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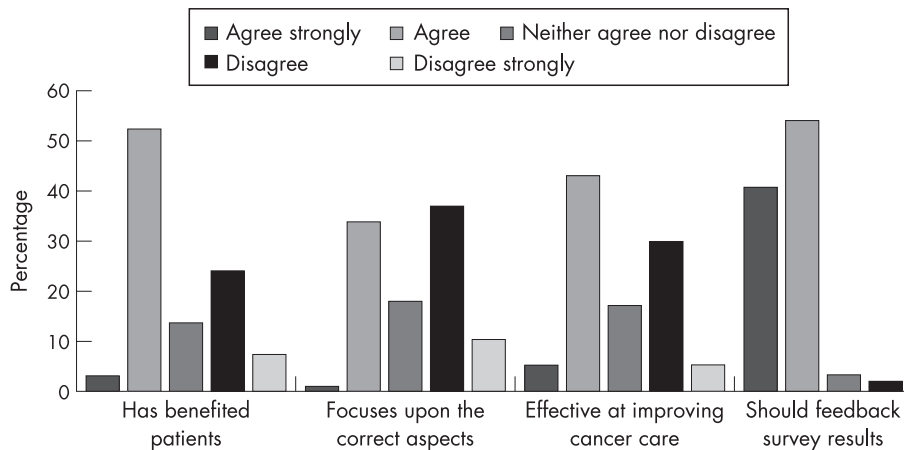
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**Lung Cancer Peer Review Survey**

The National Cancer Peer Review Programme is undertaken by peer reviewers and user reviewers resulting in assessments on the quality of cancer services for NHS patients in England.<sup>1,2</sup> Throughout 2004–2007 the peer review process has been taking place across England. Responding to some disquiet at the benefits of peer review in its current format, the BTS Lung Cancer and Mesothelioma Specialist Advisory Group decided to carry out a survey of lead lung cancer clinicians in all trusts in England who



**Figure 2** Opinions on peer review.

were undergoing peer review. The methodology of the survey is detailed in the online Appendix.

A total of 94 responses were received from approximately 150 lung cancer leads (all consultant physicians). Responses were obtained from consultants in all cancer networks in England (fig 1). The majority (93%) had been personally involved in self-assessment; 59% felt that self-assessment had been a useful process, but there was significant impact upon clinical activities (in 36%) and management activities (in 49%). Respondents were asked to estimate the time spent on self-assessment; a wide range of answers was received, ranging from no time to 168 h with a mean of 19 h and a total of 1606 h (67 days). To attend the peer review interview, 62% of consultants had to cancel clinical sessions and 27% reported difficulties in getting colleagues to attend;

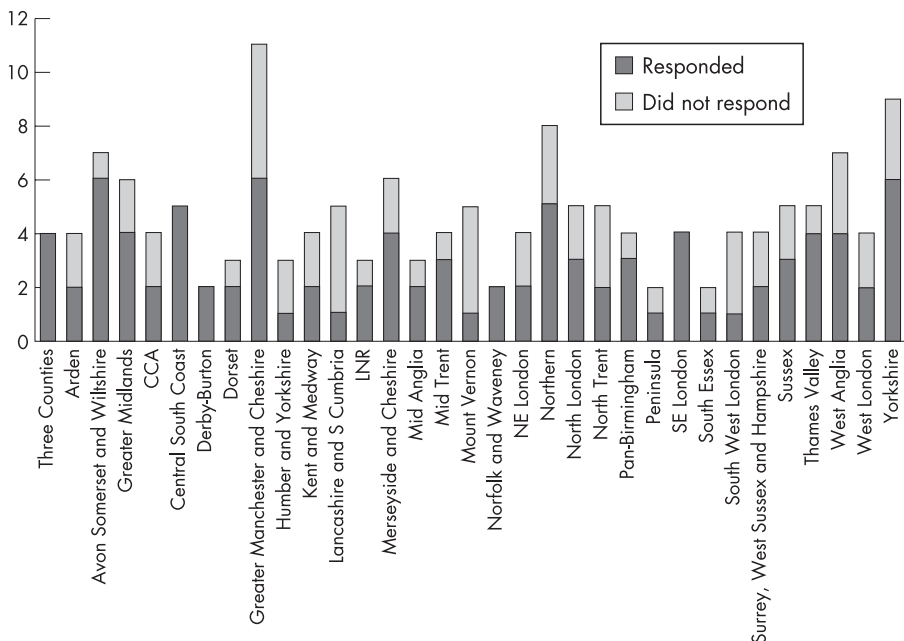
82% of respondents felt that the membership of the interview panel was appropriate. However, the format of the interview was overall felt to concentrate on the wrong aspects by 65%; 24% felt that the interview concentrated on outcomes whereas 91% felt that process and paper evidence were the main focus. Overall, 72% felt that the final report was a fair assessment of their lung cancer service.

The final questions asked for overall feelings about the peer review process (fig 2). There appeared to be mixed feelings about whether peer review had benefited patients, with only 55% giving a positive opinion. Approximately one-third agreed that peer review concentrated on the right aspects, but nearly 50% felt it did not. Similar responses were obtained to the question of whether peer review was an effective way of improving cancer care. Finally, 95% of respondents felt that the results of the survey should be fed back to those with responsibility for the peer review process.

We re-analysed the results according to seniority of the consultants, splitting them into those who were >10 years in post (n = 48) and those <10 years in post (n = 46). The results were similar in the two groups. However, the younger consultants were more likely to look upon self-assessment as a useful exercise (70% vs 56%) and were more likely to feel that peer review had benefited patients (61% vs 52%).

The survey questions allowed space for free text comments and many were made (see online Appendix).

One criticism of the results might be the rather low response rate of 61%. However, some 20% of the trusts that did not respond had valid reasons—for example, their lead clinician had since retired or moved to a different post. The survey has revealed strong feelings among lead clinicians regarding cancer peer review, and the overwhelming message of the survey is that clinicians feel that peer review is assessing the wrong things, concentrating on paper evidence of



**Figure 1** Responses by network.

compliance with measures which may not be evidence-based and which may not reflect the quality of the lung cancer service. There is a wish for teams to be assessed less on these elements of process and more on outcomes. Measuring outcomes and comparing them between units is a longer term aim of the LUCADA audit. However, some respondents did acknowledge that peer review was an evolving process and many of the measures reflected good practice.

The results of this survey will be fed back to the National Peer Review team and hopefully the comments will inform further rounds of the peer review process, thereby engaging clinicians and ensuring that all patients with lung cancer have access to high quality services.

#### P A Beckett for the BTS Lung Cancer and Mesothelioma Specialist Advisory Group

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Additional data are published in the online Appendix at <http://thorax.bmj.com/content/vol63/issue3>

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## Smoking cessation trial may be missing the point

The trial reported by Aveyard *et al*<sup>1</sup> in a recent issue of *Thorax* is a welcome illustration that primary care nurses are not being trained properly to deliver the behavioural support aspects of smoking cessation. However, the paper seems to miss this point and instead concludes that “Primary care smoking cessation treatment should provide pharmacotherapy with sufficient support only to ensure it is used appropriately, and those in need of support should be referred to specialists”.

We know from a large body of previous work and systematic reviews (as referenced in the article) that well considered and planned behavioural support doubles the increase in quit rate for smoking cessation services. In this trial, however, there was no effect. The results therefore clearly show that the current form of nurse-delivered “behavioural support” is ineffective. Indeed, I am concerned that the authors even refer to what was delivered as behavioural support. There is no evidence that any established behaviour support techniques were delivered (eg, motivational assessment, elicitation and

examination of barriers, use of action and coping plans, establishing self-monitoring regimes, use of established relapse prevention techniques). Simply asking nurses to conduct some extra telephone calls and visits without any specification of the content is pointless in terms of applying behavioural science. There is therefore a grave danger that trials such as this will be included in future systematic reviews as trials of behavioural support, even though the quality of the support offered was non-existent (or at least not established in any way). This kind of data may bias future reviews.

Furthermore, the lack of effectiveness of the nurses in this study does not mean that nurses cannot be trained to deliver this support (as the authors seem to suggest). It is my experience—and that of many other behavioural researchers<sup>2–3</sup>—that almost anyone can be trained to effectively deliver simple behavioural support techniques such as motivational interviewing, which are the same techniques commonly used in smoking cessation and have proved to be effective in the NICE and Cochrane reviews.

Yes, passing patients on to specialists would produce a much needed workstream for the hundreds of graduate health psychologists qualifying each year, but another alternative would be to train the nurses properly to do the job. This trial tells us nothing about the pragmatic effectiveness of behavioural support, as no behavioural support was apparently delivered.

#### C Greaves

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## Authors' reply

As we reported, this trial took place in the UK National Health Service (NHS) Stop Smoking Service. The NHS has developed standards for training in behavioural support.<sup>1</sup> Stop Smoking Service coordinators oversee this training and the quality of services provided in the NHS, which may involve fidelity checks and, in the region we studied, mandatory annual update training.

Greaves emphasises psychological techniques that he states are necessary for the efficacy of behavioural support. Trials in smoking cessation do not show whether or not particular forms of behavioural interven-

tion—such as cognitive behavioural interventions—are necessary for effect or whether one form is more effective than others.<sup>2,3</sup> Some components that Greaves suggests are essential—such as relapse prevention—have been shown to be ineffective.<sup>4</sup>

Behavioural support for smoking cessation in the UK is based on withdrawal orientated therapy.<sup>5</sup> This recognises that individuals come to clinical treatment services when they are highly motivated to stop but cannot do so because of nicotine dependence. The goal of therapy is to help reduce withdrawal discomfort during the first few weeks. Motivational enhancement is not usually part of treatment.<sup>6</sup>

Greaves assumes that by “specialists” we mean an army of health psychologists. We do not. The NHS provides two types of face-to-face NHS stop smoking support. One is by primary care nurses trained and monitored as we described. The other is by people who have undergone the same training but provide smoking cessation support as their main role. Frequently such specialists are nurses, but other professions are represented, although few psychologists do this work for the wage offered. The evidence from prospective evaluations is that the same kind of care provided by such specialists produces double the quit rate we saw in our study.<sup>7</sup> The difference in efficacy is not because of different training.

Evidence from other studies showing that behavioural support is ineffective even where high quality training was given to primary care professionals<sup>8,9</sup> reinforces our belief in the superiority of effectiveness of specialist over generalist support. Perhaps the other demands of the role of providing general care, or the appointment system that militates against regular support, lead to failure of trained generalists to equal the success of similarly trained specialists in smoking cessation. Until the NHS shows in independent evaluations that higher quit rates can be obtained in primary care, our advice would be for primary care professionals to refer smokers to specialist support or provide brief advice, using pharmacotherapy in both cases.

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