Reviewer's report

Title: Physicians’ attitudes about artificial feeding in older patients with severe cognitive impairment in Japan: A qualitative study.

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Reviewer: A Mark Clarfield

Reviewer's report:

1) The authors have dealt with an important subject: artificial feeding in older patients with severe cognitive impairment in Japan. They did so by sampling a group of 30 physicians inquiring into their attitudes towards tube feeding in such patients.

2) The manuscript offers useful insights into the behaviour of some Japanese physicians and the authors make a serious attempt to try to explain this behaviour.

3) The main trouble with the study is the small number of physicians in the sample and in particular, the non-random method in which they were chosen. This severely limits the validity of the study (even though it is quite possible that the attitudes expressed by these physicians actually do represent that of the majority). However, there is no way to tell. The authors mention that the informants were "pre-selected". What, however, was the "denominator" of these physicians? While this problem of such convenience sampling is not a fatal flaw, the authors should deal with its consequences more intensively both in the Methods as well as in the Discussion under “Limitations”.

4) The process of data collection used the “grounded theory approach”. My guess is that most physicians (including me) have not heard of this method. As such, it should be explained briefly in the text.

5) The authors inform us that they examined certain specialties, such as neurology, neurosurgery, gastrointestinal medicine and gastrointestinal surgery. Geriatrics is left out, although I do note that there was one geriatrician listed in Table 1. In most Western countries, it is primarily geriatricians who deal with these difficult issues, so a few words on why this is not the case in Japan would be in order. Is this a problem of sampling, or do geriatricians not deal with this issue in Japan?

6) Relating once again to the “grounded theory approach”, the authors should briefly explain what they mean by “theoretical saturation” (bottom of page 7).

7) I understand that many long-term patients are housed in acute care hospitals in Japan and this is alluded to in the middle of page 11. However, it is not exactly clear how this phenomenon leads to the use of PEG tube feeding, which I would imagine could be ordered from a chronic hospital as well as within an acute institution.

8) Further down (page 11), the authors mention that the current reimbursement system encourages PEG. Please explain a bit more.

9) On page 12 in the middle, I would suggest rewriting the sentence as follows: “…consider the serious financial situation of the nation’s health insurance system in their ANH decisions…”

10) With respect to legal issues, several times the authors mention the fear (or lack thereof) of lawsuits; a few words would be advisable on the situation of suing doctors in Japan. Is this common (as in America) or uncommon (as in the UK)?

11) With respect to reimbursement (page 17), are the prices referred to at the bottom of the page monthly, yearly?

12) The whole section at the top of page 18, following the explanations of informant no. 12, is not clear. It should be rewritten.

13) The authors inform us (page 18) that “…many physicians decide to perform PEG on a patient before they explain the procedure to the family”. This suggests that no formal consent is requested by the
physicians either from the patient (admittedly difficult, since they are usually demented) or from the legal representative or next of kin. This issue is dealt with further along in the manuscript, but perhaps would best be briefly described here so the readers can understand this important point better.

14) On page 19, the authors refer to “the small number” of physicians who presented the family with the option of withholding ANH. Given that the whole study sample is “small”, I would try to reword this sentence accordingly. It implies that there was a large sample from which a smaller one offered a particular option. At the bottom of page 19, I would write: “These four physicians shared several characteristics.”

15) (Page 21) The issue of physicians partially treating dehydration via intravenous or hypodermoclysis has been referred to in other papers such as ours in The Journal of Gerontology (Clarfield AM et al. Enteral feeding in end-stage dementia: A comparison of religious, ethnic and national differences in Canada and Israel. Journal of Gerontology: Med Sci 2006; 61A(6): 621-627). Our paper also refers to many of the cultural issues that are alluded to but not expanded upon sufficiently in this manuscript (see below).

16) With respect to the Discussion, while in many ways it was interesting, it was also lacking in some dimensions. The main problem of selection bias and the small sample I have already addressed above. As well, both in the Discussion and in the Methods we should be told what characterised the majority of patients. Were they after stroke, were they demented, did they have terminal cancer, etc. I assume that these are terminally demented patients, but this should be emphasized. As well, did the physicians distinguish between types of disease, or were they all treated similarly?

17) As alluded to above, this article cries out for international comparison. There has been quite a bit of work done, including the Canada-Israel comparison referenced above, as well as work by Susan Mitchell, Vincent Mor among others.

18) While culture and religion obviously influence the decisions related to tube feeding, there is almost no cross-cultural approach which is unfortunate, given that this would I am sure interest your readers. There have recently been two articles in JAGS dealing with Jewish, Catholic, Islamic (Clarfield et al.2003:51:1149-1154) and Hindu (JAGS 2005; 53:131-135) approaches to end-of-life care. It would be interesting if the authors could briefly compare Japanese culture and religion (which I imagine has elements of both Shinto and Buddhism) to others. A very fine series of articles looking at many religions and cultures was recently published in the Canadian Medical Association Journal and I know that one came out on “Chinese” medical ethics. I understand that China is not Japan, but they do, if I am not mistaken, share significant Buddhist elements of their historical cultures. Of particular interest in this domain is the willingness of families to “overrule” their parents’ wishes even when they know them. This is alluded to briefly in this article and has been well described in papers by Sonnenblick and Rosin in The Journal of Medical Ethics and JAGS several years ago, relating to this question among religious Jews in Israel. It might be interesting to mention the similarities between the two cultures.

19) As alluded to above, expressions like “the great majority” [middle of page 24] when we are dealing with 16/30 + 4 = 20/30 that is two thirds, somewhat overestimates the denominator of this study. These kinds of expressions should be moderated.

20) On the issue of whether demented patients towards the end of life suffer or not when food and water are withheld has been well dealt with by a Dutch group (Pasman HRW et al. Archives of Internal Medicine 2005 165: 1729-1735). This paper should be referenced

21) Apropos of my comments about culture, I would suggest that on page 28 the authors reword the sentence as follows: “Japanese physicians face legal, emotional and cultural/religious barriers when withholding...”

22) In summary, I think this interesting manuscript examines a very important issue on a critical subject for end-of-life care for the demented elderly. It suffers primarily from a small and unrepresentative sampling, as well as from a lack of a cross-cultural approach. I do think that these points could be dealt with by the authors and would recommend major revision.
General

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

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Discretionary Revisions (which the author can choose to ignore)

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What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article of importance in its field

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'