Reviewer's report

Title: The potential to improve ascertainment and intervention to reduce smoking in Primary Care: a cross sectional survey

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Reviewer: Ron Borland

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This is an interesting and innovative study. However, I have a number of serious concerns with it in its present form.

My main concern is that I think more of the analyses should have been conducted at the level of practice no patient. In particular, it is important to know if rates of misclassification vary by the proportion of patients with smoking status recorded. If would also be useful to provide the percentage of practices that achieved effectively complete and sufficiently accurate ascertainment. Also is there any relationship between the percentage of smokers in a practice (as from records) and the percentage of uncertain cases who turn out to be smokers? If length of time quit is known, (I suspect it isn’t) it should be used to review false positives. The big, and largely missed, story I got is of the huge variability between practices.

Detailed comments:
1. Abstract: The trial registration should be dropped from here as this study is not reporting on trial outcomes.

2. Background, paragraph 1. Cant you just say that recording is often inaccurate?

3. Paragraph 3. The first sentence is confusing. The fact that at some point (we never get told when) patients/practices (we don’t know which) were part of a RCT is not particularly relevant.

4. Methods, last paragraph. The claim referenced to ref 14 is a gross overstatement. The authors might briefly describe what a Townsend score is for non-UK (especially) readers.

5. Results. The proportion of patients within a practice with recorded smoking status is skewed; this means they are not a particularly useful statistic. I would like to know what proportion recorded all or nearly all (say 95% or more).

6. The proportion of smokers among unrecorded cases should be related to the percentage of patients with recorded statuses and to estimate of percentage of smokers. The variation across practices is huge. It is similarly so for identified smokers who said they weren’t.

7. Under Table 1. Did interest in help vary as a function of whether they were newly identified as a smoker or confirmed as a smoker. I would expect the former to have more interest, as they have had no opportunity to be offered it by their GP in the past.

8. Also did interest in getting help vary by practice. To interpret Table 2 as showing those 41 – 50 were most interested is inappropriate. The age range should at least include the 31 – 40 age group, and I suspect also the 51 – 60 group (if they are sig. different to 61+ and not to 51+).

9. Discussion. Focus on the 20% of inaccuracies is inappropriate. Tell us the range and try to work out what factors determine how well practices are doing.

10. Surely the research team know what percentage of returns did not give permission for the research team to see the data. In this regard I find it curious that the team had access to the patient records to be able to ascertain whether smoking status was recorded but were unable to access this other information. Surely if the practices uses this information to update their records, the research team could be given the updated figures.

I have not detailed other issues with the discussion as I expect much of it will need to change if the
suggested, by practice, focus I recommend is adopted.