Author's response to reviews

Title: Determinants of tobacco counseling among Hispanic physicians in the US: a cross-sectional survey study

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Author's response to reviews: see over
RESPONSE TO REVIEWERS COMMENTS

MS: 3939237111370940 - Predictors of tobacco counseling among Hispanic physicians: a cross-sectional survey study
(In response to a reviewer’s comment, the new title is:
Determinants of tobacco counseling among Hispanic physicians in the US: a cross-sectional survey study)

Dear editor,

We want to thank you and the reviewers for the constructive feedback we received on our manuscript. We feel that we have properly addressed all comments, and that the manuscript has been considerably improved. To reflect the reviewers’ comments we substantially expanded the data analysis and results sections, added 15 references and 3 tables, edited the entire manuscript, and revised the references to address formatting issues. Let us know if further revisions are necessary. Please find below our point-by-point response to the reviewers’ comments.

Reviewer 1: Corinne G Husten
Reviewer’s report:
General: Measures of physician barriers to providing cessation services has been well researched, although this study looks specifically at Hispanic physicians, which is a new approach.

Major Compulsory Revisions

1. Important and widely cited measures of provider barriers have been left out, such as lack of time, lack of reimbursement, concern about patient response.

Response: We agree that system-related issues, such as lack of time and lack of reimbursement are important and widely cited barriers to physicians’ counseling. Furthermore, the results of our previous study identified them as relevant factors related to Hispanic physicians’ counseling practices. Consistent with this, we concluded “that both systematic and individual approaches need to be incorporated into [physician tobacco counseling] training programs” (Soto Mas et al., 2005). As indicated throughout the manuscript, the present study reports on the results of additional analyses conducted on data which we previously reported in BMC Public Health. We have tried to avoid duplication of information, and instead we refer the reader to the previously published article. However, we agree with the reviewer that this may constitute relevant information, and should be mentioned in the present study. In the “Introduction,” first paragraph, we added two sentences and four references to address this comment.
2. In my view, the measure used for self-efficacy is not appropriate. Provider self-
efficacy should measure their confidence or comfort in providing the service(s),
not their confidence in a patient's response to treatment. The relapse rate is very
high for any individual quit attempt, so reporting that they are not confident that
they can get a person to quit just reflects reality. Two of the three measures of
self-efficacy are not cessation constructs. Confidence in ability to reduce
consumption is an inappropriate measure since multiple studies have shown that
even 50% reduction in consumption provides no improvement in mortality.
Counseling for reduction of consumption is not recommended in any guideline.
Also ability to get patients to reduce exposure to SHS is important, but not a
cessation measure.

Response: Whether perceived outcome expectations are related to behavior is
an issue which has been discussed in the literature, and which we debated when
constructing the instrument. We appreciate the opportunity to discuss it further in
this review. To clarify the issue, we added a sentence and three references (25-
27) under “Instrument,” second paragraph.

According to Bandura (1977), self-efficacy is one's confidence in attaining a
desired level of performance in a given endeavor. Self-efficacy has been
considered and studied both as a theory and as a key construct within other
theories and models. This is due to the difficulties researchers have found in
explaining and predicting human behavior, and to the fact that human behavior is
determined by a variety of factors. Thus self-efficacy has been integrated into
several popular theoretical approaches (e.g. Health Belief Model, Social
Cognitive Theory, Transtheoretical Model) which have shown certain success in
explaining behavior, and have been widely applied in health as well as other
fields such as education. These approaches generally connect self-efficacy with
outcome(s). For instance, the Social Cognitive Theory defines self-efficacy as the
“competence” to perform a certain task or behavior. People’s competency is
referred to as “efficacy expectations,” or the ability to perform an action.
According to the Social Cognitive Theory, efficacy expectations are determined
by “outcome expectations.” In other words, people’s self-efficacy regarding a
particular behavior may be determined by their expected outcome (See
discussion by McKenzie & Jurs, 1993). This perspective which relates self-
efficacy, behavior, and expectations is supported by recent research in
education. Tschannen-Moran and Woolfolk Hoy (2007) proposed that efficacy
beliefs are raised if a teacher positively perceives the outcomes to be achieved.
Landon, Ehrenreich, and Pincus (2007) go even further, and propose that self-
efficacy refers to the perceived ability to produce a particular outcome,
regardless of one’s actual abilities to perform the task. We completely
understand the reviewer’s comment regarding the appropriateness of the
questions, but also believe that our approach is sufficiently supported by the
literature. Additionally, we would like to point out the positive results of the
psychometric testing performed on the instrument, which is reported in our
related published article (Soto Mas et al., 2005).
As regards the comment on the relapse rate, we also agree that quitting smoking is a process that in most cases requires several attempts to achieve success. However, the literature suggests that physician’s advice encourages quitting attempts, and the recommendation is that physicians provide cessation counseling during every visit, independently of patient’s history of attempts (DHHS, 2000).

Regarding the comment on consumption and secondhand smoke, as indicated in the title and throughout the manuscript, this study explored tobacco counseling practices in general and not only smoking cessation. Both cigarette consumption and exposure to environmental tobacco smoke are important when addressing tobacco use prevention and control, and are associated with smoking cessation. It is recommended that physicians assess tobacco use status and nicotine dependence, both of which are associated with consumption. Similarly, smoking fewer cigarettes has been associated with successful smoking cessation (Hymowitz, et al., 1997), and reduced consumption with an increased probability of cessation (Farkas, 1999). As regards environmental tobacco smoke, studies have found that the environment is a significant factor related to addictive behaviors (Oxford, 1985), that living with other smokers lowers the likelihood of quitting, and that smoking bands are significant predictors of successful quitting (Please see recent discussion by Lee and Kahende, 2007).

3. Very similar constructs are included under attitudes (whether they perceive their intervention practices as being successful in increasing quit rates) and self-efficacy (confidence in being able to get smoking patients to quit their habit). The same construct should not be used in both categories.

Response: We disagree with this comment. Attitude is a state of mind or a feeling; a positive or negative disposition to— in this case— provide tobacco counseling. Self-efficacy is related to confidence, capabilities to produce effects. We believe our questions were properly worded to reflect the difference.

4. It is unclear how representative the members of the Hispanic Medical Society are to the overall Hispanic physician population in NM and how representative the NM Hispanic physician population is to Hispanic physicians nationally, yet conclusions are drawn for "Hispanic physicians."

Response: Thank you for the comment, it is an important issue. We were sensitive to the small sample size in the study, as discussed in “Limitations.” Consistent with this, throughout the manuscript we state the purpose of the study to be “exploratory.” However, we do consider the sample size of the study to be sufficient to warrant the publication of its results. We did estimate how well the NMHMS represented the Hispanic physician population in NM and nationally at the time of the study. We added several sentences in “Limitations” and three additional references (46-48) in this respect. Additionally, when reporting and discussing the results of the present study we have used “respondents” or “participants” instead of the general term “Hispanic physicians.” In “Discussion,” first paragraph, we added a sentence to further clarify the exploratory nature of the study “Despite the exploratory nature and limitations of the study...”

5. Provide the time frame for the study. Given the guidelines cited, it appears that it is more than 6 years old. If so, explain relevance today.

Response: We added the time frame for the study under “Methods,” paragraph 1. Data were collected in 2000-2001, and the analysis completed in 2002. We did conduct a new literature review, and we also updated the references prior to this submission to ensure the relevance of the results presented in this manuscript. Twelve references are dated after 2004. Our recent review of the literature confirmed the lack of studies exploring the tobacco counseling practices of Hispanic physicians, and the predictors of tobacco counseling among this important group of providers. This study contributes to the literature in this respect. Additionally, we also believe that the preliminary data presented in this exploratory study will encourage future research. Finally, we updated the references once again prior to this resubmission.

6. The familiarity with most population smoking cessation protocols and theories includes one very old manual (published over a decade ago). The authors cite
the AHRQ guideline (1996), but there is no mention of the 2000 update (published as a PHS guideline).

Response: We agree. We neglected to mention the updated version in the manuscript, and we added a sentence to this regard under “Instrument,” third paragraph. However, we do not think the issue is relevant to the results of the study, as the question did not include the publication date, but rather only the title of the guide (“Treating Tobacco Use and Dependence: Clinical Practice Guideline,”) which was not changed in the 2000 update.

7. Two of the sources asked about are resources in the community or self-help materials (pregnancy related). While knowledge of community resources could be an important measure, self-help materials are not an effective intervention (AHRQ guideline) and there are a lot of self-help materials out there. Thus it is unclear why a pregnancy-focused one is considered so important and given equal weight to the AHRQ/PHS guideline. I would recommend that the authors only examine whether the physicians are familiar with the PHS guideline and stages of change model.

Response: The question assessed physicians’ knowledge of smoking cessation resources. These two education modules were widely disseminated and promoted to clinicians, and we wanted to explore whether respondents were familiar with them. Under “Results,” fourth paragraph, we report on the distribution of responses to the question by individual protocol/module.

8. Physician self-report of their counseling practice behavior is not a very accurate outcome measure.

Response: We discuss the issue in “Limitations,” and include a related citation.

9. The nine items used to assess counseling practices are not provided, so their appropriateness and validity cannot be assessed.

Response: As indicated previously, we tried to avoid duplication of information, and rather refer the reader to our previous publication on the study (which discussed in detail the nine items used to assess counseling practices). The two manuscripts have a different focus.

10. I could not reproduce the response rate. The table looks like 55 physicians responded (out of 81 eligible).

Response: The response rate was 55.5%. Forty-five physicians responded (out of 81 eligible). We believe the table is correct.

11. The recommendations call for training physicians. However, the authoritative guidelines (community preventive services task force, PHS guideline) do not
recommend provider training alone as an effective intervention. Both the PHS cessation guideline and the Community Guideline with note that systems changes, such as provider reminder systems, are essential to improving intervention rate by physicians. The Community guide recommends either reminder systems alone or reminder systems with provider training as the effective interventions but states there is insufficient evidence of effectiveness for provider training alone.

Response: See Response to comment # 1. Additionally, we added a sentence in “Conclusions” to reinforce the need for system-based approaches.

Specific comments

12. Page 2 (abstract), para 1: There have been improvements in getting physicians to “ask” and “advise” that should be acknowledged (see HEDIS measures, see AHIP studies). Providing “assistance” remains poor.

Response: The most recent reports from America’s Health Insurance Plans (AHIP) and the National Committee for Quality Assurance (NCQA) –which manages the Healthcare Effectiveness Data and Information Set (HEDIS)- have only reported very modest improvements. Additionally, these reports are based on data provided by health insurance plans, not from physicians (Please see McPhillips-Tangum C, Rehm B, Carreon R, Erceg CM, Bocchino C. Addressing tobacco in managed care: results of the 2003 Survey. Preventing Chronic Disease, Public Health Research, Practice, and Policy, 2006, 3(3):1-11; The state of health care quality 2006. National Committee for Quality Assurance. Washington, D.C., 2006). There exists a consensus in the literature on the lack of significant improvement in tobacco counseling and smoking cessation by physicians. In the introduction we provide literature to support this. However, we do agree that a modest improvement may be reported. We revised the sentence in both the “Abstract” and “Introduction.”

13. Page 4, para 1, line 2: As noted above, “ask” and “advise” have improved. Also, your reference is a study done from 2001-2004, which cannot provide evidence for a statement about “last decade”

Response: Please see Ref. # 1. Although the study was conducted in 2001-2004 and published in 2006, it concluded that the results “vary little” from previous studies conducted in early 1990s. We did add another reference from a study assessing practices between 1991 and 1995.

14. Page 4, para 1. Important barriers are not mentioned (lack of time, lack of reimbursement, concern about patient response). Please also improve references. Although much of this work was done 20 years ago, there were a lot
more studies on provider barriers. Also, I believe there are newer studies, which should be included as references.

Response: See Response to comment # 1 above. We have already addressed the comment.

15. Page 6, para 1: How many Hispanic physicians are practicing in New Mexico? What proportion of Hispanic physicians are members of the NMHMS? How representative are these physicians to the overall Hispanic physician population in NM, in the U.S.?

Response: See response to comment # 4 above. We have already addressed the comment.

16. Page 9, para 2: What was the percentage compliant with guidelines?

Response: See Response to comment # 9 above. We added the data under “Results”, “Descriptive statistics,” paragraph 2.

17. Page 12, para 3, line 3: Reference about school programs seems inappropriate. Also, if formal programs do not change physician practices, why are you recommending training?

Response: We disagree. The paper relates to physicians’ practices, the topic of this study. We believe the reference is appropriate. We do recommend training, but, as is consistent with the results of our study, we describe the specific components which may be included in the training in order to make it more effective in promoting counseling (Please see “Conclusions”).

18. Page 13, para 3: mention study was limited to members of the Hispanic Physician Medical Association. Need to discuss implications for representativeness and any conclusions drawn in the paper.

Response: See Response to comment # 4 above. We have already addressed the comment.

19. Page 13, para 3: If a considerable number of Hispanic physicians in the US were educated in Latin America and Spain, why were rates so low in this sample? Serious implications for generalizability of the findings to Hispanic physicians overall.

Response: This is an important issue we discuss in “Limitations.”

Minor Essential Revisions
20. Page 2 (abstract), para 2: The abstract needs to mention that these were Hispanic physicians who were members of NMHMS.

**Response:** We made the change as recommended.

21. Page 4, para 2, line 9: Please cite references other than the authors of the current manuscript.

**Response:** As indicated throughout the manuscript, there is no literature on this topic, in this population, other than the previously published study conducted by members of this research team.

22. Page 4, para 2, line 10: Unclear how reference citing prevalence estimates support a statement that tobacco is a public health priority among Hispanics (especially since Hispanics tend to have lower prevalence than whites, black, American Indians/Alaska Natives). Please provide other references to support this statement.

**Response:** These references indicate that there are more than 6 million Hispanic smokers in need of assistance in the USA. We revised the sentence to add this information.

23. Page 4, para 2, line 11: Please reference statement about Hispanics being less likely to receive advice to quit.

**Response:** We made the changed as recommended.

24. Page 7, para 2: reference the protocols and theories listed

**Response:** We revised the paragraph and provided a link to access the cited protocols (we believe this is more practical than actual references. We also added a reference for the TM.

28. Page 7, para 2, line 6: typographical error – should be “Start”

**Response:** We made the change as recommended.


**Response:** Although HP 2010 includes an objective related to smoking cessation counseling by health care providers, it does not specify a measure. HP 2000 does include the specific measure we used in our study (Please see HP 2010 objective 1.3c. Available at: http://www.healthypeople.gov/Document/HTML/Volume1/01Access.htm#_Toc489432813).
30. Page 12, para 2, line 4: Need more references. Out of the 7, one is on developing survey measures, one is about nurses, 2 are about pediatricians so relevance to current study is more peripheral

**Response:** We believe the references are appropriate, and support studies that have explored the correlation between variables we include in our study.
Reviewer 2: Elaine Puleo  
**Reviewer's report:**  
**General**  
None  

**Major Compulsory Revisions**

1. Although results from this survey have been published elsewhere, it should not be the duty of the reader to hunt for pertinent information. Information concerning the research design needs to be more specific. Information about your primary outcome variable, tobacco-related practices needs to be provided—this would be distributional assumptions and some characteristics of the distribution itself (mean, median, sd, range etc.).

**Response:** As indicated previously, we tried to avoid the duplication of information already presented in our previous publication, and that we feel do not contribute to the present study. However, we agree with the reviewer that more information on the methods and results should be included. Under “Results-Descriptive statistics,” second paragraph, we added several sentences reporting on the results of our previous study (counseling practices). Additionally, we added a paragraph and three new tables reporting on additional data analyses we conducted including frequency and score distributions and factorial ANOVAs.

2. Table 1 is a result and should be moved to that section and discussed as such.

**Response:** We made the change as recommended.

3. Because you have such a small sample population and your response rate is low, was there any testing of whether your sample was a) representative of the full population wrt demographics of Hispanic physicians in New Mexico and b) if there were significant differences between respondents and non-respondents and/or initial respondents and later incentivized respondents?

**Response:** Please view response to comment # 4, Reviewer 1. We agree with the comment and added information in this respect. Regarding differences between respondents and non-respondents, unfortunately the NM Medical Association’s database we used for the study only contained physicians’ name and contact information. We were not able to make the comparison. Ten surveys were returned after the second request (we added this information in “Results”. However for logistical reasons we were unable to determine whether they were completed in response to the first or second request (whether they were sent prior to receiving the second letter, whether they were delayed at the post office, etc.) and therefore we did not conduct a comparison analysis.
4. Table 3 is not necessary although the discussion of the explained variance can be left in the text.

**Response:** We deleted the table as recommended.

5. A new Table 3 should present the characteristics of the respondents with respect to the independent variables of interest. Also, please label gender so one does not have to wait till the final sentence of the Discussion to determine how gender is being modeled. Bivariate models including each of the predictors and potential confounders and effect modifiers (were any other variables from table 2 considered?) should be presented in table form along with the final multivariable model. Models 1 and 2 in table 4 can be removed from the table and just presented as is in the text.

**Response:** We appreciate these comments. We realized we left out important information regarding the analyses we conducted on the data. We have deleted models 1 and 2 in Table 4, and added several paragraphs and tables to address these comments. We have also provided a more complete description of the data analysis procedures. Please see: Factorial ANOVAs in “Data management and analysis;” “Results, Descriptive statistics,” paragraph 2 for compliance data, and paragraph 5 for a description of the score distribution and Examination of the bivariate scatterplots of variables of interest. We also added several tables related to these analyses.

**Minor Essential Revisions**

6. page 4 Introduction paragraph 2 change 28.000 to 28,000

**Response:** We made the change as recommended

7. same paragraph Replace "Not only it is" with "Not only is it"

**Response:** We made the change as recommended

8. Results - paragraph 3 you have it ending with a comma - should be a period

**Response:** We made the change as recommended

**Discretionary Revisions**

9. Please explain how an IRB actually approved sending incentives to only those who hadn't responded in a timely fashion.

**Response:** We understand the comment. The study was approved by the University of New Mexico IRB. We suppose the committee considered it to be an appropriate procedure.
10. For Instrument section - it would be helpful to give more information on each of the 4 major variables - what were the ranges, means medians etc. Was any thought given to normality and/or transformation? - this is discretionary for the Instrument section but compulsory (see item 5 above) for the Table.

**Response:** Please see Response to comment # 5 above. We have already addressed the comment

11. Note that 7% of 45 respondents =3. Such percentages become meaningless with such small numbers.

**Response:** We agree. Our sample was small, and the analysis produced small numbers. Such issues are discussed under “Limitations.”
Reviewer 3: Esteve Fernandez
Reviewer's report:
General
This manuscript is aimed at presenting the results from a survey among Hispanic physicians in the U.S. on the determinants or correlates of anti-tobacco counseling. The topic is of interest, as the authors themselves elaborate in the Introduction. Some points to take into account are listed below.

Major Compulsory Revisions

1. Across all the manuscript, and beginning with the title, the authors refer to "predictors of tobacco counseling". Given the cross-sectional nature of the study, it would be preferable to refer to the variables non-causally associated to tobacco counseling as "correlates" or "determinants" (across all the manuscript).

Response:

2. In addition to the previous point, the non-causal nature of the associations studied would be clearly acknowledged in the Discussion section.

Response:

Minor Essential Revisions

3. Title: Please use "correlates" instead of "predictors"

Response: We agree with the comment, and made the change as recommended.

4. Abstract: Please indicate that the study is among Hispanic physicians in the U.S. of America. If possible, include numerical results.

Response: We revised the title, and the abstract’s background and method to make clear the study was conducted in the USA and in New Mexico. We revised the abstract, and under “Results” we included numerical data.

5. Introduction
In my opinion, the 2nd sentence should be re-written since the literature itself does not explore anything. Please change "The literature has explored..." to "Several authors have explored...". Objective: use "correlates" instead of "predictors." It is not necessary to provide further details of the correlates investigated (the domains) here. This sentence can be moved to "Methods".

Response: We made the changes as recommended
6. Methods
Use sex instead of gender (sex refers to the biologic characteristic whereas gender refers to the social construct)

Response: We feel that gender is more commonly used in the English health literature.

7. Results:
Please provide more informative titles for the tables. Have the authors checked the applicability conditions of multiple linear regression (model specification, normality of errors, homoscedasticity, absence of multicollinearity, absence of outliers and lack of self-correlation).

Response: Please see response to comment # 5 by Reviewer 2. We believe the comment has been addressed.

8. Discussion:
Please provide an explanation (or feasible interpretation) to the positive correlations between tobacco counseling practices and self-efficacy --it is consistent with the literature, but why?. Please try to interpret the apparent discrepancies between the results presented and previous studies with regard to sex. Please locate the conclusions after the limitations paragraphs. Please define who are Hispanic physicians in the U.S. Are Spanish physicians in the U.S. considered Hispanics?

Response: In “Discussion,” paragraph 3, we added two sentences and two references to explain the positive correlation between self-efficacy and tobacco counseling practices. We also added the last sentence in “Discussion” to provide plausible explanation for the discrepancy related to sex, and to clarify the term “Hispanic.” As recommended, we moved “Conclusions” after “Limitations.”
Reviewer 4: Peter A Leggat
Reviewer's report:
1. Overall. This is an interesting survey examining predictors of tobacco counselling practices. It covers a relatively small population.

Response: Thank you!

2. Title. This could be simplified. Study could be deleted. Survey suggests a cross-sectional study. Maybe just a Survey of…. It may be useful to include the location.

Response: We revised the title and included the location of the study in response to a previous comment. BMC specifically requires the inclusion of the type of study in the title.

3. Abstract. Background: Could be culled. Methods: Year of study should be given. Results: Can more results be incorporated? There are no quantitative findings at present. Conclusions: What were the main findings of the study? These should match those of the main text.

Response: In response to reviewers’ comments, we included the year the study was conducted in the narrative under “Methods;” and added quantitative data in the abstract’s “Results.” In “results,” we list the variables which were found to correlate to counseling practices.

4. Introduction. A 1.5 page introduction is given. It is suggested that a more international approach is used for the initial impact statements, given the journal’s readership. In any case, the first statement is a bit sweeping given that it relies on one reference. Are there any other impact statements that could be sourced from the literature?

Response: We added two recent references in support of the statement. We agree that the lack of tobacco counseling provided by health care might constitute an international public health issue. However, given the exploratory nature of our study and the particular characteristics of the sample, we believe that it is more appropriate to maintain our original regional and national focus.

5. It would be interesting to mention what the smoking rates are in the doctor population, especially the group to be studied.

Response: We agree. Although we included the data in our previous publication, we added a sentence in “Instrument” to indicate that we measured participants’ smoking status. We also added data related to this under “Results,” first paragraph, last sentence. Although 26.7% (n = 12) of participant physicians had smoked more than 100 cigarettes in their lifetime, none were current cigarette
smokers at the time of completing the survey. We did not use smoking status as a variable in the analysis.

Minor points:

6. Page 4, paragraph 2, 6th last line: 28,000 not 28.000.

Response: We made the change as recommended

7. The objectives are given in the last paragraph.

Response: We believe it is appropriate to justify the study first, and then state the purpose of the study.

8. Methods. It would be interesting to know whether it was known what the coverage rate was for the NMHMS? Does this include all Hispanic physicians?

Response: We added information to clarify this issue. Please see “Limitations.”

Minor comments:

9. Presumably “institutionally approved informed consent form” implies ethics clearance or was this further discussed in reference 11?

Response: The study was approved by the University of New Mexico IRB. The approval clears the study from ethical concerns.


Response: We made the change as recommended.

11. In the discussion of the instrument, it may be sufficient to mention that a Likert scale was used and just list the major variables investigated.

Response: Given that our instrument demonstrated acceptable psychometrics, we feel that readers in general and researchers in particular may benefit from the additional information provided in the instrument, including the exact wording of the questions. We will be happy to revise the sentence should there be a consensus from the reviewers.

12. Page 7, the international audience may not appreciate how popular the documents referred to under knowledge and skills are. It may be useful to fully reference these and also to perhaps mention what measures of their popularity have been undertaken.
Response: Thank you for the comment. We reworded the sentence to emphasize the dissemination efforts by USA health agencies and organizations. We also added URL links to facilitate international access to the protocols, and referenced the TM.

13. Page 8, SPSS should preferably referenced.

Response: We made the change as recommended.

14. Results. Obviously 45 is a small sample size. It does make analysis more difficult with a high likelihood of small categories. The response rate itself is satisfactory and expected in this type of survey. It may have been interesting to mention the response before the follow-up was conducted.

Response: Ten completed surveys were received after the second request. We added the information in “Results” (Please see Response to Q #3, reviewer 2).

15. Tables. There are four tables. From Table 2, it appears that physicians were not asked about their own smoking habits, which is a pity.

Response: Please see Response to Q #5 above. We did ask for participants’ smoking status and added information in this regard.

16. Discussion. The limitations of the study are described in the last paragraph after the conclusions. Should these be brought forward to the beginning of the discussion? In the limitations, it is mentioned that a considerable number of Hispanic physicians working in the US were born and educated outside the US. This is not borne out by this study (91% born in US) and may need a supporting reference. Could language be a barrier to the response by this latter group in this study?

Response: In response to another reviewer’s comment, we already moved “Limitations” so that it appears before “Conclusions.” Regarding nationality, approximately 23% of the US physicians are foreign born. We added this information, and several related reference under “Limitations.”

17. The statement that physicians play an important role in smoking cessation needs to be supported by referenced discussion.

Response: We added two references (13,29) in support of the statement.

18. Page 12, 2nd line: ETS may need to be defined, if not done so earlier in the text.

Response: To be consistent throughout the manuscript we changed it to secondhand smoke.
19. Conclusions. A one paragraph discussion is given. It does not really highlight the main findings of the study. It should be reworked and made consistent with the abstract conclusions.

Response: In “Conclusions,” we recommend training and list specific training components, and these recommendations are consistent with the results of the study. We added a sentence in reference to system-based barriers to counseling (as recommended by a reviewer). These are consistent with the abstract’s “Conclusions.”

20. Acknowledgements. Is it worth acknowledging the participants?

Response: Thank you for noticing the omission. We made the change as recommended.

21. References. There are 34 references in the year range 1987-2006 (mode~1999). The references need some general revision for journal style. The access dates on the URLs seem a little dated (2004). It would be worth checking these.

Response: We searched for more recent data, updated the URLs and the access date, and revised the narrative accordingly.