Author's response to reviews

Title: Burden of morbidity in a patient perspective - the case of sick-leave certified patients in primary care

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Second revision to be submitted 2009-01-19

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First reviewer

Reviewer: Christos Lionis
Reviewer’s report:
The revised paper satisfied all the questions and concerns that I posed in my initial evaluation.
Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.

Resulting revision:
We made no changes in the manuscript that might influence this reviewer’s aspects.

Second reviewer

Reviewer: Barbara Starfield
Reviewer’s report:
This paper is greatly improved. Two additions would improve it, however.
1. Table 1 and Figure 1 are unclear as to whether the medical record diagnoses also include the secondary review. Please clarify in the title or footnote.
2. The last sentence under ‘coding aspects’ is inappropriate. I realize that another reviewer raised the issue of medicalisation, but the sentence is off the mark because there is no evidence that making diagnoses ‘medicalises’ problems; also the ACG system minimizes the problem of additional diagnoses by coding them into categories. I suggest re-wording the sentence as follows:
The extent to which recording every diagnosis predisposes to medicalisation is unclear, but the ACG system minimizes the possibility by combining similar diagnoses into categories rather than counting them individually and adding them. Additionally, recording of any given diagnosis does not imply that any management strategies are instituted.
Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.

Resulting revision:
Ad 1. We added to the title in Table 1 and Figure 1 that the secondary coding was included in order to contain all diagnoses found.
Ad 2. We have accepted the comment in the discussion part under ‘Coding aspects’ and changed the sentence exactly as is suggested by the reviewer. The new sentence will read as follows: “The extent to which recording every diagnosis predisposes to medicalisation is unclear, but the ACG system minimizes the possibility by combining similar diagnoses into
categories rather than counting them individually and adding them. Additionally, recording of any given diagnosis does not imply that any management strategies are instituted.”

Third reviewer

Reviewer: Nils Fleten
Reviewer’s report: 
Re-review Burden of morbidity in an individual perspective – the case of sick-leave certified patients in primary care.
The revision has made the manuscript more accessible.
The suggested major compulsory revisions are to some degree undertaken.
1. The recommendation of introducing a minimum of statistic is not undertaken as the authors consider the 4-week sample of sickness certificates from GP in one Social Security office to be a full scale material. Restricted to description of findings in this limited material this would be acceptable, but of minor general interest.
In Table 1 diagnose distribution in sickness certificate and records is compared
“The diagnosis perspective
Table 1 shows the comparison on a diagnosis level between the two sources of data in terms of ICD-10 chapters. The first obvious difference could be seen when comparing diagnoses in chapter XVIII regarding signs and symptoms, where the proportion of diagnoses was quite higher in the patient records than in the certificates.”
The table show a proportion of chapter XVIII of 9.7% in records and 7.6 % in certificates, a non-significant difference at the 0.05 level, the 95% CI of the 7.6 proportion being (5.0-10.8).
2. The interesting findings of Table 1 is probably the lack of differences in diagnose distribution with the exception of chapter V mental disorders that not unlikely can be explained by the skewness introduced by selecting half the inclusion periods in July?
A discussion of this potential skewness due to half the inclusion period in the main summer hollyday period would be appropriate.
3. A clarification of what the diagnoses in general practice should represent would be appropriate before concluding about the diagnose use based on the actual findings, the main reason(s) for consulting the GP the particular day, or a cross-sectional overview of the current overall burden of sickness and illness for the patient.
If the generally accepted paradigm in Sweden is the latter, the findings might support the conclusion of urgently need of improvement..
Level of interest: An article of limited interest
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.

Resulting revision:
Ad 1.
The sentence “The first obvious difference could be seen when comparing diagnoses in chapter XVIII regarding signs and symptoms, where the proportion of diagnoses was quite higher in the patient records than in the certificates” will be changed into two new sentences as follows: “Very small differences could be seen in the comparison. One exception was the
difference when comparing chapter XVIII regarding signs and symptoms, where the proportion of diagnoses was somewhat higher in the patient records than in the certificates.”

Ad 2.
We have changed this part as follows: "Different periods of the year have been chosen for data retrieval to reduce the impact of potential seasonal variations in the diagnosis’ distribution. Our study is not intended to explore such impact, and our data are not sufficient to evaluate that aspect. When the previous diagnoses of each person are included they cover all times of the year."

Ad 3.
We will include the following sentence into the discussion part: "The reimbursement system for PHC in Stockholm County Council requires the physician to code the diagnoses that were the main reasons for consultation."