Author's response to reviews

Title: Enhancing GP engagement in hospital-based studies. Rationale, design and participation in the Diagest 3-GP motivational study.

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Author's response to reviews: see over
Prof Robert McKinley  
Senior Managing Editor  
BMC Family Practice  

28 April 2012  

Dear Prof Robert McKinley  

Re: Resubmission of manuscript No. 4942508876171573  

Please find attached a revised version of our manuscript “Enhancing field GP engagement in hospital-based studies. Rationale, design, main results and participation in the Diagest 3-GP motivation study”, which we would like to submit for consideration for publication in BMC Family Practice.  

Your comments and those of the reviewers were highly insightful and enabled us to greatly improve the quality of our manuscript. In the following pages are our point-by-point responses to each of the comments of the reviewers as well as your own comments.  

Main revisions in the text are shown using yellow highlight for additions. Please note that we have enlisted the help of a native English-speaking editor to address issues regarding English usage throughout the manuscript; this includes selection of new words to describe the 4 profiles of General Practitioners (GPs). In addition, we have added information to the manuscript that should remove confusion regarding its design and objectives; this includes a global change of the word “motivational”, which suggests an intervention, to “motivation” to describe our qualitative study of the beliefs and attitudes of GPs. We have also added a new Table 1 to clarify our methodology and a new Figure 4 that illustrates our GP profiles as a Venn diagram, as you suggested. We hope that the revisions in the manuscript and our accompanying responses will be sufficient to make our manuscript suitable for publication in BMC Family Practice.  

We look forward to hearing from you at your earliest convenience.  

Yours sincerely,  

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Responses to the comments of Reviewer #1

1. I would like, however, the authors to add a new additional introductory paragraph highlighting exactly what THIS paper is about - i.e. the qualitative study. The initial detail on DIAGEST 2 and 3 is distracting.

Response: We have added a new introductory paragraph that describes the rationale and objective of the Diagest 3-GP study.

Responses to the comments of Reviewer #2

1. I recommend for the sake of clarity that the title, aims, abstract and conclusions are better matched.

Response: We have made changes throughout each of these sections to ensure consistency.

2. The authors should also state (in the discussion/conclusion) how future researchers would use the findings from this paper in order to improve future study uptake

Response: We have added a paragraph to the discussion section that outlines how our findings could be used to improve GP engagement in future hospital-led research studies.

3. I am concerned that the reported methods do not match the stated methodologies, and phenomenology and grounded theory are referred to in the same sentence; action research methods are also included - line 225. Sampling is said to be theoretical but this is not the case (nor is it purposive). Analysis may have employed grounded theory techniques but there is inadequate description. The descriptions of the 'doctor types' bear resemblance to learning theories but no references are given. If these categories are completely new then the analytical process should be described in much greater detail. My impression is that the methodologies were not prospectively applied with sufficient rigour to guarantee the validity of this paper, and further detail and reassurances are needed if it is to be considered further.

Response: Indeed, sampling does not meet the definition given by Glaser for “theoretical sampling”. For this reason we deleted the word “theoretical”. The discussion section already stated the weakness of our sampling method.
We developed our qualitative research technique working together with Paul Van Rooyen and Etienne Vermeire in Antwerp. It was presented as a poster and validated at the EGPRN meeting in Dubrovnik in October 2009. We kept it as rigorous as we could to avoid a preconception bias. The theorisation process has been precised (Line 196 on). We made some changes to the manuscript to enforce these points. The description of our method goes far much into detail than many other published qualitative papers (a.e. Peel E et al. BMJ 2007;335:458-9.)
The aim of this paper was not in developing the first qualitative step of our work. A future paper is meant for this; your observations will be highly insightful at that time. We honestly did not recall learning theories (Gestalt approach?) when we build up our “doctor types”, which would have been a preconception, not fitting with GT. The typology rose from the verbatim, as 4 different global attitudes towards hospital-based medical specialists and their research merged from the discourses.

4. 93: ‘almost none’ – insert number

Response: We have replaced “almost none” with the correct number of GPs who attended meetings with the study team (3).
5. 94 - what is a motivational letter? Presume asking a favour of the GPs/encouraging them to drum up support- if so state it as such; if not please elaborate

Response: ‘Motivational’ not adding any value to the text was cancelled.

6. 95: ‘below 10%’ - state actual %

Response: Unfortunately, precise data were not collected by the Diagest 3 investigators because the letters sent independently by endocrinologists were outside of the Diagest 3 protocol. We have added this information to the manuscript.

Responses to the comments of the Editor

1) The paper needs further English language review in 2 areas:
   a. The general use of English: for example (and not limited to)
      i. Line 115: “how people get committed” as opposed to “make a commitment”
      ii. Line 119: “Based on” as opposed to “Because of”
      iii. Line 129: “on the best methodology” as opposed to “the most rigorous methodology”
      iv. Line 146: “Semi-directed” as opposed to “Semi-structured”

      I am unsure whether my interpretation of these phrases reflects the meanings you intended and they should be clarified. These are examples from a small part of the paper, there are many other areas where the language is open to misinterpretation.

Response: We worked with a native English-speaking editor, who reviewed the entire paper and made changes throughout.

   b. The titles given to the GP groups (revolting/obedient/resigned/activist): I suspect that they may not have translated well but the titles used are unlikely to be well received by an Anglophone primary care readership as, unfortunately, they convey a rather dismissive, perhaps even derogatory, view of GPs. I would encourage you to seek the help of a native English speaker to ensure that the translation of your initial concepts adequately reflects the intended meanings.

Response: We have renamed the titles given to the GP groups as follows:

   Revolted was changed to Slighted
   Obedient was changed to Uninterested
   Resigned was changed to Passive
   Activist was changed to Engaged

2) Analysis of the interview data: to reinforce the comments of Dr Larcombe, it is essential that the researchers who coded the data are described so that the reader can situate their analysis.

Response: We have added a new Table 1 that lists each GP and who interviewed them and then coded the transcript.

3) Foot in the door (line 182): it would be useful to bring its definition forward from line 216.

Response: We have added a notation that the definition of the “Foot-in-the-door” technique is fully described below line 242.
4) The nature of the intervention: I still have difficulty about “The GP motivational study”. It is described as an intervention yet I don’t understand what the intervention was. If asked to summarise this paper I would say:

“You had a problem getting GPs to respond to your requests for data, you created an evidence based typology of GPs’ (unflattering) views of the attitudes of hospital clinicians and their research and then did a partial validation study of the typology using a financial inducement to maximise responses. They responded either because they were offered payment or had an opportunity to tell you what they thought about hospital clinicians and their research.” I need to understand why this is an incomplete understanding your work and what exactly the GP motivational study was.

Response: We added a final paragraph to the Introduction section that, combined with the new first paragraph in the section, better clarifies that this was not an interventional study; however we hypothesized that our study of GP motivations would have an effect on GP engagement in the main study.

We also chose to change the word “motivational” to “motivation” when describing the study, which we believe added to the confusion. Our study was not intended to be motivational—that is, testing various interventions to determine whether they would motivate GPs—rather, it was intended to assess the attitudes, beliefs and motivations of GPs that were keeping them from participating in the main study. Thus, our study is now referred to throughout the manuscript as the “Diagest 3-GP motivation study.”

5) Results:
   a. The split of the 4 GP typologies into 9 is hard to follow. This might be best presented as a Venn diagram

   Response: Thank you for this suggestion. We have added a new Figure 4 that shows the 9 GP profiles as a Venn diagram.

   b. Your need to explain more clearly the basis of how you recombined the 4 initial and the 5 “split” typologies into 3: was this a pragmatic decision or a data driven decision?

   Response: The decision was a pragmatic one – we added this clarification to the Discussion section on line 438.

6) Discussion:
   a. The major problem is that I don’t understand why your “intervention” worked, which of course may reflect my confusion regarding the nature of your intervention. I need to be persuaded that an equivalent response could not have been achieved by just paying GPs a fee for returning the CRF and why describing this as a “psychosocial technique” is not overstating it.

   Response: As described above, we believe that our choice of terminology to describe the study might have introduced some confusion regarding the nature of our study. We added a paragraph at the end of the Introduction section that describes that the Diagest 3-GP study is not an interventional study, but a study of the beliefs, attitudes and motivations of GPs with regard to participation in hospital-based research. The study did not measure the effect of an intervention on GP engagement; rather, it studied the motivations themselves. For this reason, we have chosen to call the study a motivation study, rather than a motivational study, and changed this throughout the manuscript.

   b. I have difficulty with your conclusion that there “is a lack of interest in research and research culture among GPs” (line 356 on). You may have shown that your respondents hold negative
views of hospital clinicians and their research but have not shown that this can be generalised
to other research (whether conducted by other hospital or GP academics) in France. Further,
the citations used are at best selective and dated. If this were valid, how do you explain the
explosive growth of the Primary Care (and other) Research Networks in the UK in which GP
practices are key participants, the huge success of GP led research in the UK and the
Netherlands in particular but also the USA and Australia which represent very different health
economies?

Response: The introductory paragraph at the beginning of the background section highlights the
condition of research in primary care in France. It is in a phase of fast development (and the
submission of this paper testifies it), but the gap between academic GPs and field GPs is growing as
only 10% of young GPs (that have been fully educated as GP specialists) are settling in the
community. Field GPs are still considered by many French medical specialists as losers and they still
bear a complex of having been selected on failure.

c. I did not understand lines 388 and 389.

Response: We have reworded this sentence to make it more clear.

7) Conclusion:

a. Intuitively I have to agree with your conclusion that GPs who fit the “activist” typology as
described are more likely to engage with research but can’t find where you have shown
comparative response data which substantiates this conclusion.

Response: Line 353 on. Line 439 on. As this study is not interventional, there is no comparator (a
PICO assessment is not of purpose). This finding is a trend and needs to be verified, as we tried to
state clearly throughout this revised manuscript. Our sample size was just too small to show a
significant correlation between profiles and engagement, and the design of the study was not meant
to verify this hypothesis.

b. I am unconvinced of the usefulness of these typologies: they may be interesting but, if
validated, how this knowledge helps other researchers?

Response: We have added a final paragraph to the Discussion section that describes how our
findings might be useful to researchers as they design their studies in the future. (Line 449 on)

c. I don’t understand why these inform your conclusion that it would be a good thing to involve
GPs in the design of studies from the outset.

Response: There was a general feeling of exclusion and disdain in GPs because at enrolment of their
patients in the study they had felt having been put aside. They lost to view their patient that had
completely been managed by the hospital team. These feelings originated their attitude of hostility
and disinterest. (Line 298 on). This point is to be developed throughout the paper describing the
qualitative study.

d. Finally, the role of GPs research leadership has been understood and at the core of research
in primary care elsewhere for many years. The first five pages of a very “unacademic” Google
search of the terms “GP” and “involvement in Research” produced:
  http://anp.sagepub.com/content/34/2_suppl/S137.abstract
  http://www.biomedcentral.com/1471-2296/5/31
Response: Our research is unique within the existing literature in that we examined the motivations of GPs to engage in research that originated outside their practice, by hospital-based researchers, but that enrolled the GPs’ patients. We believe that the failure of the Diagest 3 main study to engage GPs presented us with an opportunity to study the motivations of these GPs and determine the barriers to participation in a specific research program that enrolled their patients but that otherwise did not involve the GPs.