Author's response to reviews

Title: Decisions that hasten death: Double effect and the experiences of physicians in Australia

Authors:

Steven A Trankle Mr (s.trankle@uws.edu.au)

Version: 2 Date: 11 February 2014

Author's response to reviews: see over
Addressing Reviewer Comments

Dear Editor in Chief,

BMC Medical Ethics

I am grateful for the opportunity to provide the revised manuscript, “Decisions that hasten death: Double effect and the experiences of physicians in Australia”, for publication in BMC Medical Ethics. The final manuscript has been formatted in accordance with the Journal guidelines. I am also thankful to the two reviewers who provided their time to comment on my manuscript. Their contribution has assisted me in further enhancing its quality.

Although there are significant discrepancies between the two reviewers on some common issues in their appraisal of this manuscript, I have endeavoured to address the large majority of comments provided by adopting the reviewers’ suggestions where they have been made. However, there are also some comments that I have strongly argued against. I have addressed each reviewer’s comments systematically, beginning reviewer one.

I appreciate your attention to this revised manuscript at your earliest convenience.

Warmest regards

Dr Steven Trankle
Reviewer 1 Clive Seale:

Point 1

Is the question posed by the authors well defined?
Yes is the short answer. The long answer is that this kind of research doesn’t really have ‘questions’ to drive it, though curiosity plays a part.

Response:
Not applicable

Point 2

Are the methods appropriate and well described?
Yes. However the comments about methodology, as opposed to method, are quite superfluous. The stuff about critical realism is irrelevant to the argument of the paper. The comment about ecological systems theory is also irrelevant. PhD students may be expected to produce this sort of thing, but it’s not needed for this paper.

Response:
This comment corresponds somewhat with that made by reviewer 3 (at points 2 and 5, and comment for page 8). I have edited the entire manuscript and removed all reference to critical realism (see p2 abstract – “methods”, p.3, p.5, p.6, p.8, p.9, p.12, p.29, p.30). I have removed reference to Ecological Systems Theory (p.12) also.
I now refer more commonly to a “multidimensional approach”, “complexity” and “multileveled influences” which is really the essential point I am making with critical realism. However, I acknowledge both reviewers comments that nothing would be lost from the paper by removing references to “critical realism”. This is an epistemological position that was needed to contextualise or ground the research in my PhD thesis and, indeed, as a much larger body of work, comprised its own chapter there.

Point 3

Are the data sound?
Yes, it’s the interpretation of the data that is a problem.

Response:
Not applicable here but addressed below

Point 4

Does the manuscript adhere to the relevant standards for reporting and data deposition? Not sure what is being referred to here

Response:
Not applicable

Point 5

Are the discussion and conclusions well balanced and adequately supported by the data?

No. This is the main problem with the MS. As noted below, the summary of literature contains incorrect interpretations as well as some other problems. I will focus on what the author makes of his data here.
Paragraph 1:

First, the practice of showing a quote and then more or less telling the reader the same thing that the quote has already told the reader is a bit annoying. For example (and there are many) at the bottom of page 11 an interview describes their situation as being like a minefield. Then the author tells us that the interviewee says their situation is like a minefield.

Response:

I acknowledge this repetition in places. This has occurred because the analysis which follows a quote or group of quotes sometimes directly refers back to content. I have now checked and addressed this throughout the document. Where the problem has occurred, I have paraphrased or simply deleted the repetition. For example, in relation to the bottom of page 11 (now p. 12), the words from Gary “…talks about it being a minefield and…” (my repetition) has been removed. Elsewhere, I have reworked sections of the analysis as appropriate, for example; in Peters quote p. 13 and Robert’s quote p. 27 (now p.28) the interpretation is now less repetitive. I needed to be a little judicious in doing this, however, because deleting some selected actual comments in my analysis, could attract further criticism in respect of my interpretations not being supported by the quote. This is something the reviewer points out in the next paragraphs.

Paragraph 2:

At other times, the author produces interpretations that are not supported in the quote. For example, the quote from Robert at the bottom of page 13 (now p.14) refers to the need for courage and risk-taking, without providing any detail as to what these risks might be. The author produces a list of speculative risks in his commentary on this quote, saying that the doctor’s actions may be monitored by others who may then become suspicious etc. None of this was mentioned by Robert.

Response:

In this excerpt, Robert also talks about having “access and means” to assist people who wish to hasten their death. The risks I mention are now tied back to literature and negate any perception of my interpretation being purely speculative. At the end of my interpretation of this section (on next page 14), I have written: “Otherwise, as Magnusson has identified in the Australian context, attempts to hasten death may be unsuccessful [17].” This bolsters the previous corresponding sentences that illustrate the particular risks to Robert.

Paragraph 3:

Just after this, Peter is said to regard control over death as a matter of choice and necessity, not something under natural, divine or legal control. Yet, the quote that then follows does not refer to any of these things.

Response:

In the excerpt, Peter speaks of patients acting under their “own volition” to end their life. This means they have a choice. It also means they take control, which stands in contrast to natural, divine or legal control in ending their life.

Paragraph 4:

A third example is on page 16 where the author claims some level of sedation or analgesia is implied by a statement made by Keith. Again, this is purely speculative.
Response:
Consistent with reviewer 3, I have substituted the word “implied” (being too strong) with “suggested”. However, in the context of this section, my interpretation is not speculative. This section is about using sedation/analgesia as a mechanism to hasten death. Keith’s excerpt talks about it being illegal to “actively” hasten death but he provides an alternative to the patient by saying he can withdraw burdensome treatment (e.g. intubation) legally, but he needs to make sure the patient is “not suffering”. He says “the patient is usually happy with that” because their wish to die is honoured. Withdrawing burdensome but life-sustaining treatment (such as intubation and/or ventilation) would likely induce considerable suffering (e.g. drowning in lung fluid) and surely requires some level of analgesia or sedation. My interpretation is entirely reasonable on that basis.

Paragraph 5:
Further, the author appears to think that ‘sedation’ is something that is produced by morphine (as in his interpretation of the quote at the bottom of page 16). Of course, morphine can sometimes have a sedative effect, but more usually midazolam is provided for sedation. In fact, running through the piece is a disturbing lack of understanding of the drugs used in palliative care and their purpose, which leads to some pretty erroneous conclusions.

Response:
I consider this comment by the reviewer particularly unjustified. I am quite aware of the sedative effects of morphine and that midazolam is the preferred choice for sedation. I am also aware that accurately titrated sedation can actually prolong rather than shorten life. My manuscript is not about the relative effects of one drug vs. another. However, in this excerpt Peter talks about using morphine to sedate and conceptualises his actions as “slow euthanasia”. This is quite a common analogy, yet one that is often despised by palliative specialists who insist sedation is titrated against need and therefore not euthanasia. Many of my participants also said this to me. But Peter uses sedation in this example to hasten death. Morphine is his choice of narcotic in this excerpt and not a word that I have used in my analysis/interpretation. Accordingly, I am at loss as to why the reviewer chose to make this personal comment. Nonetheless, I have now added another citation in my analysis of Peter’s excerpt (now on page 17) (Douglas et al 2008) [65] that confirms Peter’s conceptualisation of “sedation as slow euthanasia” is a common one.

Paragraph 6:
For example, Gary’s comment on page 19 refers to having provided sedation to control his patient’s distress. His comment to the family, that the patient will not wake up again is interpreted by the author as meaning that the doctor knew that the sedation would have death as its ‘consequence’. No evidence for this is present in the quote, and in fact midazolam when appropriately administered just as in the case of morphine – probably has no impact on length of life (a point which Jenny on page 26 is making, although the author doesn’t seem to appreciate this).

Response:
My purpose in providing the analysis is not to go beyond the excerpt. There is no mention of midazolam. Although I have not included the type of medication Gary provided, just prior to this excerpt Gary spoke about the use of phenobarbitone when midazolam and morphine were not considered suitable especially for end stage patients such as this one with a very short prognosis. Gary’s exact words were: “...and once we start this [sedation], over the next four hours he will get sleepy and he’s not going to wake up”. Not waking up is certainly a consequence of the sedation. My interpretation of this excerpt continued over the page (p.20) and here Gary explicitly stated how his actions resulted in death and how he was pleased he could stop this patient’s suffering.
In my entire manuscript there is not a single instance where have I stated that appropriately administered sedation shortens life - it is acknowledged as a vehicle by some physicians to end life and I have identified this in a number of excerpts. Indeed, by including the excerpt of Jenny on page 26, I am pointing out in its analysis, the range of views toward practices of sedation and how when it is appropriately titrated, death is not necessarily hastened. Again, this speaks to the “intent” of the physician and thus the PDE. A qualitative investigation should point out discrepant cases (BMC “RATS” guide emphasises this to reviewers) and I have deliberately provide a balanced view for the reviewer to note.

**Paragraph 7:**

On page 25 (now mostly p. 26) there is a very disturbing case of a doctor (Jeremy) who may have been panicked by the state of his patient and appears to be describing the administration of an overdose of Midazolam, which he felt had killed the patient. The author’s interpretation of this event is to believe the doctor’s point of view, which is basically that this action might be covered by the double effect idea. Well, no, this is not so. This doctor appears (and I emphasise appears, as we are not provided with dosage information) to have over reacted. Arguably a lower dose would have worked, and was certainly the way to start (as is recommended in all the guidelines on the use of midazolam in these circumstances, which say that dosage should be titrated upwards in response to the symptoms it is designed to treat, which include agitation). This doctor is in need of training. One can certainly not use his case to argue that the PDE is no good because his actions were correct. They were not correct.

**Response:**

Reviewer suggests that I “believe” doctor’s point of view. I have quoted the doctor’s words not mine. On the very next page (27) Jeremy cites the PDE in this particular case and how it would protect him despite finding it distasteful. The point being made, as Jeremy says and I comment on at length, is that there are other influences at work and Jeremy must deal with a specific situation in the moment in the best way he can. He still feels responsible, which is consistent with the argument throughout this manuscript that PDE does not consider wider motivating influences such as physician emotions, or unique psychological and moral situations. The reviewer has commented that he feels I have gone beyond the excerpts in my interpretations in a number of places in this manuscript, however, nobody can reasonably comment on whether Jeremy’s actions in this situation were correct or incorrect or, indeed, at his level of training. Jeremy may have been eminently qualified and trained, and a highly skilled palliative specialist. The data does not say this one way or the other. However, the concerns of the reviewer as to the actions of this physician only emphasise the difficulty of managing dying patients in situations that are often very unique, and with the skills and resources that are available to them. Other physicians may act very differently given the same situation. The PDE is there for physicians to draw on regardless of whether their actions were correct or not.

**Paragraph 8:**

Against this main trend of over-interpretation and naivete about drugs and clinical practice, there are some interesting and worthwhile quotes and points made around pp. 20-22, where doctors are shown describing how they get around legal restrictions.
Response:
Not Applicable

Point 6

Are limitations of the work clearly stated? Some are, but the author appears unaware of the problems listed above.

Response:

The problems the reviewer lists above are addressed above.

Point 7

Paragraph 1:

Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
Yes, but their interpretation of that work is quite often biased and inaccurate. The author has rather too much faith in the validity of the findings produced by surveys and demonstrates a worrying willingness to draw unwarranted conclusions from this body of work. For example, at the bottom of page 4 the withholding/ withdrawing ELDs and the alleviation ELD appears to be understood as ‘passive euthanasia’ which is very far from the truth. On page 5, the view that doctors felt palliative care was inadequate is not justified by the findings reported. The simple fact of such services being available says nothing much about the doctors’ judgements about its adequacy and this cannot be inferred from their actions in other areas. They may simply have preferred to do the things they did without recourse to the supposedly ‘available’ service.

Response:

On page 4, I have re-written the end of the paragraph to remove any perception of some accepted and legal practices being construed as euthanasia. It is re-written more closely to the article (Löfmark et al.) which is being cited. I have allowed the authors’ interpretation to dominate and reported them in less absolute terms (underlined). Specifically:

However, 77% reported withholding or withdrawing treatment while 83% intensified the alleviation of pain through analgesia with the probability or certainty of hastening death, and some conceptualised these practices as euthanasia. Accordingly, it appears that many Australian physicians in this study may have performed euthanasia at least once, yet on the request of patients very few complied (7%).

On page 5, I have removed “This strongly suggests...” which creates the impression that this is my interpretation of the literature and replaced the sentence opening with: “The authors strongly suggested...” which is more accurate and can be found throughout that article. However, my citation of this article was also bolstered in that same paragraph by the other literature I cited which was consistent with that article.

Paragraph 2:

In addition, the author keeps referring to ‘ambiguity and inconsistency’ in doctors beliefs and positions, and indeed at the start of the methods section claims that there is a literature review somewhere that shows this, though no reference to this review is provided. The review provided in the paper does not, to my mind, support this conclusion, so I am left wondering why the author thinks this is true.
Response:
Although early in the manuscript (page 4) there are numerous references attesting to the “inconsistency” in how physicians conceptualise end-of-life practices, I have now provided another reference to this claim (Trankle, 2013) [55] on page 7 (Methods) and again at conclusions end of p.29 (Trankle is again referenced and bolstered by an additional corresponding citation from earlier in manuscript supporting this “ambiguity and inconsistency” - Douglas et. al, 2008) [65]. The reference list citation includes a direct link to the Australian National Library Repository where my PhD thesis is stored electronically. The first five of 10 chapters were an extensive and “critical” literature review. Since submitting this manuscript to BMC in May 2013, the thesis was examined by one national and one international expert in the field and subsequently approved which allowed for my recent graduation.

Paragraph 3:

In addition, the author on page 6 presents arguments against the adequacy of the PDE. Since this is supposed to be the main conclusion of the study. It is disturbing to find the author has already decided that PDE isn’t useful any more, before even showing results of his study to the reader. It is highly suggestive a pre-existing bias, unfortunately a feature of much qualitative social research reporting I am sorry to say (I speak as someone who has done a lot of qualitative work myself).

Response:
This is not bias. My manuscript cites multiple references in this section attesting to this. Nonetheless, I have amended further by removing the reference to critical realism here in the opening sentence and hopefully clarifying better. I have written, instead (underlined): “A complex multidimensional world renders singular and less inclusive considerations explanatorily inadequate. Yet medico-legally, physicians need to operate under uni-dimensional imperatives if patient deaths are potentially hastened”. The preceding introduction highlighted end-of-life decisions and practices as anything but simplistic or black and white. In the introduction I have provide a balanced view of the PDE drawn from the literature where it is considered useful by some and problematic by others. This paragraph then further sets up the aims of the study which follow to explore the “multiple influences” behind the way physicians conceptualise, negotiate and subsequently draw on the PDE in Australia. The conclusion is about recognising a hastened death as more than only the “intent to end life”.

Point 8
Not applicable
Point 9
Not applicable
Reviewer 3 Niklas Juth:

Point 1
Is the question posed by the authors well defined? Yes.

Response:
Not applicable

Point 2
Are the methods appropriate and well described? Partly so. The qualitative method is well described, but it is unclear what the critical realist position means and how it affects the analysis of the material. Please see more detailed comments below.

Response:
This comment corresponds with that made by Reviewer 1 (point 2). As mentioned above, I have edited the entire manuscript and removed all reference to critical realism (see p2 abstract – “methods”, p.3, p.5, p.6, p.8, p.9, p.12, p.29, p.30)
I now refer more commonly to a “multidimensional approach”, “complexity” and “multileveled influences” which is really the essential point I am making with critical realism. However, I acknowledge both reviewers comments that nothing would be lost from the paper by removing references to “critical realism”. This is an epistemological position that was needed to contextualise or ground the research in my PhD thesis and, indeed, as a much larger body of work, comprised its own chapter there.
This is now also addressed for “major compulsory revisions” below.

Point 3
Are the data sound? Yes.

Response:
Not applicable

Point 4
Does the manuscript adhere to the relevant standards for reporting and data deposition? Well, usually results and discussion are separated. In this article they are merged. However, I do not think it affects the quality of the presentation of data or discussion, so this is merely a formality that the author may ignore.

Response:
Not applicable.
However, I would like to comment that the BMC instructions to authors allows for results and discussion to be “combined”. I think this is very important in the case of qualitative research and especially when reporting thematic analyses. Indeed, as Braun and Clarke point out [56], “Extracts need to be embedded within an analytic narrative that compellingly illustrates the story you are telling about your data” (p.93). By separating these sections data risks becoming fractured and the main points may be lost if only discussed separately later.
Point 5
Are the discussion and conclusions well balanced and adequately supported by the data?

To some extent. The author convincingly demonstrates that physicians refer to double effect reasoning (while at times at least) being ambiguous towards this kind of reasoning, but use it as a tool to gain support for the action they feel they should perform. This is also the most important conclusion, as far as I see.

However, the conclusion regarding the critical realist position is harder to take a stand on, since it is unclear what this position consist in and how it helps the analysis.

Also, the normative conclusions regarding revising laws do not follow from the empirical material, of course (otherwise, we would have a case of the natural fallacy). The author here needs to be more modest; perhaps the author can claim the conditional that if we would like physicians to be able to act out of compassion to a larger extent, we perhaps need to change the law.

It also sounds incredible to me that Australian law only cares about intent (or that physician thinks so). This would need to be backed up by references.

Response:
The reviewer’s concern with Critical Realism is addressed for this reviewer above at his “point 2”, below at “major compulsory revisions” and for reviewer 1 (point 2) above.

His next comment regarding the conclusions drawn and the need for modesty are noted and attended to on page 31. The original opening sentence of the last paragraph of “conclusions” now incorporates the reviewer’s suggestion (underlined), specifically: “As explicitly stated by some physicians in this study, and implied by many others, a review of current medico-legal guidelines is indicated, especially if we consider it important that physicians should be able to act out of compassion to a much larger extent”. This corresponds with the summarised “conclusions” in abstract and did not need further revision there.

As suggested by the reviewer, I have utilised references [46,47,48] that support the claim regarding “intent”. The latter two are particularly noteworthy being quite recent and written in the Australian context. These citations were originally made early in the manuscript at “Background” but I have again reiterated by citing them in “conclusions” page 30 where the point about the problematic concept of “intent” is emphasised again. The manuscript contains many examples of how physicians understand the PDE and “intent”, for example Robert provides two particularly strong exemplars on pp. 27-28.

Point 6
Are limitations of the work clearly stated? Yes

Response:
Not Applicable

Point 7
Do the authors clearly acknowledge any work upon which they are building, both published and unpublished? Yes.

Response:
Not Applicable
Point 8
Do the title and abstract accurately convey what has been found? Yes.

Response:
Not Applicable

Point 9
Is the writing acceptable? Yes.

Response:
Not Applicable

Minor Essential Revisions

Abstract and passim:
The Principle of Double Effect is referred to as a “medico-legal structure”. First, I do not know what that mean (is it something else than a legislation? What?) Second, the Principle of Double Effect is a moral principle (or rule or doctrine, it has been called all these things). However, I am not aware of any place where it is a law. Is it really in Australia? Or is it only that intent matters when hastening death (as in almost all jurisdictions) and the Principle of Double Effect expresses this kind of thinking? Please clarify.

Response:
My original “Critical Realist” positioning of this manuscript identified multilevel “structures”, legal being one of them. Upon revision of the entire manuscript and the removal of all reference to critical realism and multilevel “structures”, I have change the wording to a legal “imperative”. Attended to in abstract but revision is consistent now throughout the manuscript. An imperative is synonymous with rule or principle. The importance of “intent” when hastening death, as the reviewer mentions here in abstract, is precisely the point and is extensively reviewed in the Background section that follows immediately.

Paragraph 2
Abstract: change the sentence “the purpose of this study was to provide a greater understanding of how and why physicians in Australia will hasten death.” to “the purpose of this study was to provide a greater understanding of how physicians in Australia reason regarding how and why they hasten death” or something of the like – of course, we will not find out what they (will) do by interviewing them but how they talk about it.

Response:
I have amended accordingly. It now reads: “...the purpose of this study was to understand the reasoning behind how and why physicians in Australia will hasten death.

Page 5 and passim:
The term “euthanasia” is often and increasingly used and defined in accordance with the Dutch definition, which says that euthanasia is the administration of drugs with the intention of ending life at the explicit and voluntary request of the patient. According to this use, for instance, withdrawing treatment that results in the hastening of death would not be euthanasia. It seems that in the introduction, the author sometimes uses euthanasia in line with the Dutch definition and sometimes synonymous to the much broader term “hastening death practices”. For instance, on page 5, the author mentions “non-voluntary euthanasia”, which according to the Dutch definition would be a contradicatio in adjecto. The author should be careful to use the term “euthanasia” when the narrow
Dutch definition is presupposed and “hastening death practices” when more broad definitions are presupposed or, alternatively, explicitly explain where and why another terminology is used.

Response:
The issue the reviewer raises here is an important one. This distinction needs to made early in the manuscript to avoid confusion. I have addressed this now on page “4” where these concepts are first introduced. I have rewritten paragraph two and included the following:
“For example, in jurisdictions like the Netherlands, euthanasia is understood to be performed at the explicit voluntary request of patients and through pharmacological administration. However, death hastening practices more broadly can also be performed without the request of patients and through withdrawing life sustaining measures”.
My use of these terms throughout the manuscript is consistent but I highlight the widespread ambiguity and confusion with these terms, with physicians in this study identifying the inconsistency in how they understand them.

Page 6:

It is simply not true that “the PDE ... only consider the intent of the physician”. It also considers, e.g., proportionality in outcomes comparing the good and the bad effect. The author should take a generally accepted definition of PDE as the point of departure, e.g. Mangan’s.

Please explain or exemplify what is meant by “unique moral or emotional factors that may be relevant.”

Please rephrase or explain what is meant by “complex specificity” in the sentence: “Few jurisdictions other than the Netherlands recognise the complex specificity in end-of-life decision making.”

Response:
The paragraph on page 6 has been amended to address reviewer comment (underlined). I provide part of the paragraph below which now reads:
...However, the PDE provides generalised rather than situation-specific guidelines that more often only considers the intent of the physician [48]. Specifically, a physician is culpable if the intent is to kill but not if the intent is to alleviate suffering even with a foreseeable outcome of death ensuing as a direct consequence. Although the PDE recognises proportionality in comparing good and bad outcomes, it does not consider other extenuating influences in the physician’s motivations such as unique moral or emotional factors that may be relevant. Further, if a physician intends to end life, practices can easily be reframed as intended to address intractable suffering.
This paragraph is also strongly supported with corresponding citations.

“Unique moral and emotional factors” are addressed in the paragraph that follows by the next amendment (p7). However, the sentence was rewritten (p.6) to attend to an earlier comment (first underlined) and I have also now added another sentence (second underlined):
Although the PDE recognises proportionality in comparing good and bad outcomes, it does not consider other extenuating influences in the physician’s motivations such as unique moral or emotional factors that may be relevant. Indeed, compassion may be a particularly strong motivator.

Now on page 7 (first paragraph), I have explained “complex specificity”. Now reads:
Few jurisdictions other than the Netherlands recognise the complexity in end-of-life decision making where patient requirements, and the physician’s interaction with them, represent a unique dynamic. Prior to legalising...
Page 7 and passim:
If this is a study based on semi-structured interviews (which is claimed e.g. at page 7), there should be an interview guide. It would be useful if this guide was provided as an appendix, both in order to evaluate the method and the result (e.g. in order to determine to what extent and what way the answers and themes are directed by the questions).

Response:
This is now mentioned on page 8 (Appendix) and I have included my interview schedule as an appendix at the end of the manuscript.

Page 15-16:
In the sentence “she also uses the word “inadvertently”, which implies double effect” the word “implies” is too strong and should be replaced with “suggests” or something of the like.

Response:
I have substituted the reviewer’s word for mine. It now reads “suggests” (p.16)

Page 16:
The author conflates two separate distinctions, that between active and passive and that between intent and non-intended (but, perhaps, foreseen) effects. This is why it is wrong to say, for instance, that: “He emphasises the word “actively” when ending life, which connotes intent.” The difference between these distinctions must be upheld throughout the article.

Response:
The last sentences read:
He emphasises the word “actively” when ending life, which connotes intent. It is almost a subversive approach where Keith needs to reframe the meaning of a potential intervention along legal and professional lines.
This now reads:
He emphasises the word “actively” when ending life, but it is almost a subversive approach where Keith needs to reframe the meaning of a potential intervention along legal and professional lines.
The perceived conflation with intended/unintended is addressed and I have checked the entire manuscript accordingly to ensure that these distinctions are upheld.
However, I will comment further:
On the previous page (15) where this theme begins, there is a referenced introduction to the theme, which clarifies this distinction and that both active and passive interventions can have intended or unintended (even if foreseen) outcomes. They are not necessarily conflated terms and, indeed, the physician excerpts within that theme identify how their actions (passive through treatment withdrawal or active by administering narcotics) are conceptualised as intended or unintended (Jenny says “inadvertently” on page 16). The important point of this theme is that whatever the physician’s intervention, their “intent” can be reframed to correspond with acceptable guidelines, specifically the PDE.

Page 17:
It says: “Robert mentions “harder to accede”, suggesting that because such a decision is collaborative rather than autonomous by the physician it may be more professionally or legally risky.” I do not understand why this suggest what it is claimed that it suggests, and furthermore I do not understand collaborative decisions are more professionally or legally risky. Please clarify or leave out this sentence.
Response:
I have elected to remove the sentence which is perhaps superfluous to the theme identifying “emotional pressure”. It now (p.18) reads:
Acknowledging the legal framework he must work within, Robert mentions the difficulty of acceding to a request for death, but it may also be “harder” for Robert because the decision comes with added emotional pressure.
However, I added another reference earlier in addressing a comment from reviewer one which supported the “risks” that physicians take when hastening death (Magnusson, 2002) [17] on p14.

Page 21:
“These excerpts identify important contextualised structures that uniquely influence in the moment, specifically, those of the patient, himself, and professional and legal ones, and which also situates his experience temporally.” I do not understand this sentence at all. For instance, what does “contextualised structures” mean and what does it mean to have one’s experience temporally situated? Clarify or cross out.

Response: The excerpt is now on page 22 after document revision.
This sentence was consistent with the critical-realist framework I have since removed at the request of both reviewers. I have now also simplified the language. It now reads:
“These excerpts identify the importance of context, where specific dynamics play out that uniquely influence in the moment. For example, Keith’s experience is subject to an interaction with the patient, his developed attitudes, and professional and legal considerations”.

Major Compulsory Revisions
Page 8 and passim:
“Thematic analysis was compatible with the critical realist epistemology and theoretical considerations of the research [34], and particularly useful for examining data that was previously unexplored.” How are they compatible? In what way is it useful? This is unclear throughout the article. These problems recur in a number of places. For instance, in the abstract it is claimed that “A qualitative investigation grounded in a critical realist paradigm was focused on palliative and critical/acute settings.” How can a qualitative investigation (which this clearly is) be “grounded” in a “critical realist paradigm”? The problem is that it is unclear throughout the article what the critical realist position consist in and how it contributes to the analysis of the material. This is the major problem with this article. I do not see that anything of importance in the discussion or conclusions would be lost if the author simply drops this theoretical superstructure, which seems to me wholly unnecessary. If the author wants to keep it, then it must be clarified further.

Response:
I have addressed this comment earlier for this reviewer at his point 2 and this corresponds with addressing the same for reviewer 1 at his point 2. As explained, for the purposes of this manuscript and its much tighter scope (than a PhD thesis), and at the suggestion of both reviewers, I have removed all reference to Critical-realism from the document.

Page 12-15:
I fail to see why the paragraphs under the theme and heading Religion and sanctity of life starting with the following sentence are not separated as one or several separate themes: “However, contrary views to such commonly accepted positions on hastening death are also provided by some physicians who consider patient choice and autonomy most important in directing their position on controlling the timing of death.” They provide lines of reasoning that has no necessary connection to religion – they are about other values such as autonomy and compassion to which one may adhere regardless of religious beliefs. Please motivate why these paragraphs should be subsumed under the
theme (and the fact that the physicians invoking these values “might reject the sanctity of life position”, p 14, is not enough) or, preferably, separate what is said in one or more themes of their own.

Response:

In accordance with this reviewer’s suggestion, I have now separated into additional subthemes. I agree that one can hold religious beliefs with varying degrees of conviction while also holding other beliefs. The main theme “Religion and the Sanctity of Life Position” now is broken up to include two other subthemes which provide a clearer balance. They are: “Patient choice and autonomy” (p. 12) and “Motivated by suffering” (p.14). In doing this, I have also flagged the inclusion of these subthemes at the first sentence in “Results and Discussion” (p.9).