Peer Review File

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Reviewer A

Overall, this is an important contribution and will be of use both to the field and to future editors, reviewers, and authors in the journal. There is a great deal of valuable and important content embedded in this manuscript. However, I think in its current form, the organization might detract slightly from the underlying points. Overall, some of the content seems a big digressive and some of the transitions don't work well. I would also do a read through to clean up some of the syntax, grammar, and style.

Reply 1: thank you. We have read through the manuscript and improved these syntax, grammar, and style concerns.

Changes in the text: please see the tracked revisions.

Comment 1: The introduction is clear and sets up the aims for the remainder of the manuscript well in the final sentence.

Reply 1: we appreciate the positive comments.

Changes in the text: none.

Comment 2: In lines 54-56, the distinction between palliative medicine and hospice and palliative care is not made clear. The authors argue that these must be considered together, but it's not clear what the alternative to which they are responding is. Distinguishing hospice care from palliative medicine? Palliative medicine from palliative care? This could use a little bit of elaboration.

Reply 2: the content on the original lines 54-56 aims to show that palliative medicine is developed from the other two terms. That is why we think we should not focus on identifying the difference of these terms in the first place (as this may distract the readers). We have devoted significant text (lines 132-146) to elaborate their relationships and created Figure 1 to visualize this.

Changes in the text: none.

Comment 3: The history of palliative care section may not be optimized to the otherall flow of the paper right now. I appreciate the impetus to include some historical context about palliative medicine in the manuscript (lines 54-78). However, I am not sure this section as it is currently written is effective. The historical narrative jumps from Dr. Trudau to Dame Saunders to Dr. Mount and then to a single country establishing a subspecialty in 1987. What has been attended to versus left out feels somewhat arbitrary and the narrative doesn't feel sufficiently fleshed out. For example, "Over time, healthcare providers began to realize…" feels overly informal and conjectural. There is no reference to the growing evidence base or actual development of care delivery in the specialty. I wonder whether this section ought to be cut down to just a few sentences identifying that the specialty evolved over the 20th century with the recognition of the needs of patients with serious illnesses and that over the past several decades there's been tremendous growth in official recognition and integration in care systems globally.

Reply 3: thank you for your comment. The historical narrative review of Dr. Dame Saunders and Dr. Mount is used to elaborate the formal constitute of "hospice care" and "palliative care." These are two landmarks. The narrative review of Dr. Trudau is used to highlight that the idea has always been ingrained as the fundamental starting point of doctors and medicine. However, we agree with the reviewer regarding the latter part of this comment and great suggestion. We have revises the manuscript accordingly.

Changes in the text:

Lines 42-56, we have merged the three paragraphs together as one paragraph.

Lines 54-56, we have now used only two sentences to address the mentioned issue "Later, the development of palliative care in the 20th century recognized the needs of patients with other long-term chronic, serious, and life-limiting illnesses. Palliative care has grown tremendously over the past decades and has been officially recognized and integrated into healthcare systems globally (6,7)."

Comment 4: I also think that given the focus of the article, it would make more sense to focus on the expanding scope of palliative care rather than on its early history.

Reply 4: we cannot agree with the reviewer more that the manuscript's number one focus is the scope of palliative care. The reason we decided to write the early history is that these terms are evolving. However, the history is actually not our focus, as we only used three paragraphs (which we now condensed to only one paragraph, 247 words, based on the Reviewer's comments) to tell a very brief history. All the remaining content (lines 64-224) is aimed at finding out what is palliative care and what is its scope. The highlighted scope of APM is actually made after reviewing many classic books that encompass the expanding scope of palliative care (but we cannot list them all in this editorial. As we know there are a hundred or more while we only have no more than 2500 words to write this manuscript).

Changes in the text: none.

Comment 5: In What is palliative medicine, I think there's a lot of valuable information here. However, I do wonder whether there could be more of an argument made in this section about the evolution of the definition towards breadth, rather than merely a review of two opposing definitions. Currently, this section is constructed as "there is a broad and a narrow definition of palliative care and we use the broad definition + here are some common features of the definitions." I wonder whether it might be more effective to have this section structured as "definitions of palliative care have broadened to reflect the growing scope of the field + though definitions differ here are common features"

Reply 5: this is a great suggestion. Thank you very much. We have adjusted the whole section accordingly.

Changes in the text:

lines 62-81, "Among the few definitions of palliative medicine, we found that the definitions have evolved and broadened to reflect the growing scope of the field.

In the 2nd edition of the Oxford Textbook of Palliative Medicine published in 2003, palliative medicine was defined as *"Palliative medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is*

limited and the focus of care is the quality of life. This definition is for the specialty practiced by doctors. When describing the care offered by a team of doctors, nurses, therapists, social workers, clergy, and volunteers, it is more correct to refer to palliative care" (11). This definition limits palliative medicine to practice solely by physicians and clearly distinguishes between palliative care and palliative medicine based on the boundaries, types, and number of care providers. However, the 3rd edition of the Textbook of Palliative Medicine and Supportive Care (published in 2021) (12) divides the practice of palliative medicine into three categories: primary palliative care, secondary palliative care, and tertiary palliative care. Specifically, primary palliative care can be provided by any primary care physicians, specialists or healthcare providers, including oncologists, cardiologists, intensive care physicians, *etc.*; secondary palliative care deals with more complex problems that cannot readily be handled by primary care physicians and often requires consultation from a professional palliative care team supporting a primary care provider; tertiary palliative care specifically deals with situations that cannot be well controlled by primary care providers and treatment that is transferred to an inter-disciplinary palliative care team.

The APM journal has been adopting the broadened definitions and scope of palliative medicine."

Comment 6: I found the how are palliative medicine/palliative care, hospice care and supportive care related? and the subsequent section confusing for a few reasons. First, the authors allude to some distinctions in lines 54-56 without elaborating. This makes me wonder if this section needs to be moved earlier. Second, the depth and length of these discussions feels disproportionate to their position in the overall paper argument, which, as I see it, is that the field of palliative medicine is broad (or has broadened) and that operationalizing what the scope is can be helpful to the journal. I think giving readers some language framework is important, but really more in service of the definitions of and scope of palliative care, rather than as an entirely standalone discussion. I wonder if these sections could be shortened and moved earlier in the manuscript. I could see this being content being condensed and combined with the history section following the introduction and before the definitions.

Reply 6: we think the recommended structure adjustment is reasonable and highly respected. We agree that it would be reasonable to connect this section, which distinguishes several concepts, with the history section. However, there is a problem with this, because if the definition of palliative medicine is not made very clear first, and concepts such as palliative medicine/palliative care/hospice care/supportive care/public health palliative care are thrown out directly at first, the reader could be very confused. We have structured it in such a way that the history very quickly introduces the concept from which palliative medicine is derived, then defines it thoroughly, then helps the reader to sort out the association of several related concepts together, and on the basis of all the above being clear, the scope of APM can be clearly defined. We hope the reviewers will understand that we do not want to introduce many other terms to the reader before we have a clear definition of palliative medicine.

Changes in the text: none.

Comment 7: As a note, I do notice in the body of the manuscript, there seems to be inconsistency in use between palliative medicine and palliative care. Even if the authors note these can be used interchangeably, I would still be consistent within this manuscript.
Reply 7: Thanks to the reviewer. This was an option we discussed at length. Indeed, we did think about using one wording throughout the text to maintain uniformity. However, given that the two terms are currently used together in many cases in the field, we think that this is actually in line with the current understanding of the interdependent relationship between palliative medicine and palliative care. We feel that using these terms together is a better fit for the APM's broad scope.
Changes in the text: none.

Comment 8: Scope section: I understand the mandate to explicitly articulate the journal's scope and the authors do an admirable job doing so. A few minor points. First, "eight highlighted sections" implies these are the actual sections of the journal. Is that the case? Or are these just eight core topics in the journal's scope? I would differentiate this.
Reply 8: great point. Thank you very much. Yes, these are the planned actual sections of the journal. We have deleted the word "highlighted."
Changes in the text: line 188, "Below are eight sections of *APM*"

Comment 9: The grammar in the section bullets is confusing. "Including but are not limited to" looks like it should read as "including, but not limited to,…
Reply 9: we have revised the section bullets accordingly.
Changes in the text: lines 189-219, "including, but are not limited to …"

Comment 10: The conclusion is effective in summarizing the core components of the article.
Reply 10: thank you.
Changes in the text: none.

Reviewer B

It is important to delineate the boundaries and definition of palliative medicine, both for the journal as well as for the specialty. I do have some recommendations for revision. Please see my comments below.

Comment 1: P2 L50, consider replacing the word "hoping" with "aiming"

Reply 1: thank you. We have replaced the word as suggested.

Changes in the text: lines 38-39, “aiming to review the definition and scope of palliative medicine and to further refine and clarify the scope of the APM journal”

Comment 2: P2 L63 it is worthy to note that Dame Cicely Saunders was first a nurse and then became a physician so that she could conduct research and publish her findings, "otherwise they would not listen to me." (Youk, T. 2005. Pioneers of Hospice: Changing the Face of Dying. Madison Deane Initiative).

Reply 2: although we respectfully agree with the reviewer regarding “otherwise they would not listen to me,” based on the feedback of Reviewer 1 that our history section was too extensive in its current form, we necessarily omitted specifically noting this. The history section aims to briefly summarize the evolution path, and we have shortened this section at the above recommendations.

Changes in the text: none.

Comment 3: P3 L98. Primary palliative care can be provided by any healthcare provider in any setting, not just by physicians.

Reply 3: Yes, we totally agree with you. We have added the words “healthcare providers” here to avoid any misunderstanding.

Changes in the text: lines 78-29, “Specifically, primary palliative care can be provided by any primary care physicians, specialists or healthcare providers, including oncologists, cardiologists, intensive care physicians, *etc.*”.

Comment 4: P4 L136 Please note the discrepancy between "palliative medicine" in this line and "palliative care" in the box below it. In the first bullet point, I recommend deleting the word "medical" before care, as medicine is its own discipline.

Reply 4: We agree that the present phrasing may cause misunderstanding as you correctly pointed out. We have made revisions accordingly.

Changes in the text: lines 110-111, “Despite the many definitions, we can see that the scope of palliative medicine and palliative care has continued to evolve.”

Lines 115-118 (the first bullet in the box), “Palliative care is an active total and specialized care for individuals across all ages with serious health-related suffering due to severe illness, and especially of those whose disease is not responsive or amenable to curative treatment and/or have life-threatening illness or are at the end of life.”

Comment 5: P6 L209 the word "encompass" should read instead "encompasses."

Reply 5: thank you. We have revised accordingly.

Changes in the text: lines 190-191, “and the scope of *APM* encompasses supportive care, palliative

care, hospice care and public health palliative care."

Comment 6: P6 L235 the word "advanced" should read instead "advance"
Reply 6: After double-checking, we found the word "advanced" is the correct phrasing.
Changes in the text: none.

Comment 7: P7 L258 While I agree that palliative care and palliative medicine are interdependent, I strongly disagree that palliative care and palliative medicine should be considered "generally interchangeable". For example, one would not say that a palliative care nurse was practicing medicine. One would not say that a palliative care chaplain was practicing medicine. One would not say that a palliative care social worker was practicing medicine. This is because the practice of medicine carries its own code of ethics, regulations, and relationship to diagnosing and treating the patient. Palliative care physicians practice palliative medicine in collaboration with the rest of the palliative care team, whose disciplines carry their own codes of ethics, regulations, and relationship to the patient relative to diagnosis and treatment. For example, a patient has a terminal prognosis and primary diagnosis given by the physician, but apart from that there are nursing diagnoses that have to do with the patient's human response to the medical diagnosis and prognosis. Chaplains and social workers likewise conduct their own assessments and provide treatments appropriate to their disciplines.
Reply 7: we indeed agree with the reviewer that the two words are very closely interdependent but not interchangeable. That is why we used the term "in many ways" on line 87 and "generally" in the last paragraph to differentiate. It seems that the phrasing still causes misunderstanding. We now have deleted the sentence "Moreover, palliative care and palliative medicine should be considered interdependent and generally interchangeable" in the last paragraph to avoid any similar misunderstanding.
Changes in the text: lines 233-234, deleted the whole mentioned sentence.