PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	The realities of partnership in person-centred care: a qualitative interview study with patients and professionals
AUTHORS	Wolf, Axel; Moore, Lucy; Lydahl, Doris; Naldemirci, Öncel; Elam, Mark; Britten, Nicky

VERSION 1 - REVIEW

REVIEWER	Elizabeth Manias Research Professor Deakin University Australia
REVIEW RETURNED	10-Mar-2017

GENERAL COMMENTS	Person-centred care is an important and highly relevant topic for health professionals and consumers. There are a number of aspects that need to be addressed for this paper. Abstract The terms 'relational', 'contextual', and 'affective' aspects of partnership are mentioned without any clarification. These terms appear jargonised within the abstract upon first reading. Other terms may be appropriate instead. Otherwise, these terms should be clarified to improve understanding. Results showed informal and formal aspects of partnership. Clarify what aspects of partnership were deemed to be informal and formal. These terms should be briefly explained. The person-centred care pathway is first mentioned in the conclusions. This term should probably come earlier, within the objective. Introduction The authors state that informal relationships relate to human connectedness while formal relationships are associated with shared agreements on decisions and documentation. It is not clear why human connectedness is considered a bottom tier aspect while shared agreements on decisions and documentation are considered top tier aspects. This view does warrant some level of critique (p. 4, lines 47-52). This study is based in a centre that has implemented an evidence-based person-centred care model as a case study. A couple of brief statements explaining the model would be helpful. How was the model implemented in the hospital study site? Information is needed on what activities were carried out in the four wards to ensure that person-centred care was implemented.

Methods
The study design is appropriate for the nature of the work completed.

Nurses, assistant nurses and physicians with experience of working with person-centred care were recruited. How was this experience determined? If the model was implemented in the four study wards, it may be perceived that all professionals employed in these wards would be expected to have this experience.

What type of sampling approach was used with patients? It appears as though a convenience sampling approach was used. If this is the case, there could be the opportunity of bias in selection of patients by the nurse coordinator. The number of eligible patients who were present on each ward should be identified. How soon after discharge were interviews conducted with patients? Provide this information as a range in days for patients interviewed outside of hospital.

In looking at the interview guide for patients, it appears as though some of the phrases used were a little complex. For example, the following questions are provided on Table 2 (p. 21), 'Do you think that your resources/knowledge have been utilized?' 'What part of PCC meant the most to your experience of involvement/partnership?' Clarify if the interview guides were tested beforehand in any way.

Results
Some introductory sentences are needed about informal aspects of partnership (p. 7, line 31). What are the characteristics of this theme? In what ways was the partnership informal?

I am not clear by the statement made by MD1 'the content of the appointment gives them that feeling' (p. 7, line 57). Please clarify what this means. The term 'appointment' gives the impression that the partnership involves something more formalised than described for this theme.

On p. 8, lines 1-32, these are all positive aspects of the patient-professional relationship. Are there examples of contrary views, where proximity and receptiveness were not expressed in a way that promoted person-centred care?

Patients were prompted to discuss personal interests (p. 8, lines 43-44). Clarification is needed about the professional groups involved with this prompting, the times of day when this prompting occurred and the situations involved.

For formal partnerships, clarify the characteristics of this phenomenon in a few introductory sentences (p. 9, line 14). It is not clear how the two terms – formal and informal – are differentiated. The first time this clarification is made is in the discussion (p. 14, lines 46-49).

The authors refer to the need for professionals to 'push' or 'pass' on competence to the patient. Please clarify what this means (p. 10, lines 5-6). Additional explanation is required about the strategies used to enable patients to become well informed, knowledgeable and take responsibility for their health care.

On p. 10, line 50, '…one eats medications.' The translation undertaken here from Swedish should be changed to make the expression more meaningful.

On p. 11, lines 12-13, commencing with 'For example, discussing…' is an incomplete sentence.

On p. 11, lines 35-36, provide examples of situations in which patients participated in informed discussion, and experiencing acceptance and agreement. How were these situations played out in goal setting and planning patients' care?

In the quote provided of how documentation occurred on a 'new level' (p. 12, lines 39-46), the nurse stated that the care plan was created for the patient. This approach does not seem to be collaborative or participatory as the care plan was not developed with the patient. Further clarification is needed on this aspect.

Discussion
The authors state that relational, contextual and emotional factors for partnership took precedence in patients' minds, compared with formalising a partnership with professionals (p. 14, lines 22-25). These terms - relational, contextual and emotional factors – only appear in the abstract, introduction and discussion. There needs to be some mention of these factors in the results as they are a crucial part of understanding patient's and professionals' perspectives for partnering in care.

The authors state that some decisions were left for professionals to make because patients felt well informed. Please clarify which types of decisions were left to the professionals. It is interesting that the authors view this situation 'not as passive submission or deferment' (p. 14, lines 34-35). Further interpretation would be beneficial about the balancing act between recognising the patient as a person and the specific practical routines.

On p. 15, line 18, the authors state that most interviewees were older – older compared to whom? Questions can be raised about what follows – that patients' age may have enabled them to be feel knowledgeable while at the same time, complying with professionals' expertise. Past papers have shown that health professionals may not be fully cognisant of older patients' preferences regarding the degree of information provided and participation in decision making (see for example, Ekdahl, A. W. et al. (2011). Are elderly people with co-morbidities involved adequately in medical decision making when hospitalised? A cross-sectional survey. BMC Geriatrics, 11, 46. http://doi.org/10.1186/1471-2318-11-46).

REVIEWER	Philip Clissett University of Nottingham, England.
REVIEW RETURNED	17-Mar-2017

GENERAL COMMENTS	This is an extremely well written paper exploring understanding of person-centred care from the perspective of patients and health care professionals on wards that place an emphasis on person-centred care. My comments are minimal:

	1. The issue of ethics has not been addressed adequately. There was no real discussion of the ethical concerns that might arise during the conduct of this study and the ethical discussion (such as it was) was compressed into four lines at the bottom of page 6. In addition, it is not possible to realistically claim that all participants gave informed consent, only to outline the actions that were taken to try to ensure that consent was informed (very few actions are described here).
	2. The section on data analysis is unclear – I cannot work out how line by line coding followed by an inductive reading of the transcripts could be interpreted as a process that others could follow.
	3. Following data analysis, two main themes and four subthemes were identified. In each subtheme there was a professional perspective and a patient perspective. In my opinion, the symmetry seems to be a little too perfect. I am happy that the findings as presented are probably an appropriate reflection of the data but am left suspecting that detail is missing on how the researchers got there. In particular, as this is a study with two groups of stakeholders, it would be interesting to know how analysis was approached in light of this – were the different stakeholder interviews analysed separately, was one group analysed before the other or were they done at random. Depending on the approach used, the symmetry could have been achieved for different reasons.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Elizabeth Manias, Research Professor, Deakin University, Australia
Please state any competing interests or state 'None declared':   None declared
****
Please leave your comments for the authors below Person-centred care is an important and highly relevant topic for health professionals and consumers. There are a number of aspects that need to be addressed for this paper.

We thank the reviewers for their important comments, which were of great value for us when we revised the manuscript. We have made some substantial improvements in the manuscript.

Abstract
The terms 'relational', 'contextual', and 'affective' aspects of partnership are mentioned without any clarification. These terms appear jargonised within the abstract upon first reading. Other terms may be appropriate instead. Otherwise, these terms should be clarified to improve understanding.

Response 1: We agree that these terms are juxtaposed rather quickly in the abstract. Our analysis lies mainly on the *relational* aspects of the interaction between healthcare professionals and patients. As a relation always occurs in a context and comprises different types and levels of emotions, we agree to pinpoint relational as the main term in the abstract. [**Action line number 27**: We have revised the abstract and removed the wording contextual and relational and clarified. However, while this may increase patients' sense of responsibility and control, **research is needed to further understand how partnership is created and perceived**]

Results showed informal and formal aspects of partnership. Clarify what aspects of partnership were deemed to be informal and formal. These terms should be briefly explained.

Response 2: We decided to include some clarification about these two different aspects:

[**Action line number 37**: Insert "Informal aspects of partnership are those emerging during the interaction between healthcare professionals and patients without any prior guidelines or regulations. Formal aspects include structured ways of sustaining partnership."]

The person-centred care pathway is first mentioned in the conclusions. This term should probably come earlier, within the objective.

Response 3: We agree that the term "pathway or mechanism" is confusing as it only appears in the conclusions. We removed these terms to avoid confusion. [**Action line number 53**: remove "pathway or mechanism" and keep person-centred care]

Introduction
The authors state that informal relationships relate to human connectedness while formal relationships are associated with shared agreements on decisions and documentation. It is not clear why human connectedness is considered a bottom tier aspect while shared agreements on decisions and documentation are considered top tier aspects. This view does warrant some level of critique (p. 4, lines 47-52).

Repsonse 4: This categorization (bottom tier and top tier) was made by the cited authors (Ref 31). We do not prioritize the one over the other. Thus, we agree to include some clarification highlighting our critical stand [**Action line number 110**: Revision: "However, it is important to acknowledge that both aspects are equally crucial for partnership, Thoransdottir & Kristjansson suggest that the ethics of care, meaning the informal aspects of human connectedness, is fundamental to the establishment of a partnership".]

This study is based in a centre that has implemented an evidence-based person-centred care model as a case study. A couple of brief statements explaining the model would be helpful. How was the model implemented in the hospital study site? Information is needed on what activities were carried out in the four wards to ensure that person-centred care was implemented.

Response 5 **line number 116**:
Due to space constraints, we choose to use references to both the centres model of PCC as well as the hospital that has implementetd and tested PCC. Please see the text sections:
The University of Gothenburg Centre for PCC (GPCC) has introduced a new evidence based model[38-41], supported by a programme of training and research, which has changed clinical practice.[42] This model consists of three 'routines' of PCC namely narrative, partnership and documentation [39 42 43]
Regarding the wards, we have revised the text and elaborated more on the training:
[**Action line number 134**: Each ward took part in a 10 week PCC change management/training program, incorporating both lectures and workshops regarding the ethics of PCC, research findings from PCC studies as well as training in using different tools such as care plans and interview techniques. The ward manager chose a number of staff (RN, AN, Physicians) as change agents with the mission to be part of the training program and to implement PCC to the rest of the staff on each ward.
Reference to the model implemented by the ward.

38. Ekman I, Wolf A, Olsson LE, et al. Effects of person-centred care in patients with chronic heart failure: the PCC-HF study. *Eur Heart J* 2012;33(9):1112-9. doi: 10.1093/eurheartj/ehr306 [published Online First: 2011/09/20]

Methods
The study design is appropriate for the nature of the work completed.

Nurses, assistant nurses and physicians with experience of working with person-centred care were recruited. How was this experience determined? If the model was implemented in the four study wards, it may be perceived that all professionals employed in these wards would be expected to have this experience.

Response 7 **line number 141**: All professionals working in these wards either participated in extensive training course or co-worked with colleagues trained in this training program and collaborated with them to develop health care plan, change attitudes towards patients etc. The majority of the interviewed professional had attended the training program [**Action**: We have revised and elaborated this in the text: Each ward manager was contacted with information about the study and gave their consent. They were then asked to recruit a nurse, an assistant nurse and a physician, with experience of working with PCC and from the training program, from their ward.]

What type of sampling approach was used with patients? It appears as though a convenience sampling approach was used. If this is the case, there could be the opportunity of bias in selection of patients by the nurse coordinator. The number of eligible patients who were present on each ward should be identified. How soon after discharge were interviews conducted with patients? Provide this information as a range in days for patients interviewed outside of hospital.

Response 8 **line number 129 & 486**: We agree that the first information was provided by a nurse coordinator and this is an issue that should also be clarified in the limitations section. We also clarified that the sampling of patient interviews was a convenience sampling method in the sample and design section [**Action**: Revision in the limitations: "Another limitation in this study is that patients were first contacted by a nurse coordinator and only after agreeing to be part of the study, they were contacted by the researchers after their discharge within the first 7 days. Patients who agreed to participate in the interview study might have been more attentive to the particular aspects of PCC and eager to talk about their experience. This might have led to the tendency for positive accounts about the informal parts of partnership. However, it is equally important for the objective of the study to see how and what patients positively talk about partnership.]

In looking at the interview guide for patients, it appears as though some of the phrases used were a little complex. For example, the following questions are provided on Table 2 (p. 21), 'Do you think that your resources/knowledge have been utilized?' 'What part of PCC meant the most to your experience of involvement/partnership?' Clarify if the interview guides were tested beforehand in any way.

Response 9: We agree that these questions sound a little complex and abstract and we need to clarify that these questions were asked in Swedish by a native Swedish speaker researcher with necessary alterations and illustrations. The topics were followed systematically but often with further explanations, simplifications and extra questions by the researcher. The interview guide was therefore the skeleton of topics to be addressed, but often complemented with extra prompts. The interview guide was prepared by the research team but not tested in a pilot interview study.

Results
Some introductory sentences are needed about informal aspects of partnership (p. 7, line 31). What are the characteristics of this theme? In what ways was the partnership informal?

Response 10: [**Action line number 206**: Revision in the text: "Informal aspects of partnership are those emerging during the interaction between healthcare professionals and patients."

I am not clear by the statement made by MD1 'the content of the appointment gives them that feeling' (p. 7, line 57). Please clarify what this means. The term 'appointment' gives the impression that the partnership involves something more formalised than described for this theme.

Response 11 **line number238**: The term "appointment" sounds in English more formal than the word "besök" in Swedish. It is equally possible to translate this word as "consultation" [**Action**: Revision in the text: consultation.

On p. 8, lines 1-32, these are all positive aspects of the patient-professional relationship. Are there examples of contrary views, where proximity and receptiveness were not expressed in a way that promoted person-centred care?

Response 12 **line number 266**: Some patients had contrary views, for instance about how they thought they could bring their knowledge and experience into the care planning. As we briefly discuss it, some patients also had divergent ideas about the role of physicians when it comes to decision

Patients were prompted to discuss personal interests (p. 8, lines 43-44). Clarification is needed about the professional groups involved with this prompting, the times of day when this prompting occurred and the situations involved.

For formal partnerships, clarify the characteristics of this phenomenon in a few introductory sentences (p. 9, line 14). It is not clear how the two terms – formal and informal – are differentiated. The first time this clarification is made is in the discussion (p. 14, lines 46-49).

The authors refer to the need for professionals to 'push' or 'pass' on competence to the patient. Please clarify what this means (p. 10, lines 5-6). Additional explanation is required about the strategies used to enable patients to become well informed, knowledgeable and take responsibility for their health care.

On p. 10, line 50, '…one eats medications.' The translation undertaken here from Swedish should be changed to make the expression more meaningful.

On p. 11, lines 12-13, commencing with 'For example, discussing…' is an incomplete sentence.

On p. 11, lines 35-36, provide examples of situations in which patients participated in informed discussion, and experiencing acceptance and agreement. How were these situations played out in goal setting and planning patients' care?

Response 18 **line number 367**: We have included some more quotes as suggested. We think that both the quotes of P5 and P6 emphazise what we interpreted from the patient, both an active/ sometimes passive participation in informed discussion, but also the process of knowledge creation (P5) throughout the care period.
[**Action line number 367**: Revision:
When I say no to something, they listen to me. Whatever it might be; the discharge or anything. Or some kind of examination… I said no to an examination, and I said that: "You did that examination just six months ago, and it's very painful. Is it really necessary to do it again?" "No, then we won't do it." (P1)

Since you are part of the treatments, and you know how they are doing the plan for the treatment and are explaining in a good way. So even when you return home, you know approximately about… Well, now I know how I will deal with the medications and the treatment and everything, in a completely different way. Yes, I think… (P7)

In the quote provided of how documentation occurred on a 'new level' (p. 12, lines 39-46), the nurse stated that the care plan was created for the patient. This approach does not seem to be collaborative or participatory as the care plan was not developed with the patient. Further clarification is needed on this aspect.

Response 19 **line number** 395: in this quote, we translated directly the Swedish word, however we have revised it to "with" the patient. The written care plan was created i.e. written by the nurse and physician after the initial dialog with the patient, and then discussed with the patient at the round. So the "for the patient" is a matter of writing the care plan prior to the round meeting with the patient.

[**Action**: Revision: creating a care plan **with** the patient

Discussion
The authors state that relational, contextual and emotional factors for partnership took precedence in patients' minds, compared with formalising a partnership with professionals (p. 14, lines 22-25). These terms - relational, contextual and emotional factors – only appear in the abstract, introduction and discussion. There needs to be some mention of these factors in the results as they are a crucial part of understanding patient's and professionals' perspectives for partnering in care.

Response 20 **line number 448**: After revising the text in the abstract and clarifying the informal and formal part, we think the relational aspect has become clearer.
[**Action**:There were more formal aspects for partnership that took precedence in patients' minds, which is in line with the description of the fundamentals of human connectedness described by Thoransdottir & Kristjansson (2014), pointing toward the ethical dimension of partnership and PCC.

The authors state that some decisions were left for professionals to make because patients felt well informed. Please clarify which types of decisions were left to the professionals. It is interesting that the authors view this situation 'not as passive submission or deferment' (p. 14, lines 34-35). Further interpretation would be beneficial about the balancing act between recognising the patient as a person and the specific practical routines.

Response 21 **line number 458**: Patients were not forced to make a choice, but they were rather given guidance and information. This agreement is different from patients adhering to one care plan because they do not know what happens if they do not. Rather they develop a certain understanding of the medical condition, treatment and their effects on their lifeworld. [**Action revision in text**: Patients were not forced to make a choice, but they were rather given guidance and information.

On p. 15, line 18, the authors state that most interviewees were older – older compared to whom? Questions can be raised about what follows – that patients' age may have enabled them to be feel

knowledgeable while at the same time, complying with professionals' expertise. Past papers have shown that health professionals may not be fully cognisant of older patients' preferences regarding the degree of information provided and participation in decision making (see for example, Ekdahl, A. W. et al. (2011). Are elderly people with co-morbidities involved adequately in medical decision making when hospitalised? A cross-sectional survey. BMC Geriatrics, 11, 46. http://doi.org/10.1186/1471-2318-11-46).

Response 22 **line number 484**: We thank the reviewer for the reference and we have revised the text accordingly. **Action revision**: However, Ekdalh et al (2011) suggest that older peoples' preference for information and decision making isn´t impacted by higher age, and that the majority of patients wanted more information, not less [48].

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Reviewer: 2
Philip Clissett
University of Nottingham, England.
Please state any competing interests or state 'None declared':   None declared.
****
Please leave your comments for the authors below This is an extremely well written paper exploring understanding of person-centred care from the perspective of patients and health care professionals on wards that place an emphasis on person-centred care. My comments are minimal:

1.   The issue of ethics has not been addressed adequately. There was no real discussion of the ethical concerns that might arise during the conduct of this study and the ethical discussion (such as it was) was compressed into four lines at the bottom of page 6. In addition, it is not possible to realistically claim that all participants gave informed consent, only to outline the actions that were taken to try to ensure that consent was informed (very few actions are described here).

Response 23 **line number 175**: We agree with the reviewer that more information about the ethical considerations could be given.
Action: Revised text: All participants were free to withdraw their consent at any time during the study. Patients were interviewed after their hospital stay, in a place of their choosing to ensure that they did feel comfortable taking about the care episode. All interviews with patients were performed by researchers without a clinical background or connection to the hospital. If the patients wanted to talk to a healthcare professional regarding general or specific topics that came up during the interviews, they were able to talk to a nurse about their concerns or thoughts.

2.   The section on data analysis is unclear – I cannot work out how line by line coding followed by an inductive reading of the transcripts could be interpreted as a process that others could follow.

Response 24 **line number 186**: We used a thematic analysis, starting with a inductive, intuitive reading of the transcripts. Transcripts were independently coded by LM, ON & DL, and discussed with the whole team in order to address differences and reach a consensus.
[**Action revision in text:**

Transcripts were independently coded by LM, ON & DL, summarized and then discussed by online and face-to-face meetings. A combination of computer software (NVivo 9) and hand written methods were used and mind mapping to assist with the development of themes [44]. We then followed a deductive process to explore how the characteristics and components of partnership were experienced by professionals and patients. We explored the characteristics and components of partnership based on how they were experienced by professionals and patients. Early analysis identified categories associated with providing comfort, creating confidence and finding common ground through everyday informal interactions. In contrast, other categories revealed formalised care provided by professionals such as exchanging information, planning, evaluating and documenting care. However, when these were compared with patient transcripts patients described a simplified and practical process such as receiving some form of paperwork and knowing what was done. As analysis progressed we categorized these findings under two main themes: informal and formal

3.	Following data analysis, two main themes and four subthemes were identified. In each subtheme there was a professional perspective and a patient perspective. In my opinion, the symmetry seems to be a little too perfect. I am happy that the findings as presented are probably an appropriate reflection of the data but am left suspecting that detail is missing on how the researchers got there. In particular, as this is a study with two groups of stakeholders, it would be interesting to know how analysis was approached in light of this – were the different stakeholder interviews analysed separately, was one group analysed before the other or were they done at random. Depending on the approach used, the symmetry could have been achieved for different reasons.

Response 25 **line number 212**: We agree with the reviewer about the symmetry of the disposition of the findings. This was an intended strategy to give voice to all stakeholders about the realities of partnership. However, it is true that in some parts we had more material than we had for other themes. We mention this in our analysis as it also leads our analysis; for instance, while relational aspects are richly described, documentation was relatively less mentioned both by patients and professionals. **Action revision result**: The results are presented below to allow comparison between the 2 groups.

VERSION 2 – REVIEW

REVIEWER	Elizabeth Manias Deakin University, Australia
REVIEW RETURNED	25-Apr-2017

| GENERAL COMMENTS | The authors provided comprehensive responses with how they addressed the issues raised in the initial review of the paper. There remain a few issues that need to be addressed.

There needs to be some clarification of how rigor was ensured in the process of translating interviews from Swedish to English. This is important because of some issues raised about the use of particular English words following translation.

I am a little concerned that all interviews with patients were undertaken by researchers without a clinical background (response 23 in the revised version of the paper). In view of the topic relating to person-centred care, it is important to have some indication of how, during the course of an interview, these researchers knew when and how to ask probing questions. Some clarification about the training received by these researchers would also be helpful.

In the limitations, the authors stated: "However, Ekdalh et al (2011) suggest that older peoples' preferences for information and decision making are not associated with age, and that the majority of patients wanted more information, not less." I think this statement needs to be qualified more fully. In the Ekdalh et al. paper, the participants were aged 75 years or above. With the way the above statement reads, it implies that a wide range of ages were investigated, when in fact, all patients were aged at least 75 years. These patients wanted to have more information relating to their care, without |

	having to ask. In addition, physicians were not fully aware of patient preferences regarding their degree of communication or patients' participation in decision making. Thus, the context of the partnership involving the health professional perspective could be reinforced here.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 1
Elizabeth Manias
Research Professor, Deakin University, Australia Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below The authors provided comprehensive responses with how they addressed the issues raised in the initial review of the paper. There remain a few issues that need to be addressed.

Q1
There needs to be some clarification of how rigor was ensured in the process of translating interviews from Swedish to English. This is important because of some issues raised about the use of particular English words following translation.

Reply:

Interviews with healthcare professionals were transcribed verbatim and translated from Swedish to English by Doris Lydahl. Interviews with patients were transcribed by the research assistant Marie Hammer, translated by a research assistant, and then checked by Marie Hammer to avoid potential misinterpretation. All interviews were translated so that all members of the research team can have access to the data. Translation was literal, yet for specific idioms in Swedish which are not easy to translate, native English speakers in the research team suggested alternatives which would do better justice to the content and bilingual team members checked their accuracy. However, as it is common in this type of literal translations, some selected quotes might sound as lacking of fluency for English speaking readers.

Action: Revised text (line 170)
They were then read and checked by the team to ensure accuracy and fluency. Translation was literal, yet for specific idioms in Swedish which are not easy to translate, native English speakers in the research team suggested alternatives which would do better justice to the content and bilingual team members checked their accuracy. Any potential misinterpretations were clarified and agreed.

Q2
I am a little concerned that all interviews with patients were undertaken by researchers without a clinical background (response 23 in the revised version of the paper). In view of the topic relating to person-centred care, it is important to have some indication of how, during the course of an interview, these researchers knew when and how to ask probing questions. Some clarification about the training received by these researchers would also be helpful.

Reply:

Marie Hammer is trained in sociology and qualitative research methods. Prior to interviews, she discussed the details of the interview guide with team members trained in qualitative research methods and experienced in interviewing both healthcare professionals and patients. She also

discussed with them about when and how it is appropriate to ask probing questions. These questions were used to follow up a topic of discussion, to receive a better illustration of the discussed topics (like in "could you give some examples?") and facilitate the dialogue in a way that the interviewees feel comfortable responding to questions. For asking probing questions, Hammer paid attention to whether patients were reluctant to tell more about a specific issue or waited for some other questions from the interviewer. If interviewees did not want to talk more about a particular issue, the interviewer skipped the related probing questions and asked the following question in the guide.

Action: Revised the text line 180:
A research assistant (MH) without a clinical background or connection to the hospital performed all patient interviews. However, the research assistant is trained sociology and had previous experience of conducting patient interviews. The research assistant received guidance from the team concerning the interview guide, qualitative interview techniques and the use of probing questions throughout the present study. Probing questions were used to follow up a topic of discussion, to receive a better illustration of the discussed topics and facilitate the dialogue in a way that the interviewees feelt comfortable responding to questions. If interviewees did not want to talk more about a particular issue, the interviewer skipped the related probing questions and asked the following question in the guide.

Q3
In the limitations, the authors stated: "However, Ekdalh et al (2011) suggest that older peoples' preferences for information and decision making are not associated with age, and that the majority of patients wanted more information, not less." I think this statement needs to be qualified more fully. In the Ekdalh et al. paper, the participants were aged 75 years or above. With the way the above statement reads, it implies that a wide range of ages were investigated, when in fact, all patients were aged at least 75 years. These patients wanted to have more information relating to their care, without having to ask. In addition, physicians were not fully aware of patient preferences regarding their degree of communication or patients' participation in decision making. Thus, the context of the partnership involving the health professional perspective could be reinforced here.

Reply:
We thank Prof. Manias for this suggest to further clarify this and have revised the text to further highlight the need for responsiveness and also regarding the age.

Action: Revision line 502.

However, Ekdahl et al (2011) suggest that older peoples' preferences for information and decision making aren't fully acknowledge and/or acted upon by the healthcare professional. Patients aged 75 years and above may want more information relating to their care, without having to ask. Therefore, healthcare professionals need to be receptive and responsive to patients' preferences and tailor the information and decision making process accordingly.