Author's response to reviews

Title: Beliefs about Breast Cancer Screening: Does Practice Location Matter?

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PDF covering letter
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Dear BMC Public Health editors:

We are pleased to resubmit our revised manuscript “Beliefs about Breast Cancer Screening: does practice location matter?” You will note the change in our the title from “Approaches to Breast Cancer Screening: does practice location matter?” based on reviewer input.

We have included a point by point response to the reviewers comments (following this letter). We have also included additional figures which serve to emphasize major points.

We are submitting this revised manuscript electronically. The address for correspondence, as noted on the manuscript is:

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Thank you for your review. We look forward to your response.

Sincerely,

Martin C. Mahoney, MD, PhD, FAAFP
Chair Clinical Prevention

Revisions point by point
Beliefs about Breast Cancer Screening: does practice location matter?

Reviewer: David Gregorio

1. The words “provider related factors” have been removed from the stated purpose. Our manuscript concentrates on variations in reported beliefs about breast cancer screening among urban, suburban, and rural primary care providers. This represents a unique analysis of beliefs about breast cancer screening among the primary care clinician (MD, NPs and PAs) in these communities. (see page 1)

2. The introduction has been condensed, sections eliminated and information on guidelines highlighted. (see page 3 and 4)

3. The focus of this manuscript is on variation and not on “correct” or “incorrect” responses. We defined one “accepted” response to each item to serve as a basis from which to examine both dichotomous and polychotomous responses. While others might debate which response category is “acceptable”, the fact that responses are distributed across several categories is more noteworthy. That is, regardless of the category selected, variation in responses is apparent. It is worth mentioning that the response option which we designated as the “accepted” answer was generally observed to represent the modal response.

4. Analysis is based on primary care practice location- that is where clinical practice actually takes place. This is justified by considering that patient populations generally seek care in areas proximate to their residence.

5. The issues of sampling is addressed and expanded in the manuscript. (see page 4) Mailing addresses were obtained from the provider directories of a major regional health maintenance organization (HMO), supplemented with mailing lists from the Nurse Practitioner Association of Western New York (NPWNY), and the Western New York Physician Assistants’ Association (WNYPAA). Western New York is among the top communities in the US for Health Maintenance Organization (HMO) penetrance. For this reason, nearly all primary care providers are included in HMO practitioner mailing lists, thus we believe we have successfully solicited the target population to respond to our survey.

6. The focus here is to address variation in primary care practice. Although we agree it would be an interesting and important addition to this manuscript we do not have data on primary care practitioners acceptance of the various guidelines. Such a study would require chart review which is beyond the scope of this study.

7. The description of western New York has been shortened.

8. The number of responders has been clarified in the text. (see page 9) Of the 469 respondents, the following respondents were also excluded from analysis:
   - Persons reporting their clinical practice site outside of WNY (n = 9)
   - Persons reporting less than one year in clinical practice (n = 26)
   - Persons who did not self-identify as “residents”/“trainees”, but reported that they were neither “board-eligible” nor “board-certified” (n =1)
Persons were excluded because clinical practice site zip codes were not available (n=5). (428 complete/433 (98.9%). Thus, analyses were based upon responses from 428 practitioners: 179 physicians, 185 nurse practitioners, and 64 physician assistants.

9. Issues of sampling and generalizability are addressed in the manuscript. (see page 4 and page 13)
Beliefs about Breast Cancer Screening: does practice location matter?

Reviewer: Cathy Coyne

The manuscript has been expanded to include more specifics in the methods in order to allow for replication.

1. As suggested the title has been changed.

2. The issues of sampling is addressed and expanded in the manuscript. (see page 4) Mailing addresses were obtained from the provider directories of a major regional health maintenance organization (HMO), supplemented with mailing lists from the Nurse Practitioner Association of Western New York (NPWNY), and the Western New York Physician Assistants’ Association (WNYPAA). Western New York is among the top communities in the US for Health Maintenance Organization (HMO) penetrance. For this reason, nearly all primary care providers are included in HMO practitioner mailing lists, thus we believe we have successfully solicited the target population to respond to our survey.

3. The re-classification of zip codes from urban to suburban has been carefully explained in the text. (see page 7) Although five zip code areas in Erie and Niagara Counties had population densities exceeding 100 persons/mile² (Hamburg [1050.4/mile²], East Amherst [1068.5/mile²], North Tonawanda [1222.5/mile²], Tonawanda [3027.8/mile²], and Depew [3269.1/mile²]), they were classified as suburban areas for this study. These areas are distinctly separate from the urban centers, moreover these communities have higher socio-economic status and are not burdened with the problems often associated with urban areas. Based on these changes, 17 clinicians were reclassified (4%, 17/428).

4. An expanded description of the three mailings has been included in the text. (see page 5) An initial mailing to primary care physicians and non-physician clinicians (nurse practitioners and physician assistants) was performed in February 2001, followed by two additional mailings to non-respondents at 4-week intervals. The first follow up mailing was the same as the initial mailing and included an additional copy of the questionnaire. The third mailing was a postcard reminding clinicians to return their surveys.

5. The implications of the response rate have been clarified. (see page 12) While a potential limitation of this study is the low response rate (29.6%), it is comparable to the lower range of response rates of health care providers reported in a review article of this topic [23]. Our study relied upon a passive response system without any financial inducements for completing a multi-page mailed survey. The response rates of all of the geographic regions surveyed were similar.

6. The methods of calculating the response rate along response rate have been clarified. (see page 8) The overall response rate for the questionnaire was 29.6% (n = 469/1582). This represents all of the surveys that were sent out and not otherwise returned because of an incorrect address.

7. Beliefs have been examined separately by clinician group in the text and in the added figures. (see page 11 and figure 3) There was no overall significant difference in
agreement with three or more items by professional group. The distribution of scores for the summary index differed only between physicians and NPs (p=0.017).