PEER REVIEW HISTORY

This paper was submitted to a another journal from BMJ but declined for publication following peer review. The authors addressed the reviewers' comments and submitted the revised paper to BMJ Open. The paper was subsequently accepted for publication at BMJ Open.

(This paper received three reviews from its previous journal but only two reviewers agreed to published their review.)

ARTICLE DETAILS

TITLE (PROVISIONAL)	Experiences with approaches to advance care planning with older people: a qualitative study among Dutch general practitioners.
AUTHORS	Glaudemans, Jolien Jeltje; Moll van Charante, Eric; Wind, Jan; Oosterink, John Jacob; Willems, Dick Ludolf

VERSION 1 – REVIEW

REVIEWER	Phyllis Butow University of Sydney Australia
REVIEW RETURNED	06-Jul-2018

GENERAL COMMENTS	This is an interesting paper on the views of Dutch GPs regarding advance care planning (ACP) in primary practice, identifying both systematic and adhoc approaches to ACP. Nineteen GPs were purposively selected for diversity, and theoretical saturation was reached. This is a particularly important topic in Holland, where euthanasia is available; indeed, I felt there was a lost opportunity to explore how euthenasia is addressed in more detail. The study is novel, in that the views of GPs have rarely been explored before on this topic, with most studies focusing on oncology or palliative care settings. One criticism is a rather uncritical acceptance of ACP as positive, without good evidence. Overall, the paper was well-written with some minor English issues (outlined below). Methodologically, more information is needed on the theoretical basis for analysis, how rigor was ensured, and use of reflexivity (especially as 4 authors are GPs, who appear to be motivated towards ACP). Results will be shared with participants on publication of the study. Why not share them before to obtain feedback? Adhoc approaches are regarded as equal to systematic approaches in this paper, yet may have some downsides, including leaving such discussions too late, having many older people miss out on these discussions, and not covering all relevant issues. Perhaps the authors should comment on the dangers of using this approach exclusively, rather than in combination with systematic approaches.

	Barriers and facilitators to ACP discussion were outlined, which were expected and not novel. Nevertheless, the Discussion and Conclusions drew this material together well. Grammatical issues requiring review are presented below: Abstract Meetings were not only aimed at making agreements in anticipation on future care (of future care) but also at providing information and encouraging patients to take further steps in ACP. (change patients to older people) Due to a lack of time for and knowledge of other occasions and topics that the ones respondents used, respondents seemed to underuse other appropriate occasions and topics. (This sentence does not make sense). Introduction Although the form and precise effects of ACP in daily practice are subject of discussion, (add 'the' before subject) knowledge on occasions and topics for ACP with older people in general is lacking (knowledge of – this is an error throughout that needs to be corrected. Also we screen for, not on, we ask about preferences for, not on) (Also, occasions and topic for ACP is an odd phrase. Perhaps occasions suitable for ACP and topics appropriate to cover? – throughout the paper) METHODS added a topic concerning how respondents either knew or did not know what choice to make in acute situations. (Can you clarify what choice this was?) RESULTS NB with two types of occasions, would normally be referred to as "both" not all. When respondents systematically approached ACP they discussed the same combination of topics with older patients they invited for planned occasions for ACP. (what is the difference between systematically approached and planned occasions?) Systematic approached ACP (should be Systematically approached ACP) Respondents had negative experiences when they explained many scenarios in details, (should be detail, not details) All respondents had experience initiating and following up on ACP ad-hoc, which took place during routine care and during planned occasions. (again not sure what these planned occasions are? How can it be adhoc if planned?)

	Examples of patients they felt were likely to deteriorate in the near future were older patients who needed help for everyday activities or need medical devices, (should be needed medical devices) as well as which topics they though were worth discussing at all. (though should be thought) Discussion For both clinical practice and research, …if not only aimed at anticipating on acute situations (remove the 'on' before acute)

REVIEWER	Aline De Vleminck Vrije Universiteit Brussel (VUB), Belgium
REVIEW RETURNED	18-Jul-2018

GENERAL COMMENTS	Major comment: You state in the introduction that occasions and topics for ACP in the literature are very focused on care at the EOL (p7 lines 6-7). How are the topics from your results different than what found in the literature? It seems to me that they are also very focused on EOL (decisions), especially since the patients they are having ACP conversations with are usually 75+ or 85+. For me the results found in this study regarding the topics that can be discussed are not so different from what is known in the literature. Could you reflect on this more critically or explain this better in the discussion section? Minor comments: (p11, line 23) The results state that GPs invited patients who were assessed by them or the nurses as frail or cognitively impaired. In what way are GPs engaging in ACP with patients who are cognitively impaired? And does this correspond with the definition of ACP you are giving in the introduction? I'm not sure of the title "systematic approach to ACP" is a correct formulation. It seems more like a non-acute approach. Systematic, to me, implies that there is a planned and consecutive approach to ACP, with multiple conversation etc? But it seems that often GPs have one initiation or information sessions without any follow-up conversations (due to lach of time for example). Having 1 group sessions and then not having any follow-up conversations doesn't seem like a systematic approach to ACP. (p16 line 2-4) Did the GPs reflected themselves on what they considered as underused topics and occasions? Or is this an interpretation of the authors? If the GPs reflected on this themselves, what did they consider then as underused topics/occasions? Or did these GPs considered what they were doing as sufficient? In general, did GPs reflected on what they considered as the best approach: systematic or ad-hoc for initiation and follow-up on ACP? Or did they not express clear opinions on this? Did GPs switched over from one approach to the other (for example because of negative experiences in the past)? Are there any results on the combination of both approaches? I think that would make the results more interesting. It is interesting the one of the barriers found for discussing ACP is that GPs assumed that they knew or understood what the patient want without discussing it. We know from the literature that this is a

	big misconception. I think the authors should reflect more critically on this in the Discussion section. (and related to this also that the own goals of the GP for the conversation defines what is being discussed with the patient – this is clearly not a patient-centered approach) Were there no experiences or views on having ACP with people who are 65y-75y? Because that would be interesting to present. What could be possible occasions and topics to address with them and how? There are still some Typo's throughout the manuscript. Please check and revise

VERSION 1 – AUTHOR RESPONSE

Response to reviewer 1: Phyllis Butow

General comments:
2. This is an interesting paper on the views of Dutch GPs regarding advance care planning (ACP) in primary practice, identifying both systematic and ad-hoc approaches to ACP. Nineteen GPs were purposively selected for diversity, and theoretical saturation was reached. This is a particularly important topic in Holland, where euthanasia is available; indeed, I felt there was a lost opportunity to explore how euthanasia is addressed in more detail.

We thank the reviewer for her compliments and agree that euthanasia is a very important topic in the Netherlands. Exploring and discussing how euthanasia is addressed in more detail than we have would, to our opinion, leave too little space for discussing all reported topics that are a part of ACP with older people, which was the focus of our study.

3. The study is novel, in that the views of GPs have rarely been explored before on this topic, with most studies focusing on oncology or palliative care settings. One criticism is a rather uncritical acceptance of ACP as positive, without good evidence.

We agree that a critical view on ACP was not reflected well enough in our article and rewrote part of the introduction so to include a more critical and evidence-based view on ACP.

4. Overall, the paper was well-written with some minor English issues (outlined below).

We reviewed and corrected the presented grammatical issues.

5. Methodologically, more information is needed on the theoretical basis for analysis, how rigor was ensured, and use of reflexivity (especially as 4 authors are GPs, who appear to be motivated towards ACP).

We feel that involvement of representatives of patient organizations, GPs from the Department of General Practice and members of the Ethics Section of the Amsterdam Public Health research institute, exploration of both positive and negative experiences of respondents with ACP, and the open coding and inductive analysis enhanced reflexivity and rigor of our study design, data collection and analysis. To clarify this, we emphasized it more in the materials and methods, and in the strengths and limitations.

6. Results will be shared with participants on publication of the study. Why not share them before to obtain feedback?

We intended to member check results of this study with respondents. Unfortunately, as there was a time lag between the interviews and publication, member check of the results with respondents before publication was not feasible anymore. We added this information to the article.

7. Ad-hoc approaches are regarded as equal to systematic approaches in this paper, yet may have some downsides, including leaving such discussions too late, having many older people miss out on these discussions, and not covering all relevant issues. Perhaps the authors should comment on the dangers of using this approach exclusively, rather than in combination with systematic approaches.

We agree that using ad-hoc approaches exclusively may lead to too late ACP and many older people missing out on ACP and emphasized this more in the discussion. Systematic approaches in this study, however, seemed often to be influenced by or combined with ad-hoc approaches, as the personal situation of a patient influences ACP greatly, which we emphasized in the introduction of the results. We can, however, not judge which approach is better as our study was focused on exploring different approaches to ACP with older people in primary care, and not on determining the best approach.

8. Barriers and facilitators to ACP discussion were outlined, which were expected and not novel. Nevertheless, the Discussion and Conclusions drew this material together well.

We thank the reviewer for her feedback.

Response to reviewer 2: Aline De Vleminck

Major comment:
9. You state in the introduction that occasions and topics for ACP in the literature are very focused on care at the EOL (p7 lines 6-7). How are the topics from your results different than what found in the literature? It seems to me that they are also very focused on EOL (decisions), especially since the patients they are having ACP conversations with are usually 75+ or 85+. For me the results found in this study regarding the topics that can be discussed are not so different from what is known in the literature. Could you reflect on this more critically or explain this better in the discussion section?

We agree that topics for ACP with older people show great overlap with topics in EOL discussions and described this in the discussion. However, to our knowledge, it has not been reported before that these topics are a part of ACP with older people, varying from being relatively healthy to seriously ill, in daily practice. In addition, topics such as care and the patient's wishes regarding organ donation and place of burial, have not been reported as part of EOL discussions. Thereby, the intention to encourage patients older people to take further steps in ACP has not been reported before as being a part of ACP. We also feel that the overview of different occasions for ACP with older people in daily practice shows new opportunities for ACP with older people. We hope we reported our findings more clearly by rewriting parts of the abstract, introduction and discussion, especially by describing 'approaches to ACP' instead of occasions and topics for ACP in the abstract and introduction.

Minor comments:
10. (p11, line 23) The results state that GPs invited patients who were assessed by them or the nurses as frail or cognitively impaired. In what way are GPs engaging in ACP with patients who are

cognitively impaired? And does this correspond with the definition of ACP you are giving in the introduction?

When GPs engaged in ACP with patients who are cognitively impaired by using systematic approaches they collaborated with nurses. After nurses screened for cognitive impairment GPs discussed care and place of care, often with the patient and informal caregivers. The patients that respondents reported on still had decisional capacity to discuss their preferences, which corresponds with the definition of ACP in the introduction. To clarify this, we added this information to the results.

11. I'm not sure of the title "systematic approach to ACP" is a correct formulation. It seems more like a non-acute approach. Systematic, to me, implies that there is a planned and consecutive approach to ACP, with multiple conversations etc.? But it seems that often GPs have one initiation or information sessions without any follow-up conversations (due to lack of time for example). Having 1 group sessions and then not having any follow-up conversations doesn't seem like a systematic approach to ACP.

We understand that the term 'systematic' can be understood in different ways. We choose this term as respondents approached ACP with different people in the same way by planning occasions and discussing a fixed combination of topics. We hope we described it more clearly in this version of the article. In the example of group education meetings patients were invited for individual follow-up conversations afterwards.

12. (p16 line 2-4) Did the GPs reflect themselves on what they considered as underused topics and occasions? Or is this an interpretation of the authors? If the GPs reflected on this themselves, what did they consider then as underused topics/occasions? Or did these GPs considered what they were doing as sufficient?

GPs reflected on their practice, sometimes after we asked them about their experiences of and views with other occasions and topics that the ones they used. We have clarified this in the mentioned sentence in the result section.

13. In general, did GPs reflected on what they considered as the best approach: systematic or ad-hoc for initiation and follow-up on ACP? Or did they not express clear opinions on this? Did GPs switch over from one approach to the other (for example because of negative experiences in the past)? Are there any results on the combination of both approaches? I think that would make the results more interesting.

GPs did not reflect on what they considered as the best approach but did report they felt a more systematic approach would be good but not feasible, mostly due to a lack of time. All respondents had experience with ad-hoc approaches. Therefore, respondents who reported on systematic approaches had experience with both. We reported on the two approaches separately because reporting on the combination seemed to make the categories less clear. We have reported however, in the introduction of the results that the different approaches were used simultaneously or sequentially and emphasized this more in this version of the article.

14. It is interesting the one of the barriers found for discussing ACP is that GPs assumed that they knew or understood what the patient want without discussing it. We know from the literature that this is a big misconception. I think the authors should reflect more critically on this in the Discussion section. (and related to this also that the own goals of the GP for the conversation defines what is being discussed with the patient – this is clearly not a patient-centered approach)

We agree that GPs assumptions on their knowledge of patients' preferences is an important barrier and therefor reflected more on it in the discussion section, especially in the comparison with existing literature and implications for clinical practice.

15. Were there no experiences or views on having ACP with people who are 65y-75y? Because that would be interesting to present. What could be possible occasions and topics to address with them and how?

As reported, none of the systematic approached ACP with older people took place with people aged 65-75. With the ad-hoc approaches, GPs reported on patients aged 65 and older. However, age was not used as a reason to approach ACP ad-hoc as they reported on when patients took initiative, when a patient's situation deteriorated, or if respondents felt the provided care was not appropriate. We did however clarify this and added a patients' age where we had not described it in the previous version of this article, in the results subparagraph on ad-hoc approaches.

16. There are still some typos throughout the manuscript. Please check and revise

We checked and revised the typos throughout the manuscript.

VERSION 2 – REVIEW

REVIEWER	Phyllis Butow CeMPED/ PoCoG
REVIEW RETURNED	15-Aug-2018

GENERAL COMMENTS	The authors have comprehensively addressed reviewer comments and the paper now reads very well. It provides clear and useful information about issues in ACP within primary care for older people.

REVIEWER	Aline De Vleminck Vrije Universiteit Brussel (VUB), Belgium
REVIEW RETURNED	21-Aug-2018

GENERAL COMMENTS	All comments are well addressed by the authors.