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Reviewer A

Reviewer's Comments to Author	Reply to reviewer
This study is both novel and significant as it adds to the empirical literature on end of life and palliative care in Trinidad and Tobago -- understudied places that have high palliative care needs. The investigators encountered challenges in representative recruitment but addresses or minimized bias by focusing on home deaths. The conclusions are important and inform clinical practice by suggesting the need for training in palliative medicine in places like Trinidad and Tobago. This is a valuable empirical conclusion that will inform practice that would ultimately improve care to dying patients.	We thank the reviewer for appreciation of our paper.

Reviewer B

Reviewer's Comments to Author	Reply to reviewer	Edited in manuscript
In this article, the authors investigated problems of the end-of-life decision-making process in Trinidad and Tobago using questionnaires to general practitioners who had certified their patients' death at home. The results show the statistically significant association between palliative care training and some end-of-life care approaches, such as opioid usage. I think the focus of this study is interesting, and the results are meaningful for much better future palliative care. However, some modifications and additional explanations are needed for acceptance.	We thank the reviewer for appreciation of our paper. All changes to the manuscript are in track changes or highlighted in yellow of the marked copy.	

Following are comments and questions. (Overall) -Some grammatical errors are seen. Has this manuscript received grammatical and structural proofreading? E.g., -The necessary support to further develop palliative care in Trinidad and Tobago "in" needed. (p. 2, line 53-54) -Ununified description method in the reference.	Thank you for noting errors. Identified errors were corrected and reference method unified.	Change made to the manuscript: Page 2, line 35 . . . The necessary support to further develop palliative care in Trinidad and Tobago is needed. Change made to the manuscript: Pages 17 to 19, reference method unified.
(Methods) -The authors describe "A random sample of persons aged 18 --- (p. 3, line 117)". What does a random sample mean? In appendix 2, the participants are reported to be all home deaths from March to August 2018. If the initial participants were selected randomly, the authors need to indicate how to randomize them.	Thanks for seeking clarification. Our systematic random sample consisted of only persons who died at a private home, aged 18 years or older and died between March 1 and August 31 2018. Our sample method was random as we selected every other death represented by a death certificate (i.e., sampling fraction was 1 in 2, i.e., every other case was selected from eligible death certificates). Appendix 2 indicated the sample fraction was 1 in 2, therefore 50% of cases (752) were included in the study and 50% were excluded. Please refer to appendix 2, information highlighted in yellow.	Text added to manuscript: page 5 line 107. . . A “systematic” random sample . . ., and page 5 lines 112 to 113. . .The sampling fraction, “or the ratio of the sample to the population from which the sample will be drawn was 1 in 2, where every other case was selected from eligible death certificates”. . .

(Results) -It is stated that "96 questionnaires (31%) were returned completed --- (p. 5, line 193)". How many doctors returned these questionnaires? Since the authors describe "Multiple deaths could have been certified by the same general practitioner in our survey (p. 3, line 124)", please indicate the accurate number of general practitioners who participated in this study.	Thank you for seeking clarification. The relevant aspect of this study was the death case. A general practitioner could have reported on a maximum of three questionnaires. The method of using an independent third-party (the medical association) between responding general practitioners, researchers and the CSO, and unique identifiers on questionnaires were to protect both patient and physician anonymity, therefore, a questionnaire **cannot** be traced back to a physician. Our previous study explained this process in detail ("Developing and validating a questionnaire for mortality follow-back studies on end-of-life care and decision-making in a resource-poor Caribbean country. *BMC Palliat Care* 2020;19:123. doi:10.1186/s12904-020-00630-0") and we felt this detail was not appropriate to include in this manuscript. Please refer to page 6, lines 129 to 132. . . "A questionnaire was developed building on a study in the Netherlands. It was adapted by cognitive testing and validation to ascertain it was suitable and relevant to the T&T context, details were described (including a version of the final questionnaire) in a previous study". Please refer to page 7, lines 147 to 151. . . "To maintain their anonymity and guarantee that completed questionnaires could never be linked to a particular patient or general practitioner an independent third-party, the Trinidad and Tobago Medical Association (T&TMA) was involved in	No change made to the manuscript.

Table 4 shows the results of the statistical analysis. The authors describe that physicians with formal palliative care training were more likely to prescribe or administer opioids. Although the authors used the chi-square test, I think the chi-square test is inappropriate for this statistical evaluation. If opioids are the only drug available, the chi-square test may analyze the association between training and opioid uses. However, in a situation where there are other options, such as diazepam or other benzodiazepines, I think the chi-square test can not evaluate the association between training and opioid uses. I am not a specialist in statistics. If specialists have already checked the appropriateness of statistical analysis used in this study, please indicate such fact, including the specialist's name in the acknowledgment or as co-authors.	Thank you for seeking clarification. We used Chi-square to test for an association between the variables physician training in formal palliative care or no formal palliative care training. The stated P-values indicate the level of significance between physicians and their training, which is what we are testing. The association between the category of variables (medications) does not exclude the possibility that more than one or all medications were used in a particular case, so there is no problem with these variables overlapping.	No change to the manuscript.
(References) -Please unify the description method. Some references show volume and issue, and some show volume only. DOI is not written in some references.	Thanks for this suggestion. Changes made to references	Pages 17 to 19 (References) were unified according to the Vancouver style reference and DOI included.

Reviewer C

Reviewer's Comments to Author	Reply to reviewer	Edited in manuscript

This paper is very interesting and well written. The study design was easy to follow in the text and results and discussion matched the study aims. It is rare to read articles about end of life care in T&T, so this is fascinating information. Only a few minor suggestions.	We thank the reviewer for appreciation of our paper. All changes to the manuscript are in track changes or highlighted in yellow of the marked copy.	
First, is to describe what sample fraction means in 1 sentence within the methods section. Although you provide citations, it would be helpful for readers who aren't familiar with this to immediately understand what this means.	Thanks for this suggestion, we included a short description of the term 'sample fraction'.	Page 5, lines 111 to 113. . . The sampling fraction, "or the ratio of the sample to the population from which the sample will be drawn was 1 in 2, where every other case was selected from eligible death certificates." . . .
Second, Appendix 1 is a little confusing. I tried to follow the arrows numerically and it was difficult. Perhaps adjusting Appendix 1 to account for time may be helpful. I do think the information is important, just needs some adjusting.	Thank you for seeking clarification and for the suggestion. We attempted to simplify the diagram, we added a directional arrow (death registry box) and combined some of the steps in boxes (physician and survey manager). We also included a note.	Change made to manuscript, please refer to Appendix 1. . . "Note: In each rectangular box, the sequence of activities flows from top to bottom, some activities are done intermittently."
Lastly, in Box 1 there is a question (#18) about why discussions did not occur with patients about end of life treatments. Is this information available to include in the text or tables? I believe this is important because there is a difference when interpreting % of providers who did not have conversations with patients even though the patient was able to vs. providers who did not have conversations with patients because the patient was not able to. If this question is already accounted for in the analysis please clarify this within the text.	Thank you for seeking clarification and for your suggestion. We agree that this is an important question and if data were supplied it may assist in improving practice, however, most physicians (37%) did not respond to this question, i.e., it was left blank, and another 34% cited a multitude of reasons why discussions were not held with their patients under "other". We felt the little data offered from the remaining answer options (Patient was unconscious, Patient had significant cognitive impairment, and Patient had a psychiatric disorder) was insufficient to make any reasonable conclusions.	No change made to the manuscript.