Reviewer’s report

Title: General practitioners' views and preferences about quality improvement feedback in preventive care: a cross-sectional study in Switzerland and France

Version: 0 Date: 07 Apr 2017

Reviewer: Wouter Gude

Reviewer’s report:

I thank the authors for their manuscript. The paper presents a questionnaire study among Swiss and French GPs exploring their perceived usefulness toward receiving feedback on their preventive care performance, and how this feedback should be provided. The main results are that 44% found feedback useful; younger and those doing reportedly more preventive care were more likely to find feedback useful; its main use would be 'knowing about study results' and 'improving practice'; and the preferred feedback type would be 'a brief report' or 'a report with specific information about best practice', but definitely not 'face-to-face discussion with study investigators'.

The study is interesting because it explores GP preferences for receiving feedback before any feedback intervention is developed; the results may therefore guide future feedback designs and increase feedback acceptance in this setting. The study has a high response rate (47%). However, in my opinion there is a number of concerns that need to be addressed before publication.

1. The introduction of the study is lacking some clinical background regarding prevention in primary care e.g. why prevention is important or complex, why there may currently be suboptimal performance (and perhaps report some prevention guideline adherence rates in other settings), and why feedback could be effective to improve this. Now, it is not completely clear to the reader what certain preventive measures e.g. "blood pressure, weight and height measurement" may exactly prevent and how they may be beneficial for the patient. The study also lacks information about key differences between France and Switzerland regarding preventive care and current state of guideline adherence/implementation. This information may be essential to understand potential differences in outcome measures between the countries.

2. In the methods section there are many things unclear about the questions in the questionnaire. I do not understand the use of feedback "to know study results" and "to follow-up what is done in their practice", nor what the various types of feedback would entail exactly, such as "brief report and individual results". The authors need to clarify what is meant and state how these questions were literally (translated) formulated. The approach that the reasons for and type of feedback were multiple choice questions and that multiple answers were possible is a surprising. This would invite people to either say 'yes' to all, or select only some reasons/types even though the other reasons/types may just have been slightly less preferred. Lugtenberg et al (reference 16 in the paper) used a Likert scale which seems a more logical approach. The authors state that the selection of the feedback interventions was consensus-based following literature review, but there were still many options missing and there was no "other" option to get new ideas from the
respondents. For example, the 2012 Cochrane review of feedback interventions (reference 15 in the paper) reports many types of feedback delivery including the format (verbal/written/electronic) and source (supervisor/colleague/investigator), and many co-interventions that can be used with it.

3. The way the variables are handled in the statistical analysis seems arbitrary. There are many continuous variables that are categorized, and it is unclear why. For example, in Table 4 the variable 'number of prevention measures carried out' was dichotomized into less than 10 versus equal to or greater than 10. Age categories were chosen 0-35, 35-44, 45-54, 55-64 and 65+; it seems unclear why these categories have been chosen and not handled as continuous variable. Not handling e.g. age as continuous variable is throwing away potentially important information; therefore the authors should reconsider how they handle variables or clearly state their reasons for not doing so in the paper. Furthermore the abstract states nothing about any statistical analysis.

4. It is misleading that the results section and abstract state that the study was conducted among 1100 GPs, whereas it was actually conducted among 518 GPs (response rate 47%). Next, if 1100 GPs were invited and 47% responded, it may be interesting to see what are the differences between responders and non-responders. Given that the GPs were invited by post, the authors may have some information besides the address (e.g. gender and age) of the non-responders.

5. The numbers in the results table do not seem to add up. For example, Table 1 says that there were 160 respondents from France and 350 from Switzerland (adding up to 510) whereas the paper states that there were 518 respondents. Table 3 states that there were 163 French and 355 Swiss respondents (=518), Table 2 states 250 were under 55 years and 266 55+ (=516), 318 males and 191 females (=509), and Table 2 also reports a total being 718. Furthermore, nothing is stated about the number of missing values and how this may have introduced bias into the study results.

6. Half of Table 1's contents is unnecessary: the perceived usefulness is dichotomized so if we know 41.4% of men found feedback useful, we already know that 58.6% found it not useful. The 58.6% need not be reported. Furthermore Table 1 and 4 overlap in the message they are trying to send, namely what are the determinants for finding feedback useful or not. Table 1 may be clearer if it just reports baseline characteristics of the respondents without stating whether or not they perceive feedback as being useful, i.e. % males, mean age, % from France, mean working days per week, etc. The percentages of respondents finding feedback useful can easily be merged into Table 4 into a new column.

7. The discussion lacks a clear structure. I suggest using headings in accordance with the widely accepted structure described here: http://www.bmj.com/content/318/7193/1224. Next, the authors state (p13 lines 159-163) that feedback is more likely accepted if feedback is provided written and not face-to-face with clinicians. It would be useful if this statement is assessed in the light of Ivers' Cochrane review (reference 15 in the paper) which also shows that feedback + outreach visits (= face to face by investigators) are more effective than only feedback. Further, the limitations lack a critical appraisal of selection/response bias and the potential bias induced by the limited number of answer categories in the questionnaire (see comment 2). Due to these
biases the results may have been overinterpreted. Finally, the authors state in the discussion (p14 line 173-177) that quality circles should be implemented whereas this clashes with their results that "face-to-face discussion with study investigators" is highly not preferred. I do agree with the authors that PDCA cycles are beneficial, but the authors seem to suggest these can only conducted with investigators in a quality circle whereas they can also be conducted by GPs themselves (potentially supported by a feedback system e.g. a quality dashboard) without investigator involvement.

8. The paper may improve after being checked by a native English speaker/writer and carefully checked on spelling. For example, in Table 2 and 3 there is a missing "t" in "Contact with the study investigators". Also, "those considering a feedback" (p8 line 103) should be "those considering feedback". There is a big difference between 'useless' and 'not useful'. The tables name 'useless' whereas the main text speaks of 'not useful'.

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