Author’s response to reviews

Title: How do hospital-based nurses and physicians identify the palliative phase in their patients and what difficulties exist? A qualitative interview study

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Author’s response to reviews:

To the editor of BMC Palliative Care

Amsterdam, April 2nd 2019

Dear Dr. Engels and Dr. Zalm

Thank you for reviewing our manuscript entitled “How do hospital-based nurses and physicians identify the palliative phase in their patients and what difficulties exist? A qualitative interview study.” We greatly appreciated your positive regard of our work, the useful suggestions for improvement, and the opportunity re-submit our manuscript. We have carefully studied all comments and suggestions, cumulating in a thorough revision of our manuscript. Enclosed you will find a point-by-point response.

On behalf of all authors,

Yours sincerely,
Reviewer 1:

1. “The common belief now is that palliative care should be integrated .. ” This is not only a common belief, it is clearly defined in the WHO definition (2002) of palliative care. Also, the national Dutch quality framework for palliative care (Kwaliteitskader palliatieve zorg) uses this definition. Please add to the introduction.

Author’s response

We thank the reviewer for this suggestion. We have added the reference to the WHO definition within the introduction and also within the discussion as suggested by the reviewer in a later question. The introduction now reads (page 3, first paragraph):

“Historically, palliative care has been associated with patients that are dying. However, as stated in the WHO definition, palliative care should be integrated earlier in a patient’s disease trajectory, because this can improve quality of life, reduce symptom burden, and leads to less aggressive treatments and fewer hospitalizations (1-4).”

1.2 A general point: the paper will benefit from linguistic revision, mainly of the abstract and background sections. Also, it could be written more succinct and to the point.

Author’s response
We have taken your advice into account. The first version we had submitted was edited by a native editor. We have revised the text further in order to creating a more succinct and to the point text.

2.1 The COREQ guidelines were followed. Please add the COREQ checklist to the paper and supplement the manuscript with missing (sub) domains. See attachment.

Author’s response

The COREQ checklist was filled in and added as a supplement. The pages referred to within the COREQ checklist refer to the clean version of the manuscript.

2.2 Quite a heterogeneous set of respondents was included. Different professionals from different wards were interviewed. It is very interesting to have all these different perspectives in one qualitative paper, however further efforts should be made to more thoroughly integrate these perspectives, giving the analysis and paper more depth.

Author’s response

We are happy to hear the reviewer appreciate the different perspectives we included within this paper. Throughout the paper we have aimed to put emphasis, where possible, on whose perspective was being represented and how this differed between groups. Based on the suggestion of the reviewer, we went back to our data and have included some additional differentiation in perspectives in this paper. The additions can be found in the second paragraph of the first theme (defining the palliative phase, page 8 ) and third and fourth paragraph of the third theme (treatment trade-off, page 14 second and third paragraph).

2.3 Since interviews were audio-recorded and transcribed: what was the function of the field notes? If these notes gave extra depth to the analysis, please clarify how they did.

Author’s response

The notes we referred to here were used to summarize details of the interview and used to check with the participants if details were accurate. Also, notes were used to provide context during analyzing the data. In hindsight the term “Field Notes” may have been the wrong term, as this term is specifically used to denote data used for qualitative analysis (5). Therefore, we replaced “field notes” with “notes’ and added more information on how they were used in the data collection paragraph (page 6).
“Interviews were one-on-one and conducted in Dutch at participants’ workplace, and in two cases at a library. Notes were made during each interview, and used to make a summary of the interview which was sent to participants, and to provide context for the analysis.”

2.4 What are probes? Do you mean probing questions?

Author’s response:

Thank you for highlighting this mistake. We indeed meant probing questions. We have adjusted this in the text.

2.5 A topic list was developed. How? Based upon which criteria, input, literature?

Author’s response:

We thank the reviewer for highlighting this information missing from our methods section. We have adjusted the text within the paragraph data collection which now reads (page 6):

“The first and last authors (IF and DW) created the topic list based on previous research on this topic (6-8). The other authors critically reviewed the topics. Two pilot interviews were held, after which the authors critically reviewed the topic list and adjusted the questions accordingly.”

2.6 Please add the topic list. In this topic list, the example questions can be incorporated into it.

Author’s response:

The topic list was added in appendix 2, the example question were removed from the text.

3 Findings

3.1 Ways to define and identify the palliative phase are well-established (there are multiple tools). Emphasize that this paper is about how definition and identification takes place in the respondents’ practices.

Author’s response:
Within the background section we have adjusted the description of the research aims based on the suggestion of the reviewer and also as a response to the third question of the second reviewer. The last lines of the last paragraph of the background section now reads:

“Therefore, the aim of this study is threefold. 1) to explore how physicians and nurses working in the hospital define the palliative phase, 2) how professionals identify the palliative phase in their patients in daily practice 3) what are perceive barriers to identifying the palliative phase in daily practice.”

3.2 Keep the numbering of the four themes clear. In the second paragraph, themes are numbered differently than is the case in the sessions in which they are presented.

Author’s response:
We have adjusted the numbering within the first paragraph to coincide with the rest of the results section.

3.3 I feel like the findings section is ‘lumped together’ too much, stays on the surface and could be better structured. I would encourage the authors to have another look at how to improve this.

Author’s response:
We thank the reviewer for the suggestion to revisit our results section and to restructure it. Based on the points raised by both reviewers, we have made some major adjustments to our results section. Throughout the chapter adjustments can be found. One of the important changes we made was to move the third to fifth paragraph of the first theme (defining and identifying the palliative phase) to a separate fifth theme (interprofessional collaboration and responsibilities, page 17) The first theme has been changed to ‘defining the palliative phase’ and data that was first presented in the three other themes has been moved to the second paragraph of this theme (page 8-9). Furthermore, we revisited the data and aimed to deepen some of the findings examples can be found on page 14, second paragraph and page 15 last paragraph.

3.3 In theme 2 (defining and identifying), the respondents’ distinguishing between the ‘acute’ and the ‘extended’ palliative phase is made. Please come back to this point in the discussion: palliative care is still often linked to terminal care, whereas in fact it broader than the terminal phase.

Author’s response
We agree with the reviewer that this finding of our study needs to be revisited in the discussion. We have therefore extended the second paragraph of the discussion to include the WHO definition (page 19) and how this differs from the respondents’ definition of the palliative phase. Furthermore in the last lines of the second paragraph we now also highlight how the persistent (mis)understanding that palliative care is synonymous with the terminal phase results in late identification:

“The purpose of this study was to explore experiences and perspectives of professionals themselves. Therefore, we did not provide respondents with definitions, but instead acquired their own interpretation. Whereas some used definitions of the palliative phase similar to the ‘early palliative care model’, as proposed by Lynn et al., where palliative care starts before all curative options are exhausted (9), many participants associated the palliative phase with the moment all curative options are exhausted or the prognosis is clearly limited. The misunderstanding that the palliative phase is synonymous with the terminal phase is persistent. Consequently, identification will occur late within the hospital setting (8), which prevents patients and their relatives to benefit from early integration of palliative care (1-3).”

3.4 “Some respondents feel identification of the palliative phase is only useful when it has a clear consequence, such as withdrawal of treatment.” The question immediately popping up in my head: ‘and how about the patient?’ . Being able to have the benefits of palliative care in this example seems to be ‘taken’ from the patient. The usefulness of identification seems to be called into question by respondents. Could you elaborate on this?

Author’s response

We were indeed also surprised by this finding. We believe this stems from the point also raised by the reviewer in question 3.3 that palliative care is broader than just terminal care. Because some respondents were not fully aware of the broader context of palliative care they might have felt that there was no use to (early) identification. Based on this question posed by the reviewer, we felt that the statement might have been to bluntly written down and needed the context of how respondents defined the palliative phase to properly understand this finding. We have also added two other examples of the consequences our respondents mentioned, besides withdrawal of treatment. We have therefore further elaborated on this finding and aimed to clarify what was meant by our respondents in the second paragraph of the first theme (page 8, last paragraph):

“Many considered the moment the focus completely switches to symptom control and improving quality of life as the starting point of the palliative phase. Some believed thinking about the palliative phase was only useful when it had clear consequences such as withdrawal of treatment, discharging a patient to primary care or consulting the specialist palliative care team. The ‘acute’ palliative phase, also frequently described as the terminal phase or dying phase, was
consequently clearer defined for respondents because the focus switched fully to comfort and resulted in treatment withdrawal or palliative sedation.”

3.5 There seems to be significant room for improvement for identification as well as multidisciplinary communication and collaboration. Please make this very clear in the discussion, and give directions on how to reach this.

- “They did not often mention primary care physicians as colleagues with whom they would discuss the patients care.” GP’s have an important role in care for palliative patients, and feel that communication between them and the hospital is a barrier in the care for these patients. (see Wichmann et al. BMC Family Practice 2018, please add reference)

- The responsibility of identification is not clear in the hospital setting, and nurses apparently have a good sense of recognizing palliative patients and are more accessible, but do not feel responsible or are hesitant to ‘sound the alarm bell’. A very important finding, as research showed the benefits of integrating palliative care services early in the course of disease (for example: Temel et al. Journal Clinical Oncology 2017).

Author’s response

We agree with the reviewer that the two points raised here are important discussions points. Both findings were discussed within the discussion section but based on the suggestions here we have further elaborated on both points. Furthermore a paragraph implications for practice and research has been added to the discussion (page 22)

The point about communication with GPs is highlighted in the fourth paragraph of the discussion and now says (page 22, first paragraph):

“Collaboration between care settings to compare assessments and discuss how to respond to patients’ needs and preferences seems logical. However, only a few physicians in our study described consulting with patients’ GPs. GPs themselves experience this lack of collaboration as an important barrier to improving care for patients at the end of life (10, 11).”

The second point on the how nurses are afraid to sound the alarm is discussed within the third paragraph of the discussion (page 21, second paragraph) and within the paragraph implications for research and practise (page 22):

“Nurses could therefore be considered better assessors of when a patient needs palliative care, which is further supported by the fact that nurses in our study think that patients can more easily open up to them (vs. physicians) about discontinuation of treatment. Yet, supporting previous findings (12), nurses described feeling hesitant to disclose their observations to physicians.”
“An important barrier to overcome is insufficient interprofessional collaboration. Within the hospital, hierarchical barriers exist between nurses and physicians. Overcoming hierarchical barriers is not an easy task. Team trainings have been shown to improve collaboration at hospital departments (13), therefore a combined training on palliative care where both nurses and physicians attend could be a first step in improving collaboration on this subject.”

3.6 “However, they questioned the prognostic accuracy..” there are publications about the prognostic accuracy of identification tools like the Double Surprise Question, please add reference.

Author’s response

A systematic review and meta-analysis on the accuracy of the surprise question was used as a reference within the discussion section. Since meta-analysis are stronger evidence than single studies we left the references as it was. “Our respondents felt identification instruments that assess the palliative phase are potentially helpful in identification, but rarely used them. They doubted the prognostic accuracy, and indeed this accuracy varies widely amongst different populations (14, 15).

3.7 “Respondents said prognostication was easier in cancer patients”. This finding is not new. Please refer to Claessen et al. BMC Family Practice 2013 and Wichmann et al. BMC Family Practice 2018.

Author’s response

Indeed this is not a new finding. Within the discussion section we further elaborate on this point, while the Claessen article was already referenced for other sections of the background and discussion, we have added it here as well. The Wichmann references was also added to the two already referenced articles:

“When and whether identification occurs seems to be highly dependent on a patient’s diagnosis (8). Whereas prognostication and the weighting of treatment options is a clear transition point to the palliative phase in cancer patients, in non-cancer patients, prognostication is considered more difficult which was also found within the primary care setting (7, 11, 16, 17).”

3.8 “Respondents felt the palliative phase is poorly defined in their patients with dementia or frailty. However, they said that conversations about future care are needed early on…” Tilburgs et al (PloS ONE, 2018) wrote a review about this topic, please add reference.
Author’s response

We thank the author for the literature suggestion. However, this line comes from the results where a reference would be inappropriate. We also don’t further elaborate on this specific finding within the discussion.

3.9. After reading quote 1 on page 12 (“And you don’t want … “) I was left wondering ‘and how about the patient?’ If there is more data regarding the impact of patient perspectives on this finding, please add them to give this finding more depth.

Author’s response

The reviewer raises an important point here. We were also surprised by this finding and missed the patient’s voice in some of the respondents’ stories. Treatment trade-off has a clear interaction with patients’ preferences and needs. We have adjusted the second, third and fourth paragraph within the treatment trade-off paragraph to highlight that this indeed sometimes is a decision solely made by the physician, however not always. We also added the finding that nurses are uncomfortable with this because they don’t believe this to be in the best interest of patients.

4 Discussion

4.1 Please also apply a clearer structure/numbering to the discussion of the themes.

Author’s response

We have switched two paragraphs to coincide more with the structure of the themes within the results. Furthermore we have added a paragraph ‘implications for research and practice’.

4.2. Please repeat the WHO definition, and add the above proposed references throughout the discussion.

Author’s response

As stated in the response to question one, we have added the reference of the WHO definition within the discussion. The second paragraph of the discussion now reads (page 19):

“In 2002 the WHO stated that palliative care should be available for all patients and families facing the problems associated with life-threatening illness and should be initiated early on in disease trajectories (4). Nonetheless, a first finding of our study was the difficulty and uncertainty our respondents experienced in defining the palliative patient. This finding agrees with previous studies in primary- and secondary-care settings (18, 19), and despite the WHO
definition, discussions are ongoing on how we, as researchers and practitioners, should define palliative patients (20).”

4.2. In the background section, it is mentioned that in order to improve identification within the hospital setting and to overcome existing barriers, we need to better understand what current practice of identification looks like, and what difficulties exist. Please dive deeper into the challenge of how health care professionals can adopt a more proactive stance in identifying palliative patients.

Author’s response

We appreciate the suggestion of the reviewer and fully agree that how the determined barriers need to be overcome was not yet sufficiently discussed. As stated before we have added a paragraph on implications for practice and research where we address these barriers.

4.3. The model of Lynn et al. is brought forward in the discussion. However, I think the important point of “identification of the palliative phase will consequently occur late” can be elaborated on more, as it is a persistent issue. See point 3.3. and 3.4., too. Moreover, this finding was also reported by Horlait et al (2016, Support Care Cancer). Please add reference.

NB. As some important references seem to miss in the manuscript, I suggest to do another literature search and add references if needed.

Author’s response

We agree with the reviewer that the point ‘identification will consequently occur late’ needed further elaboration, also based on questions 3.3 and 3.4. The last sentences of the second paragraph of the discussion have thus been adjusted (page 19-20):

“Whereas some used definitions of the palliative phase similar to the ‘early palliative care model’, as proposed by Lynn et al., where palliative care starts before all curative options are exhausted (9), many participants associated the palliative phase with the moment all curative options are exhausted or the prognosis is clearly limited. This continuous understanding that the palliative phase is synonym with the terminal phase is persistent (21). Consequently, identification will occur late within the hospital setting (8), which prevents patients and their relatives to benefit from early integration of palliative care (1-3).”

We furthermore very much appreciate the literature suggestions from the reviewer throughout the questions. We had already performed an extensive literature search and many of the proposed references were in our database. We had however, made different choices in referencing because of the focus on hospital setting and identification instead of advance care planning. We have
performed new literature searches that lead references for the adjusted parts within the discussion and background.

4.4 “Physicians mainly focus on understanding diseases and their cures, nurses are trained in a more holistic approach.” This is true, but the WHO definition (2002) as well as the Dutch quality framework for palliative care nevertheless describe the four dimensions of palliative care which should be taken into account by all health care professionals. Please integrate this information when discussing this point. See points above about the definition of palliative care, and the importance of multidisciplinary and transmural (with GP’s, see Wichmann et al.) collaboration and communication.

Author’s response

The reviewer raises as valid point here. Within the first lines of the paragraph implications for research and practice we now highlight how all professionals should be aware of the benefits of early integration of palliative care and the four dimensions of palliative care (page 22)

“This study indicates that within the hospital setting there is little awareness of the early palliative care model. Both the WHO and the Dutch Quality Framework Palliative Care (kwaliteitskader palliatieve zorg) state that all health care professionals should be aware of the four dimensions of palliative care and early integration is an important aspect (4, 22). With the raising number of patients in the palliative phase in general hospital wards, efforts should be made to further educate both nurses and physicians on the benefits of early integration of palliative care and how to provide holistic care.”

4.5 Please add a table with information about the researchers backgrounds (see COREQ checklist), see point 2.1. (Background about IF’s background specifically, can be removed from the text.)

Author’s response

We have added the suggested COREQ checklist in the appendix and incorporated the researchers background. We have however left in the line about IF’s background because we refer to it in the limitations.

5 conclusion: Interesting and vigorous. Please integrate the above if appropriate.

Author’s response
We are glad the reviewer appreciates the conclusion section of this paper. With the previous suggestion of the reviewer and the second reviewer the discussion has been adjusted so that the point mentioned in the conclusion are more clearly visible within the discussion. To shorten the conclusions section (based on suggestion by reviewer two, question 23) the second half has been removed from the text.

Reviewer 2:

1. General

The WHO promotes a more integrated palliative approach. Society and the medical world tend to associate ‘palliative’ with death, end-of-life care, and oncological care. Why did the authors choose for the word “palliative phase” and not for example for supportive, palliative care or palliative needs (patient perspective)?

Author’s response:

When formulating the topic list and throughout our pilot interviews we tried the different terminologies suggested by the reviewer. We especially wanted to use the term ‘palliative needs’, however we noticed that our respondents were confused by this terminology and needed us to explain. As stated in out discussion, we purposively did not want to provide definitions because we wanted to explore professionals’ own interpretations. Their definition was what the rest of the interview continued on, using the term ‘palliative phase’ enabled us to do this.

2. Background

The authors describe the relevance

Throughout the background section, some information is mentioned twice. Maybe the authors can integrate some lines to thicken and structure the background section

Author’s response

Throughout the background section we have removed the repetitive information and revised some of the sentences to be made more succinct.

3. The authors could specify the research aim/goals more. I read three research questions to explore the current state: (1) how professionals describe the palliative phase, (2) what
professionals perceive as existing methods/elements for identification of the palliative phase and (3) perceived inhibiting factors to identify the palliative phase. Please clarify the aim of the study and please focus on the goals in the result and discussion section.

Author’s response

We agree with the reviewer that the research question as stated within the background section could do with clarification. We have adjusted the research aim within the background section and further made adjustments within the results and discussion to respond to these aims. We also emphasized more on that we explored how professionals define and identify the palliative phase in daily practice, as suggested by the second reviewer (question 4.1) Below the adjustment within the background section (page 4).

“Therefore, the aim of this study is threefold. 1) to explore how physicians and nurses working in the hospital describe the palliative phase, 2) how professionals identify the palliative phase in their patients in daily practice 3) what are perceive barriers to identifying the palliative phase in daily practice.”

4. Methods

What type of study design was chosen and why? Are there multiple cases being studied (e.g. different diseases or hospitals)?

https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-11-100

Author’s response

We apologize that our study design was unclear from our methods section. We chose a qualitative methods because for explorative studies where perspectives of people are researched, this method is particularly appropriate (23). According to Malterud, “Qualitative methods allow the exploration of phenomena as experienced by individuals” (24). Within the scope of qualitative research we chose a phenomenological approach, we did use multiple cases as suggested by the reviewer. Since our aim was to explore the phenomena “identification of the palliative phase” as experienced by individual professionals we chose individual interviews as the manner of data collection. The paragraph study design now reads (page 5):

To provide an in-depth understanding of hospital-based physicians’ and nurses’ experience with and perspectives on identification of the palliative phase within the hospital setting, a phenomenological approach was chosen (23, 24), consisting of semi-structured interviews, which is a method particularly suitable to gain a comprehensive insight into experiences and perspectives (23, 24). The interviews were held between September 2016 and 2017.
5. Could the authors add all interview questions/topic in the method section (add a box)?

Author’s response

We have added the topic list within appendix 2.

6. Using the term ‘palliative phase’ in the interview questions may have influenced/directed the results (“what makes identification of the palliative phase difficult” or “Can you tell me more about the last patient you thought was in the palliative phase”). What were the experiences of the researchers?

Author’s response

As stated as a response to question 1, choosing the terminology ‘palliative phase’ was based on the pilot interviews. We did not feel we influenced the results by using the term palliative phase because as you can see from the results, the definitions respondents used varied widely. As maybe suggested in question 1, respondents might have focused solely on oncological patients or end-of-life care because of the term palliative phase, this was however not what we experienced.

7. Did the authors use a dependent or independent coding strategy? How did they deal with coding if no consensus?

Author’s response

An independent coding strategy was used. Differences in coding were discussed until consensus was reached. If the two coders could not reach consensus, a third researcher was consulted and discussions were held until consensus was reached. We have clarified this strategy within the manuscript on page 6-7, paragraph analysis.

“IF and IN coded the initial five transcripts independently with an ‘open-coding’ scheme (inductive coding). IF and IN discussed differences in coding until consensus was reached, if difference persisted a third researcher (DW) was consulted.”

8. How did they use the fieldnotes in the analyses?

Author’s response

For our response we refer to question 2.3 of the first reviewer.
9. Why did the authors choose for an open coding technique? Did they consider coding using a palliative care model (Dalgaard) or other (disease-specific) evidence?

Author’s response

Braun and Clark described two primary methods analysis themes and patterns within their data, inductive versus theoretical. Where inductive is more data driven, theoretical is more analyst driven and as the name implies aims to provide understanding of existing theories. Because we aimed for a broader understanding of identification within the hospital setting, an inductive, and thus open coding method was chosen. It is important to mention, that the coding could never be fully inductive because some of the questions on the topic guide related to later identified themes. We have thus adjusted a part of the data analysis paragraph (page 6-7):

“Data was analyzed thematically, a method for identifying, analyzing and reporting patterns, i.e. themes, within the data (25). An ‘open-coding’ scheme was chosen because we aimed for data-driven analysis and an broader understanding of identification of the palliative phase in daily practice. IF read and reread all transcripts to become familiarized with the data. IF and IN coded the initial five transcripts independently with an ‘open-coding‘ scheme (inductive coding), however some codes resulted specifically from the questions asked for example “Are there differences in identification for different diseases?” and where therefor the result of deductive coding.”

10. Where the quotes translated by a native speaker?

Author’s response

Quotes were translated by a native Dutch speaker, and checked by the research team. A native editor checked all the quotes for readability. The research team then checked to make sure the quotes stayed close to the original Dutch.

11. Line 26 page 6: remove the word “we”

Author’s response:

We have removed the word “we”.

Results
12. The authors say (in line 41-44 p.5 methods) that they sampled respondents based on experience in palliative care. Could they add this information in the table? Could they also provide details of who works at which hospital (for example a labeling: centre 1, centre 2)?

Author’s response

We thank the reviewer for this suggestion. Within table 1, we have added a number behind the hospital to clarify where respondents worked. Furthermore, we added the experience in palliative care in a different column.

13. What was the mean duration of the interviews?

Author’s response

We have revised this within the manuscript. The first paragraph of the result now reads (page 8):

“We conducted 10 interviews with nurses, 12 with specialists, and six with residents. Table 1 presents a summary of their characteristics. The interviews lasted between 26 and 68 minutes with an average of 49 minutes.”

14. It would be interesting to reflect on the gap between the explored and desired description of the palliative phase.

a. Description

b. Did the authors see differences between settings?

c. In oncology, the palliative phase is more standardized. The term “supportive care” may have impact on professional’s and patient’s perception of care. Did respondents use other terms?

Author’s response

This question is three-fold which we will address point by point.

It is indeed interesting to reflect on the gap between the explored and desired definition of the palliative phase. Based on the suggestion by the first reviewer we have now incorporated the WHO definition of palliative care within both our background section and discussion. We already addressed in the discussion the early palliative care model as defined by Lynn et al., (9) and how not all our respondents were aware of this model and use a definition more comparable to terminal care. We have elaborated on this finding in the second paragraph of the discussion (page 19).
The second question is an interesting one which we had not yet thoroughly explore within our data, since we aimed to give a more general overview of perceptions. However it is indeed interesting to give some insight in how perceptions differ between specializations. We have therefore revisited our data and looked if we had enough data to support a differentiation. Fortunately we did and have incorporated this within the second paragraph of the first theme (page 8-9).

“How respondents defined the extended phase, and what life expectancy was attributed differed greatly between respondents. The associated life-expectancy ranged from weeks to years. Where many nurses, cardiologists and nephrologists spoke of a shorter life expectancy, geriatricians and oncologists more often spoke of a life expectancy of years.”

The third question (19.4) also reflects in question one and six posed by this reviewer. Respondents indeed sometimes used different terminology such as ‘a palliative patient’, ‘palliative care’, ‘a patient at the end of life’ or ‘terminal patients’. Supportive care was only used by two respondents in the context of the specialist palliative care team who sometimes are called supportive and palliative care teams.

d. Details on role (line41-50) is another research question.

Author’s response

While we agree that details on roles might be more fitted for a different research question, throughout our interviews this was frequently mentioned and especially nurses relied on other professionals to make the assessment of the start of the palliative phase. We therefore do we believe this paragraph does belong in our results. However, we have come to the conclusion that this subject does not fit within the first theme. We have therefore added a theme named ‘Interprofessional collaboration and responsibilities’.

15. To increase the readability of the findings, could the authors put a model/visualization of the main topics results in this section?

Author’s response

We thank the reviewer for this suggestion. We have made a model of the main topics and how they interact. We however felt this was more suitable for the discussion section and therefor refer to the figure on page 19, first paragraph.
16. Lines 46-57 p8 can be moved to “prognostication”

Author’s response

We agree with the reviewer that this belongs within the prognostication paragraph and thus moved it there (page 13).

17. Please remove the sentence 25-33 page 10 “physical – handshake”. This is not a finding

Author’s response

We thank the reviewer for this suggestion and can understand why this might not considered a finding. However, within our interviews respondents mentioned a lot of different clinical indicators which we aimed to illustrate within this paragraph. We have adjusted the paragraph so it makes more clearly these a respondents words (page 12, second paragraph).

“Many different clinical indicators were mentioned that could trigger identification: general, disease specific, physical, and psychological. One such general indicator recurrent hospitalizations. Respondents describe that physical indicators can be very clear, such as weight loss or a change in functional status, but can also be subtle. Some respondents also mentioned psychological signals such as fear, depression, and decline in cognitive function.”

18. Are conversations to obtain more information from direct colleagues, GP’s or significant others no specific method for identification of the palliative phase?

Author’s response

The reviewer raises a valid point here. A study by Claessen et al., found that GPs uses reports from medical specialist to determine if a patients needs palliative care (7). While our respondents did not often mention conversation with primary care professionals, consultations with other hospital professionals was frequently mentioned as either a manner to get confirmation of what professionals observed themselves, but also nurses and residents relied on assessment of their superiors. We have revisited the data and came to the conclusion that interprofessio nal collaboration together with responsibilities should indeed be a separate theme. We have thus added a fifth theme on page 17.

19. 3. Treatment trade-off: is the same as no options following the guideline? Treatment trade-off needs to take place with the patient (4. Patient preferences/needs)?

Author’s response
To answer the first question, treatment trade-off is not always the same as ‘no options following the guideline’. Our respondents hardly spoke of guidelines and cases they described seem to fall outside off many of the guidelines. For example cases of frail elderly with comorbidity. It seemed respondents made treatment trade-off decisions based on experience and risk-assessment and while they might know the guidelines by heart, did not mention these within the interviews.

We wholeheartedly agree that treatment trade-off needs to take place with the patients. However, as highlighted in the third and fourth paragraph of this theme, this does not always seem to occur, and especially physicians follow their own need to have tried everything before deciding there are no options left. To clarify this point, and to further highlight the interaction between the themes the concerning paragraphs have been adjusted (page 14, paragraph three and four).

Discussion

20. The findings show merely treatment/physical details, which is interesting but not surprising for the hospital setting. To what level the results may be biased by the researchers’ (hospital) background (data-collection/types of questions/analyses - coding)? IN is a physician also? Were other project members involved with another background?

Author’s response

We do believe, some bias could have resulted from the fact that IF is a physician herself, and is therefore stated within our limitations. The interview questions were made and analysis were done within the research team. The second coder IN is a physician as well, she is however training to be a general practitioner and has less experience within the hospital setting. Two other researcher have backgrounds in medicine, DW used to work as a GP and BM as a nurse, the last author RvS has not clinical experience as she is a health scientist.

21. This research is conducted in 7 hospitals/departments. Organisational factors may have influenced the results. For example, culture “respondents try to objectify this feeling”, treatment/clinical guideline mindset (“not giving up on the patient” “identification of PZ is only useful when it has a clear consequence, such as withdrawal of treatment”), tension to change behavior, awareness of palliative needs. Do the researcher think these factors were the same over all hospitals/departments that were involved in this study? What is needed to change PC practice/awareness?

Author’s response

The reviewer poses two different questions here. The first question pertains to our respondents working in different hospitals and settings. We do not believe that the factors mentioned within
the question were the same for all hospitals. Most of our respondents worked within an academic hospital where the treatment mindset could be more prevalent. However, also respondents from other hospitals highlighted this point. Because of the qualitative nature of this study we can only report on what has been said by the respondents and not report if systematic differences occur between settings.

Within the discussion we have added an paragraph implications for research and practice where we further elaborate on what is needed to change palliative care practice within the hospital setting (page 22).

22. Later in the discussion: “the purpose of this study was to assess”. Could they change the word assess in explore?

Author’s response:

We have adjusted the text to read explore instead of assess.

Conclusion

23. “furthermore, the focus … within the hospital” can be removed to the discussion part.

Author’s response:

We have removed this section from the conclusion and highlight the mentioned points within the discussion.

References


