Author’s response to reviews

Title: Truth Telling and Doctor Assisted Death as perceived by Israeli Physicians

Authors:
Baruch Velan (baruch_v@yahoo.com)
Arnona Ziv (Arnonaz@gertner.health.gov.il)
Giora Giora Kaplan (GioraK@gertner.health.gov.il)
Carmit Rubin (carmitr@gertner.health.gov.il)
Yaron Connelly (yaron.connelly@gmail.com)
Tami Karni (TamiK@asaf.health.gov.il)
Orna Tal (ornatal@asaf.health.gov.il)

Version: 1 Date: 26 Dec 2018

Author’s response to reviews:

Technical Comments:

Editor Comments:

Based on the reviewer comments and my own assessment, I have judged that major reworking of the manuscript is required. Several issues, both major and minor, have been raised by the reviewers. As regards the major issues that would need to be addressed, these are:

1) The paper needs substantial English language editing.

We apologize for not doing this prior to the first submission. This has been corrected now with the help of an English speaking colleague.
2) Many of the claims made in the manuscript are insufficiently substantiated. Concerns have also been raised that important recent literature is not included in the manuscript. Reference should, for example, be made to the most recent literature from Belgium and The Netherlands and the Israeli legislation. Particularly the discussion section needs a reworking with more and recent references.

This is indeed a serious flaw. Substantial attempts have been made to correct this in the revised version. A paragraph dedicated to the legislation in the Netherlands, Belgium, Canada, some US states and Israel is now included in the Introduction.

3) The most important major issue seems the methodology. Issues have been raised about the low response rate and the representability of the sample which was, for example, not compared with the national practitioner population. Questions about the survey and typology were also raised by the reviewers.

Response rate: We address this in detail in our response to reviewer 1.

In summary:

- A 10% response rate is indeed low, but is probably unavoidable in the methodology of nationwide poll that we have used.

- Our methodology gave us access to most of the practicing physicians in the country, without any screening or selection, without any pre-selection.

- We did get a large population of 2926 respondents, which allowed for a good representation of the variability in personal and professional traits.

- We argue that the traditional perceptions on response rates have been challenged by experts in field of survey methodology. Recent studies show that contrary to accepted theories low response rates don’t necessarily harm representability.
Representation: We address this in detail in our response to reviewer 1. Data have now been equated to the population of physicians in Israel, and the implications of missing information on the religiosity of respondents are discussed.

Typology: In matters as complex as assisted death and truth telling one can obviously use many different typologies, including those mentioned by Reviewer 2. We actually take pride in the typology that we have used. The combination of attitudes to truth telling and assisted death, allowed us to generate a typology of conceptual ethical characterization, which could provide additional insights.

Much more work is necessary to adequately make sense of the data. Both reviewers provide constructive comments about how the methodology can be improved.

We appreciate very much the constructive comments of both reviewers and made substantial attempts to correct the manuscript accordingly. Actually, major parts of the paper were rewritten. We would like to note that some of the reviewers' comments led us to search deeper into our result and attain insights that we have previously missed. We are very thankful to the reviewers for this.

BMC Medical Ethics 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:

Raphael Cohen-Almagor (Reviewer 1): I read the article with interest. There are some methodological difficulties that require clarifications before the article can be published. There are also some other small matters. These can be rectified. Please see below.

The response rate of 10% is very low, certainly much lower compared to what is usually regarded as an acceptable sample (30%). Please explain the reasons for the low response, and why you did not insist to have a wider response.

Response: A 10% response rate is considered low, but is probably an outcome of the nationwide poll that we have used. We chose to address in our survey the very wide population of 29,208 members of the Israeli Medical Association. This gave us access to most of the practicing physicians in the country, without any screening or selection. We thus avoided any potential selection and did obtain an authentic portrayal of the attitudes of Israeli doctors to ethical questions.

It is possible that the more traditional methodology of addressing a selected representative group would have yielded higher response rates, but we believe that the tradeoffs of using our approach have their merits. We did get a large population of 2926 responders which allowed for a good representation of variability in personal and professional traits.

It should be noted that the traditional perceptions on desired response rates have been challenged by experts in field of survey methodology. One of the authors (GK), who is a leading expert in Israel in survey methodology, came up with a list of papers demonstrating that, contrary to accepted theories, response rates ranging from 5-55% don't differ necessarily in representativeness.


All this is now explained (not in so many details) in a limitation section within the Discussion [page 19, last 3]

How representative is the sample? Every piece of data that you relate to the sample should be equated to the general practitioner population in Israel.

Response: After consulting with experts in statistics, we chose to present the original sample data in Table 1, but then related throughout the text to number weighted for the practitioner population in Israel. The multivariate analysis presented in Table 2 is also based on representation in the practitioner population. This is now indicated in the Methods section [page 7, statistical analysis]

Being aware that that accurate numbers are less important in this type of study, we preferred to use in the Abstract verbal descriptions rather than numicones (e.g More than half of Israeli doctors supported DAD, while only a third of them opposed DAD)

It should be noted that, surveys always carry limitations. Even if corrected for biases in representation of age/gender/occupation, one cannot correct for biases in attitude. One can always claim that only physicians that are interested in medical ethics have responded to the questionnaire, but this would be a problem even at much higher response rates
The issue of religion that one may assume is of particular relevance in Israel's end of life decision-making is missing. How many of the physicians are religious? How many of them work in religious institutions? Are the responses of religious physicians similar to the rest?

Response: The issue of religiousness is indeed very relevant to end of life decisions, and especially in Israel. Indeed earlier studies based on a limited convenience samples, suggested a negative relationship between support for more active forms of euthanasia and physicians' self-reported religiosity (Doron et al 2014; Wegner et al 2004).

During the formulation of our questionnaire, we have discussed thoroughly the implications of asking about religion and decided against it. We felt that relating to religiousness in a semi formal questionnaire, distributed by the Israeli Medical Association would be inappropriate in times when the schisms between religious and secular Israelis it at one of its peaks. Moreover, we felt that asking about religiousness will raise opposition and even affect response rate. The same type of arguments prohibited us from asking about ethnicity (Jewish or Arab), which is also very relevant to this study.

The lack of information on the representation of religious respondents in our survey population led us to conduct a rough sensitivity analysis. We assumed that religious doctors will always oppose DAD (which is not necessarily true, Wenger et al 2004) and that their representation in the study is half of the expected 16%, based on the estimated number religious Jews in the Israeli population (not ultra religious Jews that are less likely to practice medicine). At such rigorous conditions, the support for DAD in our study is expected to drop by 5%, and objection to increase by 5%, which still leaves a pronounced support for DAD.

All this is now explained (not in so many details) in the limitation section within the Discussion [page 19, starting at last paragraph].

Specific points:

p. 4, line 14: truth telling.
Corrected
The Netherlands and Belgium legislation is not recent.
Corrected (I am 72 years old and may perceive "recent" in a different way)

p. 6, line 2: ethical standards
Corrected
.

p. 6, line 41: repetitive. Delete from 2926 to 10%.
Deleted

p. 7, line 11: rephrase on the expense…
Corrected

Corrected

p. 7, bottom: relate to religion and religious hospitals.
Response: Unfortunately, we were not able to record the actual hospitals that employ the respondents in our study. A study related to this was conducted by Wegner et al. in 2004 in four Israeli hospitals. They have shown a 70% support for euthanasia among secular physicians versus 42% among religious one. Very religious physicians exhibited only 5% support, but one should note that the representation of such physicians, in their study as well as in the medical community is rather low.

It would be interesting to repeat such studies by comparing religious and non religious physicians who work in religious and non religious institutions. A targeted study in this direction could yield interesting observations on the effects of management on attitudes.

p. 9, line 31: DAD appears to depend…
Corrected

p. 9, last line: different specialization.
Corrected

p. 9, bottom: religion? Religious hospitals?
See above

p. 13, line 11: delete the, before the
Corrected
Address the issue of religion and religious hospitals.

See above

p. 15, line 1: worthy of consideration

Corrected

p. 15, line 10: does not dominate

Corrected

p. 16, second para: Evidence is required regarding the medical culture in Italy and Hungary.

Response: Our explanations on the effect of place of education were incomplete in the first version. We have tried to now correct this.

We now describe in a more details medical education abroad versus education in Israel, and explain the large diversity of the European schools where Israeli students choose to study. This
diversity precludes a comprehensive assessment of the ethical education provided abroad. Therefore, we now focus on the Israeli system and try to explain why the Israeli education can set the grounds for promoting utilitarian pragmatism, when dealing with death and truth.

All this is now explained thoroughly in the Discussion [starting page 15 last paragraph].

It should be noted that foreign medical education has become the subject of intensive debates in Israel during the last month. Calls for more scrutiny were expressed by officials in the health system, regarding accreditation of students educated in some of the more peripheral schools abroad. Also, a short survey that we have conducted among 22 students that completed medical education abroad revealed that none of them attended a formal course in medical ethics.

p. 17, third para: avoid speculation.

The speculative paragraph was deleted.


We now refer in the introduction to the studies of A Surbone when relating the complexity of truth in the medical context [page 4 end of first paragraph].

Pam Oliver (Reviewer 2): Please include all comments for the authors in this box rather than uploading your report as an attachment. Please only upload as attachments annotated versions of manuscripts, graphs, supporting materials or other aspects of your report which cannot be included in a text format.
While I appreciate that English may not be the first language of any of the authors, nonetheless both the spelling, grammar and use of English terminology generally in the paper are very poor, so that in many places sentences are ambiguous or the meaning unclear. There are also many typographical errors throughout the paper. It needs very thorough proofreading by a native English-speaker.

Proofreading by a native English-speaker was performed.

The authors have used sexist language throughout the paper, which needs to be corrected.

We have erred here. It is difficult to eradicate bad habits.

Given that Israel has had a campaign towards legalising assisted dying (AD) in recent years, it is good to see some literature coming out of the country on this topic, and also valuable that the research was undertaken by practising physicians. It would be helpful to see the study set in that context; currently there is no reference to the proposed Israeli legislation.

Response: The discourse on DAD in Israel takes place in the political domain, the legislative domain the religious domain, the public domain and the academic domain, but less so in the
medical community. The very strict ruling against DAD (up to 20 years of imprisonments for those involved in life termination), as well as strong anti-DAD sentiments of the establishment had a negative effect on open discussions in the matter. The campaign towards legalizing assisted dying, initiated in 2014 practically died out. One of the reasons for writing this paper was to revitalize the discussion.

We now provide information on the legislation of assisted death in Israel in the Introduction to set a background to our study [page 5, paragraph 2]. We then provide more information in the Discussion section [page 13, paragraph 3]

4. The discussion section at present lacks structure, tends to ramble, and could benefit from a set of sub-headings that clarify the flow of the argument/s. The introduction section could also benefit from sub-headings, for the same reason.

The Introduction section was modified and the Discussion section was basically rewritten.

5. In general, the authors’ have used a lot of surmise in the discussion section, and claims throughout the paper lack evidence from relevant literature to back them up. I’ve highlighted this for some specific instances in the following comments, but the comment applies to the paper generally.

Attempts have been made to correct this.

In general, I feel that the Discussion is somewhat light-weight and lacks analysis of the findings in terms of the cultural and sociopolitical contexts in which both truth-telling and end-of-life decision-making occur. The authors do not appear to have undertaken any cross-tabulation of data to discover whether

Attempts were made to evaluate findings in the Israeli cultural and sociopolitical context [pages 13,14].
7. 2 / 22 Replace 'bad' with 'poor' when referring to prognosis, throughout the paper.
Corrected

8. 3 / 29 Sexist language 'his' - replace throughout the paper with gender-neutral language.
Corrected

9. 5 / 52 "Missing answers to specific questions amounted to 50-150, …" Confusing - do they mean every question in the survey was missing responses? Percentages of the relevant total would be helpful where numbers are given in this way.

Response: All questions related to personal and professional information had some missing responses, and those amounted to 50-150 depending on the specific question. This is now indicated in the foot note to Table 2.

Missing responses to the quarry about DAD amounted to 34 and to the quarry about TFT amounted to 36. This is now indicated in the Results section.

Percentage in Table 2 is indeed presented as percentage of the total number of respondents in each of the categories.

10. 6 / 2-3 It's not clear why the authors chose to focus on these two particular ethical questions among the 11 apparently included in the survey, especially since they later attempt to
set out a taxonomy of practitioner ethical stances. The selection of just these two factors for comparison needs to be explained better in the introduction section.

Response: The reason for focusing on questions related to truth telling and assisted death are indicated in the introduction [Page 5, paragraph 3], and mentioned again in the Method section [Page 6, paragraph 3].

We believe that the attitude to these two dilemmas can reflect the major changes in medical ethics occurring during the last four decades. Mapping the attitudes to these two dilemmas can monitor the ongoing tension between deontological ethics and utilitarian ethics, as expressed in medical practice. While perceptions of truth telling in medicine have moved in recent decades from ethical pragmatism (lying is legitimate in medicine) to a fundamental command (lying is unethical), the trajectory of the perception of assisted dying was reverse, moving from fundamental morality (doctors don’t kill) to ethical pragmatism (assisting life termination could by justifiable).

11. 6 / 36ff Participant characteristics: These data would be better presented in a table, with each characteristic compared with the total doctor population in Israel. That comparison should include data for culture and religion, since the authors raise both of these in the Discussion section as potential explanations for data patterns in the findings.

Response: This information was provide in the first version in the form of Table 1 and was probably missed by the reviewer. Table 1 is also included in the revised version.

12. 6 / 53 The sample appears to have been selected purposively to some medical specialities, excluding others. The authors should clarify why some specialities were excluded (e.g. obstetricians, anaesthetists, oncologists). 'Surgeons' is a broad term; were oncologists in particular able to be identified as such, since, of all specialists, their practice has probably the greatest relevance to both truth-telling and assisted dying?
Response: We have indeed failed to explain our rational for selecting certain medical specialties. We realize that most of the studies in the field define specialist by their "proximity" to death and to poor prognosis. In this study we tried to define specialists by the nature of their interactions with patients, in term of duration, intimacy, mental versus bodily therapy. To this end we have focused on general practitioners, internists, surgeons, and psychiatrists, and related to all other specialists as "different".

Our findings indeed suggest that the nature of patient-physician interaction may play a role in perceptions of TFT and DAD. Most notably, GP who have the most intimate interaction with the patient are more reluctant than surgeons and internists to tell the truth or support DAD.

In an attempt to dissect between the contributions of a physician's medical experiences and the nature of the interaction with the patient, we have cross tabulated specialization and the workplace of physicians. This allowed us to focus on physicians of different specialties all employed by HMOs and therefore less exposed to terminal situations. Here again GP stood out as different from HMO surgeons. Nevertheless, the notable difference in attitude between surgeons practicing in hospitals and those in HMO (The formed being more supportive of TFT and DAD) suggests an interplay between the nature of the interactions with patients and the medical experiences accumulated by physicians.

This is now indicated in the Result section [page 8, paragraph 1] and explained in the Discussion section [starting pages 16, last paragraph].

Interestingly, 28 respondents identified themselves as oncologists. While this small number did not allow meaningful analysis, it is interesting to note that 36% of them supported truth telling and 54% of them supported DAD, suggesting that their attitudes could be similar to those of other physicians (In the tables presented here we grouped oncologists with internists). Pediatricians gynecologists and anesthetists, that were all grouped as "Different" did not express attitudes that are worth discussing.

13. 6 / 56 It's not clear why the authors chose to include psychiatrists in the sample, since (i) they have a very specific and limited role in assisted dying (assessment of mental competence only), and (ii) the notion of a 'bad' (vs good) prognosis can not readily be conceptualised as relevant in the area of psychiatric diagnostics. On this basis, there are validity issues around
comparing their attitudes with those of other medical specialties that need to be addressed in the method section.

Response: The common notion that psychiatrists don’t deal with communication of bad news, with unbearable suffering, or with terminal maladies (certain depressions are definitely fatal diseases) are not necessarily true. Actually, euthanasia and/or physician-assisted suicide of psychiatric patients is increasing in some jurisdictions such as Belgium and the Netherlands (Kim et al, 2015). It is plausible however, that psychiatrists would have different attitudes to DAD and TFT than other specialists. Moreover, the patient-physician interactions in psychiatry may have different dimensions than other interactions. All this led us to include psychiatrists in our analysis.

This is now explained in the Discussion section [page 17, paragraph 2].

14. 7 / 4 Clarify what an 'HMO' is.

Clarified

15. 7 / 20ff The survey instrument needs to be made available, so that readers can view the phrasing of questions and response option

Response: The survey was conducted in Hebrew and therefore attachment of the survey instrument would be meaningless. Instead we have now included in the Method section accurate translation of the relevant questions [Starting page 6, last paragraph]

The response options provided appear to me insufficient. Given that the authors note in the discussion section that cultural factors are known to affect doctors' decision-making around truth-telling, can the authors clarify why there was no option to reply "It will depend on the particular circumstances for the patient and/or family"? Arguably, for questions relating to ethic
stance, there should also have been an option to decline to answer the question and/or a 'Not sure' option.

Response: When designing the questionnaire, we have discussed thoroughly the wording of the "no-choice" answers and decided to minimize the possibilities of potential avoidance ("Not sure", "It depends"). We believe that in the context of an ethical survey the option of not being able to decide between two ethical options is the most appropriate. Indeed, our approach resulted in minimal avoidance as indicated by the low number of respondents who choose the non-choice option response and by the marginal number of respondents who chose not to answer the question (see response to comment 16)

The issue of dependence on the circumstances deserves a separate study. Such a study is actually underway, relying on a different format of questions and on focus group discussions. Preliminary observation suggest that, as expected, certain medical scenarios involving fatal illness are perceived as more amenable to DAD than others, and that manipulation of truth telling is again more acceptable in certain cases.

16. 10 / 33ff Would there not be at least four other combinations - respondents who either were supportive of, or oppositional to, either truth-telling or assisted dying, and answered 'cannot choose' to the other question? These respondents should also be discussed, since collectively they amount to 1/5 of the sample, and dilemmas/uncertainty are an acknowledged factor in medical decision-making

Response: This analysis was performed and revealed the following:

- 329 of respondents formed an opinion on truth telling (178 oppose, 151 support), but were unable to make a decision about DAD.

- 161 of respondents formed an opinion on DAD (53 oppose, 108 support), but were unable to make a decision about truth telling.
• 59 (2.1%) of respondents did not form an opinion neither on DAD nor on truth telling

• 55 (1.9%) of respondents did not provide an answer to these questions (missing answers), 10 of which did not answer both quarries.

This actually indicates that the rates of avoidance are minimal, and that the rates of "chronic un-decidedness" are low. The choice of the response option "I am unable to choose" appear to represent a genuine ethical statement.

This information is now provided in the Result section [page 11, paragraph 2]

We thank the reviewer for directing us to this analysis which proved to yield valuable information:

17. 11 / 1ff The authors appear to be proposing a typology of doctor attitudinal responses in relation to challenging ethical situations. While such a typology could be valuable, the authors should at least consider existing typologies and theoretical models in relation to both truth-telling and assisted dying decision-making - see for example Gamondi et al's (BMJ: Supportive and Palliative Care, Published Online First: 11 August 2017. doi: 10.1136/bmjspcare-2016-001291) (and others authors') segmentations of doctors' responses to assisted dying requests, and Oliver's (2016) 'social ecology' model of assisted dying decision-making https://researchspace.auckland.ac.nz/handle/2292/29864. I'm not fully familiar with the literature on doctors' truth-telling, but a quick scan of that literature indicates that there may be existing typologies for that as well. The authors might consider a taxonomy of medical truth-telling practice (e.g. Gallagher and Jago 'A typology of dishonesty' 2016), depending on practice context (e.g. hospitals vs HMO), rather than a typology of practitioners.

Response: There is no doubt that matters as complex as DAD and truth telling can be approached by using various typologies, and examples to these are provided now. We believe that the typologies that we have used, though apparently simple, has enabled us to gain novel insights. This is now explained in the Discussion section [Page 18, last paragraph]
The 55.2% of Israeli doctors supporting assisted dying, and only 31% not supporting it are, respectively, much higher and lower proportions than the typical one third approximately of doctors in support and the 50% or more opposing, especially in jurisdictions where assisted dying is not yet legal. However the authors have compared it primarily to US data - the 2016 Medscape report cited does not appear to have included European data, as claimed. There is no shortage of information on data from European countries where assisted dying is not yet legal, including the UK. This significant finding should be discussed in the Discussion section, in the context of Israel-specific political and cultural/religious factors or other possible contributing factors.

Response: Given the specific political and cultural/religious atmosphere in Israel, the observation that the majority of Israeli doctors support assisted dying, and even express the willingness to participate in it is indeed impressive. There is a lot to be said about this. To my (BV) opinion, the Israeli medical community is making here a statement as to its stand in the dispute between the old school and the new school in the medical establishment, in the debate between the religious forces and the secular majority in Israel, in the debate between liberal perceptions and conservative perceptions, in the debate between political perspectives and ethical perspectives. After saying all this, I am not sure if this paper is the right platform to express such interpretations. Nevertheless, we have now tried to relate to this, though less bluntly, in the Discussion section [page 13, paragraph 3]

An additional perspective that cannot be overlooked relates to the so called "Israeli spirit". Many observers attribute a specific national character to Israelis. This is said to involve disrespect of rules and procedures, tendency to improvise, to be pragmatic and to quickly adapt to changing situations (one recent book relating this is "The Israeli Mind by Alon Gratch). These tendencies most probably prevail also in the medical setting and lead doctors to be more pragmatic in their attitude and be less dogmatic about truth telling and the sanctity of life. This again is described somewhat carefully in the Discussion section [Page 14, paragraph 3]

The authors discuss the age differences primarily in terms of lifestage, skipping over 'zeitgeist' factors; generationality should be at least acknowledged in the context of the literature on generational impacts on changing medical ethics.
The possible effects of age in terms of life stage, zeitgeist and cohort are now discussed comprehensively [Starting in Page 14, last paragraph]

The greater support for both truth-telling and assisted dying among younger doctors and those educated within Israel needs to be discussed in terms of potential contributing factors such as generational change, Israeli culture versus European/US culture and how ethics are taught in Israeli medical schools.

Response: The effect of age can be explained in the context of accepted notions related to Zeitgeist and generationality (see above), and the rather high rates of support for DAD can be explained by speculating on the various aspects of Israeli culture (see response to comment 18). The notable effect of the country of education, on both truth telling and DAD remain puzzling, and requires deeper examination, which we are trying to do now [Starting on Page 15, last paragraph]

About half of the practicing physicians in Israel were educated in one of the four established medical schools in Israel. These schools do not differ substantially in their educational approach, or in the program that they offer. Ethics courses have been part of their curriculum for many years. On the other hand the education abroad is rather diverse. Doctors educated abroad include those immigrating to Israel after graduating from medical schools in their native countries (most often USSR, France and the USA), and those travelling abroad to attend medical schools (most often in Italy, Hungary Romania and former USSR countries). Because of the wide diversity in the medical education abroad, we tried to concentrate on features that characterize education in the Israeli Medical Schools, and thereby provide possible explanations for the attitudinal difference.

After consulting with colleagues who teach in Israeli schools, we propose the following explanation: In the Israeli schools "bed side" clinical studies state as early as the 3rd or 4th year of schooling. This results in a situation where the academic ethical concepts, thought in class are immediately challenged by the reality of hospital life, and by the interactions with older doctors manifesting the typical "Israeli pragmatism" (see response to comment 18). As a consequence those educated in Israel are less dogmatic about truth telling and the sanctity of life compared to those educated abroad. This hypothesis is substantiated by cross tabulating age and place of
education indicating that the effect of schooling wanes with time, and is replaced by the effect of the local atmosphere [Page 16, paragraph 3]

20. 16 / 33-34 The Discussion could benefit from a separate 'Implications' section.

An 'implications' section was added to the manuscript, as suggested.

21. 16 / 45-50 Ideally, at least some cross-tabulations should have been undertaken to identify interactions of age, gender, place of medical education and religion on respondents' attitudes.

Response: Interaction between different variables by cross tabulation was performed. Valuable information was derived in two cases.

a. Crossing age with place of education revealed that the effect of education on truth telling is more pronounced among young physicians than older ones, suggesting the imprint of the medical school is lost with time (see response to comment 19) This observation is now used to substantiate the effect of schooling on ethical attitudes

b. Crossing specialization with place of employment allowed to examine the interplay between the effect of patient-physician interaction and experience with sever medical scenarios on the attitude to DAD (See response to comment 12

In an attempt not to add cumbersome tables, we chose to provide the information on cross tabulation in the form of statements.

We thank the reviewer for directing us to this valuable analysis.

22. 17 / 17 Unclear what 'chartism' means.

This is a typing error, should read Criticism
In summary, we would like to thank the reviewers for pointing out some important aspects of this study that we have missed in our analysis, guiding us to look deeper into our findings and gain additional insight.