Author’s response to reviews

Title: How to Come to Terms with Facing Death: A Qualitative Study Examining the Experiences of Patients with Terminal Cancer

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Version: 1 Date: 17 Sep 2018

Author’s response to reviews:

9/17/2018

Dr Maria Zalm
Editor
BMC Palliative Care

Dear Dr. Zalm:

I, along with my coauthors, would like to thank you for inviting us to revise our manuscript titled “How to Come to Terms with Facing Death: A Qualitative Study Examining the Experiences of Patients with Terminal Cancer” for consideration in BMC Palliative Care.

Please find our revised manuscript with changes included based on yours and the reviewers’ comments. A point-by-point response to each comment is appended below. Again, thank you for providing this opportunity to revise our manuscript, and we hope that our paper is now suitable for publication in your esteemed journal.

Sincerely,

Ayumi Kyota
RESPONSE TO REVIEWERS

We wish to express our strong appreciation to the Reviewer for their insightful comments on our study. We feel the comments have helped us significantly improve the study.

Responses to the comments of Dr. Melissa J Bloomer, PhD, RN (Reviewer 1)

1. Page 3: line 3 you state that 20.4 million people need palliative care. The significance would be better explained if you provided the percentage of the total population, rather than just an absolute number.

Response: In accordance with the Reviewer's comment, we have changed the following text in the Background from:

The estimated number of people in need of palliative care at the end of life is 20.4 million, and the vast majority of adults receiving palliative care die from cancer (34%) [1]

To

It is estimated that 37.4% of all-cause deaths worldwide need palliative care. In higher-income countries with substantial older adult populations, this percentage may exceed 60%. Additionally, more than 34% of adults receiving palliative care eventually die due to cancer [1].

Response: We mistook the reference number. Reference [5] should refer to Backman, and reference [6] should refer to Backer. We changed the following text in the Background from:


To

Backer [6] stated that the path to death […] Buckman [5] proposed a three-stage theory […]

References
4. Backer BA, Hannon N, Russell NA. […]
5. Buchman R. Communication in palliative care: a practical guide. […]

To

5. Buckman R. Communication in palliative care: a practical guide. […]
6. Backer BA, Hannon N, Russell NA. […]

3. Page 3: line 38, remove the first name of the author, and check spelling; you state Buckman in text, but Buchman in the reference list.

Response: We changed the following text in the Background from:
Robert Buckman [5] proposed a three-stage theory [...] 

To 

Buckman [5] proposed a three-stage theory [...] 

4. Page 3: line 50, the statement relating to patients encountering increasing difficulty in doing what they were previously able to do etc. This is also true of patients with cancer who are not yet terminal. You have not adequately differentiated how the terminal patient is different.

Response: We changed the following text in the Background from:

Cancer patients who have reached the terminal stage despite attempts at treatment are likely to experience various problems, particularly as they encounter increasing difficulty in doing what they were previously able to do easily, and their physical symptoms increase as the disease advances.

To

Cancer patients who have reached a terminal stage despite attempts at treatment have various sufferings. They are realizing the approaching of death by increasing difficulty in doing what they were previously able to do easily.

5. Page 4: line 6, please provide a reference to support your statement about the use of psychiatric oncologists and then provide an explanation of how this is similar or different to 'psychosocial oncology' mentioned in the subsequent sentence.

Response: We changed the following text in the Background from:
For this reason, some patients often require mental health care from specialists such as psychiatric oncologists. Thirty-nine percent of patients in the advanced and terminal stages of cancer are referred to in-hospital psychosocial oncology services, which consist of social work, psychiatry, and psychology [7].

Therefore, it is likely that many patients with terminal cancer reach mental stability, and despite the suffering they feel about being close to death, attempt to come to terms with reality.

Therefore, it is likely that many more patients with terminal cancer attempt to attain mental stability, individually, while managing the stresses of impending death. Here, mental stability is defined by patients managing their daily life without expressing anxiety or depressive symptoms to a diagnostic level.

7. Page 4: line 35, please explain what is meant by 'vague confusion or ambiguous chaos, which are not identified as evidence spiritual pain…' This does not make sense.
Response: This means that not all patients with terminal cancer need specialized mental health and spiritual care. We have changed and added the following text to the Background from:

Cancer patients who have reached the terminal stage despite attempts at treatment are likely to experience various problems, particularly as they encounter increasing difficulty in doing what they were previously able to do easily, and their physical symptoms increase as the disease advances. Aside from physical pain, loss of meaning, loss of autonomy, being a burden, fear of future suffering, and worry occur frequently in patients with terminal cancer, who suffer unbearably [6]. For this reason, some patients often require mental health care from specialists such as psychiatric oncologists. Thirty-nine percent of patients in the advanced and terminal stages of cancer are referred to in-hospital psychosocial oncology services, which consist of social work, psychiatry, and psychology [7]. However, 76% of patients with terminal cancer do not experience any clinical depression during the month before death [8]. Problem-focused strategies are used less frequently and emotion- and belief-focused strategies are used more frequently with terminally ill patients, relative to other patients [9]. Therefore, it is likely that many patients with terminal cancer reach mental stability, and despite the agony they feel about being close to death, attempt to come to terms with reality.

Close attention has recently been paid to cognitive behavioral therapy [10] and individual meaning-centered psychotherapy [11] to help patients to deal with spiritual pain (e.g., despair and the loss of the meaning in living). In addition, some patients experience vague confusion or ambiguous chaos, which are not identified as evident spiritual pain by healthcare professionals. It is reasonable to assume that these patients make their own efforts to reach mental stability when facing these feelings. However, it is quite probable that they are considered not to require special mental health care by healthcare professionals.

To

Healthcare professionals are keenly interested in assisting with the strong anxiety and spiritual pains experienced by terminal cancer patients. Cancer patients who have reached a terminal stage despite attempts at treatment have various sufferings. They are realizing the approaching of death by increasing difficulty in doing what they were previously able to do easily. Aside from physical pain, loss of meaning, loss of autonomy, being a burden, fear of future suffering, and worry occur frequently in patients with terminal cancer, who suffer unbearably [7]. For this reason, some patients are often referred to mental healthcare specialists such as psychiatrists.
One of the most challenging roles for the psychiatrist is to help guide terminally ill patients physically, psychologically and spiritually through the dying process [8]. Close attention has recently been paid to cognitive behavioral therapy [9] and Mean-Centered Psychotherapy-Palliative Care [10] to help patients to deal with spiritual pain (e.g., despair and the loss of the meaning in living).

However, not all patients with terminal cancer are referred for specialized mental healthcare. Approximately 24% of terminal cancer patients have been diagnosed with an anxiety or depressive disorder [11]. Therefore, it is likely that many more patients with terminal cancer attempt to attain mental stability, individually, while managing the stresses of impending death. Here, mental stability is defined by patients managing their daily life without expressing anxiety or depressive symptoms to a diagnostic level. Not surprisingly, it is rather difficult to achieve mental stability in such circumstances, and the need for specialized care is often hidden among these individuals.

8. Page 4: line 52, what do you mean by 'nurses to assess patients' psychology'? Do you mean that nurses assess a patient's mental health? Are palliative care nurses in Japan trained to do this? If so, how? Is a validated tool used to assess mental health? This is not clear. It would also be valuable to state what role palliative care nurses have in mental health care.

Response: This was a translational error in 'nurses to assess patients' psychology'. We have changed and added the following text to the Background.

We conducted the present study with the expectation that our findings could help nurses better assess patients’ mental health and capture latent mental needs. In Japan, 80.2% of palliative care teams include at least one certified nurse (CN) or certified nurse specialist (CNS) [12]. The most common symptoms treated include pain (63%) and anxiety/depression/grief/emotional burden (22%) [13]. However, only 0.34% of all nurses qualify as a CN or CNS for palliative care and cancer nursing [14]. Therefore, it is often necessary for a general nurse to assess patients’ mental health and consult with doctors in order to request relevant care. It is also necessary to assess mental situation not only from tools, such as STAS-J [15] but also from patients’ narration.

9. Page 5: line 13 you state that the findings will be applicable to other countries and cultures, but will reflect the influence of East Asian culture. It is important to explain what is meant by
east Asian culture, and who this typically includes. My perception of east Asian culture is that it may include China, Hong Kong, Thailand, Indonesia, Korea etc, and some of these countries are developed and others are developing. Furthermore, there may be distinct differences between cultures, and differences in perceptions, attitudes towards, and acceptance of dying and death. Palliative Care as a discipline may also not be the same. So if the authors wish to make this claim, it needs to be justified.

Response: In this paragraph, we wanted to express global versatility over limits of the research due to an East Asian cultural influence. Therefore, that sentence was deleted. We have changed the following text in the Background from:

The findings will be applicable, at least in part, to many other countries and cultures; however, they will reflect the influence of East Asian culture.

To

The participants of this study are consistent with the global trends and are considered to have high versatility.

10. Page 5: line 18, the aim is written in a way that it is positively skewed. It assumes that cancer patient DO reach mental stability. A positively skewed aim will impact the results.

Response: We did not think that cancer patients DO reach mental stability. We have changed the following text in the Background from:

This study aimed to clarify how cancer patients reach mental stability when facing death.

To
The purpose of this study is to clarify that patients who not exhibited anxiety or depressive disorder how recognize the terminal stages and are trying to stabilize their mental health.

11. Page 5: line 30, further detail is required to explain what is meant by 'qualitative descriptive research with reference to phenomenology'. Justify the method chosen and why it was necessary. Otherwise, why not just qualitative descriptive research, or phenomenology?

Response: This study was based on a psychophenomenological approach in order to gain a deeper understanding regarding lived experiences among terminal cancer patients. In order to make this approach easier to understand, we rephrased the text. We have changed the following text in the Methods from:

The study involved qualitative descriptive research with reference to phenomenology.

To

The present study was based on a psychophenomenological approach, which is a descriptive phenomenology originating from Husserl's philosophy. This approach is designed to gain a deep understanding regarding the lived experiences of terminal cancer patients.

12. Page 5: in the participants section, I would like to point out that many patients are admitted to palliative care units at all stages of the disease progression, not just the terminal phase.

Response: We declared that the participants who were hospitalized in palliative care units were in a terminal stage. We have changed the following text in the Methods from:

As a means of recruiting patients who were aware of their terminal conditions, those in palliative care units (PCUs) in hospitals and clinics that operated according to the principle of hospice care were selected.
As a means of recruiting patients who were aware of their terminal conditions, those clinics that operated according to the principle of hospice care were selected. Additionally, patients admitted to hospital palliative care units (PCUs) after deciding not to take active treatment, such as chemotherapy, were selected.

13. Page 6: when reporting ranges eg 'aged between 53 and 94 years' it is also necessary to include a mean age. This aids the reader to understand the spread. Please do this for all ranges reported.

Response: We have inserted the means where all ranges were reported. We have changed the following text in the Methods and Results from:

Methods
Participants and Setting
The participants were 3 men and 8 women aged between 53 and 94 years. The periods for which patients had been receiving palliative care at home and in PCUs ranged from 27 to 403 days and from 14 to 107 days, respectively. […] Each interview session lasted between 22 and 135 min. Each participant was interviewed between 2 and 5 times. The overall duration of interview time for individual participants ranged between 90 and 517 min (33 interviews and overall interview time of 2,027 min for all participants).

Results
An outline of participants
Table 1 shows an outline of participants. The participants were three men and eight women aged between 53 and 94 years (mean = 72.6 years). The periods for which patients had been receiving palliative care at home and in PCUs ranged from 27 to 403 days (mean = 134.8 days) and from
14 to 107 days (mean = 35.8 days), respectively. When assessed using the palliative prognostic index, which is used to indicate prognosis [22], the survival period was predicted at up to three weeks for three participants.

Each participant was interviewed between two and five times. The participant who interviewed five times continued the interview because he strongly hoped that it would take time to talk about life history and would like to speak more. Each interview session lasted between 22 and 135 min (mean = 61.4 min). The overall duration of interview time for individual participants ranged between 90 and 517 min (mean = 184.3 min) (33 interviews and overall interview time of 2,027 min for all participants).

14. Page 6: line 23, I note that unstructured interviews were used with a common opening question. That is fine, but you need to state if there was any other way in which you guided the direction of the interviews. Was a list of guiding prompts used? Was there a list of pre-determined questions used for when the participant ran out of things to say?

Response: This study aimed to clarify how cancer patients reach mental stability when facing death. Therefore, it was necessary to encourage a deep discussion regarding participants' life and death. However, in the Japanese culture, it is not common that people speak about their own life and death. Thus, we judged that listening directly to how these individuals specifically face life and death issues was ethically inappropriate.

Therefore, we adopted unstructured interviews. We did not use a list of guiding prompts or a list of pre-determined questions so as to avoid any investigator biases. Instead, we collected information from three interviews. The first interview focused on building trust with the patient; the second interview focused on encouraging deep emotional disclosure; and the third followed up with the goals of the second interview absent any family members in attendance. Since the interview lasted about a week, we confirmed the content of the previous interview and discussed the content so as to determine whether more detail was needed in subsequent interviews. We started the next interview from the question, "Please tell me more about ~ ~ that you talked about last time."

We have changed the following text in the Methods from:
The interviews were unstructured. “How do you feel emotionally at the moment, and which views do you currently hold?” was included as the first question, inviting free narration.

First of all, in order to build a relationship of trust and deepen the understanding of the participants, they told their life histories and cancer history. The contents concerning the current emotions spoken in this scene were also analyzed. After that, the original question had done. Deeper discussions were derived from the participants based on the preceding statement compared to asking questions, such as “Can you please tell me more about that?” or “How did you feel about…?” If there was a story that the participant was shocked or suffering as a result of the terminal stage, we interviewed carefully to how they think or feel now, and how they have reached the present idea.

In order to alleviate potential stress during the interview, family members were allowed to attend certain interviews if participants requested. However, in order to encourage participants to discuss feelings they may not be comfortable disclosing to family members, family members were asked to not attend that particular interview. A total of three interviews were planned for each participant. The first interview was designed as a means to build a trusting relationship with the participant; the second interview focused on a deep disclosure of emotional reactions to the patient’s current health status; and the third interview focused on further disclosure absent attendant family members. However, as it turns out, no participant requested that a family member attend; thus, the minimum number of interviews obtained was two.

15. Page 6: did you reconfirm consent at the commencement of each interview? Did any participants die before data collection was complete?

Response: Yes, we reconfirmed consent at the commencement of each interview. There were no participants who died prior to data collection; however, five patients were excluded due to an unwillingness to continue. We have changed and added the following text in the Methods from:
**Participants and Setting**

Each participant was interviewed multiple times to ensure collection of detailed narratives. Patients with whom at least two interviews could not be conducted because of exacerbation of their physical conditions were excluded from the analysis. The analysis included 11 participants (6 and 5 patients at home and in PCUs respectively).

**Ethical Considerations**

We reconfirmed consent at the commencement of each interview.

16. Page 6: line 33, it states that one participant was interviews for a total of 517 minutes. That is more than 8 hours. It begs the question, how did you determine when a second interview was necessary, or a third, or a fourth? Did each subsequent interview commence with the same beginning question? Surely taking up 8 hours of a dying person's time needed to be balanced against the potential for what limited time they may have left. Did you have ethical approval for this degree of interviewing with each person?

Response: We also realize that the 517-minute interview was quite long and too much time for end-of-life cancer patients. We were very worried about whether long interviews would be burdensome. We generally planned an interview to be no longer than 60 minutes. The interviewer was a nurse observed the presence or absence of fatigue. The interview time was extended only when the participant desired.
Participant 6, who was interviewed five times, said he likes talking to people, and he did not feel bothered at all. After the first 90-minute interview, we asked the visiting nurse to check whether there was fatigue, deterioration of physical symptoms, or mental burden and confirmed that there were no problems. I followed the same procedure for the second and subsequent interviews. Immediately after the third interview, Participant 6 frequently disclosed his current feelings and life history hoped to discuss more during a fourth interview. The researchers examined and decided to conduct a fourth interview. The fifth interview was conducted to supplement the fourth interview and ended after 30 minutes.

We have added the following text to the Ethical Considerations and Results from:

Ethical Considerations

The purpose of the study, voluntary nature of participation and the freedom to withdraw from the study at any time, and protection of personal information were explained verbally and in writing to participants, and their written consent for participation in the study was obtained. We reconfirmed consent at the commencement of each interview. An interview was conducted only when a doctor, nurse, and nurse manager in charge judged that the interview was possible. Therefore, several interviews could not be done on the scheduled date. We generally planned an interview within 60 minutes. We verbally verified every 15 minutes after the start of the interview whether the participant was able to continue. The interview time was extended only when the participant wished.

Results

An outline of participants

Each participant was interviewed between two and five times. The participant who interviewed five times continued the interview because he strongly hoped that it would take time to talk about life history and would like to speak more.

17. Page 6: In the ethical considerations section, I think it is also important to note what mechanisms were in place to protect the interviewee who was entering people's homes.

Response: We have added the following text to the Ethical Considerations from:
For the safety and peace of mind of both the interviewer and interviewee, a visiting nurse accompanied the interviewer during the first visit to help explain the nature of the study.

18. Page 7: in the analysis section, please remove all reference to 'we' and replace with third person language. The analysis approach needs further explanation. Was there a second researcher involved in analysis to insure credibility?

Response: We have changed the following text in the Analysis section from:

In the third step, each meaning unit was transformed first- to third-person expression several times. We then transformed it from daily conversation into medical language, focusing on what patients had said or meant. We applied the transformation between 1 and 4 times per meaning unit. We concentrated on disregarding our preconceived ideas about patients’ experiences. In the fourth step, we synthesized the transformed data and structured the meaning units for each participant, concentrating on units that were essential to allow the phenomenon to manifest. In the fifth step, we synthesized all these structures into a general structure. In the analysis, attention was paid to characteristic words that were common to all participants, to clarify meaning.

To

In the third step, each meaning unit was transformed from first- to third-person expression several times, using the phenomenological reduction and free imaginative variation. The unit was transformed from daily conversation into medical language, focusing on what patients had said or meant. It was focused on participants’ remarks concerning suffering and hope regarding life and death, clarifying how each participant felt, thought about, and recognized them. A transformation was applied from one to four times per meaning unit. It was concentrated on disregarding researchers’ preconceived ideas about patients’ experiences. In this way, phenomenological reduction is indispensable for deriving meaning from the experiences of the interviewee rather than the researcher’s preconceptions [18]. In the fourth step, it was synthesized the transformed data and structured the meaning units for each participant, concentrating on units that were essential to allow the phenomenon to manifest. Focusing on how he/she recognized the situation and how he/she faced life and death helped create an individual psychological structure for each participant. In the fifth step, all individual
psychological structures were synthesized into a general psychological structure. During this analysis, attention was paid to characteristic words when facing death that were common to all participants.

**Trustworthiness**

We used the 32-item checklist, “Consolidated criteria for reporting qualitative research” [21]. At each stage, the researchers discussed the transformed meaning, individual psychological structures, and a general psychological structure. Each time we returned to the verbatim record and repeatedly discussed until complete agreement was obtained. Additionally, the study was supervised by an oncology nursing expert and a psychological expert with thorough knowledge regarding qualitative research methods. In order to secure study credibility, we conducted persistent observations. We interviewed terminal participants several times. The same researcher conducted all interviews in order to build a relationship of trust with each participant. We did not reconfirm results with the participants, as participants’ health problems and unexplored thoughts and emotions were subject to analysis. We conducted peer debriefing in order to ensure credibility and dependability. Pier was requested a research group familiar with qualitative nursing research qualified more than master's degree. The materials included verbatim records, field notes, analysis notes, and notes on the researchers’ preconceptions. The preconceptions of researchers are bracketed in parentheses to ensure confirmability. We clarified researcher prejudices by describing the researcher's knowledge at the literature review stage of the present study.

19. Page 7: Were interviews conducted in Japanese? If so, what process was used to translate the quotes included in this manuscript to English? Did you use a process of translation-back translation?

Response: All interviews were conducted in Japanese. The narration portion provided by the participant was obtained through a translation expert with knowledge of nursing. From here, the researchers discussed and revised whether the translated content accurately expressed the participants’ narration. We translated the corrected English back into Japanese, again, and confirmed whether the meaning matched the original narration. We have added the following text to the Trustworthiness section from:

All interviews were conducted in Japanese, and translation-back translation was conducted for purposes of the present manuscript.
20. Results: I would encourage the authors to consider shortening the theme names.

Response: We have changed the following text in the Abstract and Results from:

Results
The following five themes emerged for the experience of reaching mental stability when facing death in patients with terminal cancer at home or in a PCU: “I have to accept that I have developed cancer, a source of suffering,” “I have to accept the progression of cancer and the undeniable approach of my own death,” “I have to accept my need for assistance because of decline and loss of independence,” “I have to accept the unsatisfactory circumstance that people around me do not behave as I would have desired” and “I have to accept this as my destiny and as an outcome of my own past life.”

To

[…] “I have to accept that I have developed cancer,” “I have to accept the undeniable approach of my own death,” “I have to accept my need for assistance,” “I have to accept this unsatisfactory circumstance” and “I have to accept this as my destiny and an outcome of my life.”

21. Results: for each quote, please denote which participant it came from. For example, you can use brackets at the end of the quote like this: (Participant 3, interview 2) to denote it was your third participant, and their second interview. This adds to the credibility of the data and allows the reader to determine the diversity in responses and quotes selected amongst the 33 interviews.

Response: We have added brackets at the end of the quote like this, such as (Participant 3, interview 2) in the following text from:

22. Discussion: This section could do with some refinement, and improvement in the writing. Please also be sure not to assume that terminology and ideas, perhaps common to Japan or other East Asian cultures will be understood by an international audience. For example 'the non-moving body' is not a term used in Western writing, and I am unsure if this is a culturally influenced term, or poor grammar. Shouganai could also be better explained.
Response: We have changed the following text in the Discussion:

The Japanese expression, “shouganai,” which is equivalent to “I have to accept it” or “it cannot be helped” in English, is used in situations in which there is no means of resolving an issue [19]. This study demonstrated that patients told themselves that they had “to accept it” to achieve mental stability when facing death.

To

The Japanese expression, “Shouganai,” which is equivalent to “I have to accept it” or “it cannot be helped” in English, is used in situations in which there is no means of resolving an issue [23]. This term is used on a daily basis in Japan. The idea of "it cannot be helped" has been examined in various fields ranging from the extraordinary huge-scale disasters such as earthquakes [24, 25] and nuclear incident [26], economics [27], education [28], and individual identity [29]. Japanese have a fatalistic idea “Shouganai” towards they cannot change anything. This study demonstrated that patients told themselves that they had “to accept it” to achieve mental stability when facing death.

Relationship between the non-moving body and one’s surroundings

To

The unsatisfactory body and circumstances

23. Conclusion: The conclusion is weak, and is more of a summary of themes than anything else. What is essential in a conclusion, is a clear statement of how this research contributes to the scholarly evidence and debate on the topic. It must clearly justify the importance of this research and how is value-adds. You may also make clear recommendations for further research, practice and education. For example, how will these findings change the care provided to terminally ill patients?

Response: We have changed the following text in the Conclusion:
While becoming aware that participants could not modify their imminent death or destiny, they attempted to stabilize their minds. Nurses should, therefore, pay close attention to patients mental health in order to help patients achieve stability under these severe circumstances.

To

When patients realize that their death is approaching, they look back on their lives, and their struggle with cancer, and explore reasons for their current suffering. The new finding of this research is that terminal patients try to accept this “uncontrollable destiny” by accepting a limited life, an unsatisfactory body, and distressing circumstances as part of “Shouganai.” Patients are reconciled with their lives and trying to stabilize their mind each day. “Shouganai” will be expression in a sense that it tells themselves more than to communicate to others.

Nurses need to approve patient efforts to reach mental stability. This could be accomplished by nurses better comprehending patients' complicated mental patterns expressed in their daily languages. Finally, the present study suggests the need for nurses to capture the meaning of “Shouganai (I have to accept it)” for patients in order to alleviate distress at the end of life.

24. Editorial issues: Please write numbers less than ten as words, so '1' should be replaced with 'one'

Response: We have changed all numbers less than ten as words the text.

25. Check referencing as there are some errors.

Response: We have checked all references and changed some errors.

Responses to the comments of Dr. Gianluca Catania, PhD, RN (Reviewer 2)
1. I thought this was an exciting paper. Facing death at the end of life research is a highly relevant topic. There are however some issues to be addressed, some of which major. Furthermore, the manuscript needs to be revised for the English language.

Response: We have checked all the text English again. However, since it is basically impossible to modify anything other than the indicated part, we have restricted the correction only to the point indicated. We have changed English with a focus on the Background. Could you tell us if there are places that need to be corrected in the results and discussion? We are preparing to change English soon.

2. Page 1, first paragraph, line 16: "[...] healthcare professionals providing palliative care [...]"
The authors should consider to use the term "end of life care" instead of "palliative care."

Response: We have changed the following text in the Background from:

Since then, healthcare professionals providing palliative care have paid increased attention to what patients facing death feel, think, and desire.

To

Since then, professionals providing end of life care have focused on what patients feel, think, and desire regarding their impending death [3].

3. Page 1, first paragraph, line 18: "[...] facing death feel, think, desire." It seems the authors have missed the reference here.

Response: We have added the reference to the Background:

Since then, professionals providing end of life care have focused on what patients feel, think, and desire regarding their impending death [3].
References


4. Page 1, second paragraph, line 43-48: "[...] models of death acceptance have been proposed [...]" It seems the authors have missed the reference here.

Response: In this case, "several models of death acceptance have been proposed" referred to Kübler-Ross [3] and Buckman [4]. We have changed the following text in the Background from:

Therefore, several models of death acceptance have been proposed, but terminally ill patients do not always accept death, and many require mental health care to deal with their fear and depression.

To

Overall, several models of death acceptance have been proposed; however, terminally ill patients do not always accept death, and many require mental healthcare in order to manage the negative emotions generated by the awareness of their imminent mortality.

5. Page 4, first paragraph, line 3-4: I am not sure patients require mental health care, it is more common patients refer to mental health care.

Response: We have changed the reference in the Background from:

[...]For this reason, some patients often require mental health care from specialists such as psychiatric oncologists.
To

For this reason, some patients are often referred to mental healthcare specialists such as psychiatrists.

6. Page 4, second paragraph, line 28-43: I would suggest the authors revise this paragraph, it seems that they miss references here.

Response: We have changed the following text in the Background:

However, not all patients with terminal cancer are referred for specialized mental healthcare. Approximately 24% of terminal cancer patients have been diagnosed with an anxiety or depressive disorder [11]. Therefore, it is likely that many more patients with terminal cancer attempt to attain mental stability, individually, while managing the stresses of impending death. Here, mental stability is defined by patients managing their daily life without expressing anxiety or depressive symptoms to a diagnostic level. Not surprisingly, it is rather difficult to achieve mental stability in such circumstances, and the need for specialized care is often hidden among these individuals.

7. Page 5, first paragraph, line 1: this sentence should be moved to the methods section.

Response: We have changed English and moved this to the Methods section:

Participants and Setting

Japanese patients receiving palliative care at home or in palliative care units served as participants.

8. Page 5, second paragraph, line 18: one sentence paragraph is not appropriate in a manuscript.
Response: We have moved this to the Background section:

The purpose of this study is to clarify that patients who not exhibited anxiety or depressive disorder how recognize the terminal stages and are trying to stabilize their mental health. To date, no studies have focused on how terminal cancer patients achieve mental stability at this stage of life, and no methods have been established to provide nursing support for patients’ attempts in this regard.

9. Method section: Insufficient information is provided on study methods and procedures section. Mainly, rigor and truth have not been addressed. Evidence of saturation is not provided to justify sample size. The authors do not provide evidence of bracketing of personal preconceptions and biases to mitigate their effects. The manuscript does not report enough information that supports credibility, transferability, dependability, and confirmability.

Response: We have changed the reference in the Methods to the following:

Analysis

However, there is no saturation point with respect to deriving phenomenological meaning [20].

Trustworthiness

We used the 32-item checklist, “Consolidated criteria for reporting qualitative research” [21]. At each stage, the researchers discussed the transformed meaning, individual psychological structures, and a general psychological structure. Each time we returned to the verbatim record and repeatedly discussed until complete agreement was obtained. Additionally, the study was supervised by an oncology nursing expert and a psychological expert with thorough knowledge regarding qualitative research methods. In order to secure study credibility, we conducted persistent observations. We interviewed terminal participants several times. The same researcher conducted all interviews in order to build a relationship of trust with each participant. We did not reconfirm results with the participants, as participants’ health problems and unexplored thoughts and emotions were subject to analysis. We conducted peer debriefing in order to ensure credibility and dependability. Peer members were requested researchers familiar with qualitative nursing research qualified more than master's degree. The materials included verbatim records, field notes, analysis notes, and notes on the researchers' preconceptions. The preconceptions of
researchers are bracketed in parentheses to ensure confirmability. We clarified researcher prejudices by describing the researcher's knowledge at the literature review stage of the present study. Due to transferability, we conducted purposive sampling in order to obtain a diverse sample with varying backgrounds, including age, illness period, palliative care period, etc. Finally, we describe below portions of the participants’ verbatim records to provide concrete examples of extracted themes. All interviews were conducted in Japanese, and translation-back translation was conducted for purposes of the present manuscript.

10. Page 6, first and second paragraph, line 1-38: in most of the sentences in these paragraphs the authors report results (i.e., sex, age, days receiving care, time frame interview…)

Response: We have moved this to the Results section:

Results

An outline of participants

Table 1 shows an outline of participants. The participants were three men and eight women aged between 53 and 94 years (mean = 72.6 years). The periods for which patients had been receiving palliative care at home and in PCUs ranged from 27 to 403 days (mean = 134.8 days) and from 14 to 107 days (mean = 35.8 days), respectively. When assessed using the palliative prognostic index, which is used to indicate prognosis [22], the survival period was predicted at up to three weeks for three participants.

Each participant was interviewed between two and five times. The participant who interviewed five times continued the interview because he strongly hoped that it would take time to talk about life history and would like to speak more. Each interview session lasted between 22 and 135 min (mean = 61.4 min). The overall duration of interview time for individual participants ranged between 90 and 517 min (mean = 184.3 min) (33 interviews and overall interview time of 2,027 min for all participants).

11. References section: I would like to have references as current as possible. Please review your reference list and revise to delete old references (more than 5 years old) unless they are essential or are classics. You have 14 out of 32 references that are older than 10 years.
Response: We checked all references again. Except for classics, we have used new references as much as possible. We have increased the number of new documents since 2013 from 11 to 27, reduced the number of old documents before 2008 to 9 from 14.