Reviewer’s report

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

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Reviewer: Hector Rodriguez

Reviewer’s report:

The authors conducted a very solid study evaluating the amount of time primary care physicians spend on important preventive services. The analysis is straightforward and easy to follow. There are many implications for the efficient delivery of evidence-based preventive services. For example, interventions might be designed to optimize the provision of preventive services with strong evidence of effectiveness, while minimizing the amount of time spent on services with weak evidence. The authors, however, need to address important issues related to their conceptual model and methods. In particular, the authors should present their conceptual model for “tradeoffs” in the clinical encounter under time constraints. This might help their discussion. In addition, a conceptual model informed by the previous literature will be helpful when the authors discuss the consistencies and divergences from other studies.

Major Compulsory Revisions

My biggest issue with the paper is the assumption that the provision of preventive services by individual primary care physicians should be the universal standard. 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. These clinicians account for an increasing proportion of ambulatory care visits, particularly preventive visits (1). If care is organized such that advanced practice clinicians provide these services, it may make perfect sense that physicians spend little or no time on these services. If practice composition information is available for physicians, it would be important to assess the influence of primary care teams on the content of visits to PCPs. If this information is not available, then the authors should address potential confounding in the limitations section. This is especially important when the authors assert on Page 8, paragraph 1 that “the potential lack of attention” to smoking cessation is concerning. The service might be provided by health educators or other clinicians not represented in the data.

The authors should present a conceptual model to support their hypothesis about what types of care are “traded off” under time constraints, i.e., care that requires the most patient follow-up and adherence because these are not within the direct control of individual physicians. Recent literature evidence (2-4) supports that the provision of specific types of guidance are particularly sensitive to time constraints.
Results. Page 7, top paragraph. The fact that pap smears and tobacco cessation counseling took longer during chronic care visits compared to preventive care visits suggests that there may be differences in the nature/level of services provided (provided vs. discussed). Please discuss in more detail.

It is unclear how the time spent on specific services is clustered within patients. For example, do a subset of patients have lots of time spent on specific preventive services that drive the results? Can multilevel models (accounting for the clustering of topics/issues within patients) help inform this?

Some discussion of the face validity of results is important. For example, does it make sense that chronic care visits took longer?

Please discuss whether or not the pap smear has implications for reducing ethnic and racial disparities in cervical cancer screening (5). For example, does this suggest that, under time constraints, primary care physicians might skimp on pap smear guidance/provision.

Page 9, paragraph 1. Please elaborate how various guidelines for prostate cancer screening are conflicting and provide citations. This will help the argument.

Page 9, paragraph 1. Should reference the defensive medicine literature (6) if this supports the PSA “extra time” hypothesis.

Page 9, paragraph 2. The conclusion that “preventive service delivery would be improved if developers of guidelines worked together to develop and disseminate a single message to help physicians know how best to use their time with a patient based on risk factors and patient desires” seems unjustified. Couldn’t patient preferences and needs be very different? The authors might elaborate how single guidelines might be developed and be responsive to diverse patient needs? Why wouldn’t patient-centered communication approaches, like agenda-setting (7) help? What does the AHRQ tool use as inputs for decision-making?

Page 10, paragraph 1. Discuss how the tradeoffs associated with using multidisciplinary primary care team approaches. For example, patients might experience care provided by multiple clinicians as fragmented and poorly coordinated (8, 9).

Minor Essential Revisions

Page 3, paragraph 2. When the authors assert that physicians may have “too much guidance”, it is unclear what multiple guidelines are being referenced. The term “unclear” or “conflicting” may work better than “too much”.

Page 4, last paragraph. Please indicate the number of visits in each category, e.g., preventive (n=x), chronic care visits (n=x), or acute care (n=x). Also, please indicate how the visit categories are determined (by physician judgment?) and how reliable the categorization scheme is, e.g., misclassification risk.
Page 5, top paragraph. Indicate the number of visits that were excluded because no physician was seen.

Page 6, paragraph 1. Please clarify whether the dependent variable (visit length) is self-reported or not. Also, it may help the reader understand whether physicians would have any reason to overestimate or underestimate time spent because of reimbursement influences.

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

Page 8, paragraph 1. Please provide a citation and data for the national smoking rate.

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

Page 11, paragraph 1. Provide a citation for the primary care physician shortage (10, 11)

Discretionary Revisions
None.

References


**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.

**Declaration of competing interests:**

I declare that I have no competing interests