Author's response to reviews

Title: Cause-specific mortality patterns among hospital deaths in Thailand

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Author's response to reviews: see over
Dear Professor Murray,

RE: Submission of revised manuscript No: MS 3709895723150872 - Cause-specific mortality patterns among hospital deaths in Thailand

Thank you for providing an opportunity to respond to comments from the reviewers of this manuscript. Our detailed responses to comments that required specific attention are as follows.

**Reviewer: Kanitta Bundhamcharoen**

Comment 4: My previous question was on the % of confirmed and % of suggestive evidence, not the total of these. Definitions of confirmatory and weak evidence were given on page 7, but there is no definition of suggestive evidence. It is suspected that definitions of confirmed diagnosis may be different among disease categories. I wonder if % of confirmed diagnosis is very small due to perhaps limitation of personnel and equipments and thus suggestive category is created.

**Response:** We clarify here that the manuscript did originally describe three categories of evidence i.e. confirmed; suggestive and weak. We had originally considered the ‘suggestive’ category as those cases for which there was evidence in the form of a clinical diagnosis by specialist medical personnel without any supporting clinical investigations; or a written interpretation of an electrocardiogram without actual sighting of the ECG; etc.

Based on the comment from the reviewer on the previous version of the manuscript; we reviewed the data; and found that only 3% of the cases had been assigned to the ‘suggestive’ evidence category. Hence, we chose to adopt only a two category rating scale for strength of evidence; and re-categorized these cases with ‘suggestive’ evidence to the ‘weak’ category. Therefore, we eventually presented the strength of evidence on Page 11 of the revised manuscript as follows: 72 % cases with confirmed evidence; 20% as cases with weak evidence; and 8% as cases with no data on strength of evidence.

By doing so, we avoided the ambiguity that is created by the ‘suggestive’ evidence category. We hope this response clarifies this issue.

Comment 5: As suggested by the authors that it is important to understand in more detail the nature and extent of misclassification patterns in the registration data to guide remedial action, further details in relation to particular diseases will be valuable to point out why misclassification of death diagnosis occurred. From this study, I observed that 25% of the error was from inconsistency with underlying COD from medical record which is remarkable and need further investigation.

**Response:** We agree with the reviewer that the findings on inconsistency between underlying causes from registration and medical record review are important. However, we feel that further investigation into the reasons for such inconsistencies (which would vary by cause) is beyond the scope of this paper.

As instructed by the PHM Editorial Team, we are submitting a revised version of the manuscript via the electronic manuscript processing website. I look forward to hearing the outcome of this submission.

Yours sincerely,

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