Author’s response to reviews

Title: Current status of integrating oncology and palliative care in Japan: A nationwide survey

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Author’s response to reviews:

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Dr. Mitsunori Miyashita
Editor
BMC Palliative Care

Subject: Submission of revised manuscript for PCAR-D-19-00216

Dear Dr. Mitsunori Miyashita

Thank you for reviewing our manuscript entitled "Current status of integrating oncology and palliative care in Japan: A nationwide survey" (Manuscript ID: PCAR-D-19-00216).

We have revised the manuscript according to the suggestions of the reviewers. More details responses to reviewers are included later in this letter.
We would like to resubmit the revised manuscript and hope that it would meet your approval for acceptance in BMC Palliative Care.

We look forward to hearing from you soon. Thank you very much for your consideration.

Sincerely yours,

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RESPONSE TO REVIEWERS
We would like to thank the reviewers for their helpful comments. Our responses to the comments are given below, beginning with the editor’s comments followed by those for reviewers 1 and 2.

Response to Editor
Editor Comments to Author:
Please revise according to reviewers' comments.

Response: We appreciate the editor’s comment. We have revised our manuscript according to the reviewer’s suggestions as detailed below.

Response to Reviewer 1:
Comments to the Authors
The investigators conducted a cross sectional survey to examine the state of palliative care at government designated and non-designated cancer hospitals in Japan. The response rate was 269/399 (67%) for designated hospitals and 150/478 (31%) for non-designated hospitals. Matching was conducted based on inpatient beds and region. This study was well design and well written. It represents an admirable amount of work and provides important information on the state of palliative care in Japan. The following comments may help readers to better appreciate this study:

Response: We appreciate your comment. We have revised our manuscript according to your suggestion as shown below.

Comments
1. Abstract. The statement "Further investigation is warranted whether those indicators effectively work in real clinical situations." was not supported by the data presented in the abstract. Instead, consider highlighting major research/educational gaps that need to be addressed.

Response: We appreciate this comment. We replaced the concerned sentence into the following one.

Abstract Section, Page3, Line 11-12:
Further efforts are needed to address the serious research/educational gaps.

2 Methods. Please clarify if a primary outcome was defined for this survey.
Response: Thank you very much for this comment. We did not define a primary outcome due to the explanatory nature of the survey. However, we performed sample size calculation to ensure the general accuracy of the survey. We added the following sentence to explain this point.

Method Section, Page 7, Line 2-3:
We did not define a primary outcome owing to the explanatory nature of this survey.

3. Methods. This survey was sent to hospital executives. Please comment if they were expected to provide accurate details on palliative care program in their hospitals.

Response: We appreciate this comment. As written in the manuscript, the Japanese Ministry of Health, Labor, and Welfare has presented several mandatory requirements for DCH certification, such as referral criteria for PC services, institutionally accepted symptom management guidelines, and routine PC screening. Thus, DCHs are required to report their detailed clinical environment, including palliative care services, on an annually basis to the government.

4. Methods. Only a selected number of major/minor indicators were included in the survey (e.g. early referral [≥6 months before death in the outpatient setting] was not included). The investigators may want to include their rationale for this selection.

Response: We appreciate this comment. Based on our pilot tests of the survey, indicators of clinical outcomes could be heterogeneous among individual healthcare professionals and it was thought to be hard to respond to such heterogeneity from the viewpoint of hospital executives. We also considered asking the hospital office staff to respond the indicators; however, it would be a considerable burden, which can decrease the survey response rate. Thus, we decided to skip the questions about clinical outcome indicators.

Method Section, Page 7, Line 15-17:
Clinical outcome indicators were excluded because the target respondents were experiencing difficulties in answering these questions due to the heterogeneity among specialties within the same hospitals based on the pilot test results.

5. Results (p.11) "A total of 70% executive physicians in both types of hospitals did not regard their primary PC as good enough" How was primary PC defined in this survey?

Response: Thank you very much for this comment. We defined primary palliative care as palliative care provided by the primary physician and nurse. We added the following sentence to explain this point.

Result Section, Page 11, Line 8:
A total of ≥70% executive physicians in both types of hospitals did not regard their primary PC (PC services which were provided by the primary physicians and nurses) as good enough (74.7% vs. 75.3%).

6. Discussion. Consider listing multiple testing as a limitation.

Response: We appreciate this comment. We added the following sentence to explain this point.
Discussion Section, 14, Line 9-10:
Third, owing to the exploratory nature of the study, multiple tests were not adjusted which could limit the implications of the detected significant differences.

7. Table 2. "Presence of interdisciplinary palliative care team" How was this defined?
Response: Thank you very much for this comment. We defined a team of two or more occupations as an interdisciplinary team. We added the following sentence to explain this point.

Results Section, Page 9, Line 18 and Table 2 bottom line:
More than 90% of the DCHs had full-time PC staff (91.5% vs. 42.0%), interdisciplinary PC team (a team of two or more occupations) (98.5% vs. 90.0%), and outpatient clinics (95.2% vs. 58.0%), and the rates were significantly higher than that in non-DCHs.

8. Table 3. "Oncology fellows have routine rotation in palliative care" - >50% of respondents reported "no palliative care team" - this seems inconsistent with findings of Table 2. The same applies to next question. The wording "Not available" in this table should also be clarified - was it missing data or the program was not available.
Response: We appreciate this comment. It seems that the respondents might have confused the meaning of “palliative care team do not provide education,” “no palliative care team provide education” and "no palliative care team existing." Since all such responses are equivalent to "Not available for the palliative care education," we integrated the responses in Table 4.

Response to Reviewer 2:
Comments to the Authors
Thank you for the opportunity to review this paper on the title "Current status of integrating oncology and palliative care on Japan: A nationwide survey". The theme of this paper is informative. I have several minor comments; as follows.

Response: We appreciate your comment. We revised our manuscript according to your suggestion as indicated below.

Comments
(1) Background:
I think that both "early integration of PC" and "early and continuous delivery --- from the time point of cancer diagnosis" are important. Please add the explanation in detail about the differences between them.

Response: We appreciate this comment. To our knowledge, the main target population within the academic literature context has been patients with advanced cancer (e.g., Temel JS 2010 NEJM). Additionally, the Japanese government emphasizes care delivery to all cancer patients, including those at early and advanced stage. We added the following sentence to explain this point.

Background Section, Page 4, Line 10-11:
Similarly, the Ministry of Health, Labor, and Welfare in Japan has been enhancing the early and continuous delivery of quality care for patients with cancer (both early and advanced stage) from the time point of cancer diagnosis via the Cancer Control Act since 2007.
(2) Background and methods:
P4.113 ; DCH >>> government-designated cancer hospitals (DCHs)
P5.111-12; government-designated cancer hospitals (DCHs) >>>DCH

Response: Thank you very much for this comment. We corrected as indicated.

(3) Discussions:
"Further efforts to develop education and research infrastructures are valuable"
I agree this opinion. If you have any concrete plans and/or ideas on this point, please describe.

Response: Thank you very much for this comment. We revised the sentence as below.

Discussion Section, Page 13, Line 10-11:
Further efforts to develop education and research infrastructures (e.g. employing tenured or full-time
PC faculty who engages the education and research) are valuable.