Author's response to reviews

Title: Estimated time spent on preventive services by primary care physicians

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Author's response to reviews: see over
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To the Editor:

Thank you for your positive response to our submitted manuscript: “Estimated Time Spent on Preventive Services by Primary Care Physicians”.

We found the reviewers’ comments helpful and constructive, and, in the following, we respond to the comments sequentially. Additions to the text are underlined for ease of reference.

Reviewer #1.

1) Use of demographic covariates.

In our multivariate model, we did in fact control for the effects of demographic variables such as those described by the reviewer (including age, sex, race, insurance type, and patient type [new vs. established]). However, we had only advised the reader of this in a brief footnote to Table 2. We have changed Table 2 to add rows for these variables (showing the effect of these variables on visit length) and have also added to the Methods section to better explain the analytical approach (p.7).

2) The authors suggest reasons for deficiencies in preventive care…but do not shed any light on these reasons… The authors would be well served by focusing their preliminary discussion on issues that they plan to address in the research. Then … be very clear about how their research informs these specific issues.

We agree that we are not attempting to address multiple reasons for physician behavior but are focusing on one specific element, the system-level variable of available time in patient care. Our objective, supporting background, and conclusions have been clarified on pp. 4 and 12.

3) The conclusions should show what new insights this study provides.

See above (point #2) – the conclusion is now made more clearly on page 12.

Reviewer #2.

4) The authors should present their conceptual model for “tradeoffs” in the clinical encounter under time constraints.

Models that explain physician behavior do exist, especially Cabana (1999) and Walsh/McPhee (1992); however, these models incorporate a number of potential factors (e.g., physician factors, patient factors, and systems factors) affecting access to and quantity and quality of care, while our study focuses specifically on the system issue of time. We attempt to strike a balance between placing our paper in a context and not overreaching what can be explained by the available data (as Reviewer #1, in point #2, asks us to avoid). We have added statements addressing the fact that this paper is limited to investigation of a single, system-based limiting
factor on the provision of preventive services on pp. 4 and 12. In terms of a more complex conceptual model, this paper’s focus is rather simple: how do physicians spend time on preventive services. Introducing a complex model of tradeoffs as the reviewer suggested seems to go beyond the scope and data for this paper and contradicts somewhat the request of Reviewer 1. We are encouraged by the reviewers’ comments to investigate further broader determinants of time use using other data sources.

5) Many PCPs are supported by advanced practice clinicians (nurse practitioners and physician’s assistants) who are often responsible for delivering preventive services to the PCP’s panel…The service might be provided by health educators or other clinicians not represented in the data.

For each visit in the dataset, a multiple-response option question asks what providers were seen at the visit. For the paper as first submitted, we used this variable to select only those visits in which a physician was seen (as described on p.5). Further analysis shows that only 1.4% of those visits included a physician’s assistant (PA) and .77% included a nurse practitioner (NP) for the visit in question. In the revised version, we have dropped these visits from the analysis (p.5).

The limits of the NAMCS prevent us from knowing whether other supplemental care providers (e.g., PA, NP, nutritionist etc.) are seen in separate, undocumented visits, although if they were, the physician would not likely address the service at all, rather than spending less time on it. As such, the mean time spent would not be affected. Regardless, we now address this point in the Limitations section (p.12).

6) The authors should present a conceptual model to support their hypothesis about what types of care are “traded off” under time constraints.

See point #4, above.

7) May be differences in the nature/level of services provided (provided vs. discussed) in chronic care visits compared to preventive care visits.

We have added detail with regard to Pap smears and smoking cessation on p.9.

8) Do a subset of patients have lots of time spent on specific preventive services that drive the results?

We are not sure we fully understand this comment. As mentioned in point #1, we have controlled for demographic characteristics in our multivariable model (this may not have been clear in our previous submission), so the effect of the major demographic “subsets” (e.g., male vs. female, older vs. younger, etc.) should be accounted for.

9) Some discussion of the face validity of results is important. For example, does it make sense that chronic care visits took longer?
Given that a large proportion of especially elderly Americans have multiple chronic diseases and that more than one disease problem is usually covered in a typical chronic care visit\textsuperscript{1,2} it seems likely that the chronic disease visit would be the longest type of those available.


10) Please discuss whether or not the Pap smear has implications for reducing ethnic and racial disparities in cervical cancer screening. For example, does this suggest that, under time constraints, primary care physicians might skimp on Pap smear guidance/provision.

It certainly is possible that if physicians spend less time on Pap smears, it could negatively affect preventive service delivery to patients from race and ethnic minorities. At least one study has shown that visits with ethnic minorities tend to be shorter than Whites.\textsuperscript{1} Thus, with shorter visits, physicians may forgo discussing or actually doing Pap smears. However, these analyses, and many others have not found a race difference in visit length.\textsuperscript{2-4} Thus, it may not be likely that less time spent on Pap smears would indicate any different care for patients from ethnic minorities.

2) Hu P and Reuben DB. Effects of Managed Care on the Length of Time That Elderly Patients Spend with Physicians during Ambulatory Visits: National Ambulatory Medical Care Survey. Medical Care. 2002; 40:606-613

11) Please elaborate how various guidelines for prostate cancer screening are conflicting and provide citations.

This has been added – p.10.

12) Reference the defensive medicine literature if this supports the PSA “extra time” hypothesis.

Excellent suggestion – this has been added (p.10).

13) The conclusion that “preventive service delivery would be improved if developers of guidelines worked together… based on risk factors and patient desires” seems unjustified.

The reviewer is correct that the sentence oversimplifies a complex issue – we have removed this comment.
14) Discuss how the tradeoffs associated with using multidisciplinary primary care team approaches.

This has been added – p.11.

15) The term “unclear” or “conflicting” may work better than “too much” [guidance].

Agreed – change made, p.3.

16) Please indicate the number of visits in each category.

Agreed, a number of additions have been made to clarify these points, p.5. Also, the risk of misclassification would be similar to that of any data collected via pen-and-paper survey in that the data can reflect only the judgment of the respondent.

17) Indicate the number of visits that were excluded because no physician was seen.

This has been added – p.5.

18) Please clarify whether the dependent variable (visit length) is self-reported or not.

Clarification that time is self-reported has been added – p.5. Because these data are not connected in any way with reimbursement reports, over- or underestimation due to reimbursement incentives is not likely.

19) Please break out results into subsections so that they are easier to follow.

The results section is divided into two relatively brief sections with separate subheaders.

20) Please provide a citation and data for the national smoking rate.

This has been added, p.9.

21) Page 8, paragraph 2. Please cite “other work that shows that physicians do not address tobacco cessation consistently or adequately”

References have been added, p.9.

22) Provide a citation for the primary care physician shortage.

This is a helpful suggestion – our understanding of the primary care physician shortage is informed by AAFP and ACP data such as that used in Bodenheimer (2006) and we have added this reference, p.12.

Again, we thank the reviewers for their helpful and constructive comments. Please do not hesitate to contact us again for further suggestions or clarifications.
Sincerely,

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