Author's response to reviews

Title: Understanding the work of general practitioners: A social science perspective on the context of medical decision making in primary care

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Author's response to reviews: see over
BMC Family Practice- Letter to the Editor,

Dear Editor,

Thank you for giving us the opportunity to submit a revised manuscript.

We also wish to thank both reviewers for their insightful comments and suggestions.

You will find below a point by point response to the concerns of the reviewers.

Sincerely,
Dr. Robert Geneau

Compulsory Revisions

Reviewer no 1: Richard Thompson

1) *Overall I think the authors need to do more to explain why they chose this theoretical approach and acknowledge or discuss its potential limitations. Many readers of the article will be totally unfamiliar with this theory.*

We have added further justification on page 4 for the choice of structural theory to guide the study process.

The reviewer refers to the “adaptive structuration theory”. Desanctis and Poole (1990) borrow from Giddens to criticize the technocentric view of technology use in groups and organizations and emphasize the social aspects. This is exactly what we wanted to do in this paper- use structuration theory to emphasize the social aspects of decision-making in primary care. The reviewer is right to say that many readers will be totally unfamiliar with structuration theory. We didn’t think that the readers of BMC Family Practice would be interested by a full-blown theoretical paper. Given the length of the paper, and the fact that we consider our empirical material to be very interesting and consequently deserving enough space, we have purposefully avoided making this paper centered on structuration analysis. It would have been a totally different kind of paper, for a different journal and a different audience.
We wanted to acknowledge the use of structuration theory in guiding the study process and its benefits in analysing practice-based (qualitative) data. In the end, an important message is that there is a middle road between purely empirical or purely theoretical papers.

2) **It is important to describe the structure and delivery of primary care in Canada further (perhaps in a boxed summary).**

We have added more information on page 5-6 about primary care models in Quebec (while mentioning that health care is a provincial jurisdiction in Canada).

3) **The focus of the article is medical decision making. This term is very broad. It would help to be clearer about what sort of decisions the authors are addressing within their research. Later in the paper this is extended further to “medical decision making and …professional life in general” There is a big difference between decisions related to billing codes and those related to treatment options for example. It would help to be clearer about the focus of the research on decision making.**

We agree with the reviewer that the concept of “medical decision-making” is very broad but this paper, as indicated in the title, is about the work of GPs and the context of medical decision making in primary care. The context is very broad and our findings show that contextual factors may influence how physicians manage their time which, in turn, may ultimately influence decisions about treatment options, etc. We feel that the originality of this paper lies with the demonstration of how these different dimensions are interrelated (contextualized decision making processes).

We now mention on page 4 that we consider the praxis of GPs as a social phenomenon.

Friedson also showed that decisions about the organization of professional work can influence clinical decisions.


4) **There is a wider literature on the effects of fee for service on behaviour that is not referred to in this paper**

Our original manuscript already contained three highly relevant references directly related to payment mechanisms in primary care. We have added three references:


5) **This study was undertaken in 2001-2003 – are the data still valid in 2007? Why has it taken so long to submit or analyse these data – the authors should acknowledge and discuss this.**

The findings presented in this paper were part of Dr. Geneau’s doctoral thesis completed in 2005. The thesis, over 300 pages long, was written in French. Part of the findings have already been presented in English in another journal:


To address the validity issue, we have added this sentence in the methods’ section on page 6: “GPs working in private clinics accounted for around 70% of all primary care doctors in Quebec at the time of the study while around 13% of GPs worked in CLSCs. (ref GRIS). Since 2002, a new model called “Family Medicine Group” is being implemented in the province (reformed fee-for-service with financial resources allocated to practices for hiring nurses) but the FFS and CLSC models remain predominant. The FFS model is predominant in all Canadian provinces (70.4% of all primary care physicians) although health care is a provincial jurisdiction (College of Family Physicians of Canada, 2005)”.

Furthermore, in a qualitative paradigm the emphasis is placed on the transferability of findings to other contexts. We believe that the richness of the empirical material allows for the conclusions drawn to be applied to other primary care contexts where similar organizational models are present.

6) **The authors state that they added 5 GPs from different settings in order to reach data saturation. I can understand why further interviews might be added if the researchers felt that data saturation had not been reached, but why choose different settings at this stage? This merits explanation.**

Some of the sites recruited either had few full time physicians or some physicians declined participation in the study. After completing all of the interviews with consenting physicians in the eight selected sites we felt that more interviews were needed but we were forced to recruit physicians from different organizations. This point is now clarified in the methods section on page 6.
7) The concept of “ontological security” is introduced in the discussion but not adequately explained

The concept is now defined at the end of the background section, on page 4.

Furthermore, there is discussion of “anxiety and self-esteem introduced for the first time on p19 – it is not clear where this comes from in their results.

Below are two text passages from the empirical section that, we feel, provide the basis for raising these issues in the discussion section. Please note that these quotes were selected out of hundreds of pages of interview transcripts. We have additional empirical material to support the statements made in this paper but these quotes were selected because they summarize nicely what others may have said less eloquently or with more words.

Page 13:
Finally, clientele characteristics have a major impact on both the length of consultations and the scope of practice of GPs. Some of the respondents deliberately avoid specific groups of patients:

“There are some degrees of uncertainty that I would not want to be dealing with at this stage in my career. If someone brings a baby in my office, I’m going to be sweating.”

(GP, private clinic, urban)

Page 15:
For example, as the proportion of time dedicated to walk-in services increases, the availability of the physician for regular appointments decreases. This situation translates into a delay of sometimes 1-3 months between regular appointments, which, according to all respondents, represents a source of uncertainty and anxiety:

“I can tell you that it is very stressful to know that you can’t see people… within a month or two.”

(GP, private clinic, urban)

8) Overall I sense that the findings are consistent with a wider body of research an understanding about decision making that is not addressed or referred to here. For example, the discussion of the impact of patients’ requests on tests and referrals is presented on p20 almost as if a new finding, but I’m sure others have reported this.

Regarding the impact of patients’ requests on tests and referrals we did have in our original document a reference to Greer et al. (2002), one of the best papers on this topic from our perspective. We have added one additional reference:
Reviewer no 2: Margareth Maxwell

1) Given the central focus which consultation time plays in impacting on GP practice and driving unintentional consequences, this paper would benefit from a more thorough exploration of the literature relating to consultation times (or fast and slow doctors) and outcomes.

There are two instances in this paper where very specific quantitative data is cited in support of their arguments (p15 and p16). The authors should describe how they collected or came by this data. The statement on p16 which states "a difference of 5 minutes in the length of the consultation is enough to modify a GPs approach and attitude" is particularly worrying in this regard. Many researchers who have conducted large and complex studies of consultation times, processes and outcomes may take issue with this.

We have added, on page 7 in the methods section, more details about the interview guide (the interview guide comprised questions related to how GPs manage their time (length of consultation, etc.).

Regarding the statement on page 15 (a difference of 5 minutes in the length…) we have added the appropriate context in support of the statement made. GPs who have worked in both a CLSC and a private clinic setting during their career acknowledged that fee-for-service leads to shorter consultations and the “one problem per visit” rule. This phenomenon has been observed elsewhere as well.

We have also added some material in the discussion about this issue, including three references:


Minor essential revisions:
1) Anxiety and self-esteem as predominant facets and preoccupations shaping Gp professional experiences is brought out in the discussion but perhaps not as explicitly in the findings section. I'm not sure confidence over knowledge and skills equates with 'self esteem'(as might be defined within mental health promotion literature), perhaps a change in terminology is required here.

On page 19 (discussion), we deleted the reference to the concept of “self-esteem” because it was not absolutely necessary to support our argumentation in this particular paragraph.

Giddens do consider that ontological security is necessary in order to maintain self-esteem.

2) There are some instances where it is unclear whether the authors are making a point of interpretation/reflecting on potential consequences of actions or reporting actual descriptions from transcripts. E.g. p12 first para - are certain patient groups or diseases actually excluded by GPs, do they have statements to that effect?

All statements can be supported with empirical material. The reviewer refers to one example in particular (page 12):

A physician can join an organization in which GPs have all developed a “mini-specialty”. From that perspective, the exclusion of certain groups of patients or diseases can be the unintended outcome of peer-to-peer interactions rather than an entirely planned and intentional personal decision.

We feel that the quote (just above that paragraph) that starts with “Some physicians here are less comfortable with kids. Between us we know” illustrate that point sufficiently. We could provide other examples if necessary. For example, one of the eight sites is comprised of three male doctors and one female doctor. The latter ended up with seeing mostly female patients, not by choice (on the contrary she longed for a diversified case-mix of patients) but because some of her male colleagues were not comfortable dealing with women’s health issues.