Falls are a common problem encountered in the care of older patients. There is consensus that multifactorial interventions can reduce the risk of further falls in high risk seniors without dementia. Numerous efficacy studies have shown this. This paper has two stated purposes – report on the effect on participation rates, participation characteristics and generalizability of two different recruitment strategies used in the FACT study; and, describe the design, intervention and characteristics of study participants in the FACT study. While I enjoyed the article I’m unconvinced that it adds in a significant manner to our knowledge about the management of falls. I have a number of concerns/comments about this trial that are as follows –

MAJOR COMPULSORY REVISIONS

1. Ethics: When will it become ethically unacceptable to have a control group in a falls study who are essentially offered little if anything to decrease their risk of further falls? Comprehensive assessment with fall risk identification coupled with a plan to deal with those identified factors has become, in my opinion, the standard of care that should be provided to community-dwelling seniors who have fallen (see J Am Geriatr Soc 2001, 49:664-72). While it would be quite appropriate to perform an equivalency trial or to investigate some particular aspect of an intervention, I would question the advisability of having a control group that is only offered social visits, a pamphlet and usual care. The authors make the argument that while a multifactorial intervention has been shown to work in efficacy studies, an effectiveness study (what they refer to as a “pragmatic trial”) is required. While I can agree with that, I don’t feel this necessarily means that the control group should be offered so little. I would ask them to elaborate on this and provide justification for their study design.

2. Background: I found this rambling and unfocused. I question the need to review the intervention literature in such detail. For example, wasn’t the PROFET study included in the referenced Cochrane review (reference #7)? Why pull it out for specific comment? I would only refer to work that is specifically relevant to this study. Some comments are made as a general statement when it has a more specific connotation – for example, the comment about over 90% of seniors accessing primary care yearly refers to New Zealand and may not be true for other jurisdictions. While I think too much was give about interventions that were not relevant to this study and paper, there was relevant literature dealing with the challenges encountered in recruiting older patients that is not referenced (e.g., Prev Sci 2002 Mar;3(1):1-22; J Am Geriatr Soc 2001 Aug;49(8):1039-45 – this report in particular was relevant in my opinion).

3. Definition of terms: It would have been useful for the authors to have defined what they meant by certain terms like “pragmatic trial”, “primary care”, “accredited visitors” and “large [and small] practice.”

4. Methods: In my opinion they did not adequately describe their exclusion criteria and recruitment strategies. For example, exactly how did they screen for dementia? What did they mean by “unstable or progressive medical condition”? Many conditions like osteoarthritis and osteoporosis are arguably progressive. What exactly was on the page given to patients in waiting rooms? I assume it was more than just a question. As for the mail-out, who sent the letter? The practice or the researchers? Who signed the letter? What was said in the letter? Were patients only told to answer the letter if they had a fall? I'm surprised that all 2,705 letters were apparently successfully delivered. Where I work a number would not have been delivered because of an error in the name/address or patients moving. Were these documents piloted? The page handed out and the letter mailed could have been provided as appendices.

5. Results: The comment that the first recruitment strategy didn’t work efficiently in smaller practices is presented more as an opinion rather than in an objective manner. As this is an important point that the authors wish to make, actual data should have been presented. The assumed fall rate of 30% for the postal method was at best an educated guess. They should have performed a sensitivity analysis looking at various rates. The two recruitment methods did lead to different over-all recruitment rates. The recruitment rate for the waiting room method was 12.3% (90/729) vs. 8.2% (222/2705) for the postal method. This difference is significant (chi-square = 11.91, p < 0.001). This isn't noted by the authors.

6. Discussion: It seems a stretch to extrapolate from one large practice to the statement made on page 12...
that “… systematic screening for previous falls and recruitment within practice waiting rooms is successful in large practices …” Shouldn’t they base this on more than one example? They should emphasize that their estimate of a 40% participation rate using a postal method is an imprecise estimate.

MINOR ESSENTIAL REVISIONS

1. Methods: Why did they lower the age threshold to 55 for Maori and Pacific people? Do they think their unit of analysis should be the practice or the individual? If the individual, how do they plan to deal with the potential effects of the characteristics of the practice? The described waiting room recruitment strategy was not the placement of a research nurse in a waiting room that they said they were going to utilize in their Background section (bottom of page 4). What steps did they take to ensure those who obtained outcome measures were blinded? Did they determine if the blinding worked? Was there only one nurse co-coordinator or were there more than one? How was this person trained? What type of back-up did the nurse co-coordinator have? On page 8 they mention referring to the family physician and/or a geriatrician. Is the family physician noted the subject’s attending family physician? Who is the geriatrician they mention? In my jurisdiction, nurses would not be able to make all the referrals and/or requests for investigations noted in Table 1. Is there more information available about the assessment algorithm or is Table 1 the full package? For example, I wondered what threshold was used to make a referral to the family physician and/or geriatrician.

2. Results: I don’t understand the distinction between “New Zealand European” and “other European” (bottom of page 10).

3. Figure 2: In the right hand side of the figure, third box from the top, shouldn’t the estimated figure of 811 fallers be used rather than 386 (see text, page 10)? It gives a false impression to put in this row “fallen” and “responses”.

What next?: Reject because too small an advance to publish

Level of interest: An article of limited interest

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.