Author’s response to reviews

Title: What do Japanese residents learn from treating dying patients? The implications for training in end-of-life care

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Author’s response to reviews:

Dear reviewers

We truly appreciate your kind comments. We revised our manuscript according to your suggestions, as detailed below.

> Eileen McKinlay, MA (Reviewer 1): What do residents learn from treating dying patients? The implications for training in end-of-life care

> Originality: The paper describes the experience and reactions of Japanese residents when caring for patients who are dying in acute hospital settings. There seems little work published on this topic from a Japanese context. The paper has potential to stimulate debate about training needs in Japan and countries that have similar education programmes where palliative medicine and End of Life (EOL) care does not appear to be included.

> Our response 1: Thank you for your constructive feedback on our manuscript.

> Quality: The paper is readable but there are a number english-language linguistic errors including choice of words/phrases which do not quite reflect the meaning as it seems intended. For example the phrases: "diagnose the patients conditions calmly", "high power difference and words "bewilderment". Some statements/sentences would benefit from further detail to ensure clarity. For example, clarifying what sort of inexperience the residents described in the following sentence: "...residents become aware of their inexperience not only as doctors but also as human beings", and explaining what is meant by "voices that validated them in their strenuous efforts".
Also, there are some sentences which appear out of context eg "In reality it was not always possible to find a concrete solution."

> Our response 2: We appreciate your suggestion on our linguistic errors. We carefully revised the manuscript according to your comments, as shown below. We have also engaged an English editing service to correct the English.

1) diagnose the patients conditions calmly → to exhibit a professional attitude in diagnosing the patient’s condition

2) high power difference → “High power distance” is one of the cultural dimensions by Hofstede. We added the definition according to the reference.

3) bewilderment… → Dilemmas in confronting the reality of medical uncertainty

4) residents become aware of their inexperience not only as doctors but also as human beings → we rephrased as “viewed themselves not only as being an incompetent doctor but also as having a useless existence in society.”

5) voices that validated them in their strenuous efforts→ we revised these sentences.

6) In reality it was not always possible to find a concrete solution → we revised these sentences.

> Title: I would advise including 'Japanese residents' in the title.

> Our response 3: Thank you for your comment. We added “Japanese” in the title, as you suggested.

> Abstract: Concise and generally understandable but I wonder if the use of the term EOL care may be thought to mean palliative medicine. From what is written it does not seem that residents were undertaking palliative medicine; it seems they were caring for dying patients. This was exemplified in the Theme 1.3 where the residents report they were "put into a place in which they cared for the sick without being able to do anything”. This does not describe a palliative medicine approach where goals of care are recognized to have changed. This point is noted in the limitation but ideally should be noted earlier.

> Background: Following on from above it would be helpful to make it clear whether this paper is about caring for 'dying patients' who may or may not be receiving palliative/EOL care OR patients who are formally receiving palliative or EOL care. It seems to be the latter in which there is not always agreement that the patient is dying and treatment goals have changed.

> Our response 4: Thank you for your important comments. We reconsidered the usage of these terms and rewrote them throughout the manuscript. What we intended was to discuss the implication for “EOL care” through studying residents’ perceptions of caring for “dying patients”, including “terminally ill patients”.
> The literature review ideally should also include: dilemmas for young doctors when treatment purpose is unclear, how they can be supported to address this. I would encourage you to expand the initial context section to include an overview of the educational preparation in Japan for doctors caring for dying patients and also the status of palliative medicine and EOL care in Japanese hospitals. This will frame the dilemmas that young doctors face in their day to day work.

> Our response 5: Thank you for your suggestions. We inserted references 4, 5, and 10 in the background section.

> I would suggest referring to Kolb's learning theory in a later section- it seems out of place in the Background.

> Our response 6: As suggested, we moved this part to the design and theoretical framework section.

> Study Design and Methods: Did you ask residents whether they had received any palliative medicine or EOL education in their undergraduate education? Why was asking about career choice relevant and does it make a difference in this study.

> Our response 7: We asked about the previous learning experiences of EOL care. We added this information in the section on the participants. We omitted the information on career choice, as suggested.

> It is not clear if this is a content or thematic analysis, as the themes seem to be framed or collected under Kolb's stages: please make this clearer. If the former, introduce Kolb's theory here and provide a brief overview and descriptive figure as not all will be familiar with it.

> Our response 8: We added the explanation of Kolb’s theory and revised the study design and methods section. Since this study was designed based on Kolb’s theory, we selected “thematic theoretical analysis”, which is driven by the researcher’s theoretical interests and is focused on some specific aspects of the data with the underlying theoretical framework [14].

> Data analysis: more detail is needed to inform the reader about how quality was assured in the data analysis. Include more information about coding (use of electronic software), the process for validation with second and other authors and whether any form of member checking occurred with participants.

> Our response 9: We described the process of analysis in more detail.

> Results: As noted above it is unclear whether Kolb's theory determined the themes or whether the themes were first determined and then compared with Kolb.

> Our response 10: Please see our response 8.
The themes are interesting and in most cases well described. There is some material currently in the Discussion (the section around interprofessional teamwork which should be in Results.

> Our response 11: As you suggested, we moved this part to the results (theme II -2) and inserted the related interview comment.

> Discussion: This section links back to Kolb's theory in the first paragraph but then not again; use this theory to frame the discussion.

> Our response 12: We rewrote the discussion section with Kolb’s theory.

The implications for training could be further emphasized. Consider having a training point at the end of each paragraph or instead reviews/discuss the findings in relation to extent literature then add a final paragraph summarizing all the training points in one section.

> Our response 13: As you suggested, we revised and clarified the implications for education at the end of each paragraph in the discussion. We also added Table 4 to summarize the implications.

Consider including the literature which shows early and systematic provision of palliative medicine education in undergraduate education lays the groundwork for further experiences.

> Our response 14: We added references 16 to 19.

Note the dissonance that residents experience when they see unhelpful modeling from attending physicians. It would be helpful to reiterate what the young doctor saw was not necessarily 'recognised' palliative or EOL care; this exemplified by feeling they had screwed up when someone died.

> Our response 15: Thank you for your useful comments. We have noted the dissonance of the residents’ experiences, as you suggested. We added the examples of unhelpful modeling that caused the dissonance in the discussion section.

The paragraph on reflection is interesting although I am unsure how the three learning points noted relate back to the reflection theme; this needs clarification.

> Our response 16: We deleted the learning points, given that they overlapped with theme 2 in Table 3.

> Conclusion: More firmly link back to training needs and strategies to do this.

> Our response 17: Since we summarized the implications in Table 4, we have made the conclusions section more concise.

> Bente Malling, Ph.D, MD, MHPE (Reviewer 2): The paper sets out to explore residents' experiences from EOL-care and what they learn from treating dying patients. Indeed an important issue in all cultures. Therefore the paper is of interest to a broad audience and the
findings do contribute to our knowledge on how to educate future physicians on this important matter, even if no clear directions on how to conduct this education are made. The authors provide us with a discussion on possible ways of how to educate in the future. The conclusion is rather strong taking the explorative character of the study into consideration. The paper is well written and the ethical issues appropriately addressed.

Our response: We truly appreciate your kind comments.

The title is appealing and reflects the content of the paper.

The abstract is clearly written and gives a good overview. However, the conclusion gives a rather strong direction on how to educate in the future that is not quite in harmony with the explorative character of the investigation. I suggest that the phrase "will help improve" is changed to "might improve" (p 1 line 33) since it is a suggestion - not something that the authors have investigated.

Our response 1: We changed this text to “might”, as you suggested.

The authors have chosen to interview residents and the findings are interesting and give reason to reflect on our practice. However, it might be necessary to explore the perspectives from the attending doctors and the nursing staff too. I understand and acknowledge that this is beyond the scope of this study.

Our response 2: We agree with your comment. We added the need for further exploration from the perspectives of attending physicians and nurses in the limitations section.

The conclusion is rather strong: "By providing them with more opportunities to learn strategies to manage or cope with their emotions and difficult situations, their professional identities can be developed more effectively" (p 14 lines 26-28). This might be right - but was not investigated in this study. To provide feedback taking emotions into consideration also is commonly agreed - but again not the focus of this study? Therefore the conclusion should be brought into more coherence with the investigation indeed done.

Our response 3: Thank you for your comment. We have made the conclusions section more concise and summarized the implications in Table 4.