PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Doctors’ perspectives on adhering to advance care directives when making medical decisions for patients: an Australian interview study
AUTHORS	Moore, Nadia; Detering, Karen; Low, Tessa; Nolte, Linda; Fraser, Scott; Sellars, Marcus

VERSION 1 – REVIEW

REVIEWER	Jessica Simon University of Calgary, Canada Dr Simon is a physician consultant for Advance Care Planning and Goals of Care, Alberta Health Services, Calgary Zone.
REVIEW RETURNED	11-Jul-2019

GENERAL COMMENTS	The paper addresses an internationally important topic and adds to the understanding of how physicians utilize and respond to legally documented advance care directives (ACD), through a qualitative study of physician responses to clinical scenarios with “values” and “instructional” directives. There are a number of revisions that could enhance the readers’ ability to interpret the findings. Major revision suggestions: 1. Legal Context – a box or paragraph is needed to describe the legislation in use in the jurisdiction at the time of the interviews. This box could include a brief outline about what could be legally documented in directives in that state and what the obligations were for physicians responding to those directives and the person’s medical treatment decision maker if appointed (e.g. does that decision maker have a legal responsibility to follow the patient wishes if documented or to “act in the best interest” of the patient, can people specify treatments they want or only treatments they don't want in the ACD). Plus the authors should note of any hospital policies or procedures in place for the use of ACD. Although the authors provide a reference for the legislation, such a box is necessary because as the authors point out (line 17, page 5) there is much variation from place to place in the terminology, scope and legal status of ACD and embedding the context in the paper will allow readers to make sense of the quotes and findings. For example how accurate is the doctor’s perception that they would be protected from legal consequences if “one was trying to do the best for the patient” in that jurisdiction? 2. Methods – There is an incomplete description of the qualitative method. The ways in which the authors drew “from the principles of grounded theory” methodology are not provided. In the checklist they say no field notes after interviews or memos were used during analysis and there is no exploration of the researchers’ own biases, assumptions and connection to the topic or training in grounded

	theory. The authors suggest that theoretical saturation was reached and also that all those consenting to the study were interviewed, can they say when (after how many interviews) saturation appeared to have been reached and how this was saturation confirmed in the subsequent interviews. They present a thematic schema but not a theory of how physicians use ACD. The lack of detail about their adherence to the method and calls in to question the credibility of the findings as influenced by “Grounded theory” study. It does however seem to fit more with thematic analysis as described in ref 23. If this study was not influenced by grounded theory maybe that mention should be removed. 3. Potential limitations of the study are not well explored. For example in considering scenario 3 they do not provide whether the patient’s wife is the legally appointed decision maker or not. In the resulting theme “Navigating family opposition” are they able to describe how participants view family members and surrogate decision makers e.g. are they perceived as distinct by participants or as carrying equal weight? Might have being explicit about the wife’s role in this scenario have allowed this to be explored? Also in the manuscript the authors use the term Advance Care directive as the focus of their study but their question guide used the broader term “advance care plan” and ref 22 names the legal document in use in that State as an advance care directive. Please can the authors comment on whether these terms are considered interchangeable in that area or why they asked doctors about “advance care plans” rather than “advance care directive?” Some reflection guided by ref 23 would be useful on the extent to whether the thematic method chosen is the most appropriate for their study, have they avoided the pitfalls? Had they considered other methods like Thorne’s interpretive description? 4. Discussion – Could the authors comment on whether they noted qualitative differences between physicians of different specialties perspectiveson using ACD, for example comparing palliative care providers and the cardiologists? Minor comment Table 1 – what is a “relieving” physician – this is not an internationally recognized term, if it is a physician providing temporary or “locum” coverage for another physician maybe provide that physician’s primary specialty or service they were covering if known or if a “relieving” physician is something else please explain.

REVIEWER	Francesca Bosisio Lausanne University, Switzerland
REVIEW RETURNED	05-Aug-2019

GENERAL COMMENTS	This article addresses a very important issue. Methods are appropriate and provide an in-depth understanding of physicians’ barriers to ACDs application. The paper is well written and well-structured. For this reason, I recommend its publication with major revisions, however. I would suggest: - Improving the definition and scope of ACP and ACDs and their articulation - Improving the discussion, for instance by referring to literature about power logics in doctor-patient-family relationships and (physicians’) psychological defense mechanism in decisional conflict situations. Indeed, I feel that the interviews are well conducted, the findings are very rich, and the discussion rises very good points.

Nevertheless, the discussion is a little bit too descriptive and lacks assumptions about what may explain these findings and their implications for research and implementation of ACP and ACDs.

General comment

This article addresses a very important issue. Methods are appropriate and provide an in-depth understanding of physicians' barriers to ACDs application. The paper is well written and well-structured. For this reason, I recommend its publication with major revisions, however. I would suggest:

- Improving the definition and scope of ACP and ACDs and their articulation
- Improving the discussion, for instance by referring to literature about power logics in doctor-patient-family relationships and (physicians') psychological defense mechanism in decisional conflict situations. Indeed, I feel that the interviews are well conducted, the findings are very rich, and the discussion rises very good points. Nevertheless, the discussion is a little bit too descriptive and lacks assumptions about what may explain these findings and their implications for research and implementation of ACP and ACDs.

My specific comments are listed here below:

1. Page 5, Lines 1-17: With regard to the definition and scope of ACP, I would extend it in order to make more explicit that ACP also support patient's reflection about their values and goals of care. Making their preference known, through an ADC is only one of the outcomes of the broader shared decision-making process that will hopefully lead to healthcare that is consistent with patient's preferences.
2. Page 5, Lines 26-8: ACDs and ACP are not only for end-of-life care. There are patients with neurocognitive diseases that lack – completely or partially – decision-making capacity during years (i.e. people with Alzheimer's disease, Parkinson, and other dementias) and for who surrogates and professionals make daily decisions about healthcare.
3. Page 5, Lines 36-7: ACP and ACDs stress not only substitute and advance autonomy but also relational.
4. Page 5, Line 47: I would add shared decision-making
5. Page 7, Lines 15-29: I would add few words about why you chose those topics and how you developed your interview guide. Is it based on the literature review? Or previous findings of the research team?
6. Page 8, Line 44: Grounded theory is more a theoretical framework/stance than a data analysis method. For this reason, I would mention in the data collection that you broach the subject without theoretical a priori, consistent with principles of the grounded theory. Perhaps this reflection link to the way in which you developed your interview guide? (see my previous comment)
7. Page 8, Line 48: were some interviews coded by two independent analysts and divergences between codes discussed? (interjudge comparison)
8. Page 8, Line 50: sometimes it is difficult to make all the codes/categories fit in a broader consistent framework. Did you have codes or categories that diverged from one another or your broader framework? If so, how did you manage them?
9. Page 22: I am not sure to understand what "relieving" means in "Area of practice". Also, is "experiences with ACDs" participating in conversations about ACDs, writing them or applying them or all that?
10. Page 9, Results: I feel that ACDs and ACP are sometimes

	used interchangeably in the results. For instance, page 9, line 52, I guess that it is ACP that provides the patient with an opportunity to reflect upon their preferences based on past experiences. For this reason, I wonder if during the interview the interviewers checked the interviewees understanding of ACP, respectively ACDs, and differences between these concepts. 11. Page 10, lines 51-56 and Page 11, line 6-10: the quotations you displayed in table 2 under “Navigating family opposition” suggest to me that physicians are not actually facing family opposition but are only assuming that family is opposed or not ready to “let go” the patient. In my opinion, this difference is important since it translates the asymmetry of powers between patient and their family and physicians and explains why in theory physicians support the principle of patient autonomy, but in practice they feel difficult to apply ACDs and/or to engage all parties in shared decision-making about future or ongoing treatments and why often times doctors unilaterally make decisions based solely on their assessment of patient’s and family’s best interest or decision-making capacity. This is a point that it seems to me is relevant to several results and comments in your paper. 12. Page 11, Lines 19-38: all three scenarios depict instructional directives that refuse resuscitation, intubation, or other LST. In scenario 3, it’s the family that wants all possible treatments to be used. If the first part of the paragraph refers to physicians’ past experiences and not to the scenarios, you should say so. Moreover, I was wondering if you explored what “futile” means for interviewees. If so, I would add few words on that topic. 13. Page 12, Line 24: see comments 11 14. Page 12, Lines 45-48: I feel that the concept of “ethical considerations” should be furthered. Indeed, I feel that in your interviews physicians only seem to base their decision on the principles of benevolence and non-maleficence. The fact that often times they seem keen to override autonomy and that they do not mention (in the quotes you displayed) justice and equity suggest that “ethical considerations” do not really play an essential role in their decision. In this sense, “the reasonable person criteria” may be the back door for paternalism. 15. Page 13, Doubting rigor of the decision-making process: see comment 13. Moreover, this concern may translate physicians’ psychological avoidance in a situation of decisional conflict. 16. Page 13, Line 26-29: in your quotation table at the chapter “Doubting rigor of the decision-making process” nothing is said about the patient being coerced by the family. What it seems to me is said is that interviewees distrust the conditions in which the decision-making process happened. This is a very important point since scientific literature suggests that in healthcare institutions, conditions for patient autonomy are often times challenged by professionals’ lack of training or time and institutional procedural constraints. I would either rephrase or add a quotation that support your statement. 17. Page 13, Questioning patients’ ability to understand treatment decisions. Did interviewees discuss the potential of ACP in improving this point? The question was asked? If so, I would say few words. ACP is indeed an opportunity to provide the patient with information about treatments in general and treatments that are appropriate to their situation, including in case of an emergency. 18. Page 15, lines 6-15: it’s interesting that doctors wish more leeway for themselves to adapt ACDs to concrete situations but seem skeptic about according the same privilege to surrogates or proxies (the legal representatives of the patient). On this point, I

	wonder if the authors explored with the interviewees their perceptions of surrogate's role and their interactions with surrogates. Indeed, ACP and ACDs uphold advanced decision-making (by the patient) and substitute decision-making (by the surrogate). I have the feeling that the way in which physicians engage in shared decision-making (for an actual or advance healthcare decision) with the patient and the surrogate is not sufficiently explored or made explicit in your research. This consideration makes me wonder once more what the authors mean by "experience with ACDs", see comment 9. 19. Page 16, Lines 52-60: I feel that those sentences are a bit contradictory, see comments 14 20. Page 17, Lines 56-59: very good point, to be deepened 21. Page 18, Lines 31-49: excellent point too. What do you suggest could be made to uphold patient autonomy? What about training physicians throughout medical school? Or involving patients and relatives in teachings about patient autonomy and surrogate role? Was it made in Australian medical schools or ACP training? Participative approaches in research, implementation, and teachings are gaining momentum to improve healthcare practices.

VERSION 1 – AUTHOR RESPONSE

Reviewer #1

1. **Legal Context – a box or paragraph is needed to describe the legislation in use in the jurisdiction at the time of the interviews. This box could include a brief outline about what could be legally documented in directives in that state and what the obligations were for physicians responding to those directives and the person's medical treatment decision maker if appointed (e.g. does that decision maker have a legal responsibility to follow the patient wishes if documented or to "act in the best interest" of the patient, can people specify treatments they want or only treatments they don't want in the ACD). Plus the authors should note of any hospital policies or procedures in place for the use of ACD.**
Although the authors provide a reference for the legislation, such a box is necessary because as the authors point out (line 17, page 5) there is much variation from place to place in the terminology, scope and legal status of ACD and embedding the context in the paper will allow readers to make sense of the quotes and findings. For example how accurate is the doctor's perception that they would be protected from legal consequences if "one was trying to do the best for the patient" in that jurisdiction?
As advised, we have created a Box summarising the key legal information:

Box 1: Legal context in Victoria, Australia
Medical Treatment Act 1988[1]: • A competent person can refuse treatment in relation to a current condition by completing a legally binding Refusal of Treatment Certificate.

- A competent person can appoint an enduring power of medical attorney with the powers to consent, refuse and/or withdraw treatment.

Guardianship and Administration Act 1986[2]

- Person responsible, identified as default substitute decision-maker within the Act, can consent to or decline to consent to medical treatment; however they cannot refuse treatment.
- When making a decision the substitute decision-maker must act in the best interests of the person for whom they are making decisions. The paramount factor in determining the person's best interests is the wishes of the person, so far as they can be ascertained.[3, 4]

Common Law

- A person can complete a non-statutory advance care directive (inclusive of values and treatment preferences). It should be signed, dated and witnessed.[4] The legal standing of such documents has not been tested with Victoria, Australia. However, it was expected that given case law in New South Wales[5], common law directives would be upheld in Victoria.

Austin Health

- Within the health service there are policies relating to advance care planning, informed consent (including where the patient lacks capacity) and limitation of life-prolonging treatment. These policies document clear explanation of the relevant legislation and the legal basis for statutory and non-statutory advance care directives. Information on the identification and role of the substitute decision-maker is also included in hospital policies

(Page 6, paragraph 2 – marked copy)

2. **Methods – There is an incomplete description of the qualitative method. The ways in which the authors drew "from the principles of grounded theory" methodology are not provided. In the checklist they say no field notes after interviews or memos were used during analysis and there is no exploration of the researchers' own biases, assumptions and connection to the topic or training in grounded theory. The authors suggest that theoretical saturation was reached and also that all those consenting to the study were interviewed, can they say when (after how many interviews) saturation appeared to have been reached and how this was saturation confirmed in the subsequent interviews. They present a thematic schema but not a theory of how physicians use ACD. The lack of detail about their adherence to the method and calls in to question the credibility of the findings as influenced by "Grounded theory" study. It does however seem to fit more with thematic analysis as described in ref 23. If this study was not influenced by grounded theory maybe that mention should be removed.**

We confirm that we have drawn from principles of grounded theory studies. Consistent with grounded theory studies, we used an inductive approach to coding and analysing qualitative data.[6] Moreover, thematic analysis, the method used for analysis in the current study, is commonly used for analysing grounded theory studies,[7] and is considered the foundational method for qualitative analysis.[8]

Consistent with qualitative reporting guidelines[9], data saturation refers to when little or no new information was being obtained from subsequent interviews and is not the outcome of any one interview because it is a gradual process. This is described in the manuscript as follows:

"Face-to-face semi-structured interviews were conducted from February to April of 2017 by two investigators (T.L., S.F.) until thematic saturation was reached, defined as the point at which few or no new concepts or themes were arising from subsequent interviews" (Page 7, paragraph 3 – marked copy)

3. **Potential limitations of the study are not well explored. For example in considering scenario 3 they do not provide whether the patient's wife is the legally appointed decision maker or not. In the resulting theme "Navigating family opposition" are they able to describe how participants view family members and surrogate decision makers e.g. are they perceived as distinct by participants or as carrying equal weight? Might have being explicit about the wife's role in this scenario have allowed this to be explored?**

   In the interview guide the participants were not informed as to the legal standing of the wife in Scenario 3. This scenario was designed to be quite broad to stimulate discussion from the participants about family interactions in general rather than focusing on substitute decision-makers. The aim of the current study was to describe the attitudes and perspectives of doctors regarding ACD adherence and the utility of ACDs in clinical practice. Whilst the substitute decision-maker's role is related to this aim, it was not the primary focus of the current study and represents a potential avenue for future research. We have addressed this in the manuscript is follows:

   "*In addition, future research could complement the current findings by characterising clinicians' perspectives and experiences regarding the role of family and legally appointed substitute decision-makers*." (page 21, paragraph 1 – marked copy)

4. **Also in the manuscript the authors use the term Advance Care directive as the focus of their study but their question guide used the broader term "advance care plan" and ref 22 names the legal document in use in that State as an advance care directive. Please can the authors comment on whether these terms are considered interchangeable in that area or why they asked doctors about "advance care plans" rather than "advance care directive?"**

   At the time the interviews were conducted the Victorian government supported the term 'advance care plan' which was used to refer to advance care planning documentation[4]. Since the interviews were conducted, new legislation has been introduced which specifies the term 'advance care directive'[10] and so this is the terminology we adopted in writing the manuscript. The terms were essentially interchangeable in the Victorian context at the time of the interviews being conducted.

5. **Some reflection guided by ref 23 would be useful on the extent to whether the thematic method chosen is the most appropriate for their study, have they avoided the pitfalls? Had they considered other methods like Thorne's interpretive description?**
   We used thematic analysis because it offers a flexible approach to analysing qualitative data, using a systematic and scientific process, to generate new insights and elicit a richer description of the data overall.[11] The themes generated answer specific research questions and can generate a thematic framework (results) that can be translated into implications useful for practice and policy.[8] We note interpretive description also draws heavily from grounded theory, such as to develop " a coherent conceptual description that taps thematic patterns"[12]. Moreover, to further ensure robustness of our methodology and in accordance with criteria for reporting qualitative research[9], we used a) purposive sampling to promote inclusion of participants from a variety of medical specialties and experience; and b) investigator triangulation when formulating the preliminary themes from the transcripts to ensure our analysis captured the range and depth of the data collected.

6. **Discussion – Could the authors comment on whether they noted qualitative differences between physicians of different specialties perspectives on using ACD, for example comparing palliative care providers and the cardiologists?**

   This is an important question that was considered during the analysis. We investigated whether different specialists may have different perspectives about the use of ACDs however in this study we did not find substantial qualitative differences between different specialties.

7. **Minor comment: Table 1 – what is a "relieving" physician – this is not an internationally recognized term, if it is a physician providing temporary or "locum" coverage for another physician maybe provide that physician's primary specialty or service they were covering if known or if a "relieving" physician is something else please explain.**

   This participant was a doctor providing temporary cover for several wards including haematology, oncology and palliative care. Table 1 has been updated to reflect this person's specific areas of practice (Page 23 – marked copy).

Reviewer #2

1. **Page 5, Lines 1-17: With regard to the definition and scope of ACP, I would extend it in order to make more explicit that ACP also support patient's reflection about their**

values and goals of care. Making their preference known, through an ADC is only one of the outcomes of the broader shared decision-making process that will hopefully lead to healthcare that is consistent with patient's preferences.

As advised, we have added information to the introduction to clarify the scope of ACP:

"*ACP assists patients' personal reflection about their values and goals of care, and can be supported by the completion of an advance care directive (ACD), a document designed to inform medical decision-making in the event the patient loses capacity to make or communicate decisions*." (Page 5, paragraph 1 – marked copy)

2. **Page 5, Lines 26-8: ACDs and ACP are not only for end-of-life care. There are patients with neurocognitive diseases that lack – completely or partially – decision-making capacity during years (i.e. people with Alzheimer's disease, Parkinson, and other dementias) and for who surrogates and professionals make daily decisions about healthcare.**

   As advised, we have removed reference to end-of-life care:

   "*Completion of an ACD is considered to be a key component of ACP because ACDs provide written support and guidance for clinicians and family members when making medical decisions on behalf of the person*". (Page 5, paragraph 1 – marked copy)

3. **Page 5, Lines 36-7: ACP and ACDs stress not only substitute and advance autonomy but also relational.**

   As advised, we have updated paragraph 2 to include reference to relational autonomy:

   "*Legal frameworks have supported this evolution, providing greater emphasis on approaches to medical decision-making which encompass substituted judgement, as well as relational autonomy.*" (Page 5, paragraph 2 – marked copy)

4. **Page 5, Line 47: I would add shared decision-making**

   As advised, we have added reference to shared decision-making:

   "*The emergence of ACP can be attributed to the rising value of autonomy in society, and increased legal emphasis on informed consent to medical treatment, and shared decision-making*." (Page 5, paragraph 2 – marked copy)

5. **Page 7, Lines 15-29: I would add few words about why you chose those topics and how you developed your interview guide. Is it based on the literature review? Or previous findings of the research team?**

   The interview guide was developed based on a literature review regarding clinician's experiences with ACP, and discussion among the research team. The scenarios were

developed and reviewed with ACP clinicians prior to being used in interviews.
To clarify we have revised the manuscript as follows:

"*An interview guide was developed for this project by the research team (see Supplementary item S1), based on literature review followed by discussion and consensus among the research team*." (Page 8, paragraph 1 – marked copy)

6. **Page 8, Line 44: Grounded theory is more a theoretical framework/stance than a data analysis method. For this reason, I would mention in the data collection that you broach the subject without theoretical a priori, consistent with principles of the grounded theory. Perhaps this reflection link to the way in which you developed your interview guide? (see my previous comment)**

   Consistent with grounded theory we used an inductive approach to coding and analysing the data[6], which was undertaken using thematic analysis. Please also see our response to reviewer 1 comment 2. In addition, our response to item 5 details our approach to creating the interview guide, which was based on a literature review regarding clinician's experiences with ACP, and discussion among the research team.

7. **Page 8, Line 48: were some interviews coded by two independent analysts and divergences between codes discussed? (interjudge comparison)**

   Interviews were not coded independently by two different investigators, rather the coding framework was developed collaboratively. We used investigator triangulation with two investigators when formulating the preliminary themes from the transcripts, to ensure our analysis captured the range and depth of the data collected. Investigator triangulation involves the participation of two or more researchers in the analysis to provide a more comprehensive insight and interpretation to the data.[13]

8. **Page 8, Line 50: sometimes it is difficult to make all the codes/categories fit in a broader consistent framework. Did you have codes or categories that diverged from one another or your broader framework? If so, how did you manage them?**

   All concepts that were substantiated in the data were able to be integrated into the thematic framework. This was achieved through an iterative process of framework development where the framework evolved as coding progressed. Some themes included different perspectives represented by separate codes, combined into a single subtheme. For example, in the subtheme 'Distrusting outdated preferences' (page 14), some participants raised concern about ACDs that were outdated, whereas others felt comfortable using these ACDs as long as they were felt to still be appropriate for the current situation.

9. **Page 22: I am not sure to understand what “relieving” means in “Area of practice”. Also, is “experiences with ACDs” participating in conversations about ACDs, writing them or applying them or all that?**

   “Relieving”: This participant was a doctor providing temporary cover for several wards including haematology, oncology and palliative care. Table 1 has been updated to reflect this person’s specific areas of practice (Page 23 – marked copy).
   With regard to “experience with ACDs”, all participants were asked whether they have ever used an advance care plan to guide the treatment they have delivered to a patient. This question was designed to understand whether participants had experience with applying ACDs in practice. Responses were recorded in the demographics table as ‘yes’ or ‘no’.

10. **Page 9, Results: I feel that ACDs and ACP are sometimes used interchangeably in the results. For instance, page 9, line 52, I guess that it is ACP that provides the patient with an opportunity to reflect upon their preferences based on past experiences. For this reason, I wonder if during the interview the interviewers checked the interviewees understanding of ACP, respectively ACDs, and differences between these concepts.**

    In the results ‘ACP’ refers to general discussions regarding treatment preferences and goals of care, and ‘ACDs’ refers to written documentation of values and treatment preferences. In general, the interviews focused on discussing ACDs and their specific application in clinical situations, rather than a broader discussion of ACP. Interviewers did not formally check each interviewee’s understanding of these concepts however clarification was given when required. In regards to the example given (page 9, line 52), as suggested we have altered the wording to avoid any confusion here:

    “*For instance, some doctors felt that ACDs provided patients with an opportunity to have a say about “wanting or not wanting a certain kind of treatment”, after considering past treatment experiences*.” (Page 10, paragraph 4 – marked copy)

11. **Page 10, lines 51-56 and Page 11, line 6-10: the quotations you displayed in table 2 under “Navigating family opposition” suggest to me that physicians are not actually facing family opposition but are only assuming that family is opposed or not ready to “let go” the patient. In my opinion, this difference is important since it translates the asymmetry of powers between patient and their family and physicians and explains why in theory physicians support the principle of patient autonomy, but in practice they feel difficult to apply ACDs and/or to engage all parties in shared decision-making about future or ongoing treatments and why often times doctors unilaterally make decisions based solely on their assessment of patient’s and family’s best interest or decision-making capacity. This is a point that it seems to me is relevant to several results and comments in your paper.**

We have revised the title of this subtheme to reflect that participants were perhaps ‘anticipating’ potential conflict with the family rather than describing the particular scenario at hand. The subtheme is now titled ‘*Anticipating family opposition*’ (page 11 – marked copy)

12. **Page 11, Lines 19-38: all three scenarios depict instructional directives that refuse resuscitation, intubation, or other LST. In scenario 3, it’s the family that wants all possible treatments to be used. If the first part of the paragraph refers to physicians’ past experiences and not to the scenarios, you should say so. Moreover, I was wondering if you explored what “futile” means for interviewees. If so, I would add few words on that topic.**

    In Scenario 3 participants were first presented with a values directive stating that the patient ‘values life above everything’. Participants decided that despite this ACD, they would not provide life-prolonging treatment on the basis that treatment would be futile. We have altered the paragraph to clarify this point:

    “*For example, in Scenario 3, a very unwell patient with a poor prognosis had a values ACD that requested all available treatment to be given*.” (page 12, paragraph 2 – marked copy)

13. **Page 12, Line 24: see comments 11**

    See response 11

14. **Page 12, Lines 45-48: I feel that the concept of “ethical considerations” should be furthered. Indeed, I feel that in your interviews physicians only seem to base their decision on the principles of benevolence and non-maleficence. The fact that often times they seem keen to override autonomy and that they do not mention (in the quotes you displayed) justice and equity suggest that “ethical considerations” do not really play an essential role in their decision. In this sense, “the reasonable person criteria” may be the back door for paternalism.**

    As suggested we have revised this phrase to use the term ‘best interests’ rather than ethical considerations given that physicians tended to base their ethical decisions primarily on best interests:

    “*Overall, doctors appeared to have minimal concerns regarding potential legal consequences of not following ACDs, choosing instead to prioritise what they believed to be the patients’ best interests in their decision-making*.” (page 13, paragraph 3 – marked copy)

15. **Page 13, Doubting rigor of the decision-making process: see comment 13. Moreover, this concern may translate physicians’ psychological avoidance in a situation of decisional conflict.**

    This issue is further discussed in the Discussion:

"*Doubts about validity, including currency of decisions, were particularly prominent where participants disagreed with the treatment decision specified in the ACD… On the other hand, participants in this study did not tend to raise validity concerns if they agreed with the decision in the ACD or thought it was appropriate for the situation. This suggests that doubts about validity were raised as a justification for overriding ACDs*." (page 18, paragraph 3 – marked copy)

16. **Page 13, Line 26-29: in your quotation table at the chapter "Doubting rigor of the decision-making process" nothing is said about the patient being coerced by the family. What it seems to me is said is that interviewees distrust the conditions in which the decision-making process happened. This is a very important point since scientific literature suggests that in healthcare institutions, conditions for patient autonomy are often times challenged by professionals' lack of training or time and institutional procedural constraints. I would either rephrase or add a quotation that support your statement.**

    As advised have removed reference to family coercion:

    "*For example, these doctors believed that ACP is sometimes completed as a "tick box" where important details about treatments are not discussed*." (page 14, paragraph 2 – marked copy)

17. **Page 13, Questioning patients' ability to understand treatment decisions. Did interviewees discuss the potential of ACP in improving this point? The question was asked? If so, I would say few words. ACP is indeed an opportunity to provide the patient with information about treatments in general and treatments that are appropriate to their situation, including in case of an emergency.**

    This point was not specifically raised by participants however it does link in with the subtheme 'Doubting rigor of the decision-making process'. Some participants discussed what they considered best practice ACP to be, such as a detailed conversation where treatment options and possible outcomes and issues can be explained and understood by patients (see page 14, paragraph 2 – marked copy).

18. **Page 15, lines 6-15: it's interesting that doctors wish more leeway for themselves to adapt ACDs to concrete situations but seem skeptic about according the same privilege to surrogates or proxies (the legal representatives of the patient). On this point, I wonder if the authors explored with the interviewees their perceptions of surrogate's role and their interactions with surrogates. Indeed, ACP and ACDs uphold advanced decision-making (by the patient) and substitute decision-making (by the surrogate). I have the feeling that the way in which physicians engage in shared decision-making (for an actual or advance healthcare decision) with the patient and the surrogate is not sufficiently explored or made explicit in your research. This**

consideration makes me wonder once more what the authors mean by "experience with ACDs", see comment 9.

This is an interesting point which would be valuable to explore in detail regarding doctors' perspectives and experiences with surrogate decision-makers. The interview was structured to include a scenario involving family members dispute of the ACD (Scenario 3) and the resulting ideas raised were included the thematic framework. The aim of the current study was to describe the attitudes and perspectives of doctors regarding ACD adherence and the utility of ACDs in clinical practice. Whilst the surrogate decision-maker's role is related to this aim, it was not the primary focus of the current study and represents a potential avenue for future research. We have addressed this in the manuscript is follows:

"*In addition, future research could complement the current findings by characterising clinicians' perspectives and experiences regarding the role of family and legally appointed substitute decision-makers*." (page 21, paragraph 1 – marked copy)

19. **Page 16, Lines 52-60: I feel that those sentences are a bit contradictory, see comments 14**

    As advised, we have revised this phrase:

    "*In this study, consideration of what doctors perceived to be the patients' best interests was found to be more influential in medical treatment decision-making than legal requirements*." (page 18, paragraph 1 – marked copy)

20. **Page 17, Lines 56-59: very good point, to be deepened**

    As advised, we have expanded on this point:

    "*On the other hand, participants in this study did not tend to raise validity concerns if they agreed with the decision in the ACD or thought it was appropriate for the situation. This suggests that doubts about validity were raised as a justification for overriding ACDs. Many participants appeared to only question the validity of ACDs when they felt that the patient's choices were inappropriate or unreasonable for the situation.*" (page 19, paragraph 1 – marked copy)

21. **Page 18, Lines 31-49: excellent point too. What do you suggest could be made to uphold patient autonomy? What about training physicians throughout medical school? Or involving patients and relatives in teachings about patient autonomy and surrogate role? Was it made in Australian medical schools or ACP training? Participative approaches in research, implementation, and teachings are gaining momentum to improve healthcare practices.**

Suggestions for increased education and training for health professionals are raised in the section 'Implications for practice, policy and future research' (see page 20, paragraph 3). We also suggest an integrated approach to ACP where doctors and substitute decision-makers are involved in ACP discussions early in order to increased doctors' confidence in the validity of ACDs.

Yours sincerely,

Nadia Moore
Advance Care Planning Australia

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VERSION 2 – REVIEW

REVIEWER	Jessica Simon University of Calgary, Canada Dr Simon is a physician consultant for Advance Care Planning and Goals of Care, Alberta Health Services, Calgary Zone.
REVIEW RETURNED	16-Sep-2019

GENERAL COMMENTS	Thank you for your response to the reviewers concerns. These have been adequately addressed.

REVIEWER	Francesca Bosisio Lausanne University Hospital, Switzerland
REVIEW RETURNED	19-Sep-2019

GENERAL COMMENTS	The authors addressed most of reviewers' comments. For this reason, I recommend to accept the paper. I would suggest few minor revisions: - In the introduction, the authors mention relational autonomy but do not explain it. I would find interesting to read how ACP support it. Indeed, this is an essential feature that distinguish ACP from traditional ACDs. Indeed I feel that despite some revisions, the authors still use ACDs (values ACDs in particular) and ACP as synonyms (see for instance page 19, lines 31-5 and page 20, lines 51-4 in the change track version) - In the data analysis section, the authors mention the grounded theory. I would skip reference to the grounded theory since thematic analysis backs induction. If the authors inspired from others principles of grounded theory, I would suggest to mention them explicitly.

VERSION 2 – AUTHOR RESPONSE

Reviewer #2

- In the introduction, the authors mention relational autonomy but do not explain it. I would find interesting to read how ACP support it. Indeed, this is an essential feature that distinguish ACP from traditional ACDs.

We have revised the manuscript to remove reference to relational autonomy. The relevant legal frameworks do not specifically endorse this approach as was stated in the manuscript – rather, substituted judgement is favoured (see Box 1 for a summary of the legal context). We thank the reviewer for highlighting this and, thus, have decided to remove the reference to relational autonomy in the introduction to minimise confusion for readers given that this is not the focus of our particular study:

"Legal frameworks have supported this evolution, providing greater emphasis on a substituted judgement approach to medical decision-making" (page 5, paragraph 2 – marked copy)

- Indeed I feel that despite some revisions, the authors still use ACDs (values ACDs in particular) and ACP as synonyms (see for instance page 19, lines 31-5 and page 20, lines 51-4 in the change track version)

To clarify these definitions, advance care planning (ACP) refers to the process of clarifying and discussing a person's treatment preferences, goals and values, whereas advance care directive (ACD) refers to written documentation of the person's ACP preferences. The ACP preferences in the ACD may encompass specific treatment preferences and / or describe a person's values and beliefs. As such, the term 'values' ACD refers to an ACD which expresses a patients' values and thus can be framed in a broader sense – we have defined 'values' and 'instructional' directive according to Victorian legislation in Box 2 to avoid any confusion here.

In regards to the specific examples given, on page 19 we suggest that values ACDs can provide "broader context" for treatment decisions since they provide a more detailed explanation of the patients values which can inform treatment and care preferences, and "act as general guidance" for decision-makers rather than as legally binding instructions (consistent with the law in this state).

On page 20 we raise the "importance of supporting patients to create relevant, up to date, and clear ACDs that are clinically useful for doctors". This refers to the writing of ACDs to enhance their usefulness as legal documents in clinical scenarios.

- In the data analysis section, the authors mention the grounded theory. I would skip reference to the grounded theory since thematic analysis backs induction. If the authors inspired from others principles of grounded theory, I would suggest to mention them explicitly.

We confirm that we have drawn from the principles of grounded theory in this qualitative study. Our analysis was undertaken using thematic analysis[1] – this method is consistent with grounded theory and is used for analysing grounded theory studies.[2] We used an inductive approach to coding and analysis of the qualitative data which was drawn from grounded theory.[3]

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