Reviewer's report

Title: "Walk-ins" (self referrals) seeking care at an emergency department or general practitioner out-of-hours service: a cross-sectional comparison

Version: 1 Date: 14 December 2010

Reviewer: Paul Giesen

Reviewer's report:

The authors examined differences in patient characteristics between self-referrals at an ED compared to a GP cooperative in Switzerland and analysed which factors predict whether patients choose to go to the ED or GP cooperative. Similar studies have already been performed in other (European) countries.

Major compulsory revisions:

- This is a “we too” study. The authors should describe more explicitly why it is important and relevant to perform this study in Switzerland too. Do they think their results would be different from other European countries?
- The GP cooperative was a 24-hours service (60.4% of patients visited between 7:00 and 19:00). Why do you call this an out-of-hours service? Daytime data from the GP cooperative are used in the study and pooled with the data from the night doctor. The title and introduction make the readers believe it concerns out-of-hours care. It is unclear how GP cooperatives are organized in Switzerland. A suggestion is to include a box with the main features of GP cooperatives, like in ref 37.
- The Zurich City Hospital Waid has a GP cooperative integrated in the ED, with one access point for patients. I assume that the GP cooperative used in your study was a more traditional GP cooperative, separated from the hospital. Is this true? If not, the patients could not freely choose to attend the ED or GP. In that case, please describe the implications for generalisability of the results.
- The data collection included winter and summer at the GP cooperative, but only summer at the ED. The authors state that “the effects on the results will probably be small because the known variation in diagnoses according to season is likely to affect the ED and the GP-C similarly”. This argument does not hold, because the GP-C data are corrected for the seasonal variation (because both summer and winter are included) whereas the ED data are not. It is a major limitation of the study that the ED data do not include winter data and should not be disregarded.

Minor essential revisions:

- The use of the term “(non)-urgent care”. Why is “non” placed between brackets? In most cases, the brackets should be deleted, because the reader should read non-urgent. For example in the abstract: “Emergency departments in
- Why did the authors choose to give only 22.7% of the walk-ins a ICPC-2 code? Why not all?
- Why was intra-rater reliability and not inter-rater reliability used for the ICPC-2 coding? And was Cohen’s kappa calculated on chapter level or specific diagnosis level?
- Table 1: Please add the results on Mode of contact (home, practice, telephone contact) for the GP cooperative and results on Diagnostics for both settings.
- Page 6: “Characteristics were documented for the first, second and the last patient contact by the GP”. Which of these contacts was used in the study to score the mode of contact, diagnostics performed etc? Or were all of these contacts included, meaning that patients were included more than once in the sample?
- Discussion: The study showed that at the ED, more diagnostics were performed. The authors relate this to the differing distribution of diagnoses between the ED and GP-C. However, ED doctors more often perform diagnostic tests for the same health problems than GPs. GPs tend to be more restrictive in using tests and are more focused on anamnesis and physical examination. Also, ED doctors have financial reasons to perform tests (they bring in money by performing X-rays, for example). The authors could add these considerations to their discussion of the results. They should not just conclude that more diagnostics were needed at the hospital.
- Discussion: What do the authors mean by “bring the GPs to where patients go” on page 13. What kind of solution do they suggest? Do you mean an integrated GP cooperative/ED? (see ref 27)
- Discussion/Conclusion: the authors state that the health problems showed only partial overlap and therefore conclude that different patient needs require different models, which should complement each other. Please pursue this subject taking a different perspective: are the problems presented at the ED at the right place? Or can they be treated by GPs, increasing efficiency and reducing costs? (see also ref 37).
- Discussion: a further limitation should be included: the research is limited to an urban area. Can the results be generalised to the whole country?
- GPs had to fill in questionnaires for each patient contact. It is known that this leads to under-representation. Especially at night, GPs do not want to fill in questionnaires and in the morning, they have forgotten an substantial part of the specific patient data. Please comment on this in the discussion.

Discretionary revision:
- Choose either to use the term “walk-in” or “self-referral”. Now the terms are used both and this is confusing
- Abstract: 1.901 contact were used for the analyses. In the abstract, the authors mention an N of 2.974. This figure includes non-self-referrals and is thus less
relevant than the number of 1.901 that was used for the analyses. Mention this number in the abstract and also give the N for the ED and GP cooperative separately (N=1.133 and N=768 respectively)

- Page 9: “Distribution of referral-times to the GP-C did not differ in the different evaluation periods”: please remove this sentence to the second paragraph on page 8.

- Figure 2, 3, 4 and 5: please provide the percentages behind each bar.

- Figure 5: this is the only figure in upright direction. Please present this figure in the same way as the other bar charts.

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.

Declaration of competing interests:

I declare that I have no competing interests