In Reply In large-scale epidemiological studies such as ours, measurement of the exposure and outcome is seldom error-free or even with the highest possible precision. Frank and colleagues have developed a walkability index using parcel-level information and validated this measure through travel surveys in 2 regions of the United States in 2010. Their walkability index is a composite index including residential density, retail floor area ratio, intersection density, and land use mix, and it was designed to be related to transportation preference. Such data were not available for our study, which was conducted in Finland and covered a time period from 2003 to 2013. Similarly, although self-reported smoking is a strong predictor of a range of smoking-related health outcomes, some misreporting is still possible and ideally assessment of cotinine concentrations would have complemented self-reports to add precision to the assessment of smoking status. In our study, only self-reported data on smoking were available. Furthermore, we could not assess walking ability of the participants or individual differences in perceiving the distance to the nearest tobacco outlet.

It is important to consider whether these limitations are a serious threat to the validity of our study. We compared smoking behaviors using a within-individual analysis of participants who lived nearer tobacco outlets at one point in time and further away at another time point. In this design, the participants were their own controls, and therefore the observed within-individual increase in quitting among smokers when the distance from home to the nearest tobacco outlet increased is unlikely to be owing to between-individual differences in reporting style, walking ability, transportation preferences, or differences in ways of perceiving distance. Thus, we would consider lack of data on these characteristics an implausible source of major bias in our study. More generally, most of the measurement issues raised by the authors are presumably nondifferential with respect to smoking status—they probably attenuated the true associations.

Lee and colleagues also argued that lack of data on subjective perception of the distance to the nearest tobacco outlet was a limitation. Such perceptions are undoubtedly an important focus in psychologically oriented research, but our study sought to find more objective evidence that will facilitate design of smoking-related interventions and policy. In that respect, the geographic information system–assessed distance to the nearest tobacco outlet, which was our exposure, seems a more useful intervention target. This assessment was based on street networks.
Advancing the Health of Lesbian, Gay, and Bisexual Adults

To the Editor In an Original Investigation in a recent issue of JAMA Internal Medicine, Gonzalez et al,1 using national health surveillance data, observed that lesbian, gay, and bisexual (LGB) adults experience health disparities that warrant clinician attention. These findings were described, incorrectly, as “the first to capture the disparity in a population-based sample rather than a convenience or clinic-based sample.”2 It is not yet integrated in our electronic health records or public health reporting systems. Furthermore, these data systems are not designed to explain why these differences exist nor how systems should be redesigned to respond to the patient-centered needs of LGB individuals. To advance the health of the LGB population, science must build on what is known and move with the proper protections to collect sexual orientation data as a necessary aspect of health care services.

Susan D. Cochran, PhD, MS
Ilan H. Meyer, PhD
Vickie M. Mays, PhD, MSPH

Author Affiliations: Departments of Epidemiology and Statistics, University of California, Los Angeles Fielding School of Public Health, Los Angeles (Cochran); Williams Institute, University of California School of Law, Los Angeles (Meyer); Departments of Psychology and Health Policy and Management, University of California, Los Angeles, Los Angeles (Mays).

Corresponding Author: Susan D. Cochran, PhD, MS, Department of Epidemiology, University of California, Los Angeles Fielding School of Public Health, PO Box 951772, Los Angeles, CA 90095 (cochran@ucla.edu).

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In Reply We thank Cochran et al for their insightful comments, and we agree that our study1 on health disparities in the lesbian, gay, and bisexual (LGB) population adds to the mounting body of evidence that people who identify as LGB experience worse health outcomes compared with their heterosexual peers, potentially due to the stressors that LGB people face as a result of interpersonal and structural discrimination. As Cochran and Mays have previously noted, “research on LGB populations is still in its infancy,”2 compared with health disparities research on racial and ethnic minority populations. Other researchers have also noted that the work to resolve health disparities in the LGB population has barely begun.3 Our study helps broaden the knowledge base on LGB health disparities to the readers of JAMA Internal Medicine, as it is imperative for clinicians to understand, accept, and address the health needs of LGB and transgender (LGBT) patients. We encourage JAMA Internal Medicine to continue publishing important findings documenting LGB health disparities and best practices for eliminating those disparities. Doing so will help health care providers implement positive changes in their practice. Meanwhile, recent developments at the National Institutes of Health will help build the research capacity for LGBT health. Specifically, the National Institute of Minority Health recently designated sexual and gender minorities as a health disparity population for research purposes.4 This designation will broaden funding opportunities and research on LGBT populations, among other sexual and gender minorities. We commend these efforts and encourage high-impact journals, like JAMA Internal Medicine, to continue reporting new discoveries and advancements in LGBT health.

Gilbert Gonzales, PhD, MHA
Carrie Henning-Smith, PhD, MPH, MSW
Julia Przedworski, BS

Author Affiliations: Department of Health and Policy, Vanderbilt University School of Medicine, Nashville, Tennessee (Gonzales); Department of Health Policy and Management, University of Minnesota, Minneapolis (Henning-Smith); University of Minnesota School of Public Health, Minneapolis (Przedworski).

Corresponding Author: Gilbert Gonzales, PhD, MHA, Department of Health Policy, Vanderbilt University School of Medicine, 2525 W End Ave, Ste 1200, Nashville, TN 37203 (gilbert.gonzales@vanderbilt.edu).

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