Author’s response to reviews

Title: Clinical performance comparators in audit and feedback: a review of theory and evidence

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Author’s response to reviews:

Dear editor,

Thank you very much for considering our manuscript entitled ‘Clinical performance comparators in audit and feedback: a review of theory and evidence’. We would like to thank the four reviewers for their time and efforts to read our manuscript very well and their valuable comments. You requested us to attend to the comments and suggestions the reviewers made. We did so with pleasure. Please find below our point-by-point response.

Yours sincerely,

Wouter T. Gude, MSc
Reviewer #1: Dear Wouter T. Gude and colleagues,

Congratulations on your work! I have read your manuscript with great interest and provide some suggestions below that I am hoping will be helpful in your revision of the manuscript.

INTRODUCTION:

- Your definition of what audit and feedback is (‘a summary of clinical performance over a specified period of time’) appears too brief for me here - and I could not find further explanations that can give me a clear understanding of how audit and feedback normally is implemented. I think it is worth describing the range of interventions that may be categorized under the A&F label - e.g. written A&F, online A&F, A&F with feedback provided by expert / supervisor …. etc. I am assuming that these are the types of A&F that have been included in your work - but correct this, if I am wrong.

RESPONSE 1.1: Yes, there are many ways to implement A&F and these are all included in the review. To provide a clearer picture of what A&F is and can look like, we added the following sentence to the Introduction: A&F appears to be most successful if provided if provided by a supervisor or colleague, more than once, both verbally and written, if baseline performance is low, and if it includes explicit targets and an action plan.

Methods:

- I find it difficult to fully follow the methods section, and I think it needs to be further developed before it can be considered a fully detailed methodology. The following are a couple of thoughts on how to do that - they are not capturing everything and should be viewed as an illustration of what I would be interested in understanding better.

• Basically, you are describing to have used the following streams of literature:

  o 2 systematic reviews focused on A&F studies. Why are these the best "go-to-places" for realizing your project, why not conduct your own SR?

RESPONSE 1.2a: We conducted a secondary review because these reviews have already identified existing A&F interventions in the literature. Because the Cochrane review originates from 2012, we also included the more recent systematic review of electronic A&F, which dates from 2017 (published in Implementation Science). While this approach would not be acceptable for a meta-analysis, we felt that it was sufficiently thorough for the purposes of our review. It is very unlikely that a new SR would have found additional types of performance comparators.
A separate SR focused on theories used in A&F - combined with expert outreach and a "supplemental" theory-focused lit search based on a separate method. Why (a)? And if (a), then why (b) and (c) - and why the particular method for (c)?

RESPONSE 1.2b: A number of theories have already been explicitly used in published A&F trials; these are included in the SR by Colquhoun et al (ref 17). However, we could not exclude that other theories exist that have not been used (explicitly); therefore only depending on the theories from Colquhoun’s SR would increase bias. For that reason we extended our inclusion of theories through expert outreach and a literature search following a methodology specifically developed for that purpose (ref 18). We feel that this has led to a comprehensive list of candidate theories for this study.

An unspecified evidence synthesis that appears to be in progress that probably focuses on qualitative studies. However, you are not providing a lot information about this evidence synthesis project. Why was this necessary? What was the method used to identify studies - is it a full SR?

RESPONSE 1.2c: The qualitative evidence meta-synthesis is indeed a full SR and has now been provisionally accepted for publication at Implementation Science (ID: IMPS-D-19-00025) and will be fully cited when this study will be published. We added to the Methods: “Empirical studies were the randomised trials included in the two reviews [1,2], and qualitative evaluation studies included in the systematic review and meta-synthesis that was recently undertaken by part of the study team [19].”

It is unclear to the reader how you analyzed your data - no information is provided about this in the methods section, and one can only make assumptions based on the presentation of your results. For example:

- Did you use a particular framework?

- How did you triangulate the different sources of data (RCTs - theories - qualitative findings) and let them 'talk to each other' - in other words: Which source of literature had which function in your analysis?

RESPONSE 1.3: We added to the second paragraph of the Methods: “From the included theories and randomised trials we summarised relevant predictions and evidence. From the qualitative studies we extracted and coded excerpts in batches using Framework Analysis [20] and Realistic Evaluation [21,22] (see details in [19]). We used an iterative process to formulate mechanisms for each comparator, and refine and generalise the across the included theories and empirical studies [23,24].”
RESULTS:

- To begin with, I would expect to see a summary of the key characteristics of the studies that you have included. I am aware that these data are likely provided as part of the original SRs but there is information that is relevant to include here, because it may affect your findings. E.g., are these clinical health studies only? Was the majority of studies conducted in the U.S. or elsewhere? Were low-, middle- and high-income settings included? Which health areas were included? Were there any limitations on language, years etc.?

RESPONSE 1.4: A wide variety of countries, clinical settings, and clinical topics were included in the SRs. We added a new Table 1 in the Results summarising the key characteristics of studies across the three SRs (publication date, risk of bias, continent, setting, clinical feedback topic). We added the following text in the Results: “Table 1 summarises the key characteristics of the included 146 RCTs [1,2] and 65 qualitative evaluation studies [19] of A&F interventions”.

Table 1. Study characteristics.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Randomised controlled trials (n=146); n (%)</th>
<th>Qualitative studies (n=65); n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012-2016</td>
<td>2 (1)</td>
<td>42 (65)</td>
</tr>
<tr>
<td>2006-2011</td>
<td>36 (25)</td>
<td>15 (23)</td>
</tr>
<tr>
<td>1996-2005</td>
<td>76 (52)</td>
<td>8 (12)</td>
</tr>
<tr>
<td>1986-1995</td>
<td>20 (14)</td>
<td>-</td>
</tr>
<tr>
<td>Before 1986</td>
<td>12 (8)</td>
<td>-</td>
</tr>
<tr>
<td>Risk of bias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk</td>
<td>47 (32)</td>
<td>9 (14)</td>
</tr>
<tr>
<td>Moderate/unclear</td>
<td>73 (50)</td>
<td>47 (72)</td>
</tr>
<tr>
<td>High</td>
<td>26 (18)</td>
<td>9 (14)</td>
</tr>
<tr>
<td>Continent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North America</td>
<td>82 (56)</td>
<td>22 (34)</td>
</tr>
<tr>
<td>Europe</td>
<td>46 (32)</td>
<td>37 (57)</td>
</tr>
<tr>
<td>Australia</td>
<td>11 (8)</td>
<td>2 (3)</td>
</tr>
</tbody>
</table>
Africa 2 (1) 2 (3)
Asia 4 (2) 0 (0)
South America 0 (0) 2 (3)

Clinical setting
Outpatient 99 (68) 31 (48)
Inpatient 37 (25) 30 (46)
Other/unclear 10 (7) 4 (7)

Clinical topic
Diabetes/cardiovascular disease management 32 (22) 20 (31)
Laboratory testing/radiology 21 (14) 0 (0)
Prescribing 33 (23) 11 (17)
Other (e.g. preventive care; nursing; surgery) 52 (36) 34 (52)

- By the way, your remark under limitations that you only used trials that tested interventions within research rather than routine settings comes rather late - that would be a piece of information that I would expect in the aforementioned introductory results section

RESPONSE 1.5: An implication of using systematic reviews to identify A&F interventions is that these interventions were tested in research setting. We made this more clear by summarising the study characteristics in beginning of the Results section, and extending the limitations section in the Discussion (see response 1.9).

- I would turn around your approach to tables and include the supplementary table 1 in the text and refine it further - it helps to understand how you used your different streams of literature. It could be improved by disentangling these streams into one column with RCTs derived from the two SRs, one column for theory sources and one column describing mechanisms. The current table 1 might be better for an electronic supplement - but it would also be okay to keep it in the text.

RESPONSE 1.6: We followed the reviewer’s suggestion placed the previous Supplementary Table 1 into the main text as Table 2 (after the Table 1 summarising the study characteristics). To fix the order in which tables are referenced we moved around some sentences in the first Results paragraph.
- I do understand your choice to structure this section by comparator but would have preferred a clearer structure for each of the comparator sections such that I as a reader have a chance to understand:

  • These findings are derived from the 146 RCTs
  
  • This is what the theory literature says about how these comparators might work in practice
  
  • These are the mechanisms that we identified in qualitative studies and few additional RCTs

I am not sure whether this would mean to "over-structure" your paper - and whether greater clarity in the methods section already might address this indirectly such that further subheadings within sections are not necessary. Maybe give this some thought while revising the paper - it is not a 'must edit', rather view it as a 'suggestion'.

RESPONSE 1.7: We appreciate this suggestion from the reviewer. Also in light of the other reviewers’ comments we would prefer to keep the structure of the Results as it was (which corresponds with the reviewer’s three bullet points, but grouped by comparator type [benchmarks, trends, explicit targets]). We hope with the revised Methods section the reader is more prepared for this. To further facilitate this we wrote at the end of the Methods: “In the Results, we presented the descriptions and frequency with which performance comparators have been used in randomised trials of A&F interventions, followed by the comparators’ mechanisms supported by theory and empirical evidence.”

DISCUSSION:

- Some results appear 'undiscussed' here. For example, you highlight the lack of theory use for almost all studies that you examined. I would use the discussion section to reflect on: Why is theory use important? How can it improve the choice of comparators and the use of A&F? etc.

RESPONSE 1.8: Previous A&F interventions have often ‘blindly’ chosen to include ‘mean performance’ benchmarks; often ignoring their consequences to the feedback message and response by its recipients. A substantial opportunity to increase A&F effectiveness is missed when available theory and empirical evidence is not explicitly considered to inform the choice for comparator. This means: making an (theory and evidence) informed choice for the performance comparator could increase the effectiveness of A&F. To clarify this we modified the first part of the implications section in the Discussion to read: “We have identified a wide variety of comparators that may be included in feedback messages, as well as mechanisms and outcomes that potentially occur as a consequence of those comparators in terms of what message the feedback conveys (i.e. whether and how it reflects discrepancies with desirable practice), and how recipients might respond, and ultimately the effectiveness of A&F. Many of the mechanisms we identified originate from behavioural science which offers a great amount of
theoretical and empirical evidence not often taken into account by feedback designers [4,17]” and “A&F designers should explicitly consider these factors and the mechanisms we presented and offer justification for their choice of comparator”.

- I like the rest of the discussion and your choice to focus on implications. However, given that your studies focus on research settings only - any thoughts on how the implications you describe would change if real world setting trials were the focus? And should that lead to you emphasizing that recommendations can only be made for how to improve A&F comparator practice as part of research setting trials? Just a thought.

RESPONSE 1.9: We added a sentence in the limitations: “In particular, because A&F in research settings likely emphasizes performance improvement whilst routine A&F may focus more on performance monitoring; we expect that the comparators and mechanisms we identified are more aimed at activating recipients to improve practice, rather than only supporting recipients to assess their performance”.

LIMITATIONS:

- Depending on the type of studies that you have included (per my first point under 'Results' above), you may need to consider further limitations - e.g. what if the majority of studies comes from the U.S.?

RESPONSE 1.10: Given the wide variety of study settings/types (which we clarified in the Results as per the reviewer’s suggestion; see response 1.4), we do not expect any limitations on this matter.

All the best for progressing this in the coming time!

Kind regards

Bianca Albers

Reviewer #2: Thank you for the opportunity to read this interesting review of current and best practices in the choice of performance comparator in audit and feedback interventions - a pertinent topic given the plethora, and variable effectiveness, of audit and feedback interventions in the implementation science literature. Based on your review of more than 140 trials, 12
behavioural theories, 5 RCTs and 42 qualitative A&F studies, the review summarises different categories of performance comparators, and identifies the mechanism of their potential effectiveness mapped to behavioural theory. You have provided practical advice to improve the design of performance comparators in A&F interventions. Importantly, you conclude that best practice in A&F requires tailoring of comparators to the issue and audience at hand and highlights an ongoing requirement for needs assessment rather than the possibility to prescribe a one size fits all approach to A&F design. You also conclude A&F interventions should limit the amount of comparators being displayed while offering the opportunity to access more detail if required; provide performance trends but not trends alone; and encourage feedback recipients to set personal, explicit targets guided by relevant information. It would be interesting to include examples from the literature of where these principles of good comparator design have been followed and whether these studies effected greater change. You note the need to undertake further head-to-head trials comparing different types of comparators to test their effectiveness and this would be a valuable addition to the literature.

RESPONSE 2.1: Due to the large variety in comparator use across trials, a meta-regression to quantify the effects of each comparators would be underpowered. Although we have made four general suggestions, there remains an important ‘subjective’ aspect to the choice of performance comparator which depends on the clinical setting, topic, and recipient (e.g. suggestion 2: “balance the credibility and actionability of the feedback message”). Hence, we argued that researchers and A&F designers explicitly consider these suggestions, theory, and evidence, and provide their rationale to explain their choice.

This is a clearly written and informative article, however, there are a number of typos throughout that need correction prior to publication.

RESPONSE 2.2: We reread the entire manuscript and removed any typos.

Reviewer #3: Section/topic # Checklist item Reported on page #

TITLE

Title 1 Identify the report as a systematic review, meta-analysis, or both. Pg. 2 "review" & pg. 3 "secondary review"

ABSTRACT

Structured summary 2 Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal

RESPONSE 3.1: We thank the reviewer for this comment, yet a lack of space prohibits us from including the specific mechanisms in the abstract.

INTRODUCTION

Rationale 3 Describe the rationale for the review in the context of what is already known. Pg. 4. Theory informed research on how to best design & deliver A&F interventions.

Objectives 4 Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS). Pg. 4. Describe choices for delivering clinical performance comparators in published A&F interventions. Identify the associated mechanisms from theories and empirical studies that might have implications for effective A&F.

METHODS

Protocol and registration 5 Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number. None.

Eligibility criteria 6 Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale. Presumed to be use of clinical comparator in clinical practice change.


Information sources 7 Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched. Pg. 4. 2012 Cochrane Review; 2017 systematic review 1982-2011; 2006-2016. Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, CINAHL. Contact with experts. Supplemental theory-focused literature search.
Search 8 Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated. Pg. 5. Recommend including supplemental theory-focused literature search as this was 'new' and conducted by the authors.

RESPONSE 3.3: We added the search strategy as a supplemental file. This search strategy is however the same as Brown et al.’s publication with Implementation Science (ID: IMPS-D-19-00025). We will let the editor decide whether to add this as a supplemental file to this paper as well; or that the reference to Brown’s paper will suffice.

Study selection 9 State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis). Pg. 4. No explanation for choice of 2012 Cochrane review inclusion; 2017 systematic review; or supplemental theory-focused literature search. Possibly based on advice from experts mentioned as being authors.

RESPONSE 3.4: The 2012 Cochrane review and 2017 systematic review are the current reviews of A&F; we have conducted a secondary review. We feel like this gave us a comprehensive list of A&F interventions – conducting our own systematic review would unlikely have yielded different results. We added a sentence about this in the limitations (see response 1.2a).

Data collection process 10 Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators. Pg. 5. Developed a data extraction sheet & guide. Guide & sheet piloted by 2 reviewers on 10 studies. Piloted again on 10 studies. Data independently extracted. Disagreements resolved through discussion. No mention of confirming data from investigators. Theories identified from systematic review. Communication with experts. Literature search. Qualitative evaluation studies from a review being currently conducted. Why, how, or when a behaviour occurred. The process, rationale for data sources, and description of the undertaking related to identifying mechanisms is less clear and can be confusing. I would not be able to replicate this part of the review.

RESPONSE 3.5: We clarified in the second paragraph of the Methods that the investigators were involved/confirmed, and how the data sources were combined to formulate/identify mechanisms (see response 1.3).

Data items 11 List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made. Pg. 5. Comparators. Origin. Values delivered. Rationale for use.

Risk of bias in individual studies 12 Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis. Not clear. Did the Cochrane studies include bias assessment? And the authors chose to go with that? Was risk of bias conducted on qualitative evaluation studies? Or is this not relevant to qualitative methods?
RESPONSE 3.6: We added new Table 1 summarising the study characteristics; including their quality appraisal (see response 1.4).

Summary measures 13 State the principal summary measures (e.g., risk ratio, difference in means). Pg. 5. How were the results consolidated?

RESPONSE 3.7: We addressed this point in response 1.3.

Synthesis of results 14 Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I2) for each meta-analysis. Pg. 5. Consolidated results were discussed, refined, and agreed with in an iterative process. Please clarify this process. What does refined mean in this context? i.e. what does 'refined' practically look like?

RESPONSE 3.8: We formulated mechanisms; and if new results from the included studies made it necessary to change the formulation we would refine it with the aim to generalise across studies and theories (also relating to terminology). We added to the Methods: “We used an iterative process to formulate mechanisms for each comparator, and refine and generalise the across the included theories and empirical studies [ref].”.

Risk of bias across studies 15 Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies). Not presented

RESPONSE 3.9: We addressed this in response 1.4 and in the limitations in response 1.2a.

Additional analyses 16 Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.

RESULTS

Study selection 17 Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram. Pg.10. Reviewed 146 randomised trials. And 42 qualitative studies.

Study characteristics 18 For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations. Pg. 6 onwards. Comparators; theories

Risk of bias within studies 19 Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12). Not presented

RESPONSE 3.10: We now added quality appraisal of each included study in Table 1 (see response 1.4).
Results of individual studies 20 For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot. Pg. 6.- 10. Comparators; theories.

Synthesis of results 21 Present results of each meta-analysis done, including confidence intervals and measures of consistency. Descriptions and frequency comparators used from interventions. Comparators mechanisms.

Risk of bias across studies 22 Present results of any assessment of risk of bias across studies (see Item 15). Not provided

Additional analysis 23 Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).

DISCUSSION

Summary of evidence 24 Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers). Suggest authors discuss barriers to using audit and feedback for the purpose of clinical care improvement. Pg. 11. Recommendations when choosing comparators.

RESPONSE 3.11: There exist numerous barriers to using A&F for clinical care improvement, however this outside the scope of this paper.

Limitations 25 Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias). Pg. 13. Limited to research setting only. Quality of reporting. Lack of consistency to terminology. Performance comparators at an aggregated level. Did not explore influence of way comparators displayed or represented in feedback messages. Meta-regression would be under powered.

Conclusions 26 Provide a general interpretation of the results in the context of other evidence, and implications for future research. Pg. 14. Need to deliberately consider mechanisms of comparators and justification for their choice.

FUNDING

Funding 27 Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review. Pg. 14. Under "funding" not applicable has been selected. Under "acknowledgements" funding sources are reported.

RESPONSE 3.12: We moved the Acknowledgements to the Funding section.
Reviewer #4: IMPS-D-19-00007

Clinical performance comparators in audit and feedback: a review of theory and evidence

Thank you for the opportunity to review the above manuscript. The manuscript presents a multi-method study reviewing the often-used audit and feedback process, specifically considering the selection and use of comparators. This manuscript is very well structured, covering key elements and is very well written. There are multiple strengths to the current study, including the multiple methods used: the secondary analysis of available results, extending results by qualitative accounts of A&F and incorporations of theoretically-based explanations. Drawing on behavioural and social sciences to explore and explain A&F practices is a significant contribution to quality improvement approaches. The limitations were well considered and the authors conclude with suggestions when selecting comparators.

I have very few comments for the authors to consider:

- Page 4, line 58 - when describing the 2017 review, reference is made to electronic A&F. While the authors indicate that the results are limited to the time period of the reviews, I wondered what the reference to electronic meant? Some brief explanation (e.g., example, what proportion if known) as this latter review extends the literature sourced a further 5 years than the initial review, to 2016.

RESPONSE 4.1: The 2017 review only focused on electronic A&F only; i.e. not verbal or paper-based feedback. A&F systems nowadays are often electronic, and therefore felt that including only the 2012 Cochrane review might be slightly outdated – despite including over 4 decades of A&F research. To our knowledge these reviews together create the most comprehensive view of A&F studies to date.

- Page 6, line 45 - when considering "... that benchmarking was more effective...", is this perceptions of effectiveness from participants in the qualitative work or were qualitative studies only selected based on actual effectiveness results?

RESPONSE 4.2: Participants in the cited qualitative studies felt that benchmarking against irrelevant or incomparable reference groups was unfair, and consequently rejected the feedback, and took no action to improve practice. We changed the sentence into: “Qualitative studies
reported that recipients were more likely to accept the benchmark when they considered its reference group relevant and comparable [37–39,42,43,56–58]; as also hypothesised by Reference Group Theory [27].”

- Given the paucity of A&F literature drawing on behavioural and/or social science theories, and the clear contributions possible of their inclusion, I wonder if the authors could include some steps for those considering A&F comparators as to how to incorporate a theoretical perspective in their work, in a meaningful way.

RESPONSE 4.3: We appreciate this comment. Our study helps A&F designers to choose comparators by summarising the theory and evidence about comparator mechanisms and providing four practical suggestions. However, “A single type of comparator that works for all recipients and for all care processes or outcomes targeted by the A&F intervention may not exist”; and we cannot prescribe designers which comparators are best, nor which theory should be used for their specific intervention, because there are many factors (e.g. relating to the recipient, setting, topic, and goal of the intervention) that need to be taken into account. However, our study found that previous studies often have not made informed nor explicit decisions about comparators, and have often compared to the group mean. Mean comparisons are unlikely to raise standards comprehensively across healthcare professionals; hence those studies have missed substantial opportunity to reach larger effect sizes through their A&F intervention. Our study lists a wide variety of options and discusses their mechanisms, and pros and cons. In our implications section, we advocate that A&F designers make an informed and explicit choice for comparators, and be transparent in their reporting: “A&F designers should explicitly consider these factors and the mechanisms we presented and offer justification for their choice of comparator”.

Overall, the paper was of great interest, very informative and a pleasure to read.