PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Health system reforms, violence against doctors and job satisfaction in the medical profession: a cross-sectional survey in Zhejiang Province, Eastern China
AUTHORS	Hesketh, Therese; Wu, Dan; Wang, Yun; Lam, Kwok Fai

VERSION 1 - REVIEW

REVIEWER	Zhu Wei Xing Zhejiang Normal University, China
REVIEW RETURNED	05-Sep-2014

GENERAL COMMENTS	This is a timely and important paper which addresses the very topical issue of doctors' satisfaction. There is much discussion about this in the Chinese media and I believe this is also relevant and interesting for doctors in England. I think it is very good that the authors have also focused on the problem of violence which is a worry for many doctors in China now. This is the first paper to cover such a broad definition of satisfaction that I have seen. Although the sample size is not big, 202 doctors across the three levels of care still provides good insight into how doctors think. However, this can only be a snapshot and much bigger studies are needed. This is essentially a pilot. The introduction is good and helps an international audience to understand the major issues in the health system since the reforms started. The methods are simple and clear. The job satisfaction score appears to have been developed for the purposes of the paper, and has not been validated. This should be stated as a limitation. But it enables the comparisons to be made between the levels and so strengthens the argument. In the discussion a section should be added which explores more about the fact that satisfaction is highest at primary level. Is this mainly about low expectations and less hard work. It might be expected that the higher status at higher level would increase the satisfaction of these doctors, but this is not that case, it seems. The implications of this for the future of the medical profession are very important. Doctors with low level of training are more satisfied The statistics are quite basic - so I say it does not need a specialist review..

REVIEWER	Osman Hayran Medipol University School of Medicine - TURKEY
REVIEW RETURNED	05-Sep-2014

GENERAL COMMENTS	-Sampling method is not appropriate. All results may be biased since the sample was selected purposively. Purposive sampling method are generally used during qualitative studies and not appropriate for such a study. -Sample size was not calculated. -There are many missing cases. -Because researchers have designed the job satisfaction questionnaire themselves, there may be several biases during the selection and/or translation of the questions. There is no information about the validity and reliability of the job satisfaction questionnaire. -There are several presentation mistakes in Tables 1 and 5. (e.g.: Classification of the quantitative data) -The statement on page 9: "…29% of primary care doctors had an undergraduate degree compared with 93% and 96% at county and provincial level respectively" is not clear.

REVIEWER	Olaf Gjerløw Aasland Institute for Studies of the Medical Profession Oslo, Norway and Institute of Health and Society University of Oslo, Norway
REVIEW RETURNED	29-Oct-2014

GENERAL COMMENTS	This is truly a report from «another world». My knowledge about the Chinese health care system is limited – I was on a study trip to Beijing for one week in May 2012 where we visited various hospitals, health care centers and universities, and mainly saw the upsides. And I have read a few articles. The main problem with this article is that it mainly deals with the secondary causes of doctor discontent on an individual and local level. The root causes: long hours, low pay, low status and lack of trust, are described, but with little discussion on why such conditions are so prevalent, and to what extent they can be alleviated. If the general working conditions for all Chinese doctors are as critical as is here described, the differences between the three levels of healthcare are less important, at least for the international reader. The role of medical associations In most democracies issues like doctors' working hours, remuneration and security would have high priority and be topics of political discussion. They would be major motives for having a professional organisation in the first place, for the protection and support of its members. In some advanced welfare societies professional organisations may also serve as a constructive opposition, and there would be deliberations between the government and the professions on topics like working hours, salaries and security. The only mentioning of medical associations I can find in this article occurs in reference 50, where four medical associations are credited for their recommendation of "zero tolerance to medical violence". Does this mean that Chinese medical associations have no political power? For an international audience this article would need a broader and deeper discussion on the role

	and potential of medical associations, and in this particular case why they seem to be without influence. The need for more sociological and international perspectives In the introduction, when describing a reduction in the doctors' unauthorized overprescribing for informal payment, the authors call this corrupt practice a reduction in the doctors' autonomy. This is of course correct in one sense, but it is also an example of how a perverse market situation can lead to "unprofessional autonomy". In my opinion this paper would profit considerably from comparing the Chinese traditions of patient-doctor relationship with some other cultures, especially the practice of informal payments and other examples of corruption. Of special interest would be to check out research on what has happened in the former European totalitarian states during their journeys towards modern democracies. See e.g.: http://archive.transparency.org/global_priorities/other_thematic_issues/health/service_delivery/informal_payments Yi Nao as endpoint variable The authors write (p. 6) that violence against health personnel is not unique in China, and cite several articles from various other countries. I have not read all these papers, but I would think that not many, if any of them describe a situation similar to the Chinese tradition of Yi Nao. According to China Daily of May 8 2014, The Ministry of Public Security in Wenling, Zhejiang Province had to place three police officers per 100 medical workers in hospitals. This unbelievable situation is well discussed in the article, but is the only remedy zero agression campaigns? I would really like to see an integrated overarching discussion, with Yi Nao as the "dependent variable", for instance following a line like this: too low income, too heavy workload and and sub-optimal work organisation produce desperate, immoral and cynical doctors who in order to survive exploit their patients, and the patients react in desperation with more aggression. This is not merely a question of individual patient-doctor relationships; it is the expression of a non-sustainable and dysfunctional health care system where the doctors lack true professional autonomy. I am aware that I am asking for a rather different paper, with less emphasis on local Chinese variation and more emphasis on the difference between China and other states where doctors have a better platform to work from. I am also aware, since I have colleagues and friends who regularly work in China, that not all parts of the Chinese medical system are as bad as the ones described here. Your paper was very interesting and informative, but needs more perspectives on the shortcoming of the system.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name Zhu Wei Xing
Institution and Country Zhejiang Normal University, China
Please state any competing interests or state 'None declared': None declared

This is a timely and important paper which addresses the very topical issue of doctors' satisfaction. There is much discussion about this in the Chinese media and I believe this is also relevant and interesting for doctors in England. I think it is very good that the authors have also focused on the problem of violence which is a worry for many doctors in China now. This is the first paper to cover such a broad definition of satisfaction that I have seen.

Although the sample size is not big, 202 doctors across the three levels of care still provides good insight into how doctors think. However, this can only be a snapshot and much bigger studies are needed. This is essentially a pilot.

The introduction is good and helps an international audience to understand the major issues in the health system since the reforms started. The methods are simple and clear.

The job satisfaction score appears to have been developed for the purposes of the paper, and has not been validated. This should be stated as a limitation. But it enables the comparisons to be made between the levels and so strengthens the argument.

Reply: We have stated the limitations of the job satisfaction score on page 25.

In the discussion a section should be added which explores more about the fact that satisfaction is highest at primary level. Is this mainly about low expectations and less hard work. It might be expected that the higher status at higher level would increase the satisfaction of these doctors, but this is not that case, it seems. The implications of this for the future of the medical profession are very important. Doctors with low level of training are more satisfied.

Reply: We appreciate the reviewer's comments on this point. We have added comments to cover this on page 22.

The statistics are quite basic - so I say it does not need a specialist review.

Reviewer: 2
Reviewer Name Osman Hayran
Institution and Country
Medipol University School of Medicine - TURKEY
Please state any competing interests or state 'None declared': None.

-Sampling method is not appropriate. All results may be biased since the sample was selected purposively. Purposive sampling method are generally used during qualitative studies and not appropriate for such a study. -Sample size was not calculated.

Reply: Little work has been done in this area before. We acknowledge that the sampling method is

not ideal with the potential for bias, and the generalisability is limited. We have emphasised this in the limitations. However, a sample of 202 doctors from 10 health facilities from all three different levels of hospital and in areas across a range of socioeconomic status, does provide insight into the experiences and attitudes of doctors.
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-There are many missing cases.

Reply: Missing values are actually low at around 5%, especially given the personal nature of some of the questions.

-Because researchers have designed the job satisfaction questionnaire themselves, there may be several biases during the selection and/or translation of the questions. There is no information about the validity and reliability of the job satisfaction questionnaire.

Reply: We recognize this as a limitation and we have added this to the text on page 25. While we drew on existing international validated questionnaires for most of the items, this risk excluding key information for the Chinese context. So we added some items, for example, about the bonus system and violence. The comparisons between the three different levels of hospital nonetheless have internal validity. But the individual items are more important and indicate what specific aspects of doctors' work are contributing to job satisfaction.

-There are several presentation mistakes in Tables 1 and 5. (e.g.: Classification of the quantitative data)

Reply: If we understand the reviewer correctly, the question is about the classification of variables in Table 5 which is seemingly inconsistent with Table 1 and Table 2. The variable of level of hospital is revised accordingly in Table 5 on Page 17 (explanations of levels of hospitals are on Page 6). Regarding other variables, for the purpose of comparing the job satisfaction score among subgroups, we combined levels of responses to avoid some very small numbers in some cells so as to make the comparisons more reliable.

-The statement on page 9: "…29% of primary care doctors had an undergraduate degree compared with 93% and 96% at county and provincial level respectively" is not clear.

Reply: This has been revised (Page 9) as "Only 29% of primary care doctors had obtained a five-year formal medical education qualification compared with 93% and 96% at county and provincial level respectively".

Reviewer: 3
Reviewer Name Olaf Gjerløw Aasland
Institution and Country Institute for Studies of the Medical Profession
Oslo, Norway

and

Institute of Health and Society
University of Oslo, Norway
Please state any competing interests or state 'None declared': None decleared

This is truly a report from «another world». My knowledge about the Chinese health care system is

limited – I was on a study trip to Beijing for one week in May 2012 where we visited various hospitals, health care centers and universities, and mainly saw the upsides. And I have read a few articles.

Reply: We appreciate the reviewer's honesty about his limited knowledge of China. As in many settings the Chinese show outsiders the best – and they are reluctant to discuss negative aspects. I myself, as a foreigner, have been working in China (in different areas) for nearly 30 years and I am still learning all the time. I can assure the reviewer that our findings are not untypical of the many parts of China I travel and work in.

The main problem with this article is that it mainly deals with the secondary causes of doctor discontent on an individual and local level. The root causes: long hours, low pay, low status and lack of trust, are described, but with little discussion on why such conditions are so prevalent, and to what extent they can be alleviated. If the general working conditions for all Chinese doctors are as critical as is here described, the differences between the three levels of healthcare are less important, at least for the international reader.

Reply: The point of the paper was to quantify the problems discussed. The underlying causes and in-depth analysis will require qualitative research which we are currently undertaking. The differences between the three levels are crucial to our arguments. In the ongoing reforms the government is focusing on primary care. Our findings show a worrying situation of specialists' low work satisfaction, with systemic problems contributing to this phenomenon. On the positive side such findings can be used to encourage current/future medical professionals to become primary care doctors, and despite this being regarded as "lower level", the job can be very satisfying.

The role of medical associations

In most democracies issues like doctors' working hours, remuneration and security would have high priority and be topics of political discussion. They would be major motives for having a professional organisation in the first place, for the protection and support of its members. In some advanced welfare societies professional organisations may also serve as a constructive opposition, and there would be deliberations between the government and the professions on topics like working hours, salaries and security. The only mentioning of medical associations I can find in this article occurs in reference 50, where four medical associations are credited for their recommendation of "zero tolerance to medical violence". Does this mean that Chinese medical associations have no political power? For an international audience this article would need a broader and deeper discussion on the role and potential of medical associations, and in this particular case why they seem to be without influence.

Reply: The reviewer is correct. The Chinese medical associations have very limited power regarding the protection of health workers' interests. We have added a note on this (page 24). Much of their work centres around non-controversial issues such as continuing education. Medical associations are very rarely involved in medical disputes and are not seen as accountable in these situations by either the doctors or the public. The problems are seen as the responsibility of the employer i.e. the hospital. Because of this, further discussion on the role of medical associations is irrelevant for the context of this paper.

The need for more sociological and international perspectives

In the introduction, when describing a reduction in the doctors' unauthorized overprescribing for informal payment, the authors call this corrupt practice a reduction in the doctors' autonomy. This is of course correct in one sense, but it is also an example of how a perverse market situation can lead to "unprofessional autonomy". In my opinion this paper would profit considerably from comparing the

Chinese traditions of patient-doctor relationship with some other cultures, especially the practice of informal payments and other examples of corruption. Of special interest would be to check out research on what has happened in the former European totalitarian states during their journeys towards modern democracies. See e.g.: http://archive.transparency.org/global_priorities/other_thematic_issues/health/service_delivery/informal_payments

Reply: We agree with the above and it would be interesting to compare root causes of the unprofessional medical practice and disputes. The varying contexts of different countries would elicit a wide range views on this topic. However, we believe, that the Chinese system's post-reform conditions are unique, so direct comparison to other countries is difficult, and this would in any case require a whole separate new paper.

Yi Nao as endpoint variable

The authors write (p. 6) that violence against health personnel is not unique in China, and cite several articles from various other countries. I have not read all these papers, but I would think that not many, if any of them describe a situation similar to the Chinese tradition of Yi Nao. According to China Daily of May 8 2014, The Ministry of Public Security in Wenling, Zhejiang Province had to place three police officers per 100 medical workers in hospitals. This unbelievable situation is well discussed in the article, but is the only remedy zero agression campaigns? I would really like to see an integrated overarching discussion, with Yi Nao as the "dependent variable", for instance following a line like this: too low income, too heavy workload and and sub-optimal work organisation produce desperate, immoral and cynical doctors who in order to survive exploit their patients, and the patients react in desperation with more aggression. This is not merely a question of individual patient-doctor relationships; it is the expression of a non-sustainable and dysfunctional health care system where the doctors lack true professional autonomy.

Reply: We agree that violence against health workers is widespread. It has for many years been described as a public health problem by WHO. But Yi Nao (and its extent) is probably unique in China. Although the term Yi Nao is widely used in China, there is no agreed definition at present. Yi Nao literally translates as 'hospital disturbance'. But it is used to cover a range of behaviours from verbal abuse to murder, sometimes involving illegal gangs and blackmail to extract financial compensation. See our BMJ paper "Violence against doctors in China" cited as reference 12. As the paper describes, Yi Nao reflects deep societal problems and the doctor-patient relationship is just one facet. Therefore to regard the Yi Nao as an "endpoint variable" would be impossible at this stage. We are planning to do a further study to examine the Yi Nao phenomenon in more depth.

We are not sure what the reviewer means by "zero aggression campaigns", but we do agree with the reviewer's comment on the dysfunctional healthcare system. However the reasons for a dysfunctional health care system are a lot more complicated than under-funding and lack of professional autonomy. Contributing factors probably include the medical education system, the public's general education level and health literacy, accessibility of health information.

I am aware that I am asking for a rather different paper, with less emphasis on local Chinese variation and more emphasis on the difference between China and other states where doctors have a better platform to work from.

I am also aware, since I have colleagues and friends who regularly work in China, that not all parts of the Chinese medical system are as bad as the ones described here.

Reply: Just to emphasise, the uniqueness and complexities of the Chinese system make direct

comparisons difficult, and indeed this would be a different paper altogether. The colleagues and friends referred to will mostly have seen the best of the system. Of course it is not all bad and our paper does not say that. Some doctors do gain satisfaction from their work, but there are many underlying grievances. There are many reasons why outsiders cannot get a full picture – hierarchies suppress open critique in the health system (e.g. promotion depends on toeing the line). An anonymous survey, however, can reveal attitudes which doctors will often not express openly. And much of the dissatisfaction is expressed in the media and social media, which I guess the colleagues and friends referred to don't access.

Your paper was very interesting and informative, but needs more perspectives on the shortcoming of the system.

Reply: Due to the ongoing health reform process, which is progressing across the country at different speeds, it is difficult even for an insider to get a full picture of the system. But we have focussed on the shortcomings and this is in fact the message of the paper. We're not sure how we would provide more "perspectives" with the constraints of the word count. This could however be included in a different paper, which will cover our qualitative findings.

VERSION 2 – REVIEW

REVIEWER	Zhu Wei Xing Zhejiang Normal University PR China
REVIEW RETURNED	21-Nov-2014

GENERAL COMMENTS	I am happy with the changes made and think the paper is now ready for publication. This is an important contribution to our knowledge about doctors satisfaction and the health reform in China.

REVIEWER	Olaf Gjerløw Aasland Institute for Studies af the Medical Profession Oslo. Norway and Institute of Health and Society University of Oslo Norway
REVIEW RETURNED	24-Nov-2014

GENERAL COMMENTS	1. As stated in my first review, this is truly a report from another world. Unfortunately, the authors also respond "from another world" by concluding that the necessary measures to be taken for Chinese doctors to be more satisfied are reduction in workload, increase in salary, and more punitive measures against individuals who commit violent acts against doctors. Hence my hope that the interpretation and discussion of these data could be lifted up to a more systemic and political level proved futile. The authors still only discuss on a reactive and individual level. 2. Why are they not interested in putting high workload, low pay and patient aggression into a broader perspective? They say in their comments to my intervention that "the point of the paper was to quantify the problems discussed. The underlying causes and in-depth analysis will require qualitative research which we are currently undertaking" and this may of course be part of the reason for their reluctance to include a more systemic discussion. However, in the Introduction of the paper they (still) write: "There is evidence that this situation is worsening, so urgent measures are needed to

	reverse this trend. Clearly, such measures need to include addressing the underlying causes of this discontent. The aim of this study was to explore these underlying causes through surveying the views of doctors working at three levels of the health system: tertiary, secondary and primary care." Therefore, the paper does not hold its promise to explore the underlying causes. I don't agree that a discussion of the underlying causes and a deeper analysis will necessarily require another (qualitative) study; there are plenty of quantitative papers on this topic already. Here are two from our group: Aasland OG, Rosta J, Nylenna M. Healthcare reforms and job satisfaction among doctors in Norway. Scandinavian Journal of Public Health 2010; 38: 253-8. Voltmer E, Rosta J, Siegrist J, Aasland OG. Job stress and job satisfaction of physicians in private practice: comparison of German and Norwegian physicians. Arch Occup Environ Health 2012; 85 (7): 819-28. The latter is also an example of how a common (validated) instrument for job satisfaction can be used for international comparisons. 3. To follow up on the authors' reply to my review: I mention that that the paper may be more of local, Chinese interest than suited for an international audience, particularly since it puts so much emphasis on the differences between the three levels of health care in China. Their response to this is: "The differences between the three levels are crucial to our arguments. In the ongoing reforms the government is focusing on primary care. Our findings show a worrying situation of specialists' low work satisfaction, with systemic problems contributing to this phenomenon. On the positive side such findings can be used to encourage current/future medical professionals to become primary care doctors, and despite this being regarded as "lower level", the job can be very satisfying." This is all good and well, but for me it indicates strongly that the target groups the authors have in mind are mainly the Chinese government and their Chinese medical colleagues. I would like to see better arguments for why an international reader must study 3-4 extensive tables where the main points are local variations on a sad theme. 4. In my review I asked about the role of medical associations, and the authors confirm that "The Chinese medical associations have very limited power regarding the protection of health workers' interests". And they continue: "Medical associations are very rarely involved in medical disputes and are not seen as accountable in these situations by either the doctors or the public. The problems are seen as the responsibility of the employer i.e. the hospital. Because of this, further discussion on the role of medical associations is irrelevant for the context of this paper." OK, but in my mind this piece of information is very relevant, particularly "for the context of this paper"! Here is a good opportunity to discuss some of "the underlying causes" a bit deeper, by including two important actors that seem to fail their responsibilities; the employers and the medical associations. By the way, the authors in they comment are not sure what I mean by "zero aggression campaigns". I actually borrowed the expression from their reference

	number 51: CMA. United call for "Zero tolerance to medical violence" by Chinese Medical Association, Chinese Medical Doctor Association, Chinese Hospital Association and Chinese Health Law Society. http://www.cma.org.cn/index/xhdt/20131029/1383026180011_1.html (accessed 11 Feb 2014). 5. Finally, I agree with the comments on method from the other reviewers (small and not representative sample, home-made job satisfaction instrument). 6. Between the lines of my comments above can be read a disappointment in receiving a revision almost identical to its first generation. But I am aware that my comments call for a change in perspective, from national to international, and from individual to political. A more fundamental revision in other words. It must now be up to the Editor to decide whether this is interesting and/or viable.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 1

Reviewer Name Zhu Wei Xing

Institution and Country Zhejiang Normal University

PR China

Please state any competing interests or state ‘None declared’: None declared

I am happy with the changes made and think the paper is now ready for publication. This is an important contribution to our knowledge about doctors satisfaction and the health reform in China

Reply: We appreciate the reviewer’s recommendation for publication.

Reviewer: 3

Reviewer Name Olaf Gjerløw Aasland

Institution and Country Institute for Studies af the Medical Profession

Oslo. Norway

and

Institute of Health and Society

University of Oslo

Norway

Please state any competing interests or state ‘None declared’: None declared

1. As stated in my first review, this is truly a report from another world. Unfortunately, the authors also respond ”from another world” by concluding that the necessary measures to be taken for Chinese doctors to be more satisfied are reduction in workload, increase in salary, and more punitive measures against individuals who commit violent acts against doctors. Hence my hope that the interpretation and discussion of these data could be lifted up to a more systemic and political level proved futile. The authors still only discuss on a reactive and individual level.

Reply: We have not ignored systemic and political issues: the health reforms themselves are inherently political and systemic in nature and the paper focuses on the impact of the reforms. We mention the impacts of changes to health insurance which have made healthcare more accessible and hence increased workload, patients' (often unreasonable) expectations, inadequate government investment in healthcare, the absence of gate-keeping in primary care, as well as the public's distrust in primary care, which leads to massive demand at higher level facilities. All of these are underlying causes of doctors' dissatisfaction.

2. Why are they not interested in putting high workload, low pay and patient aggression into a broader perspective? They say in their comments to my intervention that ” the point of the paper was to quantify the problems discussed. The underlying causes and in-depth analysis will require qualitative research which we are currently undertaking” and this may of course be part of the reason for their reluctance to include a more systemic discussion. However, in the Introduction of the paper they (still) write: ” There is evidence that this situation is worsening, so urgent measures are needed to reverse this trend. Clearly, such measures need to include addressing the underlying causes of this discontent. The aim of this study was to explore these underlying causes through surveying the views of doctors working at three levels of the health system: tertiary, secondary and primary care.” Therefore, the paper does not hold its promise to explore the underlying causes. I don't agree that a discussion of the underlying causes and a deeper analysis will necessarily require another (qualitative) study; there are plenty of quantitative papers on this topic already. Here are two from our group:

Aasland OG, Rosta J, Nylenna M. Healthcare reforms and job satisfaction among doctors in Norway. Scandinavian Journal of Public Health 2010; 38: 253-8.

Voltmer E, Rosta J, Siegrist J, Aasland OG. Job stress and job satisfaction of physicians in private practice: comparison of German and Norwegian physicians. Arch Occup Environ Health 2012; 85 (7): 819-28.

The latter is also an example of how a common (validated) instrument for job satisfaction can be used for international comparisons.

Reply: See above for the response to the charge of not addressing underlying causes.

We cannot discuss or draw conclusions which don't come from our data. We have already put high workload, low pay and patient aggression into as broad a perspective as our data will allow. However, we have not attempted, for example, to unravel the complex societal causes of the Yi Nao phenomenon. We believe this is very important, but this is a first paper in this area, and we are currently conducting a further study which we believe is necessary to explore these issues.

In acknowledgement of this point, we have added a note in the conclusion on Page 25 to say that more research is needed to explore the underlying causes of doctor dissatisfaction in more depth.

With all due respect, the reviewer's own papers mentioned above, do little to illuminate the “underlying” causes of high job satisfaction of Norwegian doctors.

3. To follow up on the authors' reply to my review: I mention that that the paper may be more of local, Chinese interest than suited for an international audience, particularly since it puts so much emphasis on the differences between the three levels of health care in China. Their response to this is: "The differences between the three levels are crucial to our arguments. In the ongoing reforms the government is focusing on primary care. Our findings show a worrying situation of specialists' low work satisfaction, with systemic problems contributing to this phenomenon. On the positive side such findings can be used to encourage current/future medical professionals to become primary care doctors, and despite this being regarded as "lower level", the job can be very satisfying."

This is all good and well, but for me it indicates strongly that the target groups the authors have in mind are mainly the Chinese government and their Chinese medical colleagues. I would like to see better arguments for why an international reader must study 3-4 extensive tables where the main points are local variations on a sad theme.

Reply: The reviewer is correct that one of our purposes is to raise the awareness of the Chinese government and Chinese medical colleagues on this issue. We also believe that our findings are of interest to health workers and policy-makers in other countries which are facing difficulties in retention or recruitment of doctors, or which are facing problems of patient violence against health workers. We have to stress the different context of China, in order to make it understandable for an international audience. Just for the record, we don't think that the papers on Norway would be of more interest for an international audience than a paper on China. But we certainly acknowledge that there may be lessons about how to improve job satisfaction from the high levels in Norway (Page 25), so we have cited the reviewer's papers in support of this.

4. In my review I asked about the role of medical associations, and the authors confirm that "The Chinese medical associations have very limited power regarding the protection of health workers' interests". And they continue: "Medical associations are very rarely involved in medical disputes and are not seen as accountable in these situations by either the doctors or the public. The problems are seen as the responsibility of the employer i.e. the hospital. Because of this, further discussion on the role of medical associations is irrelevant for the context of this paper."

OK, but in my mind this piece of information is very relevant, particularly "for the context of this paper"! Here is a good opportunity to discuss some of "the underlying causes" a bit deeper, by including two important actors that seem to fail their responsibilities; the employers and the medical associations. By the way, the authors in they comment are not sure what I mean by "zero aggression campaigns". I actually borrowed the expression from their reference number 51:

CMA. United call for "Zero tolerance to medical violence" by Chinese Medical Association, Chinese Medical Doctor Association, Chinese Hospital Association and Chinese Health Law Society. http://www.cma.org.cn/index/xhdt/20131029/1383026180011_1.html (accessed 11 Feb 2014).

Reply: We agree (and it seems obvious) that "employers and medical associations fail their responsibilities" but we can't draw that conclusion from our data. We cannot make assumptions beyond what our data tell us. Zero tolerance to workplace violence policy has been proven as an effective way of preventing violence against health workers. This has a very different meaning from "Zero aggression campaign". Zero aggression campaign is based on the Zero Aggression Principle which means firstly "don't threaten or initiate force"; secondly "limit force to defensive purposes only".

5. Finally, I agree with the comments on method from the other reviewers (small and not representative sample, home-made job satisfaction instrument).

Reply: Little work has been done in this area before. We acknowledge that the sampling method is not ideal with the potential for bias, and the generalisability is limited. We have emphasised this in the limitations. However, a sample of 202 doctors from 10 health facilities from all three different levels of hospital and in areas across a range of socioeconomic status, does provide insight into the experiences and attitudes of doctors.

Regarding the instrument, while we drew on existing international validated questionnaires for most of the items, this risk excluding key information for the Chinese context. So we added some items, for example, about the bonus system and violence. We think the individual items are more important and indicate what specific aspects of doctors' work are contributing to job satisfaction.

6. Between the lines of my comments above can be read a disappointment in receiving a revision almost identical to its first generation. But I am aware that my comments call for a change in perspective, from national to international, and from individual to political. A more fundamental revision in other words. It must now be up to the Editor to decide whether this is interesting and/or viable.

Reply: A fundamental revision along the lines suggested is an entirely different paper requiring a different study. We have written this paper based on the data collected and the local context, just as the reviewer himself did for his articles about doctor job satisfaction in Norway. Indeed his own papers don't address "the change of perspective" which he is expecting from us.