Author's response to reviews

Title: Patterns of complementary and alternative medicine use amongst outpatients in Tokyo, Japan

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Author's response to reviews: see over
Editor
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Dear Editor

Re: MS: 1428371468179573 - Patterns of complementary and alternative medicine use amongst outpatients in Japan

We would like to thank the reviewers for critically analysing our paper. We have the pleasure of submitting a revised manuscript having done all the necessary revisions requested by the reviewers. Please find below our responses to the individual reviewers comments.

Reviewer 1 (Aslak Steinsbekk)

Major Compulsory Revisions - The author must respond to these before a decision on publication can be reached. For example, additional necessary experiments or controls, statistical mistakes, errors in interpretation.

1) The references are old, the newest one is from 2001. A more updated presentation of the current knowledge is needed in the introduction and this should be used in the discussion to put the current study in perspective.

We have now updated our references in the introduction and discussion sections.
and have put our study in perspective.

2) The introduction focuses only on use of CAM in general populations. It should focus on studies in outpatient settings as that is what this survey is all about. The literature referenced should also reflect the issues in the survey like prevalence, disclosure, perceived effect etc.

Thank you for this valid point. We have now discussed more about CAM usage in the outpatient settings to reflect on this point. We have also referenced appropriately to reflect the different issues in the survey (ie – prevalence, disclosure, perceived effect etc).

3) Definition of CAM. The exact wording used should be given in the methods and at least a discussion of the impact on the prevalence of using different criteria for which types of therapies to be included should be given. My opinion is that e.g. healthy eating is not a CAM therapy, although it is included in some studies, but the main point is that a clear definition is needed to understand how the authors thinks on this issue.

We have now included the definition of CAM used in our paper. We have included this definition in the methods and have also discussed the impact of different CAM definitions on prevalence. We have also included our rationale of including certain CAMS in our questionnaire. Finally the definition of healthy eating has been improved – we actually surveyed this in our questionnaire as “health foods (kenko shokuhin) and dietary supplements”. We thought that in our paper we should write it as “healthy eating” as we initially thought this term would include both health foods and dietary supplements but clearly this term is ambiguous and therefore we have changed this to “health foods and dietary supplements”.

4) To more clearly identify the factors associated with CAM use, a multivariate analysis should be done (e.g. a logistic regression analysis).

We have now added a new author to our manuscript – a statistician from University of Cambridge Centre for Applied Medical Statistics who has reviewed all our statistics including performing a multi-variate analysis on our results.
Unfortunately the multivariate analysis did not add / identify any other factors associated with CAM use other than what we have already shown in our uni-variate statistical analysis therefore we have not updated / included these results in the revised manuscript.

5) The consequence for generalisability should be discussed more as the sample differs substantially from the general population with regards to education level. This raises the question if the sample also differs in other respects and if the survey method lead to some sort of systematic bias.

Thank you for this comment. Our study was concerned with analysing the Japanese population attending a typical DGH outpatient clinic which offer both primary and secondary care services where patients can “walk in”. The population is therefore expected to be different from that of the general Japanese population and we have discussed this further in our discussion. We have also discussed the ways in our methodology that we ensured that no systematic bias was been inadvertently introduced.

Discretionary Revisions: These are recommendations for improvement which the author can choose to ignore. For example clarifications, data that would be useful but not essential.

1) I think that all the strengths and limitations of the study should be presented together and not in between discussion of the results.

We have updated our discussion to reflect this point.

2) Too much of the information in the tables is also stated in the text in the result section.

We have also updated our results and tables to ensure that the information complements (rather than duplicates) the results section and the tables.
Reviewer 2 (Ignacio Correa-Velez)

Major Compulsory Revisions - The author must respond to these before a decision on publication can be reached. For example, additional necessary experiments or controls, statistical mistakes, errors in interpretation.

1) The reference list, and more importantly the introduction and discussion sections, need to be updated. There have been more recent articles exploring prevalence and reasons for using CAM among the Japanese population in a variety of setting.

We have now revised the whole of the introduction and discussion to incorporate some more recent articles exploring the prevalence and reasons for using CAM among the Japanese population. References have been updated to reflect these.

2) There is no clarity about how CAM therapies/modalities are categorized for the paper. For instance, healthy eating doesn’t seem to be CAM but good medical practice (either orthodox or complementary). Do the authors refer to dietary supplements? That’s different from healthy eating.

We have clarified the definition of CAM therapies and modalities and have revised and updated the methods section. We have also discussed our reasoning for incorporating the different categories of CAM in the discussion section.

The definition of healthy eating has been improved – we actually meant surveyed this in our questionnaire as “health foods (kenko shokuhin) and dietary supplements”. We thought that in our paper we should write as “healthy eating” as we initially thought this term would include both health foods and dietary supplements but clearly this term is ambiguous and therefore we have changed this to “health foods and dietary supplements”.

3) As stated in the CAM definition presented in the Introduction section, CAM is culture-bound (i.e. what constitutes mainstream medicine or CAM may be different across cultures). It would be useful in the introduction to briefly set up the scene of what constitutes mainstream medicine in a Japanese context (given the international readership of the journal). It has been reported that up to 70% of medical practitioners in Japan use some form of CAM.

We have set a scene on what constitutes CAM in Japan and that CAM is culture bound. We have also set a scene of what constitutes mainstream medicine and have also discussed about the Japanese healthcare system.

4) Did the survey that was given to participants contain a definition of CAM? Were some examples of CAM given in the survey (e.g. list of CAM modalities that participants were asked to tick?).

The survey did contain a definition of CAM and this has been now stated in our methods section. Patients were asked to tick the CAM modalities that they have used in the past 12 months. There was also a section under CAM use called “others” for patient to tick and specify other CAM used.

5) The paper would benefit from a better categorization/analysis of reasons for CAM use. Some of the reasons given in the paper seem to intersect (e.g. musculo-skeletal problems and pain control). Most people (especially those who are attending hospitals) use CAM because they suffer from one or more health conditions (e.g. arthritis) but would have more specific reasons for using CAM (e.g. pain relief, get better, improve overall wellbeing, perceived lack of side-effects, dissatisfaction with conventional medications). A better analysis would be to present separately health conditions for which CAM was used (e.g. musculo-skeletal, gynecological, etc) and other analysis with specific reasons for use.

Thank you for mentioning this important point. We have now reanalysed and better grouped / categorized the reasons for CAM use (Table 5). We have incorporated a second table analysing the types of CAM used according to the 3 commonest medical conditions suffered by CAM users (Table 4).
6) Was the question about reasons for CAM use an open-ended question (or were participants asked to tick from a list of common reasons for CAM use)?

The question about reasons for CAM use was a combination of tick list from a list of common reasons given for use and a space for participants to write their specific reason for CAM use not listed on the questionnaire.

7) It is important to differentiate reasons for CAM use from predictors of use (e.g. gender, education, financial status)

We have now differentiated the predictors of CAM use: gender, age, income, education level and causative reasons for use: medical conditions suffered. This differentiation has been incorporated in our results section and tables.

8) The methods section needs more detailed information: Time frame of data collection (one day? several days? weeks?); more information about the survey methods used (was the questionnaire based on previous studies?); if the average turnover of the hospital is 1000 outpatients per day, why only 515 adults were invited to participate (e.g. 50% were children? not all were asked? were all specialities included?)

We have revised the methods section and have incorporated the time frame of data collection, age group of our participants (all adults above 18) and our survey methods. We apologise for the typing mistake in the original manuscript – we sampled all patients above 18 only (and not 16 as it was originally written). The average turnover of 1000 outpatient per day was a guesstimate and as such, we have removed this from the methods section as it is not accurate. We invited 515 adults to participate as we felt that we had sufficient number to allow statistical analysis and for valid conclusions to be made.

9) An important point to mention is that the oncology clinic was not included in the sampling (perhaps the hospital doesn’t have this clinic?). This may have changed substantially the prevalence of CAM use (this issue needs to be addressed in the discussion).
Our study was concerned with analysing patients attending the primary and secondary care clinics run by Shiseikai Daini Hospital in Tokyo where patients are allowed to just “walk in” to see the specialists. We have discussed this unique Japanese healthcare concept where primary / secondary care provision is blurred in both our introduction and discussion section. Clinics such as oncology and chronic pain clinic are specialist tertiary referral clinics which patient cannot attend without referral therefore we did not sample these clinics.

10) The study surveyed people attending conventional medicine clinics (and therefore sick people who were conventional medicine users) and this may also explain the low proportion of patients reporting dissatisfaction with conventional medicine as a determinant of CAM use.

We have addressed this issue in our discussion section.

11) My main concern with the statistical analysis is that is mostly univariate. A multivariate analysis would have been more interesting!

We have now added a new author to our manuscript – a statistician from University of Cambridge Centre for Applied Medical Statistics who has reviewed all our statistics including performing a multi-variate analysis on our results. Unfortunately the multivariate analysis did not add / identify any other factors associated with CAM use other than what we have already shown in our uni-variate statistical analysis therefore we have not updated / included these results in the revised manuscript.

**Minor essential revisions**

1) It is stated that all participants were adults but the age range was from 16 to 92. How many minors were included in the sample?

We apologise for this typing mistake. Our sample were all adults above age 18 and consequently did not include any minors.

2) Should the p-value in the Abstract Results section (and also in table 1) be p=0.025 (and not p=<0.025)?
We have updated our abstract results sections and tables to reflect the accurate p-values.

We hope that the revised manuscript is now ready for acceptance and publication. Please do not hesitate to contact us should you need any further information.

Yours sincerely,

Dr Satoshi Hori
(on behalf of the authors)