Author’s response to reviews

Title: Changes in professionals' beliefs following a palliative care implementation programme at a surgical department: a qualitative evaluation

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Authors response to the reviewer’s critique.

Our sincere thank you to the critique and constructive suggestions. We have carefully considered the suggestions and comment below the amendments made.

While we have undertaken changes related to the constructive suggestions from the referee, we have also done minor clarifications and changes throughout the paper.

#1 Thank you for the opportunity to read this paper that explores health professionals’ beliefs after they participated in an educational programme on delivering palliative care. The study claims to be a comparative before and after qualitative design. I do not believe it is comparative as the authors are not comparing those who participated in the educational programme with a comparison group. I would argue that the study is simply follows a before and after qualitative approach.

We agree, the study is a before and after qualitative design rather than a comparative. We have changed this terminology throughout the manuscript.

#2 Background:
The background is well written and offers a comprehensive range of references. It will be useful if the authors could provide a more robust justification for why they focused on a surgical department. If the authors could shed light on the palliative care needs of patients in this type of ward it would be interesting. Is there any evidence that the needs of these patients are currently poorly attended to or underserved?

We agree that the paragraph about palliative care needs of patients in the context of surgical care needs clarification. We have added clarifications (background, line 12, 15, 18-21, page 3) and included references to two recent studies by Lilley et.al (2016, 2017). We have no support for assuming patients to be underserved in surgical care, however, the project was driven from clinical practice observations regarding patients need for improved symptom relief and a lack of palliative care expertise at surgical department.

#3 It would be useful for the authors to explore the relevance of implementation science in the delivery of this educational programme.

We had already in the first submission included a reference to an implementation science model (the PARiSH model; background, line 12, page 4) but agree we could expand this. For this reason, we have added an expanded discussion related to implementation science (pages 16-17).

#4 My main problem with the aim is that new knowledge may change beliefs but do beliefs change clinical behaviour? I believe this, facilitated by education that would be a better topic to explore in detail, as it is this that has potential to change patient and family centred outcomes. This is a problem with many studies in this field; most being small-scale, and often assessing small-scale, often assessing the effect of training on clinicians’ self-reported confidence or attitudes rather than patient outcomes or staff behaviours.

We agree this is an important issue. Yes, observation of behaviour would make a stronger design, but also a more of intervening in practice situations and requiring additional resources. For this reason, we claim that the chosen design was appropriate and could be considered a relevant step given the limited knowledge related to implementation of specialized palliative consultations in hospitals.

We have added a short elaboration on this in the discussion: first, relating the result to implementation science (page 16-17) and included references to two studies by Nilsen et.al (2012) and Michie et.al (2014) and secondly highlighting methodological limitations (method discussion line 24-32 page 20), and clarified some of the previous discussion of methods (line 4-6, page 22).

#5 Methods:
The intervention is well described in the methods section. The authors do not state if changes were made to the course partway through after requesting the views of course participants. This will be useful to know.

The structure of the seminars was maintained throughout the course, and we have added this clarification, (methods, implementations strategy, line 26-29, page 5).

### #6 Sample:

There may be some bias in the recruitment of potential participants. The authors state that the sample emanated from participants’ personal interests. It will be useful to understand if the authors purposefully sampled those who attended the course from a wider pool of potential participants in order to achieve a fair representation of those under enquiry.

Interested staff on the three wards were invited, and all who volunteered were offered to participate. We have clarified the sampling principle (methods, sample, line 5-8 page 6).

### #7 The analysis is detailed and well described but there is no mention of how the authors attempted to maximise rigour in their analysis for example they could have made use of dual coding, member checking, and attention to non-confirmatory/deviant cases among other strategies. The authors state the analysis was carried out by the person who was not present during the focus groups. Why was this the case? A detailed rationale for this is important to understand.

We have added some details to how the rigour was maintained (method, analysis, line 29-31, page 8 and line 1-2, page 9): and the analysis related to the method discussion line 24-32, page 20).

The reason for the author not being present in the focus groups was practical; this author was not involved in the project at the time when the focus group discussions were performed. This is clarified (method, design, line 7 page 5 and method discussion, line 2, page 22).

### #8 Results: The findings are interesting and at times well described. Some of the quotes the health professionals do not always follow the narrative that accompanies them. A lot of reference to ‘prior to implementation…’ and ‘after implementation…’. At times this is rather repetitive.

Thanks for pointing out this. We have scrutinized and made minor changes throughout the result section.

### #9 Many of the issues highlighted by the findings are already well known in the literature. In what ways do these issues resonate in different ways within surgical departments? This would be more interesting to explore.
As mentioned in the first paragraph in the discussion, focus on the surgical department was on acute intervention and cure before implementation, while complexity, involvement, suffering and quality of life emerged in the discussion after implementation. As there is lack of palliative competence and consultation services on the absolute majority of surgical departments in Swedish acute hospitals, well established issues from palliative care, e.g. symptom relief, communication and family involvement risk to be absent. However, the results of our study show that implementation of these issues is possible.

In the first paragraph of the conclusion section line 14-15, 21-25 page 22, we have inserted a sentence that our study confirms the feasibility of a palliative care implementation strategy with a combination of integration and consultation strategies.

#10 Discussion.

Again this is well written but I go back to my main point that it is important to understand whether the before and after beliefs of health professionals' working in surgical wards influence their clinical behaviour. This is more important to understand. It would also be useful to understand whether these beliefs that influence behaviour remain in place over time, or are in fact used as a foundation to build on.

We have clarified this issue and problematized the relationship between professional beliefs and clinical behaviour, in the discussion page 16-17.

#11 The limitations are interesting. The authors do not shed light on whether course participants may have been influenced by other programs of education but may have been taking place at the same time. Changes in belief may be contingent on many other factors above and beyond the course that was offered.

We agree and have expanded the discussion about various factors that might have influenced the result, method discussion line 1-5 page 21.

#12 It would be useful to be more critical about the use of focus groups as the sole source of data for this study given that there is evidence of lack of communication and tension between surgical and medical staff. Would face-to-face interviews have elicited different views?

The discussion about the data source is expanded at method discussion, line 19-26, page 21.