How generalisable are results of studies conducted in practice-based research networks? A cross-sectional study of general practitioner demographics in two New South Wales networks

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Objective: To compare the demographics of general practitioners in two practice-based research networks (PBRNs) and to explore the generalisability of research findings from these PBRNs.

Design, setting and participants: Cross-sectional questionnaire-based study of two geographically-based PBRNs — Hunter New England Central Coast Network of Research General Practices (NRGP) and Primary Healthcare Research Network-General Practice (PHReNet-GP) — during August–September 2010. All 183 GP members of both PBRNs were invited to participate; of these, 140 (77%) participated.

Main outcome measures: GPs’ demographics, use of languages other than English in consultations, and previous participation in research. Practices’ use of practice nurses. Socioeconomic status and rurality or urbanicity of practice location.

Results: Compared with PHReNet-GP GPs, NRGP GPs were more likely to work in a practice employing a practice nurse (100% v 53.8%; 95% CI for difference, 30.5%–61.8%; P < 0.001), worked in larger practices (2.9 more full-time-equivalent GPs per practice; 95% CI, 2.1–3.6; P < 0.001), and were less likely to work in a major city (33.7% v 89.7%; 95% CI for difference, 42.8%–69.3%; P < 0.001). NRGP GPs also worked in practices with a different spectrum of socioeconomic disadvantage, and were less likely to have been involved in research as a researcher (35.4% v 76.9%; 95% CI for difference, 25.3%–57.8%; P < 0.001). Fewer NRGP GPs consulted in languages other than English (8.9% v 64.1%; 95% CI for difference, 39.1%–71.2%; P < 0.001). There were also differences between these and national general practice statistics.

Conclusions: These results suggest possible lack of generalisability of findings from some types of studies conducted in single PBRNs. In such circumstances, collaboration of PBRNs may produce more generalisable results.
Demographics and characteristics of general practitioners and practices for two practice-based research networks in New South Wales, with formal assessment of group differences

<table>
<thead>
<tr>
<th>NRGP (n = 101)</th>
<th>PHReNet-GP (n = 39)</th>
<th>PHReNet-GP v NRGP difference (95% CI)</th>
<th>P</th>
<th>NRGP and PHReNet-GP (n = 140)</th>
<th>National comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age, years</td>
<td>49.0 (SD, 10.0)</td>
<td>48.1 (SD, 9.7)</td>
<td>−0.8 (−4.5 to 2.9)</td>
<td>0.67</td>
<td>48.7 (SD, 9.9)</td>
</tr>
<tr>
<td>Male sex</td>
<td>58.0%</td>
<td>69.2%</td>
<td>11.2 (−6.2 to 28.7)</td>
<td>0.21</td>
<td>61.2%</td>
</tr>
<tr>
<td>Mean GP experience, years</td>
<td>18.5 (SD, 11.4)</td>
<td>17.9 (SD, 9.2)</td>
<td>−0.7 (−4.8 to 3.5)</td>
<td>0.76</td>
<td>18.3 (SD, 10.9)</td>
</tr>
<tr>
<td>Mean number of sessions per week for individual GPs</td>
<td>6.8 (SD, 2.9)</td>
<td>7.4 (SD, 3.1)</td>
<td>0.7 (−0.5 to 1.8)</td>
<td>0.24</td>
<td>6.9 (SD, 3.0)</td>
</tr>
<tr>
<td>Mean practice size, no. of FTE GPs</td>
<td>6.1 (SD, 1.8)</td>
<td>3.2 (SD, 2.4)</td>
<td>−2.9 (−3.6 to −2.1)</td>
<td>&lt;0.001</td>
<td>5.3 (SD, 2.4)</td>
</tr>
<tr>
<td>Practice nurse employed in practice</td>
<td>100%</td>
<td>53.8%</td>
<td>−46.2 (−61.8 to −30.5)</td>
<td>&lt;0.001</td>
<td>87.1%</td>
</tr>
<tr>
<td>Mean FTE practice nurses per FTE GP</td>
<td>0.47 (SD, 0.2)</td>
<td>0.23 (SD, 0.3)</td>
<td>−0.23 (−0.33 to −0.14)</td>
<td>&lt;0.001</td>
<td>0.4 (SD, 0.3)</td>
</tr>
<tr>
<td>Consult in another language</td>
<td>8.9%</td>
<td>64.1%</td>
<td>55.2 (39.1 to 71.2)</td>
<td>&lt;0.001</td>
<td>24.3%</td>
</tr>
<tr>
<td>Fellowship of RACGP or ACRRM</td>
<td>64.0%</td>
<td>74.4%</td>
<td>10.4 (−6.3 to 27.0)</td>
<td>0.22</td>
<td>66.9%</td>
</tr>
<tr>
<td>Graduated in Australia</td>
<td>70.3%</td>
<td>64.1%</td>
<td>−6.2 (−23.7 to 11.3)</td>
<td>0.49</td>
<td>68.6%</td>
</tr>
<tr>
<td>Involved in research as a researcher</td>
<td>35.4%</td>
<td>76.9%</td>
<td>41.6 (25.3 to 57.8)</td>
<td>&lt;0.001</td>
<td>47.1%</td>
</tr>
<tr>
<td>ASGC-RA classification of practice postcode</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>33.7%</td>
<td>89.7%</td>
<td>56.1 (42.8 to 69.3)</td>
<td>49.3%</td>
<td>77.3%16</td>
</tr>
<tr>
<td>Inner regional</td>
<td>57.4%</td>
<td>7.7%</td>
<td>−49.7 (−62.5 to 37.0)</td>
<td>43.6%</td>
<td>15.1%16</td>
</tr>
<tr>
<td>Outer regional</td>
<td>8.9%</td>
<td>2.6%</td>
<td>−6.4 (−13.8 to 1.1)</td>
<td>7.1%</td>
<td>6.2%16</td>
</tr>
<tr>
<td>Remote or very remote</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.3%16</td>
<td></td>
</tr>
<tr>
<td>SEIFA quintile of practice postcode</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (most disadvantaged)</td>
<td>18.8%</td>
<td>23.1%</td>
<td>4.3 (−11.0 to 19.5)</td>
<td>20.0%</td>
<td>11%20</td>
</tr>
<tr>
<td>2</td>
<td>24.8%</td>
<td>10.3%</td>
<td>−14.5 (−27.2 to −1.8)</td>
<td>20.7%</td>
<td>na</td>
</tr>
<tr>
<td>3</td>
<td>26.7%</td>
<td>10.3%</td>
<td>−16.5 (−29.3 to −3.6)</td>
<td>22.1%</td>
<td>na</td>
</tr>
<tr>
<td>4</td>
<td>22.8%</td>
<td>20.5%</td>
<td>−2.3 (−17.3 to 12.8)</td>
<td>22.1%</td>
<td>na</td>
</tr>
<tr>
<td>5 (least disadvantaged)</td>
<td>6.9%</td>
<td>35.9%</td>
<td>29.0 (13.1 to 44.8)</td>
<td>15.0%</td>
<td>24%20</td>
</tr>
</tbody>
</table>


RESULTS

Of 183 members of the two PBRNs, 140 GPs (77%) returned questionnaires. Of these, 101 were NRGP members (response rate, 76%) and 39 were PHReNet-GP members (response rate, 78%). Comparisons of results for each of the practitioner and practice characteristics for the two networks are presented in the Box. NRGP practices were significantly more likely to employ a practice nurse, were larger, and were more likely to be located outside a major city. NRGP GPs worked in

Elections approval

Our study received ethics approval from the human research ethics committees of the University of Newcastle and University of New South Wales.
practices with a different spectrum of socioeconomic disadvantage, and were significantly less likely to have been involved in research. Furthermore, significantly fewer NRGP GPs consulted in languages other than English.

Combined results of the two PBRNs are presented in the Box, along with national-level figures for comparison, where available. Comparison of individual PBRN and/or combined NRGP-PHReNet demographics with national figures suggests potentially important differences, notably in practice size, consultations in non-English language, employment of practice nurses, and rurality or urbanicity of practice.

**DISCUSSION**

The response rates of the two networks were similar, despite NRGP membership being at the practice level, and PHReNet-GP at the individual clinician level.

Significant differences in practice size, rurality, socioeconomic status, employment of practice nurses and frequency of non-English language consultations raise the question of possible differences on these parameters between PBRN GPs and other Australian GPs. Consideration of national GP characterictic data seems to support this contention. This calls into question the generalisability to the wider Australian general practice environment of results from studies conducted in such networks.

A number of factors, however, mitigate this conclusion.

First, the extent to which these differences compromise the external validity of network studies depends on the research question. In studies in which patients, rather than GPs, are the unit of analysis, selection bias in recruitment itself.24 This raises the possibility of individual networks collaborating with other geographically based networks if there is a fit of a particular project with the combination of networks. The obvious example is where sample size considerations require expansion of the study sample frame.

Another scenario is where a combination of networks will provide a more generalisable sample when representativeness is desirable. As illustrated in the Box, for some parameters, a combination of GPs from the two PBRNs provides a demographic profile that more closely approximates the national profile. There may be an opportunity to “mix and match” potentially collaborating, geographically based PBRNs within Australia in order to find the appropriate settings for particular research projects.

GPs in our PBRNs are much more likely to have been involved in research than GPs in a previous Queensland study (47.1% v 14.4%).25 This greater engagement may well represent effect rather than, or as well as, cause. Rationale for PBRNs includes bottom-up capacity building as well as top-down recruitment functions. In addition to providing a means of recruitment for researchers (top down), PBRNs provide an opportunity for practitioners to become involved in research and acquire research literacy and experience (bottom up).

A further pragmatic consideration is that although PBRN GPs may not be comparable to the national GP population for some important attributes, such as size of practice and ASGC-RA classification, this is also likely to be the case for any sample of randomly recruited GPs. Response rates are often poor in this setting (unlike our response rate of 77%) and the responders may be systematically different from the reference population of GPs in ways that are similar to those of PBRN GPs. A German study found characteristics of network and non-network GPs recruited to a regional study to differ from national reference data, and to differ in similar ways.20 This is in the context of a higher participation rate in the study by network as opposed to non-network GPs (66% v 23%). The interplay of response rate (optimal via PBRN recruitment) and theoretical generalisability (via random probability sampling) may produce similar representativeness of study samples, regardless of which recruitment strategy is pursued. In another Australian study, compared with ours, GPs’ mean age more closely approximated (but sex distribution of GPs less closely approximated) national statistics.27 Furthermore, PBRN-based recruitment is more efficient (recruitment is targeted via a smaller sample frame and efficient intra-PBRN communication). No matter what the recruitment strategy, careful analysis of participants based on publicly available data is therefore crucial for the assessment of generalizability.26

PBRN GPs in our study were 2.7 years older than GPs nationally and more likely to be women (38.8% v 37.2%). A German study found that, compared with national reference data, its participating PBRN GPs were 0.7 years younger and more likely to be men (76.4% v 66.5%).20 A UK study also found PBRN GPs to be younger than national comparisons.20 As in our study, this PBRN contained relatively few small practices. Similarly, another UK study found network practice size to be larger than that of other local practices.

PBRN-member participants in US studies, compared with non-PBRN participants, were older and, unlike our study’s NRGP-members, more likely to be in urban practice.30 Thus, despite differences in PBRN member and non-member demographics in several countries, there is no consistent pattern in these differences.

National-level coordination of PBRNs will facilitate collaboration of regionally based PBRNs. Maintenance of autonomy and geographic integrity of individual networks is still vital to continuing engagement of local practitioners and bottom-up capacity building, but central facilitation of collaborations is also required.

Further research should examine the composition of patient populations recruited to studies via PBRNs.

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**COMPETING INTERESTS**

None relevant to this article declared (ICMJE disclosure forms completed).

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