

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Understanding patients' experiences of the wish to hasten death: an updated and expanded systematic review and meta-ethnography
AUTHORS	Rodríguez-Prat, Andrea; Balaguer, Albert; Booth, Andrew; Monforte-Royo, Cristina

VERSION 1 - REVIEW

REVIEWER	Brian Kelly University of Newcastle, Australia
REVIEW RETURNED	26-Mar-2017

GENERAL COMMENTS	<p>This is a review addressing a topic of significant clinical and public interest. Of particular value is the systematic approach to synthesising qualitative findings in this field. The issue of "Wish to Hasten Death" has been the focus of a number of clinical studies, often limited in sample size, but nevertheless providing in-depth qualitative perspectives on the experiences of people with advanced and terminal illness. The strength of such studies is their exploratory nature, the insights obtained into the patient experience and capacity to inform hypothesis generation. The Wish to Hasten Death, and the questions surrounding euthanasia and assisted suicide need to be examined in robust clinical research, and this paper aims to synthesis the findings from qualitative research from a range of studies to strengthen the clinical and scientific understanding of this problem. The methods of synthesising qualitative findings across a wide range of studies is challenging and this paper provides an important step forward in this regard.</p> <p>There are some areas of clarification required:</p> <ul style="list-style-type: none"> -I could not identify a working definition of the "Wish to Hasten Death" in the text -this would be helpful given the definitional problems in this field and, as the authors state, the "fluctuating, ambivalent, subjective and complex nature of such wishes". A more detailed critical examination of how the term is defined in these previous studies would be helpful and important to interpreting the findings. -the methods used to verify/confirm thematic analysis would be of interest. While the authors report verification within the literature search strategy (eg identifying the studies), more information on the process of synthesising the qualitative findings and confirmation of themes would be helpful and necessary in my opinion. -the previous point specifically concerns some apparent ambiguity and potential inconsistency in the thematic categorisation of data (supplementary Table -S5). Some statements are categorised as indicating the theme of "pain" or the broad set of "physical factors" when the link with the content is unclear.. eg Section 1.2 <p>'Psychological Factors, reference to a quote "not much hope etc" is categorised as "progressive Physical deterioration" when the quote</p>
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	<p>refers only to patient deterioration. Also section 3.5 "No, not this moment..." is categorised under the them of Pain and Having control, when this does not seem apparent in the quote. These are only two examples, and it would be helpful to understand how decisions regarding thematic categorisation were made and verified among the authors. this issue is important as it influences the conclusions drawn regarding the salient themes.</p> <p>-teh categorisation of themes into Physical and Psychological themes is somewhat artificial and problematic given the overlap in these factors. This overlap is evident in the text and complexity of intersecting concerns within the quotes (eg loss of sense of dignity and self, loss of value etc, appearing frequently in the "Physical Factors" theme). This complexity reflects clinical experience and our understanding that perception and meaning of physical suffering are important, and the inevitable difficulty in trying to delineate physical from psychological suffering. Would it be more accurate to summarise using potentially more informative themes such as "concerns about dignity and value". Similarly the subtheme of "suffering" is applied at times but unclear why in some cases and not others - this may reflect the need to communicate more clearly with the reader the process that the authors undertook.</p> <p>-on page 10 reference is made to all studies identifying "physical factors (symptoms) were a key issue". this may need some clarification, where even in the summary data provided, the concern related to fear of future physical symptoms, rather than actual current physical symptoms</p> <p>-the authors should check that the referencing is correct - eg when referring to qualitative studies to ensure that the papers quoted are appropriate (in one instance the report cited was presenting quantitative findings from a mixed methods study..eg ref 2.)</p>
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REVIEWER	Professor David Kissane Monash University, Melbourne, Australia
REVIEW RETURNED	28-Mar-2017

GENERAL COMMENTS	<p>This is a specific focus on qualitative studies, of which 14 were identified to examine the wish to hasten death. Five themes were presented.</p> <p>The manuscript would be improved by the following:</p> <ol style="list-style-type: none"> 1. In your flowchart of study selection, show the reasons in boxes in Figure 1 for why records were excluded at screening and again at full-text review. 2. What have you missed is a crucial question? One issue that jumped out at me was shame. Shame is a prominent mediator of suicidal thinking and it was present in your material. For example P6-(24). "My face... looks like a melonI look like a frog in heat." P6-(9) "I have faecal incontinence...." Shame surely belongs as a key psychological factor and is more than a loss of dignity. Cognitive impairment is another neglected theme. 3. In the discussion, no effort is made to discuss how these qualitative findings inform and overlap with quantitative findings. One approach would be through a proper "Clinical Implications" section in the discussion. On P35, there is a totally inadequate statement, "although depression is reportedly associated with WTHD." Much more should be said about depression in a report that is full of comments about "hopelessness", "helplessness", "miserable",
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	<p>“purposeless”, “not interested at all”, “wretched”, and so on. When is depression a clinical problem? When is it missed? When does it interfere with the capacity for rational suicide?</p> <p>4. Other clinical issues to discuss beyond depression include the extensive literature on demoralization, including the recent studies showing that demoralization is a more powerful mediator of the wish to hasten death than depression. A third clinical issue is a more detailed discussion of the family under the communicative function.</p> <p>5. On P37, line 46 is a claim that the temporal aspect of WTHD is only captured in qualitative studies – not true. See Chochinov in Lancet 1996, 1999.</p> <p>There are a number of typos and grammatical errors.</p>
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VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Reviewer Name: Brian Kelly

Institution and Country: University of Newcastle, Australia

Please state any competing interests or state ‘None declared’: Nil

Please leave your comments for the authors below

This is a review addressing a topic of significant clinical and public interest. Of particular value is the systematic approach to synthesising qualitative findings in this field. The issue of "Wish to Hasten Death" has been the focus of a number of clinical studies, often limited in sample size, but nevertheless providing in-depth qualitative perspectives on the experiences of people with advanced and terminal illness. The strength of such studies is their exploratory nature, the insights obtained into the patient experience and capacity to inform hypothesis generation. The Wish to Hasten Death, and the questions surrounding euthanasia and assisted suicide need to be examined in robust clinical research, and this paper aims to synthesis the findings from qualitative research from a range of studies to strengthen the clinical and scientific understanding of this problem. The methods of synthesising qualitative findings across a wide range of studies is challenging and this paper provides an important step forward in this regard. ⇒Thank you for these remarks.

There are some areas of clarification required:

-I could not identify a working definition of the "Wish to Hasten Death" in the text -this would be helpful given the definitional problems in this field and, as the authors state, the "fluctuating, ambivalent, subjective and complex nature of such wishes". A more detailed critical examination of how the term is defined in these previous studies would be helpful and important to interpreting the findings.

⇒Thank you for this suggestion. As per your suggestion, we have included a brief description of what we consider to be the WTHD for the purpose of this study, with the aim of being as general as possible, following the criteria we used in the meta-ethnography we update here.

We decided not to mention in the introduction an operational statement on WTHD in which some members of our team worked (Balaguer et al. 2016) in order not to confuse the reader. Given that this statement did not affect the selection criteria of the studies or the subsequent analysis of the studies included.

Later on, in the discussion section, we discuss how the findings of this update are perfectly consistent with the statement we mentioned (see p. 19) almost all of which is included there.

- the methods used to verify/confirm thematic analysis would be of interest. While the authors report verification within the literature search strategy (eg identifying the studies), more information on the process of synthesising the qualitative findings and confirmation of themes would be helpful and necessary in my opinion.

⇒Done. We have added the description of the analysis and synthesis process according to Noblit and Hare's proposal (see Methods' section).

- the previous point specifically concerns some apparent ambiguity and potential inconsistency in the thematic categorisation of data (supplementary Table -S5). Some statements are categorised as indicating the theme of "pain" or the broad set of "physical factors" when the link with the content is unclear. eg Section 1.2 'Psychological Factors, reference to a quote "not much hope etc" is categorised as "progressive Physical deterioration" when the quote refers only to patient deterioration. Also section 3.5 "No, not this moment..." is categorised under the theme of Pain and Having control, when this does not seem apparent in the quote. These are only two examples, and it would be helpful to understand how decisions regarding thematic categorisation were made and verified among the authors. This issue is important as it influences the conclusions drawn regarding the salient themes.

⇒Thank you for this suggestion. In effect, many of the quotations refer to various, interlinked themes so it is difficult to make a clear distinction between some of them (i.e. it is not possible to clearly distinguish between suffering and pain or other physical and psychological factors). In accordance with your comment, we have added a paragraph that develops this idea in the discussion section (See page 22, second paragraph).

In additions, two researchers from our team (ARP & CMR) have reviewed the quotations in Table S5, independently and have tried to be more precise in the classification (See Table-S5). We have also substituted the title 'related themes' for 'some of the related themes' in the third column of the table as there are other themes that we have not added. Lastly, it is worth pointing out that the quotations have been categorised taking into account the initial analysis of original authors and their descriptions in the original studies.

- the categorisation of themes into Physical and Psychological themes is somewhat artificial and problematic given the overlap in these factors. This overlap is evident in the text and complexity of intersecting concerns within the quotes (eg loss of sense of dignity and self, loss of value etc, appearing frequently in the "Physical Factors" theme). This complexity reflects clinical experience and our understanding that perception and meaning of physical suffering are important, and the inevitable difficulty in trying to delineate physical from psychological suffering. Would it be more accurate to summarise using potentially more informative themes such as "concerns about dignity and value".

⇒We totally agree. We agree that the separation of physical and psychological themes is somewhat artificial, in the sense that physical illness cannot be separated from the experience of illness. These factors were treated independently in order to be able to analyse them in more depth. However, in the discussion that we have tried to explore in more depth how these factors are inseparable.

On the other hand, we agree that the theme "concerns about dignity and value" is present in more quotations. Bearing in mind your feedback, we have reanalysed the quotations and highlighted in Table S5 (Some of the related themes) the presence of the loss of the sense of dignity, loss of value, etc. when they were potentially present.

Similarly the subtheme of "suffering" is applied at times but unclear why in some cases and not others - this may reflect the need to communicate more clearly with the reader the process that the authors undertook.

⇒In the case of suffering, we have tried to express that it was categorised as the overarching theme,

we identify it in all of the quotations (also bearing in mind the analysis by the authors of the original studies) It reflected physical, psychological, existential social (...) suffering. First, we categorised suffering as another theme. However, when we read and reread the quotations we realised that this theme is transversal and the other themes cannot be understood without the experience of suffering.

-on page 10 reference is made to all studies identifying "physical factors (symptoms) were a key issue". This may need some clarification, where even in the summary data provided, the concern related to fear of future physical symptoms, rather than actual current physical symptoms

⇒Here we can see again the overlap between physical and psychological aspects. .We have added this nuance into the discussion section (see pages 22-23, in marked copy manuscript).

-the authors should check that the referencing is correct - eg when referring to qualitative studies to ensure that the papers quoted are appropriate (in one instance the report cited was presenting quantitative findings from a mixed methods study. eg ref 2.)

⇒Thank you for this suggestion. We have revised the references and corrected the error. We apologise for this error.

Reviewer: 2

Reviewer Name: Professor David Kissane

Institution and Country: Monash University, Melbourne, Australia

Please state any competing interests or state 'None declared': 'None declared'

Please leave your comments for the authors below

This is a specific focus on qualitative studies, of which 14 were identified to examine the wish to hasten death. Five themes were presented.

The manuscript would be improved by the following:

1. In your flowchart of study selection, show the reasons in boxes in Figure 1 for why records were excluded at screening and again at full-text review.

⇒Done. We have modified Figure 1 describing the reasons why the studies were excluded.

2. What have you missed is a crucial question? One issue that jumped out at me was shame. Shame is a prominent mediator of suicidal thinking and it was present in your material. For example P6-(24). "My face... looks like a melonI look like a frog in heat." P6-(9) "I have faecal incontinence...." Shame surely belongs as a key psychological factor and is more than a loss of dignity. Cognitive impairment is another neglected theme.

⇒ Thank you for this interesting suggestion. We agree with your comment. Initially it was not explicitly included. However, following your comment, we have added a paragraph in the discussion to discuss the concept of dignity in more dept. We have added some ideas that would include the notion of shame (i.e. loss of image, loss of self...). After a reanalysis of the quotations, we have incorporated the concept of shame in Table S5 ("some of the related themes").

As for "cognitive impairment", despite the fact that in the literature about dignity, it has been seen as an important factor, it only emerged in our analysis in two quotations: in one, in a hypothetical way and in the other as a foreseen situation. Nevertheless, we have added this theme to "other related

themes” (see Table S5) and we have explained in the discussion that the loss of the sense of dignity can be affected by cognitive impairment, or fear of suffering from it.

3. In the discussion, no effort is made to discuss how these qualitative findings inform and overlap with quantitative findings. One approach would be through a proper “Clinical Implications” section in the discussion.

⇒Thank you for the suggestion. We have added a paragraph to address this point in more depth (See pages 26 and 27, in marked copy manuscript).

On P35, there is a totally inadequate statement, “although depression is reportedly associated with WTHD.” Much more should be said about depression in a report that is full of comments about “hopelessness”, “helplessness”, “miserable”, “purposeless”, “not interested at all”, “wretched”, and so on. When is depression a clinical problem? When is it missed? When does it interfere with the capacity for rational suicide?

⇒We completely agree with your comment. Clinical depression is a key element to bear in mind for any person who expresses the WTHD. We have tried to address in more depth the fact that depression has been linked to the WTHD and suicidal ideation (See discussion section, page 21 and 22 in marked copy manuscript). With the statement “only three of the 14 included studies referred to the need to address depression” we wanted to highlight that, in the studies in this synthesis, only 3 mention the need to address depression in these patients explicitly in the discussion or implications for clinical practice.

4. Other clinical issues to discuss beyond depression include the extensive literature on demoralization, including the recent studies showing that demoralization is a more powerful mediator of the wish to hasten death than depression.

⇒We agree with your comment. We have added a paragraph linking the WTHD to demoralisation in these patients. (See discussion section, page 22, in marked copy manuscript).

A third clinical issue is a more detailed discussion of the family under the communicative function.

⇒Thank you for your suggestion. We have now discussed this issue in more detail (See discussion section, page 24, in marked copy manuscript).

5. On P37, line 46 is a claim that the temporal aspect of WTHD is only captured in qualitative studies – not true. See Chochinov in Lancet 1996, 1999.

⇒We agree with your comment, we have modified this erroneous sentence and referenced the studies that you mention (see page 25, second paragraph).

There are a number of typos and grammatical errors.

⇒We have reviewed the manuscript carefully and corrected these errors.

VERSION 2 – REVIEW

REVIEWER	Brian Kelly University of Newcastle
REVIEW RETURNED	28-May-2017

GENERAL COMMENTS	The manuscript has been strengthened particularly through expansion of the discussion to integrate findings with the existing published research findings (specifically quantitative studies and research addressing depression and WTHD).
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	<p>A number of identified gaps have been addressed.</p> <p>Nevertheless, it would remain helpful to improve the clarity of the paper, to address some issues</p> <p>1. to include in the text the key terms used in the search (rather than in the supplementary table). The reason for this lies in the importance of being clear to the reader the definition being used and related scope of the search. While the authors have provided a more clear definition of WTHD, it is important for the reader to see clearly how this was reflected in the search itself.</p> <p>2. The issue regarding adequacy of categorisation (eg into physical, social and psychological factors) remains, and although this is acknowledged by the authors, it is a point that bears being strengthened in the limitations section. When reviewing the text of responses it is clear that such a categorisation can sometimes underestimate the interwoven nature of these themes.</p> <p>3. The point above becomes particularly important in addressing the clinical implications of the findings. The paper would be strengthened considerably by drawing out how the findings can inform clinical response to the WTHD and ways in which care at end of life can be improved. The findings provide a number of important indicators for ways to improve the health care for patients at end of life - the focus on understanding the source of suffering, issue of dignity (and potential application of steps to enhance the experience of dignity as described in the work by Chochinov and others) or therapeutic steps to address demoralisation; and the importance of clinicians appreciated the role of the meaning of physical symptoms and physical suffering, and the role of attention to family factors/ social context as another example (including available strategies to guide clinicians in caring for families of dying patients). In line with this, is the need I believe, to further strengthen the focus on how these findings align with the quantitative findings regarding depression and WTHD. the qualitative data provides a detailed account of the common symptoms and features of depression (hopelessness, helplessness, loss of self esteem and related sense of burden to others) - this has important clinical implications in regards to the importance of identification/assessment and effective treatment of depression in this setting. The findings in this respect appear to complement the quantitative findings regarding depression and its link to WTHD from studies identified in the discussion, and hence the clinical implications of this could be drawn out more clearly (eg manifestations of depression and demoralisation that clinicians need to be alert to).</p>
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VERSION 2 – AUTHOR RESPONSE

Reviewer: 1

Reviewer Name: Brian Kelly

Institution and Country: University of Newcastle

Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below

The manuscript has been strengthened particularly through expansion of the discussion to integrate findings with the existing published research findings (specifically quantitative studies and research

addressing depression and WTHD).

\Thank you very much for your feedback.

A number of identified gaps have been addressed.

Nevertheless, it would remain helpful to improve the clarity of the paper, to address some issues

1. to include in the text the key terms used in the search (rather than in the supplementary table). The reason for this lies in the importance of being clear to the reader the definition being used and related scope of the search. While the authors have provided a more clear definition of WTHD, it is important for the reader to see clearly how this was reflected in the search itself.

\Done. Thank you for the suggestion.

2. The issue regarding adequacy of categorisation (eg into physical, social and psychological factors) remains, and although this is acknowledged by the authors, it is a point that bears being strengthened in the limitations section. When reviewing the text of responses it is clear that such a categorisation can sometimes underestimate the interwoven nature of these themes.

\Done. We have added this point into the limitations section.

3. The point above becomes particularly important in addressing the clinical implications of the findings. The paper would be strengthened considerably by drawing out how the findings can inform clinical response to the WTHD and ways in which care at end of life can be improved. The findings provide a number of important indicators for ways to improve the health care for patients at end of life - the focus on understanding the source of suffering, issue of dignity (and potential application of steps to enhance the experience of dignity as described in the work by Chochinov and others) or therapeutic steps to address demoralisation; and the importance of clinicians appreciated the role of the meaning of physical symptoms and physical suffering, and the role of attention to family factors/ social context as another example (including available strategies to guide clinicians in caring for families of dying patients). In line with this, is the need I believe, to further strengthen the focus on how these findings align with the quantitative findings regarding depression and WTHD. the qualitative data provides a detailed account of the common symptoms and features of depression (hopelessness, helplessness, loss of self esteem and related sense of burden to others) - this has important clinical implications in regards to the importance of identification/assessment and effective treatment of depression in this setting. The findings in this respect appear to complement the quantitative findings regarding depression and its link to WTHD from studies identified in the discussion, and hence the clinical implications of this could be drawn out more clearly (eg manifestations of depression and demoralisation that clinicians need to be alert to).

\Thank you very much for this interesting comment. We very much appreciate your new suggestions and have sought to incorporate them into the manuscript.

VERSION 2 – REVIEW

REVIEWER	Brian Kelly University of Newcastle, Australia
REVIEW RETURNED	13-Jul-2017

GENERAL COMMENTS	I believe the authors have addressed the key issues.
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