Author's response to reviews

Title: Heterogeneity Of Breast Cancer Risk Communication Profiles Of General Practitioners and Breast Surgeons In France, Germany, Netherlands and the UK

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

Please find enclosed the revision of our manuscript entitled: “Heterogeneity Of Breast Cancer Risk Communication Profiles Of General Practitioners and Breast Surgeons In France, Germany, Netherlands and the UK” which we would like to submit for publication in *BMC Cancer* as an original article.

We thank the reviewers for their constructive comments and hope this new version will be suitable for publication. Responses to their comments are described below.

Sincerely yours,

Claire Julian-Reynier, MD, MSc.
Research Director
UMR912, Inserm (National Institute for Health and Medical Research) and Institut Paoli-Calmettes (Regional Comprehensive Cancer Center)
Detailed answers to Reviewer’s comments

Reviewer: Laura Scherer

Reviewer's report:
This article, Heterogeneity Of Breast Cancer Risk Communication Profiles Of General Practitioners and Breast Surgeons In France, Germany, Netherlands and the UK, provides a clear and concise description of risk communication practices among health care practitioners across Europe. As such, it is clearly important that these data are documented, so that researchers can be aware of potential problems (or lack thereof) in cancer risk communications, which can inform future research and communication interventions.

That said, I found that this data report was lacking in terms of interpretation. Below, I highlight some questions that arose while reading this manuscript:

1) First, I could not find Figure 1 in the main uploaded document or in the supplemental materials. This made it difficult to interpret the results, because this figure apparently described the items that physicians responded to. Any revision would have to include these details.

Author’s answer: We do apologize for the omission of figure 1; it has now been added.

2) Following point #1, it was unclear whether physicians’ reports were preferences for risk communication, or their estimation of how they actually communicate risk. This point could probably be clarified with the inclusion of Figure 1. However, even when Figure 1 is included, it will be critical to discuss how self-reported risk communication could differ from actual risk communication practices. Are physicians reporting what they would ideally communicate, what they believe they communicate (whether or not it is ideal), or what they actually communicate?

Author’s answer: As presented in Figure 1, physicians’ reports were about their estimation of how they actually communicate risk. We were concentrating more on the issue of beliefs which are likely to be a mix between what they consider they would do and what they consider they should do. We discussed this point in the discussion section (cf lines 289-294)

3) The data clearly show that HRT and family history risks are discussed most often, and factors such as obesity, exercise, alcohol, etc., are discussed less frequently. However, the risks that are discussed less frequently are also risks that have less data, and more ambiguous data, associated with them. So doesn’t it make sense that they are discussed less frequently? A discussion of this point should have greater prominence.

Author's answer: We agree with this comment and gave greater prominence in the discussion section (cf lines 246-247)

4) The authors need to provide more thorough discussion of why ‘Numerical Balanced Presenters’ are the gold standard for risk communication. It is important for readers to receive at least a brief review of this literature, rather than simply making a statement that it is the best method and providing citations.

Author’s answer: We introduced the statement on ‘the best standard’ for risk communication in the introduction adding a very brief review of the literature (introduction lines 83-90)

5) Similar to point #4, this article could have a greater impact if the authors discussed the implications of the different communication methods. In other words, I would like to see an expansion of the type of discussion that appears on page 10. For example, can the authors speculate as to why ‘Positively Unbalanced Presenters’ were the most common cluster? And if this is good or a bad thing, i.e. something warranting change? I felt that the authors went a bit too far in terms of presenting a dry, impartial report of the data—the reader could benefit from being told explicitly what the literature says about whether these strategies good, bad, ambiguous, etc.

Author’s answer: Thank you for this remark. Actually with the remark from the other reviewer about the labels attributed to the clusters, we found it clearer to expand the discussion about
the most prevalent group of doctors who did not present the probability to ‘not’ develop cancer. We expanded this discussion (discussion section, lines 259-270)

6) On page 7 the authors state that the French physicians were removed from the analyses. Which analyses were they removed from? I see that they appear in most of the tables. Please clarify this point.

Author’s answer: We agree that the first version of the manuscript was not clear enough about this point. A specific group of French physicians (a subgroup of gynaeco-obstetricians but not all!) were removed from the analyses because their practice was very specific and only focused on obstetrics or medical gynaecology; after discussion with the co-authors from the other countries it was clearly an issue of having a group of practitioners not comparable to those observed in the 3 other countries either GPs or Breast Surgeons. For this reason we excluded these gynaeco-obstetricians not practicing breast surgery from the analyses presented here. We simplified a lot the presentation both in the methods and results sections (paragraph Incrisc study and study sample) since this presentation had already been explained in a first analysis of the survey focusing on another different issue (den Heijer et al. 2013, ref 20).
Reviewer's report
Title: Heterogeneity Of Breast Cancer Risk Communication Profiles Of General Practitioners and Breast Surgeons In France, Germany, Netherlands and the UK
Version: 2  Date: 24 September 2014
Reviewer: Amy Downing
Reviewer's report:
Major compulsory revisions
This is an interesting manuscript, however I have a few major concerns about the presentation of results and interpretation.
1. I found it very difficult to understand the labels given to the groups (eg verbal negative unbalanced) and to get a feel for what the differences between the groups were. I think the choice of labels needs some thought or at least there needs to be a much clearer description of what the labels mean. Perhaps an example vignette and the possible responses would help this?

Author’s answer: Defining labels to characterize a specific cluster was difficult because of the multiple dimensions of risk communication; actually we were not completely satisfied with the previous choices. Your comments helped us to think differently. In the first version of the paper we had described the content of risk communication based on what the doctors had selected as risks communicated based on the example of “Louise’s” vignette Q11-3 (figure 1): positive framing of risks (meaning disease risks through absolute/relative risks) negative framing of risks (meaning the risk of not having the disease) and risk formats (numbers vs verbal). We reversed the process, using this time the risks “not” communicated in the specific clusters.
We described now the 5 clusters as follows:
- cluster 1: “Verbal Formulation missing & Relative Risk missing”
- cluster 2: “Negative Framing missing”
- cluster 3: “Verbal Formulation missing”
- cluster 4: “No Formulation missing”
- cluster 5: “Numbered Absolute Risk missing”

2. With such a low response rate and the variation in response across the countries I find it difficult to know whether any differences seen are ‘real’. It is not clear from the text what factors have been included in the multivariable adjustment (although it is in the tables). The authors need to make it very clear that any differences by country are require further investigation.

Author’s answer: In the text we described more in depth on what factors the results have been adjusted (page 6, lines 145-146). We agree on the fact that country differences deserve further investigation. This has been added in the discussion section (lines 297-298)

3. Following on from point 2, I personally find the differences between GPs and breast surgeons more interesting and it may be better to place more emphasis on that rather than on the country differences.

Author’s answer: We have followed your suggestion (see discussion lines 259-273, lines 300, 302)

Minor essential revisions
1. Abstract results - ‘The most frequent one was characterised by positively unbalanced risks and by the fact that only 2.9% stated that they would present the probability not to present cancer’. I do not understand this sentence - positively unbalanced suggests that they are presenting an overly positive view but this is at odds with not presenting the probability to not develop cancer. It doesn't make sense to me, please re-phrase. This also applies to the results, line 201.

Author’s answer: we rephrased the abstract with the new cluster labelisation. Actually ‘positive’ framing corresponds to framing the occurrence of an event (here the cancer occurrence) whereas negative framing corresponds to framing the ‘non’ event (ie, they do not develop cancer). We agree that positive framing corresponds to a ‘non-happy’ event and negative framing to a ‘happy one” but
this is the terminology used when talking about risks in epidemiology. We hope this is now more understandable in the revised version.

2. Introduction, line 73 - 'Presently faced with...' This sentence does not make sense. Please rephrase.
Author’s answer: we have rephrased

3. Introduction, line 81 - Move the objective to end of the paragraph.
Author’s answer: done

4. Methods - state what is included in the statistical adjustment.
Author’s answer: done

5. Discussion, line 241 - change ‘family’ to ‘family history’ to be clear that it does not relate to contraception.
Author’s answer: done