Appendix J. Bibliography of Excluded Articles

article not received prior to report production

recoded: exclude for design

Alexander P. An investigation of inpatient referrals to a clinical psychologist in a hospice. Eur J Cancer Care (Engl) 2004;13(1):36-44. [Rec#: 118]
recoded: outcome unrelated to pts/family/non-prof

American Pain Society Quality of Care Committee. Quality improvement guidelines for the treatment of acute pain and cancer pain. A. JAMA 95;274(23):1874-80. [Rec#: 50185]
recoded: exclude for design

article not received prior to report production

article not received prior to report production

article not received prior to report production

article not received prior to report production

article not received prior to report production

article not received prior to report production

Bass DM and Bowman K. The transition from caregiving to bereavement: the relationship of care-related strain and adjustment to death. Gerontologist 90;30(1):35-42. [Rec#: 412]
article not received prior to report production

article not received prior to report production

article not received prior to report production

recoded: no outcomes specified

article not received prior to report production

article not received prior to report production

article not received prior to report production

article not received prior to report production

article not received prior to report production

recoded: no outcomes specified

article not received prior to report production

article not received prior to report production

recoded: data older than 1990

recoded: data older than 1990

recoded: data older than 1990
Appendix J. Bibliography of Excluded Articles

Recoded: exclude for design

Recoded: data older than 1990

article not received prior to report production

Butler JV, Pooviah PK, Cunningham D, and Hasan M. Improving decision-making and documentation relating to do not attempt resuscitation orders. Resuscitation 2003;57(2):139-44. [Rec#: 40494]
Recoded: outcome unrelated to pts/family/non-prof

article not received prior to report production

article not received prior to report production

article not received prior to report production

Castle NG, Mor V, and Bansazk-Holl J. Special care hospice units in nursing homes. Hosp J 97;12(3):59-69. [Rec#: 10112]
Recoded: outcome unrelated to pts/family/non-prof

article not received prior to report production

article not received prior to report production

article not received prior to report production

Recoded: outcome unrelated to pts/family/non-prof

Recoded: about chemo/surg/stents/laser/radiation

article not received prior to report production

article not received prior to report production

article not received prior to report production

Recoded: useful only for background

article not received prior to report production

Recoded: outcome unrelated to pts/family/non-prof

article not received prior to report production

Recoded: not about end of life care

article not received prior to report production

article not received prior to report production

article not received prior to report production

Recoded: no outcomes specified
Appendix J. Bibliography of Excluded Articles


Fakhoury WK and McCarthy M. Can the experience of caring at home affect carers' retrospective evaluation of community care services? Scand J Caring Sci 98;12(3):179-85. [Rec#: 2191] article not received prior to report production


Francis DF and Billick IL. Knowledge, attitudes, and behavior of elderly persons regarding living wills. Arch Intern Med 91;151(2):277-80. [Rec#: 2531] article not received prior to report production

Gamble ER, McDonald PJ, and Lichstein PR. Knowledge, attitudes, and behavior of elderly persons regarding living wills. Arch Intern Med 91;151(2):277-80. [Rec#: 2531] article not received prior to report production
Appendix J. Bibliography of Excluded Articles


Grande GE, Todd CJ, and Barclay SI. Support needs in the last year of life: patient and carer dilemmas. Palliat Med 97;11(3):202-8. [Rec#: 2778] article not received prior to report production

Greisinger AJ, Lorimor RJ, Aday LA, Winn RJ, and Baile WF. Terminally ill cancer patients. Their most important concerns. Cancer Pract 97;5(3):147-54. [Rec#: 11708] article not received prior to report production


Appendix J. Bibliography of Excluded Articles


Hickman SE, Tilden VP, and Tolle SW. Family reports of dying patients' distress: the adaptation of a research tool to assess global symptom distress in the last week of life. J Pain Symptom Manage 2001;22(1):565-74. [Rec#: 3189] article not received prior to report production


Higginson IJ, Wade AM, and McCarthy M. Effectiveness of two palliative support teams. J Public Health Med 92;14(1):50-6. [Rec#: 3204] article not received prior to report production


High DM. Why are elderly people not using advance directives? J Aging Health 93;5(4):497-515. [Rec#: 3205] article not received prior to report production

Hilden HM, Louhlia P, Honkasalo ML, and Palo J. Finnish nurses' views on end-of-life discussions and a comparison with physicians' views. Nurs Ethics 2004;11(2):165-78. [Rec#: 3207] article not received prior to report production


Inman L. Advance directives. Why community-based older adults do not discuss their wishes. J Gerontol Nurs 2002;28(9):40-6. [Rec#: 3475] article not received prior to report production


Appendix J. Bibliography of Excluded Articles


Kane RL, Homyak P, and Bershadsky B. Consumer reactions to the Wisconsin Partnership Program and its parent, the Program for All-Inclusive Care of the Elderly (PACE). Gerontologist 2002;42(3):314-20. [Rec#: 41718] article not received prior to report production


Kavlic SM, Atweh N, Possenti PP, and Ivy ME. The role of advance directives and family in end-of-life decisions in critical care units. Conn Med 2003;67(9):531-4. [Rec#: 3774] article not received prior to report production


Kennedy C and Cheston SE. Spiritual distress at life’s end: finding meaning in the maelstrom. J Pastoral Care Counsel 2003;57(2):131-41. [Rec#: 3841] Recoded: useful only for background


Koffman JS and Higginson IJ. Fit to care? A comparison of informal caregivers of first-generation Black, Caribbean and White dependants with advanced progressive disease in the UK. Health Soc Care Community 2003;11(6):528-36. [Rec#: 3989] article not received prior to report production


Krutk RE. The effects of single-session music therapy interventions on the observed and self-reported levels of pain control, physical comfort, and relaxation of hospice patients. Am J Hosp Palliat Care 2001;18(6):383-90. [Rec#: 4074] article not received prior to report production

Appendix J. Bibliography of Excluded Articles

Kurtz ME, Kurtz JC, Given CW, and Given B. Predictors of postbereavement depressive symptomatology among family caregivers of cancer patients. Support Care Cancer 97;5(1):53-60. [Rec#: 41113] article not received prior to report production


Lawton MP, Moss M, and Glicksman A. The quality of the last year of life of older persons. Milbank Q 99;47(1):82-7. [Rec#: 41975] article not received prior to report production


Lloyd-Williams M. Screening for depression in palliative care patients: a review. Eur J Cancer Care (Engl) 2001;10(1):31-5. [Rec#: 13136] article not received prior to report production


McMillan SC and Weitzner M. How problematic are various aspects of quality of life in patients with cancer at the end of life? Oncol Nurs Forum 2002;27(5):817-23. [Rec#: 5023] article not received prior to report production


Appendix J. Bibliography of Excluded Articles

McWhinney IR, Blass MJ, and Orr V. Factors associated with location of death (home or hospital) of patients referred to a palliative care team. CMAJ 1995;152(3):361-7. Comment in: CMAJ 1995 Feb 1;152(3):337-40. PMID: 7828097. [Rec#: 5040] article not received prior to report production


Meyers JL and Gray LN. The relationships between family primary caregiver characteristics and satisfaction with hospice care, quality of life, and burden. Oncol Nurs Forum 2001;28(1):73-82. [Rec#: 5128] article not received prior to report production


Mor V and Masterson-Allen S. A comparison of hospice vs conventional care of the terminally ill cancer patient. Oncology (Huntingt) 1990;4(7):85-91; discussion 94, 96. [Rec#: 13841] article not received prior to report production


Morita T, Tsunoda J, Obuse S, and Chihara S. Perceptions and decision-making on rehydration of terminally ill cancer patients and family members. Am J Hosp Palliat Care 1999;16(3):509-16. [Rec#: 5340] article not received prior to report production


Appendix J. Bibliography of Excluded Articles

O’Connell LJ. Changing the culture of dying. A new awakening of spirituality in America heightens sensitivity to needs of dying persons. Health Prog 96;77(6):16-20. [Rec#: 14115] article not received prior to report production


Seale C and Kelly M. A comparison of hospice and hospital care for the spouses of people who die. Palliat Med 97;11(2):101-6. [Rec#: 6878] article not received prior to report production
Appendix J. Bibliography of Excluded Articles


Smucker WD, Ditto PH, Moore KA, Druley JA, Danks JH, and Townsend A. Elderly outpatients respond favorably to a physician-initiated advance directive discussion. J Am Board Fam Pract 93;6(5):473-82. [Rec#: 7190] article not received prior to report production


Stuart B and Coulson NE. Use of outpatient drugs as death approaches. Health Care Finance Rev 94;15(3):63-82. [Rec#: 7421] article not received prior to report production


Tattersall MH, Gattellari M, Voigt K, and Butow PN. When the treatment goal is not cure: are patients informed adequately? Support Care Cancer 2002;10(4):314-21. [Rec#: 7561] article not received prior to report production


Appendix J. Bibliography of Excluded Articles

Recoded: not about end of life care

Recoded: no outcomes specified

Tong KL, Porterfield P, and Mills I. Vancouver General Hospital Palliative Care Unit utilization review. J Palliat Care 93;9(1):32-6. [Rec#: 7697]
Recoded: outcome unrelated to pts/family/non-prof

Recoded: not about end of life care

article not received prior to report production

article not received prior to report production

article not received prior to report production

van der Riet P and Mackey S. Therapeutic massage: an education program for rural and remote workers in the palliative care field. Aust J Rural Health 99;7(3):186-90. [Rec#: 16027]
Recoded: outcome unrelated to pts/family/non-prof

article not received prior to report production

article not received prior to report production

Recoded: no outcomes specified

Walsh D and Nelson KA. Communication of a cancer diagnosis: patients' perceptions of when they were first told they had cancer. Am J Hosp Palliat Care 2003;20(1):52-6. [Rec#: 8000]
article not received prior to report production

Recoded: not about end of life care

article not received prior to report production

Westlake C and Dracup K. Role of spirituality in adjustment of patients with advanced heart failure. Prog Cardiovasc Nurs 2001;16(3):119-25. [Rec#: 35983]
article not received prior to report production

article not received prior to report production

Recoded: not about end of life care

article not received prior to report production

article not received prior to report production

Recoded: exclude for design

article not received prior to report production

Recoded: exclude for design

Worley K and Henderson S. Speaking of difficult choices: the creation of a drama and dialogue group on end-of-life choices. Gerontologist 95;35(3):412-4. [Rec#: 8319]
Recoded: no outcomes specified

article not received prior to report production
article not received prior to report production

Recoded: exclude for design
## Appendix K. REVIEWER COMMENTS
"Evidence Report on End-of-Life Care and Outcomes"

<table>
<thead>
<tr>
<th>Group</th>
<th>Section</th>
<th>Comment</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>...the economic cost of caregiving at end-of-life is not given a full discussion.</td>
<td>Due to limited time and resources, economic issues were beyond the scope of this report.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>About midway through the document, it seemed to me that a great deal of content seems to be written from a geriatrician's perspective. ...some of the text is more appropriate for a review of chronic illness care or geriatric care.</td>
<td>The end of life will certainly have a geriatric tone, since most dying now is in older persons, and since we did not address dying of children at all. We did not take up the special issues of aging or of younger and mid-life adults who face fatal illness. The age-related issues would deserve special attention in an ensuing project.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>I don’t believe that such a negative interpretation of the data is either beneficial or scientifically accurate.</td>
<td>We hope you will mention this at the State of the Science Conference. It may be that one should accept as evidence some insights arising from other study designs, or that one should call for funding of stronger designs.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>The document reads as if it is written by several different people with very inconsistent format and quality.</td>
<td>We have tried now to impose more stylistic control.</td>
</tr>
<tr>
<td>TEP</td>
<td>Overall</td>
<td>.. you refer to an unpublished systematic review—the review has been published by the National Institute of Clinical Excellence. It was published in 2004.</td>
<td>We have updated the citation.</td>
</tr>
<tr>
<td>TEP</td>
<td>Overall</td>
<td>... you should explain up front the need to be narrowly focused and address some issues and not all</td>
<td>The revised history of the project in Chapter 1 makes more clear just how much we did not get to address.</td>
</tr>
<tr>
<td>TEP</td>
<td>Overall</td>
<td>...as long as we refer to palliative care as end of life care, no one will be in our denominator for research studies. Palliative care should be need- and complexity-based, not prognosis-based.</td>
<td>We did use &quot;end of life&quot; in that broad sense, focused upon serious and eventually fatal illness. We did not include palliative care for stable but serious conditions. Since the task order specified &quot;end of life care,&quot; we did feel that we were obliged to stay with that term and scope.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>...the Evidence Report seems to lack attention to race/ethnicity and culture.</td>
<td>We have added summaries of observational studies which address these issues.</td>
</tr>
<tr>
<td>TEP</td>
<td>Overall</td>
<td>...there seems to be little attention given to end of life issues that may be ethnically or culturally specific.</td>
<td>We have added summaries of observational studies which address these issues.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>...use the more inclusive language of palliative care. By continuing to refer to our field as end-of-life care, I think that we are sending the wrong message....</td>
<td>We have struggled with this recent change in the field. The task order is given in terms of &quot;end of life care.&quot; We mostly have to stay allegiant to the task as written. We have used &quot;palliative&quot; when that is not misleading, and we have used the broadest definition of the field of &quot;end-of-life,&quot; that of serious and eventually fatal chronic illness.</td>
</tr>
</tbody>
</table>
# Appendix K. REVIEWER COMMENTS

## "Evidence Report on End-of-Life Care and Outcomes"

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Overall</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>Having been a Joanne Lynn employee, I know she has done a substantive amount of quality improvement work. What can be learned from this literature? If there is &quot;no high quality evidence&quot; what evidence of supposed less quality is there? In the way that evidence is assessed, evidence arising from quality improvement is not generally taken to be very reliable. In this project, we addressed only prospective cohort and case-control designs among descriptive studies. No quality improvement work would have qualified.</td>
<td></td>
</tr>
<tr>
<td>Peer</td>
<td>Suggest you have a final reader who reviews for acronyms.</td>
<td>Acronyms are now defined upon first use.</td>
</tr>
<tr>
<td>Peer</td>
<td>The conclusions reached in almost every section (there is not evidence) are just not consistent with my reading of the report and my perception of the evidence.</td>
<td>The structure of the evidence review requires looking first at intervention trials, then at the strongest designs of descriptive studies. We stretched that some to include some thoroughly retrospective and uncontrolled studies, but still, the summary of the sections regarding the stronger designs is often going to be fairly disappointing in tone.</td>
</tr>
<tr>
<td>TEP</td>
<td>The document also pays little attention to issues surrounding age.</td>
<td>That is true. More than three-quarters of all deaths are now past age 65, so most studies of the end of life are among persons commonly considered to be elderly. However, only a few differentiate between the older elderly and the younger elderly. Indeed, many studies are biased by having median ages well under 65 - especially studies of cancer and heart disease. Obviously, studies of frailty would emphasize the older patient. Lubitz et al and Shugarman et al have shown that age is a strong determinant of medical care costs in the last year of life, with a progressive decline with age. However, no study comes to mind that associates age itself with better and worse dying. Surely that would be a good area for study and we mention it now in the chapter on recommendations.</td>
</tr>
<tr>
<td>Peer</td>
<td>The outline seems to fall apart as the report moves along.</td>
<td>We have tightened up the explanation of the progress and the outline.</td>
</tr>
<tr>
<td>Federal</td>
<td>The reader's confidence is undermined when they learn (repeatedly) that the research team had &quot;limited time.&quot; How significant was the lack of time?</td>
<td>This report was given substantially less time and had substantially more literature to review than a typical EPC project. The report is very straightforward about the strategies that we used in order to complete the most useful work possible in the time allowed. Undoubtedly, another project with more time and resources, would address more topics and seek broader literature.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>The tone and voice of the paper changes multiple times... because it was written by a number of different individuals... in some places it is less of a review and more of a personal interpretation of the data.</td>
</tr>
<tr>
<td>------</td>
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<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>There is a lack of consistency in the details in which the evidence was reviewed.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>This reviewer generally agrees with the great majority of the findings and above all with the conclusions with the authors regarding the state of the art of research in this area.</td>
</tr>
<tr>
<td>Peer</td>
<td>Overall</td>
<td>Throughout the draft the term &quot;medicine&quot; is used, and while the meaning is not clear... It is a major concern that there is not more interdisciplinary focus and also that literature from other fields is not recognized.</td>
</tr>
<tr>
<td>Peer</td>
<td>Introduction</td>
<td>It is useful to add cancer as one of the major causes of dyspnea.</td>
</tr>
<tr>
<td>Peer</td>
<td>Introduction</td>
<td>It may help to – in the first chapter—lay out your definitions that inform the review.</td>
</tr>
<tr>
<td>Federal</td>
<td>Introduction</td>
<td>Last full sentence is very clumsy.</td>
</tr>
<tr>
<td>Federal</td>
<td>Introduction</td>
<td>Last paragraph - &quot;Other mean a large...&quot; needs re-write.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>I worry that by limiting the data to &quot;end-of-life care&quot; that you have missed a large number of relevant articles... in cancer pain and dyspnea topics, which I have reviewed recently there are important references you have left out.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>It is also possible that media also contributes to variation in populations. Some studies and interventions receive much more media attention and draw greater localized efforts at system change and collaboration in some regions than others.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>It would be important to explain the JADAD scores to the reader and use them consistently.</td>
</tr>
<tr>
<td>Author</td>
<td>Section</td>
<td>Comment</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>TEP</td>
<td>Methods</td>
<td>...in the discussion of symptoms, I do think that it would be worthwhile to list all of the symptoms that have been described in patients in the last year of life and then discuss why you have chosen to address only those included here.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>The introductory chapters do give the methodological details of how the selection was made. Listing all symptoms and their rates is not directly responsive to the task order, though we recognize the importance of a wide array of symptoms (especially in considering the course to death from all diseases).</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>That would be very useful to do. Perhaps there will be an opportunity to do much more focused reviews, building upon this base.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>I am surprised that the topic of withdrawal of life-support was excluded.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>It would be a good topic for a future, focused, review. Perhaps the NHLBI would be interested, or NIDDK.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>It seems appropriate to add a disclaimer acknowledging that the synergistic impact of multiple or sequential interventions is not considered with this methodology. I recommend this disclaimer be included in Section H, p.76 which has not yet been written. This section explores outcome variations among populations.</td>
</tr>
<tr>
<td>TEP</td>
<td>Methods</td>
<td>This is an important point which has been added to our discussion.</td>
</tr>
<tr>
<td>TEP</td>
<td>Methods</td>
<td>In many contexts, that seems to be a better term. We did not change the term in this report, since we aimed to stay close to the language and categories of the Task Order.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>Suggest you make clear what you mean by &quot;grey literature&quot;</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>This is now defined.</td>
</tr>
<tr>
<td>TEP</td>
<td>Methods</td>
<td>The attached review from our group indicates in detail some of the difficulties with measuring satisfaction.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>We have added text addressing these measurement issues.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>The authors characterize their clinical trials using the JADAD score. There is considerable controversy about the appropriateness of this score for the judgment of the quality of clinical trials particularly when non-pharmacological interventions are involved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We recognize the controversy, but still claim that it helps demonstrate the rigor and merit of research design. Furthermore, it is a requirement of the sponsor (OMAR) to use this scale.</td>
</tr>
</tbody>
</table>
### Appendix K. REVIEWER COMMENTS

**"Evidence Report on End-of-Life Care and Outcomes"**

| Peer | Methods | The authors have missed a very considerable contribution made during the 1980s and 1990s. It would have been desirable to start the search in 1980. | We agree. However, we have done all we could in the shortened time frame allowed. Either someone might get to go back and fill in older work, or it will become less important to do over time. Insofar as the existing systematic reviews mostly go back into older literature, our use of them will bring in insights from that work. |
| Peer | Methods | The authors once again make emphasis to a very limited number of symptoms and this needs to be addressed | Have done, see above. |
| Peer | Methods | The draft suffers from a lack of core definition of terms. | The introduction has been revised to address this issue. |
| Peer | Methods | The exclusion of clinical trials about chemotherapy, radiotherapy, stent, laser, etc., is concerning. The authors need to discuss the fact that there may be need for more in depth review of this area in the future. | As for many of our restrictions, this one also would be well worth doing. As Irene Higginson noted in explaining why her reviews used the same restriction, these treatments are not ordinarily at the heart of the palliative care enterprise. Of course, there are exceptions, but we simply had to follow suit in order to have any opportunity to deal with over twenty thousand articles. |
| TEP | Methods | The review and ranking process makes sense and is well described. | Thank you. |
| Peer | Methods | There are a number of devastating symptoms that have not been part of this review. It is important to emphasize that delirium, cachexia, and chronic emesis are all much more frequent than depression and anxiety, both in the cancer and a large percentage of the non-cancer populations. Fatigue is an almost universal symptom and there has been no review of this major symptom complex. The authors need to emphasize that they have conducted a very partial review of the symptom distress experience. | We have now stated the limitation early on and in the section reporting results. |
| Peer | Methods | There are also large gaps in the literature review regarding bereavement. | Due to limited time and resources, bereavement issues were beyond the scope of this report. |
| Peer | Methods | There is a lack of a clear, concise framework to guide this entire analysis. | The rewriting of Chapter 2 and the clarifications throughout should make this less of a problem. |
### Appendix K. REVIEWER COMMENTS

**"Evidence Report on End-of-Life Care and Outcomes"**

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Section</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>Throughout the text there are weak definitions in use of the term &quot;qualitative&quot;. There is confusion about qualitative methods versus qualitative analysis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Most qualitative studies involved focus groups or unstructured interviews of individuals. We have added this information.</td>
</tr>
<tr>
<td>Federal</td>
<td>Methods</td>
<td>Were issues of reimbursement / pay for performance / quality considered under question 2c?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. We did not address economic issues.</td>
</tr>
<tr>
<td>TEP</td>
<td>Methods</td>
<td>You discuss alternative pain interventions…perhaps it would be useful to say why/how the interventions that are reported were chosen for inclusion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We have tried to make the Cambridge balloting more clear, including it in the text as well as in an Appendix.</td>
</tr>
<tr>
<td>TEP</td>
<td>Methods</td>
<td>Your search methods and rationale are clearly stated and defended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thank you.</td>
</tr>
<tr>
<td>Peer</td>
<td>Methods</td>
<td>Your use of unpublished literature (the two systematic reviews) worries me. …your justification for use of unpublished sources should be stronger.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indeed, the strongest unpublished review has now been published, so this is less of a concern.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results</td>
<td>A major problem for me is the lack of consistency in the details in which the evidence was reviewed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is much more consistency now in the degree to which studies are characterized.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results</td>
<td>For some studies that I know well, the interpretation and the reanalysis of them are nihilistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The revisions will address some of the problems of tone, but it is still true that the typical EPC report focuses heavily upon &quot;quality of research design,&quot; which values randomization, large study populations, blinding, etc. The literature in end-of-life care does not have much strength in that sort of study.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results</td>
<td>I would think that the draft would benefit greatly by…having each major section with a very clear, defined summary.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We have added such paragraphs to the results section.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results</td>
<td>..randomized controlled trial of hospice at home conducted by Todd and colleagues – do you have a reference from the BMJ from 1999?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This intervention study is now discussed under topics caregiver concerns and symptoms.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results</td>
<td>…report would benefit greatly from some summary paragraphs to synthesize the key findings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We have added such summaries at the end of the results section.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results</td>
<td>I would like to see more information on symptoms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Due to limited time and resources, our review was limited to the following symptoms: pain, dyspnea, depression, and behavioral symptoms.</td>
</tr>
</tbody>
</table>
## Appendix K. REVIEWER COMMENTS
**“Evidence Report on End-of-Life Care and Outcomes”**

<p>| Peer | Results | In the healthcare system issues, I thought there were some studies of case management and RN homecare practices, that in fact did show positive results in heart failure. | The literature for heart failure is fairly positive, and the reviews of that literature are now clearly laid out in the paragraphs on heart failure in Chapter 3 section on continuity. |
| Peer | Results | It would be helpful if you gave more data about the methods used in the qualitative studies…. | Most qualitative studies involved focus groups or unstructured interviews of individuals. We have added this information. |
| Peer | Results | The authors have not reported on the randomized controlled trials on the administration of prompt sheets. A significant number of studies have been conducted [see Butol P, et al, Bruera E, et all]. It is not clear why these papers were not captured by the review. | We were unable to obtain the Butol article in time to include in our report. |
| Peer | Results | The summaries seem unduly short and not particularly helpful. | We have tried to balance the page limit with the extensive literature. The summaries are short, though mostly in line with the style in evidence reports. At the least, we hope that they are enough to point the reader to the useful literature for the reader's interests. |
| Peer | Results | There are many places through the text in which summary comments are made without citing the particular study. | These have been eliminated from the first three chapters. The summary perspectives of the working team are restricted to Chapter 4 on recommendations. |
| TEP | Results | There is a very large amount of literature which has examined the effectiveness of rehabilitation type interventions….it might well be worth you making a reference to this literature. | We now reference the sample that comes up with our search strategy. This does not reflect the large literature that is not particularly focused upon end-of-life. |
| TEP | Results - ACP | Although you include in the references the data from Emmanuel, I don't see a discussion of that paper as to caregiver burden from the particular issue of the stress on the caregiver, which appears to be multifaceted and related to high burden of disease. You do reference the paper. | The new version of the report spells out much more about this paper, including this point. |
| TEP | Results - ACP | It is extremely difficult to engage in meaningful communication regarding advance directives if professionals cannot communicate well with patients and families. | That is true, but we did not include general issues of communication in this review. |
| Federal | Results - ACP | No summary for section G on advance care planning. | This section has been completed. |</p>
<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Section</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer</td>
<td>Results - ACP</td>
<td>Nowhere in the document is the Physician Orders for Life-Sustaining Treatment (POLST) program described. …that might most effectively be listed at the top of page 67 under &quot;Information/Record Continuity.&quot;</td>
</tr>
<tr>
<td>Federal</td>
<td>Results - ACP</td>
<td>Regarding advance care planning... let’s admit it, they are a conceit and secondly ethically suspect.</td>
</tr>
<tr>
<td>Federal</td>
<td>Results - ACP</td>
<td>The section on advance care planning seemed extremely weak for me. This entire section reads as if it is the professional’s plan, not the patient's.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Continuity</td>
<td>…on the discussion of advanced directives again are there any published papers in the national database and whether that has had any impact of a use of a national database.</td>
</tr>
<tr>
<td>Federal</td>
<td>Results - Continuity</td>
<td>Expand the Continuity section if possible. An important topic that gets little attention.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Continuity</td>
<td>The discussion of continuity and coordination of care doesn’t get into the issue of transfer orders</td>
</tr>
<tr>
<td>Peer</td>
<td>Results - Family &amp; Caregiver</td>
<td>…why is the section on caregiver burden placed under the Key Questions 2a and 3a (pg. 54)?</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Family &amp; Caregiver</td>
<td>In the Caregiving section (perhaps this is already implied), I think we need to point out that there is great variability in cultural expectations of care, and very little research to understand this in a systematic way.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results - Measures</td>
<td>Ultimately the value of these tools is related to their ability to be used effectively in the clinical setting.</td>
</tr>
</tbody>
</table>

Because we address all intervention trials and most prospective cohorts, we did not include many descriptive reports with other designs. Nevertheless, we agree with the reviewer that this work is important and have included it in the paragraph concerning especially important descriptive articles in the section on advance care planning.

We are glad to point out that an evidence report requires that we report the data. Strong conclusions may be taken by others.

These sections have been completed.

This section has been revised extensively.

The literature on advance directives and advance care planning was remarkable for the diversity of small studies with a variety of interventions or situations that were neither sustainable or generalizable. A national database of any sort would undoubtedly be helpful in building a more useful literature.

This section has been expanded.

There is now some attention to these issues. There was not much evidence base with regard to transfers in end-of-life or palliative care.

We have revised the section headings so this is no longer the case.

This has been added to the Discussion section of the report.

See response just above.
## Appendix K. REVIEWER COMMENTS
"Evidence Report on End-of-Life Care and Outcomes"

<table>
<thead>
<tr>
<th>Reviewed</th>
<th>Section</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer</td>
<td>Results - Measures</td>
<td>It is of concern that the &quot;validity&quot; of clinical indicators continues to be defined by their psychometric properties rather than by the results of application in the clinical setting. This is probably true. There are very few rigorous reports of usefulness of measurement strategies in clinical medicine.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Measures</td>
<td>Farsides B, Dunlop RJ. Measuring quality of life: Is there such a thing as a life not worth living? BMJ 2001;322:1481-3. Could you include? This is indeed an important conceptual piece. Because it did not include original research it was not captured by our original search. We have now cited it.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Measures</td>
<td>Have you reviewed George LK, Research design in end-of-life research: state of science. The Gerontologist 2002;42:86-98. Yes - we cite her early in the work on the point of the scope of the field, for example.</td>
</tr>
<tr>
<td>Federal</td>
<td>Results - Measures</td>
<td>I have always had severe reservations about whether measures used to determine &quot;successful&quot; EOL are valid. As you note at various points in the review, quality of life, quality of care, satisfaction, etc. is almost entirely dependent on who you ask and when That would be a potential springboard for an influential editorial, perhaps. The Task Order specified &quot;satisfaction&quot; and &quot;better and worse outcomes.&quot; Our work was tied to the reports that addressed those concepts. Obviously, one of the outcomes of our work is to note that, as the reviewer says, there is no settled understanding of the merits of various ways to come to the end of life.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Measures</td>
<td>The Support Team Assessment Schedule is widely used. STAS is a unique tool that assesses the clinical outcomes and intermediate outcomes of palliative care We have included a description of this instrument in our measures section.</td>
</tr>
<tr>
<td>Federal</td>
<td>Results - Measures</td>
<td>waiting 6 months after the patient has died is probably too long for an accurate measurement of certain experiences. I am not sure if this is important to this report - but I would love to have the issue raised as a potential problem We did not provide a review of the methodological issues in end of life care, of which this is one of the more troubling. That would be a good topic for future work.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Satisfaction</td>
<td>Satisfaction is such a weak measure, your recommendations seem to support ongoing measurement for it. Would you be bold enough to suggest that it is not the approach that should be used? We have added some language suggesting that broader constructs are needed - for example, &quot;...the overall measures of a desirable care system may require constructs other than satisfaction&quot;. We have also suggested that satisfaction alone is not sufficient - but must be linked to processes of care.</td>
</tr>
<tr>
<td>Federal</td>
<td>Results - Satisfaction</td>
<td>First full paragraph - &quot;...although that interventions...&quot; needs re-write This paragraph has been rewritten.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Symptoms</td>
<td>There has been a Cochrane review examining the control of breathlessness We agree that this is an important review. We included it in our final report under discussion of dyspnea.</td>
</tr>
</tbody>
</table>
## Appendix K. REVIEWER COMMENTS
"Evidence Report on End-of-Life Care and Outcomes"

<table>
<thead>
<tr>
<th>TEP</th>
<th>Results - Symptoms</th>
<th>I am of the opinion that there is an expanding literature on the treatment of depression in the elderly, which would be coded in that fashion not specifically disease related.</th>
<th>We agree that this is a limitation of our report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEP</td>
<td>Results - Symptoms</td>
<td>... it’s not exactly clear to me whether it is useful for you to refer to the previous State of the Science meetings that have focused on some aspects of these symptoms, particularly pain and emotional symptoms. I may be opening up a Pandora’s box but there is a literature of recommendations that exist that are not captured anywhere in this report.</td>
<td>These were included because they were systematic reviews - this is the EPC methodology. We recognize that there is a large non-systematic literature that hasn't been included, especially clinical practice guidelines, and have added language to note this.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Symptoms</td>
<td>A study by DuPen of a pain intervention demonstrated that the existing medical oncology pain approaches are not as good as pain expertise.</td>
<td>Since the DuPen study used a pre-post evaluation of a quality improvement endeavor, we did not include it as a priority research design.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Symptoms</td>
<td>I couldn’t help but wonder if the behavioral issues described under AD are in fact ‘end of life’ issues.</td>
<td>As the broader understandings of “end of life” would have it, serious chronic illness that worsens through to death would count - thus advanced dementia is in the category. This comports with the work of the national hospice organizations to reach out to serve dementia patients, too.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results - Symptoms</td>
<td>It is worth emphasizing more strongly, the need for effective ways to quantify and compare distressing symptoms other than pain over time.</td>
<td>This has been added to the recommendations.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results - Symptoms</td>
<td>The authors have missed a study on the role of oxygen versus air in patients with lung cancer subjected to exercise [Bruera E, et al, Palliative Medicine 2003] and a randomized control trial between morphine and placebo conducted before the study by Mazzocato et al [Bruera E, et al, 1993].</td>
<td>We were unable to access these articles in time to include in our report.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results - Symptoms</td>
<td>The discussion of complementary and/or alternative medicine treatments is troublesome to me. For example, very broad terms such as “behavioral therapy” or “relaxation” are used. But one has no sense of what particular modalities were being evaluated in a given study.</td>
<td>We have tried to give a little description when citing a study of CAM. Reviews of CAM include a variety of approaches and the reader will have to go to the source to follow up on the specific modalities.</td>
</tr>
</tbody>
</table>
## Appendix K. REVIEWER COMMENTS

**"Evidence Report on End-of-Life Care and Outcomes"**

<table>
<thead>
<tr>
<th>Peer</th>
<th>Results - Symptoms</th>
<th>The information regarding anxiety and depression reads as if it is being taken from some other polished document.</th>
<th>The writer in this section was better at drafting. This was not copied from some other document.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer</td>
<td>Results - Symptoms</td>
<td>The whole paragraph on pain is vague. The first sentence is inappropriate since there is no need for &quot;high quality evidence&quot; to support the palliation of pain at the end of life in conditions other than cancer.</td>
<td>We have removed that sentence and revised the paragraph. We do believe more studies of pain in conditions other than cancer are warranted.</td>
</tr>
<tr>
<td>Peer</td>
<td>Results - Symptoms</td>
<td>Under &quot;Pharmaceutical Interventions&quot; the authors have not captured a large number of studies on different opioid formulations....</td>
<td>We agree. We captured some, but not all of this literature. Due to the quantity of literature on this topic and limited time frame, we relied on systematic reviews.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Symptoms</td>
<td>We should emphasize that key aspects of the &quot;basic epidemiology&quot; of pain and other symptoms in cancer and non-cancer populations is not only the prevalence, but the incidence or rate at which these symptoms occur. This point was emphasized in the NIH symptom conference last year.</td>
<td>This has been added to the research recommendations.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results - Symptoms</td>
<td>Your analysis of the Smith reference doesn't really capture the importance of that study. There are two important features of that study that are not mentioned. First, patients were cared for in a standard oncology practice and when they received a pain assessment for potential participation in the trial, they received pain expertise management. This evaluation had a clear impact on their pain before they even entered the trial. Secondly, those patients who had the intervention with improved pain management lived longer than those who did not.</td>
<td>We have incorporated these important modifications to our interpretation of the study.</td>
</tr>
<tr>
<td>TEP</td>
<td>Results- Family &amp; Caregiver</td>
<td>I am not sure if you are aware of the review on carer interventions with Harding and I conducted....</td>
<td>This systematic review went to the measures section.</td>
</tr>
<tr>
<td>TEP</td>
<td>Recommendations</td>
<td>…recommendation that should come out of this work is to undertake cross state and cross country studies</td>
<td>This is a very important recommendation that does not arise naturally from the examination of existing data. Since the reviewer will have the opportunity to present a good case for this at the conference in her session, we will be supportive without rewriting to make the case in the evidence report.</td>
</tr>
<tr>
<td>Peer</td>
<td>Recommendations</td>
<td>I am unsure why in your final recommendations you talk about the neural basis of dyspnea. This was not a focus of the review.</td>
<td>We agree. Reference to the neural basis of dyspnea has been removed.</td>
</tr>
<tr>
<td>Peer</td>
<td>Recommendations</td>
<td>I’d suggest putting much of the summary information that is currently contained in recommendations into your section summaries.</td>
<td>We have revised the document accordingly.</td>
</tr>
<tr>
<td>Peer</td>
<td>Recommendations</td>
<td>In the recommendation section it might be easier if you used a consistent style – summarizing first what was known and then what is not known.</td>
<td>Recommendations have been extensively re-written.</td>
</tr>
<tr>
<td>Peer</td>
<td>Recommendations</td>
<td>These final sections become less of a review and more of a personal narrative and evaluation by the reviewer of the literature and interpretation of implications.</td>
<td>We have revised toward a settled style and a straightforward reporting of findings and recommendations.</td>
</tr>
<tr>
<td>TEP</td>
<td>Recommendations</td>
<td>...one is left with the impression that there is so little evidence of any value that there is not much basis for the existence of the field. It is a glass half full versus glass half empty disagreement. I hope you will reconsider the negative tone of the summary comments. The difference is subtle but important for this audience.</td>
<td>Thank you. The recommendations have been revised extensively.</td>
</tr>
<tr>
<td>TEP</td>
<td>Recommendations</td>
<td>…there is no clear executive summary that contextualizes the state of the science in an overall manner and that gives clear recommendations for the types of studies, designs and methodological approaches that will be required to answer the priority/key questions in the field.</td>
<td>An executive summary is now provided.</td>
</tr>
<tr>
<td>Federal</td>
<td>Recommendations</td>
<td>Chapter 4 needs a wrap-up section/paragraph</td>
<td>This section has been completed.</td>
</tr>
<tr>
<td>Federal</td>
<td>Recommendations</td>
<td>From a policy perspective, it would be good if you would summarize (using bullets) the research recommendations after each section in Chapter 4. That way policy makers can quickly identify what are the research needs.</td>
<td>This has been done.</td>
</tr>
<tr>
<td>TEP</td>
<td>Recommendations</td>
<td>I don't understand what the phrase “research estimation” means (about line 7 from the top).</td>
<td>This has been changed to “further research”.</td>
</tr>
<tr>
<td>Federal</td>
<td>Recommendations</td>
<td>I found the recommendations weak considering again all that is not known.</td>
<td>These have been strengthened.</td>
</tr>
</tbody>
</table>
### Appendix K. REVIEWER COMMENTS

**"Evidence Report on End-of-Life Care and Outcomes"**

<table>
<thead>
<tr>
<th>TEP</th>
<th>Recommendations</th>
<th>It is probably worth stating that not only do we need to understand the use of non-pharmacological therapies, but we also need to understand the sequencing and combining of pharmacological and non-pharmacological therapies--apparently there is nothing in the literature on this very important clinical issue.</th>
<th>This has been added to the Discussion section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>Recommendations</td>
<td>Satisfaction section needs work</td>
<td>This section has been revised.</td>
</tr>
<tr>
<td>Peer</td>
<td>Recommendations</td>
<td>The conclusion reads like a very polished editorial or a lecture given by a palliative care leader to inspire future work, but it is not consistent with the remainder of the document or in scientific terms.</td>
<td>The concluding section has been entirely replaced and rewritten.</td>
</tr>
<tr>
<td>Peer</td>
<td>Recommendations</td>
<td>The recommendations section presently lacks much luster and seems oddly organized.</td>
<td>Recommendations have been extensively re-written.</td>
</tr>
<tr>
<td>Federal</td>
<td>Recommendations</td>
<td>The recommendations should be formatted as bolded statements and following by discussion.</td>
<td>We have revised accordingly.</td>
</tr>
<tr>
<td>TEP</td>
<td>Recommendations</td>
<td>There are two further references that might be very helpful for your research: [1] Chapter 13 in the NICE guidance manual deals specifically with a review of the evidence and the future directions for research. [2] Similarly, the recent World Health Organization guidance on Palliative Care for Older People and Palliative Care: The Solid Facts deals with research recommendations.</td>
<td>We read both documents and agree with many of the suggestions. This is reflected in the revised Discussion section.</td>
</tr>
<tr>
<td>Peer</td>
<td>References</td>
<td>This draft report has not yet undergone professional copyediting and has a number of typographical errors....reference 50 and 52 are both the same reference.</td>
<td>These errors have been corrected and we have undertaken much more copyediting.</td>
</tr>
</tbody>
</table>