

## Peer Review File

Article information: <https://dx.doi.org/10.21037/apm-23-381>

### Reviewer A

1. I have some specific issues which authors should considered.

ABSTRACT: Line 46. "The researchers, professionals from the multi-professional team, and patients' families helped fulfill the patients' wishes". What does authors mean by this? I wonder, if it is a results of this study?

**Response:** Thank you for your input. The text has been modified to make it clearer. The text was modified in the abstract (page 2, line 47-50 ) and in the results (pages 11-12, lines 340-347).

*Previous text:* The researchers, professionals from the multi-professional team, and patients' families helped fulfill the patients' wishes.

*New text:* In this study, the GWCG was effective in fulfilling 90% of the patients' wishes, and this was only possible with the support of the researchers, members of the interdisciplinary team, and patients' families. The most important wishes, among the 10 cards chosen as very important for each patient, were discussed with the interdisciplinary team of the palliative care unit, and we endeavored to fulfill them. Only two patients requested the recording of advance directives in the medical record. However, some wishes, such as going on an airplane or visiting a beautiful farm, were not possible due to the patient's end-of-life clinical condition.

2. METHODS: Word cloud is presented in Figure 1, but how it was prepared and how it was used to interpret the participants' narratives in this study? The role of word cloud in this study remains unclear for me.

**Response:** Thank you for your pertinent comments, we have appreciated. In general, qualitative analysis software, such as NVivo, does not completely structure the analysis process. However, combined with the complete process of content analysis, which is often performed manually, allow a valid analysis with reliable results. Specifically, regarding the word cloud, where the more times the term appears in the responses, the bigger its size. That is, it has a higher frequency. This type of technique is used only to illustrate the distribution, facilitating the visualization of the data. We explain in more detail in the text of the article.

In *Methods*, in *Data analyses*, page 5, lines 146-150:

*Previous text:* Qualitative analysis was performed by program NVivo 11 Pro (QRS International Pty Ltd)"

*New text:* "Using the NVivo 11 Pro Software (QRS International Pty Ltd), a word cloud was generated to interpret the participants' narratives regarding this question.

The word cloud strategy can provide meaningful analysis of qualitative data by providing interpretations through text size and color. The more times the word appears in the responses, the bigger its size. That is, it has a higher frequency.

3. See also ABSTRACT Lines 40-41 and PAGE 8, Lines 301 -302. PAGE 3, Line 98.

Karnofsky permormance scale need reference. PAGE 3, Line 96.

**Response:**

ABSTRACT Lines 47-48

We rewrote the sentence.

*Previous text:* Of the 15 patients studied, only one reported that they did not initially like playing the cards

*New text:* "Out of the 15 patients studied, only one reported that they initially did not enjoy playing the cards."

Page 12, Lines 365 -366

A word cloud was created using the main terms described by the patients regarding the meaning of playing with GWCG (Figure 2).

PAGE 4, Line 106. Karnofsky permormance scale need reference.

Response: We included the references

Karnofsky DA, Burchenal JH. The clinical evaluation of chemotherapeutic agents in cancer. In: MacLeod CM. (eds). *Evaluation of chemotherapeutic agents*, New York: Columbia University Press, 1949, pp. 191–205

Zubrod CG, Schneiderman M, Frei III E, et al. Appraisal of methods for the study of chemotherapy of cancer in man: comparative therapeutic trial of nitrogen mustard and triethylene thiophosphoramide. *J Chronic Dis* 1960; 11(1): 7–33

PAGE 6, Line 156.

Response: We included a flowchart to present the recruitment and eligibility of the patients.

Figure 1.

4. How participants were recrtyed in this study? Did researcher had any contact person in unit?

**Response:** We included the new text in lines (116-118) page (4)

The patients were recruited with the assistance of doctors and nurses from the Palliative Care Unit, where the researchers had direct contact with these professionals.

5. Authors have used COREQ checklist which is attached in the manuscript. Please refer to it in the article text.

**Response:** Thank you for this suggestion. We have included it in the text of the methodology. (page 4, lines 97-98).

*New text:* The qualitative method followed the *Consolidated Criteria for Qualitative Research Reports*.(ref)

ref. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual*

6. RESULTS: Table 1. Any patient did not select Go Wish Card number 32 "I want to participate in my care planning"? I would like to see this result in Results section and also discussion of this in DISCUSSION. I think and it seems that most others cards include aspects of care planning.

**Response:** No patient chose card 32, see table 1. This can be attributed to the absence of Advance Care Planning culture in Brazil. Although we have recently initiated the process of patient education in our institution, it is still in its early stages and faces numerous cultural barriers.

7. DISCUSSION: Patients chose themselves the card category i.e. very important, more or less important or less important. Are results generalizable? Is subjectivity of the results one limitation of this study also? I would like to know what kind of further plans authors do have. How authors are planning to continue their work?

**Response:** We believe that these results are generalizable. The selection of the cards, in itself, reflects the subjectivity of each individual and their personal preferences. Currently, we are conducting a clinical trial to assess the effectiveness of the cards in patients with longer life expectancies who are not receiving specialized palliative care. In this trial, we will also evaluate the cards that were not chosen by the patients.

*New text: page 15, lines 449-456.* The current set of statements on the cards contributes to the advancement of meaningful outcomes for patients with palliative care needs. However, further research is needed to encompass diverse patient populations, care trajectories, and cultural contexts in order to explore the full spectrum of care goals for patients in the EOL. Additional studies can delve into the conversational processes that address immediate needs and investigate the potential evolution of wishes and priorities over time. This comprehensive approach will enhance our understanding of end-of-life care and facilitate the development of tailored interventions to meet the unique needs of patients in palliative care.

8. REFERENCES: Source number 11 is not in English. In my mind it should be.

**Response:** Thank you for this suggestion

11. Bardin, L. Content Analysis. Lisbon: Editions 70. 2011

### **Reviewer B**

Thank you for this interesting and important paper which brings important contribution to the research on Go Wish card use in an understudied context. While I applaud the authors for this relevant study from an important context, I also have some concerns and questions which I hope authors will consider for improvement of the paper.

1. Overall in the first two paragraphs of the introduction, I would recommend authors to review their referencing, as they cite varied sources within the same brackets, and do not use established literature. WHO and white papers/delphi study papers could give descriptions of PC and advance care planning (ACP) more weight.

**Response:** Thank you for your suggestion. We have included the WHO reference about palliative care, but we have kept the cited literature because they are important to the subject described.

Reference:

World Health Organization. WHO Definition of Palliative Care [Internet]. Geneva: World Health Organization; 2023. Available: [www.who.int/cancer/palliative/definition/en](http://www.who.int/cancer/palliative/definition/en).

2. While the authors state that the international literature on GWCG is limited, key papers are missing, see suggestions under comment #18.

**Response:** We have adjusted the text and included some more references in the discussion .

*New text: page 3, lines 86-89.* Although there are already some studies in the literature regarding the use of GWCG in oncology patients, no study has specifically evaluated Brazilian oncology patients in palliative care. Our study aimed to investigate the most significant end-of-life desires among Brazilian cancer patients receiving palliative care.

3. Under study design, authors refer to a method with referencing that is almost 50 years old. While primary sources are always valued, this may need support from more contemporary sources. How has this method evolved and been used since the 1970s? Is it still a valid method?

**Response:**

Content analysis is understood as a set of techniques for analyzing communications, aimed at obtaining, through systematic and objective procedures for describing the content of messages, indicators (quantitative or not) that allow inferences of knowledge regarding the production/reception conditions (inferred variables) of these messages. It is regarded as a set of methodological tools, **continuous evolution**, that aims to analyze different contributions of content, whether verbal or non-verbal, through a systematization of methods employed in data analysis.

BARDIN, Laurence. Content Analysis. Lisbon: Editions 70, 2011.

BARDIN, Laurence. Content Analysis. Lisbon: Editions 70, 2010.

BARDIN, Laurence. Content Analysis. Lisbon: Editions 70, 2004.

Bardin, L. Content Analysis. Lisbon: Editions 70. 1977

4. L98 – I am not familiar with the Karnofsky performance scale, can you please describe this briefly? What was the justification for using this scale as an eligibility criterium?

**Response:** The Karnofsky Performance Scale is a tool used to assess the functional status and overall performance of individuals, particularly those with chronic illnesses or undergoing medical treatments. It measures the individual's ability to carry out daily activities, such as self-care, mobility, and engagement in social and occupational

activities. The scale assigns a numerical score ranging from 0 to 100, with higher scores indicating better functioning and performance. It provides healthcare professionals with a standardized way to evaluate and communicate the functional abilities and limitations of patients, helping to guide treatment decisions and monitor progress over time.

Karnofsky DA, Burchenal JH. The clinical evaluation of chemotherapeutic agents in cancer. In: MacLeod CM. (eds). *Evaluation of chemotherapeutic agents*, New York: Columbia University Press, 1949, pp. 191–205

Zubrod CG, Schneiderman M, Frei III E, et al. Appraisal of methods for the study of chemotherapy of cancer in man: comparative therapeutic trial of nitrogen mustard and triethylene thiophosphoramide. *J Chronic Dis* 1960; 11(1): 7–33

5. L122 – Please evolve on the statement about the level of detail in data collection ensuring transparency and rigor, as it is not clear what authors are referring to.

**Response:** Thank you for this suggestion.

*Previous text:* This level of detail in the data collection process helps to ensure transparency and rigor in the qualitative research methodology used in our study.

*New text:* page 5, lines 134-136. This level of detail in the data collection process helps to ensure transparency and rigor, analyzing different contributions of content, whether verbal or non-verbal, through a systematization of methods employed in data analysis.

6. It is not clear who screened potential participants for eligibility. Was this done by clinicians or researchers?

**Response:** We included the new text in line (116-118) page (4)

The patients were recruited with the assistance of doctors and nurses from the Palliative Care Unit, where the researchers had direct contact with these professionals.

7. L139-140 – I believe authors are describing reasons for non-participation here, this could be clarified. Furthermore, the reasons for non-participation given, leads readers to question how these individuals were considered eligible, as the reasons for non-participation matches closely with exclusion criteria stated above. Please clarify.

**Response:** This is a very important request, so we have included a flowchart to present patient recruitment and eligibility.

*New text:* page 6, lines 155-156. Out of the 268 identified patients, 15 fulfilled the eligibility criteria.

Figure 1. Participant Inclusion Flowchart

8. L142 – Please clarify the term “regular health self-perception”.

**Response:** Participants were asked to rate their own health using a 5-point scale: 1 - Very good; 2 - Good; 3 - Regular; 4 - Poor; 5 - Very poor. Participants were instructed to select the option that best reflects their perception of their overall health status.

We wrote a paragraph to clarify this doubt and included it in the methodology (page

4, lines 118-122 ).

*New text:* Patients were interviewed face-to-face and completed sociodemographic and clinical informations. Additionally, they were instructed to indicate their overall health status by selecting the option that best reflects their perception from the following scale: 1 - Very good, 2 - Good, 3 - Regular, 4 - Poor, 5 - Very poor.

9. L149-150 – What do authors refer to when stating a statement as most chosen? Does this refer to most chosen among top ten choices? Ranked no 1?

**Response:** When we refer to a statement as "most chosen," it typically means that the statement was selected by the majority of patients. It does not necessarily indicate that it is the top-ranked or ranked number one choice. The term "most chosen" implies that the statement received a higher frequency of selection compared to other options but does not specify the exact ranking or order among the choices.

*New text:* page 6, line 164-166

Table 1 shows the frequency of patients' card selections that met the criteria of being categorized as 'very important'. Among these choices, Card 19, which states 'I want my family and friends close to me', was the most frequently chosen option, with a total of 14 patients.

10. Data analysis is incompletely described. Authors mention practice of pre-analysis, material exploration , etc according to Bardin, but how was this actually operationalized in their study? It is stated that the card statements defined emerging categories, which leads to confusion over inductive/deductive design. “Emerging” would suggest an inductive design, while card statements defining categories would point to a deductive design.

**Response:**

**new text:** page 5, line 140-142

The authors pre-established and named the study categories based on the 10 most frequently chosen cards by the patients and in this way analyzed the speeches related to these.

10 a. Also, the expression of Nvivo software performing the qualitative analysis is incorrect as Nvivo is a tool to support researchers' qualitative analysis, but does not perform analysis itself. Unless authors consider the creation of a word cloud the full qualitative analysis?

**Response:** The text has been adjusted

*Previous text:* Qualitative analysis was performed by program NVivo 11 Pro (QRS International Pty Ltd)”

*New text:* page 5, lines 146-150. Using the NVivo 11 Pro Software (QRS International Pty Ltd), a word cloud was generated to interpret the participants' narratives regarding this question.

The word cloud strategy can provide meaningful analysis of qualitative data by providing interpretations through text size and color. The more times the word appears

in the responses, the bigger its size. That is, it has a higher frequency.

10b. While authors have submitted a completed COREQ checklist, important information is lacking in the methods section. Please re-visit COREQ items: 9, 11, 17, 20, 22, 24, 25, 26.

**Response: We have adjusted the text according to coreq-32**

11. L154-156 Authors mention themes here derives from interviews, but it is not clear how these themes fit into the category, and how they relate to interview data. Authors may want to revisit this section to check for abstraction level in analysis.

**Response: This item was answered in question 10**

12. L181-185 This quote seems to describe clear needs for communication with health care staff, which is not matched with result text.

**Response:** We have modified the text and added another patient's speech.

New text: page 7, lines 200-203 ... *the nurses, doctors, who care for us who are very ill, everything is very different from how I was cared for ... so this here for me is a wealth ... I thank them all ... I like it here very much (referring to the palliative care unit) ... Ah, I'm happy ...I feel safe and confident here". (Patient 5)*

13. L205-208 It is not clear to me why this paragraph is bolded.

**Response:** Sorry, it was an editing error. We have adjusted the formatting.

**New Text:** page8, lines 224-227.

Helping others was essential for nine patients. This card brought the patients the feeling of retribution, of giving back all the care received while getting sick or helping others accept the fragile condition in which they find themselves by generously providing a friendly word.

14. The statements of the Brazilian GoWish statements seem to be different than the original US GoWish statements, reference to this somewhere in the manuscript could be useful for the readers.

**Response:Excelente suggestion. Thank you!**

**The text was included and referenced in the introduction (page 3, lines 76-77 )**

**New text:** The Go Wish Cards Games, were translated into Brazilian Portuguese by the Brazilian Society of Geriatrics and Gerontology

15. L224 Is the “special wishes” card equivalent to the US “Wild card”?

**Response: Yes, it is.**

16. L291-293 Authors state here that the GWCG facilitated fulfillment of patients’ wishes, which is indeed an important finding, possibly the most important contribution

to the literature by this study. However, authors do not report on how this was measured or studied, which I would strongly urge authors to include in their report in order to validate and highlight this important finding.

**Response: We have inserted text in the paragraph to further explain this condition. New text: pages 11-12, lines 340-347**

In this study, the GWCG was effective in fulfilling 90% of the patients' wishes, and this was only possible with the support of the researchers, members of the interdisciplinary team, and patients' families. The most important wishes, among the 10 cards chosen as very important for each patient, were discussed with the interdisciplinary team of the palliative care unit, and we endeavored to fulfill them. However, some wishes, such as going on an airplane or visiting a beautiful farm, were not possible due to the patient's end-of-life clinical condition.

17. Overall in the result text, authors seem to mix more generalized descriptions of palliative care scenarios with data derived from the study, which confuses me as a reader and also is a threat to reliability of the study. Please revisit e.g. lines: 153-156, 188-195, 215-217, 240-241, 253-254, 256-258, 265-267.

**Response:**

**Previous text:** This category highlights the significance of relationships with loved ones in the lives of these patients. The interviews conducted with patients revealed themes such as love, dedication, fortitude, warmth, peace, sacredness, calm, and other adjectives and feelings that emphasize the effectiveness of these relationships. This suggests that patients value the presence and support of their family and friends during their end-of-life care, and consider these relationships to be an important aspect of their overall well-being and quality of life during this challenging time.

New text: page 6, lines 169-173.

This category highlights the importance of patients' relationships with their loved ones. The patients' speeches revealed that family means love, dedication, strength, warmth, peace, calm and other feelings that emphasize the importance of the family context. Thus, the presence of family and friends denotes support and is necessary especially in end-of-life care.

*"... They are everything to me, I always want to have my family close by, that alone would be enough...they are the ones who give me strength...I want these people to be around until the end...Family is everything... Family is sacred." (Patient 15)*

Previous text: This category highlights the importance of effective communication and



the need for patients to have their wishes respected by their families during the end-of-life (EOL) process. This category underscores the need for open and honest conversations between patients and their families to ensure that patients' preferences are honored during the process of dying and death. Many patients may not express their preferences and desires to their loved ones, resulting in family members making decisions on their behalf based on their own perceptions of what is best for the patient.

New text: page 7, lines 206-211

The end-of-life process is often challenging for individuals, particularly in countries where death remains a taboo subject and discussions about end-of-life wishes encounter various barriers. Consequently, situations can arise where patients may not express their desires, and family members may struggle to accept their loved ones' choices. This category emphasizes the significance of effective communication and underscores the importance of honoring patients' wishes by their families throughout the end-of-life (EOL) journey.

***Category 4 - I want to be able to help other people (Card 24)***

Response: We have included.

New text: page 8, lines 234-236

"To help people in the way of being, for example...to show what I experienced, how I deal with it...I never questioned God because I went through it...and I wanted to show that to people" (Patient 13).

Previous text: The multiple symptoms that patients may experience during the end-of-life (EOL) process can be unbearable. These symptoms may include physical symptoms such as pain and shortness of breath. For eight patients in this study, it was of utmost importance that these symptoms are effectively controlled during the EOL period, allowing them to have a dignified and comfortable death.

New text: page 8, lines 239-241

For eight patients in this study, ensuring effective control of symptoms such as pain and shortness of breath during the end-of-life (EOL) period is of utmost importance, thus providing a dignified and comfortable death without unnecessary suffering.

page 8, line 243

*"I don't want this suffering at the end of life, I want to go away in peace" (Patient 9).*

***Category 6 - I have special wishes (Card 36)***

We have included.

New text: page 9, lines 264-274

*"...I want to be cremated...that is my will...I don't want ritual, you don't need any of that...and I also want the world to know, to whom it may concern, that I was happy because I had my son, my son was my happiness... " (Patient 10).*

*"My special wish is to attend my daughter's 15th birthday party... perhaps I won't be here anymore at her wedding (tearfully), so I would like to be present at her 15th birthday celebration... she will be dressed as a debutante, like a beautiful bride" (Patient 11)*

*"It's a dream I've always had, I've never traveled by plane and I would like to travel with my husband somewhere but just to travel by plane really...I think I'm going to die and I haven't traveled by plane (laughs)" (Patient 12).*

Previous text: This category emphasizes the importance of creating a peaceful and dignified environment for patients during the end-of-life process. Patients expressed their preferences for the environment in which they would like to spend their final moments, whether it be a specific place such as a hospital or their own home. They described how they envisioned this environment to be, with the aim of feeling at peace and maintaining their dignity.

New text: page 10-11, lines 277-280

Patients expressed their preferences for the environment in which they would like to spend their final moments, whether it be a specific place such as a hospital or their own home. They described how they envisioned this environment to be, with the aim of feeling at peace and maintaining their dignity.

page 10, lines 286-291

"...A calm and pleasant environment is my home, no fighting and no arguing, calm.... I didn't want to die in the hospital...I want to die at home to be with my family...and in the hospital it ends up not being that way ... My home is the best environment for me" (patient 11).

"I think that the place where I am, here (hospital), is already a calm and pleasant environment ... that's what I deduced when I thought of this card ... "(patient 15).

Previous text: During the end-of-life process, patients often express a strong desire to say thank you, express their love, apologize, and bid farewell to their loved ones. These feelings were frequently reported during the interviews, with gratitude being the most prominent emotion expressed by patients. Healthcare professionals and caregivers play a vital role in creating opportunities for patients to express their emotions and communicate their feelings before their passing.

New text: page 10, lines 294-299

Some feelings were reported frequently during the interviews, with gratitude being the most prominent emotion expressed by the patients.

"...I always thank God and the people around me, you for example...I thank you for all this, I thank you for what I go through, the difficulties, I thank you for the weaknesses because everyone has them, I have a lot of gratitude ..." (Patient 9).

Previous text: Aggressive medical interventions at the end of life can sometimes lead to a decrease in the quality of life for patients, and may not align with their wishes for a peaceful dying process. Five patients in the study considered Card 3 as very important, indicating their preference to not be kept alive by machines if their death is imminent, in order to minimize suffering for both the patient and their family caregivers.

New text: page 10, lines 306-308

Five patients in the study considered Card 3 as very important, indicating their preference to not be kept alive by machines if their death is imminent, in order to minimize suffering for both the patient and their family caregivers.

page 11, lines 314-322

*"...I think that cancer has an evolution, it is incurable in my case, and there will come a time when they will only keep me alive and I do not want this...I prefer sedation, without suffering, without pain and agony...but with sedation that I can stay calm and go away...Death is a certainty, there is nothing more that medicine can do, there is no way to reverse the case... It is postponing suffering for me and my family, and I don't want to be a burden to my family" (Patient 10).*

*"I think it is an unnecessary suffering, you are already going to die and stay there keeping a body, it is a suffering for those who stay... " (Patient 13).*

### ***"What did playing the cards mean to you?"***

We included, page 12, lines 350-355

*"... it was a very, very, very... enlightening game... I think everyone should play, if I had known before... I would have played before, but at this time going through what I'm going through, this is the right time to play, everyone should play." (Patient 1, died 100 days after GWCG)*

*"It was good, it defined things...it was cool, I got to define things that I hadn't thought of, that mattered... ." (Patient, died 83 days after GWCG)*

18. Also, in the result section, authors describe very briefly how participants have reasoned about the card statements, but as this is captured on a very superficial level, it leads to the question of what this adds other than what can be inferred from the card statement. I would like to urge authors to read the following publications and consider what their important study can add to the extant literature:

Exploring Community-Dwelling Older Adults' Considerations About Values and Preferences for Future End-of-Life Care: A Study from Sweden - PubMed (nih.gov)

P-74 Advance care planning awareness: Using the go wish card game to assess the modern Japanese view of life and death | BMJ Supportive & Palliative Care

Identifying End-of-Life Preferences Among Chinese Patients With Cancer Using the Heart to Heart Card Game - Tong Li, Xianbo Pei, Xiaoli Chen, Shuqin Zhang, 2021 (sagepub.com)

Values and preferences for future end-of-life care among the indigenous Sámi - Kroik - 2022 - Scandinavian Journal of Caring Sciences - Wiley Online Library

Community perspectives of end-of-life preparedness - PubMed (nih.gov)

The cultural adaptation of the go wish card game for use in Flanders, Belgium: a public health tool to identify and discuss end-of-life preferences (biomedcentral.com)

Translation and Cultural Adaptation of the Go Wish Game: Thinking About Personal Values to Promote Advance Care Planning - PubMed (nih.gov)

Developing and using a structured, conversation-based intervention for clarifying values and preferences for end-of-life in the advance care planning-naïve Swedish context: Action research within the DöBra research program - PubMed (nih.gov)

Use, usability, and impact of a card-based conversation tool to support communication about end-of-life preferences in residential elder care – a qualitative study of staff experiences | BMC Geriatrics | Full Text (biomedcentral.com)

I would personally enjoy reading more in-depth descriptions of participants' reasoning about the card items and their preferences, which would also serve as an important contribution to the literature. As it is presented now, the results on participants' reflections on the card statements are too shallow to add to the evolving research front. Another alternative could be to evolve more on participants' experience of using the GWCG. In figure 1, there seems to be important and interesting data which is not reported on in the manuscript in its current form.

**Response:**

We added additional testimonies from the patient, aiming to broaden the reasoning and taking into account the construct in question, which are the desires they chose.

We thank you for this brilliant review. Your insights are highly relevant and greatly contribute to the advancement of this scientific article. Thank you very much.

19. After reading the results and discussions, I returned to the aim of the study to review how the manuscript addresses the aim initially stated. I would therefore strongly encourage authors to re-visit and re-consider the formulation of the aim. In categories 1-10 of the results, I would seriously question if this corresponds to “understanding the significance of the GWCG”.

**Response: We agree with you.**

**Previous text:** Our study aimed to understand the significance of GWCG in discussions about the EOL wishes of patients in Oncology PC.

**New text:** (Abstract and introduction)

Our study aimed to investigate the most significant end-of-life desires among Brazilian cancer patients receiving palliative care.

20. Overall in the discussion section, discussion of this study's findings in relation to other relevant studies is largely lacking (see suggestions for relevant literature above). This study brings important perspectives from an understudied context (oncological palliative care), however, reviewing its findings in relation to previous studies would further the knowledge base greatly. Also, after the study aim has been re-considered, authors will want to revise the discussion and conclusions to actually address the aim more clearly.

**Response: As per your suggestion, we have re-evaluated the discussion and conclusion.**

**pages 13-14, lines 383-407**

The utilization of GWCG in palliative care clinical practice holds the potential to overcome the resistance commonly observed among patients and their family caregivers when discussing end-of-life matters (24, 25). A study examining the impact and dissemination of GWCG in the community revealed that these cards served as an effective "ice breaker," facilitating conversations about end of life and positively influencing individuals' capacity to address death-related issues within various social contexts (26). Engaging in discussions about end-of-life wishes using GWCG can prove to be a valuable and advantageous approach for patients, as it fosters open dialogues about emotions and preferences while emphasizing the significance of articulating and documenting care preferences in advance. This approach has the potential to enhance the provision of comprehensive and compassionate care throughout the dying process (10). End-of-life care conversations have demonstrated significant benefits in improving the quality of end-of-life care (27). One workshop demonstrated that using GWCG was effective in motivating Japanese who may have difficulty talking about their end-of-life wishes or making autonomous decisions. The game may encourage them to participate more actively in Advance Care Planning (ACP) and lead them to consider their future preferences regarding medical care (28).

The applicability of the Go Wish Card Games extends beyond individual patient encounters. They can also be utilized in group settings, educational workshops, and community outreach programs to foster a broader understanding of end-of-life care and encourage proactive discussions about ACP. It can enhance patient-centered care, promote shared decision-making, and ultimately contribute to the provision of compassionate and person-centered end-of-life care (29). Statement cards can assist palliative care patients in expressing important end-of-life aspects that may be difficult to articulate. These cards provide prompts and structure, enabling patients to communicate their thoughts, desires, and concerns more effectively (3).

pages 14-15, lines 432-441

In our study we prioritized not only identifying but also fulfilling the most important wishes of the patients. We believe that it is essential to enable the inclusion of this practice in the daily routine of Palliative Care, where the GWCG can be a useful tool in the more humanized and person-centered care. The patients in this study expressed that the cards and choosing cards were helpful in facilitating the process of putting thoughts, feelings, and memories into words. The more directed conversations sparked memories and brought insights that helped patients understand what was most important. For some, taking the time to choose cards made it easier to think, decide, and talk about difficult issues. Although the conversations evoked feelings of sadness, they were considered to be valuable, prioritization moments, and the patients expressed their gratitude.

page 15, lines 450-457

The current set of statements on the cards contributes to the advancement of meaningful outcomes for patients with palliative care needs. However, further research is needed to encompass diverse patient populations, care trajectories, and cultural contexts in order to explore the full spectrum of care goals for patients in the EOL. Additional studies can delve into the conversational processes that address immediate needs and investigate the potential evolution of wishes and priorities over time. This comprehensive approach will enhance our understanding of end-of-life care and facilitate the development of tailored interventions to meet the unique needs of patients in palliative care.

page 16, lines 466-473

## **Conclusion**

The use of the GWCG in the oncology palliative care setting made an important contribution to open discussions about patients' values and preferences, as well as being an easy-to-use, understandable, and flexible tool. Among the 36 cards, the card "I want my family and friends close to me" was the one chosen most often by patients, highlighting the importance that family and friendship relationships throughout life can also be highlighted in the EOL process. Prioritizing the fulfillment of patients' wishes

was one of the main strengths of this study. Our study suggests working with these wishes as a framework for person-centered care.

General:

“End-of-life” is abbreviated repeatedly in different sections of the text, please revise. Table 1. It is not clear to me why some items are italicized, while others are not.

**Response:** We have adjusted these items

### **Reviewer C**

This qualitative study presents the use of GWCG in aiding EOL discussions. The theme is obviously fascinating and at the heart of the practice of oncology and palliative care. The major interest of the study is to re-emphasize the importance of discussion, anticipation, respect for the wishes of the sick person (at the end of life, and throughout the illness). This is an exploratory work, before a before-and-after study, in a homogeneous population.

1. However, there is not a lot of new information, and there is a lack of vision on the recruitment and engagement of patients (few, in 6 months, pandemic or not...), the levers and barriers to initiation of dialogue, practical use, effective drafting of living wills, outcome of patients, respect or not of their wishes.

**Response: Response:** This is a very important request, so we have included a flowchart to present patient recruitment and eligibility. The GWCG may be the beginning of discussions about end-of-life wishes, since there is no institutional or even patient culture of Advance Care Planning in Brazil. Although we have recently started the patient education process in our institution, it is still in its early stages and faces numerous cultural barriers.

New text: page 6, lines 155-156. Out of the 268 identified patients, 15 fulfilled the eligibility criteria.

Figure 1. Participant Inclusion Flowchart

OTHER COMMENTS:

- Only 15 over a 6-mo period. How were they selected? Number of patients admitted ("flow-charté)? (62 beds, 6 months, only 31 eligible patients?)

**Response**

New text: page 6, lines 155-156. Out of the 268 identified patients, 15 fulfilled the eligibility criteria.

Figure 1. Participant Inclusion Flowchart

- The GWCG came late in the PC process (Would it be acceptable earlier?)

**Response:** The GWCG was not late in the PC, however the clinical conditions at that time, during the Covid-19 pandemic, somewhat contributed to the low inclusion of patients. Currently, we are conducting a clinical trial to assess the effectiveness of the



cards in patients with longer life expectancies who are not receiving only specialized palliative care.

- Selection bias: “those who want to...”. What for the others?

**Response:**

According to the eligibility criteria, Figure 1, it is possible to identify how the process of inclusion of patients was, those who did not accept to participate may have had the influence of the cultural barrier of not talking about end of life.

- What means “regular health self-perception”?

**Response:** Participants were asked to rate their own health using a 5-point scale: 1 - Very good; 2 - Good; 3 - Regular; 4 - Poor; 5 - Very poor. Participants were instructed to select the option that best reflects their perception of their overall health status.

We wrote a paragraph to clarify this doubt and included it in the methodology (page 4, lines 118-122 ).

*New text:* Patients completed questionnaires to collect sociodemographic and clinical information. Additionally, they were instructed to indicate their overall health status by selecting the option that best reflects their perception from the following scale: 1 - Very good, 2 - Good, 3 - Regular, 4 - Poor, 5 - Very poor.

- Cards “not important at all” signifies also something and are a revealer information. Their absence should/could have been discussed.

**Response:** For this study, we did not evaluate the more or less important cards and also the not at all important cards. However, in the new ongoing clinical trial, we will evaluate all cards within these criteria.

- Special wishes: “to be cured” (impossible) differs from “taking a memorable trip” (possible). How were used this information furnished by the patients?

**Response:** In these cases, the patients were aware that "to be cured" was not in the possibility of realization due to the advanced disease condition, although the patients wished for it, there was a discussion of the impossibility of not realizing this wish. Regarding "Taking a memorable trip", some patients had this wish, the interdisciplinary team as well as the health institution itself tried to make it happen, but it was not possible due to the patients' clinical conditions and even death.

- So what: How were recorded the desires of the patients in the medical chart? Were classical advance directive written/recorded?

**Response:** Thank you for your input. The text has been modified to make it clearer. The text was modified in the abstract (page 2, line 47-50 ) and in the results (pages 11-12, lines 340-347).

*Previous text:* The researchers, professionals from the multi-professional team, and patients' families helped fulfill the patients' wishes.

*New text:* In this study, the GWCG was effective in fulfilling 90% of the patients' wishes, and this was only possible with the support of the researchers, members of the

interdisciplinary team, and patients' families. The most important wishes, among the 10 cards chosen as very important for each patient, were discussed with the interdisciplinary team of the palliative care unit, and we endeavored to fulfill them. Only two patients requested the recording of advance directives in the medical record. However, some wishes, such as going on an airplane or visiting a beautiful farm, were not possible due to the patient's end-of-life clinical condition.

- Who was the applicant? Patients, physicians (oncologists, palliative care practitioners?), nurses? Noteworthy, physician's representations are the main barrier toward EOL discussions, rather than patients themselves.

**Response:**The patients.

- "Quick applicability". How many time, in practice, for the "games" (discussions)?

**Response:**

new text: page 6,, lines 160-161

The average interview time was 33 minutes. The average time between the GWCG and patient death was 50.3 days, ranging from 10 to 100 days.

#### **Reviewer D**

I appreciate having been able to read and review this work. This project, which explored use of the Go Wish Card Game (GWCG) in the palliative care oncology setting, has many merits, and I appreciate the authors' efforts to test and describe patients' experiences using important communication tools in sensitive clinical settings. This being said, the paper as it is currently written may not be fit for submission - I believe it would benefit from a re-write with a careful eye for detail, as errors impacted the readability of the writing. Additionally, tailoring the methods to have greater detail, removing new results from the discussion and instead presenting them within the results section, bolstering the limitations to reflect the small sample, and spending more time introducing the card game and clarifying how this paper fits into the existing literature would greatly improve the paper.

**Response:**

Thank you very much for your valuable insights. We have dedicated significant effort to enhance the writing of the article, incorporating your suggestions as well as those from other reviewers. As a result, the article has undergone modifications across all its sections.