Author's response to reviews

Title: Attitudes Of Developing World Physicians To Where Medical Research Is Performed And Reported

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PDF covering letter
We are grateful to the reviewer who has identified a number of relevant points. We have made a number of changes to the text as suggested, and feel that these strengthen the paper considerably. We provide detailed responses to each point, and a description of the changes we have made.

1. Relative influence of different diseases in different places. We accept this point, and have added to Page 13, para 3: “In addition, it is possible that the influence and credibility of various information sources may be different for different clinical problems in different settings.”

2. Understanding of the questions. We acknowledge the weakness of asking the respondents questions rather than observing their clinical practice, and have made this point previously in the Discussion “We report answers to a questionnaire rather than observations on practice, and have not established the validity of the stated responses.” To add to the point the Reviewer makes about national pride, we have added to Page 13, para 3: “It is possible that ‘national pride’ may explain the large difference seen between local and regional journals.”

3. Figures show ‘little difference’ to be the largest category. On re-reading the manuscript, we note inadequate description of the way the data were produced for presentation as Figures. We have clarified this by adding a sentence to the Statistical Methods, on page 6, para 1: “Graphs are presented to show the difference between perceived influence of respective research/journals in comparison with local research/journals as the reference. If the difference was -2 or less, then the graph reported "prefer local"; if the difference was -1, 0, or 1, then the graph reported "little difference", and if the difference was greater than or equal to 2, the graph reported "prefer other".” The way the difference categories were derived from the 5-point Likert scale (see below) presumably accounts for the distribution of categories seen in the graphs. We have not made much comment on the Figures in the paper, but have separately reported statistical tests of the likelihood of practice being influenced, and hope that this clarification we have added will help the readers interpret the results presented in the Figures.

4. We do not know how many journals/papers the physicians read, but we did report (Table 1) that over 75% of physicians at each study site had access to a medical library. We have not reported another finding that at least 85% of respondents at each study site reported that they had access to “up to date” information to medical journals. As requested by the reviewer, we have added to our text on page 14, para 2: “Although the respondents to our survey reported high levels of access to medical libraries (Table 2), and also reported high levels of access to “up to date” medical journals, we do not know which journals they are or if they were read. Unfortunately, even in the ‘best’ settings worldwide, medical practice is not necessarily driven by peer-reviewed evidence.”

5. Comment on which journals included in response to above.
6. The questionnaire provided examples of a region, and we have added a section to the Discussion describing this as a possible explanation of the low credence given to regional journals and research: page 13, para 3: “The understanding of ‘region’ may also be difficult, we gave examples in the question of East Africa, Asia and Latin America.”

7. Type of research. The question asked about ‘clinical research’ and we have added ‘clinical’ to the first line on page 5 in the Methods section to clarify this.

8. We did agree initially on a sampling frame, but local conditions necessitated a change in some places. We have stated in the Methods section “Each centre was asked to identify hospitals and physicians within those hospitals who would be expected to treat patients with pneumonia, in a way that would represent the generality of tertiary and secondary hospital settings in their region” and we accepted any sampling mechanism that would lead to that type of study sample. We think that this quite accurately described what happened, and have now added to line 13, page 4, para 1 “due to local circumstances” after “The sampling procedure varied between centres”.

9. We just asked about access and did not elaborate on it.

10. We have added the exact items on the Likert scale to the Methods section (Page 5, line 4) “(very unlikely, unlikely, neutral, likely, very likely)”.

11. The larger study just refers to the previous publication from this study, which reported on the variability in the stated clinical practice that the physicians would adopt given a patient with pneumonia as described in a case scenario. We have added this explanation to the Methods section (page 5, line 5) “…which examined variations in stated clinical practice based on a case scenario of a patient with pneumonia” [9].

12. We have added “where each investigator gave the questionnaire to a sample of physicians to assess comprehension and feasibility” to explain pretesting a little further on Page 5, para 2.

13. We have added the word “strong” before “possibility” for selection bias on page 13 (line 3, para 2) in order not to downplay selection bias as requested.

14. We have revised the Conclusions (Page 15) to more accurately reflect the preceding content “Since local research and publications were considered most likely to change clinical practice, the conduct of high quality local research is likely to be an effective way of getting research findings into practice in developing countries. Local research should be encouraged through education and collaboration and supplemented by appropriate education programs to guide physicians on how to use evidence.”

We hope that these changes make the paper acceptable for publication.