Reviewer's report

Title: Approaches to Breast Cancer Screening: does practice location matter?

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Reviewer: Dr Cathy Coyne

Level of interest: A paper of limited interest

Advice on publication: Unable to decide on acceptance or rejection until the authors have responded to the compulsory revisions

Examination of differences among urban, rural, and suburban practices of primary care providers regarding breast cancer screening is very important. As the authors state in their manuscript, persons in rural areas tend to have higher mortality rates of certain cancers, including breast cancer. However, I have concern whether the manuscript, as written, adds significantly to our understanding of this problem. I encourage the authors to consider my comments and make revisions to their manuscript to address them. As written, the paper does not provide sufficient detail for others to replicate it, nor does the reported outcome of the study address the question regarding provider practice. All of the following suggested revisions are considered compulsory.

Study purpose and methods:

1. The title and the stated purpose of the study noted in the abstract imply that the results suggest what primary care professionals use as approaches to breast cancer screening their patients. However, the way in which the authors describe the wording of the questions, the responses to which comprise the results section of the manuscript, and the basis of the authors' discussion. However, as I read the questions reported in paragraph 3 of the methods section, it appears that they are inquiring about beliefs rather than practices. For example, one item reads "At what age should an average-risk woman initiate screening for breast cancer using clinical breast examination?" It does not ask "At what age do YOU initiate screening for breast cancer for an average-risk patient using clinical breast examination?" As stated by the authors in the paragraph above the Methods section "multiple factors contribute to practitioner compliance: provider related, guideline related, patient related, and environment related variables." Thus, although a practitioner may agree with a certain "approach", his or her actual practice may be quite different. I suggest that the authors clarify what they mean by "approach" and reconsider how responses to the multiple choice items inform our understanding of the "breast cancer screening practices" of providers.
2. It is not clear to this reviewer why the sampling frame for physicians was a major regional health maintenance organization. What proportion of the rural population are members of this particular HMO? Why did the investigators not choose to use the NY Board of Medicine or medical society? How might this effect the study outcomes? This should be discussed. It is also not clear if the investigators excluded providers who see mostly pediatric patients, which may significantly affect their responses. This should be reported.

3. Although the authors described how practices were categorized into urban, suburban, and rural areas, the scientific rationale for using "local opinion" as a reason for categorizing some areas as suburban or rural when their population density suggested otherwise was not fully explained nor justified. This would limit the ability to replicate the study - who's opinion should be considered? A standard approach to categorization is more acceptable.

4. In the first paragraph of the methods section, the authors state that they sent out a mailing in February 2001 followed by two additional mailings to non-respondents at 4 week intervals. Did these follow-up mailings contain only a letter or did they also contain another copy of the questionnaire? Who were the letters from? More details on the methodology used would be helpful.

Results and discussion:

5. Although the authors address the fact that the response rate is quite low (29.6%) they state that this is "comparable" to the response rates of other health care provider surveys as reported in a review article (Kellerman and Herold, 2001). However, the cited article, reporting on studies that examined ways to increase response rates in provider surveys, reported that the studies reviewed obtained response rates ranging from 14% - 98%; few articles reviewed had response rates of less than 30%. In addition, Kellerman and Herold cite a study that examined the response rates of 321 mail surveys and found that the mean response rate of physician surveys was 54%, much higher than the response rate reported in this study. In addition, because the authors do not provide any information about the non-respondents, it is not clear that they do not differ from the respondents. I suggest that the authors provide information on the non-respondents (e.g., for physicians - specialty, location of practice - if possible). The implications of the low response rates need to be discussed in greater detail.

6. In reporting the response rate, the authors did not note whether any of the addresses they had were incorrect, resulting in returned, unopened surveys, which would affect the response rate. This should be reported.

7. The authors suggest in the Discussion section that one of the strengths of the study is that it included physicians, nurse practitioners, and physician assistants. I agree. Yet the authors do not report on the beliefs (and practices) of any of these groups independently, only in aggregate. An interesting question to answer with these data would be "how do these three provider groups differ" in their attitudes, beliefs, and/or practices regarding breast cancer screening. It is not clear why the data were not analyzed in this way, only in aggregate. Some of the demographic and practice characteristics of the respondents (Table 1) may be explained by such analysis. In addition, some of the variation between rural, suburban, and urban practices may be explained by profession.

Competing interests:

None declared.