Peter thanks for that. Submitting an appeal sounds like the way to go. I’ve added some lines and made some small changes to the text below, including hyperlinks for references. Very grateful if you could put this slightly altered text through the appeal process. I’m not usually inclined to create more work for anyone, but this is an issue that I feel pretty strongly about.

Thanks again for your help.

Best wishes

andrew

The reasons stated for not deciding to publish our paper were the lack of a patient author and unanswered questions about the practical implementation of socioeconomic enquiries in healthcare settings.

Regarding the absence of a patient author. The fact of that absence is obviously incontrovertible. But my firm belief is that this issue demands a far greater engagement of patients than that. Before implementing changes to practice it would be important to seek the views of a range of patients though interviews and focus groups. This principle might apply to all healthcare changes, but perhaps to this proposal more than most. I would be very happy to make this point specifically in the paper.

Reviewer 3 noted the absence of a patient author and, relatedly, asked whether patients had already been asked about this proposed change to practice. Perhaps too this should have been made clearer in the paper. There is already a considerable literature from the US and Canada in which patients’ opinions have been obtained on the subject of socioeconomic enquiries and found to be largely approving: paving the way for implementation in those contexts. Anecdotally, in my own personal experience, I have discussed this issue informally with a number of patients and found that once the logic behind socioeconomic enquiries is understood there is a general willingness to provide the information. To some extent this may not be surprising. Most people are very willing to openly discuss their education, occupation, employment, and housing. And even information about income is already discussed with bank managers, mortgage lenders, and, notably, health and life insurers, so a case might well be made for similar discussions with doctors, who tend to enjoy higher levels of public trust than the aforementioned. Furthermore, working as a GP for homeless and vulnerably housed people in Oxford, I already ask most of these questions routinely because the answers are directly relevant to discussions with patients and shared decisions about their care: employment questions might result in a patient being given a sick note; discussions about income and benefits payment might result in a referral to our in-practice social worker or to the citizen's advice bureau; and enquiries about accommodation might prompt letters to housing agencies and influence prescribing decisions (for example, ensuring that people living on the streets are not given medications in quantities that they are unable to store and that might put them at risk of theft or violence).

Reviewer 3 also suggested that socioeconomic enquiries were motivated by an attitude of physician paternalism, or would be experienced as such by patients. Whilst I take this concern seriously, I strongly disagree that acknowledging and engaging with the social determinants of patients’ health and healthcare represents medical paternalism. Indeed, I would argue that it is less paternalistic to engage with these issues and open a possible discussion about them between doctor and patient that to not do so, which is the state of affairs currently. The physician and sociologist Howard Waitzkin has studied this subject extensively using conversation analysis methods and observed how doctors subtly but routinely shut down conversation about social factors when patients try to raise these issues. This is paternalistic and unhelpful, but it constitutes ‘usual care’ in a pressured healthcare environment in which biomedical factors are prioritised over social determinants.

Moreover, although social factors are not asked about or openly acknowledged, their health impacts are so powerful and pervasive across society that health professionals are routinely engaged in the task of
endeavouring to ameliorate those impacts through clinical care. The routine management of cardiovascular risk in the UK provides an instructive example. Current NICE guidelines advise clinicians to "use the QRISK2 risk assessment tool to assess CVD risk for the primary prevention of CVD in people up to and including age 84 years." With a few exemptions, the UK population will be periodically subject to this CVD risk assessment by a GP using the online QRISK2 tool. The NICE guidelines further advise, "complete as many fields of the risk assessment tool as possible." In addition to age, blood pressure, and so on, one of the fields to be completed on QRISK2 is the patient's postcode. The postcode is used in the QRISK2 algorithm to determine the Townsend deprivation score for the area in which the patient lives. This area-based deprivation score then influences the patient's CVD risk as calculated by QRISK2. And since CVD risk levels determine medical management in the NICE guidelines, the deprivation score will also influence decisions that will be made around such things as blood pressure medications and statin prescribing. Leaving aside the concerns already described in our paper about using postcodes to define deprivation, it will be apparent from the above that the clear intent here is that doctors should treat socially determined disease risk using medications (with the associated risks of medication side effects and harms). Importantly, this is done without a discussion about social determinants and their role ever having occurred between patient and doctor (and without any attempt to challenge those social determinants either at an individual or societal level). I find this current practice not only ethically dubious, but more paternalistic than the alternative I propose.

To cite my own work experiences alluded to above, I feel that any risk of appearing paternalistic by asking patients about income, employment, or housing is outweighed by the potential benefits that might result from those enquiries. Even among patients who are not experiencing homelessness and for whom the impact of other social determinants may be less acute, I would suggest that socioeconomic enquiries are likely to be experienced as no more (and possibly less) paternalistic than other routine and necessary enquiries about, for instance, alcohol and tobacco use, or diet and exercise.

Ultimately, concerns about paternalism and how socioeconomic enquiries may be perceived by patients do not constitute a reason for not making those enquiries, but rather they are a reason for making those enquiries sensitively and with appropriate explanation of why the questions are being asked. The team referred to in Toronto used the slogan "We Ask Because We Care" to accompany their enquiries about socioeconomic factors, as well as enquiries about ethnicity, sexual orientation, disabilities, immigration status, and so on.

The editorial team also referred to having unanswered questions relating to the practical implementation of the proposed socioeconomic enquiries. The questions unanswered were not specified, but I can imagine that they might include some of the following:

Who should make the enquiries? (Doctors, nurses, or admin staff?)

And how? (Should patients be sent forms to complete, or given a form on arrival at the practice, or should the enquiries be slipped into consultations, or done by doctors over the phone, etc?)

How often should the enquiries be made? (acknowledging that income and employment status are likely to change over time)

What about privacy / security? (noting that secure electronic medical records have been adopted across UK primary care and are already routinely used to store highly sensitive and confidential patient information)

These questions, and no doubt others, should be the subject of the patient engagement activities alluded to above. The aim would be to explore acceptability, consider best practices for implementation, and better understand what accompanying patient information might usefully be provided.

That said, there is learning to be had from other contexts. With regard to assessing income or financial security, for instance, in Switzerland, Bodenmann and colleagues found that the single question 'Did you
have difficulties paying your household bills during the last 12 months?’ was acceptable to patients and identified patients at risk of forgoing healthcare for economic reasons (sensitivity 74.1%, specificity 79.9%). In Canada, Bracic and colleagues found that the question ‘Do you (ever) have difficulty making ends meet at the end of the month?’ was a good predictor of poverty (sensitivity 98%, specificity 60%).

Also, there is relevant experience in the UK. Between 2006/07 and 2011/12 the Quality and Outcomes Framework (QOF) provided financial incentivisation for the recording of patient ethnicity in primary care. This resulted in doctors openly asking patients about ethnicity and prompted UK general practices to include a question about ethnicity on their registration forms for new patients. Ethnicity data collection in UK health care settings provides a useful precedent for socioeconomic data collection, whilst accepting that socioeconomic data collection, unlike ethnicity data collection, will need to be periodically repeated.

Finally, one of the reviewers suggested that this paper was a call to action. I hope that the above remarks will make clear that it was not exactly intended as such. Rather, it is intended as a wake up call. A call to start giving this issue the consideration that it deserves. The ten years of lost life expectancy due to socioeconomic contexts in the UK represent a greater impact than that of the ‘obesity epidemic’. The health risk associated with being poor in Britain is closer to the health dangers of smoking. Yet I have observed no substantial effort on the part of the medical profession to respond to the UK’s worsening socioeconomic health inequalities. Getting the data would be a start. The Toronto team mentioned above referred to the old aphorism, ‘You can’t manage what you don’t measure’.

To conclude, the subject of socioeconomic data collection in healthcare settings fully deserves to be discussed and considered by patients.

The unanswered questions about implementation absolutely need to be resolved.

But first the issue needs to be put on the table. There needs to be an acknowledgement among healthcare professionals of the absence of socioeconomic data in healthcare settings. And an acknowledgement of the implications of that absence. As well, it might be acknowledged that the absence of socioeconomic data collection has no convincing logic or rationale to uphold it (other than untested suppositions about acceptability) and that no UK research has yet been done on the subject. Our analysis paper was intended to prompt thought and discussion among healthcare professionals, and ultimately to stimulate further work on this subject. The BMJ is an ideal medium for achieving those objectives. I do hope that you might reconsider publishing our paper.