Author’s response to reviews

Title: To what degree do patients actively choose their healthcare provider at the point of referral by their GP? A video observation study.

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Author’s response to reviews:

To the Associate Editor of BMC Family Practice
Christopher Barton, PhD

October 7, 2019

Dear Editor, dear dr. Christopher Barton

Thank you very much for reviewing our manuscript. We also greatly appreciate the reviewers for their complimentary comments and suggestions. Below, we provide a point-by-point response to the reviewers’ concerns. We hope that you find our responses satisfactory and that the manuscript is now acceptable for publication in BMC Family Practice. We look forward to your response.

On behalf of all authors,

Yours sincerely,
Aafke Victoor, PhD

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Points received on October 3

1. Please rename Introduction to Background.

Introduction is now renamed to Background.

2. Please include list of abbreviations.

A list of abbreviations is now included.

3. Please include consent for publication.

We completed the Declarations section and included Consent to publish.

4. Please include figure legend headings.

The figure heading is included in the manuscript on page 5. We do not have a figure legend.

5. We note that the Declarations section in your manuscript has not been completed and may be missing information. Please read the following information and edit your manuscript accordingly.

We completed the Declarations section.

Points received on September 9

Reviewer 1:
This study is a secondary analysis of data obtained from a study that looked at aspects of the doctor-patient relationship through video-tape review. It aimed to explore the degree to which patients participate in decision making about who and where to be referred to for specialist consultation and investigative services --- within the context of care covered by insurance policies. This should be of interest to those working within such systems, especially to family doctors who are concerned as to whether they are patient-centred, or not. It should also be of interest to those not working under such conditions, but who wonder if adds or reduces constraints to practice. There are a number of easily remediable edits suggested to help make this a more readable paper.

1. Page 1, Title: " do patients themselves choose....." This is not a truly accurate description of what this study is looking it. Perhaps more accurate would be to say: "To what degree do patients choose....."

We followed your advice.

2. Page 1,Title: ".....choose their health care provider". This is ambiguous since they already have a health care provider, i.e. their GP. And in this study there is also reporting on being referred for a test or an Xray. So, it seems more accurate to say " choose the consultant or test site for additional care..."

Indeed, it should be clear that the paper is about referrals by GPs. However, patients are referred to a healthcare provider for different reasons, e.g. treatment, diagnostics. The title is now: To what degree do patients actively choose their healthcare provider at the point of referral by their GP? A video observation study."

3. P2, background: early in the Introduction of the paper there should be a definition of "managed competition" since this has varied meanings in different locales.

Very early in the paper, on page 4 and 5, managed competition is extensively explained.

4. P2, L20, 22: "more than half" may suggest more than it is; more accurate to say " just over half". Then to say almost half 2 lines later, is redundant. Perhaps say : "the remainder.." This re-wording would also apply to lines 27-29.

We followed your advice.

5. P2L19: "....divided into 3 groups..." Then we learn that some and a lot are combined into one grouping. I do not recall any rationale in the body of the paper for this combination, and think such a justification is needed. Since question 4 of your protocol is very clear there were 3 categories, I think results need to be reported using the 3 categories since they reflect 3 distinct processes of care.

We do not mean to combine groups, but only say that just over half of the patients had at least some input, thus more or less choose in the way policy makers assumed they would. In the rest of the paper, results are displayed separately for the three groups.
6. P3L33: The word "referral" is predominantly used in the paper. But the term "consultation" also appears, and at times seems to used interchangeably. I think early in the Intro the authors should define their terms. For example, in my community, consultation means sending a patient for an opinion and referral means transfer for further care. What is the intent of the authors in this paper?

“With ‘consultation’ we mean the process of getting advice from a GP and we define ‘referral’ as the transfer of care for a patient from the GP to another doctor or clinic for further diagnosis and/or treatment.” is added to the research aim.

7. P4L36: "what is the definition of "demand-oriented" care? This may not be a term known to international readership.

We added a definition early in the Introduction: “Central regulation of the provision of health care is replaced by a system based on flexible markets in which consumers can express their demands and in which the providers can meet these demands”.

8. P4L38: "these reforms": I am not sure what "these" modifies. Is demand-oriented care. If the latter, how is that a reform?

We rephrased the first sentence into: During the last decade, in many European countries healthcare systems are reformed towards a demand-oriented care system in order to improve the quality of care and to contain costs.


We added “of healthcare provider and insurance policy”.

10. P4L40: "insurers got…” The word "got' is likely slang and could be replaced with "were given".

We followed your advice.

11. P4L41-45: These 5 lines overlap in content, and would be better if they were combined, for greater clarity.

We followed your advice and now say: “The intention was to create a competitive healthcare market system in which three players interact on three healthcare markets: health insurers compete for enrollees/patients on the health insurance market and healthcare providers compete for patients/enrollees on the healthcare provision market. On the healthcare purchasing market, health insurers negotiate with care providers”.

12. L45L48-49: this seems like an incomplete sentence or something that should attach to the previous sentence.
We adjusted the sentence: “Only when they have the right information and can compare policies, they will keep health insurers sharp on the price and quality of the policies they offer”.

13. Throughout the Intro the tenses of sentences varies and may be confusing. It seems to arise from different uses of the words "would, could, should". These are nuanced words in English that often present difficulty.

We all reread the introduction and now use the words "would, could, should" more consistently (checked by an English native speaker).

14. P5L70: replace "which" with :who".

We followed your advice.

15. P5L70: the sentence that is supported by references 12-15……If this research exists, why is the current research necessary? A partial explanation appears later in the Research Aims on page 6, L107-108, that this current research is meant as an update, but if so, something needs to be done with L70.

We rephrased, replaced and adjusted parts of the introduction. For instance, we replaced part of the research aim to the Background section.

16. P6, L87: alternative appears twice,

We replaced the second ‘alternative’ by ‘other’.

17. P6, L92: a reference is needed after the word "department".

A reference was added.

18. P6L94: a reference is needed after the word "providers".

A reference was added.

19. P6L94: the last phrase seems out of context, or words may be missing.

We added some words to the last phrase to clarify it (“… and the length of a consultation may be too limited to be able to look up and discuss choice information [25]”).

20. P6L100-110: Much of this is not Research Aim, but better in background or intro section.

We replaced the text that you refer to to the Background section.

21. P7L116-129: This recruitment section is confusing in that we are told about outcome of the recruitment, before the recruitment process is actually described. These outcomes also are best reported in results section.
We replaced the outcome of the recruitment to the results section.

22. P7L118-121: much of these sentences is redundant, having appeared earlier in paper.

The redundant sentences are removed.

23. P7L117-129: in the recruitment, who approached the doctors for participation? What were they told was the goal of the study they would be in? In 2016, how many were approached to get the 18% participation rate. As well, I think it is more accurate to talk of participation rate in this study, not response rate. (L135).

We explain that the GPs were approached by the researchers. We also explain that patients and GPs were told that the study was about GP-patient communication, but not that their referral decisions were being analysed. We replaced the outcome of the recruitment to the results section (where we talk of participation rate) and describe how many GPs and patients we approached in the Method section.

24. P7L134-135: the number of videos done is more appropriate for results section. As well, why are the "response rates" reported separately for the 2 years? I didn't see anything to suggest the videos from each year were treated differently..

We replaced the total number of videos to the Results section. Response rates were reported separately, because it concerned two different data acquisition periods. In 2015, 36 GPs from the eastern part of the Netherlands were approached. In 2016, a further 44 GPs, located in other parts of the country, were approached. In our opinion, readers could gain a more complete understanding of the participation rate if we describe the participation rate for the two periods separately.

25. P8L138: in the consent process, what were the patients told the study was about?

Patients were told that the study was about GP-patient communication in general. In the article we wrote: “GPs and patients knew were told that the study was about GP-patient communication but were unaware that their referral decisions were being analysed.”

26. P8: The section Analyses, reads more like a Data Collection section. As well, we are referred to Additional file#1: in the 14 item questionnaire, item 4 describes how the involvement of the patients was assessed and assigned to one of the three groups. Since this is the foundation of this study, the criteria from item 4 should appear as a Table in the body of the paper.

We added this item as a Table to the Method section.

27. P9L180: approval by a medical ethics committee was not required----but what about a research ethics committee?

A Medical Ethics Committee concerns research ethics.
28. P10, L189-90: why are mental health care providers treated as a separate group? Are psychiatrists, social workers, etc not specialists. Perhaps earlier in the paper, a definition of specialist might be included. (…..in my jurisdiction of practice, Family Physicians are recognized as specialists).

Mental healthcare providers are not treated as a separate group anymore. Additionally, we rephrased the sentence (“The 117 patients in this study were referred to a variety of healthcare providers, such as mental healthcare providers or other medical specialists such as gynaecologists or dermatologists”).

29. P10L189-195: I am confused by the numbers: of 117 patients, 57 are accounted for as to who they were referred to. What of the remaining 60? They are not all likely to have been referred to 60 other different types of health care providers.

We did not report on all the different types of health care providers patients have been referred to. For some it was only one patient (such as haptonomy) for others there could be more patients.

30. P10L195: what is haptonomy?

Haptonomy is a treatment in which touch between the therapist and the patient can contact with the feelings that are stored in the body. We added this definition to the paper.

31. P10L199: "most patients had low educational level"….The categories are a bit confusing, with low education = primary or vocational; medium education=secondary school or intermediate vocation; high education =tertiary education. So, the word "low" is being used in 2 different contexts. Can these be differentiated—otherwise it is hard to interpret who is really low education and that is important in understanding what roles patients may actively take in their care.

We clarified the categories and meanwhile found a mistake. The mistake had been made when adding the background characteristics of the patients to the data set. We solved the problem and analysed the background characteristics again. Therefore, changes were made to Tabel 2. In order to be sure that no other mistakes took place another researcher checked the process again.

32. P11 Table: under Gender, replace "man" with male, and consider adding the stats for females. Since men and women generally have different involvement in their health care, the differential stats for gender would be valuable to look at.

We followed your advice.

33. P13L212:….."It is obvious that…." How was it obvious?

For example, the GP would say: “You have a referral letter and you have to call this number to make an appointment”. The GP nor the patient had mentioned the provider the patient was being referred to.
34. P13L207-231: This section could be simplified and retained better if in tabular form.

We added a table (Table 3) with results from this section.

35. P14L268-286: most of this can be simplified or removed because it repeats what has already been reported in results.

The text you refer to has been simplified and condensed.

36. P18L359-60: why is the east Netherlands sample a limitation? Is there an issue of generalization? If so, what is hypothesized?

We added the bolded text: “Another limitation is that 20 of the 28 GPs were from the east of the Netherlands, because of which our results might not be generalizable to an entire population. Nevertheless, our sample matches the population of Dutch GPs with regard to age and gender.”

37. P18L376L: the conclusion needs to be concise and at the moment it can be reduced by removing what already appears in the Discussion.

The conclusion has been simplified and condensed by removing what already appears in the Discussion.

Reviewer 2:

1. Please check all formatting correct, font sizes are different in some paragraphs (ethical considerations at 180)

All formatting was checked and adjusted when needed.

2. Please revise comment on kappa score, 0.64 and a range of 0.45-.092 is not substantially high, indication of why this might be the case as a limitation.

According to Sim & Wright (2005), a Kappa score of 0.64 indicates substantial reliability. We added an extra limitation to the Discussion: “Yet another limitation is that the lowest Kappa score that we had (0.45), was moderate [27]. However, the agreement score for this item was better (mean 64.9%). Nevertheless, our results should be considered with some caution.”

3. Comment on why there was no cross coding between coders

There was cross coding between three observers. First, five consultations were observed by the three observers together to test the observation protocol and to make adjustments. A random ten percent of the consultations were rated by three observers (AP, MM and CK) independently in order to assess interrater reliability.
4. Comment required on reflexivity of coders

Five consultations were observed by the three observers together to test the observation protocol and to make adjustments. We added to the Method section that: “Additionally, each time, after about twenty-five recordings, the observers discussed the observation protocol to discuss difficulties they encountered and to reach consensus about how to fill out the protocol.”

5. In limitations, comment required on observation effects of video recordings on behaviour eg possible Hawthorne effect

We added the bolded phrase: “Therefore, the Hawthorne effect, a possible limitation of observational research, is minimal and our results mirror the actual daily situation in general practice.”