Author's response to reviews

Title: An improved method for physician-coded verbal autopsy reduces the rate of discrepancy: Experiences in the Nouna Health and Demographic Surveillance Site (NHDSS), Burkina Faso

Authors:

Maurice YE (ymaure@yahoo.fr)
Eric Diboulo (dibouloeric@yahoo.fr)
Louis Niamba (niamba_louis@yahoo.fr)
Ali Sié (sieali@yahoo.fr)
Boubacar Coulibaly (boubacar.crsn@fasonet.bf)
Cheik Bagagnan (cheik.crsn@fasonet.bf)
Jonas Dembelé (sohandemb@yahoo.fr)
Heribert Ramroth (heribert.ramroth@uni-heidelberg.de)

Version: 9 Date: 17 June 2011

Author's response to reviews: see over
Dr Maurice YE  
MD, MPH  
Nouna Health Research Centre  
Ministry of Health, Burkina Faso  
B.P. 02  
Nouna, Burkina Faso  

To  

PHM Editorial Team  
Tel: + 1-206-897-2881  
Email: editorial@pophealthmetrics.com  

Dear Sir/Madam,  

It was a great pleasure for me that the manuscript entitled “An improved method for physician-coded verbal autopsy reduces the rate of discrepancy: Experience in the Nouna Health and Demographic Surveillance Site (NHDSS), Burkina Faso”.  
”, which was re-submitted a weeks ago, has been reviewed again and returned back for additional clarification  

With the re-submission of this cover letter and the revised manuscript, we hope to fulfill all the requirement of the reviewers.  

As a main point to notice first of all, the manuscript was now again checked by a native English speaker.
Point-by point responses.

Reviewer: Rasika Rampatige

The reviewer Rasika Rampatige, has no further comments on the manuscript submitted. We are very grateful to its valuable contribution.

Reviewer: Bruce Neal

Reviewer's report:

Point 1. The abstract is very long

We agree with the reviewer. Corrective measures were taken, and the abstract counts now 348 words.

Point 2. The conclusions are not well justified. If you are trying to identify a pattern of mortality it doesn't matter if you assign a cause to every death. Simply that those you assign a cause to give you the right pattern. Which the authors have demonstrated very nicely is the case with their first method. Specifically, while that first method fails to get agreement for a large proportion it still gives an almost identical pattern of mortality for the population as the second method for which agreement is much better. So while agreement has been improved the final data of interest have not.

Our data possibly suggests that trying to identify a pattern of mortality doesn't mean to assign a cause to every death. Here, the death pattern is not affected in both methods, but the proportion might possibly be different in another setting after introducing of the physician panel. Clearly, the suggested method is more time consuming and costly, but it is also more efficient. However, this is the first time that such a panel discussed the questionable cases.

Point 3. Another point that is not really addressed is that better agreement doesn't mean a more reliable result. Having 98.5% agreement is almost implausibly high and almost certainly 98.5% of causes are not correctly assigned. Indeed, all the data that we saw at the recent Bali conference suggest that the reviewers are doing far far worse than this. This does not seem to be appreciated by the authors.

The idea here is to code each death which often is not done within the formal health facilities. In our case, the physician coders of the panel were experienced persons, which lead to a better agreement on the diagnoses. This explains why the agreement
is high and somehow could translate a certain quality given the experience of physician.

4. So, is this a better method. I don't think so. Sure you get more agreement but what does that mean? More agreement on some correct diagnoses, more agreement on some incorrect diagnoses, and no real impact on the final estimated mortality pattern. With greater cost and longer timelines attendant upon the additional review step. I think the authors need to be much more cautious about their conclusions.

The response in point N°4 is the same as that provided in N°2

5. it would also be helpful to know how many causes the physicians could code to. Was it a restricted list? Or could they assign any ICD code at any level? And if the latter how did they decide what agreement was? Same broad diagnosis or exactly the same code to every decimal point?

We used a restricted list based on ICD10.

6. The authors state in the discussion that the narrative contains important information. While that might seem intuitive, I am not sure there is evidence to support that. And indeed, we again have evidence to the contrary. Use of a good structured questionnaire may well be as effective as adding in narrative data.

This has been considered within the discussion. Indeed as shown by Fottrel (Fottrell 2007, PopHealthMetr Prob Model VA). However, as the VA questionnaires differ widely for different surveillance sites, higher impact information might be found in other questionnaires.

About the English, the final version was checked by native English speaker for grammar and spelling.

Conclusion
At this stage of the submission process, these are the informations that the team could provide to clarify the issues raised.

We remain open for further clarifications

Sincerely, yours

Dr Maurice Yé
MD, MPH
Centre de Recherche en Santé de Nouna
PO BOX 02 Nouna
Tel : +226 70244811, +22620537043, e-mail : yemaure@yahoo.fr
While hoping that our manuscript will fulfill your need and interest