PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	What are Healthcare Providers' Understandings and Experiences of Compassion? The Healthcare Compassion Model: A Grounded Theory Study of Healthcare Providers in Canada
AUTHORS	Sinclair, Shane; Hack, Thomas; Raffin, Shelley; McClement, Susan; Stajduhar, Kelli; Singh, Pavneet; Hagen, Neil; Sinnarajah, Aynharan; Chochinov, Harvey Max

VERSION 1 – REVIEW

REVIEWER	Philip Larkin University College Dublin, School of Nursing Midwifery and Health Systems, Dublin,Ireland
REVIEW RETURNED	02-Oct-2017

GENERAL COMMENTS	Thank you for your paper. I have enjoyed reading it and feel it offers an important contribution to our understanding of the application of compassion from theory to practice. It is well designed and reported overall. I do think that there are two points I would make. 1. I think in pg 7, Line 6, the meaning of 'theoretical gap' may not be clear to the clinical reader in this context. Perhaps it could be reviewed? 2. On pg 12, line 26, although I appreciate the importance of the virtue concept, I feel it would be strengthened if the term virtue was described a little more clearly, In contrast to other sections where headings and terms are explained, here I feel it is presumed rather than stated and it is a very important section of the study. Overall, I found this a very insightful and reflective contribution.

REVIEWER	Nathan S. Consedine University of Auckland New Zealand
REVIEW RETURNED	02-Oct-2017

GENERAL COMMENTS	Monday, October 02, 2017 bmjopen-2017019701 – The healthcare provider compassion model: a grounded theory study. Submitted to: BMJ Open The submitted report presents grounded theory analyses of qualitative data from focus groups and interviews regarding the views, attitudes, experiences, and beliefs regarding compassion from 57 healthcare providers (HCPs). In addressing compassion in healthcare, the report is in an area of increasing research attention

	and the attempt to characterize how HCPs "see" compassion is potentially important. Although there are some areas where greater detail would be useful, the research appears to have been competently conducted and generally in line with qualitative research methodologies. These strengths noted, there are several interrelated theoretical, methodological, and operational issues that detract from the work as it currently stands. These issues are described in greater detail below. One initial issue concerns the nature of the healthcare provider compassion "model" and the way it is described. The Introduction to the submission does not make it clear what the interview and focus group derived content is supposed to be (or inform) a model of. Is it a model regarding the nature of compassion, its place in healthcare, the ways it might be expressed, or some combination of these three? There are other parts of the submission where it seems that characterizing the way HCPs define compassion is more central (p. 12) or where the data are seen to "serve as a framework" (e.g., p. 3). In combination with the fact that while the review and critique of prior literature justifying the study may be broadly accurate, it is somewhat generic, these considerations make the incremental contribution of the submission hard to determine. What, specifically, is being added by this piece? Any resubmission should more clearly and specifically establish what prior work has not considered and, ideally, do so in a way that logically leads to both the research questions and the design decisions (including the sample selection). Relatedly, it does not seem appropriate to position the model as a "healthcare provider" compassion model when, empirically, it is more accurately characterized as an in-depth study of 57 persons specifically working in palliative care. Given the purpose of the submission in generating understanding among HCPs, the focus on palliative care is not justified as written. More broadly, and despite acknowledging the limitation imposed by this recruitment focus, the possibility that multiple aspects of the participants' responses reflect issues, beliefs, experiences, or dynamics specific to the palliative care domain means that it is inappropriate to deem this a "healthcare provider" model; there is simply no way to be sure that the characterization of compassion evident in the narratives are general views or whether they are particular to those persons working in palliative care environments. For example, several of the themes include elements of practice (e.g., spirituality or embodied virtues) that appear differentially relevant to end of life care rather than being generally relevant to compassion. Given suggestions (e.g., Fernando & Consedine, 2014) and evidence (Fernando & Consedine, 2017) that there are discipline-specific issues for compassion in medicine, any resubmission should more carefully restrict interpretations such that it presents a study of compassion in the specific context of palliative care. The empirical focus of the submission should be reflected in the title. The design, staging, and methodologies are generally appropriate to the research domain under investigation. There are, however, a few areas in which greater detail would enable the reader to critically evaluate the piece more readily. First, and as noted, a justification for the decision to concentrate on carers in the palliative environment would be useful. If the purpose of the paper is to investigate compassion in healthcare, why only focus on these persons? Second, it would be useful to know a bit more regarding who conducted the interviews and focus groups. How many

	interviewers were there, were they blind to research design, and were any checks of consistency across interviewers conducted? This latter question would enable the report to evaluate the possibility that interviewers "confirmed" expectations in some way, something that needs to be considered. What training did they have? Were the same codes emerging comparably across interviewers? Three, a justification for the decision to specifically recruit persons that were seen as "exemplary" is needed. This approach might seem to risk biasing the sample towards (a) a certain type of person and (b) highly salient (rather than necessarily modal or representative) instances of compassion. What purpose is being served here? Four, although I am not an expert in Straussian methods, my impression is that this approach tends to be more linear or purposeful than some other grounded theory methodologies and more prescriptive in its approach to both coding (in general) and developing relationships or predictions regarding the associations among the coding categories. In any case, it would be useful if any resubmission more clearly justified this choice of methodology. More broadly, the process by which the coding was conducted is not entirely clear. It seems as though multiple authors (who are not blind to expectation) completed the coding process more or less in parallel, with significant amounts of consensus coding (i.e., meetings). Detail is needed here. Specifically, how many narratives were coded independently and is there any evidence of convergence between coders? Did the same codes reliably emerge across coders and across transcripts and was there any evidence of content saturation? Does "consensus" mean they sat and talked until agreement was reached? For what proportions of the codes was this process necessary? What does it mean to say the authors had qualitative experience? Finally, there are several points at which the submission suggests that the model guides practice and interventions but details are scanty. The Discussion section of the paper seems more a recapitulation of the findings than it does a systematic reintegration of the data into the existing literature investigating compassion in palliative care (or other medical) settings. Equally, it would be useful if the submission specifically explained how the data/interpretations lend themselves to practice guidance and/or what specific interventions it suggests should increase compassion. Compassion as an embodied virtue, for example, appears to have relatively low utility from an interventional perspective.

REVIEWER	dr. C.J.M. van der Cingel Windesheim University, Zwolle. the Netherlands
REVIEW RETURNED	18-Oct-2017

GENERAL COMMENTS	The study is a valuable contribution to the already existing and growing body of knowledge on the concepts and theories on compassion in care. Nevertheless, the authors do not seem to acknowledge enough the work done by others when claiming there is a lack in evidence based understanding of the construct of compassion and other claims (abstract and throughout the background section). Also, proper and understandable clarification of this model's relations between concepts are missing. The model itself is therefore too vague and has overlap between concepts that isn't explained sufficiently. Overall more clarification and elaboration is needed in order to understand the process of arriving to the

model as well as understanding the content of the model as a whole.

Next to that some other comments can be made such as:
- information and decription on how analysis is done is unclear
- long sentences do not improve the readability; throughout the manuscript long sentences should be modified into readable text.
- paragraphs are not built up in a simple understandable language.

When these improvements and modifications are made the manuscript can be a very valuable contribution to our (empirically gained) knowledge of compassion.

Reviewer comments on 'The Healthcare Provider Compassion Model: A Grounded Theory Study'
Van der Cingel, October 2017.

Page and line	Comment
p1-line24&30-31 letter	Claiming that this study provides for 'the first patient informed theoretical model of compassion' or 'being the first of it's kind' is giving no credit too other studies and models already developed on compassion in (nursing) care. The studies of f.e. Lown and myself (van der Cingel) do explore patient perspectives. Papadoupoulos and myself do also explore healthcare providers (nurses) perspectives and develop and describe dimensions and a model for compassion in care. Other publications than referenced should be considered in order to see the work and foundation of these models such as: ▪ Van der Cingel M. (2014) Compassion: The missing link in quality of care. Nurse Education Today. Volume 34(9), p1253-1257. ▪ van der Cingel M. (2009) Compassion and professional care: exploring the domain. Nursing Philosophy. 10, 124-136. ▪ Developing tools to promote culturally competent compassion, courage, and intercultural communication in healthcare; I Papadopoulos, S Shea… - Journal of …, 2016 - jcompassionatehc.biomedcentral. … ▪ Measuring compassion in nurses and other healthcare professionals: An integrative review; I Papadopoulos, S Ali - Nurse education in practice, 2016 – Elsevier • Factors facilitating nurses to deliver compassionate care: a qualitative study; Vahid Zamanzadeh, Scandinavial Journal of Caring Sciences Also, many other theorists have shed their light on compassionate care previously, if you look careful enough on nursing theories developed earlier specifically humanistic nursing theories such as Peterson & Zderad and Travelbee. You may look also at some less recent references such as

		(which is only a small selection of a rich source of literature on compassion in nursing): ▪ Chambers, C., Ryder, E., 2009. Compassion and Caring in Nursing. Radcliff publishing Ltd., Oxon. ▪ Schantz, M., 2007. Compassion: a concept analysis. Nurs. Forum 42, 48–55. Even though not all of these studies are based on empirical evidence, they do provide a theoretical model. The work done by these scientists provide for a theoretical as well as an empirical foundation of the work presented in this study and on which we all can built our work on. This should be recognised and acknowledged.
	p3-line11 p5-line10-18 p5-line 20-22&37-39 p6- line13-18	'*an evidence based understanding of the construct and its associated* *dimensions from the perspective of healthcare providers is lacking.'* *'there is a lack of research investigating HCPs understandings and experiences of providing compassionate care* *directly.'* *'the absence of direct patient accounts of compassion'* *'most of which utilized predetermined researcher generated* *definitions rather than establishing conceptual validity from the perspective of individuals actually involved in providing*

		compassion.'
		'lack of specificity in identifying the key domains of compassion, delineation of compassion to related concepts such as care, empathy and sympathy; and methodological rigor'
		The same comment can be made on all these claims: they do not acknowledge the work of others and seem to underestimate the value of other studies. Most claims simply are not true; studies have been done that show empirical evidence of patient's as well as healthcare provider's accounts which specify key concepts of compassion and which are done with rigor.
		Most of these quotes seem to lean heavily on a reference of a review by the author of the study presented, of which, although it is an excellent review, the conclusion (stating f.e. that 'Despite its centrality to quality care and its ubiquitous usage throughout the literature, an empirical understanding of the nature of compassion is not well developed.') can be criticized.
		Based on the data presented in the review one could claim with equal confidence that the nature of compassion has been well researched in the past few decades and provides for a thorough understanding of compassion in daily practice on which we can built further research such as presented in the manuscript.
		Next to that, it is not making a strong case if claims made do not have other references than a references of one's own.
	Table 1.	Nurses and physicians clearly are the majority of participants. If the aim of the study was to provide for a heterogenous sample of multidisciplinary perspectives then why should physicians and nurses be overly present? If one would take into account perspectives of different kinds of healthcare providers, an equal representation would have been sufficient.
	p7-line6	'*and to address theoretical gaps'*
		Needs explanation, in what way theoretical gaps are addresses when certain types of participants are recruited? Also: in what way 'theoretical sampling' has been used? Please explain to readers what it is and why it is used.
	p7-line 23	Reference 'develop the theoretical model and reach saturation (Table 1).' Seems odd; table 1 refers to participants

		only and does not shed any light on the development of the model nor how saturation was reached.
	p9-line20-22	3 of 15 individuals were participating in focusgroups as well as in interviews. How were they identified as being exemplary providers of compassion? And isn't there the risk of selection bias?
	line 24	Unclear who are study participants n=5? From focusgroups, interviews, which healthcare providers etc. also why these 5?
		Why aren't there patients in the stakeholders focusgroup? While outing critique on studies who did not include patients as an important source for empirical evidence, patients are not represented as a stakeholder in this study.
		Criteria for rigor: needs explaining.
	Line 30	
	Table 2	Question 4 seems leading or at least has the underlying premises that compassionate care is inhibited. Needs explanation and/or some grounding in an argument that this premises is likely or plausible
	p12-line 11	Straussian GT needs to be explained, readers nowadays may not know about the history and different forms of GT; also GT has evolved since Glaser and Strauss so more detail is needed in order to understand what has been done
	line 20-27	Description on how the analysis is done, sequence of analysis of transcripts etc. is very unclear. It seems that the analysis of all transcripts is done in the same way and all data is treated as being/coming from a same source, which seems odd. There are 3 stages in the process mentioned and topics-lists and aims of these stages differ, so in what way and sequence was the iterative process of analysis done regarding these three stages? Exactly what data in what stage was coded in an open, axial or selective way? How did the themes emerge in this process, which researchers were involved at what time and way.
		Which remaining interviews?
		Please give a full and clear insight into the process of

	Line 46	analysis.
	p13-line 6	It is not very common to refer to a quantitative term such as a core variable when using qualitative research methods. Please use qualitative semantics such as themes or categories of definition.
	line 6-18	Also the 'core variable'' described seems to me a definition of compassion. However a (another?) definition is given in the same paragraph consisting of just a slightly different phrase and addition of some aspects. What is the difference? and why would one need two statements describing the phenomenon under study (compassion) that are so close to one another?. Next to that, in what way is the definition composed of the themes or key dimensions that emerged in analysis, how did the researchers arrive to this definition? What steps in content analysis and according to GT, or was it thematic analysis?, were made? Please explain in more detail and choose one definition of the phenomenon under study.
	p13-line 28-40	It is not clear to what kind of internal processes participants refer, a response based in virtues does not necessarily consists of an internal process. If there is a process that serve as a catalyst, then how does this process look like? The way this paragraph is described makes it incomprehensible for readers what participants shared. It also raises questions on how this category or dimension emerged from the data. Citations give do not illustrate what is been said in the text. There's a lot of information to capture within just a few lines, which leaves a lot of questions. For example when compasison is conceptualized as a multi- dimensional construct, what is meant to be said, does this refer to the dimensions that yet are to be presented? And in what way are behaviours and skills associated to the construct or personal qualities? Which behaviors and skills are we talking about? It is very confusing for readers. Semantic terms are confusing as well; for one and the same word more than one term is used; f.e. catalyst and medium; category and dimension; qualities and virtues etc. This affects consistency and readability, please use one and the same term throughout the manuscript when referring to something. Are personal qualities virtues? Is seems to me that a virtue is something very general for human beings not something personal. Again semantics that are confusing. Also, how do the virtues mentioned relate to compassion, which as a phenomenon is also considered to be a virtue in itself (f.e. by

		Aristitotle and also contemporary philosophers and sientists such as Martha Nussbaum.)
	Line 57	
	p14-line 3	Routine care and sympathy and empathy are mentioned as being other expressions of care. They seem to me quite different in nature, routine care being something quite different while empathy and sympathy are more close to compassion. These expressions needs more explanation in why and how they differ from compassion.
	Line 19	I do not quite understand why it is plural in presence embodied virtues (why not embodied virtue) because it seems to me the quotes say something about compassion and not about other or more virtues. It also is a contradiction, presence being one thing/quality/dimension? and virtues the same virtues as in personal qualities? The difference between personal qualities and presence: embodied virtues is not becoming clear enough
	p51 and further	The intentional component of compassion (which can be recognised in a lot of other literature on compassion) is described beautifully, one thing that does not become clear however is why and how intention is linked to presence.

	p16-line 30-31	Seeing the patient as a person is being described as one of the aspects within the description of the dimension coming to know the person, next to accepting the person and engaging the patient in a sensitive matter. Does this title/description of the dimension covers all aspects sufficiently? It seems to me semantically the description is missing the aspect of acceptance.
	p17-line 36 and further	Within the dimension Accepting The Person Where They Are At, some very compelling but also intense narratives are used to illustrate this particular dimension of acceptance within compassion. I find it surprising that these narratives are mentioned specifically within this dimension; aren't their narratives within the data that would fit other dimensions as well? It seems unbalanced.
	p18	One could argue that some dimension have a lot of overlapping aspects and are not mutually exclusive or at least not distinct from each other. This can be said of Relational Space and Forging a Healing Alliance. What would be the difference exactly, it does not become clear in the descriptions or through citations. Also presence is again an aspect as it is in the first dimension as well in 2 other aspects (Presence: Embodied virtues and Intention: embodied presence). When all 3 ''forms'' of presence indicate specific behaviour or a specific aspect it should be made very clear what the differences are in meaning or concrete behaviour of the nurse.
	p18 line 46	Relational communication again overlap with for relational space? Please indicate the differences in significance of these dimensions as well as for therapeutic relationship and in depth understanding of the person with other aspects/dimensions. Is it possible that these dimensions can or should be understood from the viewpoint of one specific part of the construct of compassion such as the volitional, rational, affective, behavioural part? This would probably make more sense to a reader if these were overarching perspectives in which the different dimensions and aspects are to be understood and diversified. Some of this clarification is given at line 15-20 at page 20 but it would be very helpful if this kind of information on how to understand the dimensions was give at the beginning of the result section. This citation expresses a pitfall of compassion in which projection is involved; I would say it does not refer to in-depth understanding of the person that much, but much more to a form of empathy and strategy of the nurse in which she

		understands herself and is able to reflect and think about what it really means to 'set oneself asides' and take the perspective of the other person.
	p20-line30	
	p20 line 36	This dimension (ameliorating suffering) seems to me the behavioural aspect of compassion.
	line 33-53	A lot of citations within the whole results section are clustered, f.e. these 4 citations. Although citations are helping and illustrative for the reader in order to understand what a dimension comprehends, it is a lot to take in 3 or 4 quotes at once. I would advise to position every citation immediately after the text to which a citation is illustrative. This implies more clarification in the text and more careful consideration in choosing which citation is most relevant to what you want to illustrate.
	p23-line 8-15	The model referred to did not became fully clear in the result section. The concepts of the model were described but no overview of the complete model, nor an explanation or further clarification is given. Especially clarification of the relations between concepts, overlap, coherence etc. is necessary in order to understand what the value of the model is. The illustration of the model in figure 2 is not that helpful in revealing relations or significance of the model. Also, claims made in this paragraph, that it addresses theory as well as serve as a pragmatic tool, are not elaborated as well, so please enlighten how theory is addressed and how the model can be seen/used as a pragmatic tool.
	Line 29-41	Very long sentence, and therefore incomprehensable. The remark that there is oscillation in reality seems to me very important but then again how does this oscillation happen and what is the significance? The example given in line 48 and further makes a start to explain this but also does not clarify what alternative pathways are meant.
	p24 line 32-41	Also a very important notion that compassion has/consists of 'an intentional, discerning and targeted modality. Nevertheless other research and theories have made these claims as well,

		therefore these results should be compared with other work and literature. The idea that compassion can be seen as a form of personalised healthcare should also be elaborated on, in what model of personalised care or person centred care does the concept of compassion and specifically thuis model fit?
	Line 48-53	The distinction to empathy and sympathy should be explained much earlier in the manuscript, also this is one of more aspects of the differences between these concepts. The reader might want to have a better understanding of these related concepts.
	p25 lines 25-37	This paragraph suggests that this study does what I believe is missing as mentioned above; I do not see in what way the study results enlighten us on the relation between empathy and compassion… what does the '' higher, more sustainable states of 'feeling for' and 'doing for', in contrast to empathy where it functions as an endpoint' really means, what does that say about the nature of both concepts and how is this to be deducted from the results in the study?
	line39	See other comments on the idea of virtues. This claim seems too presumptuous as well; Aristotle already saw compassion as a virtue in itself, as have a lot of others. Why should we be surprised about the recognition of the idea of virtues as primary motivation to compassionate behaviour? Also, what virtues are we talking about and how do they relate to compassion as compassion is not a virtue in itself? (on which claim I would like to see argumentation.
	Line 50-51	Very interesting to see compassion as a process of self/provider congruence, needs elaboration, see also my description of compassion being a response which explores the same idea on how compassion should meander with the patient's process of mourning

	p26	Strengths and limitations; good points to mention; what did you do to limitate them? I would think interreliability of the analysis and researchers involved is therefore of importance, please explain if and how this was done in order to improve validity and reliability
	Line 27	Please give tangible recommendations, it is not enough to simply claim the model is a tool for practice if there is not an explanation on how to use it exactly. In what way can 'the requisite skills, behaviours, and qualities' be cultivated for example; this should at least be explained.
	p27 line 8	The conclusion that compassion is uniquely expresses by each professional comes as a surprise, especially because the discussion section mentions cultivating skills behaviours and qualities which implies that these can be recognised and thus are of a more general nature. So instead of making this a contradiction, please enlighten how this can be understood as a nuance.

REVIEWER	Claire E. Sorenson, PhD, RNC-NIC, CCRN Chicago, IL, USA (no current academic affiliation, recent graduate of Rush University, College of Nursing)
REVIEW RETURNED	05-Nov-2017

GENERAL COMMENTS	Background was very well written. You have built a strong argument for the need for this study and provided relevant supporting information. Background line #15 "HCPs" should be possessive, please address this. Background paragraph 2 was a bit difficult to read due to inclusion of so much information in list form. Perhaps there is a way to restructure this to make it flow a bit better. All examples, were, however, very well supported. When and how was consent obtained? Study population. I appreciated that you included many ancillary staff members in the study because they are imperative members of our teams and often overlooked in research; however, in your background and abstract you spoke to front line and direct healthcare providers. Would you consider housekeepers or unit clerks, for example, to be front like or direct healthcare providers? It would be useful to address this in your discussion. Data collection, line 8. Were there 35 HCPs who all participated in

	seven focus groups (i.e. did participants return for focus groups seven times), or were there a total of 35 participants in seven focus groups? This wasn't clear. The description of the data analysis was very concise and clear. The results were well summarized and organized in a way that made sense to the reader. The discussion was thorough and put the results in context of previous work on the concept of compassion from patient perspective. The authors explained clearly how the two models related to one another. They also discussed findings that they both expected and found surprising, all while tying the discussion together with past work regarding compassion. I would like to have seen more discussion related to the early conceptual definitions of compassion that they authors reference throughout the paper, to see more specifically how their findings both compare and contrast with the assumed definitions/conceptualizations used in the past. Additionally, the inclusion of ancillary staff in the sample was a nice insight. However, as I mentioned previously in the comments, if unit clerks and housekeepers are not considered front line providers (and perhaps the authors consider them to be, and this should also be addressed), how does their experience of compassion compare to that of healthcare providers? It seems these roles may be drastically different from the bedside HCPs, so perhaps there were some differences in how each experienced compassion? The authors may consider how this conceptualization of compassion relates to work on compassion fatigue, and how this improved understanding of compassion itself will help researchers and clinicians understand the "cost of caring." Overall, I believe this will be an excellent addition to our understanding of compassion with a few minor revisions. It was a brilliant use of grounded theory (which was explained beautifully and concisely in the methods for those unfamiliar with qualitative methods). I thank you for the opportunity to review this work, and look forward to seeing it in revisions and publication.

VERSION 1 – AUTHOR RESPONSE

To: The Editor, BMJ Open

Re: Response to Reviewers Comments--"The Healthcare Provider Compassion Model: A Grounded Theory Study" BMJ OPEN 2017-019701

Date: December 1, 2017

My co-authors and I thank you for the review of the above mentioned manuscript. We are particularly grateful for each of the Reviewer's astute comments and the considerable time and effort that went into their reviews.

We reviewed the feedback as a research team. We have addressed each of the Reviewers' concerns in supplementary file, modifying the manuscript accordingly using 'tracked changes' as requested.

Because of the feedback, we are confident that the manuscript is much stronger. There were some recommendations, however, where there were divergent views on specific issues between the four Reviewers, and other comments which we admittedly did not fully agree with. We pointed this out in the Table.

While the tracked changes which are evident in the manuscript reflect the attention we paid to the Reviewers' comments, please be assured that the fundamentals of the manuscript are unchanged. The reporting of the research design, results and conclusions are materially unchanged. In light of the considerable edits that are evident via tracked changes, we have also provided a clean copy for reviewers convinience.

Please find enclosed the revised manuscript. It is an honor to submit to BMJ Open. Thank you again for your time, effort and consideration of our manuscript.

Sincerely,

Dr. Shane Sinclair

Associate Professor, Cancer Care Research Professorship
Faculty of Nursing, University of Calgary
2500 University Drive NW Calgary, Alberta Canada. T2N 1N4
Ph: (403) 220-2925 Email: sinclair@ucalgary.ca

VERSION 2 – REVIEW

REVIEWER	C.J.M. van der Cingel Windesheim University the Netherlands
REVIEW RETURNED	19-Dec-2017

GENERAL COMMENTS	The authors have considered all comments of the reviewers with care as shows in their response and revised manuscript. Even though I do not agree with all responses made, I do believe the manuscript is now eligable for publication. I believe the study adds considerably to the understanding of compassion in healthcare today. I therefore would advise to accept. I did add some suggestions and answers in response to remarks of the authors in the attachment and some additional articles that might interest the authors/researchteam, in which f.e. compassion is mentioned as a value for person centred care.

REVIEWER	Claire E. Sorenson, PhD, RNC-NIC, CCRN United States
REVIEW RETURNED	24-Dec-2017

GENERAL COMMENTS	Very little background in the abstract. While it did provide context for the study, I would not consider the background complete. The background section, however, provided adequate information to

	understand the context of this study and the existing research on the topic. The discussion of findings and their implications was thorough and included excellent examples from the interview transcripts to support the conclusions presented by the authors. These revisions addressed most of the concerns presented by this and other reviewers. I do believe that more emphasis on whether or not the results are able to be generalized to other healthcare specialties would be prudent, I don't see it as a barrier to publication of this manuscript in its current form. Thank you for resubmitting with revisions, I think this will make an interesting addition to the body of literature on compassion.

REVIEWER	Nathan S. Consedine University of Auckland, New Zealand
REVIEW RETURNED	27-Dec-2017

GENERAL COMMENTS	bmjopen-2017019701.R1 – The healthcare provider compassion model: a grounded theory study. Revised manuscript submitted to: BMJ Open The revised report shows considerable improvement over the initial submission. The authors have clearly paid attention to the issues raised in the initial round of reviews and either (a) adapted the submission accordingly and/or (b) provided a rationale as to why changes are not needed. As previously, the work remains important, and supplementing a priori theoretical positions on compassion in health with contextual content that reflects the experience/meaning of compassion among PCPs remains important. There are two issues that remain: First, with respect to the issue of generalizability (i.e., whether a palliative care sample is suited to providing data informing a general model), while I agree that a general model is of interest to a broad readership, I must continue to express concern. In maintaining their earlier position, the authors argue (a) palliative care is “special” or, at least, a good starting point for study and (b) that this limitation to generalizability is clearly acknowledged in the manuscript. Neither of these arguments changes the fact that the data from a small, specific, and self-selected sample are being interpreted as reflecting a general view when they may or may not. Suffering is in evidence in all areas of healthcare and acknowledging a critical interpretative limitation after the fact does not adequately mitigate the problem. I agree with the authors that future studies are free to replicate, adapt, refute etc as they see fit. I am just not sure why the onus should be on subsequent studies to “refute” a claim or characterization that should not be made in the first place. Second, I have some lingering concerns regarding the use of the terms “theory,” “theoretical,” and “model” in the submission. Although these data might be seen as informing a theory, a theory is typically a structured or formal set of ideas and predictions intended to explain some element of the natural world. The work that has been presented certainly appears to have been conducted within a particular methodological framework but, in my opinion, the data

	presented would be more accurately termed a characterization of compassion in palliative care rather than a theory.

REVIEWER	Philip Larkin University College Dublin, Ireland
REVIEW RETURNED	05-Jan-2018

GENERAL COMMENTS	I have enjoyed reading this paper It is a very well executed study, reflecting a high quality qualitative methodology and some really interesting findings. The model will certainly serve practice and opens opportunity for further work in the future. I would support its publication at this time.

VERSION 2 – AUTHOR RESPONSE

To: The Editor, BMJ Open

Re: Response to Reviewers Comments--"The Healthcare Provider Compassion Model: A Grounded Theory Study" BMJ OPEN 2017-019701

Date: December 1, 2017

My co-authors and I thank you for the review of the above mentioned manuscript. We are particularly grateful for each of the Reviewer's astute comments and the considerable time and effort that went into their reviews.

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Please find enclosed the revised manuscript. It is an honor to submit to BMJ Open. Thank you again for your time, effort and consideration of our manuscript.

Sincerely,

Dr. Shane Sinclair

Associate Professor, Cancer Care Research Professorship

Faculty of Nursing, University of Calgary

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Reviewer #1	**Authors' comments**
I think in pg 7, Line 6, the meaning of 'theoretical gap' may not be clear to the clinical reader in this context. Perhaps it could be reviewed?	We have modified the sentence and provided examples to make this more understandable to a clinical audience.
On pg 12, line 26, although I appreciate the importance of the virtue concept, I feel it would be strengthened if the term virtue was described a little more clearly, In contrast to other sections where headings and terms are explained, here I feel it is presumed rather than stated and it is a very important section of the study.	We agree that this was not sufficiently described in our original submission and have modified this section accordingly. We added a sentence to contextualize participants' understandings of virtues in contrast to contemporary connotations that readers may bring with them which equate this term to religion, spirituality, piety or morality.
Reviewer #2	
Although there are some areas where greater detail would be useful, the research appears to have been competently conducted and generally in line with qualitative research methodologies.	Thanks.
The Introduction to the submission does not make it	We agree that while it may be clear to us as researchers, it is imperative to be clear to readers. As a result, we have added a

clear what the interview and focus group derived content is supposed to be (or inform) a model of. Is it a model regarding the nature of compassion, its place in healthcare, the ways it might be expressed, or some combination of these three?... What, specifically, is being added by this piece? Any resubmission should more clearly and specifically establish what prior work has not considered and, ideally, do so in a way that logically leads to both the research questions and the design decisions (including the sample selection).	detailed sentence (5th sentence in the Background section) describing the objective of the model, which is then followed by a number of additional sentences in the same paragraph that position the model in relation to previous work, demonstrating what it adds to the literature in the process.
Relatedly, it does not seem appropriate to position the model as a "healthcare provider" compassion model when, empirically, it is more accurately characterized as an in-depth study of 57 persons specifically working in palliative care… despite acknowledging the limitation imposed by this recruitment focus, the possibility that multiple aspects of the participants' responses reflect issues, beliefs, experiences, or dynamics specific to the palliative care domain means that it is inappropriate to deem this a "healthcare provider" model; there is simply no way to be sure that the characterization of compassion evident in the narratives are general views or whether they are particular to those persons working in palliative care environments. For example, several of the themes include elements of practice (e.g., spirituality or embodied virtues) that appear differentially relevant to end of life care rather than being generally	In relation to your comments querying whether the reported themes and model is limited to, and indicative of the field of palliative care specifically versus HCPs understandings of compassion in general, we respectfully feel that we have duly acknowledged this limitation. We have now provided a further explanation of this limitation with the addition of two paragraphs in the Limitations section. In this section we also provide a perspective for why palliative care, with its interdisciplinary approach, represents a natural starting point within the field of healthcare to develop an empirical model of compassion-- a foundation that other researchers can choose to replicate, build on, or refute within their specialty. We also feel that the broad applicability of the model will resonate with the broad readership of BMJ Open. Based on the reviewer's comments, we introduced a sentence acknowledging variance in barriers and facilitators of compassion based on medical specialty and professional experience conducted by other researchers in the field (Fernando & Consedine 2014, 2017) and this potential limitation in our study. Furthermore, in regards to the potential issue that this reviewer raises about an overly 'palliative care' understanding of compassion (e.g. spirituality) we note that this is neither reflective of the study data nor our presentation in the manuscript as the word spirituality did not appear anywhere in the original submission and occurs once in the revision, within the theme: Virtues--- in order to mitigate potential confusion and to provide greater clarity based on both this reviewers feedback and

relevant to compassion. Given suggestions (e.g., Fernando & Consedine, 2014) and evidence (Fernando & Consedine, 2017) that there are discipline-specific issues for compassion in medicine, any resubmission should more carefully restrict interpretations such that it presents a study of compassion in the specific context of palliative care.	reviewer 1. We do nonetheless want to clarify that unlike other studies which focused on barriers and facilitators, the focus of the current manuscript was on the concept of compassion and key domains of compassionate care. We recognize that question 4 of our interview guide inquires about inhibitors to compassion. Responses to this query generated considerable data which we recognized would not fit into the current manuscript. It will be the subject of a companion manuscript.
The design, staging, and methodologies are generally appropriate to the research domain under investigation. There are, however, a few areas in which greater detail would enable the reader to critically evaluate the piece more readily • First, and as noted, a justification for the decision to concentrate on carers in the palliative environment would be useful. If the purpose of the paper is to investigate compassion in healthcare, why only focus on these persons?	As noted above, we have modified the limitations section of the manuscript to further justify the choice of palliative care providers, namely because of the prevalence of suffering (which compassion is predicated on) and the importance of compassion particularly when curative interventions are not available.
• Second, it would be useful to know a bit more regarding who conducted the interviews and focus groups. How many interviewers were there, were they blind to research design, and were any checks of consistency across interviewers conducted? This latter question would enable the report to evaluate the possibility that interviewers "confirmed" expectations in some way, something that needs to be considered. What training did they have? Were the same codes emerging comparably across interviewers?	We have expanded the data collection section to provide details on the interviewer. We also note in this section that there were a total of 15 interviews conducted. In the revised data collection section we also have explained how we assured the fidelity of the interviews and protocol training that was provided. Regarding your question about the consistency of coding, we address this in response to the Reviewers fourth query about methodology below.

• Three, a justification for the decision to specifically recruit persons that were seen as "exemplary" is needed. This approach might seem to risk biasing the sample towards (a) a certain type of person and (b) highly salient (rather than necessarily modal or representative) instances of compassion.	While the risk of bias, in general, is not as paramount a concern in qualitative research in comparison to quantitative research, this is a valid point which we have further addressed in the 3rd sentence of the 1st paragraph of the data collection section. As noted by the reviewer and acknowledged in the limitation section (last paragraph), while qualitative research does not attempt to control bias in the same way as quantitative studies, there is an inherent risk that participants nominated like-minded individuals or exemplary clinicians who had atypical instances of compassion. In addition to acknowledging this in the limitation section, we feel that because these individuals were nominated by their peers (versus purposive sampling based on researchers predetermined definitions and preferred individuals); the ongoing and iterative analysis process of grounded theory (whereby subsequent interview data is compared and contrasted with previous data to insure consistency) and the fact that these individuals were clinicians and aware of the clinical realities associated with compassion—it is our view that the strengths of this approach outweigh potential shortfalls.
• Fourth..it would be useful if any resubmission more clearly justified this choice of methodology. More broadly, the process by which the coding was conducted is not entirely clear. It seems as though multiple authors (who are not blind to expectation) completed the coding process more or less in parallel, with significant amounts of consensus coding (i.e., meetings). Detail is needed here. • Specifically, how many narratives were coded independently and is there any evidence of convergence between coders? Did the same codes reliably emerge across coders and across transcripts and was there any evidence of content saturation? Does "consensus" mean they sat and talked until agreement was reached? For what proportions of the codes was this process necessary?	We have modified the data collection sentence and added an additional sentence to the data analysis section explaining our rationale for using grounded theory. In terms of the coding process, as noted above, we have provided greater detail on this in the data collection section, including a greater description of how transcripts were first coded independently and then coded as a group in order to enhance rigour. We also have included a sentence in the manuscript itself (versus simply stating this in the required appendix as per BMJ Open review policy) indicating that we met the 32 criteria for reporting qualitative research as outlined in the COREQ checklist (which addresses the specific concerns related to rigour raised by the reviewer and many more). Finally, we have provided greater detail regarding the role of three members of the authorship team (NH, HMC, AS) in auditing the coding process and schema. We are a uncertain what the Reviewer means by "narratives". If the Reviewer means "transcripts", each member of the analysis team coded all transcripts independently (i.e. 7 Stage 1 focus group transcripts, 15 individual interviews, and 2 Stage focus groups=24 transcripts) which we detail in the data analysis section.

• What does it mean to say the authors had qualitative experience?	The manuscript indicates we reached data saturation at the end of the study population section. It is our view that modifications to the analysis section clarifies both the consensus process and convergence between coders (i.e. they coded transcripts first independently; consensus involved resolving disputes in coding among team members; delineating and removing codes that that were not specific to compassion; and having additional members of the research team insure the quality of the coding process and the coding schema). As described in the manuscript, because grounded theory uses the constant comparative technique, the same codes not only were reached between reviewers but across participants and transcripts, culminating in a coding schema that contained every individual code thereby ensuring that data was reflective of the group as a whole and not the opinion of one participant. At the same time, individual perspectives are not discarded in qualitative research, rather they are verified in subsequent interviews with other participants—a process known as theoretical sampling which we refer to in the first sentence of the first paragraph of the study population section. In terms of "qualitative expertise", we have provided additional details in the Data Analysis section and can provide more detail if the Editor feels it is necessary. It is our view that providing the initials of the individuals that we refer to as qualitative experts is also helpful as this allows interested readers to substantiate our claims further (i.e. can see our other related publications).
Finally, there are several points at which the submission suggests that the model guides practice and interventions but details are scanty. The Discussion section of the paper seems more a recapitulation of the findings than it does a systematic reintegration of the data into the existing literature investigating compassion in palliative care (or other medical) settings. Equally, it would be useful if the submission specifically explained how the data/interpretations lend	We have revised the Discussion and study strength/limitations sections as a whole to address this general concern. Specifically, in addition to our previous comments about the modification of the entire strengths/limitations section we added specifics in the discussion section about the impact this study has on a multidimensional understanding of compassion in the field and the impact that this has on training both future HCPs and current HCPs which are currently primarily focused on enhancing affective compassion, which while being an important medium for enhancing compassion does not provide specifics on the clinical skills, behaviours and actions (practical training) of optimal compassionate care. We have also added further detail to the final paragraph of the Discussion section on the potential impact that our study might have on policy and approaches to compassionate care that treat it

themselves to practice guidance and/or what specific interventions it suggests should increase compassion.	as a job expectation.
Reviewer #3	
The study is a valuable contribution to the already existing and growing body of knowledge on the concepts and theories on compassion in care.	Thank you
The authors do not seem to acknowledge enough the work done by others when claiming there is a lack in evidence based understanding of the construct of compassion and other claims (abstract and throughout the background section)	While we did reference these works in our initial draft, we agree that the important contributions of leaders in the field may get buried in the reference list, not giving the acknowledgement they deserve in the actual text. We have highlighted the pioneering work of leaders in the field, in the 4th sentence of the introduction and in the discussion section (2,3,4 paragraphs), while also referencing the additional articles you brought to our attention.
Also, proper and understandable clarification of this model's relations between concepts are missing. The model itself is therefore too vague and has overlap between concepts that isn't explained sufficiently. Overall more clarification and elaboration is needed in order to understand the process of arriving to the model as well as understanding the content of the model as a whole.	We have modified the results section to better illustrate the relationship between categories and have expanded the discussion section considerably to address this particular issue.
Information and description on how analysis is done is unclear	We note that this was a concern of Reviewer #2 as well. In addition to our comments addressing Reviewer 2's comments above we have provided additional detail in the methods section. We also want to acknowledge that it can be challenging to provide sufficient detail and still respect the word limit of the Journal.

Long sentences do not improve the readability; throughout the manuscript long sentences should be modified into readable text.	We have extensively edited the article to address this concern.
Paragraphs are not built up in a simple understandable language	We have extensively edited the article to address this concern.
Reviewer 3 (additional Feedback in Attachment)	
p1-line24&30-31 Claiming that this study provides for 'the first patient informed theoretical model of compassion' or 'being the first of it's kind' is giving no credit too other studies and models already developed on compassion in (nursing) care. The studies of f.e. Lown and myself (van der Cingel) do explore patient perspectives. Papadoupoulos and myself do also explore healthcare providers (nurses) perspectives and develop and describe dimensions and a model for compassion in care. Other publications than referenced should be considered in order to see the work and foundation of these models such as: Van der Cingel M. (2014) Compassion: The missing link in quality of care. Nurse Education Today. Volume 34(9), p1253-1257. van der Cingel M. (2009) Compassion and professional care: exploring the domain. Nursing Philosophy. 10, 124-136. Developing tools to promote culturally competent compassion, courage, and intercultural communication in healthcare; I Papadopoulos, S Shea…	We reviewed the original submission and were unable to find the specific incidences you are referring to. Could we ask you have a look at this most recent version and if you encounter any such areas of concern we would be grateful to have them pointed out. We have altered the Background to recognize contributions of others to this emerging field of research. Further, we also modified the Background to clarify the importance of developing a HCP and Patient generated definition of the nature of compassion in establishing construct validity. This is important, and different than asking patients or HCPs about what they associate with compassion or situations that come to mind when they think about compassion (van der Cingel) or administering a survey about compassion (Lown) utilizing an *a priori* definition of compassion, particularly as it relates to measuring compassion (Sinclair et al., Measuring Compassion in Healthcare. *The Patient,* 2017, 10(4):389-405.). This is further substantiated by Perez-Bret's 2016 systematic review of the compassion in healthcare that concluded "A large number of authors have defined compassion, with certain nuances that differ from case to case. This raises the need for specificity in the definition of the term" We have added the additional references you provided

- Journal of …, 2016 - jcompassionatehc.biomedcentral. … Measuring compassion in nurses and other healthcare professionals: An integrative review; I Papadopoulos, S Ali - Nurse education in practice, 2016 – Elsevier • Factors facilitating nurses to deliver compassionate care: a qualitative study; Vahid Zamanzadeh, Scandinavial Journal of Caring Sciences Also, many other theorists have shed their light on compassionate care previously, if you look careful enough on nursing theories developed earlier specifically humanistic nursing theories such as Peterson & Zderad and Travelbee. You may look also at some less recent references such as (which is only a small selection of a rich source of literature on compassion in nursing): Chambers, C., Ryder, E., 2009. Compassion and Caring in Nursing. Radcliff publishing Ltd., Oxon. Schantz, M., 2007. Compassion: a concept analysis. Nurs. Forum 42, 48–55. Even though not all of these studies are based on empirical evidence, they do provide a theoretical model. The work done by these scientists provide for a theoretical as well as an empirical foundation of the work presented in this study and on which we all can built our work on. This should be recognised and acknowledged. p3-line11 p5-line10-18 p5-line 20-22&37-39 p6- line13-18 'an evidence based	We are aware of and agree that Paterson and Zderad's Humanisitic Nursing Theory, Roach's 5 C's of caring and many other scholarly works, within and outside of nursing have spoken about compassion. As we identified in our scoping review, while compassion is a liberally employed term in healthcare, there is less in the way of empirical, direct patient and HCP accounts, investigating their understandings and experiences of compassion directly. As noted above, we have tried to clarify this and underscore the importance of this foundational step (establishing an accurate definition of the construct of interest) in scientific inquiry in the first paragraph of the background as without this compassion is easily (and has been) conflated with routine care, empathy, sympathy, person centred care, resulting in a lack of specificity. While Chambers and Ryder provide a "framework for compassionate practice- evidence and challenges" (pg. 186) this does not equate with a theoretical model in both a general sense and specifically as it doesn't illustrate how the dimensions relate to one another as depicted in Figure 2. Furthermore, as another recent review of compassion in the nursing literature summated about Chambers and Ryders work "With the exception of empathy, which is often identified as a component of compassion, none of these themes [discussed by Chambers and Ryders] (i.e. empathy, dignity, listening, diversity, choice, and empowerment) are necessarily part of, or reliant upon compassion" (McCaffrey et al, Compassion: A critical review of peer-reviewed nursing literature. *Journal of Clinical Nursing,* 2015, 24:3006-3015.) Dr. Maria Schantz's landmark work is a concept analysis of compassion utilizing Walker and Avant's method and doesn't present a theoretical model of compassion. Likewise, Chambers and Ryders work is theoretical, utilizing very helpful case studies to elicit reader reflection, but it doesn't provide a theoretical model that illustrates the key domains of compassion and how they interact with one another. We hope that our modifications clarify each of these concerns. Again, to clarify, in general there is a lack of studies on HCP perspectives on compassion (we acknowledge the handful of studies that have been undertaken in the background, discussion and reference list). Further, there is a dearth of studies that specifically investigate HCPs "understanding of the construct of compassion" (with the exception of Vivino's study of psychotherapists and Kneafsey's study of key stakeholders in healthcare). While there are studies, as noted above, that ask HCPs perspectives on aspects of compassion, this is different than asking them 'What is compassion'?. We believe that our carefully chosen words accurately reflects this, which we have further clarified in the 1st paragraph of the Background section. In addition to the clarification mentioned above, we have modified this statement specifically and have described research investigating HCP understandings and experiences as nascent (emerging). Changed 'absence' which we agree read like an absolute

understanding of the construct and its associated dimensions from the perspective of healthcare providers is lacking.'	statement (i.e. none) to a 'lack of' which as noted above acknowledges the important pioneering work that has begun while recognizing that a gap still exists and future research needs to be undertaken in this area. Please see explanation provided above and the modified 1st paragraph which qualifies and clarifies this point.
'there is a lack of research investigating HCPs understandings and experiences of providing compassionate care directly.' 'the absence of direct patient accounts of compassion' 'most of which utilized predetermined researcher generated definitions rather than establishing conceptual validity from the perspective of individuals actually involved in providing compassion.' 'lack of specificity in identifying the key domains of compassion, delineation of compassion to related concepts such as care, empathy and sympathy; and methodological rigor'	This sentence, referring to the few studies that asked participants to directly define compassion (Vivino and Kneafsey) were not interdisciplinary, did not identify the key domains of compassion and delineated and conflated (Vivino's definition includes empathy and sympathy) compassion with related terms and were not methodologically rigorous. We therefore feel that it is accurate Again, this was not our intention and we realize that the confusion was due to a lack of clarity on our parts in terms of what are intention was—something that we have exercised diligence within this current iteration and our comments herein
The same comment can be made on all these claims: they do not acknowledge the work of others and seem to underestimate the value of other studies. Most claims simply are not true; studies have been done that show empirical evidence of patient's as well as healthcare provider's accounts which specify key concepts of compassion and which are done with rigor. Most of these quotes seem to lean heavily on a reference of a review by the author of the study presented, of which, although it is an excellent review, the conclusion (stating f.e. that	We limited our references to our recent scoping review of the topic, trusting that readers could refer to this for more specific detail. While we don't have the space to reference similar claims by individual compassion researchers, we have added two additional recent reviews by other authors (McCaffrey 2015 and Perez-Bret 2016) that after synthesizing the literature came to the same conclusion, namely that "A large number of authors have defined compassion, with certain nuances that differ from case to case. This raises the need for specificity in the definition of the term" (Perez-Bret, 2016). We hope this sufficiently substantiates these claims

'Despite its centrality to quality care and its ubiquitous usage throughout the literature, an empirical understanding of the nature of compassion is not well developed.') can be criticized. Based on the data presented in the review one could claim with equal confidence that the nature of compassion has been well researched in the past few decades and provides for a thorough understanding of compassion in daily practice on which we can built further research such as presented in the manuscript. Next to that, it is not making a strong case if claims made do not have other references than a references of one's own**.**	
Nurses and physicians clearly are the majority of participants. If the aim of the study was to provide for a heterogeneous sample of multidisciplinary perspectives then why should physicians and nurses be overly present? If one would take into account perspectives of different kinds of healthcare providers, an equal representation would have been sufficient.	Thank you. We have added a sentence acknowledging this point in the limitation section.
p7-line 6. 'and to address theoretical gaps' Needs explanation, in what way theoretical gaps are addresses when certain types of participants are recruited? Also: in what way 'theoretical sampling' has been used? Please explain to readers what it is and why it is used.	We have clarified this sentence and modified it to provide greater explanation about what theoretical sampling is within grounded theory—i.e. "The basic question in theoretical sampling (in either substantive for formal theory) is: what groups or subgroups does one turn to next in data collection" (Glaser & Strauss, The Discovery of Grounded Theory, pg. 47).
p7-line 23. Reference 'develop the theoretical model and reach saturation (Table 1).' Seems odd; table 1 refers to participants only and does not shed any light on the development of the model nor how saturation was reached.	We have modified this sentence accordingly.
p9-line20-22. 3 of 15 individuals were participating in focus groups as well as in	We have clarified how exemplary healthcare providers were identified in the first paragraph of the data collection section.

interviews. How were they identified as being exemplary providers of compassion? And isn't there the risk of selection bias?	In terms of the possibility of selection bias, while this isn't a primary concern of qualitative research, we acknowledge the possibility of this in the last paragraph of the strengths and limitations section "while the snowball sampling technique of Stage 1 participants nominating Stage 2 interviewees was novel and largely beneficial, it nonetheless may have diminished the heterogeneity of the sample, as participants may have inadvertently nominated like-minded individuals"
line 24. Unclear who are study participants n=5? From focus groups, interviews, which healthcare providers etc. also why these 5? Why aren't there patients in the stakeholders focus group? While outing critique on studies who did not include patients as an important source for empirical evidence, patients are not represented as a stakeholder in this study. Line 30. Criteria for rigor: needs explaining.	We have clarified in the main body of the manuscript what we were specifically meaning by 'study participants' (i.e. participants who participated in stage 1 and 2 of the study). We did not include patients in the key stakeholder group because our focus in this study was exclusively on HCP and we felt that our previous study that developed a patient model of compassion obtained their perspective, including patients' perspectives on the qualities, skills and behaviours of compassionate healthcare providers. We have modified this section, summarizing the essence of these important concepts.
Table 2 Question 4 seems leading or at least has the underlying premises that compassionate care is inhibited. Needs explanation and/or some grounding in an argument that this premises is likely or plausible	Originally, when we were developing the protocol, we had worded this question using the terms 'compassion fatigue' which is a prevalent phenomenon in the literature and in clinical practice. We modified question 4 because we felt the original wording of 'compassion fatigue' was loaded and leading. While we feel that the premise that compassionate care is inhibited can be substantiated from the compassion fatigue and other sources of literature, we did not have the space in this manuscript to include it. As such we are planning to publish a companion manuscript focused on facilitators and (based on the volumous data we obtained related to question #4) to compassion that will address the important point you make here. We have nonetheless, added a section immediately preceding

	Table 2 which describes how we guarded against bias (mostly interviewer bias as per reviewer #2's points), including evaluating the interviewer's comments and the appropriateness of the questions.
p12-line 11. Straussian GT needs to be explained, readers nowadays may not know about the history and different forms of GT; also GT has evolved since Glaser and Strauss so more detail is needed in order to understand what has been done line 20-27. Description on how the analysis is done, sequence of analysis of transcripts etc. is very unclear. It seems that the analysis of all transcripts is done in the same way and all data is treated as being/coming from a same source, which seems odd. There are 3 stages in the process mentioned and topics-lists and aims of these stages differ, so in what way and sequence was the iterative process of analysis done regarding these three stages? Exactly what data in what stage was coded in an open, axial or selective way? How did the themes emerge in this process, which researchers were involved at what time and way. Line 46. Which remaining interviews? Please give a full and clear insight into the process of analysis.	This is an excellent point, that we as qualitative researchers struggled with not only in this paper but other qualitative manuscripts that we have submitted to journals whose word count do not provide the necessary space to fully describe the method, including the important differences between Classical (Glaserian), Straussian, and Constructivist (Charmaz) approaches to GT. To that end we have added more information about theoretical sampling, GT's criteria for rigour, and the analysis of the transcripts (as the reviewer indicated this was particularly unclear) in the methods section. We also provided greater detail about the coding process, including which members of the research team were involved in each stage. Our aim was to provide enough additional information to non-qualitative readers of BMJ Open in order to orientate them sufficiently to GT so that they could understand the study. We referenced relevant publications to direct interested readers to explore the method further according to their wishes. While submitting our manuscript to a qualitative journal that allowed for a greater description of the method was considered, we decided that it was more important to reach a broader audience and in doing so, hopefully highlight the importance of qualitative methods in the process. In short, we now feel that we provided as much of the essential information we could in light of the readership and restrictions of the journal. We have corrected and clarified this sentence We also have provided greater clarity in the previous section about the purpose of selective coding.
p13-line 6 It is not very common to refer to a quantitative term such as a	Core variable is the language of GT that is directly from Strauss and Glaser (Discovery of Grounded Theory, 1967) that explains

core variable when using qualitative research methods. Please use qualitative semantics such as themes or categories of definition. line 6-18. Also the 'core variable'' described seems to me a definition of compassion. However a (another?) definition is given in the same paragraph consisting of just a slightly different phrase and addition of some aspects. What is the difference? and why would one need two statements describing the phenomenon under study (compassion) that are so close to one another? Next to that, in what way is the definition composed of the themes or key dimensions that emerged in analysis, how did the researchers arrive to this definition? What steps in content analysis and according to GT, or was it thematic analysis?, were made? Please explain in more detail and choose one definition of the phenomenon under study.	participants main concerns with as much variation as possible. You may also be familiar with Holton's 'Grounded Theory as a Research Methodology, Grounded Theory Review, 2008 where the concept and centrality of the core variable to GT is covered in detail. As such, we feel this term is methodologically congruent and is an accurate reflection of what we were trying to get at. The core variable emerged from the data (identified in Axial Coding) itself and explains core phenomena of interest and how the categories relate to one another. After data analysis was completed (Open, Axial and Selective Coding) the core variable and the theoretical model was vetted through Stage 3 participants. We then honed the core variable into a definition of compassion that provides more detail and is presented in a more concise, linear and flowing manner. We delineated in the manuscript that one is core variable and the other is a definition that was generated after the core variable was identified and further verified by Stage 3 participants which we describe in the data analysis section.
p13-line 28-40. It is not clear to what kind of internal processes participants refer, a response based in virtues does not necessarily consists of an internal process. If there is a process that serve as a catalyst, then how does this process look like? The way this paragraph is described makes it incomprehensible for readers what participants shared. It also raises questions on how this category or dimension emerged from the data. Citations give do not illustrate what is been said in the text. There's a lot of information to capture within just a few lines, which leaves a lot of questions. For example when compassion is conceptualized as a multi-dimensional construct, what is meant to be said, does this refer	Thank you for your comments which we have incorporated into the manuscript which we believe have made our manuscript clearer. While we have tried to address as many of your concerns here as possible, we also took into consideration the comments of other Reviewers who did not raise these concerns or even felt the opposite. In order to make the manuscript more readable, we have removed unnecessary and confusing wording (internal process, motivator/medium, catalyst/conduit) from this section as we agree it was unnecessarily wordy and vague. We have also provided greater detail about what precisely this category is about vs. relying on vague terminology that leaves it to readers to weed through and interpret in a multitude of ways. In doing so we feel that it now is not only clearer but the connection between the quotes and the description of the category is more congruent.

to the dimensions that yet are to be presented? And in what way are behaviours and skills associated to the construct or personal qualities? Which behaviors and skills are we talking about? It is very confusing for readers. Semantic terms are confusing as well; for one and the same word more than one term is used; f.e. catalyst and medium; category and dimension; qualities and virtues etc. This affects consistency and readability, please use one and the same term throughout the manuscript when referring to something. Line 57. Are personal qualities virtues? Is seems to me that a virtue is something very general for human beings not something personal. Again semantics that are confusing. Also, how do the virtues mentioned relate to compassion, which as a phenomenon is also considered to be a virtue in itself (f.e. by Aristotle and also contemporary philosophers and scientists such as Martha Nussbaum.)	In terms of the multidimensional construct, we have clarified this sentence to better reflect that we were referring to the model that ultimately emerged from the study, parleying this back to this category in order to demonstrate how this category related to the entire model which is an important aspect of grounded theory vs. thematic analysis which is not concerned with the relationship between themes per se. We have edited the manuscript to assure consistency in terminology throughout the manuscript. While we have been diligent in using the language of categories and themes in in the results section in order to be consistent with GT we adopted the language of 'dimensions' in the discussion section as this is what essentially the finalized categories of compassion are, and this also allowed us to be consistent with the terminology of other researchers who utilize the language of dimensions. We also removed the term 'domain' as this was also used interchangeably with dimensions in our initial submission. We feel that participants' conceptualization of virtues as a personal quality is supported by the Oxford dictionary which defines virtues as "a *quality* considered morally good or desirable in *a person*' Scholars have opined on the nature of virtues for millennia. This is far beyond the scope of our research. We agree that scholars have considered compassion a virtue in its own right, and acknowledge this in the Background section of the article and take this up further in the Discussion section. Here in the Results section however, we were focused on presenting data generated from our study integrating the views of others contained within the background section with our findings in the discussion section.
p14-line 3. Routine care and sympathy and empathy are mentioned as being other expressions of care. They seem to me quite different in nature, routine care being something quite different while empathy	We have modified this sentence to make clear this important distinction.

and sympathy are more close to compassion. These expressions need more explanation in why and how they differ from compassion. Line 19 I do not quite understand why it is plural in presence embodied virtues (why not embodied virtue) because it seems to me the quotes say something about compassion and not about other or more virtues. It also is a contradiction, presence being one thing/quality/dimension? and virtues the same virtues as in personal qualities? The difference between personal qualities and presence: embodied virtues is not becoming clear enough p51 and further The intentional component of compassion (which can be recognized in a lot of other literature on compassion) is described beautifully, one thing that does not become clear however is why and how intention is linked to presence.	We have modified this section in order to convey the results in a more cogent manner and to better reflect the exemplary quotes which are referring specifically to the role that virtues play in caring for a patient, building on the previous theme which describes them as motivators but doesn't necessarily say how these qualities actually relate to practice. This is one of the strengths of grounded theory: it is concerned with a social process (i.e. how compassion flows or how the categories relate to one another) not simply a descriptive (ethnography), interpretive (hermeneutics) or thematic account labelling the key ingredients. We have added a second sentence to the Data Analysis section to provide further detail regarding this. We have added a clarifying sentence in this section linking presence (embodied virtues) to intention.
p16-line 30-31 Seeing the patient as a person is being described as one of the aspects within the description of the dimension coming to know the person, next to accepting the person and engaging the patient in a sensitive matter. Does this title/description of the dimension covers all aspects sufficiently? It seems to me semantically the description is missing the aspect of acceptance. p17-line 36 and further. Within the dimension Accepting The Person Where They Are At, some very compelling but also intense narratives are used to	We have added the term 'see' to the description of the category of 'coming to know the person'. In terms of the Reviewers comment about the absence of acceptance, we assume that the Reviewer was meaning the absence of 'seeing' which is in line with their previous comments, as acceptance is explicitly mentioned in the description.

illustrate this particular dimension of acceptance within compassion. I find it surprising that these narratives are mentioned specifically within this dimension; aren't their narratives within the data that would fit other dimensions as well? It seems unbalanced.	We struggled as a group of authors to understand this comment as we were unsure whether the Reviewer felt that the narratives in this section could have equally been attributed to another theme or if they felt that there were other narratives in the data, not currently mentioned in this section, that would better illustrate this theme. By way of a general response, these narratives emerged from our analysis process outlined in the Methods section, which was in congruence with Straussian GT whereby we individually coded manuscripts (including the quotes in this section), coded them collectively as a group, and coded them again through Axial coding—as such we feel this and the coding of the quotes in this section were generated from the data and were assigned to this theme after debate and reaching consensus as group. In regards to the former interpretation (that the narratives could have easily been attributed to another theme) specifically, we agree, that when it comes to dynamic, experientially and relationally based, multi-dimensional constructs such as compassion, it is difficult to delineate where one category begins and another ends as many of the quotes relate to other categories or dimensions. In part this is why we choose GT as a method, because it focuses on a social process and how the dimensions of the theory related (and in some instances overlap) with other categories. In terms of our second interpretation (that additional narratives that that better reflect the themes need to be selected from the transcripts), again, we chose the most salient quotes to substantiate this section through the analysis process outlined above which involved multiple coders and included independent analysis. Additionally, in developing the manuscripts, we were diligent and had lengthy deliberations about which quotes best illustrated the theme or category, resulting in the group of authors choosing the quotes herein as a result. Perhaps most importantly, we cannot think of a more powerful set of individuals (a holocaust soldier, a sex worker, or a flagrantly difficult patient) that better illustrate the role and power of acceptance as it relates to compassion.
p18 One could argue that some dimensions have a lot of overlapping aspects and are not mutually exclusive or at least not distinct from each other. This can be said of Relational Space and Forging a Healing Alliance. What would be the difference exactly, it does not become clear in the descriptions or through citations. Also presence is again an aspect as it is in the first	Yes, we acknowledge that there is some overlap between dimensions which is to be expected in a GT study which is focused on process, flow, conditions/consequences, etc., related to a dynamic and complex phenomena (compassion). We have provided more detail about this feature of GT, which is particularly true of the category of 'Relational Space' which wasn't a mutually exclusive category, as the three categories of 'Forging a Healing Alliance'; 'Coming to Know a Person' and 'Ameliorating Suffering' are subsumed/nested within it. We have also clarified this within the description of the category of relational space.

dimension as well in 2 other aspects (Presence: Embodied virtues and Intention: embodied presence). When all 3 ''forms'' of presence indicate specific behaviour or a specific aspect it should be made very clear what the differences are in meaning or concrete behaviour of the nurse.	In terms of presence, we indicate in the 'Coming to Know the Person' that unlike the first use of presence, which was about the HCPs presence, we are now describing how HCPs came to know the person by attuning to *the patients'* presence, depicting a sequential flow from internal features of compassion within HCPS (qualities, feelings of love, kindness, etc..) to how these intersect with the patient's presence in clinical care.
p18 line 46. Relational communication again overlap with for relational space? Please indicate the differences in significance of these dimensions as well as for therapeutic relationship and in depth understanding of the person with other aspects/dimensions. Is it possible that these dimensions can or should be understood from the viewpoint of one specific part of the construct of compassion such as the volitional, rational, affective, behavioural part? This would probably make more sense to a reader if these were overarching perspectives in which the different dimensions and aspects are to be understood and diversified. Some of this clarification is given at line 15-20 at page 20 but it would be very helpful if this kind of information on how to understand the dimensions was given at the beginning of the result section.	In terms of the query about overlap, please see our comments above as this an expected feature of GT studies vs other forms of qualitative research. We have added a clarifying sentence to the description of 'Forging a Healing Alliance' to better illustrate that yes, in fact these 'dimensions' (or themes) are a part of a specific part (or category/domain) of the model—the category of 'Forging a Healing Alliance'. We hope that this makes it clearer to the reader.
p20-line30 This citation expresses a pitfall of compassion in which projection is involved; I would say it does not refer to in-depth understanding of the person that much, but much more to a form of empathy and strategy of the nurse in which she understands herself and is able to reflect and think about what it really means to 'set oneself asides' and take the perspective of the other person.	

	We respectfully disagree that trying to feel with the patient and HCPs putting themselves in the patient's shoes is a pitfall of compassion. More importantly this was not a sentiment that was derived from our data which is the focus of the Result section. We do agree however, that compassion shares with empathy the ability to 'feel with' another person which we described earlier (and refer the reader back to in this section) in the description of the theme 'Intention'. Here participants made an important distinction between the shared feature (shared by both empathy and compassion) of emotional resonance/feeling with in relation to compassion where it functions as a starting point to a more evolved process of 'feeling for' and really understanding what the patient needs, not what HCPs think they need. We have taken a careful and thoughtful look at this section and feel that this is as clear as we can make it. In regards to projection, while this is different than emotional resonance, we have provided greater detail about how participants spoke about guarding against projection and transference by modifying the 'Intention' section where this topic was situated according to study participants.
p20 line 36 This dimension (ameliorating suffering) seems to me the behavioural aspect of compassion. line 33-53. A lot of citations within the whole results section are clustered, f.e. these 4 citations. Although citations are helping and illustrative for the reader in order to understand what a dimension comprehends, it is a lot to take in 3 or 4 quotes at once. I would advise to position every citation immediately after the text to which a citation is illustrative. This implies more clarification in the text and more careful consideration in choosing which citation is most relevant to what you want to illustrate.	Yes, this is correct. Yes, we wrestled with how to best present the quotes, including having them more embedded and dispersed within our description. We ultimately decided to present them in the fashion we did because in our experience, while an embedded approach has its strengths it can often feel disjointed versus being a part of a collective whole. Additionally, in our previous publications this format of presenting qualitative data within mainstream healthcare journals has been preferred by journal editors (including some who have required us to include all quotes as an appended table which we don't prefer), including BMJ Open (Sinclair et al. 2015. Patient and healthcare perspectives of the importance and efficacy of addressing issues in an interdisciplinary bone marrow transplant clinic: a qualitative study. *BMJ Open*, 5:1-10).
P 23- line 8-15. The model	We feel that the modifications we have made in response to the

referred to did not became fully clear in the Result section. The concepts of the model were described but no overview of the complete model, nor an explanation or further clarification is given. Especially clarification of the relations between concepts, overlap, coherence etc. is necessary in order to understand what the value of the model is. The illustration of the model in figure 2 is not that helpful in revealing relations or significance of the model. Also, claims made in this paragraph, that it addresses theory as well as serve as a pragmatic tool, are not elaborated as well, so please enlighten how theory is addressed and how the model can be seen/used as a pragmatic tool. Line 29-41. Very long sentence, and therefore incomprehensable. The remark that there is oscillation in reality seems to me very important but then again how does this oscillation happen and what is the significance? The example given in line 48 and further makes a start to explain this but also does not clarify what alternative pathways are meant.	Reviewer's previous queries about overlap and the relationship/flow between categories has addressed these concerns and improved the manuscript considerably. While Figure 2 is first presented to the reader at the beginning of the Results section so they can refer to it in reading the categories and themes that follow, we did not provide a thorough overview of the model at this juncture as we felt it could be misread by readers that the model was superimposed on the themes/categories that followed. We also did not feel that this is congruent with GT methodology which was birthed in response to sociological research in the 60's that superimposed grand theories onto cultural studies. In fact, Glaser and Strauss, stressed the importance of researchers holding their theoretical assumptions about their study data at bay and not interpreting or assuming the theoretical model to quickly but to let the data generate it (i.e. theory that is grounded in the data). Finally, we felt that presenting a description of the model at the outset was also incongruent with our process of data analysis (open, axial, selective), as the model and core variable were only developed (Methods section) after all data had been analyzed (i.e. the Results section). Thus it is our view that presenting a more fulsome discussion of the model in the Discussion section is better situated after a description of the 'parts (categories/themes) in the results section. We do agree that a greater explanation of what is meant by 'a pragmatic tool' and 'addresses a theory-practice gap' is needed and have provided this in the discussion section (particularly paragraphs 2,3 and the last paragraph) We re-wrote this paragraph. We also removed the reference to alternate pathways as we felt it represented another 'double-barreled' sentence on our part. We instead, address this point (not using the ambiguous language of pathways) in the revised 2nd paragraph of the discussion section.
p24 line 32-41. Also a very important notion that compassion has/consists of 'an intentional, discerning and targeted modality. Nevertheless other research and theories have made these claims as well, therefore these results should be compared with other work and literature. The idea that compassion can be seen as a form of personalized healthcare should also be	In addition to interfacing with van der Cingel's multidimensional understanding of compassion in the revised 2nd paragraph of the discussion we have also cited this work in the specified section, along with Joan Halifax's work (5th paragraph of the discussion section). In terms of the idea that compassion can be seen as a form of 'personalized healthcare' we are unaware of anyone who has linked these two notions together and therefore do not have any

elaborated on, in what model of personalized care or person centred care does the concept of compassion and specifically this model fit?	references for this, which is why we qualified this statement with the word 'suggest'. We are trying to spur further thought from readers (researchers, clinicians, policy makers) in this day and age of 'personalized medicine' (which is really about 'genetic medicine' and not the person) that perhaps we need to begin a new discourse about 'personalized healthcare' (borrowing their terminology) that puts the person front and center again (and not simply their genomes) with compassion being the vehicle.
Line 48-53. The distinction to empathy and sympathy should be explained much earlier in the manuscript, also this is one of more aspects of the differences between these concepts. The reader might want to have a better understanding of these related concepts.	We agree that the differences between sympathy, empathy and compassion are important but we simply do not feel that we have the space (word limit) to delve into these topics in greater detail. In the same way that we felt we had to be strategic and parsimonious about which aspects of GT to share with readers, we felt that embarking into a comparison and contrast between sympathy, empathy and compassion wasn't feasible and might detract from the prime focus of this paper which is the construct of compassion and its various dimensions specifically. What we have done is provide the interested reader with references to articles that are dedicated to comparing and contrasting these concepts specifically.
p25 lines 25-37. This paragraph suggests that this study does what I believe is missing as mentioned above; I do not see in what way the study results enlighten us on the relation between empathy and compassion… what does the '' higher, more sustainable states of 'feeling for' and 'doing for', in contrast to empathy where it functions as an endpoint' really means, what does that say about the nature of both concepts and how is this to be deducted from the results in the study?	We have removed these sentences based on our response to the reviewers related concern above as they are correct- as while study participants did make reference to empathy in discussing aspects of compassion (ex. Virtues) they were not asked for their perspectives on this directly.
line39. See other comments on the idea of virtues. This claim seems too presumptuous as well; Aristotle already saw compassion as a virtue in itself, as have a lot of others. Why should we be surprised about the recognition of the idea of virtues as primary motivation to compassionate behaviour? Also, what virtues are we talking about and how do they relate to compassion as compassion is not a virtue in itself? (on which claim I would like to see argumentation.	As per our previous comments about compassion being considered a virtue (by Aristotle and others) we feel that we have addressed and clarified this concern, in both the Background and Discussion section where we acknowledge that others have conceptualized compassion as a virtue in and of itself. Our results, as reflected in this section of the manuscript (line 39), are different in that compassion was never identified by study
Line 50-51 Very interesting to see compassion as a process of self/provider congruence, needs elaboration, see also my description of compassion being a response	

which explores the same idea on how compassion should meander with the patient's process of mourning	participants as a virtue in its own right (see Virtues theme) but rather the embodiment of a range of virtues (in relation to addressing the suffering of another individual, which we feel this sentence accurately describes. We have added a greater explanation of self/provider congruence within the two additional paragraphs that now follow this sentence/introduction of this concept.
Strengths and limitations; good points to mention; what did you do to limitate them? I would think interreliability of the analysis and researchers involved is therefore of importance, please explain if and how this was done in order to improve validity and reliability. Please give tangible recommendations, it is not enough to simply claim the model is a tool for practice if there is not an explanation on how to use it exactly. In what way can 'the requisite skills, behaviours, and qualities' be cultivated for example; this should at least be explained.	Thank you for your comments regarding the strength/limitations of this section, which are in keeping with those of other Reviewers. As a result of these comments we have modified the strength/limitations section in its entirety which we believe now addresses your concerns, while also providing more detail about the clinical utility of the model in the discussion section.
The conclusion that compassion is uniquely expresses by each professional comes as a surprise, especially because the discussion section mentions cultivating skills behaviours and qualities which implies that these can be recognised and thus are of a more general nature. So instead of making this a contradiction, please enlighten how this can be understood	Thank you for this final point (and thanks again for the comprehensive review). We have added sentences in the Discussion which weave together the individual nature of each health care provider while considering what knowledge, skills, behaviors and qualities might be teachable.
Reviewer #4	
Background was very well written. You have built a strong argument for the need for this	Thank you.

study and provided relevant supporting information.	
Background line #15 "HCPs" should be possessive, please address this.	Corrected.
Background paragraph 2 was a bit difficult to read due to inclusion of so much information in list form. Perhaps there is a way to restructure this to make it flow a bit better. All examples, were, however, very well supported.	We agree and have revamped this paragraph significantly because of this issue.
When and how was consent obtained?	We added a sentence describing this in greater detail (3rd last sentence of the Study Population section).
Study population. I appreciated that you included many ancillary staff members in the study because they are imperative members of our teams and often overlooked in research; however, in your background and abstract you spoke to front line and direct healthcare providers. Would you consider housekeepers or unit clerks, for example, to be front like or direct healthcare providers? It would be useful to address this in your discussion.	See below (three boxes below this one)
Data collection, line 8. Were there 35 HCPs who all participated in seven focus groups (i.e. did participants return for focus groups seven times), or were there a total of 35 participants in seven focus groups? This wasn't clear.	We added further clarification in the 2nd sentence of the Data Collection section indicating that individual participants were able to attend only one of the focus groups.
I would like to have seen more discussion related to the early	We have added a sentence to the background regarding the

conceptual definitions of compassion that the authors reference throughout the paper, to see more specifically how their findings both compare and contrast with the assumed definitions/conceptualizations used in the past.	importance of definitions and have added a more fulsome discussion about conceptualizations of compassion in the 2 and 3 paragraphs of the Discussion section which provides greater details about how other researchers have defined compassion.
Additionally, the inclusion of ancillary staff in the sample was a nice insight. However, as I mentioned previously in the comments, if unit clerks and housekeepers are not considered front line providers (and perhaps the authors consider them to be, and this should also be addressed), how does their experience of compassion compare to that of healthcare providers? It seems these roles may be drastically different from the bedside HCPs, so perhaps there were some differences in how each experienced compassion?	Thank you for this follow up point to your previous point about study population. In terms of the contrasting views while the specific examples of compassion were shaped by individual's role within the healthcare team, there was congruence among participants to the overarching categories and themes of the model. This is in part reflective of the description of broad categories of compassion rather than providing granular behaviours of individual HCPs or individual codes—As a result while we feel the categories and themes of the model provide much needed specificity regarding the specific domains of compassion, we believe they are flexible and transferable to various roles within the team.
The authors may consider how this conceptualization of compassion relates to work on compassion fatigue, and how this improved understanding of compassion itself will help researchers and clinicians understand the "cost of caring."	We recently published a review on the compassion fatigue literature. The current study generated considerable data on HCPs' perspectives on what impedes compassion (Question #4 in the Interview guide) and other perceived facilitators and barriers to compassion. We will be present this in a manuscript in the near future.
Overall, I believe this will be an excellent addition to our understanding of compassion with a few minor revisions. It was a brilliant use of grounded theory (which was explained beautifully and concisely in the methods for those unfamiliar with qualitative methods). I thank you for the opportunity to review this work, and look	Thank you for sharing these thoughts, particularly your comments about the description of the methodology and its fit with the study. We agree and are glad that you found it to be the ideal approach as well.

forward to seeing it in revisions and publication.	
Editorial Comments	
Please revise your title to state the research question, study design, and setting (location). This is the preferred format for the journal.	Done
Please provide specific page numbers for each item in the COREQ checklist.	We have indicated this on the amended COREQ checklist

VERSION 3 – REVIEW

REVIEWER	Nathan S. Consedine University of Auckland, New Zealand
REVIEW RETURNED	01-Feb-2018

GENERAL COMMENTS	Thursday, February 1, 208 bmjopen-2017-019701.R2 – The healthcare provider compassion model: a grounded theory study. Revised manuscript submitted to: BMJ Open The revised report again shows considerable improvement over the initial submission. The authors have clearly paid attention to the issues raised in the second round of reviews and either (a) adapted the submission accordingly and/or (b) provided a rationale as to why changes are not needed. As previously, the work remains important, and supplementing a priori theoretical positions on compassion in health with contextual content that reflects the experience/meaning of compassion among PCPs remains important. The authors have responded comprehensively to the concern expressed in earlier reviews regarding the treatment of data from a palliative care environment as suited to informing a "general" model. While I am not entirely convinced that the participating clinicians having a broad range of prior clinical experience substantively changes the generalizability issues (i.e., presumably they "ended up" in palliative care for self-selecting reasons), the fact that patients with a range of conditions were being treated is important. The fact that the relief of suffering is explicit in the mandate for clinicians working in the palliative care environment may or may not suggest that a sample of HCPs from this context are suited to informing a general model. In any case, the authors' have done what can be done to acknowledge these issues and the submission remains a timely and important contribution to research in an underdeveloped area. The

	work is well presented and comprehensive and will be an important resource as research into compassion in health moves forward.