Reviewer’s report

Title: Prevalence and profile of unrecognised palliative patients in hospitals

Version: 3 Date: 15 October 2010

Reviewer: Merryn Gott

Reviewer’s report:

This is a very interesting paper on a topic that has been highlighted as neglected in palliative care research. I think it would benefit from some revisions and hope the suggestions below are helpful in this regard.

Discretionary Revisions:

It would be very interesting to follow up the patients to see how accurate the care providers prognosticate estimates were (maybe for a separate publication). Is this possible? I’d just be really interested to see the data.

Minor Essential Revisions:

In the Abstract, the sentence beginning ‘There were marked differences...’ needs clarifying. (Differences between what and what?)

Reference 6 was conducted in a single hospital, but did not focus on imminently dying patients or those in specialized care. Please check the other references in this section as well.

Please can you clarify what ‘short’, ‘medium’ and ‘acute’ hospitals mean within a Belgium context?

Tables 1 and 5 are slightly confusing. It is unclear what ‘univariate analysis’ is being referred to and what the p value refers to in Table 1.

Did the ‘outlying’ hospital have any specific characteristics that may explain the findings?

Can you say more about what the occupancy rates were? (at least the range).

Please can you clarify your use of multivariate analysis and specifically how the outcome ‘prevalence’ of palliative care patients was categorised?

Major Compulsory Revisions

There is no statement on ethics approval. In the UK a similar study was not approved by the ethics committee because they felt patients should give to consent to a health care professional being interviewed about their care.

Obviously, however, there are diverse approaches to ethics in different countries. Some ethical statement is important.

More information about palliative care provision in Belgium would be helpful in the introduction in order to enable the reader to contextualise and consider the applicability of findings internationally.
Please can you clarify the timing of the survey? Was one day spent in each hospital? And the patient had to have been on the Ward for 48 hours previously at the time the Ward was visited? (Why was this criteria adopted?)

In the Discussion the authors state that ‘not all physicians agreed to be interviewed’. Can you discuss this in the methods? What was the response rate for nurses and physicians? What implications does this have for the generalisability of the findings?

The definition of palliative care used is fundamental to this study. Is this a definition that the authors composed themselves? Why did they choose not to adopt a national or international (e.g. WHO) definition? The definition chosen is not exactly in line with many of the former - e.g. the WHO definition does not include the caveat ‘with no possibility of obtaining remission, stabilization or improvement of this illness’ and rehabilitation, for example, now has an accepted role in palliative care in many countries. The definition chosen itself is not a problem (‘palliative care’ is a contested term) - further discussion of how it deviates from other definitions would however be helpful.

You say that ‘patient need’ was too subjective to measure. However, you do not discuss the fact that the care providers understandings of which patients are ‘palliative’ will also be subjective to some extent. In particular, you do not discuss the difficulties health care providers have in estimating prognosis, but rather use language that implies this is accurate (e.g. One third of patients had a life expectancy..). It would be worth looking at reference 6 again as a difference in this study was the use of case note review which identified a significant number of patients as meeting the ‘palliative’ criteria adopted who were not identified by the health providers. It also found a lack of congruence between Doctors and Nurses regarding patients who could be termed ‘palliative’ (even when they were given the same standard definition). Did you examine this issue? Finally, the definition used in that study was not ‘palliative and supportive care’, but a recognised definition just of palliative care. This relates to the earlier point and the fact that ‘palliative care’ is a contested term. (This paper may be interesting in this context - Pastrana et al. Palliat Med, 2008; vol. 22, 3: pp. 222-232).

It’s unclear in the second paragraph of the discussion which sample size calculation is being referred to. Was a formal sample size calculation done, or does this refer to an estimated sample?

How were the hospitals ‘randomly’ selected? This needs further exploration if representation of the ‘national level’ is being claimed.

In the conclusion, you state that ‘a comfort care plan’ was adopted in 70% of cases. However, a discussion of the extent to which this intention is congruent with high levels of interventions being received is important. The extent of congruence between physicians and nurses regarding expectations of care is interesting and indicates v good communication. Can you just confirm that they were interviewed separately?

Thank you again for the opportunity to read this very interesting paper.
**Level of interest:** An article of importance in its field

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

I declare I have no competing interests.