Author's response to reviews

Title: Doctor and practice characteristics associated with differences in patient evaluations of general practice

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Author's response to reviews:

Dear Editor

We have now revised our manuscript according to the editor's and reviewers' comments. Below this letter we provide our comments to the two reviewers. One reviewer has proposed a simplification of tables 3-7. We will let a decision on that along with that of a further statistical review be up to the editor. The other reviewer suggests the preparation of a table displaying univariate statistics of the GP clinic participation rate in the ten counties, patient survey completion rate and county-wise percent not used in analysis due to missing data. We let the editor decide whether or not such a table should be prepared.

We made the following format changes: we added a title page and abstract, a conclusions paragraph, an authors' contribution-paragraph and a competing interests-paragraph.

I hope these changes along with the revision of the manuscript will be satisfactory enough to consider the paper for publication.

Yours sincerely
on behalf of the authors

Dr. Hanne Heje

Replies to the comments of referee 1:

(Numbers refer to the sequence of comments)

Major revisions:

1. A brief description of the development and validity of the EUROPEP instrument has been added to the material and methods section.

2. A text box displaying the 23 items of the EUROPEP instrument has been added.

3. A table displaying the GP participation rate, patient survey completion rate and "not used in analysis" rate will be worked out if the editor finds it to be an advantage to the interpretability of the paper.

4. a. We agree with the referee in that the dichotomization that we conducted as a part of our analyses may have resulted in loss of information compared to the use of the assessment as a continuous variable. We still think that there may be some controversy about whether to handle the Likert scale as a continuous
scale. Because of their immediate readability we chose to present prevalence ratios as our outcome measure. Hence the need for a dichotomization of the assessments into positive or not positive.

b. We agree with the referee that associations not adjusted for the confounding effect of various GP characteristics may not be meaningful for policy and health planning purposes. That was the reason for our choosing to do so. The tables (as they were submitted) present both the unadjusted prevalence ratios and those adjusted for only patient confounding patient characteristics and those adjusted for confounding GP characteristics as well.

5. We have tried to tighten up the introduction and have hopefully succeeded.

Minor revisions:

1. A textbox has been added with a short description of the Danish primary care system.

2. See above.

3. The funding of the DanPEP project is outlined in the acknowledgements section. A very brief description of the project has been added to this section.

Replies to the comments of referee 2:

We appreciate the efforts by the referee to improve the manuscript, but we are also embarrassed that - despite competent external proofreading - this was necessary.

(Numbers refer to the sequence of comments)

1. Sentence reworded

2. "Duration of listing" has been reworded.

3. ...patients’ evaluation of general practice care...

4. ... that training practices obtained less favourable assessments than non-training practices.

5. We are not able to add references to this sentence, but as we use the word "may" we do not claim, but merely suggest, that patients' evaluation of care differ with different contexts.

6. A textbox has been added with a short description of the Danish primary care system.

7. Changed to 16%-34%

8. "Signed in" has been changed to "entered".

9. We did not ask the GPs to record if a questionnaire was handed to a patient visited at home. Visiting a
patient at home changes the setting of the encounter in some aspects, and an assessment by a patient most often visited at home may be different. Unfortunately, we did not have the opportunity to carry out such analyses.

10. Good point! We reworded the phrase.

11. This phrase has also been reworded.

12. A clarifying phrase "Practice information from GPs working in the same practice was crosschecked" has been added.

13. Patients are listed with a specific practice, but can attend another GP during the regular GP's vacation or if the patient needs medical assistance while visiting another part of the country. We intended to gain information about the extent of patients' use of general practice and therefore deliberately chose to ask for frequency of attendance at a GP.

14. The patients were asked to assess the practice regarding items concerning accessibility. This has been added.

15. The reminders were sent out by the research office, which has now been added.

16. "Registered" has been changed to "recorded".

17. The sequence of the tables has now been corrected.

18. See reply to comment number 6.

19. The ICCs have been added.

20. It must be up to the editor to decide whether or not to conduct a statistical review.

21. None. It has been moved.

22. The paragraph has been reworded as an attempt to emphasize the methodology aspects of bringing up results at this point.

23. The sequence of the tables has now been corrected.

24. The sentence has been rephrased.

25. Changed into "We saw practically no association with practice urbanisation."

26. The reviewer is quite right! "...only influenced..." has been changed to "...was only associated with...".

27. The manuscript will undergo careful, external proofreading before resubmission.
28. The manuscript will undergo careful, external proofreading before resubmission.

29. The GPs in study may not be representative for the entire Danish GP population. They entered the study voluntarily – many of them at a time when patient evaluations and feedback of results was a quite controversial matter in Danish general practice. We do have access to information about the GPs’ gender, age, seniority, practice type and localisation of their practice and are hence able to analyse the representativity of the GP sample regarding these characteristics. Still, the sample may not be representative regarding attitudes and other matters, which may be associated with GPs’ propensity to enter a patient evaluation study and about which we have no information.

Our GP sample contains GPs from all over the country and from both urban and rural areas, and the GPs are well distributed between the different stratas (Table 1 (former Table 2)). As we studied associations between GP characteristics and patient evaluations, not absolute levels of satisfaction, we have no reason to doubt that the found associations will also be valid for those GPs who did not enter this study.

30. "categorised in order to be able to have to categories" has been changed to "categorised into two categories".

31. Agree.

32. "substituting GPs" has been changed to "locums".

33. We are aware of several interesting and relevant UK papers, some of which are included in the list of references.

34. Of course! "size of the staff" has been changed to "number of staff".

35. "attend" has been changed to "conduct".

36. Agree.

37. The last sentence has been reworded.

38. A concluding paragraph has been added.

39. In order to present as complete data as possible and in order to demonstrate the significance of the stepwise adjustment for patient and practice characteristics we choose to present the tables 3-7 as those submitted. On the other hand, we also agree with the referee in that this results in very large tables. We will let it be up to the editor to decide the lay out and extent of the tables.

40. See above.

41. The headings of tables 3-7 have been changed to "Most positive assessments" and "Poor assessments" which we find to agree the most with the way we processed the data.