Author’s response to reviews

Title: "Right to recommend, wrong to require". An empirical and philosophical study of the views among physicians and the general public on smoking cessation as a condition for surgery.

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"Right to recommend, wrong to require". An empirical and philosophical study of the views among physicians and the general public on smoking cessation as a condition for surgery.

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BMC Medical Ethics

To the editors,

Thank you for your detailed response to our submission. We feel that the paper has improved considerably thanks to your suggestions. We have re-worked the entire paper. Below you will find a point-by-point walk-through of the changes we have made in response to your comments (YC).

(YC) Both reviewers identify the problem of reconciling the qualitative and quantitative data with the recommend-not-require interpretation.

Response: We have addressed this topic by reframing the interpretation of the qualitative data throughout. See the Discussion section, second paragraph; "The merits of “recommendation” versus “requirement” strategies” section, first paragraph, and the conclusion section, as well as further answers to reviewers below.
(YC) On a related note, both reviewers notice weaknesses in the interpretation of a “paradoxical” level of agreement about the need for smoking cessation.

Response: We have dealt with this by clarifying our interpretations and removing the term “paradox” which we agree may be misleading. See the Discussion section, second and third paragraphs, as well as further answers to reviewers below.

(YC) Both reviewers also had objections to the discussion of paternalism, bringing up important issues that are not adequately covered in the text.

Response: We have rewritten the “Paternalism” section with the intention of bringing out the points made by the reviewers. See also further answers to reviewers below.

(YC) Manuscript p. 4, line 36: “disproved” should be “disapproved”

Response: We have changed accordingly. See the corresponding line.

(YC) Manuscript p. 4, line 49: “stand back in prioritization” sounds strange. Perhaps “receive lower prioritization”

Response: We have changed accordingly. See the corresponding line.

(YC) Manuscript p. 6, line 18-31: I agree with the reviewer’s concern that the section on trust and values is confusing. More particularly, I am not seeing how the trust relates to the philosophy of science topic, value neutrality (which is usually used in reference to the ideal of scientific conduct uninfluenced by one’s personal social and political values). Perhaps this is just a case of unfortunate choice of words?

Response: We have specified the manner in which we have used and developed the distinction between trust and value-neutral/influenced as a surrogate for good/desirable and bad/undesirable (=influenced by personal values) as well as value-neutral (=not influenced by personal values) – see method section and strength and limitation section. Further we have stressed that the terms are used in this particular sense in this context only. Please see the second paragraph of the “Vignette” section.
“demarcation issues” usually refers to the demarcation between science and pseudo-science. The worry that accepting marginal issue X might eventually lead to accepting the totally unacceptable Y and Z is usually described as a “slippery slope problem”.

Response: We have changed to the term “delimitation issues”. Please see the “Analysis of comments” section, first paragraph, and Table 3.

“merit” should be “merits”

Response: We have changed accordingly. See the corresponding line.

My biggest concern with the paper is the incorporation of qualitative data to override or make assumptions about the quantitative data that are not justified. The main conclusion of the paper is that participants favour a "recommendation" approach. However, this is based on an interpretation of the qualitative data and its application in a quantitative fashion. Over 80% supported the statement that it is ok to make treatment "conditional" upon smoking cessation. The authors then use qualitative statements by a small minority of participants to reinterpret this data and argue that by conditional they mean "recommendation" not requirement. This goes against the meaning of the word conditional. To make this further claim about "Recommendation" would require an additional question specifically examining this in a further study. I believe that the authors are therefore making a methodological error in the quantitative application of qualitative data and making a claim that the data does not support. Similarly I believe that the claim on page 11 (and again on page 15) that participants reject the requirement strategy is simply not supported by the data. That question was never put the survey participants. Given that the authors appear to support a recommendation approach (one that I believe is ethically justifiable), are the authors making a value impregnation of factual aspects?

Response: We greatly appreciate the tongue-in-cheek suggestion that we have gotten caught in our own trap – it is certainly possible. Furthermore, we agree that we were too rash on this topic in the previous version. We have rewritten the relevant paragraphs to explicitly acknowledge the weak support that the comments make throughout. We now conclude merely that some respondents may express support for the "recommendation”strategy. Please see the Discussion section, second paragraph; "The merits of “recommendation” versus “requirement” strategies” section, first paragraph, and the conclusion section. In response to the suggestion as to how to improve a possible future study, please see the “Strenghts and weaknesses” section, second paragraph.
The other major concern for the paper is the discussion about the high rates of agreement with the claim that smoking cessation is necessary to reduce post-operative harms. The authors use much of the discussion to speculate about what they see as the unreasonably high agreement with this view. I would argue that the large agreement with the claim is the fact that this view is stated in the vignette:

"According to the surgeon, smoking infers an increased risk of difficult wound healing and infections after hip replacement surgery."

It is widely recognised that survey participants are likely to support scientific or medical claims given to them in questionnaires or vignettes. Participants tend not to want to be seen as not knowing a fact that they have been told by experts. It would have been preferable to determine what participants knew prior to exposing them with information in order to assess their knowledge. The current study demonstrates that they accept this assertion. While I do not think that this is problematic for the discussion about the ethical acceptability or support for subsequent policies to get people to stop smoking prior to surgery, I believe that it makes a lot of the discussion about the source of this view redundant.

Response: Again, we thank you for the comment, to which we cannot but agree. The suggested explanation put forth by both reviewers – that the respondents were influenced by information from the vignette – seems fully convincing regarding the answers from the public. However we think it may not represent the full explanation regarding the answering patterns from the physicians. Please see our reworked interpretation in the Discussion section, second and third paragraphs

I found the discussion to be rather long and could benefit from a clearer more succinct structure.

Response: We have tried to improve the flow through the discussion, as well as made it shorter. Please see the new Discussion section in its entirety.

The rationale for interviewing clinicians and the general public could be made clearer. How would the views of each population impact upon the policy debate? Presumably each would have slightly different impacts upon policies regarding preoperative smoking cessation.

Response: We agree. However, we must confess that we had actually expected that the general public would have been more permissive towards this 57 year old farmer, considering his expressed preferences and autonomy. Other studies indicate that the general public often supports patients’ or relatives’ wishes. Thus, we had expected a difference in attitudes between the general public and the physicians. We have no precisely worked out view of how such a
difference in attitudes would have played out in policy, but as noted there was no such difference. All in all, however, it seems natural to assume that the general acceptance of the public as well as the relevant profession is important for the successful implementation of health policies. Please see the last paragraph of the Introduction section.

(YC) The paper also combines an experimental approach to the views of stakeholders with an ethical analysis. It is not clear how the authors see how the empirical data on stakeholder views influences, or not, ethical deliberations about the acceptability of proposals such as making smoking cessation a requirement for surgery. I think that these aspects of the paper are something that needs to be made more explicit in the discussion of the results.

Response: We think that the empirical and the ethical questions are two different questions, that is: the fact that most persons within a certain population actually (as far as we can say by empirical investigations) hold a certain ethical opinion has no relevance itself for the acceptability of the opinion. It is this we try to make clear in the last paragraph of the Introduction section.

(YC) I did not fully understand the assessment of trust in response to health information. In particular how this relates to the impact of values on judgement of facts (the section on value impregnation of factual aspects). It would have been interesting to measure the level of stigma and negative moral judgements towards smokers and correlate with attitudes towards the acceptability of conditional smoking cessation or justifications for such support.

Response: We have specified the trust issue in relation to personal values in the method section and in the Strengths and weaknesses section. If we assume that a paternalistic argument presupposes negative moral judgments regarding the patient (or his capacity to make informed and rational decisions), we may correlate this with the respondents’ inclination to accept a demand for smoking cessation in this situation.

(YC) The discussion about paternalism and the role it plays in motivating attitudes towards requiring smoking cessation is interesting, but was under-developed: was support based on paternalistic motivations, stigmatising attitudes or a wish to punish the smoker.

Response: We have clarified this in the ‘paternalism section’ even though we propose that they may have been the result of all three – these are all possible explanations that are not mutually exclusive. Please see the rewritten Paternalism section
The methods could be more clearly explained. For instance it wasn't easily clear whether participants could opt for more than one reason for supporting a conditional smoking cessation. It seems odd to have asked whether people support reasons against conditional smoking cessation when they have just signalled support for such a proposal.

Response: We have tried to clarify this in the rewritten text. The respondents were able to agree to sub-arguments supporting or rejecting their stance in response to the main statement. Thus, what resulted was an assessment of the overall attitude as well as a mapping of agreement with different sub-arguments from both sides of the discussion. This means that it was possible for responders to agree to an argument for a position that they disagreed to. Please see the second paragraph of the “Questionnaire section”

The introduction is a little long and unstructured. The paper in general could be made tighter and more concise and focussed.

Response: We have shortened paragraphs 5 and 6 of the introduction. However, since we are asked to elaborate on some points, the text as a whole is roughly the same size as before.

It was difficult to know which groups of participants were being referred to in the results - e.g. second paragraph on page 8. Were responses between GPs and surgeons similar to justify combining?

Response: Yes, they were. Please see the second paragraph of the “Agreement with the main statement…” section in Results.

Reviewer 2: This paper reports on an empirical study where physicians and members of the general public were asked whether they agree that smokers should be required to quit smoking prior to surgery. The reasoning behind this is that there is increased risks of complications where people smoke up to, and after, some surgical procedures, leading some organisations and surgeons to refuse surgery to those who continue to smoke. The ethical considerations around this position are interrogated by the authors and compared to public and physician views.

This is an interesting and well written study with a sound justification. The general study design is appropriate, with an appropriate sample size and recruitment methods. I think improvements can be made to the literature review and the discussion, which I have outlined below:
The introduction could benefit from a discussion of the current clinical climate, where it is seen as a duty to address patient smoking. There is increasing encouragement to identify and address a patient's smoking as an ethical obligation, due to the threat that smoking poses to a patient's health. For example, Richter and Ellerbeck (Addiction, Vol 110) argue that all smokers should be given best-practice treatment (pharmacotherapy + behavioural intervention), regardless of whether they express a desire to quit. Smoking is increasingly seen as a "chronic disease" (US Public Health Guidelines - Fiore et al, 2008) rather than a lifestyle choice, therefore there is an increasing obligation on healthcare professionals to intervene in a patient's smoking. This could contribute to a climate where surgeons feel it is their responsibility to intervene where a patient smokes.

Response: Thank you for the references, we have added them. We have also rewritten the beginning of the third paragraph of the Introduction in accordance with the comment.

(YC) Much of the authors' discussion centres around the fact that participants agreed with making surgery conditional on quitting smoking, but that risk of surgery is only "moderately" increased if smoking. However participants were not given any information stating that risk was only "moderate." While this is acknowledged by the authors to some extent, they also state that the "bulk of this discussion will be devoted to this apparent paradoxical phenomenon: why does an activity with a moderate risk profile (smoking before and after orthopaedic surgery) give rise to near uniform support making surgery conditional upon its cessation." It seems very likely that if people are informed there is a risk, and it is a risk the surgeon has deemed appropriate to address/intervene, they are likely to assume that it is a significant risk, therefore one worth avoiding. The authors need to more clearly discuss the limitations of their methodology in this regard. Perhaps reference to literature on how people interpret risk would be beneficial here.

Response: We agree and have accordingly rewritten our interpretation of the qualitative data. Please see our previous comments to the other reviewer and the rewritten Discussions section, paragraphs two, three and four.

(YC) The other "odd miscomprehension" that the authors discuss also seems likely to be a methodological artefact. That is, that participants agreed that people should have to stop smoking for surgery, and then commented that this should rather be a recommendation, and shouldn't be strictly enforced. Participants were only given one option in the original question: to agree or disagree that quitting smoking should be required prior to surgery. The open-ended results, while limited due to their small number, are of interest because they show that agreement with this statement is not necessarily wholehearted, but often a qualified agreement. Participants may have agreed to a "recommend" rather than a "require" strategy if the former option was presented as the first of two options. And if people were given the choice of recommend or require, they may
have preferred the recommend strategy. This speaks to the importance of allowing open-ended questions in order to allow people to qualify their survey choices, or of conducting qualitative research prior to developing quantitative items.

Response: We agree and have rewritten all passages regarding the possible support for the recommendation strategy among respondents. Please see our comments above and the rewritten Discussions section (second paragraph) and the Strengths and weaknesses section.

(YC) No information was provided on how this vignette was developed. The authors should add some justification of why they chose certain elements of the vignette, i.e., gender, age, surgery type.

Response: We agree and have changed accordingly. The reason why we used a 57 smoking farmer (in that age often a man) was the fact that he had paid tax during his whole life and had been healthy until now – and accordingly not used the healthcare system before. We thought that it would make at least the general public more inclined to support the farmer’s autonomy and preferences. Please see the first paragraph in the “Questionnaire” section.

(YC) The discussion around "value impregnation" (Page 12, Line 49 onwards) seems too hypothetical. While some participants provided open-ended responses, participants were not questioned about their values about smoking. As mentioned previously, it is more likely and consistent with the results and method, that people overstated the risk due to the lack of information provided about the "moderate" nature of the risk.

Response: While it is true that respondents were not asked about their values about smoking, we tried to assess that issue “through the back door” by using the value-neutral/value-influenced methodology – please see previous comments in this document as well as the clarification provided in the rewritten Questionnaire section, paragraph two as well as the Strengths and weaknesses section. Thus we do not agree that talk of value impregnation is entirely hypothetical here.

(YC) While the discussion around paternalism is worth having, there are also ethical issues involved in NOT addressing patient smoking when provided with the opportunity. Moreover, the tobacco industry have used such arguments about paternalism to argue that the "nanny state" is trying to force smokers to quit, and taking agency from people who choose to smoke. The paper by White, Oliffe & Bottorff (2013, Sociology of Health and Illness, Vol 35) could be referred to in this regard.
Response: We agree and have rephrased our position accordingly. Please see the beginning of the “The merits of recommendation…” section, as well as the end of “Conclusions”.

(YC) On Page 13, Line 46 the following quote is presented as an example of paternalism "It only shows the doctor cares about the patient." It's questionable whether this quote represents paternalism. Care does not necessarily equate with paternalism.

Response: We agree. The section on paternalism has been rewritten in its entirety, please see the new version.

(YC) One Page 14, Line 23, the authors discuss why the peri-operative period should be a "preferred" situation to assist smokers with quitting. They state that "We are therefore concerned that the insistence of using this precise moment to discuss the patient's smoking habits is partly based upon a (paternalistic) wish to reap health benefits from the patient's vulnerable situation at that moment." But the authors provide no evidence that is a "preferred" period. There is an overall encouragement for all health professionals to identify a patients smoking status and assist them to quit at all opportunities. For example, the US Tobacco Dependence Treatment Guidelines (Fiore et al, 2008) state that "Numerous effective treatments exist, and tobacco use assessment and intervention are considered to be requisite duties of clinicians and health care delivery entities." Moreover, it seems that most of the paternalistic attitudes in their results are from the general public, rather than physicians.

Response: It is quite right that we provide no evidence that it is a preferred period. We merely mention that this is a possible view, and focus our discussion on whether it is a good view. The scope of this article is on the question of demanding smoking cessation prior to surgery – as a stand-alone strategy or as a strategy for long time smoking cessation.

(YC) The authors conclusion that it is right to recommend surgery, but not to require it, seems simplistic based on a previous discussion about the costs and benefits of postponing surgery in order to allow (or require) the patient to stop smoking. As they note "In the case where the expected positive effects are small, and the "costs" in terms of suffering by waiting are large, then the "recommendation" strategy fails." Also, they acknowledge that "If the medical risks of surgery exceed the expected gains, then surgery should not be performed." When it comes down to it, this must be a judgement made by the surgeon, therefore a blanket "recommend" strategy does not seem to hold.

Response: We have clarified our moral point of departure in the beginning of the “The merits of recommendation…” section. To sum up, we are more concerned in situations like this with
considerations of autonomy than considerations of cost-benefit. The argument, having clarified this, is valid, but it is of course open to criticism.

Other minor points

(YC) The reference list is not formatted consistently. Many of the journal titles are not capitalised, but some are; the same with the article titles.

Response: We have made changes accordingly. Please see the rewritten reference list.

(YC) On page 3, Line 59 it would be good to add how this requirement strategy might be implemented by physicians (e.g., urine cotinine testing or carbon monoxide in exhaled breath), as readers may be curious as to how smoking status is confirmed.

Response: We have changed accordingly. Please see the end of second paragraph in Introduction.

(YC) On page 5, Line 23, a definition of "masking" would be helpful.

Response: The passage has been taken out for economy of reading.

(YC) On Page 5, Line 35, the word "plausible" doesn't really fit here. "Defensible" may be a better choice.

Response: We have changed accordingly. Please see the corresponding line.

(YC) Add information about ethical approval of the study. Were participants provided with an incentive to participate? If so, this should be listed.

Response: We have changed accordingly and added the information asked for. Please see the Ethics section.

(YC) On Page 8, Line 37, it is standard practice to represent very small p valued such as this as p<0.001.
Response: We have changed accordingly. Please see the corresponding line

(YC) Page 11, Line 4, remove the "a" - typographical error.

Response: We have changed accordingly. Please see the corresponding line.