Author's response to reviews

Title: Geriatric Day Hospital: opportunity or threat? A qualitative exploratory study of the referral behaviour of Belgian general practitioners.

Authors:

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Author's response to reviews: see over
Dear editor,
Dear reviewers,

We would like to thank the editor and reviewers for their very interesting and helpful remarks. In answer to these remarks, we reviewed the manuscript. In attachment we uploaded the document with all the changes marked in green.

In the following paragraphs we explain in detail how we complied with the remarks and suggestions of the reviewers (the text in Italics refers to the comments files we received from the reviewers).

Comments Reviewer 1: Markus Themessl-Huber

Background section
1. The background section’s structure is somewhat confusing. It is difficult to identify the focus of the manuscript. The topics vacillate between general and specific information rather than moving from the general to the specific (i.e. introduction of the CCM-aspects of the GDH-GP related issues; Belgian health care – GP related issues – GDH). As a result, the main focus on GPs in the research question comes as a surprise as most of the information is about the rationale for and structure of the GDH. Re-structuring the background section and providing more information about issues surrounding GP involvement/engagement would help to clarify and strengthen the manuscript’s focus.

We fully agree with this remark of the reviewer.
We reviewed the entire background section thoroughly, introducing a clearer line of thoughts in this section and deleting all information which is not essential to come to the aim of this study.

Methods
Design
2. More information is needed on the research design. Even in an exploratory project, what was the rationale for choosing FGD over interviews?

A strength of FGD is the dynamic of the group. By discussing several topics in group a process of sharing and comparing is installed. FGD can also encourage people to discuss non-sensitive topics. This information was added to the methods section.

3. A moderator and observer are mentioned as part of the FGDs, who were they (GPs, researchers, etc.)?
The Dutch speaking FGDs were moderated by Fien Desmyter (master in psychology) and observed by Piet Vanden Bussche (GP).
The French speaking FGD were moderated by Christiane Duchesnes (GP) and observed by Valérie Massart (master in social sciences).
Both Fien Desmyter and Christiane Duchesnes are experienced and trained qualitative researchers and focusgroupmoderators.
Fien Desmyter and Piet Vanden Bussche are researchers at the Department of General Practice and Primary Health Care at Ghent University. Christiane Duchesnes and Valérie
Massart are researchers at the Department of General Practice at the Université de Liège. Additional information was added to the manuscript.

4. Why were GPs observed (how did that help to answer the research question)?

5. What criteria were used for populating the observation form?

Piet Vanden Bussche and Valérie Massart mainly observed the focus group discussions to build up familiarity with the discussions. This helped them later in their contribution to the analysis and interpretation of the data. Further, the observers took care of the practical arrangements during the FGD (collecting informed consent forms, changing the tapes, …) and gave feedback/suggestions to the moderators during the break (e.g. informing the moderator about a participant who shared an interesting experience with his colleague during the filling in of the informed consent forms, suggesting further discussion about a subtheme that was brought up). Finally, the observers took field notes using an observation form. These notes were limited to notes about the background of the participating GPs that came up during the discussion (experience, particularities about the practice, …), the times when the tapes were changed, when participants left the room to answer their phone, the major themes that were discussed. These fieldnotes were not coded or included in the analysis but were simply used during coding and analysis to remember what happened during the discussion. Because of the limitation of the word count of the paper and the little relevance of the observation for the analysis and interpretation of the data, we deleted all the text referring to the observation. However, if the editor wishes we can also add the above information in the text.

6. What qualitative data analysis framework was used (what kind of thematic analysis)?
We added more information about the analysis framework in the paper.

7. How were the codes defined (a priori and/or in the course of the analysis)?
The technique of open ended coding was applied. We added this information in the paper.

8. At what stage in the FGD was the local information on GDHs introduced to GPs?
The information was introduced after an exploration of the GPs knowledge and experiences with the GDHs. As most FGDs flagged because GPs hardly knew about the existence and/or functioning of the GDHs, we gave them information about the general concept of GDHs (financing, organization, aims, …) and about the local situation (the GDH in their area, its capacity, the leading doctor, …).
This explanation is added in the paper in the methods section. We also repeated this in the results part because it seems important that readers are well-aware we did this when they read the results section.

Procedure

9. Please outline the rationale of using a random selection of GPs when you then combined it with snowballing? Why did you not use purposive sampling?

10. Potential biases of the different selection criteria for Dutch and French speaking groups were not made explicit (different cultural contexts, mixed groups of GDH use in the Dutch groups vs. separate user and non-user groups in the French groups.
The main reason for the different selection criteria for the Dutch and French speaking groups is the difference in culture between the Northern and the Southern part of Belgium: in Flanders local quality peer review groups are a regular channel for asking the opinion of GPs,
used by the government, local policy makers and researchers. In the French speaking part of Belgium, this is much less the case. There, GPs are more often contacted individually.

In concordance with these habits, we opted in Flanders to contact the chairman-GP of local quality peer review groups and asked him to participate in the study. Once the chairman agreed to participate, the FGD was scheduled on the agenda of the next meeting of the group.

In the French speaking areas the official database of GPs was used to select participants. Because this database contains only the names and addresses of all GPs, further selection based on gender, age, years of experience,… was not possible. Therefore, to select names of the list a random selection was made. In this case a random selection meant the highest chance of variation. Any other way of picking names of the list would have embodied a higher risk of less variation (e.g. a selection of the first 10 GPs on the list would have resulted in a selection of GPs which were related (same surname) or were all from a same ethnic group (surnames beginning with an “a” in Flanders are predominantly from people with a non-Belgian origin). The selected GPs were contacted by telephone and invited to participate in the study. To maximize participation of traditionally hard-to-reach GPs (i.e. GPs who do not respond to invitations for participation in studies), some participants were asked to invite and motivate their local colleagues. This information was added to the paper. We also added additional information to the strengths and limitations part of the paper.

11. How did the researchers know that data saturation had been reached?
A priori we decided how many FGDs we were planning to organize, so our main goal was not to organize FGDs until we reached data saturation. However during the data collection we observed no new topics came up and many aspects GPs brought up were heard before, suggesting that data saturation was reached. However, we made the referral to data saturation in the text less strong and changed it to “In the last two FGDs no new information occurred, suggesting that data saturation was reached.”

12. What information was given to GPs about the research project?
All GPs were given both written and oral information about:
- the objectives of the study
- the background of this study and its funder
- the researchers
- the timing of the study
- what will be done with the results (research report for the government + scientific publication)
- further all information needed to be able to sign an informed consent was given (anonymous analysis of data, withdrawal from the study possible at any time, no risk attached to participation, insurance policy, who to contact in case of questions afterwards)

13. At the beginning of the results section you mentioned that the discussions got stuck at the beginning because GPs did not know about GDHs.
See q.8.

14. Was any ethics clearing required? If so, was it granted? If not, can you make explicit that no ethics clearance was required?
Thank you for bringing this up. We mistakenly did not add any information about the ethics approval. This study was approved by the Ethics Committee of the University Hospital Ghent and the Comité d'Ethique Hospitalo-Facultaire Universitaire de Liège (EC registration number: B67020083854). Subsequently, the study was submitted at the Commission for the protection of privacy. This declaration was registered and published in the public register of the commission (PC processing number: VT005005950).

This information was added to the paper.

Participants

15. 106 GPs took part but what was the size of the GP pool?

I’m afraid we do not understand this question very well. In case the total number of GPs is meant: there are 7,912 GPs in the Flemish speaking part and 5,137 in the French speaking part of Belgium (data reflecting the situation at 31/12/2008, as described in the yearly statistics by the Federal Public Service Health, Food Chain Safety and Environment).

However, sample size is of less importance in qualitative research than the variation of the sample and saturation. We did all the possible to reach variation. And as in the last two FGDs no new information occurred, it can be suggested that data saturation (at least what concerns our research questions) was reached.

Results

16. The titles of the subsections are not always self-explanatory. Introductory remarks outlining the type of findings in the respective sections as well as summarizing paragraphs would help the reader to better understand the findings.

When re-reading our initial paper, we fully agree with this comment. We adjusted the titles and added introductory parts in the different sections of the results part of the paper.

17. I would have preferred the use of direct quotations in the text rather than in tables. Tables could be used to summarize sections.

The quotes were moved to the text. Consequently Table 3 has been deleted. We added summarizing text in the different sections of the results part of the paper.

18. Information is missing on why some GPs were familiar with GDHs. What does ‘by chance’ mean?

GPs who were familiar with the concept of GDHs learned about them unintended (e.g. a GP’s patient was referred to a GDH by a geriatrician).

We added this information to the paper.

19. Generally, it would be helpful to know whether certain points were raised by a single or by various GPs.

Analysis of FGDs might indeed consider the density of the responders’ comments in its context. For example, a participant’s quote, which was mentioned only once, can be considered as very important if the emphasis or intensity by which the participant mentioned it, was considerable high.¹

Unfortunately, it is unfeasible in this study to identify which aspects were mentioned by exact how many GPs. Seen the very interactive character, it is difficult to hear on the tapes how

many people agreed. However, we added in the text indications about the extent to which a
certain point was emphasized by the group (a lot of GPs, some, a few, …).

20. Likewise, it would be helpful for the reader to know what statements are based on GPs
actual experiences and which are based on assumptions of newly informed GPs.
Since the majority of the respondents did not know about GDHs, the majority of the
statements are based on GPs’ assumptions. We added this information to the methods section
and repeated this in the results section as we think that it is important that readers are well-
aware of this when they read the results section.

21. Also, it would be good to have an indication about the level of agreement within FGDs on
the issues mentioned (i.e. how many are ‘some’ GPs, line 103).
See also q.19
When we used the term ‘some GPs’ we mean that more than one GP, in more than one FGD
brought that particular issue up.
The task of qualitative researchers in the analysis process is to look for clues, for trends and
patterns in the answers which given in the different FGDs. Of course when some answers
repeatedly come up in the discussions, or even dominate the discussions (in this study for
example the fact of not being recognized), this theme can be identified as a main theme. In
this study, these formed the backbone of the result part of this paper. Opinions that were
expressed only once are also considered as important but they did not form the main structure
of the paper. To answer questions about the importance of a certain barrier (quantifying),
other(quantitative) techniques are required.

22. Do you have information about GP knowledge on other services for older people? Does
this differ from their knowledge of GDHs?
In general GPs are believed to have good knowledge about medical, secondary care services.
However, there is no clear and valid data available about this in Belgium.

23. Lines 96ff: Was this information provided by the researchers during the FGDs or is this
information based on GPs who had been informed about GDHs prior to the study? This
would be an important difference (i.e. it would be about actual experience vs.
assumptions).
See also q.8.
This information was provided by the researchers during the FGDs, when GPs asked a lot of
questions concerning the GDHs in their region. The statements given by the GPs afterwards
reflect their perceptions based on available, true information given by the researchers.

Discussion
24. The discussion reads more like a summary of results than an analysis and synthesis of
results. Also, additional results are presented, which had not been mentioned in the
results section. Very few links are obvious with information provided in the background
section.
25. The implication for practice section provides more analysis and synthesis. More of this
would be needed in the discussion section. However, even in the implications section new
information is introduced.
Thank you for this feedback. We completely changed the discussion part of the paper. We
structured the discussion according to the structure in the results part. We added more detail
to the results section and summarized the findings in the conclusion part more. Each part of
the summary is directly followed by a discussion part (instead of first summarizing all results
and then discussing all results) Because we deleted a lot of unnecessary information in the background section, the link with that section is now clearer. We also added some more and more recent references.

Minor Essential Revisions

Methods

Design

26. The total number of participants should be listed here.
We made that information more clear. However, if the reviewer agrees, we would suggest to put it into the “Participant Characteristics” section.

27. On line, 59, text is missing before and/or after ‘Verbatim’
We changed this in the paper.

Standards of reporting

28. Please revisit the reference section, some tidying up is needed.
We checked all references and tidied them up.

Comments Reviewer 2: Horst Vollmar

Major Revisions

Thank you for this comment on which we totally agree. We added more detail to the methods section.

30. Methods (line 59): “observation form” What was observed? There is nothing about the observation in the result or the discussion section. Why not?
See also q.4 and q.5
Piet Vanden Bussche and Valérie Massart mainly observed the focusgroup discussions to build up familiarity with the discussions. This helped them later in their contribution to the analysis and interpretation of the data. Further, the observers took care of the practical arrangements during the FGD (collecting informed consent forms, changing the tapes, …) and gave feedback/suggestions to the moderators during the break (e.g. informing the moderator about a participant who shared an interesting experience with his colleague during the filling in of the informed consent forms, suggesting further discussion about a subtheme that was brought up). Finally, the observers took field notes using an observation form. These notes were limited to notes about the background of the participating GPs that came up during the discussion (experience, particularities about the practice, …), the times when the tapes were changed, when participants left the room to answer their phone, the major themes that were discussed. These fieldnotes were not coded nor included in the analysis but were simply used during coding and analysis to remember what happened during the discussion. Because of the limitation of the word count of the paper and the little relevance of the observation for the analysis and interpretation of the data, we deleted all the text referring to the observer. However, if the editor wishes we can also add the above information in the text.

31. Procedure: Why the differences in recruitment in the Dutch and the French speaking part?
Please see q.9
32. Why mixed groups in one part and different groups in the other part?
Please see q.9

33. Line 71-72: “…data saturation was reached.” How defined?
See q.11

34. Analysis (line 83): What kind of method? Grounded theory, Mayring, other method?
How?
See q.6
More detailed information is added to the paper.

35. Where is the observation? Why only one researcher? (bias possible!)
36. Please add something like that to the limitations: “only one researcher for each part, a
team would have been a better strategy for analyzing the results”.

37. Strengths and limitations (line 07): Why was the analysis of both groups was quasi unisonous?

See also q.4, q.5 and q.10

After two FGD, the two main researchers (FD and CD) first analysed the two transcripts independently. Next, they met several times to develop a consensus on the coding system. This classification system was then used to analyze the transcripts of the following FGDs. After coding all transcripts, the coded data were analyzed by the two research teams independently each using the OSOP-method. This method involves reading through each section of data in turn and noting, on single sheet of paper (OSOP), all the different issues that are raised by the coded extracts, along with the relevant respondent IDs if possible (not for all coded extracts the respondent was identifiable). Each team consisted of minimum 3 persons with a wide variation in backgrounds (GP, social scientist, psychologist, methodologist). The complete OSOP provided the research team with a summary of all the issues within the code and the IDs of the relevant respondents next to them (if available). The next step was axial coding in which the research team considered how the identified issues might group together in broader themes. Consequently, both research teams met and presented the themes they identified. It was interesting to see that the analysis by both teams was very similar: both teams identified the same main themes and many of the more detailed aspects were similar in both parts of the country. The identified themes were discussed until consensus was reached about one set of main themes and about the underlying aspects of the themes. These themes formed the backbone of the result section of this paper.

We also added more detail about the coding to the paper.

38. Please add more experiences from other countries (comparison). Do they have the same problems? (I am quite sure).
It was interesting to experience already so little differences between two culturally different groups in the study itself suggesting that these experiences may be more universal. This is also mentioned in the recent WHO publication of the world health report 2008 Primary care now more than ever, chapter 1 ‘trends that undermine the health systems’ response’, page 11 Hospital-centrism: health systems built around hospitals and specialists
39. **What are the implications for further research and implementation projects?**
This part is expanded in the paper.

40. **Table 3: How do you develop these categories?**
See q.17. The quotes are in the text now, consequently table 3 has been deleted.
The categories were developed during the analysis process.
After coding all transcripts, the coded data were analyzed by the two research teams independently using the OSOP-method. This involves reading through each section of data in turn and noting, on a single sheet of paper (OSOP), all the different issues that are raised by the coded extracts, along with the relevant respondent IDs. The complete OSOP provided us with a summary of all the issues within the code and the IDs of the relevant respondents next to them. The next step was axial coding in which we considered how these issues might group together in broader themes. Consequently, both research teams met and the themes identified by the research teams were discussed until consensus was reached about one set of main themes and about the underlying aspects of the themes. These themes formed the backbone of the result section of this paper.

**Minor Essential Revisions**

41. **Background (line 45 and 46): “…, only 40% of the patients…” How many patients?**
In a reference period of 3 months, only 40% (n=800) of the patients in GDH (n=1,992) were referred by their GP. We added these details to the text.

42. **Background (line 45-47): A description in detail would be helpful. Some data about the average physician-patient contact (patients per day)? What is the “average” referred rate?**
We contacted several governmental departments and researchers in the field but none of these sources could provide us with this information.

43. **I would prefer more and newer references in the discussion part of the manuscript.**
More and more recent references were added.

44. **Conclusion (line 49-51): I suggest to eliminate the sentence “top down approach is not successful”. If not, please add some further evidence for that thesis.**
We deleted this sentence.

45. **Ethics vote?**
Thank you for this remark. We mistakenly did not add any information about the ethics approval. This study was approved by the Ethics Committee of the University Hospital Ghent and the Comité d'Ethique Hospitalo-Facultaire Universitaire de Liège (EC registration number: B67020083854). Subsequently, the study was submitted at the Commission for the protection of privacy. This declaration was registered and published in the public register of the commission (PC processing number: VT005005950).
This information was added to the paper.

**Discretionary Revisions**

46. **Please introduce the abbreviation GDH in the background section (line 28).**
We added this in the background section.

47. **Please introduce the abbreviation FGD in the tables.**
We added this.

We hope we answered satisfactorily your questions and remarks. If there are any further questions, please do not hesitate to contact the corresponding author. We thank you in advance for your interest in our paper and we are looking forward to the publication!

Sincerely,
In name of all the researchers,

Sara Willems, MA, PhD
Senior researcher
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