PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Intellectual disability and mental health problems: a qualitative study of general practitioners' views
AUTHORS	Fredheim, Terje; Haavet, Ole; Danbolt, Lars; Kjønsberg, Kari; Lien, Lars

VERSION 1 - REVIEW

REVIEWER	Elizabeth Barley, senior lecturer, Florence Nightingale School of Nursing and Midwifery, King's College London,
REVIEW RETURNED	07-Dec-2012

THE STUDY	This qualitative interview study investigates GPs' experience of people with intellectual disabilities and mental or behavioural problems. A minor point: the authors used the term 'handling' people with intellectual disabilities, it would be preferable if this could be changed to a word with less negative connotations eg helping or managing or 'working with'. Study aim: 'to explore the experiences, competences, attitudes and role of GPs......' this is clear, however the term 'competences' should be removed or changed as it is not possible to determine if the GPs are competent by interviewing them. It could be 'perceived competence', but you would have to make sure that you addressed this specifically in the interview, which at the moment it doesn't appear that you have. The same applies to the term role - perhaps you mean the GPs' 'perceived' role? Methods: under participants you state that 'it was estimated that a smaple size of 7 to 10 ...would be required to achieve sufficient data and identify key themes' - on what is this estimate based, the reader needs to be convinced that this is the case in order to believe that all themes have been captured. setting - this section really describes your data collection process rather than the study setting. data collection - the two questions cited are very broad, it would be useful to see the topic guide, the 'additional checklist' that you refer to or a list of prompts used. You seem to be interested in whether an evidence based approach is taken, it would be useful to know what evidence based treatments/management strategies are available - you hint at this in places but for the non-specialist it would be useful to spell them out.
RESULTS & CONCLUSIONS	I can't see figure 1, so can't comment on this. I would like to see more quotes which directly support the reported results. For instance, p8 'GPs described limited training....', 'GPs

	saw the advantage of being a faimily doctor'..... P8 'none of them had knowledge of the NMA's internet course' - did you ask them directly? Also, what is this course? Descriptions of some of the examples of patients described by the GPs may help the reader understand the issues better. Discussion - I agree that your study highlights the complexity of providing services to these patients. Your finding that GPs are uncertain/unhappy about the available specialist care is also important. My main difficulty is around your conclusion that GPs' practice is experience rather than evidence based - this seems to be true, but what I can't tell from your paper is what evidence based treatment/policy/guidelines are available. You refer to things such as health checks and psychotropic medication use, but also state that there is a lack of standard guidelines. Is it the case that evidence based management strategies are available but that GPs ignore them/are unaware of them (in which case it would be good to understand why) or is it that the only option GPs have when dealing with these patients is to rely on their own experience? in which case it would be good to highlight what their specific difficulties are and how they could be addressed. From your 'comparison with exisiting literature' section it seems that the latter case is more likely, but this needs to be demonstrated consistently throughout the paper before it can be published. Otherwise this is an interesting paper. Finally, you could make more of the fact that this is an under-researched area and the equity of care implications. You should be commended on starting to address this!
REPORTING & ETHICS	As far as I can tell there are no conflicts of interest. I can't see a number relating to the ethical approval.

REVIEWER	Yona Lunsky, PhD Centre for Addiction and Mental Health Toronto, Canada I have no competing interests in reviewing this manuscript.
REVIEW RETURNED	18-Dec-2012

THE STUDY	This is a qualitative study and so some of the methodological questions do not apply but there is no N/A choice. I think their description of their coding process was clear. In this study, participants are doctors, not patients but they are well described. That being said, it is important because this is an international audience to provide some information about the training of GPs as it relates to intellectual disabilities in addition to policy and services in the jurisdiction where this is written. The role of the GP and resources available to the GP vary by jurisdiction.
RESULTS & CONCLUSIONS	I would have liked to have sen further illustrative quotes to support some of the ideas put forth.
GENERAL COMMENTS	I thought this was a very interesting brief paper on a topic that does not receive significant research attention in mainstream medical journals. Using qualitative data, it provides a model to describe the process by which physicians work with this patient group (patients with ID and MBP) in their practice. The findings are important and

speak to the need for further education and resources for GPs.

In general, I would like to see further illustrative quotes along with a richer discussion and contextualizing of findings. This would give greater assurance that the qualitative findings are accurate. It would be important to refer further to other qualitative studies on the experience of physicians serving this population. (ex. Wilkinson et al 2012. IDD, 50(3), 243-250). There are also qualitative studies of physicians working hospital settings that would be relevant. It might also be important to contextualize the experience of doctors with the experience of patients as part of the discussion. Several papers have been written on that. Some parts of the results do not seem particularly focused on issues unique to patients with ID and MBP. THis is important to comment on. Other issues are more specific to the MBP issues, particularly decisions around treatment and working with other professionals. If the theme of this paper is the unique challenges of MBP, then this should be made quite salient.

I offer some specific comments below:
With regard to available tools and resources, there are guidelines and tools for GPs available and it could be helpful to make reference to them (e.g., Canadian Consensus Guidelines on Developmental Disabilities, Cdn Fam Physician, 57, 541-53).

I think the figure is a helpful guide to understand study results but there are some inconsistencies between the paper and figure that could be corrected.

The first box on left hand side: Before consultation could be changed to BASIS for Decisions, or Basis for treatment. The bottom box in that column could be renamed patient background because it is not about the patient's knowledge but about knowledge the GP has on the patient's background.

SEcond column: Type could be revised to read type of appointment. THe next two boxes, routines/rituals and communication/observation, get confused in the results section. It would be clearer if the text on page 10 begins with discussion of patient rituals and routines, and then a discussion on communication and obervation.

Treatment (pg 11)
the GP is actually making 1 decision with 2 choice options. COuld be rewritten as two choices the GP has when trying to solve the patient's...

Evaluating and Continuing Treatment (p13)
It was not clear to me whether the GPs felt like the meetings with non physicians ("Collaborators") were tailored in part to them ("structured towards their attendance") or whether they felt "left alone" in that process. Maybe the authors wanted to suggest that GPs felt including in discussions sometimes but others felt excluded. THis is an important finding so it needs to be clear. Is the sense of isolation because the GP does not feel like an expert or because the GP is excluded or feels excluded from these meetings?

Discussion
Summary of main findings: I did not think that this paragraph adequately summarized study findings.

	Comparison with existing literature: I do not think thise section compares existing literature adequately. The only literature included is on efficacy of medications. There is a broader literature on physician preparedness and comfort. It would also be important to discuss training initiatives in the author's jurisdiction but also internationally to assist in helping GPs to feel more competent. Some key papers were not included here, including the work of Nick Lennox on physician attitudes and knowledge.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Elizabeth Barley, senior lecturer, Florence Nightingale School of Nursing and Midwifery, King's College London

This qualitative interview study investigates GPs' experience of people with intellectual disabilities and mental or behavioural problems.

A minor point: the authors used the term 'handling' people with intellectual disabilities, it would be preferable if this could be changed to a word with less negative connotations eg helping or managing or 'working with'.

Answer: Thank you for noticing us on the negative connotations of the term “handling”. It is changed to managing or helping.

Study aim: 'to explore the experiences, competences, attitudes and role of GPs......' this is clear, however the term 'competences' should be removed or changed as it is not possible to determine if the GPs are competent by interviewing them. It could be 'perceived competence', but you would have to make sure that you addressed this specifically in the interview, which at the moment it doesn't appear that you have. The same applies to the term role - perhaps you mean the GPs' 'perceived' role?

Answer: It is changed in accordance to the suggestions from the reviewer. As you say, it could be unclear to talk about competence and roles, since we did not explore that in a quantitative manner. Perceived role and competence is a better description, and this is what is discussed in the results section.

Methods: under participants you state that 'it was estimated that a smaple size of 7 to 10 ...would be required to achieve sufficient data and identify key themes' - on what is this estimate based, the reader needs to be convinced that this is the case in order to believe that all themes have been captured.

Answer: I have removed the part about estimation of sample size, since that is unclear and impossible to tell for sure. The researchers agreed that the transcripts from the interviews contained enough material to identify important themes. We can however not be sure that other important themes and issues could have been captured if even more participants had been interviewed.

setting - this section really describes your data collection process rather than the study setting.

Answer: It now contains a bit more about the setting, in addition to a description of the non existing relationship between the participants and the interviewers.

data collection - the two questions cited are very broad, it would be useful to see the topic guide, the 'additional checklist' that you refer to or a list of prompts used.

Answer: A list of additional prompts has been added, with a special focus on the keywords interesting for this paper.

You seem to be interested in whether an evidence based approach is taken, it would be useful to know what evidence based treatments/management strategies are available - you hint at this in places but for the non-specialist it would be useful to spell them out.

Answer: In the background section we have added a few sentences on this issue.

I can't see figure 1, so can't comment on this.

Answer: It is not clear why you couldn’t see figure 1, but reviewer 2 has commented on this, and it is now changed due to this comments.

I would like to see more quotes which directly support the reported results. For instance, p8 'GPs described limited training....', 'GPs saw the advantage of being a faimily doctor'.....

Answer: Some quotes have been added to more directly illustrate and support the reported results.

P8 'none of them had knowledge of the NMA's internet course' - did you ask them directly? Also, what is this course?

Answer: The participants were asked directly, and some additional information on this course has been added.

Descriptions of some of the examples of patients described by the GPs may help the reader understand the issues better.

Answer: On page 8, in the beginning of the results section, we have added a case description to help the reader understand the complexity of these issues.

Discussion - I agree that your study highlights the complexity of providing services to these patients.

Your finding that GPs are uncertain/unhappy about the available specialist care is also important.

My main difficulty is around your conclusion that GPs' practice is experience rather than evidence based - this seems to be true, but what I can't tell from your paper is what evidence based treatment/policy/guidelines are available. You refer to things such as health checks and psychotropic medication use, but also state that there is a lack of standard guidelines. Is it the case that evidence based management strategies are available but that GPs ignore them/are unaware of them (in which case it would be good to understand why) or is it that the only option GPs have when dealing with these patients is to rely on their own experience? in which case it would be good to highlight what their specific difficulties are and how they could be addressed. From your 'comparison with exisiting literature' section it seems that the latter case is more likely, but this needs to be demonstrated consistently throughout the paper before it can be published. Otherwise this is an interesting paper.

Answer: Our results demonstrate that the GPs rely mainly on experience based knowledge. We have added some suggestions to an explanation of this finding in the “discussion section”. Some more specific information on the availability of literature and courses on this topic have been added. The question of evidence based practice is not a case of either/or, but the situation is complex, and it can be that ignorance, poor availability of courses/literature, little focus on this group of patients and trust in own experience together can explain the results better. We hope this is better demonstrated through the paper in the revised version.

Finally, you could make more of the fact that this is an under-researched area and the equity of care implications. You should be commended on starting to address this!

Answer: Thank you for pointing this out. This fact is addressed with more clarity a couple of places in the revised paper.

As far as I can tell there are no conflicts of interest. I can't see a number relating to the ethical approval.

Answer: The number relating to the ethical approval is 10-2008 SI.

Reviewer: Yona Lunsky, PhD

Centre for Addiction and Mental Health

Toronto, Canada

I have no competing interests in reviewing this manuscript.

This is a qualitative study and so some of the methodological questions do not apply but there is no N/A choice. I think their description of their coding process was clear.

In this study, participants are doctors, not patients but they are well described. That being said, it is important because this is an international audience to provide some information about the training of GPs as it relates to intellectual disabilities in addition to policy and services in the jurisdiction where this is written. The role of the GP and resources available to the GP vary by jurisdiction.

I would have liked to have sen further illustrative quotes to support some of the ideas put forth.

Answer: Several quotes have been added, as the same comment was put forth from reviewer one as well.

I thought this was a very interesting brief paper on a topic that does not receive significant research attention in mainstream medical journals. Using qualitative data, it provides a model to describe the process by which physicians work with this patient group (patients with ID and MBP) in their practice. The findings are important and speak to the need for further education and resources for GPs.

In general, I would like to see further illustrative quotes along with a richer discussion and contextualizing of findings. This would give greater assurance that the qualitative findings are accurate. It would be important to refer further to other qualitative studies on the experience of physicians serving this population. (ex. Wilkinson et al 2012. IDD, 50(3), 243-250). There are also qualitative studies of physicians working hospital settings that would be relevant. It might also be important to contextualize the experience of doctors with the experience of patients as part of the discussion. Several papers have been written on that. Some parts of the results do not seem particularly focused on issues unique to patients with ID and MBP. THis is important to comment on. Other issues are more specific to the MBP issues, particularly decisions around treatment and working with other professionals. If the theme of this paper is the unique challenges of MBP, then this should be made quite salient.

Answer: This is a comment that helps to clarify and increase the quality of the paper. Some further illustrative quotes have been added, and a case description has been added to help the reader understand the complexity of the issues in this paper. The findings from Wilkinson et al. have been described and added, both in the background section, and comparison with existing literature section. The paper has also been more focused on the special MBP issues, by adding specific information about education and papers, giving some description of typical challenges faced by the GPs, and discussing this unique challenge in the “discussion section”.

I offer some specific comments below:

With regard to available tools and resources, there are guidelines and tools for GPs available and it could be helpful to make reference to them (e.g., Canadian Consensus Guidelines on Developmental Disabilities, Cdn Fam Physician, 57, 541-53).

Answer: These Canadian guidelines have been described shortly in the background section, and are also mentioned as a starting point to provide GPs with important peer reviewed literature on this topic.

I think the figure is a helpful guide to understand study results but there are some inconsistencies between the paper and figure that could be corrected.

The first box on left hand side: Before consultation could be changed to BASIS for Decisions, or Basis for treatment. The bottom box in that column could be renamed patient background because it is not about the patient's knowledge but about knowledge the GP has on the patient's background.

SEcond column: Type could be revised to read type of appointment. THe next two boxes, routines/rituals and communication/observation, get confused in the results section. It would be clearer if the text on page 10 begins with discussion of patient rituals and routines, and then a discussion on communication and obervation.

Answer: The figure is now corrected in response to these comments, and the results section better correspond to the figure when it comes to results in the subcategory “consultation”.

Treatment (pg 11)

the GP is actually making 1 decision with 2 choice options. COuld be rewritten as two choices the GP has when trying to solve the patient's...

Answer: This has been corrected in response to the comment.

Evaluating and Continuing Treatment (p13)

It was not clear to me whether the GPs felt like the meetings with non physicians ("Collaborators") were tailored in part to them ("structured towards their attendance") or whether they felt "left alone" in that process. Maybe the authors wanted to suggest that GPs felt including in discussions sometimes but others felt excluded. THis is an important finding so it needs to be clear. Is the sense of isolation because the GP does not feel like an expert or because the GP is excluded or feels excluded from these meetings?

Answer: This is important to clarify. Some additional information and quotes are added to better describe the situation the GPS are faced with, especially on p 14 and 15. The feeling of “being left alone” was mentioned when they were faced with medical questions, and the GPs had no collaborators to discuss these issues with in collaborative meetings.

Discussion

Summary of main findings: I did not think that this paragraph adequately summarized study findings.

Answer: The summary of main findings has been changed to better describe the findings as the revised paper now appears.

Comparison with existing literature:

I do not think thise section compares existing literature adequately. The only literature included is on efficacy of medications. There is a broader literature on physician preparedness and comfort. It would also be important to discuss training initiatives in the author's jurisdiction but also internationally to assist in helping GPs to feel more competent. Some key papers were not included here, including the work of Nick Lennox on physician attitudes and knowledge.

Answer: The comparison with existing literature have been extended. When it comes to training initiatives, some information about this issue have been written in the background section.

VERSION 2 – REVIEW

REVIEWER	Elizabeth Barley Senior Lecturer Florence Nightingale School of Nursing and Midwifery 57 Waterloo Road London SE1 8WA I have no competing interests.
REVIEW RETURNED	21-Jan-2013

THE STUDY	the questions relating to statistical methods are not appropriate for

	this qualitative study. Q3 - the participants are doctors not patients, their representativeness in terms of Norwegian GPs in general has been discussed.
REPORTING & ETHICS	The number associated with ethical approval is provided in the author's response letter, it should also be reported in the manuscript.
GENERAL COMMENTS	All suggested revisions appear to have been made. The paper is now much clearer. A couple of minor corrections are needed: p2 'handling' the authors have changed this word to 'managing' elsewhere, but this negative term is still used in teh article summary. p4 intro: the Norwegian Medical association internet course should be referenced. There are a few typos/grammatical errors throughout, proof reading by a native English speaker should help with this: for instance: p5 first para: a qualitative study have - should be 'has'; 2nd para There is however few studies - should be 'are'; p7;FU questions were taken from a list of key words; number o fpatients in the GP's patient group' - this doesn't seem clear; p9 first para faced with, managing - delete comma; 'hard regulated diabetes' - suggest 'difficult to control diabetes'?; heavily smoking - should be heavy smoking (although even light smoking is bad!); alcohol drinking should be 'drinking alcohol'; p14 last para 'this was told to lowering..' - suggest 'this was considered to lower'? discussion p 16 1st para mainly relies - should be 'rely'; the second last sentence of this para seems unclear. p18 final sentence - more detail could be given as this sentence doesn't tell us much - suggest recommendation that guidelines need to be developed and disseminated to GPs, rather than focusing on the Canadian ones which most readers will not know about.

REVIEWER	Yona Lunsky Clinician Scientist, Associate Professor CAMH, University of Toronto CANADA I have no competing interests
REVIEW RETURNED	30-Jan-2013

THE STUDY	Abstract: The results in the abstract are too general. Key messages (pg 2) are more in line with study findings. I would like to see further references on training of physicians to work with this population, and on attitudes and knowledge of physicians.
RESULTS & CONCLUSIONS	I think the message is not clear and the discussion requires further revision. Only parts of the results and discussion address issues unique to GP's working with patients with MBP The main issue discussed in the discussion is on medications but there are several results that are not discussed at all, which are equally important.
GENERAL COMMENTS	ABSTRACT: The abstract is somewhat vague. Objectives: consider PATIENTS instead of PEOPLE Results: The GPs provided different meanings.. (this is unclear, doesn’t describe findings, just topics or topics.) Conclusions: This potential is not yet fully exploited. Consider saying instead: However, they do not appear to be drawing from evidence

	in making treatment decisions. They find it difficult to …(should be some mention of their emotional experience). I think the manuscript is improved in some areas (clarity of organization in results, and additional quotes and details). Introduction: I do not think the introduction has been modified sufficiently. The added sentence on the primary guidelines from Canada and the Norweigan internet course does not fit. Could say instead: Similarly, guidelines have been developed in other countries (Canada, US). Training is available internationally (cite Australia, US, through the AAMDDD, also UK) but not clear how widely used… The addition of Wilkinson study was just one example, there are other qualitative studies of physician experience. There is not sufficient information on study findings in intro. And other studies are not mentioned. Also, the second to last paragraph or final paragraph should demonstrate what has been done that applies to DD and MBP, and where gaps are. Final paragraph of intro should be corrected in terms of tenses (HAS instead of HAVE, ARE instead of IS) Results: not sure what HARD REGULATED DIABETES means, but it may be obvious to the GP On page 12, the quote is quite similar to quote on p10. Did the interviewee say the same thing twice? Did anyone else comment on this besides that person? Would be nice to include different related quotes and demonstrate similar themes from different participants rather than repeating same theme twice by single participant. Discussion The first paragraph is expanded but primarily only on one point: that education is limited and they do their work based on experience despite information on best practice being available. I think this point can be made more succinctly but the other points should be summarized here as well: sense of isolation, important role physician plays when collaborate with patient and caregivers, issue re: medications. The comparison with existing literature paragraph introduces topic of medication for first time but does not compare other results to literature. The addition of the Wilkinson paper does not give enough information to show how results are in line with findings: Which results? All of them? About medication? Other topics to contextualize with literature would include attitudes and comfort of physicians, training in other jurisdictions, how other jurisdictions have helped physicians to become more comfortable, importance of the GP relationship with patient… These are just examples but I think the discussion needs to discuss more than it does. In general, I think the paper could better demonstrate the true challenge of GPs with regard to these patients with MBP. Dealing with medical issues alone is not the challenge. The real difficulty is the complex interplay between emotional health and physical health.

VERSION 2 – AUTHOR RESPONSE

Reviewer: I have no competing interests.

Elizabeth Barley
Senior Lecturer
Florence Nightingale School of Nursing and Midwifery
57 Waterloo Road
London
SE1 8WA

The number associated with ethical approval is provided in the author's response letter, it should also be reported in the manuscript.

All suggested revisions appear to have been made. The paper is now much clearer.
A couple of minor corrections are needed:
p2 'handling' the authors have changed this word to 'managing' elsewhere, but this negative term is still used in teh article summary.
p4 intro: the Norwegian Medical association internet course should be referenced.
There are a few typos/grammatical errors throughout, proof reading by a native English speaker should help with this: for instance:
p5 first para: a qualitative study have - should be 'has';
2nd para There is however few studies - should be 'are';
p7;FU questions were taken from a list of key words; number of patients in the GP's patient group' - this doesn't seem clear;
p9 first para faced with, managing - delete comma; 'hard regulated diabetes' - suggest 'difficult to control diabetes'?; heavily smoking - should be heavy smoking (although even light smoking is bad!); alcohol drinking should be 'drinking alcohol';
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discussion p 16 1st para mainly relies - should be 'rely';
the second last sentence of this para seems unclear.
p18 final sentence - more detail could be given as this sentence doesn't tell us much - suggest recommendation that guidelines need to be developed and disseminated to GPs, rather than focusing on the Canadian ones which most readers will not know about.

ANSWER: Thank you for your suggestions, comments on grammatical errors and unclear sentences. All your suggestions has been considered and changed. The number associated with ethical approval is provided in the manuscript.

Reviewer: Yona Lunsky
Clinician Scientist, Associate Professor
CAMH, University of Toronto
CANADA

I have no competing interests

Abstract: The results in the abstract are too general. Key messages (pg 2) are more in line with study findings.
I would like to see further references on training of physicians to work with this population, and on attitudes and knowledge of physicians.

I think the message is not clear and the discussion requires further revision.
Only parts of the results and discussion address issues unique to GP's working with patients with

MBP
The main issue discussed in the discussion is on medications but there are several results that are not discussed at all, which are equally important.

ABSTRACT: The abstract is somewhat vague.
Objectives: consider PATIENTS instead of PEOPLE
Results: The GPs provided different meanings.. (this is unclear, doesn't describe findings, just topics or topics.)
Conclusions: This potential is not yet fully exploited. Consider saying instead: However, they do not appear to be drawing from evidence in making treatment decisions. They find it difficult to …(should be some mention of their emotional experience).

ANSWER: The abstract is changed to better describe the results as suggested by the reviewer.

I think the manuscript is improved in some areas (clarity of organization in results, and additional quotes and details).

Introduction: I do not think the introduction has been modified sufficiently. The added sentence on the primary guidelines from Canada and the Norweigan internet course does not fit. Could say instead: Similarly, guidelines have been developed in other countries (Canada, US). Training is available internationally (cite Australia, US, through the AAMDDD, also UK) but not clear how widely used… The addition of Wilkinson study was just one example, there are other qualitative studies of physician experience. There is not sufficient information on study findings in intro. And other studies are not mentioned. Also, the second to last paragraph or final paragraph should demonstrate what has been done that applies to DD and MBP, and where gaps are.

Final paragraph of intro should be corrected in terms of tenses (HAS instead of HAVE, ARE instead of IS)

ANSWER: Thank you for valuable comments. The suggestions are considered and changes are done in response to the concerns of the reviewer.

Results: not sure what HARD REGULATED DIABETES means, but it may be obvious to the GP

ANSWER: The phrase has been changed to "difficult to control diabetes".

On page 12, the quote is quite similar to quote on p10. Did the interviewee say the same thing twice? Did anyone else comment on this besides that person? Would be nice to include different related quotes and demonstrate similar themes from different participants rather than repeating same theme twice by single participant.

ANSWER: These quotes are similar in a way, but in the same time different. The same doctor talks about two different patients. The quote on p10 is chosen to exemplify the importance of being a family doctor with relation to other family member of the patient, while the quote on p12 is chosen to illustrate the importance of letting the patient take their time to do their routines and rituals. And similarly, both patients are showing confidence with their GP.

Discussion
The first paragraph is expanded but primarily only on one point: that education is limited and they do their work based on experience despite information on best practice being available. I think this point can be made more succinctly but the other points should be summarized here as well: sense of isolation, important role physician plays when collaborate with patient and caregivers, issue re:

medications.

The comparison with existing literature paragraph introduces topic of medication for first time but does not compare other results to literature. The addition of the Wilkinson paper does not give enough information to show how results are in line with findings: Which results? All of them? About medication? Other topics to contextualize with literature would include attitudes and comfort of physicians, training in other jurisdictions, how other jurisdictions have helped physicians to become more comfortable, importance of the GP relationship with patient… These are just examples but I think the discussion needs to discuss more than it does.

In general, I think the paper could better demonstrate the true challenge of GPs with regard to these patients with MBP. Dealing with medical issues alone is not the challenge. The real difficulty is the complex interplay between emotional health and physical health.

ANSWER: These are valuable comments, and are considered important. Some additional references have been added, and some more of the results are discussed. We have chosen to discuss some of the issues. There are a number of themes that emerged as relevant to discussion, so many that we found out that we had to select the topics which were most prominent in the interviews with the GPs.