Author’s response to reviews

Title: Trends in descriptions of palliative care in the cancer clinical practice guidelines before and after enactment of the Cancer Control Act (2007): Content analysis

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Author’s response to reviews:

Dr. Maria Zalm
Editor-in-Chief
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Dear Dr. Maria Zalm

Thank you for inviting us to submit a revised draft of our manuscript entitled, “Trends in descriptions of palliative care in the cancer clinical practice guidelines before and after enactment of the Cancer Control Act (2007): Content analysis” to BMC Palliative Care. We also appreciate the time and effort you and each of the reviewers have dedicated to providing insightful feedback on ways to strengthen our paper. Thus, it is with great pleasure that we resubmit our article for further consideration. We have incorporated changes that reflect the detailed suggestions you have graciously provided. We also hope that our edits and the responses we provide below satisfactorily address all the issues and concerns you and the reviewers have noted.

To facilitate your review of our revisions, the following is a point-by-point response to the questions and comments delivered in your letter dated October 22.

Asao Ogawa (Reviewer 1): Dear authors,

Thank you very much for this interesting work I was able to review. For the better understanding of your work, I have some questions:

Response

Thank you for your kind words.

Comment 1

In Cancer control programs in Japan, the aim of "palliative care from the time when cancer is diagnosed" is different from the emphasis of palliative and end-of-life care. In cancer control programs 2nd, "palliative care from the cancer diagnosis" includes the supports for coping with cancer by primary care teams. So, this programs demand that the cancer designated hospitals provide the distress screening and that the physicians providing cancer treatments achieve the basic distress management skills. So, I wonder that the narrow definition of you adopted ("care given to a patient when there is no response to curative treatment and life-expectancy is less than one year") and domains are inappropriate for assessing the effects of the Cancer Control Act.
Maybe it would be better to review the aims of Cancer control programs and modify the domains to grasp the meanings of the political proposals.

Response 1

Thank you very much for your questions and comments.

As you pointed out, “palliative care from the time when cancer is diagnosed” was listed in the cancer control programs that took effect in 2007. In our study, we included the cancer clinical practice guidelines published before 2007. Although palliative care had already been recognized at that time as “palliative care from the time when cancer is diagnosed”, this definition did not fully penetrate the clinical setting, where about 80% of patients with cancer died without receiving palliative care. In the present study, based on the situation of cancer care at that time in Japan, we considered palliative care as “care given to a patient when there is no response to curative treatment and life expectancy is less than one year.”

However, as you pointed out, this does not match the definition of “palliative care from the time when cancer is diagnosed” in cancer control programs (Phase 1). Therefore, we added this newly defined viewpoint and additionally investigated the presence or absence of the following terms in the clinical guidelines before and after the enforcement of the Cancer Control Act.

1) Investigation of the description about the new definition “palliative care from the time when cancer is diagnosed” (before enforcement → after)

Only one CPG (colorectal cancer) → four CPGs (esophageal cancer, stomach cancer, pancreatic cancer, colon cancer)

2) Investigation of the description of the term (before enforcement → after)

Palliative care: 8 → 9
BSC (best supportive care): 3 → 7
Palliative therapy (surgery/radiation): 8 → 7
Symptomatic treatment: 4 → 5
Palliative care and BSC: 9 → 10 (all selected guidelines)

The reason why there have been fewer descriptions of palliative therapy since the enactment of the Cancer Control Act is because palliative therapy was changed to symptomatic treatment in the guidelines for ovarian cancer clinical practice. Based on these results, fewer than half of all CPGs have described the new definitions that had been adopted since the Cancer Control Act. However, references to the terms “palliative care” and “BSC” as well as to the definition of
“palliative care since diagnosis” have increased, and the interest in palliative care in CPGs as a whole increased both before and after enactment. We added a discussion regarding these points and the contents of the survey to the revised manuscript as below.

p. 10, l. 192-198

In addition, the description of “palliative care from the time when cancer is diagnosed” stated in the Cancer Control Act was stipulated only in the colon CPG before implementation, compared with the esophageal cancer, stomach cancer, pancreatic cancer, and colon cancer CPGs after implementation. Furthermore, in the second survey, the number of guidelines describing the terms “palliative care”, “best supportive care (BSC)”, and “symptomatic treatment” had increased (Table 4).

p. 16, l. 311-317

We considered palliative care as “care given to a patient when there is no response to curative treatment and life expectancy is less than one year” based on the content of cancer control programs, the situation in Japan in 2007, and descriptions in a previous study. Although this definition does not correspond with the description “palliative care from the time when cancer is diagnosed” used in cancer control programs, we believe that indications in cancer diagnoses regarding how the perception of palliative care changed before and after the Cancer control Act have been enforced.

Comment 2.

Some clinical practice guidelines, which did not show the collaboration with the Japanese Society of Palliative Medicine at the front description, were cooperated by recommending the committee members in the official way. I wonder that the deep consideration of the methodology are needed.

Response 2

Thank you for providing these insights.

We confirmed the CPGs for the two sessions (2007 and 2015) whether any relationship with the Palliative Medical Society was referred or not in the three points as “guideline executive committee”, “external review committee”, and “guideline development committee”. As a result, we confirmed that there was no mention of these items in CPGs at either time point. In addition, there was no description as to whether the guideline developers included members from the
Japanese Society for Palliative Medicine. Therefore, the participation of members of the Japanese Society for Palliative Medicine at the individual level is unknown.

As the method of analysis, we used “content analysis,” which is an established qualitative analysis method. Therefore, our analysis is based on only the information included in CPGs. In AGREE II, which is a basic and widely-used method for evaluating CPGs, only the description contents are checked. The consultation with the Japanese Society for Palliative Medicine that you pointed out seems to correspond to “AGREE II No 13. EXTERNAL REVIEW: Report the methodology used to conduct the external review.” Even if this is done, there is no target of analysis other than the information described above. These points were added to the revised manuscript as below.

p. 11, l. 200-205

We confirmed the CPGs for the two sessions in 2007 and 2015 that were covered for the three points of the society (guideline executive committee, external review committee, and guideline development committee) regarding the relationship with the Palliative Medical Society. As a result, we confirmed that there was no mention of these items in CPGs at either time point. In addition, there was no description as to whether the guideline creator was a member of the Japanese Society for Palliative Medicine.

p. 15-16, l. 312-316

As a method of analysis, we used “content analysis,” which is an established qualitative analysis method. Therefore, our analysis is based on only the information included in CPGs. In AGREE II, which is a popular method for evaluating CPGs, only the content of description in CPGs is checked. Therefore, there is no target of analysis other than the information described above.

Nobuhisa Nakajima (Reviewer 2):

This is a content analysis study to count lines in all texts of relevant clinical practice guidelines. The theme of this study is important, and the results will be returned to the clinical practice. I have several comments; as follows.

Response
Thank you for your kind words. We have revised the manuscript per your comment. Please find below.

Comment 1

#1: l 76-77; Cancer Control Ac → Cancer Control Act

Response 1

Thank you for your comment. This has been corrected in the revised manuscript.

Comment 2

#2: l 81-83; "An investigation of ... in clinical practice." Please quote several papers which support this opinion.

Response 2

Thank you for your comment. We have added following references in the revised manuscript.


Comment 3

#3: l 135-136; "two investigators" / "the two medical investigators" ... Are they the same or not?

Response 3
Thank you for your suggestion. “The two investigators” and “the two medical investigators” have the same meaning. We unified this as “the two investigators”.

Comment 4

#4: l 146, 150, 152, 158;

In the part of CPG of breast cancer, "chemotherapy" / "chemo therapy" / "drug therapy" were used. Please use the same word.

Response 4

Thank you for your suggestion. These terms have been unified as “chemotherapy” in the revised manuscript.

Comment 5

#5: l 177-182;

The dates in the manuscripts (l 177-182) are different from the dates in Table 3 (eg. ovarian ca; 1.7% or 2.1%, 10.5% or 5.1%, pro ca; 12.9% or 9.0%, ⋯)

Response 5

We apologize for these inconsistencies. This has been corrected in the revised manuscript.

Comment 6

#6: l 192-194;

I am afraid that I can't find the date that prove the description on l 192-194. Where in the manuscript, table of figure?

Response 6

Thank you for your comment. Among the 17 items, “spiritual issues”, “family roles and responsibilities”, “ethics, laws, and policies”, and “physician roles in advocacy and policy” were not mentioned, so these were not included in the figure. However, we have added these in the revised Figure.
Comment 7

#7: l 207:

"Palliative care workshops" ⋯ I recommend to describe more concretely, for example, "PEACE project".

Response 7

Thank you for your comment. We added the following descriptions about “PEACE project” in the revised manuscript.

p. 12, l. 226-230

In addition, to enable all physicians who care for cancer patients to learn the basic principles of palliative care, palliative care workshops as part of the “Palliative care Emphasis program on symptom management and Assessment for Continuous medical Education (PEACE) project” have been conducted throughout Japan.[23]

Comment 8

#8: l 244-245; "In previous studies, ⋯"

Are there any other studies in addition to the study by Mast KR [13]? If so, please quote?

Response 8

Thank you for your comment. This term has been corrected to the singular in the revised manuscript.

Again, thank you for giving us the opportunity to strengthen our manuscript with your valuable comments and queries. We have worked hard to incorporate your feedback and hope that these revisions persuade you to accept our submission.

Sincerely,

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