Author's response to reviews

Title: Association Between Tobacco Use of Pulmonologists and Their Efforts in Promoting Smoking Cessation During Their Routine Clinic Practices, in Turkey: a cross-sectional study

Authors:

Pinar Pazarli Bostan (pinarpazarli@yahoo.com)
Canan Karaman Demir (drcanankaraman@yahoo.com)
Osman Elbek (osmanelbek@yahoo.com)
Sule Akcay (msuleakcay@gmail.com)

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Author's response to reviews: see over
Reviewer 1: Susi Ari Ari Kristina

1. The title: please make it simple and easy to be understood. Use the word "practice" instead of "implementation", since the smoking cessation counseling is already to be a routine practice by pulmonologists, not the new program.
   The title was totally changed according to the other reviewer’s suggestion.

2. Use consistent wording. Example: counseling, instead of counselling
   It was fixed.

3. Change the term "comprehensive versus regular counseling" to be "brief intervention 5A versus 3A" in order to make it clear and avoid misunderstanding.
   Please refer Fiore 2008 Guideline for the term.
   These terms were changed according to the other reviewer’s suggestion.
   Fiore 2008 Guideline was referred in references (written in red color) as 18th reference instead of the reference below.

4. "Advice" must be change to be "advise". Please read carefully the 5A steps
   It was changed. (written in red color in the text))

5. Please explain did respondent fully understand the 5A steps that authors asked in the questionnaire. It is important since the questionnaire was self-administered. For example: Is there any previous training about 5A cessation for physicians?
   Some knowledge about this subject was added in the methods section looked like it was marked with a highlighter pen beginning with line 152.

6. Please add in discussion's part about others articles in cessation counseling among pulmonologists to support your findings.
   We couldn’t find any article in cessation counseling among pulmonologists to support our findings.
   But we find a new article about “Effectiveness of smoking cessation using motivational interviewing in patients consulting a pulmonologist” and we added this article to the references as 7th reference instead of the article below.

7. Please consider the Stage of Change theory in discussion. It is necessary since the steps of 5A is rely on this theory. For example: Assist and Arrange work for patients who ready to quit, and the first 3A is suitable to those who not ready to quit.
   We added a part for stage of change theory in the discussion looked like it was marked with a highlighter pen, in line 252.
Reviewer 2: Silvano Gallus

Main points:

1) The English language needs a major revision for the presence of a number of typos, punctuation errors, and mistakes of the English language. Although some sections are well-written, in some sentences various errors preclude the understanding of the text meaning. This is the case for example of the conclusion of the Abstract. A native English speaker with editorial experience and skills in public health should read the manuscript and make appropriate changes.

A native English speaking colleague with editorial skills read the manuscript and made changes.

2) How is it possible to adjust “provision of smoking cessation counseling” by “having experience in smoking cessation outpatient clinic”? It is obvious that the two variables are strongly correlated. In my opinion it is something like adjusting BMI by body weight. Please, avoid to commit this potential over-adjustment. Obviously, conclusions will change, since the difference in counseling by smoking status remains significant. Thus, “pneumologists” who smoke provide less frequently counseling compared to non-smokers. This would become one of the main conclusions of the present paper.

The term “having experience in smoking cessation outpatient clinic (SCOC)” was changed as “practicing in SCOC” and we added some more information about the needed conditions for “practicing in SCOC” in the introduction section (in the line 107) and also in the methods section (in the line 156) looked like it was marked with a highlighter pen and tried to explain that any pulmonologist can not practise in SCOC cause he/she should have training and certificate.

Our aim in this study was to see the pulmonologists’ efforts in promoting smoking cessation counseling during their “routine clinic practices” that every pulmonologist perform. So we don’t agree that there is a potential over-adjustment. However when we took “practising in SCOC variable” out from the logistic regression model according to the reviewer’s suggestion (and we took only “sex and age variables” in the model), current smoking still was not found associated with providing high effort on promotin smoking cessation.

Our aim was to investigate “the association between tobacco use of pulmonologists and their efforts in promoting smoking cessation”. We didn’t deal with all the predictors for providing high effort in promoting smoking cessation, we just wanted to see its relation with current smoking. So we dealted only with the confounders for this relation. And we saw two variables related with both exposure and outcome that indicated them as confounders. These counfounders can be seen commonly in both Table 1 and Table 2.

We added the sentences looked like it was marked with a highlighter pen in the results part and tried to explain why we used “sex and practising in SCOC” as confounders.

3) The smoking prevalence by 9% in this population of physicians is relatively high as compared to other countries (see for example: Sarna L, et al. Are health care providers still smoking? Data from the 2003 and 2006/2007 Tobacco Use Supplement-Current Population Surveys. Nicotine Tob Res
2010;12:1167-71). Moreover, among physicians, lung specialists should be those with the lowest smoking prevalence. Finally, as correctly addressed in the Discussion section, an under-reporting of smoking is likely in this population. I suggest authors to add this concept in the conclusions of both the Abstract and the main text.

We added this concept in the conclusion of the abstract and the main text looke like it was marked with a highlighter pen.

4) In the Abstract and in the main text, conclusions should be supported by results.

Total of the conclusion in the abstract was changed.

The first paragraph of the conclusion in the main text revised as supported by results.

Other points:

1) Please, also provide in the Results section the proportion of “pneumologists” providing comprehensive counseling separately for former and never smokers.

The information was written in the results part in red color.

2) In the Abstract, Results and Conclusions sections cover less than 30% of the length of the entire Summary. Please, substantially reduce the Background and Methods sections (avoid the mentioning of the 5A’s in the Background, and provide only the information required to justify Results and Discussion of the Abstract) and possibly include more results/comments.

We reduced the background with avoiding the mentioning of 5A’s in it.

We reduced the methods section with taking the sentences “Each of the steps of 5A’s protocol measured on a 4 point scale from “never” to “always” that dichotomize responses: 0 point for “never or sometimes” and 1 point for “frequently or always”.Scores were added across the 5 components.” from its content.

We revised the results and changed the conclusion part according to suggestion.

3) Please, spell out “SC” in the Abstract.

SC was stated in the Abstract as “smoking cessation”.

4) “Regular counseling” does not give the idea to mean “low effort in smoking cessation advice”. I rather suggest to substitute “comprehensive vs. regular counseling for smoking cessation” with somwthing similar to: “high vs. low effort in promoting smoking cessation”.

We substituted “comprehensive vs. regular counseling for smoking cessation” with high vs. low effort in promoting smoking cessation and marked in red color in the text.