PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	The characteristics of patients attached to near-retirement family physicians: a population-based serial cross-sectional study in Ontario, Canada
AUTHORS	Premji, Kamila; Green, Michael; Glazier, Richard; Khan, Shahriar; Schultz, Susan; Mathews, Maria; Nastos, Steve; Frymire, Eliot; Ryan, BL

VERSION 1 – REVIEW

REVIEWER	Kevin Grumbach University of California
REVIEW RETURNED	20-Jun-2023

GENERAL COMMENTS	This manuscript adds to a series of excellent articles previously published by members of this research team reporting the results of studies of family physicians with a comprehensive scope of practice in Ontario and other provinces. The overall method of classifying comprehensive physicians in primary care is sound, building on solid prior work. The biggest challenge I have in reviewing this manuscript is trying to clearly discern what is new in this manuscript that meaningfully adds to the prior published work. What do we know from the authors' previously published studies? We know that the proportion of family physicians in Ontario with comprehensive practice has been declining in recent years, that this is true for physicians in all age groups, and that similar proportions of male and female physicians are in comprehensive practice. What then is the new information contributed by this manuscript? This manuscript reports some additional information about practice characteristics of comprehensive FPs in Ontario (e.g., roster size). The data are displayed in supplemental e-tables and figures; they allow for comparison across FP groups among comprehensive FPs, but do not provide comparative data for non-comprehensive FPs. When the denominator is all comprehensive FPs, the % by age group in displays such as eFigure 1 and eTable 1 is a function of both proportion of that age group that is comprehensive and the total N in the age group. The manner in which these data are presented as a % of all comprehensive FPs does not allow one to discern the degree to which trends in % are attributable to trends in those two components (size of the age cohort vs the proportion of FPs within that cohort with comprehensive practice). Overall, the data on physician characteristics did not strike me as containing much new policy-relevant information that provided a lot of new insights beyond what I have gleaned from their prior published research. I may have missed the key inferences they were trying to make with the large amount of physician and practice characteristic data they present.

	The data that are more novel are the data on patient characteristics of comprehensive FPs, as previous studies have not reported results for patient data. But here again, I am trying to discern the take-home policy relevant message from all the detailed data reported on patient characteristics stratified by FP age cohort. Much of the data displayed in Table 1 and eTable 5 seem to me to be unsurprising secular trends in patient characteristics, reflecting an aging population in Ontario with more morbidity, and a trend of greater ethnic diversity. These secular trends seem to be fairly consistent among the patient panels of comprehensive FPs in all age cohorts, and not unique to the near-retirement age groups. The authors' conclusion that "Comprehensive FPs cared for increasingly older groups of patients with increasing complexity over time" strikes me as a valid one, but one that is true for all comprehensive FPs in Ontario (and probably for most types of physicians in Ontario) and not just for near-retirement FPs. My sense is that the authors' principal aim in this study is to specifically quantify the number of people in Ontario who are likely to lose their comprehensive FP in the coming few years due to physician retirement, describe the characteristics of these patients, and assess the capacity of the Ontario FP workforce to absorb these patients. The authors highlight this workforce policy context when they state "HHR planning requires an understanding of the needs of patients who will soon lose their primary care provider due to retirement, as well as an understanding of the capacity of the remaining and incoming workforce." The first clause in this statement is addressed by the data reported in the manuscript in Table 1. But there is a second clause in this sentence that the authors do not directly address: the capacity of the remaining and incoming workforce. To address that part of the policy relevant research question would require presenting data on the estimated comprehensive FP additions to the workforce during the period when the projected number of comprehensive FPs retire. The information provided in the manuscript and tables does not directly provide such an estimate. As a result, after reading the manuscript, my main take home messages are that a substantial proportion of comprehensive FPs in Ontario are in older age groups (as are many non-comprehensive FPs), many of them are likely to retire in the next several years, there is a growing challenge keeping FPs of all ages in comprehensive models of practice, and there are questions about workforce planning to ensure sufficient future numbers of comprehensive FPs in the province to meet the health needs of an aging population. But I cannot from the data presented in the manuscript make clear inferences about whether in fact the FP workforce in the coming years will be sufficient to maintain the existing supply per capita of comprehensive FPs. Based on all this, my recommendations to the authors are: 1) to more concisely present only the data from among the large amount of results presented that are novel and critical to justifying the most important workforce interpretations they hope to share with readers (I would limit this largely to the new data on patient characteristics and a few key physician/practice characteristics such as roster size), and 2) to consider how they might want to more convincingly address the portion of their research question about the capacity of the future comprehensive FP workforce (if this is indeed a critical aim of their study), such as by including additional data to model projected entrants and exiters from the comprehensive FP workforce in the coming years to estimate net change and be able to make conclusions about the adequacy of future capacity. I share the

	authors' worry about the adequacy of future comprehensive FP capacity in Ontario as many comprehensive FPs approach retirement, but don't believe that the data presented provide the evidence to go from worry to scientific fact. The authors have great expertise in Canadian FP workforce research and rich data to analyze key issues such trends in comprehensive FPs. Their work highlighting the importance of focusing on comprehensive FPs as the backbone of primary care delivery has been critical to illuminating the need for this type of categorization, rather than simply looking at the undifferentiated FP supply. I believe there is a story to tell from this latest set of analyses, but in its current form, it was hard for me to discern the clear story that this chapter tells. Specific comments: p.14/lines 28-30: "Older physicians increasingly practiced FTE (2008: 58.4%, 2013: 67.0%, 2019: 72.6%)." Those cited data are only for the 65-69yo group, not all older physicians. 17/36-8: "we anticipate that by 2025, nearly 1.7 million Ontarians may lose their comprehensive FP to retirement" Please be specific if this is a projection for 2019-2025 (ie, what is the start date for the period ending in 2025 for this projection?).

REVIEWER	Stephen Peckham University of Kent, CHSS
REVIEW RETURNED	18-Jul-2023

GENERAL COMMENTS	Family practitioners, and wider primary care teams, are having to support and care for more complex patients with multi-morbidities and long-terms conditions in most advanced health care systems. This paper places this universal concern within a specific Canadian context. In areas where there has been long-term attachment between patients and physicians it is likely, as the data here shows, that as patients develop health problems in later life their physicians, who are also growing older, need to deal with more complexity. As the authors correctly note an ageing primary care workforce nearing retirement is common and therefore ensuring sufficient recruitment to the workforce is essential. In this paper the authors highlight that within the Ontario context, the issue is of particular concern where more younger, new doctors are less likely to practice comprehensive care. In contrast in the UK the issue is more connected with part-time working rather than not practising full primary care. Overall, I thought this is a well written paper. However, while gender differences and some reference to rural/urban practice was highlighted, I was surprised that there was not more discussion about inequalities identified in the data in table 1. I was interested to know whether the declining comprehensive care practitioners - while differentiated urban/rural were also concentrated in particular deprived neighbourhoods for example, or were older etc. It was also not clear whether those practising in team environments were supported by other primary care workers - a little more contextual information would have been helpful for an international readership. These are minor points as the data has been used to highlight the central issue of a declining comprehensively practising FP workforce. I do wonder whether something in the

	discussion/conclusion noting how other jurisdictions have approached this issue by widening the type and roles of non-FP primary care practitioners might also be considered as well as a focus on the FP. I think reference to some of these issues would enhance the article for an international rather than just Canadian audience

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

	Comment	Response	Page(s) and Section(s)
1	What then is the new information contributed by this manuscript? This manuscript reports some additional information about practice characteristics of comprehensive FPs in Ontario (e.g., roster size). The data are displayed in supplemental e-tables and figures; they allow for comparison across FP groups among comprehensive FPs, but do not provide comparative data for non-comprehensive FPs.	We agree that the unique contributions of this manuscript should be more clearly emphasized. We have now modified the wording throughout the manuscript and tightened the type of information presented in our Results to reflect our main research objectives: To characterize the primary care needs of patients who will soon lose their comprehensive FP to retirement, and the practice characteristics of the near-retirement comprehensive FP workforce. The same degree of analysis conducted for the comprehensive FP workforce is outside the scope of this project for the non-comprehensive workforce. For the non-comprehensive workforce, we are also unfortunately limited by small cell sizes. For example, we were unable to stratify non-comprehensive FPs by both age and sex due to small cell sizes. However, we have provided some additional description of the non-comprehensive workforce in the new version of eTable 1, and we have added detail around the Ns of the subgroups of non-comprehensive FPs without attachments in Figure 1b. Please see also the response to Comment 2 below for further details on eTable 1.	2 (Abstract), 3-4 (Strengths and Limitations), 6 (Introduction), 7 (Methods), 10-18 (Results), 18-20 (Discussion) Supplemental eTable 1 Figure 1b and related prose on p.8-9 (Methods)
2	When the denominator is all	We appreciate this excellent point. We	Supplemental

	comprehensive FPs, the % by age group in displays such as eFigure 1 and eTable 1 is a function of both proportion of that age group that is comprehensive and the total N in the age group. The manner in which these data are presented as a % of all comprehensive FPs does not allow one to discern the degree to which trends in % are attributable to trends in those two components (size of the age cohort vs the proportion of FPs within that cohort with comprehensive practice).	have now replaced the original eTable 1 with a new eTable1, which presents all non-comprehensive physicians (with or without patient attachments) by FP age group. This table also depicts the proportions of non-comprehensive FPs using two different denominators: all FPs, and all FPs within that age group. To Reviewer 1's point, we draw new conclusions once the size of the age cohort itself is taken into consideration. Specifically, we see that, albeit at a higher proportion than their mid-career counterparts, a relatively stable proportion of the younger age cohorts (<35 and 35-44) are in non-comprehensive scopes of practice. Age-related shifts are occurring at the age groups above 44. This is also now reflected in the prose (see Abstract, Results, and Discussion sections).	eTable 1 Pages 2 (Abstract), 10 (Results), 19-20 (Discussion)
3	Much of the data displayed in Table 1 and eTable 5 seem to me to be unsurprising secular trends in patient characteristics, reflecting an aging population in Ontario with more morbidity, and a trend of greater ethnic diversity. These secular trends seem to be fairly consistent among the patient panels of comprehensive FPs in all age cohorts, and not unique to the near-retirement age groups.	We agree that the trends observed extend beyond the near-retirement groups of physicians and, furthermore, reflect broader population trends related to aging. We have now modified the wording in the manuscript to acknowledge this, and to reflect that the trends around complexity relate to all comprehensive FP patients, including those nearing retirement.	3 (Abstract – Results), 15-18 (Results), 20 (Discussion)
4	My sense is that the authors' principal aim is to specifically quantify the number of people in Ontario who are likely to lose their comprehensive FP in the coming few years due to physician retirement, describe the characteristics of these patients, and assess the capacity of the Ontario FP workforce to absorb these patients.	We agree that this is our intended key objective and that this is diluted by the volume of results presented that do not directly relate to this or that reiterate previous research. We have now modified the title, Results, and Discussion sections to focus more clearly and concisely on this objective.	1 (Title), 10-18 (Results), 18-21 (Discussion)
5	My recommendations to the authors are: 1) to more concisely present	Thank you for this recommendation. We agree, and to improve the focus, we've removed information from the	10-18 (Results)

	only the data from among the large amount of results presented that are novel and critical to justifying the most important workforce interpretations they hope to share with readers (I would limit this largely to the new data on patient characteristics and a few key physician/practice characteristics such as roster size),	prose that is unrelated to the main research objective but is available in tables/figures.	
6	and 2) to consider how they might want to more convincingly address the portion of their research question about the capacity of the future comprehensive FP workforce (if this is indeed a critical aim of their study), such as by including additional data to model projected entrants and exiters from the comprehensive FP workforce in the coming years to estimate net change and be able to make conclusions about the adequacy of future capacity.	We agree that, although our study Objectives did not include modeling the future workforce, our prose elsewhere may have suggested that such modeling was intended, which in turn made our key aims less clear. We have now amended our wording throughout to indicate that on the supply side, our focus is on the existing workforce. Furthermore, while modeling the future workforce is outside the scope of our study, we have added in the Strengths and Limitations section, as well as in the Discussion section, information on how our findings around workforce trends (e.g., physician sex, FTE, roster size, practice scope, preferred practice model) can be applied to other data sources on incoming physicians in order to anticipate capacity. This more clearly reflects our intentions around the utility of our analyses when it comes to understanding the future workforce. Primary care policy implications related to demand, specifically population growth, are also now mentioned in the Discussion, to complement our findings around anticipated demand as complex patients lose their FPs to retirement.	3 (Strengths and Limitations), 6 (Introduction), 7 (Methods – Outcomes and Covariates section to explicitly state "existing" workforce with respect to supply), 20-22 (Discussion)
7	p.14/lines 28-30: "Older physicians increasingly practiced FTE (2008: 58.4%, 2013: 67.0%, 2019: 72.6%)." Those cited data are only for the 65-69yo group, not all older physicians.	Thank you for pointing this out. We have now amended this line to specify that these percentages pertain to the 65-69-year old age group, and have added the results for the 70+ group.	15 (Results)
8	17/36-8: "we anticipate that by 2025, nearly 1.7 million Ontarians may lose their comprehensive FP to	Thank you – we have now made this clarification in both the Discussion section of the main manuscript and	3 (Abstract – Conclusion), 18

	retirement" Please be specific if this is a projection for 2019-2025 (ie, what is the start date for the period ending in 2025 for this projection?).	the Conclusion section of the Abstract to indicate that this was indeed a projection for 2019-2025.	(Discussion)

Reviewer 2:

	Comment	Response	Page(s) and Section(s)
1	I was surprised that there was not more discussion about inequalities identified in the data in table 1. I was interested to know whether the declining comprehensive care practitioners - while differentiated urban/rural were also concentrated in particular deprived neighbourhoods for example, or were older etc.	We strongly agree with the importance of highlighting inequities. In this study, we are unable to identify the neighbourhoods within which FPs are located, and our cross-sectional study design prevents us from longitudinally following FPs exiting the workforce to determine whether socially vulnerable patients are being disproportionately impacted. However, in Table 1, we have summarized the high proportion of vulnerable patients who are attached to physicians nearing retirement. We have also made an amendment to the Discussion section to more explicitly express the equity concerns that relate to these findings.	Table 1 Page 19-20 (Discussion)
2	It was also not clear whether those practising in team environments were supported by other primary care workers - a little more contextual information would have been helpful for an international readership.	Thank you for this recommendation. We agree, and have now added contextual information to the Results section around the types of practitioners supporting FPs who practice in team-based models of care and the funding source for this model.	16 (Results)
3	I do wonder whether something in the discussion/conclusion noting how other jurisdictions have approached this issue by widening the type and roles of non-FP primary care practitioners might also be considered as well as a focus on the FP.	We agree with this excellent recommendation and have added a new paragraph to the Discussion section on this subject.	21-22 (Discussion)

VERSION 2 – REVIEW

REVIEWER	Kevin Grumbach University of California
REVIEW RETURNED	16-Oct-2023

GENERAL COMMENTS	I appreciate the authors' efforts to address my feedback. I thank

	them for removing some of the text on detailed results that I suggested were distracting and revising the introduction to emphasize the focus on patient characteristics. However, I must candidly say that I don't believe that the most important thrust of my concerns have been satisfactorily addressed: 1) the inability to discern how the 2 discrete factors of age-cohort specific trends in comprehensive practice and trends in the age distribution of the FP workforce contribute to the highlighted findings of trends FPs in comprehensive practice according to age cohorts measured as the percentage of total comprehensive FPs; and 2) the inclination to make strong inferences about the adequacy of the future workforce to absorb patients from retiring FPs without including formal demand-supply projections to justify their many statements in the discussion section suggesting that future supply will be inadequate. 1. Comprehensive FP cohort trends The authors mention that "We have now replaced the original eTable 1 with a new eTable1, which presents all non-comprehensive physicians (with or without patient attachments) by FP age group. This table also depicts the proportions of non-comprehensive FPs using two different denominators: all FPs, and all FPs within that age group." It appears to me from the material included in the pdf for the resubmission that eTable 1 is the same version as included with the original submission, and that the authors mean to refer to eTable 2, which is revised to include columns with both denominators. I still find it very challenging to toggle between eTable 1 and eTable 2 in an effort to make sense of all this, especially with eTable 2 displaying the converse of the data in eTable 1 by showing data on non-comprehensive FPs instead of comprehensive FPs. At the risk of being a micromanaging reviewer, might I suggest to the authors that they make eTable 1 a Table showing the data in eTable 2, but showing data for comprehensive rather than non-comprehensive FPs. I recommend placing such a table first since it has the most basic, important information that the reader needs to know to understand secular and age-cohort specific trends in comprehensive practice. And then in the new eTable 2 (formerly eTable 1), for the first column of data for each age cohort for the Comp FP item, show the data within a cohort using the total N of FPs in the cohort as the denominator rather than the denominator of all comprehensive FPs of any age. The other issue that makes it tricky to make sense of the current eTable 1 is that some of the % data are row % (eg, %M or F) and others are column % (e.g., % comprehensive FP). Because eFigure 1 displays all the comp FP data by age and gender, the authors could in fact consider simply deleting the entire first 3 rows of data in current eTable 1 given the complexity of understanding the denominator for these cells and its duplication with the data shown in the figure. So why am I being such a nuisance in perseverating about this? It is because, for example, when I read on page 10 "the proportion of FPs practicing comprehensive primary care declining from 77.2% in 2008 (n =7,673) to 70.7% in 2019 (n = 9,377) (Supplemental eFigure 1). This was driven by mid-career and near-retirement physician groups (age groups 45 and above) shifting away from comprehensiveness…" and I then look at the data in the eTables to understand the data behind these interpretations, it is very difficult to identify the data that support the authors' contention. And when later on the same page I read "In the 55+ age group, the proportion of comprehensive FPs increased from 35.7% in 2008 to 38.2% in

	2019," the phrasing makes me mistakenly think that this is referring to the percent of FPs in that age cohort in comprehensive practices. More correct would be to say, "Between 2008 to 2019, FPs in the 55+ age group represented a growing proportion of all comprehensive FPs, increasing from 35.7% to 38.2%." For a reader like me who really wants to understand just what the authors are reporting and what the data truly show, it remains tough going. 2. Inferences about future comprehensive FP workforce capacity The authors still have many statements in the discussion section that make inferences about the inadequacy of the future comprehensive FP workforce: p.16/line 15: "eroding gains in primary care attachment to date" Given that their data shows a large growth over the period studied in the number of FPs in the <35 and 35-44 yo cohorts, and a reversal in recent years in the decline in the % of FPs in the younger cohorts eschewing comprehensive practice, how do they know that the entering cohorts of FPs will not be able to absorb the patient panels of retiring physicians? p.16, 42-3: "limited capacity in existing workforce to absorb" and p.18/13-14 "limited capacity among early career FPs to absorb that workload." Here again, without presenting a formal demand/supply model, this seems more a conjecture than a conclusion deriving directly from the data presented and the study findings. I get why the authors are worried. Many patients in Ontario currently do not have an FP and there are pervasive concerns about access to primary care and workforce adequacy. It's just that the authors get ahead of their study in using the data presented to make strong assertions that the impending retirement of comprehensive FPs in the older cohorts will be a decisive factor overwhelming the capacity of the future FP workforce, without presenting a model that quantitively estimates that future capacity relative to future population demand. The reader really has no idea how many comprehensive FPs will be added to the workforce in 2019-25 to potentially offset the projected retirement of the FPs currently caring for 1.7M Ontarians. I am certainly comfortable with the authors' raising a concern about whether the workforce will be adequate, without being quite so strong in their assertions that it will definitely not be adequate in terms of absorbing the patients of retiring FPs. They could, for example, take the list of things that they mention as potentially reducing the future workforce capacity of comprehensive FPs—younger FPs possibly not electing comprehensive practice at the same rate as their predecessors, gender distribution and FTE and retirement ages, recent declines in medical school graduates training in FP, immigration policy, etc.—and suggest that these are the types of variables that modeling of the future comprehensive FP workforce would need to consider. The authors' focus on workforce issues is important and they have advanced the field by illuminating the key dimension of comprehensive FP practice. Overall, I would encourage the authors to continue to consider how to help the reader focus on the forest of the most important take home message they wish to convey that is supported by their data, amidst the trees of the voluminous data they include in their manuscript and supplements (which might merit some further pruning) and their inclination to let their conclusions get a bit ahead of what their data support.

REVIEWER	Stephen Peckham University of Kent, CHSS
REVIEW RETURNED	1-Oct-2023

GENERAL COMMENTS	Thank you for responding to the reviewer's comments and revising the manusciript accordingly. I note the acknwledgement of limitations which meant some aspects could not be addressed.

VERSION 2 – AUTHOR RESPONSE

Reviewer 1:

	Comment	**Response**	**Page(s) and Section(s)**
Comprehensive FP cohort trends			
1	"…I suggest to the authors that they make eTable 1 a Table showing the data in eTable 2, but showing data for comprehensive rather than non-comprehensive FPs. I recommend placing such a table first since it has the most basic, important information that the reader needs to know to understand secular and age-cohort specific trends in comprehensive practice…"	We appreciate the reviewer's guidance in ensuring our exhibits are easily interpretable. We have followed his recommendation regarding our exhibit on comprehensiveness. eTable 2 has now been removed and replaced with a new eTable 1. This eTable 1 now includes the data for comprehensive FPs rather than for non-comprehensive FPs alone. As well, in keeping with the reviewer's recommendation for our first revision, we have again provided proportions using two different denominators: all FPs, and all FPs within that age group. (First round comment from Reviewer 1: "The manner in which these data are presented as a % of all comprehensive FPs does not allow one to discern the degree to which trends in % are attributable to trends in those two components (size of the age cohort vs the proportion of FPs within that cohort with comprehensive practice).") Overall, this exhibit now allows for a clear apprehension of the secular and age cohort-specific trends in comprehensive practice.	eTable 1 (formerly eTable 2)

		In our manuscript prose, we have also made revisions to the Results section that map to the above change, such that we have moved up the prose that maps to Supplemental eTable 1 so our prose now follows the order in which the eTables are numbered.	Results, p.9-10
2	[continuation from Comment #1 above] "…And then in the new eTable 2 (formerly eTable 1), for the first column of data for each age cohort for the Comp FP item, show the data within a cohort using the total N of FPs in the cohort as the denominator rather than the denominator of all comprehensive FPs of any age. The other issue that makes it tricky to make sense of the current eTable 1 is that some of the % data are row % (eg, %M or F) and others are column % (e.g., % comprehensive FP). **Because eFigure 1 displays all the comp FP data by age and gender, the authors could in fact consider simply deleting the entire first 3 rows of data in current eTable 1 given the complexity of understanding the denominator for these cells and its duplication with the data shown in the figure."**	We thank the reviewer for his careful consideration and suggestion to remove the first three rows (the covariate "Comp FPs N(%))" in a new eTable 2 (formerly eTable 1). We understand his concern that including the first three rows (the covariate "Comp FPs N(%)" creates confusion interpreting the table due to the way %s are presented. We also see his point that eFigure 1 also displays data by age and sex. That said, the proportions presented for the Comp FP covariate in our original eTable 1 differ from the proportions presented in eFigure 1. The original eTable 1 presents proportions using a denominator of the comprehensive FP workforce, and eFigure 1 presents proportions using a denominator of the overall FP workforce (i.e., comprehensive and non-comprehensive combined). The intent of eFigure 1 is to illustrate changes in the overall FP workforce's practice of comprehensiveness over time by age and sex. We acknowledge	

		that this distinction was not made clear enough to the reader. We have therefore addressed the reviewer's concerns around our exhibits via the following revisions, which improve clarity and preserve the distinctions between the eTable vs the eFigure: 1. We have separated the original eTable 1 into eTable 2a and eTable 2b. 2. eTable 2a is now dedicated to describing the comprehensive FP workforce by age and sex, with the denominator being the Comp FP workforce (these were the first three rows in the previous eTable 1). To assure clarity, we have added a footnote explaining the interpretation of the proportions described. 3. eTable 2b describes the practice characteristics of comprehensive FPs. The first five covariates listed in the table are now consistently expressed as means and SDs within each physician age group, stratified by physician sex, which makes interpretation of these covariates in the table straightforward. 4. The only covariate in eTable 2b that is expressed as "N (%)" is the last covariate listed: "FTE". To aid in the reader's interpretation of this, we have added an asterisk beside this covariate that maps to a footnoted explanation. 5. eFigure 1 now has the term "all" in	eTable 2a and 2b eTable 2a

		the title. (Note: this term was already in the “y” axis title, so the axis title are unchanged.) We have also added to this exhibit data labels and footnotes to aid in interpretation and make clearer how the exhibit differs from the data presented in eTable 2a.	
		7. We have added prose in the Results section to clarify when we are discussing the overall FP workforce (i.e., eFigure 1) and when we are turning our attention to the comprehensive FP workforce (i.e., eTable 2a and 2b).	eTable 2b
		These revisions: 1) Assure clarity in the interpretation of former eTable 1 (now eTable 2a and eTable 2b); 2) Preserve detail around the comprehensive FP workforce itself by keeping it in its own eTable 2a; and 3) Clarify the distinction between eTable 2a and eFigure 1.	eTable 2b eFigure 1

			Results, p.9-10
3	"…[W]hen later on the same page I read "In the 55+ age group, the proportion of comprehensive FPs increased from 35.7% in 2008 to 38.2% in 2019," the phrasing makes me mistakenly think that this is referring to the percent of FPs in that age cohort in comprehensive practices. More correct would be to say, "Between 2008 to 2019, FPs in the 55+ age group represented a growing proportion of all comprehensive FPs, increasing from 35.7% to 38.2%.""	We thank the reviewer for pointing this out. We agree that what we intend to convey is the growing proportion of the overall comprehensive FP workforce that this age group represents. We have now amended our wording accordingly.	Results, p.10
Inferences about future comprehensive workforce capacity			
4	"…how do they know that the entering cohorts of FPs will not be	We appreciate the reviewer's point about avoiding assertions around the future workforce's capacity. We agree	Discussion,

	able to absorb the patient panels of retiring physicians?….without presenting a formal demand/supply model, this seems more a conjecture than a conclusion deriving directly from the data presented and the study findings." "I am certainly comfortable with the authors' raising a concern about whether the workforce will be adequate, without being quite so strong in their assertions that it will definitely not be adequate in terms of absorbing the patients of retiring FPs. They could, for example, take the list of things that they mention as potentially reducing the future workforce capacity of comprehensive FPs—younger FPs possibly not electing comprehensive practice at the same rate as their predecessors, gender distribution and FTE and retirement ages, recent declines in medical school graduates training in FP, immigration policy, etc.—and suggest that these are the types of variables that modeling of the future comprehensive FP workforce would need to consider."	with the suggestion to instead frame this part of the Discussion around potential considerations for future modeling. We have revised our Discussion section and believe we have now addressed this concern. Note that in this section of the Discussion, we've now removed the statement describing hypotheses around physician gender as it relates to FTE practice and roster size. This was done to maintain flow in this revised section (i.e., to keep this paragraph limited to describing potential considerations for modeling) and also because this information is already in the Background section of the manuscript.	p.16-17 Discussion, p. 17