Author's response to reviews

Title: General practices’ beliefs about effectiveness and intentions to recommend smoking cessation services: qualitative and quantitative studies

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Author's response to reviews: see over
Dear Dr Lolu da-Silva,

General practices’ beliefs about effectiveness and intentions to recommend smoking cessation services: qualitative and quantitative studies

Please find attached a further copy of this manuscript revised to take account of the comments we received from yourself and the reviewers. These were very helpful and in our view have improved the quality of the manuscript. We will first of all respond to the comment made by yourself and than move on to describe how we have addressed the additional comments made by the reviewers.

Comment 1. Include statement regarding informed consent in the methods section:
- Amendments to address this issue have been made in the manuscript.

Responses to comments from Andrew Wilson:

Comment 1. Complexity of stop smoking services:
- Reviewer Andrew Wilson is right in highlighting that practice nurses are being trained by the central services. Such training, formally referred to as Level 2 support, usually involves a one-day training session at the PCTs’ central services. PCTs also offer booster sessions for already trained Level 2 advisors and try to provide continued support.
- It was our intention to draw attention to the fact that current evidence suggests that group support, which is usually provided by the central services is more effective than one-to-one support. The reasons for this difference are not well understood but might be related to better training of the smoking cessation advisors at the central services, as these are full-time advisors trained to Level 3 standards, and the group support itself (see McEwen et al 2006).
- We have amended the relevant sections for clarification and to incorporate these comments.

Comment 2. Clarification about group versus individual support:
- Amendments to address this issue have been made which include the re-labelling of NHS clinics to central support services.

Comment 3. Additional information for table 3:
- Twenty-five (6.8%) GPs did not intend to recommend central or local support to their patients, whilst 104 (28.3%) intended to recommend both. Because there is a total of nine potential combinations between the coded categories (intend, neutral, do not intent) and the inability to clearly represent this in the table, we have decided not to include this information in the analysis of the manuscript.
- Unfortunately data are not available on the extent to which GPs perceived that no local services were available to them. We did ask whether a practice nurse trained in smoking cessation was working at the practice but local services were specified as including pharmacists trained in smoking cessation as well. However, of the 135 GPs who did not intend to refer to a local service, 85 had a practice nurse trained in smoking cessation at their practices suggesting that non-availability of a local service does not account for the majority of intentions not to refer.

Comment 4. No GPs with negative view about support services in study 1:
In study 1 the negative views about the effectiveness of the central support services are documented through the expressed lack of personalized attention that GPs expected smokers to receive from such services, and through the difficulties of accessing the central services. The latter was thought to lead to lower enrolment generally, enrolment at a time when motivation levels had already dropped, and higher drop-out. Although other reasons were mentioned by individual GPs in the interviews, including negative views about local services (e.g. not skilled enough, rely too much on protocols), they were not judged as warranting representation through independent themes and were therefore not retained in the results.

Comment 5. Rearrangement of discussion, e.g. top of p14:
- Amendments have been made to address this.

Responses to comments from Tim Lancaster:

Comment 1. Shortening for readability:
- We have tried to attend to the comment made by Tim Lancaster and shortened the article where we deemed appropriate without changing the message of the manuscript.

Responses to comments from Anja Schumann:

Comment 1. Re-organization of methods section:
- We agree that the manuscript gains clarity by a brief section describing the design of the studies. We have included sections describing the design of each study at the start of each respective methods section. We felt however that making additional changes to the layout did not improve readability of the manuscript. The aims of each study immediately precede the methods section of each respective study.

Comment 2. Why was bootstrapping used:
- Bootstrapping was used because it is a nonparametric method and thus provides estimates that are independent of the assumptions of normality. There were small deviations in some variables as stated in the manuscript. Bootstrapping also allows the calculation of significance for the indirect effects. As mentioned by Anja Schumann, bootstrapping may also be used when sample sizes are small. This was not the case in the current study. Recommendations for path analysis suggest sample size of at least 10 times the number of parameters (Kline, 1998). In the current study 20 parameters are calculated (incl. direct, indirect, and total effects) requiring a sample size of only 200 participants.

Comment 3. Hypothesis for relationships between beliefs are not spelled out; could a simpler analysis be used:
- The specified paths between the beliefs in the paths analyses follow the logical principle of study 1. Both perceived sufficient personalization and perceived low-attendance were mentioned by GPs as factors influencing their perceptions of the effectiveness of the local support and of the support received at the central support services (i.e. NHS clinics). Similarly, GPs mentioned in study 1 that they believed the services to be cost-effective because they saved people’s lives (i.e. because they are effective at helping people to stop smoking). This is in line with our perspective, in that a perception of cost-effectiveness is necessarily preceded by the evaluation of its effectiveness and monetary cost. Unfortunately we did not measure perceived monetary cost. We perceived that individually spelling out the hypothesis for each path
would be too lengthy and repetitive for this manuscript and have hence refrained from doing so.

- Path analysis assembles the variables usually seen in an unstructured and one-dimensional form in multiple regression analysis into a structure of presumed causal paths between the variables. The variables thus form a set of presumed causal sequences and are laid out in a path diagram for clarity. Path analysis helps to organise causal thinking and adds valuable information in terms of the structure of beliefs described above. Path analysis requires prior commitment about the appropriate causal ordering of all the variables included. It follows that the presumed links between variables are thereby tested and can be refuted. If not refuted, they stand as compatible with the hypotheses. That path analysis does not prove the validity of a causal model is therefore a valid and important point made by Anja Schumann. We did not try to give the impression that it does. To highlight this we have added a sentence in the discussion to emphasise this (p. 16, lines 12-13). We strongly argue however that path analysis is retained in this manuscript because without it the structure of different beliefs and intentions, cannot be accurately captured. Path analysis, supported by the use of bootstrapping, efficiently and reliably tests the direct and indirect relationships between the respective variables.

Comment 4. Did the authors create a sum score of the two intention items for the path analysis:

- No, the mean between the two intention items was used in order to retain the ability to interpret the unstandardised paths.

Comment 5. Mix-up of terms:

- Amendments have been made in the manuscript to remove the confusion of terms.

We look forward to hearing from you.

Yours sincerely,

Theresa Marteau        Florian Vogt        Sue Hall