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Title	**The lesser of two evils: a qualitative study of quetiapine use by family physicians**
Authors	Martina Kelly MBBCh MA, Tim Dornan MD PhD, Tamara Pringsheim MD MSc
Reviewer 1	Dr. Mary Chiu
Institution	Mount Sinai Hospital, Psychiatry, Toronto, Ont.
General comments (author response in bold)	Reviewer 1: 1. p.3, line 41: For non-medical audience, it would be helpful to briefly state the four recommendations under “Choose Wisely campaign”. **These are now added.** 2.p.3, line 45: “Yet physicians prescribe quetiapine when there are good reasons for not doing so”- was this reported in the literature or was this based on empirical evidence or both? Please clarify. **We believe that the significant number of reports indicated widespread off-label prescribing, in the presence of safer alternatives to indicate a level of indiscriminate prescribing.** **However, given the complexity of addressing this within the introduction we have opted to remove this sentence.** **(an example would be: Saad and colleagues conducted a survey of health care professionals and found that although most were aware of the FDA warning, only half (49 percent) reported that they changed the way of prescribing based on this notification. Reasons why they did not respond to the warning include: no alternative treatment available, lack of guidance, lack of evidence, and poor data availability. The authors concluded that antipsychotics continued to be prescribed for dementia among older adults.** **In Canada, Valiyeva found that regulatory warnings were associated with small relative decrease** **(3 percent–5 percent) in the use of atypicals among elderly patients with dementia, but they did** **not reduce the overall prescription rate. Despite these decreases, atypical antipsychotics** **continued to be a common treatment option used among elderly dementia patients.)** Reviewer 1: 3. It was stated on p.10, Line 27 that “member checking” was done. This should be mentioned in the Methods section on p.5: a. Did all participants participate in member checking? b. Who else besides the participants were involved? **Thank you, we have moved that part of the text, so that it now reads as: We gauged the trustworthiness of our findings by sending our final template and draft paper to all participants as a form of member checking. Four participants responded and agreed with the findings. In addition, we presented findings at three family medicine conferences (provincial, national and international).** 4. There were 4 main themes presented in Table 2 and Appendix B, but only 3 of them were presented in the Results section. Need to insert a sub-title “My patients are fine on low doses” on p.7, Line 35. **Thanks – now added as a subheading** 5. Authors may include an operational definition of “complex patient” on p.6, Line 5. Suggestion: “… low income , unemployment, and homelessness. They are referred as ‘complex patient’ hereafter.” **This is now added.** 6. It is implied that the answer to the key question stated in the title of paper – lesser of two evils? – is “yes”. That is based on perspectives of family physicians, who seemed to be trying to “make” quetiapine the lesser of two evils in their practices by monitoring patients and by prescribing in lower doses etc. The reasons to prescribe quetiapine or continuing a pre-existing prescription may be ambiguous, and may be driven by patients’ experience (i.e. “keep the patient functioning”) or by patients’ requests (Fig 1). Future research may seek input from patients’ regarding use of quetiapine and the two discourses may be compared. **We have added this as a suggestion for further research.** 7. Another reason for high prescription rates for quetiapine could also be due to the fact that psychoeducation/therapies (p.10, line 50) have been attempted, with less than ideal outcomes. These are time/resource-intensive solutions, so while family physicians may be aware of these “alternatives” (p.11, line 10), they could be hesitant to implement these in their practice which are usually

	time-constrained environments. **We have added a section on use of interdisciplinary teams to the discussion.** **We have replaced the word 'alternatives' with choices.** 8. Authors wrote "family physicians' quetiapine prescribing was much less paradoxical… than evidence at an epidemiological level could ever suggest". While that is implied in the study findings, it still begs the question of: does that make it ok to prescribe broadly if physicians are doing everything they can (as indicated in the themes) to lower side effects and other risks? Should there be clear, strongly recommended guidelines re: dosage/targeted patient population (i.e. defined complex patients) that physicians would follow? **Thank you, we have added this under the section on implications.** Typological corrections Minor comments: 9. p.16, Line 35 – "…the drug to avoid of in this patient population." should read "…the drug to avoid in this patient population." **Amended, thank you.**
Reviewer 2	D.W. Wranik PhD
Institution	Dalhousie University, School of Public Administration, Halifax, NS
General comments (author response in bold)	1. p.3, line 41: For non-medical audience, it would be helpful to briefly state the four recommendations under "Choose Wisely campaign". These are now added. 2.p.3, line 45: "Yet physicians prescribe quetiapine when there are good reasons for not doing so"- was this reported in the literature or was this based on empirical evidence or both? Please clarify. **We believe that the significant number of reports indicated widespread off-label prescribing, in the presence of safer alternatives to indicate a level of indiscriminate prescribing.** **However, given the complexity of addressing this within the introduction we have opted to remove this sentence.** **(an example would be: Saad and colleagues conducted a survey of health care professionals and found that although most were aware of the FDA warning, only half (49 percent) reported that they changed the way of prescribing based on this notification. Reasons why they did not respond to the warning include: no alternative treatment available, lack of guidance, lack of evidence, and poor data availability. The authors concluded that antipsychotics continued to be prescribed for dementia among older adults.** **In Canada, Valiyeva found that regulatory warnings were associated with small relative decrease** **(3 percent–5 percent) in the use of atypicals among elderly patients with dementia, but they did** **not reduce the overall prescription rate. Despite these decreases, atypical antipsychotics** **continued to be a common treatment option used among elderly dementia patients.)** 3. It was stated on p.10, Line 27 that "member checking" was done. This should be mentioned in the Methods section on p.5: a. Did all participants participate in member checking? b. Who else besides the participants were involved? **Thank you, we have moved that part of the text, so that it now reads as: We gauged the trustworthiness of our findings by sending our final template and draft paper to all participants as a form of member checking. Four participants responded and agreed with the findings. In addition, we presented findings at three family medicine conferences (provincial, national and international).** 4. There were 4 main themes presented in Table 2 and Appendix B, but only 3 of them were presented in the Results section. Need to insert a sub-title "My patients are fine on low doses" on p.7, Line 35. **Thanks – now added as a subheading** 5. Authors may include an operational definition of "complex patient" on p.6, Line 5. Suggestion: "… low income , unemployment, and homelessness. They are referred as 'complex patient' hereafter." **This is now added.** 6. It is implied that the answer to the key question stated in the title of paper – lesser of two evils? – is "yes". That is based on perspectives of family physicians, who seemed to be trying to "make" quetiapine the lesser of two evils

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