Author’s response to reviews

Title: Shared decision making with oncologists and palliative care specialists effectively increases the documentation of the preferences for do not resuscitate and artificial nutrition and hydration in patients with advanced cancer: a model testing study

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Author’s response to reviews:

Dear Dr. LeBlanc

Greetings! Thank you for giving us the opportunity for a revision. We have incorporated the excellent comments from the reviewers into the revised manuscript. The point-by-point response is presented following this letter. We sincerely hope you will find our manuscript suitable for publication in BMC Palliative Care.

Respectfully yours,
Tai-Yuan, Chiu, MD, MSci
Technical Comments:

Editor Comments:

Thank you for making these revisions to the prior comments and suggestions from reviewers. There remain a number of significant issues that require attention before this manuscript can be considered further.

Response:

Thank you for giving us the opportunity for a revision. We have made great efforts to incorporate the excellent comments from the reviewers for the revision.

BMC Palliative Care operates a policy of open peer review, which means that you will be able to see the names of the reviewers who provided the reports via the online peer review system. We encourage you to also view the reports there, via the action links on the left-hand side of the page, to see the names of the reviewers.

Reviewer reports:

Ida Korfage, PhD (Reviewer 1): Review PCAR-D-19-00151_R1

SDM with oncologists and pall care specialists effectively increases the documentation of the preferences for DNR and artificial nutrition and hydration in patients with advanced cancer: a model testing study

I would like to thank the authors for their revisions and their clear responses to my earlier feedback. I think the manuscript has indeed improved.

Response:

Thank you for your kind words.
The abstract still lacks important information that would enable the readers to appreciate the meaning of the findings. You see, as a reader I need to know which change occurred because of the introduction of the model. You conclude that introduction of the model increased rates, but do not enable the reader to see how you reached that conclusion. At the moment the increase in rates of documentation after various steps WITHIN the model is reported. I need to know the rates of documentation BEFORE the steps of the model, ie. Before choice talk, and the rates of documentation OUTSIDE the model, ie. Documentation of people who did not have the choice, option, and decision talk.

If not all numbers are available, can the authors then give an estimate or at least acknowledge this limitation.

Response:

Thank you for the comment. From the hospital administrative data, the patients with advanced cancer only had 52.3% of documentation on DNR who died in our hospital during the study period which might represent the rates of documentation outside the model. Also, no participants had their preferences on DNR or ANH documented before joining the model. We added these numbers with the description “Comparing to 52.3% of DNR documentation among patients with advanced cancer who died in our hospital, the rate increased to 80.9% (206/255) after the decision talk in our model.” in the abstract. We have also added this information to the methods and results in the main text in line 239 – 241 and 289 - 290.

I ask the authors to also report in the abstract how many people refused to participate in the study, i.e. number and percentage.

Response:

We have added the number and percentage in the results section of the abstract.

Could you indicate what a higher Eastern Cooperative Oncology Group Performance Status means, i.e. better or worse performance?

Response:
We have revised the description to “A worse Eastern Cooperative Oncology Group Performance Status….” Thanks for your recommendation.

The authors now added at page 12: Hence, the documentation of DNR and ANH through the SDM process symbols the benefits of earlier palliative care integration as the congruence of patients, family, and medical professionals on the choices of life-sustaining treatments at the EOL.

I appreciate the effort to link the benefits of palliative care to the documentation of DNR and ANH, but think the documentation could rather be seen as potentially a first step to bring about huge changes in complex processes.

Response:

Thank you for your comment. Indeed, we agree that the documentation could be seen potentially as the first step for huge changes. The value of early ACP as a key component of optimal palliative care is recognized in NCCN and ASCO cancer treatment guidelines, and the preference documentation about life-sustaining treatments for better end-of-life care is suggested in the ACP for cancer patients. We have revised the description to “Hence, the documentation of DNR and ANH through the SDM process may be viewed as the initiation of earlier palliative care integration…” at page 8, line 140.

The authors now added at page 20: 375 patients with advanced stage solid tumors met the inclusion criteria, and 255 patients were willing to participate in the model.

This is important information. Please also add the percentage (225/375). And please also report how many of the eligible patients were asked to participate.

Response:

Thanks for the suggestion. We asked all of the 375 patients who met the inclusion criteria to participate. We have modified the first paragraph in the results section to “Between September 2016 and August 2018, 375 patients with advanced-stage solid tumors met the inclusion criteria and were asked to participate. A total of 255 patients (68%) were willing to participate in the model.”
Amy Tan (Reviewer 2): Thank you for the opportunity to review the major revisions for this manuscript. The overall writing, content and flow of the manuscript is much more clear and improved in this version.

Response:

Thank you and we appreciate your kind comment.

I do still have some suggestions that I hope would further help with the clarity of the paper as follows:

There are a few language and syntax errors that would need to be corrected, including the conjugation of some verbs. For example: Line 348 having instead of have, Line 365 possibility instead of possibilities and 216/217-be clearly conscious (and competent?) instead of "have a clear conscious".

Response:

We have made the corrections according to your comments. Thanks!

Please clarify if line 79- durable power of attorney- is this referring to medical or financial? In many jurisdictions around the world, the financial POA is not an explicit part of ACP, which focuses on healthcare preferences.

Response:

Thanks for the suggestions! We referred to the medical durable power of attorney mainly for health care. We have clarified this in line 79.

It is still unclear after careful reading of this manuscript as to whether the outcome measure was the decision to NOT resuscitate or was it documentation about whether DNR or resuscitation was desired by the patient (example line 379). For example, if after the SOP process, a person still chose to be resuscitated, was this accounted for? Or was this seen as a negative outcome, even if it was made with appropriate informed and shared decision-making?
Response:

Thank you for the comment. We defined the model as effective when the patient had documented the preference on DNR or ANH even if the patient chose to be resuscitated or receiving ANH after the SOP process. The text in the Methods section line 233 – 239 were revised to “In the “decision talk,” preferences on DNR and ANH were then documented with patients’ signatures even the patient chose to be resuscitated or receiving ANH. The DNR documentation form was then uploaded to the national electronic health record by social workers if the patient chose not to be resuscitated, and the ANH preferences were documented in the hospital electronic information system by palliative care specialists.”

This, I would perceive, is also another limitation of this study- given its narrow scope of the overall ACP process, and its focus on EOL treatments in a time where the current discourse is that ACP should focus on overall values and goals and not specific hypothetical medical decisions. Are the authors able to articulate why they chose to focus only on DNR and ANH documentation, which is a small part of the overall ACP process- can the motivation for this decision please be articulated?

Response:

We appreciate the comment. The target population of the study and the SOP model are patients with advanced cancer. We had added this in the abstract, background section, line 43. The importance of documenting preference on EOL care during ACP in these patients is demonstrated in previous studies.[1,2] Among seriously ill oncology patients, the lack of AD regarding care options during the end of life could lead to negative consequences for patients and caregivers.[3-5] Communication and documentation of EOL care preferences in ACP among cancer patients is also encouraged.[6,7] Moreover, Taiwan is the first in Asia to have the Patient Right to Autonomy Act and the Act allowed the patients to have the documentation of their preferences on DNR and ANH through ACP. The above reasons are our motivation to report the DNR and ANH documentation in the model. We articulated the motivation with “The importance of documenting preference on EOL during ACP in these patients is demonstrated, and the lack of advance directives regarding care options during EOL could lead to negative consequences for patients and caregivers. Communication and documentation of EOL care preferences in ACP among cancer patients is also encouraged. Furthermore, Taiwan is the first in Asia to implement the Patient Right to Autonomy Act. The Act, which is enacted in 2019, states that patients have the right to receive or refuse life-sustaining treatments and ANH in specific clinical conditions after ACP (Additional file). Through the process of ACP, the Patient Right to Autonomy Act provides the legal basis to help the patients make decisions regarding the treatment options provided by the physician.” in the Background section, lines 93 – 104.
In line 329 I don't believe that you can make the assertion that this is an "ideal" process. I would recommend feasible, especially given that the paper mentions (in passing) that this is a model testing. Thus, I don't think that the authors can say for certain that this will be an "ideal" intervention as it was a prototype test for feasibility and early outcomes.

Response:

We agree with the reviewer’s recommendation and have revised the description to “feasible.”
Thanks!

For line 331, I would suggest adding "EOL" before treatments for clarity.

Response:

We have added “EOL” according to your suggestion.

Another overall comment is that the authors describe that this study was a test for their model. I would suggest adding outcomes from the implementation and feasibility of this work as part of the "model-testing" as the outcomes reported would be early expected outcomes from a test/pilot feasibility study. I would also suggest clarifying that this was a pilot/test study in the abstract.

Response:

We agree with the reviewer’s suggestion and have now indicated the outcome came from a pilot study in line 65 in the abstract, line 326 in the discussion, and line 403 in the conclusion.

References:


