Author's response to reviews

Title: Documentation of Best Interest by Intensivists: A Retrospective Study in an Ontario Critical Care Unit

Authors:

Andrew B Cooper (andrew_cooper@oslerhc.org)
Mohana Ratnapalan (mohana.ratnapalan@sunnybrook.ca)
Damon C Coles (damon.scales@sunnybrook.ca)
Ruxandra Pinto (ruxandra.pinto@sunnybrook.ca)

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Author's response to reviews: see over
Margaret L Campbell Comments
1. We have expanded the general description of the hospital ICU setting and included data on admitting diagnoses for the six-month study period January to June 2006.
2. Admission Diagnosis has been added to our descriptive data on the study cohort.
3. We have added information pertaining to the composition of the critical care medicine team including subspecialty fellows and residents in specialty training programs.
4. We chose up to ten notes because the number of notes per patient in the cohort, making our analysis on 260 notes. The median notes per patient was median 2 per patient, range 1 to 10. As you can see the maximum number of notes are 10; so we are reporting analysis of all notes for the selected patients in the cohort. We have described the exclusion criteria for notes in our methods section.
5. Meaning of “Clinical notes only after death” refers to cases in which the only documentation was a written or dictate death summary added by Health Records after death. The text has been revised to make this clear.
6. Illustrative examples of notes in each quartile of word length have been added as Table 4 Representative Clinical Notes. We agree that this is more illuminating than our histogram of word counts.
7. The agreement between investigators MR and AC, who analyzed the data separately, is referred to. Text has been changed to make this clear.
8. Results have been separated from the discussion.
9. Tables have been inserted before the discussion to improve readability.
10. We acknowledge the weakness of our trial design in the limitations paragraph at the end of the discussion. Our observed agreement between reviewers MR and AC for domains of quality was poor, perhaps owing to the high proportion of null results. Our percentage agreement results are more representative and show moderate agreement between the two observers when there actually was a result matching a domain of quality.
11. Again, the domains of quality required subjective judgment to assign during analysis. A shortcoming of our methodological quality is that we did not conduct training on the relevant considerations for the two reviewers. I have synthesized the major provision of the act relevant to best interest as thematic categories.
12. Figure 1 is deleted, and in place are representative examples of notes as discussed above.

Karin T Kirchhoff Comments

1. We have provided a breakdown of the sample of charts, showing why some charts from the time period are not analyzed and our final dataset is 260 clinical notes. We have noted that no electronic charts were in use during the study period.
2. Additional information on the Act is provided, and the practice applications of the Act are discussed in our discussion of Scardoni.
3. Yes, we are saying that kappa was reduced because of a skew from a high number of zero / null / absent results. Our percentage agreement results are more representative and show moderate agreement between the two observers when there actually was a result matching a domain of quality. We present the values for kappa in Tables 6 and 7.

Hoping that the re submitted manuscript will now meet your standards.

Sincerely,

Dr. Andrew B Cooper