

## Original article

# Physician and patient survey of allergic rhinitis: methodology

Methodology for Disease Specific Programme (DSP<sup>®</sup>) surveys designed by Adelphi Group Products is used each year to survey patients and physicians on their perceptions of treatment effectiveness, symptoms and impact of diseases. These point-in-time surveys, conducted in the USA and Europe (France, Germany, Italy, Spain and UK), provide useful information on the real-world management and treatment of diseases. This paper describes the methodology for the DSP survey in allergic rhinitis, detailing the preparation of materials, recruitment of physicians, data collection and data management.

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Data derived from randomized controlled trials are considered to be the gold standard for evaluating the efficacy of a treatment intervention against the current standard of care. However, the scope of these trials is limited in terms of evaluating and describing the needs of the broader group of patients seen in everyday practice. Point-in-time surveys provide additional data to show the effectiveness and impact of a treatment in the real world and, despite the potential for confounding biases, often provide new insights that can be used as the basis for future research.

Under the banner of 'Disease Specific Programmes' (DSPs), patients were recruited prospectively for a series of surveys of physicians' and patients' perceptions of treatment effectiveness, and symptoms and impact of diseases. These studies have provided useful information on the real-world treatment of diseases and allowed comparison of physician and patient responses.

The methodology for the DSP surveys was designed by Adelphi Group Products. Surveys in respiratory disease have been run annually in the USA and Europe (France, Germany, Italy, Spain and UK) over a number of years. This paper describes the methodology for the DSP survey in allergic rhinitis (AR), detailing the preparation of materials, recruitment of physicians, data collection and data management.

## DSP methodology

### Preparation of DSP field materials

Data collection for the DSP survey involved initial physician interviews and an evaluation of the physicians' workload. The evaluation of patients with AR was administered using two paper-based structured questionnaires: a patient record form (PRF) completed by physicians and a patient self-completed (PSC) form completed independently by patients. The questionnaires included predominantly adjectival responses but also some free-text responses. Many of the questions in the survey are the same each year but new questions specific to that year may also be included. To ensure that the questions were clinically meaningful, unambiguous and relevant for the AR disease area, the DSP materials were piloted using practising physicians.

In 2006, the physician-completed PRFs were structured under the following headings: patient demographics, diagnosis (and comorbidities), diagnostic investigations, symptomatology, medical therapy, reasons for choice of medicines, patient involvement and awareness of their condition, patient compliance, consultation history and impact of the condition on the patient. Similar data were recorded by patients on the PSC form, including information on the following: perceptions about the medicines taken for AR; disease history and

consultation history; triggers, symptoms and severity of disease; the impact of AR on sleep, normal activities, sport and leisure, work or school; and health-related quality of life.

The DSP materials were developed in UK English, necessitating accurate translation of the data collection forms into other languages. To ensure consistency and accuracy of the translations, the same translators were used at all stages of the programme, and all translated materials were checked by a native speaker to ensure the translated forms accurately reflected the intended meaning of the original form.

#### Recruitment of physicians

Fieldwork personnel fluent in the local language were responsible for the recruitment of participating physicians as well as the collection, collation and audit of all completed DSP materials. All fieldwork agencies in each country were affiliated to a national body that governs data collection procedures and laws in that country and were subject to annual and/or random audits.

Data collection was carried out in accordance with national and international bodies that govern data collection procedures and laws; including the World Association of Opinion & Market Research Professionals [formerly European Society for Opinion & Market Research (ESOMAR); <http://www.esomar.org>] and the US Department of Health and Human Services (HIPAA; <http://privacyruleandresearch.nih.gov>). All data processing and collection procedures were conducted in accordance with the standards laid down by HIPAA, ESOMAR and the Market Research Society (MRS) Code of Conduct (<http://www.mrs.org.uk>) using quality control standards that generally exceeded those specified by the BMRA\* and which form British Standard BS ISO 20252 (<http://www.bsi-global.com>). No direct contact was made at any time between the DSP research team and either the physicians or patients included in the survey.

The AR DSP recruited primary care physicians, allergists, and ear, nose and throat specialists, accommodating local country physician types as appropriate. One

hundred and five physicians were selected from each of the European countries plus 140 physicians from the USA. To avoid potential selection bias as a result of variable population densities in different geographical regions in a given country, an appropriately larger sample of physicians was identified in densely populated areas than in more sparsely populated areas. Uptake was generally far greater in urban areas, therefore; DSPs had a higher representation of urban practices or hospitals.

Candidate physician respondents were identified by members of the country-specific fieldwork team from public lists of healthcare professionals. They were checked for their eligibility to participate in the DSP in terms of specialty, location (hospital or office), whether they were personally responsible for treatment decisions, and how many patients they saw in a typical week (in total and with the relevant respiratory condition), to ensure that the diary process could be completed in a 3-week period. Candidate respondents who met predefined eligibility criteria were subsequently invited to participate in the full programme. Repeated physician participation in DSP annual surveys was permitted. The physician respondents were reimbursed for their time during the interview and for the completion of the PRF.

#### Data collection

*Stage 1: Physician interview.* The initial stage of the DSP was an in-depth, face-to-face interview with the physician. The interview sought to ascertain doctor attitudes and knowledge of the pharmacological properties of medicines used in AR, awareness of prescribing recommendations and new treatments, and unmet needs with current therapy options. In addition, the physician was asked to provide full treatment history for two patients with AR who had been diagnosed between 1 and 3 years ago. This was to facilitate the construction of a treatment algorithm for patients recently diagnosed with AR.

*Stage 2i: Physician workload.* Physicians completed a workload form to document the number of patients seen (both in total and with AR) for a period of 5 consecutive days after the interview conducted at Stage 1.

*Stage 2ii: Physician-completed patient record form.* Primary care physicians were asked to recruit the next four consecutive patients, and specialists were asked to recruit the next 6–12 consecutive patients who consulted for AR. At the time of the survey, patients were consulting either for their AR (either routinely or as an emergency) or for another condition. The determination of eligibility of patients was made by the physician based on diagnostic judgment and clinical impression from the signs and symptoms, and any relevant tests conducted during routine practice. For each patient, the physician completed an anonymized and detailed PRF.

\*The BMRA is the trade association for the British market research industry. It was formed in April 1998 by the merger of the two previously established trade associations: ABMRC (Association of British Market Research Companies) and AMSO (Association of Market Research Survey Organisations). It aims to: (i) represent and promote the professional and commercial interests of its members; (ii) increase the professionalism of the industry and (iii) promote confidence in market research. BMRA membership is for companies whose primary business is market research, while membership of the Market Research Society (MRS) is for individuals who work in research. All BMRA companies must sign up to, and follow the conditions of, the Quality Charter and the Constitution. All Members must also strictly adhere to the codes of conduct of the MRS or ICC/ESOMAR. The BMRA supports the Market Research Quality Standards Association (MRQSA).

*Stage 3: Patient self-completed form.* Patients whose data were collected on the PRF at Stage 2ii were invited by the physician to complete a PSC form. The PSC form was confidential to the patient and returned to the physician in a sealed envelope so that physicians did not see the patient's responses. Completion of the PSC form was not obligatory and a patient's decision not to complete the PSC form did not disqualify the data recorded on the PRF. The PSC form and PRF for a patient were linked at the analysis stage.

#### Data management

Data accrued by physicians and patients on the respective forms were collected and collated by the fieldwork personnel. These data were checked and ambiguities were clarified by the physician. Open-ended data were translated back into UK English by the translator of the initial questionnaire. For each set of fieldwork materials (PRF, PSC form, workload page and doctor interview), response fields were precoded during the preparatory phase to facilitate entry into an electronic database for analysis. Assigned codes were checked at this stage to ensure the data entered into the electronic database accurately reflected the data field.

Data were entered into an electronic database using the preassigned codings for both the physician and patient responses. Random selections of 10% of entered data

were checked for accuracy. Where the work was not carried out satisfactorily, the electronic data was checked, re-entered and a further 10% check made.

#### Conclusion

Methodology for DSP surveys designed by Adelphi Group Products is used each year to survey patients and physicians on their perceptions of treatment effectiveness, symptoms and impact of diseases. These point-in-time surveys, conducted in the USA and Europe (France, Germany, Italy, Spain and UK), provide useful information on the real-world management and treatment of diseases. Results of these surveys in AR in 2006 are reported in this supplement.

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