Reviewer's report

Title: An international survey of physicians regarding clinical trials: A comparison between Kyoto University Hospital and Seoul National University Hospital

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Reviewer: zelda tomlin

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Major compulsory revisions

The authors have responded to the points raised in my original review and the paper is now much improved. However, a few points remain that should be fairly easy to deal with:

5) The authors do not make clear how the questionnaire was developed. The questionnaire was a modified version of a previous one designed with the involvement of one of the authors (Sumi et al, 2009) which, in turn, was a modified version of an earlier questionnaire (Yanagawa et al, 2006). This is not adequate to explain to the reader how the questions were developed (based on what – literature review?), tested and piloted. The explanation on each question in the methods section is unnecessary.

For readers interested in the design of the original questionnaire, can the authors say whether References 14 and 15 include an explanation of design? I still think that some detail needs to be given about how the questionnaires (the original and the current one) were developed. I note that there is a reference to this in the Discussion, but there needs to be a brief explanation in the Methods too.

8) The meaning of some of the questions is unclear/overlapping. For example, what are ’infrastructure’ related problems and how do they differ from ’systemic support from hospital’? Similarly, how do problems with ’enrolment of subjects’ (incidentally, the preferred term these days is ’participants’) differ from problems with ’obtaining informed consent’? What were the problems/merits identified in the ’others' option in these sections?

The authors’ explanations of the difference between systemic support/infrastructure and between enrolment/informed consent are helpful but can they please add these to the paper by inserting them in brackets after each term (p 14, lines 9, 10, 13, 15).

9) A distinction is made between barriers/problems associated with ’trials’ and industry-sponsored multinational trials with different answer options (Q 10 and Q16). What was the rationale for this? Many of the factors could apply to both kinds of trials. Quality of (multinational) trials was seen as a bigger problem at KUHP than at SNUH; as it is unlikely that there is a big difference in the quality of
trials that two hospitals are exposed to, this may need explaining: is it, for example, that the expectations of KUHP doctors are higher?

The authors haven’t dealt with the second point here (on quality).

11.3 The higher percentage of trials terminated due to adverse events at SNUH compared to KUHP (26% v 8%) may need a comment. Furthermore, the other reasons given by SNUH doctors are intriguing and troublesome and also need comment: adverse events (a higher percentage than at KUHP), sponsor’s request, protocol violation, publication of similar trial results elsewhere, unfeasible research design. Some of these appear to be avoidable shortcomings, with implications for resource use in trials.

The authors explain that the higher % of adverse events at SNUH may be due to the higher risk profile of the trials there. Can they please add this to the paper, with a brief explanation on p 15, after the last sentence, on line 15.

11.4 While the Discussion addresses the infrastructural and operational factors in limiting the number of trials in Japan, it does not address other findings. For example, the authors explain the higher tendency of KUHP physicians to refer to recruitment problems in terms of the limited availability of eligible patients to any single hospital in Japan, compared to South Korea. However, they offer no explanation for the higher percentage of Japanese physicians referring to problems in obtaining informed consent compared to those in South Korea.

Can the authors provide a little more analytical comment on the issue of informed consent as they have done with some of the other points? Could the fact that South Korean doctors regard informed consent as less problematic be due, in part, to the higher proportion of Phase 1 trials if the participants in these are offered payment (if they are)? What may be other reasons for the difference in perceptions between the two countries?

Limitations:

There seems to be some conflation of two different kinds of limitation (p 28, lines 9–12 and 22-24).

The point about differences between the two cohorts in the two hospitals (lines 22-24) is the limitation highlighted in lines 9-12 (differences in response rate and composition at the two hospitals). The other selection bias - more doctors interested in trials responding than those who’re not - is a different point and may apply equally at both hospitals. These points need to be separated.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Needs some language corrections before being published
**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

I declare that I have no competing interests.