Author's response to reviews

Title: A comparison of patient recall of smoking cessation advice with advice recorded in electronic medical records

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Dear Dr Samet

Thank you for the reviewers' comments on our article which compares rates of recording of smoking cessation advice amongst patients in a large, nationally-representative, UK primary care database (The Health Improvement Network), with rates of patient recall of cessation advice from a national survey.

We have made a number of changes to our paper to address these comments, which are detailed below and highlighted in red in our manuscript.

We hope that the changes we have made to our paper are satisfactory, but should you require any further amendments then we would be happy to make these.

Yours sincerely,
Lisa Szatkowski

Comments from the Associate Editor:

"In addition to the comments of the reviewers, the findings need far more in-depth consideration in the discussion. The manuscript provides results from two indicators for the offering of smoking cessation; neither can be considered as the "gold standard". Physician documentation was clearly responsive to the change in billing and may be over-reported. The patient reports are subject to misclassification, likely in the direction of under-reporting. Additionally, the response rate to the survey is poor and potential information bias that is variable over the years cannot be excluded. Given the differences in the measures, comparability would not be anticipated. The manuscript needs to give more emphasis on the question of which is the best indicator for quality of care".
We agree that both indicators (GP entries in medical records and patient reports to questionnaire surveys) cannot be considered as a ‘gold standard’ for monitoring the provision of smoking cessation advice from GPs to patients. Indeed it is likely that neither are entirely suitable for purposes of monitoring this aspect of GPs’ clinical behaviour and this is likely to be particularly so under the QOF where such monitoring determines payments to GPs. Rather we have compared two sources of information on GPs’ advice to patients over the period that the QOF was introduced and have provided an interpretation for differences observed between these two data sources over time. We do not propose that either method should be used as an indicator for quality of care, rather we discuss the pros and cons of each and invite the reader to form their own decisions on this matter. In addition to the changes made below, we have now highlighted the limitations of both data sources in the abstract conclusion.

Reviewer: Fong-ching Chang

“There is a need to describe how GPs provide cessation services. Is the intervention the same from 2000 to 2009? This might influence patients’ recall. There is also a need to further describe financial incentive for recording of cessation advice.”

We have added a sentence to our introduction describing how GPs provide cessation advice – usually as a simple intervention lasting no more than one or two minutes during the course of a routine consultation. We state that the financial incentive to record patients’ smoking status was introduced in 2004 and has not changed since, and add a sentence to clarify that before this point in time GPs were still able to advise smokers to quit and record this in their notes, though there was no financial incentive to do so. We have added to our explanation of the financial incentives for the recording of cessation advice and now detail the specific medical conditions this relates to. We also give an indication of how much money this incentive is worth to a practice. We provide a reference readers can use to seek further information should they so desire.

“It is problematic that the Patient Survey did not collect the information of patients’ smoking status. The results were not adjusted by smoking status. Since smokers tend to have lower response rate, this might underestimate the prevalence of recall of cessation advice.”

We now acknowledge this limitation in our discussion.

“Since there are lots of reasons that may influence the results, the conclusion needs to be more conservative. The conclusions may not be adequately supported by the data.”

We believe that, with the suggested changes made to the manuscript, this now more clearly describes the strengths and limitations of our analyses and the discussion and conclusions are appropriate.
Reviewer: David DB Coultas

“Methods, first paragraph: Have there been any smaller scale direct observation validation studies conducted of the Read codes? If so, it would be useful to reference. If not, this may deserve greater consideration in the discussion.”

To our knowledge there have not been any direct observation validation studies conducted of the cessation advice Read codes, and we now consider this in our discussion.

“Discussion, paragraph 5: The discussion may be strengthened by greater consideration of the literature on discordance between patient and physician recall of smoking cessation advice. For example, longer duration of advice and visit type may be associated with recall (Flocke, Stange. Prev Med 2004;38:343-9).”

For this manuscript, the most important aspect regarding recall of smoking cessation advice is to consider whether factors influencing this might have changed between Patient Survey years. We have considered this carefully but have not made a detailed review of the factors which impact on concordance of recall. However, we do feel that we have summarised succinctly the literature on concordance of recall, offering potential explanations for the discordance between patient and physician recall of smoking cessation advice, and have provided a number of links to relevant research should the reader wish to follow these up.

“Discussion: The results of this analysis call into doubt the effectiveness of the financial incentive to promote smoking cessation advice and thus have major public policy implications. However, the ultimate effectiveness of the incentive policy is the prevalence of smoking, which decreased during the period of this analysis, and not patients’ self-report of receiving smoking cessation advice. Therefore, the relevance of these results may be questioned by some and this issue deserves greater consideration in the discussion.”

Thank you for the suggestion that our results call into question the effectiveness of the financial incentive to provide smoking cessation advice. We agree this is an important point and now discuss this in our article.

Whilst we agree that the ultimate effectiveness of such an incentive can be measured by a reduction in the proportion of people who smoke, smoking prevalence was declining in the UK before, as well as during, the period of analysis and a number of other tobacco control interventions which might impact on prevalence were introduced. It is, therefore, impossible to say whether any decline in prevalence after 2004 was attributable to the financial incentive, or whether it was just the continuation of a longer-term trend. For this reason we have chosen not to consider this issue in our discussion.
“References, #11: This reference is not in J Epidemiol Community Health or in PubMed.”

This reference cites a peer-reviewed conference abstract published in a Supplement to the Journal of Epidemiology and Community Health, and is available online.