Reviewer's report

Title: The role of general practitioners' burnout in their involvement in patients' mental health problems: a study of videotaped consultations

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Reviewer: Karin E Isaksson Rø

Reviewer's report:

This subject is an important contribution to the discussion regarding the relationship between self-evaluation and objective evaluation of functioning in physicians with burnout.

Coding video-taped consultations is a good way to evaluate general practitioner/doctor performance in an objective way.

• Major compulsory revisions:

The authors present interesting data. However, both the Introduction and the Discussion/Conclusions should be more balanced in relation to the existing literature. See comments below. In addition there are comments regarding the overall editing of the manuscript.

1. The authors draw firm conclusions of the implications of their study (they recommend an attitude of detached concern). The study does not have the potential to support this conclusion, although it can be part of a discussion (see Conclusion in Abstract and Conclusions)

2. The Background should be more balanced:

(i) 2nd paragraph: Studies have shown that burnout is associated with more self-perceived medical errors (references 15-17 refer to two studies of self-perceived errors and one that does not have a measure of burnout - but of hours worked/day). Among the few studies that have been done using objective measures, doctors reporting burnout did not commit more errors, whereas depressed doctors did (Fahrenkopf AM, Sectish TC, Barger LK et al. Rates of medication errors among depressed and burnt out residents: prospective cohort study. BMJ 2008;336:488-91). This could support the findings in this study that self-reported burnout does not correspond with quantitatively or qualitatively poorer care for patients.

(ii) Regarding equity theory: Patient contact is often experienced by the GP as the rewarding part of the job – as stated. An alternative possibility is therefore that if a doctor feels tired or worthless in some respects, more patient focus might be a way of increasing the rewards (feeling of identity and value). This could also help explain the findings in this study.

3. The last sentence in the Background section belongs under Methods.
4. The Design (under Methods) should be split into two sections, one describing the design of the study and one describing the Subjects. The design is a bit hard to follow. (Could be improved by adding a flow chart? – see under discretionary revisions).

Gender and age distribution as well as a more direct description of the representativity of the 126 doctors who participated in the video registration should be given.

5. Burnout measure (under Methods). Psychometric testing of UBOS and distinct cut off points should be given. Low, middle and high as well as very low and very high are referred to without clearer definitions. Describe which cut-off points low and high in Table 3 refer to?

6. Measure of GPs communication (under Methods): What is the unit of the subscales in RIAS, number of utterances or seconds spent with each type of utterance? (i.e. what do numbers in first part of Table 3 denote?)

7. Inter-rater reliability is mainly given as Intra-Class-Coefficient ICC.

8. The first paragraph of the discussion is written as if the two models described are the only models possible? What about influence on burnout from other sources?

The connection between the first paragraph and subsequent paragraphs starting with “secondly, thirdly…” is difficult to follow. Are they alternative explanatory models to the one presented in the first paragraph?

9. In paragraph 3 of the discussion: Is there a reference to support this way of reasoning? Other studies have found that self criticism (closely related to neuroticism) is associated with a higher capacity for empathy (Firth-Cozens J. Emotional distress in junior house officers. BMJ Clinical Research Ed. 1987;295:533-6.).

10. In paragraph 5 in the Discussion the major causes of stress and lack of job satisfaction for GPs are said to be “organization and paper work” and the results in this study confirm that doctors primarily are dissatisfied with time for managing the practice, time for education etc – which are problems on a system level. “Patient care contributes positively to their job satisfaction”. I miss a discussion of the implications of this. Could changes at the system level be important – parallel to individual changes?

11. The second and the beginning of the third paragraph in the Conclusions are part of the discussion. Conclusions should be made shorter and spring directly out from the discussion.

12. In the second paragraph of Conclusions there is a discussion of the patient perspective – longer consultations being a benefit for patients with mental health problems. I miss a discussion of the “long” consultations in this study that are only 11.4 minutes on average - actually a very short time. What implications does
this have for good care from GPs, when the study show that talk about psychological and social problems increase with only this little longer consultation?

13. Methodological considerations:

(i) The authors have commented that the findings are unusual with respect to the distribution of doctors with emotional exhaustion compared to the two other dimensions. Is it possible to comment on what differences another cut-off (more commonly used?) would mean for the analyses? Or does this sample differ from other samples in ways that could explain the low percentage above cut-off on emotional exhaustion?

(ii) Could include a comment concerning the degree of overlap between being high on emotional exhaustion, depersonalisation and low on personal accomplishment and dissatisfaction with available time. Do we see the same consultations rated several times according to the different dimensions in Table 3?

• Minor Essential Revisions:

1. The title is “heavy”. Should be reformulated?
(e.g. Does doctors´ burnout affect involvement with patients´ mental health problems? A study of videotaped consultations in general practice.)

2. Abstract: Results: Last sentence difficult to understand. Should it be “….psychological evaluations of patients…”?

3. Tables:

(i) Appendix: Labels to the columns are missing. (Is it the same as in Table 1 with first column showing levels for all GPs and second and third column showing levels for GPs with high levels of burnout/dissatisfaction?

(ii) Table 3: The table needs to present what units the figures represent and the range of the scales. That N means number of consultations should be defined in the table. The Confidence Intervals for the data should be presented.

4. Language: Needs some language corrections before being published. There are several language mistakes or “confusions”:

Some examples:

(a) In Background: 4th paragraph: “This principle can, except for interpersonal relationships…” What does “except for” mean in this context?

(b) Under Discussion: Main findings:

(i) Main findings and Discussion subheadings should be merged. (Now discussion is used as a sub-heading under Discussion).

(ii) First sentence: “Against the expectations” should be “Contrary to the
expectations”
(iii) Last paragraph: “scoring low” should be “with low scores”

(c) Under Discussion: discussion.
(i) Second paragraph: The last sentence (“On the other hand, this group of….) is difficult to understand in the context. Can it be rephrased?
(ii) One does not say “fourthly” or “fifthly”. This should be rephrased.
(iii) Fourth paragraph, first sentence. “…these GPs are less effectively…” should be “..less effective..”
(iv) Fifth paragraph, first sentence, “GPs who are dissatisfies with the available patient time”. As I understand the text the word “patient” should be omitted.
(v) Fifth paragraph under Discussion: Discussion, last sentence: Phrased in a way to mean exactly the opposite of what the meaning is. “at least” should not be used in that way. This should be rephrased.

(c) Under Discussion: methodological considerations, second paragraph, last sentence:
“It is plausible to think that both GPs as patients influence” should be “..to think that GPs as well as patients..”

(d) Heading Table 3. Should be “adjusted for” (not corrected)…

• Discretionary Revisions:
1. Methods: “Secondary analyses were performed…” Could say what the first analyses were.
2. Methods: A flow chart of the participation of GPs and number of consultations would be easier to follow.
3. References: Usually presented with Authors, Title of the paper, Journal, Year, Volume and pages. Here year has been put after authors.

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being published

Statistical review: Yes, but I do not feel adequately qualified to assess the
statistics.

Declaration of competing interests:

I declare that I have no competing interests.