Author’s response to reviews

Title: Out of hours care: A profile analysis of patients attending the emergency department and the general practitioner on call.

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Author’s response to reviews: see over
Dear editor,

Pleas find enclosed our revised paper: ‘Out of hours care: A profile analysis of patients attending the emergency department and the general practitioner on call.’

We are grateful to all reviewers for the very accurate revision of our manuscript. This enabled us to improve our paper. (changes are highlighted using ‘track-changes’ in the manuscript as well as in the ‘tables’ document)

In this document we formulate the answers of the authors on all the questions/remarks of the reviewers. We cited the adapted paragraphs of the text when necessary.

We hope to have clarified the ambiguity that was mentioned. We certainly remain available for further explanations.

We add the questionnaires that were asked for. We used a Dutch and French version of the questionnaires. Following questionnaires will be uploaded with the new manuscript:

- Enquetespoedpatient 20050118: Dutch questionnaire used at the ED
- Enquetehuisartspatient 20050118: Dutch questionnaire used at the GP service
- Questionnaire urgences fr 18-01-2005: French questionnaire used at the ED
- Questionnaire MG fr 18-01-2005: French questionnaire used at the GP service

We regret that we do not have an English version of the questionnaires used.

We asked a English native speaker to revise the English language of the text and adjusted when necessary.

Please do not hesitate to contact me as the first author if more information is needed.

On behalf of the research team,

Yours sincerely,

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Reviewer: Suzanne Richards

1. Is the question posed by the authors well defined?

Reviewers comment:
Minor essential revision: More detail describing precisely how GP out of hours care are accessed and delivered in Belgium would be beneficial in the methods (context subheading). This would allow the international audience to contextualized the findings more readily. For example, in the UK patients who call their GP surgery out-of-hours are automatically given the phone number redirecting them to the local, independent, out-of-hours primary care service (some practices automatically redirect calls as well). This service may be a GP (not-for-profit) co-operative or private (commercial) provider commissioned by the Primary Care Trust. When reaching the out-of-hours service, the call is then triaged by a clinician (generally a GP), who then decides on the management plan (phone advice, treatment centre visit, home visit, go direct to ED). How does the process work in Belgium specifically? Are there different models (you mention co-operatives in the discussion) or is it practice or practitioner based. The ED model description is adequate, but not that different from most countries. In the UK, although patients have free choice regarding access to ED’s too i.e. although the GP can ‘gatekeep’ and refer people to ED – the patient can go directly to ED if they so wish.

Answers of the authors:
We agree that the context was not clearly described. We clarified the context in the manuscript with the following explanation:
‘Providing 24 hours coverage is a legal obligation of GPs in Belgium.[17] GPs organise out-of-hours care in rotation systems. This service is organised by local general practitioner organisations. In these small scale organisations, GPs on call usually work from their private practices. Most of the local GP organisations use a phone number which immediately leads to the out-of-hours care facility. Patients have to inform themselves which GP is available and where the practice is located. Prior telephone contact is not necessary; patients can walk in without appointment. There is no telephone triage; no consultation over the telephone is performed. Patients can come to the doctor’s practice or ask the GP on a home visit.[16] Since 2003, in some regions in Belgium, the first general practitioner cooperatives (GPC) emerged.’

2. Are the methods appropriate and well described?
Minor essential revision: The data collection methods need to be more clearly defined. How did the research team access details on patients seeking care from GP services to then telephone them to administer a questionnaire (particularly as the patient had not provided consent for the research team to access their records). What happened if the patient did not leave a telephone number? This method was different from ED departments. Can the authors be sure that all patients consulting at ED were offered questionnaires? Who asked the ED patient to complete a questionnaire – was it the clinician or a researcher?

Answers of the authors:

We clarified the interview method in the manuscript, by adapting the text as follows:

*A semi-structured questionnaire was developed, based on literature, and piloted for this study. It comprised 6 domains and 39 questions. Senior medical students were trained to interview the patients at the various data collecting sites. They performed face-to-face interviews at the ED and telephone interviews with the GP patients, after the doctor’s visit. At the ED patients were asked to participate at the moment of entrance and data were collected immediately thereafter. As GP service was in many cities offered by more than one GP per region, we decided to collect data from these services by phone immediately, on the day of the visit. GPs asked all patients whether they were willing to participate. If they agreed, the telephone number of the patient was registered in order to be contacted by the interviewer after the GP visit.*

We can be sure that all patients at the ED were offered questionnaires because the interviewers approached the patients at the entrance of the ED. All patients visiting the ED were asked to participate. We were able to check non-participation using the total number of patient contacts over the study period at the ED.

Major essential revision: The analysis plan is unclear and requires amending. I was unclear whether or not the final model presented was univariate (as implied on pg 7, final paragraph) or multivariate. My uncertainty arises, in part, as the results section describes (on page 9) the ‘best fitting model’ in which 11 independent variables were used – which implies an adjusted model. If the analysis was restricted to a univariate analysis, this weakens the paper considerably. I would recommend conducting a multivariate analysis prior to publication, as the authors have all the necessary data and can then present much stronger statements regarding predictors of service use. Some of the variables identified (assuming a series of univariate/unadjusted analyses were conducted) might then become non-significant as there is clearly potential for confounding relationships between variables such as country of origin, language skills, gender and even age (assuming migrants may be younger males).

Answer of the authors:

The final model presented indeed is a multivariate model. Some chi²-tests were performed where applicable but to rule out confounding relationships we based our major conclusions on the binary logistic regression analysis. We clarified this in the text as follows:

*Binary logistic regression analysis with service choice (GP or ED) as the dependent variable, was used to compare patient and socio-economical determinants between
both patient populations, computing odds ratios with their 95% CI. The choice of the determinants, relevant for this multivariate analysis was based on literature. (Mitchell 1994; Sanders 2000; Martin, Martin et al. 2002)'

I was also unclear regarding the dependent variable. Was it one variable with two categories (GP as reference category versus ED). This is important as the interpretation of the OR’s in the subsequent results and Table 4 are difficult without clearly understanding this.

Answer of the authors:
We added the reference category (GP) in the text, and clarified this in table 4. The text was adapted as follows:

‘We used binary logistic regression analysis with the use of the service (ED or GP) as dependent variable (GP being the reference category).’

A little more information on how the patient characteristics variables were entered into the model would also be beneficial. For example, age was collected as a continuous variable, but it would appear that it was entered as categorical variable with three levels. How were these levels selected?

Answers of the authors:
Age data were indeed registered as a continuous variable. During the process of analysis we tested both strategies, entering age as a continuous variable into the model as well as a categorical variable. The last strategy was easier to use in order to search for interaction with other independent variables. As ‘age’ did not result in any significant changes in the model (nor as a continuous, nor as a categorical variable in 3, 4 or 5 categories) we choose to present the results of the best fitting regression model, being the one in which we entered age as a categorical variable in three categories.

On page 12, first paragraph of the findings section you present an OR and CIs for males seeking help for minor trauma from ED departments versus females. I think this is new data i.e. not from Table 4 – and if so, this should be presented in the results section, before being discussed in the findings.

Answers of the authors:
We agree with the remark that this result also had to be mentioned in the results chapter. Therefore we added a text fragment, including two tables (table 2 and 3) illustrating the differences at the ED and the absence of a significant difference at the GP services.

‘On Chi² analysis, we found that men are more likely to seek help at the ED for minor trauma, compared to women. (OR=1.329, 95% CI: 1.010-1.749) This difference is not significant at the GP services (OR= 0.820, 95% CI: 0.507-1.327).’

The result of ‘young’ men rather seeking help at the ED is a conclusion of the reference mentioned in the discussion part. Therefore we removed the term ‘young men’ at the beginning of the paragraph and adapted the text as follows:
‘Men are more likely to seek help at the ED, often with ICPC codes relating to minor trauma (OR for male patients seeking help for ‘minor trauma’ versus female patients: OR= 1.329, 95% CI: 1.010 – 1.749). This confirms results of former research in which specifically young men rather seek help at the ED for minor trauma, suggesting that they appear to link their problem to technical examinations. (Philips H 2009)’

3. Are the data sound?

Major essential revisions
The results section was quite difficult to follow, as the authors present proportions without reference to frequency data in both the text and in tables. I recommend presenting % (n/N) wherever such data are reported. This is particularly important as in places, data are restricted to two of the four localities, and hence the sample available for analysis can vary dramatically for different comparators.

Answers of the authors:
We added N or proportions where necessary.

The data presented in Table 1 is difficult to interpret, and requires clarification. For example, the first data rows presents mean ages without information on variability (e.g. confidence intervals, or a standard deviation). The data do not require two decimal places. Some form of significance test has been undertaken ('p<0.05'), but what was the comparator? Is it mean age in the two groups (ED versus GP), or % of refusers versus participants in the two groups compared? Similar comments can be made for subsequent rows of data. Please critically review this table and amend.

Answers of the authors: We agree with this comment. We removed the original table 1 and added the data in the manuscript. This enables us to explain the results and to clarify the message. We added following paragraph:

‘Refusal rate was significantly lower in the GP visitors. The mean age (33.6 y, SD 34.2) of the participants was not significantly different from the mean age of the non-participants (38.0 y, SD 24.2) (P >0.05). Men were more likely to refuse participation than women did (p<0.01). The relative numbers of subsequently hospitalised patients were significantly higher in the nonparticipants group (p < 0.01). The mean age of the patients that visit the GP on call is 35.7 (SD 45.9) years, which is significantly higher than the population at the ED (32.2 years, SD 23.3) (p<0.05).’

Conform the comments of another reviewer, we added a new table 1, describing the patient characteristics at the GP services and the ED.

On page 9 the analysis of the proportion of patients who were subsequently hospitalized as a result of being taken to hospital by emergency services (e.g. ambulance) was reported as significantly higher than people who came via self-referral. As this analysis cannot adjust for underlying casemix/severity – is it really worth while statistically testing the observed difference?
Answer of the authors:
We agree that this analysis has no added value to the study. We do not use this result in our discussion or conclusion part, therefore we removed this paragraph.

Table 4: This table contains much redundancy. For example, Beta and SE are not required (the odds ratio is simply the exponential of beta i.e. the same data, and the associated 95% CI of the odds ratio tells you all you need to know about variability). Drop Beta and the SE in favour of the odds ratio and 95% CI. Present frequency/proportion data in its place. For example, I would like to know the % (n/N) females consulting GP versus ED, and the associated OR and 95% CIs.

Answers of the authors:
We dropped the unnecessary columns in the table 5. As we did a multivariate analysis, it is not completely clear to us whether the percentages or n/N are of any added value. If the results section would be clarified by adding the results of Chi² tests we are prepared to add these data. In our opinion a multivariate analysis is more appropriate in this study, but we can add the 2x2 tables if wanted.

Should the authors undertake multivariate analysis, both unadjusted and adjusted OR/95% CI data should be presented. I am sorry this feedback is a little unclear (it arises in part, due to my confusion regarding the analysis strategy), but all of it is couched in the assumption that this is univariate analysis. If this is an adjusted model, my comments would be different again, and I would be requesting likelihood ratio testing rather than presentation of Waldtest data etc.

Answers of the authors:
We are looking forward to the reviewers comments on the multivariate analysis. Meantime we already add the model summary of our model of binary logistic regression analysis using the backward stepwise method with the -2Log likelihood. If the reviewer would appreciate insight in our analysis, we are willing to send the output of our data analysis.

<table>
<thead>
<tr>
<th>Step</th>
<th>-2 Log likelihood</th>
<th>Cox &amp; Snell R Square</th>
<th>Nagelkerke R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1819.444</td>
<td>.101</td>
<td>.137</td>
</tr>
<tr>
<td>2</td>
<td>1819.483</td>
<td>.101</td>
<td>.137</td>
</tr>
<tr>
<td>3</td>
<td>1821.644</td>
<td>.100</td>
<td>.136</td>
</tr>
</tbody>
</table>

a. Estimation terminated at iteration number 5 because parameter estimates changed by less than .001.
4. Does the manuscript adhere to the relevant standards for reporting and data deposition?

**Much greater clarity of the analysis and results section is required.**

Answer of the authors: we hope to have adapted the text and tables in a way that clarifies the used analysis and results.

5. Are the discussion and conclusions well balanced and adequately supported by the data

I cannot make any firm recommendations at present, as I do not fully understand the analysis undertaken. I would be happy to comment once the analysis approach has been clarified.

Answer of the authors: We would be happy to further clarify the reviewers’ comments.

6. Are limitations of the work clearly stated?

A range of limitations are clearly presented. However, if the modeling was restricted to univariate analysis, I would expect some rationale as to why this approach was undertaken.

Answer of the authors: we did use multivariate analysis.

7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?

**Yes**

8. Do the title and abstract accurately convey what has been found?

Title is accurate. Abstract may need to alter depending on analysis strategy.

Answer of the authors: We checked the messages in the abstract and adapted where necessary.

9. Is the writing acceptable?

Mostly fine, although some minor editing of the English is required. For example, ‘data’ are plural not singular (e.g. data were, not data was etc). Given the recommendation for major revision, I have not provided this level of detailed feedback yet. However, I would be happy to comment more precisely on the revised text once it is closer to the finished article.

Answer of the authors: We corrected the suggested errors.
Reviewer: Dan Lasserson

MAJOR COMPULSORY REVISIONS

1. 50% of the data are missing for a key variable – diagnosis. This is of some concern and needs explanation, given that data collectors were 'trained'.

Answer of the authors:

Missing data on the diagnosis indeed is of some concern. We agree with the reviewer and mentioned this in the manuscript.

Indeed, trained medical students interviewed the patients. We only have missing data on diagnosis in the patient group that went to see the GP or asked the GP on a home visit. Possibly the doctor did not communicate the diagnosis to the patient, or the patient did not remember or understand. Therefore not knowing the diagnosis at the moment the trained student called to interview the patient. Another possibility is that the trained students in both regions (Brussels and Charleroi) forgot to ask those questions, whereas the students in Ghent and Antwerp did register the diagnosis without missing data.

Lucky enough we have two regions (Ghent and Antwerp) where missing data on diagnosis are limited, that way we can describe (for that region) the number of diagnoses in each ICPC2 chapter. Compared to similar research in literature, our data seem to be valid, despite of the highlighted limitations.

2. Use of logistic regression modelling. Logistic regression predicts the probability of an event. In this paper, rather than ‘yes’ or ‘no’ for attendance at one emergency service (the event to be predicted) the outcome variables are ‘ED’ or ‘GP’. Strictly speaking LR modelling is on collected data that predicts a future event, rather than waiting for the event to occur (attending ED or GP) and then talking to the patients to see what reasons might have existed previously to predict why they chose the ED or the GP. I am not convinced that a model is needed. I think it is probably statistically purer to just report the demographic make up of patients attending each service, and commenting on important differences, generate hypotheses for further testing as to what predicts choice of emergency service. Patients can also choose to stay at home and not consult, so to conclude that not speaking a language or being a certain age predicts choice, one would need to know more about all members of a group defined by those criteria. As a survey of service use I think it is valid to report who uses the different services and speculate on why the differences are there, but I would be wary about modelling this from data collected in this way (a cohort with various levels of indicator variables such as income etc. that is followed over time with out of hours ED or GP usage as outcome variables would be more secure and appropriate for LR modelling). You may wish to get a statistician's opinion about this too.
Answer of the authors:
Because this comment is not consistent with the comment of another reviewer who states that regression analysis is a useful statistic method for this study design and research question, it is unclear to us, how to deal with this. To be more explicit, we enumerate some reasons for using binary logistic regression analysis in this study.
We only used patient characteristics in the regression model and no ‘reasons’ patients mentioned for choosing one or another service. Therefore the model can be used to predict, based on patient characteristics (gender, having a family doctor, language, nationality, insurance...) the probability of one person to choose for GP or ED during out-of-hours. This is a correct way of analysis in this context. The study design was set up to interview patients that already choose either one service. We did not aim to be able to make any decisions on people who might have postponed seeking medical help or even not considered to seek help at all. We agree that this is an interesting research question, but answering it is not possible with the study design we used, and out of scope of our research question. However, we can refer to former research our study group performed, in which we interviewed ‘consumers’ of out-of-hours care; meaning people who are not in need of any medical care at the moment of the interview, but who are approached with a questionnaire about medical help seeking behavior during out-of-hours based on fictional scenario’s. One of these studies is recently published in Quality and Safety in Health Care (Philips, H., et al., Experience: the most critical factor in choosing after-hours medical care. Qual Saf Health Care, 2010, April 29 [Epub ahead of print].)
The proposal to just report the demographic make-up of patients attending each service is justifiable, but doing so, we cannot test for any interactions between independent variables and just report about descriptive data. Yet, here appears the added value of regression analysis.
Also the suggestion of a cohort that is followed over time is a useful tool. We performed this kind of research to study the effect of the implementation of a GP cooperative on case load at the GP cooperative and ED. (What's the effect of the implementation of general practitioner cooperatives on caseload? Prospective intervention study on primary and secondary care. BMC Health Services Research 2010, 10:222)
We hope to have clarified our opinion about the analysis and why we choose this methodology. Because the inconsistency of both reviewers we prefer to keep the analysis for now. We are certainly willing to add univariate analysis results in the manuscript if this could add clarification to the presentation of the results and if the reviewers appreciate this.

3. The 'reason for encounter' variable needs some clarification for the general reader. It is classified in organ system terms but I think readers are more interested in the answer to the question ‘Why did you come?’ which is reported in table 3 as the answer to ‘Why did you seek help at the ED?’; Was a similar question asked to people attending GPs? This would be of great interest.

Answer of the authors:
With ‘reason for encounter’ we asked the patient with which medical problem he came to the GP or the ED.
We agree that the reason for choosing either one service is of great interest too, but we did not ask these questions to the GP users in this study. Indeed, a similar table as table 3 would have been of great value.

However, we do have some detail about these data. Simultaneously we performed a qualitative study in Ghent and Antwerp, specifically designed to explore the reason for seeking help at the ED or the GP services. In future we will report the findings of this research. Submission of the manuscript is foreseen in the nearby future.

MINOR ESSENTIAL REVISIONS

1. Methods, Context: ‘not in common use’ would be better than ‘no common use’

We adapted this in the manuscript

2. Methods, Materials, 2nd para: how was participation ‘guaranteed’? Please clarify.

All parties were well informed and approached from the beginning of the development of the study design, giving them the opportunity to intervene before starting the study and enhancing motivation. Regular contact of the researchers and presence of the interviewers at the different locations enabled us to guarantee participation.

3. Methods, Materials, 3rd para: please clarify 3rd sentence ‘As GP service..’ were the patients subject to a telephone interview at the time of consulting the GP?

The telephone interview took place after the doctor’s visit, on the same day. We clarified this now in the manuscript:

‘A semi-structured questionnaire was developed, based on literature, and piloted for this study. It comprised 6 domains and 39 questions. Senior medical students were trained to interview the patients at the various data collecting sites. They performed face-to-face interviews at the ED and telephone interviews with the GP patients after the doctor’s visit. At the ED patients were asked to participate at the moment of entrance and data were collected immediately thereafter. As GP service was in many cities offered by more than one GP per region, we decided to collect data from these services by phone immediately, on the day of the visit. GPs asked all patients whether they were willing to participate. If they agreed, the telephone number of the patient was registered in order to be contacted by the interviewer after the GP visit.’

4. Methods, Materials, 4th para: what do you mean by ‘co-ordinates’?

We clarified this in the manuscript by replacing ‘co-ordinates’ by ‘telephone number and address’.
5. Conclusions. I would actually include in the results section that 50% of income data was missing – this may help explain why it is not explanatory in modelling.

Answer of the authors:
We added this in the results section.

6. Table 1. Could you show the demographic data by ED and GP separately? - this would be very helpful for the reader although as you have missing data it may not be possible for the group as a whole.

Answer of the authors:
We agree that table 1 was very difficult to interpret. We preferred to describe the data of that table in the text and added following paragraph in the manuscript:

‘Refusal rate was significantly lower in the GP visitors. The mean age (33.6 y, SD 34.2) of the participants was not significantly different from the mean age of the non-participants (38.0 y, SD 24.2) (P >0.05). Men were more likely to refuse participation than women did (p<0.01). The relative numbers of subsequently hospitalised patients were significantly higher in the nonparticipants group (p < 0.01). The mean age of the patients that visit the GP on call is 35.7 (SD 45.9) years, which is significantly higher than the population at the ED (32.2 years, SD 23.3 ) (p<0.05).’

We also added a new table in which we describe the main patient characteristics at the GP service and the ED.

7. Table 4, for the general reader, does not easily convey the important findings and the wald test and S.Es are not needed, just the ORs and CIs will describe the findings adequately.

Answer of the authors:
We agree, and adapted the table following these suggestions.
Reviewer: David Dunt

Major revisions:

1. **Context**: A number of features of the Belgium healthcare system, some of which are described in the Discussion are unfamiliar to non-Belgium readers, e.g., the nature of medical insurance. Their absence hinders understanding of the article. They should be outlined in Context.

   **Answer of the authors:**

   We agree with the reviewer’s remarks. One of the other reviewers also made suggestions to clarify the Belgian healthcare system. We adapted the manuscript, more specifically concerning the medical insurance item mentioned above, we added the following sentence:

   > ‘In Belgium, almost 99% of the population is covered with compulsory health insurance. (European Observatory on Health Systems and Policies 2007)’

2. **Discussion (Findings)**: The absence of data on the severity of the medical problems and the income of the patients are major limitations and should be considered under that section. The absence of income is particularly significant since financial reasons for selection of location for care are frequently under-reported in these interview situations.

   **Answer of the authors:**

   We agree with the reviewer that data on severity and income are of major concern.

   Measuring severity was not the scope of this study, therefore we cannot discuss nor conclude anything concerning this item at this moment. However, we performed another study in which we registered severity at ED and GP services and also compared the interpretation of the patients with that one of the physician. These data are not published yet. We also plan an intervention study in which we assess the evolution of the severity of the complaints at ED and GP services, before and after the implementation of a GP cooperative where the GP has a gatekeepers role.

   On the other hand, we regret having missing data on income. As you mentioned, this is a major limitation of the study. In the questionnaire we included two questions about income; one question with income in different categories of monthly salaries and the second one for those who were rather reluctant to answer the first question, about how they experience the end of the month, financially spoken. Even then, we still have missing data.
For these reasons we intend to perform a new study in a qualitative design, in which it is more feasible to assess income and other socio-economic determinants.

The severity will be assessed in a new intervention study in which severity will be compared between ED and GP services during out-of-hours in a before/after prospective study design with the implementation of a GP as intervention. This will enable us in the future to correct for the severity when assessing the choice of a service.

We also added following paragraph in the section ‘limitations of our study’:

‘As severity of the medical problem was not included in the questionnaire, we have to take into account that we may not compare the reasons for seeking help at either one service in a valid way, for severity is a confounding factor. We may not conclude on ‘appropriate’ or ‘inappropriate’ use based on these findings, neither was this the scope of this study. We missed data on income. For this reason we intend to perform a new study in a qualitative design, in which it is more feasible to assess income and other socio-economic determinants.’

The proposals for improvement seem poorly developed and unsupported by the international literature. The literature is referred to in passing but not strongly related to the study’s findings and how these contribute to this literature.

Answer of the authors:
We removed the poorly supported conclusions and clarified the other conclusions by adding information in the context and results section.

Minor revisions:

Abstract: The outline of the methods should be more detailed. The Discussion and Conclusion should be revised in line with revisions to the Discussion and Conclusion in the full article.

Answer of the authors:
We adapted the abstract to the changements in the manuscript.

Materials: it is not completely clear if the 6th year medical students interviewed patients in the ED and GP surgeries in the same way.

Anwer of the authors:
We clarified this in the methods section:

‘A semi-structured questionnaire was developed, based on literature, and piloted for this study. It comprised 6 domains and 39 questions. Senior medical students were trained to
They performed face-to-face interviews at the ED and telephone interviews with the GP patients after the doctor’s visit.’

Conclusion: Some material in the Conclusion (including the policy proposals) is not really concluding in nature and should be repositioned.

Answer of the authors: we adapted the manuscript and removed the parts that were less supported and of minor interest.

Table 1 is close to uninterpretable - there are no column headings, the horizontal percentages are unhelpful. The row on age is quite unclear. Table 2 and 4 could be trimmed, with the latter only reporting significant results.

Answer of the authors:
We adapted the tables following the suggestions of all 3 reviewers.