

The organization of the health care provider's practice influenced patient participation in research: a multilevel analysis

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Abstract

Objective: To analyze the participation of the patients in a survey about prevention, according to their own medical (hypertension and inclusion during house call) and social (occupational class and birthplace) characteristics and characteristics related to the organization of their physicians' practice.

Study Design and Setting: Fifty-nine randomly recruited physicians from the Paris metropolitan area enrolled every consecutive patient seen during a 2-week period. Actual patient participation (responding to the telephonic questionnaire) was analyzed with a logistic mixed model separately for male and female patients.

Results: The participation rate among 4,106 eligible patients was 66.7% and varied among physicians (from 48.7% to 80.8% for the 10th and 90th percentiles of the distribution). Participation was better for higher occupational classes, patients included during office visits, men with hypertension, and women born in France. After controlling for all patient characteristics, participation was best if the physician saw at least some patients by appointment [odds ratio (OR), 2.12; 95% confidence interval (CI): 1.12, 4.01 for men and OR, 3.38; 95% CI: 1.72, 6.63 for women]. This characteristic explained 14% of the variability between physicians for participation by men and 28% of that by women.

Conclusion: Cluster studies should take the characteristics of the health care providers into account in their design, particularly their practice organization. © 2013 Elsevier Inc. All rights reserved.

Keywords: Patient participation; Primary health care; Patient characteristics; Office organization; Physician characteristics; Study design

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1. Introduction

For observational and interventional epidemiologic surveys to collect data directly from the individuals, these subjects must consent to participate. Poor participation always raises the issue of the generalizability of the study's results [1] and even of their internal validity, if they might bias estimates [2–6]. In cluster or multistage sampling [7], individuals are not directly recruited. Instead, the researcher uses these individuals' membership in groups to sample at the group level (and then, for multistage sampling, to sample again within each group). This type of design can be advantageous from a practical perspective when there is no established list of individuals or when they are

What is new?**Key finding**

- Patients of general practitioners (GPs) who see at least some patients by appointment participated at higher rates in the studies of prevention.

What this adds to what was known?

- Patient participation rates varied substantially between health care providers.
- These variations were explained in part by whether the physician sees patients by appointment and not by the social composition of his patients.

What is the implication and what should change now?

- In cluster studies, both the design and analysis of participation should consider the practice organization of the GPs recruiting patients.
- The identification of the GP characteristics associated with greater participation by their patients and the determination of the characteristics that explain the variability in participation rates between doctors must continue.

naturally assembled in groups as they are in primary care, clustered according to their primary care physicians. This sampling method can also be chosen for particular reasons, for example, to analyze the association between a specific health outcome and some characteristics of the health care provider. In this type of study, the participation of the patients is probably associated with the characteristics of both the patient and physician.

Studies of patients' characteristics have shown variable (in both direction and intensity) associations between participation and sex [8–14], social position [13–17], and health status [9,14,17–21]. Some of the discordances in the results from the literature probably correspond to the type of studies examined (interventional or observational) and the recruitment settings (general population, workplace, hospital, or primary care). As observational studies in primary care account for a relatively small portion of the literature, the precise role of patient characteristics in this context remains to be specified.

Studies exploring physician-related barriers to patient participation in research [12,22–26] often highlight the lack of time and the potentially negative effect on the physician–patient relationship. Most of these studies, however, have focused on physicians' opinions or self-reported problems with recruitment or patients' reports of their intentions; few have assessed the association between physician-related determinants and their patients' actual

participation. To the best of our knowledge, no study has yet specifically examined the effect of the type of organization of the health care provider's practice on patient participation. Nonetheless, this organization is an essential component of participation in studies in which the physicians themselves recruit the patients during their visits [19] as in our cluster study, the "Paris Prevention in General Practice" (PPGP) survey. In such a situation, the survey is not suggested by a stranger but is part of a preexisting therapeutic relationship [22]. A study conducted after discharge [12] found that the patients most satisfied with their care and with the availability of their doctor during their hospitalization were more inclined to participate in a study conducted by the hospital. Some patients may consider the study to be a form of reciprocity [27]. Organization with a consultation time sufficient to create the conditions for good interaction between physicians and their patients should promote the latter's participation [28]. Moreover, the ability of the general practitioners (GPs) to persuade patients to agree to participate probably also depends on their ability to find the time during these consultations to define the study's objectives, practical aspects, and value, as well as to answer questions.

The aim of this article was to analyze the participation of the patients in the PPGP survey as a function of both their own medical and social characteristics and characteristics related to the organization of their GPs' practice.

2. Methods

The PPGP survey was an observational cross-sectional survey that took place in the city of Paris and its inner ring of suburbs, that is, its three bordering districts, from December 2004 to October 2006. It was designed to document social inequalities in preventive care (gynecological cancer screening, i.e., mammography and cervical cancer screening [29], tobacco and alcohol consumption, and cardiovascular risk) provided by GPs.

2.1. GP recruitment

We used a listing of GPs in the study area purchased from the French telephone company to contact a random selection of practitioners. To ensure social diversity among patients, the sample was constituted after stratification for the socioeconomic level of the GP's office area (proportion of families earning too little to pay income tax, categorized in tertiles). The eligibility criteria for the physicians were participation in the national health fund insurance system, age younger than 65 years, in practice for more than a year, practice of general medicine at least 2 and a half days a week, and general practice only (or also homeopathy, acupuncture, hypnosis, psychotherapy, etc., if those activities did not exceed 10% of their total volume). The physicians were recruited according to a procedure that combined

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