Author's response to reviews

Title: Assessment of Dizziness Among Older Patients at a Family Practice Clinic: A Chart Audit Study

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Assessment of Dizziness Among Older Patients at a Family Practice Clinic: A Chart Audit Study

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Response to Reviewers' Comments:

Reviewer 1, Lucy Yardley:

It is true that in our introductory review of the literature we have included information from studies in working age people, mixed populations and in the elderly without organizing our presentation of the literature into three separate categories. However, most of the literature we cite refers to mixed age groups or to the elderly. The background section does indicate that the frequencies of specific diagnoses of dizziness differs according to the age of the population studied as well as the setting.

We agree with the reviewer's second comment. The term 'benign', while technically correct is not a clinically useful term. We have rewritten this sentence to reflect the reviewer's comments.

We agree with the reviewer's third comment We have made note that a further limitation of this study is that in our study we do not know clinical diagnoses were accurate, reliable or better predicted clinical outcome or management for the patient.

Reviewer 2, JP Michel

1. We think that the background review of the problem in this paper is comprehensive and well written and outlines clearly the rationale for the study.

2. The reviewer's major criticism is the relatively small sample size of the study. The sample of 50 was randomly selected out of possible sample of 310 charts. As the reviewer is likely aware, among the many challenges of conducting chart audit studies is determining the appropriate sample size. If one is looking only at one or two outcomes (e.g. did the patient have a Pap test done or not?) it is relatively straightforward to calculate an appropriate sample size for an audit. However, when the audit involves multiple discrete variables such as this study, it is very difficult to calculate an appropriate sample size. Because of the length and complexity of the charts that we chose to audit, as in many other chart audit studies, in part the sample size is one of convenience.

3. The reviewer's observation that for almost all variables the number of not documented cases was higher than the number of documented cases is, in fact, a significant finding of this and other chart audit studies. Physicians frequently fail to document whether or not they assess problems. One of the messages that we would like to deliver to family physicians is the need to improve their documentation of problems in the chart.
4. We are not sure that we fully understand the reviewer's comments about "predisposing risk factor" versus "key quality indicator" etc. Key quality indicators were derived from a consensus in the literature about indicators of the quality of the clinical assessment for each dizziness sub-type and this is what we present in Table 5. In fact, one of the main messages of the study is that most of the assessments do not include these key quality indicators and that this likely reflects a low level of quality in the way family physicians assess dizziness in their patients.

5. Thank you.