Author’s response to reviews

Title: Advance directives in France: Do junior General practitioners want to improve their implementation and usage? A nationwide survey

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Author’s response to reviews:

Dear editor, Dear reviewer,

Thank you for the opportunity to provide a new version of our manuscript. We have carefully taken into account reviewer comments in the revised manuscript. Please find below our point-by-point response to reviewers’ comments.

Colleen Cartwright, PhD, MPH, B Soc Wk (Hons), ADA (Reviewer 1): The authors have addressed all of the concerns I raised in my initial review. The paper is now of sufficient quality to publish.
Reviewer 2 (Reviewer 2): REVISION ASSESSMENT FROM THE ACADEMIC PEER REVIEWER:

Reviewer comments: The answers to the reviewers questions are detailed and very helpful but a lot of this information should go in the text eg in relation to the French legal system and the title should include the word France within it, eg, Advance Directives in France ................. .

As suggested by Reviewer 2, the title was modified, including “in France”.

The manuscript itself is very short and much of the helpful detail that the author(s) provide in relation to the reviewer's questions should appear in the text.

As suggested by the Reviewer, we add part of the previous answers (cf. responses to the first review, joined to the current review) within the text:

- Page 5, line 23: “In France medical studies are constituted of two different periods: a first one (six years) of initial and common formation and a second one (“internat”) during which they choose a medical or surgical specialty, and work in different wards to lean specificity of their future job. This is probably close to “fellowship” in the US. This period lasts three years for general practitioners. This was our target population.”

- Page 6, line 5: “No official promotion of the study was available but two authors (SW and AH) have sent mails to the head of GPR in each university. Three reminders mails were sent to each group of GPR (one group per City/University). Individual mails were also sent when they were available. We try to contact educational leaders without any answer.”

- Page 10, line 3: “In our study, a very small percentage of responders would “systematically take AD into account”. Such a decision could be questionable considering that according to the 2005 French law, physician should have taken AD into account. The survey was not designed to explain such observations, but we already know that until the modification of the ethical law in France (2016) many doctors considered that patients where not competent to decide what level of therapeutic intensity they should receive and affirm they would not apply these AD arguing of the impossibility to be sure the patient did not have change his/her mind since the AD were wrote, or considering the patient unable to take an “informed decision” due to the lack of information concerning ICU or surgery, etc… On the other hand, many clinicians were much more afraid of legal consequences of a therapeutic withdrawal or withholding than of an excess in intensity of care. Moreover despite large modification in the current law, weaknesses remain leading French physician to keep some distance from AD. In emergency situation, “stabilization
of the patient condition” could and (probably should) be done before taking AD into account, at least in case of uncertainty about patient status. Moreover, many semantic points remain unanswered, for example: AD are often considered as wished for “end of life” situation, but except for chronic diseases, this notion is far unclear leading to an excess of aggressive treatment of severe conditions even in case of DNR wishes of the patient; another example could be the notion of “refusal of therapeutic relentlessness” which does not mean anything, leaving the clinician to choose when the treatment becomes futile. These points of weakness of the law, this supposed difference between the text and spirit of the law and the fear of not doing enough (in curative cares) are favoring intensity instead of comfort care in many situations.

Other parts of the previous answers were already integrated in the whole manuscript:

- Page 4, line 14: “This first version of the law was not legally binding for physicians, but should “be taken into account” for ethical reflections when the patient is unable to express his opinion. There was, however, a priority of medical practice over patients’ preferences, and physicians were allowed not to take AD into account because of uncertainty in sustainability of patients’ choices or because of apparent discrepancy between patients’ status and AD, suggesting that the wishes expressed by the patient were not taken with sufficient knowledge, and AD must be less than three years-old to be valid.”

- Page 7, line 1: “2310 residents filled out our survey over a total of 10 942 GPR”

- Page 10, line 6: “(mean percentage of women in the whole GPR population of interest during the study period: 62.9%)”