Reviewer's report

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

Version: 2 Date: 27 August 2007

Reviewer: Ron Borland

Reviewer's report:

General
(see below)

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

This paper is much improved, but it still contains elements of the previous draft that are no longer supported by the reanalysis. In particular, the conclusions (both abstract and main text) need major revisions. In my opinion, the main points are: That while in many practices ascertainment of smoking status is incomplete and/or inaccurate, failure to act appropriately on known status still remains the biggest challenge. (Optional) If GPs could be shown greater benefit of regular intervention, they might be more conscientious in both ascertaining smoking status and in assuring that information was kept up to date. NB. This is based in part on the finding that identified smokers were more likely to want help.

Other significant issues

The variability in misreporting is huge. Use of 20% misclassification is thus misleading. This at least needs to be acknowledged. (Optional) It would be useful to rank practices on a combined index of ascertainment and accuracy. This would give an empirically defined achievable standard that could be set, and act as a framework for expecting better performance in future. Similarly the proportions of unknowns reporting to be smokers varied widely –was this related to the proportion of non-ascertained cases?

Paragraph before conclusion. “The lack of correlation” sentence. This maybe true, but the real issue is that high ascertainment does not preclude accuracy – so both can be achieved.

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

(see below)

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Discretionary Revisions (which the author can choose to ignore)
Background paragraph 3. The first sentence seems out of place.
Under Table 1. The 42.4% ascertainment is a clear outlier – this needs to be taken into consideration.

It would be sensible to recommend finding out ex-smoker status and years abstinent in future research of this kind, to get an idea of how frequently re-ascertainment should occur.

The first sentence of the discussion misses the point. The important question is what determines failures, not the averages.

Last sentence of 2nd paragraph. This is presumptive, there is no focus on factors predicting accuracy.

The “Although 41%…..paragraph. This would work better if you started with the 5% treated and showed that many are not, getting help they want, the % being difficult to accurately estimate, but is at least……

Later that paragraph. The issue of the disadvantaged. Surely the first thing to do is to ensure that the identified smokers among the disadvantaged are appropriately assisted.

What frequency of updating of records would be recommended? ie a period not to exceed where practical. Also how might GPs go about achieving this? Something along these lines would strengthen the Discussion.

Point 6 of my previous review. I was asking for an estimate of the % of smokers in each practice, based on practice records, adjusted by data from the survey. There seems to be huge variation, and it would be of interest to see whether the error rates were related to the percentage of smokers. As identified non-smokers were not surveyed, a practice strategy of coding as non-smoker unless identified as a smoker would result in very high ascertainment and very low error rates (by your method), as you do not attempt to assess the false negative rate.

What next?: Accept after minor essential revisions
Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:
No competing interests