of needs and wishes followed, so that palliative care needs could be detected – I don’t think that there is any GP willing to offer palliative care when there are no needs yet, but that at this moment many palliative care needs go undetected because GPs don’t think of asking their patients about palliative care needs. Screening patients with the SQ/SPICT can help to detect palliative care needs timely where present, because a positive SQ of a positive SPICT can prompt the GP to ask questions, which are currently not included in their routine assessments, to screen for palliative care needs… But adding these very subtle elements to the text would probably make the article too long again and not focused on the main topic of recruitment.

You are right that we as researchers have to be careful when proposing interventions to GPs who are participating in research that those interventions are too big for them to handle. In our training we always stressed the resources the GP has, particularly in the Palliative Home Care Team and the Palliative Care Network. PHCT deliver home visits, even in early palliative care, to assist GPs with screening for palliative care needs, and with thinking of (sometimes creative) solutions. Thank you for highlighting this aspect, I explained more about the content of the training.

Thank you for your suggestion on finding patients where they are prevalent and going to the GP with a name and a plan. I included this more clearly in the discussion than it was before.

On ‘too much work for potentially small numbers of patients’ when talking about the 2 week audit. Firstly, we recommended GPs to look at their patient consultation and home visit list of the last two weeks, and score them at once, not necessarily after every consultation/home visit prospectively – I included this in the project summary (‘prospectively or retrospectively’).

Secondly, in fact, we experimented with the method you propose. In the latter period of the study, after having seen how difficult many GPs found it to fill the baseline questionnaire, I have visited a GP on myself, who had his online agenda on the computer of the last weeks, and while he mentioned the characteristics of the patients and yes or no to the surprise question I wrote down what he said and later on, I gave him the tables which he had to insert in the online baseline-questionnaire. This assessment indeed took something like 10 minutes. But this was not the general way of doing this, so it is not included in this paper.

A last point I want to make here: the reason why we asked GPs to make a list of all patients seen in 10 days and all eligible patients for our project, is only to find patients to be recruited, but also to have a prevalence rate of palliative care situations in the different settings (GP surgery/home visits/institutions), this is worth another article.
Thank you very much for your suggestions, I rewrote particularly the discussion section. I also deleted the discussion on the British mortality follow back survey and the Australian telephone survey, because other discussion points were more focused on GP and patient recruitment, which is the topic of the article. I also found and included a very interesting Italian study which gives me more hope again about GP-driven identification of early palliative care situations. And I found two other articles reporting patient recruitment issues in palliative care, citing their suggestions for improvement.