

# Palliative Medicine

## Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care – recommendations based on a methodological systematic review

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| Keywords:                     | Delphi technique, palliative care, methodological systematic review, reporting standard   |
| Abstract:                     | <p>Background: The Delphi technique is widely used for the development of guidance in palliative care, having impact on decisions with relevance for patient care.</p> <p>Aim: To systematically examine the application of the Delphi technique for the development of best-practice-guidelines in palliative care.</p> <p>Design: A methodological systematic review was undertaken using the databases PubMed, CINAHL, Web of Science, Academic Search Complete, and EMBASE.</p> <p>Data sources: Original articles (English language) were included when reporting on empirical studies that had used the Delphi technique to develop guidance for good clinical practice in palliative care. Data extraction included a quality appraisal on the rigour in conduct of the studies and the quality of reporting.</p> <p>Results: 30 empirical studies (1997-2015) were considered for full text analysis. Considerable differences were identified regarding the rigour of the design and the reporting of essential process and outcome parameters. Furthermore, discrepancies regarding the use of terms for describing the method were observed, e.g. concerning the understanding of a "round" or a "modified Delphi study".</p> <p>Conclusions: Substantial variation was found concerning the quality of the study conduct and the transparency of reporting of Delphi studies used for the development of best-practice-guidance in palliative care. Since credibility of the resulting recommendations depends on the rigorous use of the Delphi technique, there is a need for consistency and quality both in</p> |

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## Review Article

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### Title

**Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care –  
recommendations based on a methodological systematic review**

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## Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care – recommendations based on a methodological systematic review

### Abstract

**Background:** The Delphi technique is widely used for the development of guidance in palliative care, having impact on decisions with relevance for patient care.

**Aim:** To systematically examine the application of the Delphi technique for the development of best-practice-guidelines in palliative care.

**Design:** A methodological systematic review was undertaken using the databases PubMed, CINAHL, Web of Science, Academic Search Complete, and EMBASE.

**Data sources:** Original articles (English language) were included when reporting on empirical studies that had used the Delphi technique to develop guidance for good clinical practice in palliative care. Data extraction included a quality appraisal on the rigour in conduct of the studies and the quality of reporting.

**Results:** 30 empirical studies (1997-2015) were considered for full text analysis. Considerable differences were identified regarding the rigour of the design and the reporting of essential process and outcome parameters. Furthermore, discrepancies regarding the use of terms for describing the method were observed, e.g. concerning the understanding of a “round” or a “modified Delphi study”.

**Conclusions:** Substantial variation was found concerning the quality of the study conduct and the transparency of reporting of Delphi studies used for the development of best-practice-guidance in palliative care. Since credibility of the resulting recommendations depends on the rigorous use of the Delphi technique, there is a need for consistency and quality both in the conduct and reporting of studies. To allow a critical appraisal of the methodology and the resulting guidance, a reporting standard for Conducting and REporting of DElphi Studies (CREDES) is proposed.

**Short title:** Guidance on Conducting and REporting DElphi Studies (CREDES)

**Key words:** Delphi technique, palliative care, methodological systematic review, reporting standard

**Key statements****What is already known about the topic?**

- The Delphi technique is a relevant source of evidence in healthcare research.
- It has been employed in palliative care research for diverse purposes, but its application as a method for the development of best practice guidance has not been systematically examined.
- Guidance has been proposed for enhancing rigour and transparent reporting of Delphi studies; however, clear recommendations on the conduct of Delphi studies and a reporting standard for their publication in peer-reviewed journals to date are not available.

**What this paper adds**

- Demonstration of the use of the Delphi technique, including evidence on variation in study design, study conduct, and reporting, for the production of consensus, knowledge, and guidance on good clinical practice in palliative care.
- Recommendations on the rigorous conduct of studies using the Delphi technique for the development of best practice guidance in health care, and a standard for the transparent reporting of Delphi studies (Conducting and REporting of DELphi Studies CREDES).

**Implications for practice, theory or policy**

- The recommendations resulting from this review constitute an internationally applicable guidance for the conduct and reporting of studies using the Delphi technique in health care research.
- We suggest that these can serve as a guide for researchers undertaking Delphi studies, for authors publishing them, as well as for reviewers and journal editors when evaluating the quality of the study design and the transparency of reporting.

## Background

### ***The Delphi technique in developing professional guidance***

Since the 1950s, the Delphi technique has become an increasingly important tool used to address issues in health and medicine, and an attractive method for developing consensual guidance on best practice.<sup>13-15</sup>

The primary purpose of the Delphi technique is the formation of consensus or the exploration of a field beyond existing knowledge and the current conceptual world.<sup>16,17</sup> It is characterised by four methodological features which enable the involvement of experts with diverse backgrounds irrespective of their geographical location:<sup>16,18-20</sup> (1) a group of experts, called “panellists”, is questioned about the issue of interest; (2) the process is anonymous in order to avoid social pressure and conformity to a dominant view (bandwagon effect); (3) the procedure is iterative in nature, comprising several rounds of enquiry; and (4) the design of subsequent rounds is informed by a summary of the group response of the previous round. It can be tailored to the particular requirements of the research objective, ranging from open and exploratory to standardised confirmatory approaches.<sup>20,21</sup>

In this review, the term *Delphi technique* is used to refer to the method as such; *Delphi study* describes a research endeavour employing the Delphi technique as a method; *Delphi survey* relates to the actual survey (rounds) conducted as part of the Delphi technique; and *Delphi process* covers the overall process of consensus building during a Delphi study.

### ***The role of the Delphi technique in palliative care research***

With the increasing professionalization of palliative care, there are expanding demands concerning the quality and quantity of palliative care service provision. In an environment of rapidly increasing knowledge there are continuously changing assumptions about best practice and healthcare professionals need guidance for their clinical decisions. Defining professional standards and developing guidance on best practices have become important concerns in order to guide the commissioning of services, the organisation of care, and the allocation of resources.<sup>1</sup>

Evidence from meta-analysis, randomised controlled trials (RCTs) or high quality observational studies is considered of highest quality to inform professional guidance.<sup>2</sup> In comparison, expert consensus is regarded as the lowest grade of evidence.<sup>3</sup> However, in palliative care research,

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3 for ethical, economic, or practical reasons it is not always appropriate to undertake clinical trials  
4 or large-scale observational research.<sup>4-6</sup> As a consequence, sparse evidence from RCTs and  
5 observational studies has been identified for relevant areas of symptom treatment.<sup>7-12</sup>

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8 Many clinical guidelines are therefore grounded in expert opinions and experiences<sup>13</sup>, captured  
9 using consensus building processes such as the Delphi technique. The method has been  
10 adopted by researchers and key opinion leaders in palliative care for the development of clinical  
11 guidelines, treatment recommendations, and assessment tools; to define diagnostic criteria,  
12 disease classification, and quality indicators; and to establish frameworks for policy and  
13 advocacy.<sup>18</sup> The resulting recommendations are endorsed by leading authorities and  
14 professional organisations in the field; they are cited and used as a resource for scientific  
15 justification and health policy decision making. Hence, the results of Delphi studies constitute an  
16 important foundation for decisions with relevance for clinical practice.  
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### 25 26 27 ***Rationale and aim of this study***

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29 In order for the Delphi technique to be a reliable and credible source of evidence in palliative  
30 care research, an examination of the rigour in its application is warranted.<sup>20,22</sup> To assess the  
31 soundness of the resulting guidance and its contribution to the scientific and clinical knowledge  
32 base, it is important to systematically examine the rationale for choosing the Delphi technique;  
33 its conduct; and the quality and transparency of reporting.<sup>22</sup> Biondo et al.<sup>18</sup> have examined the  
34 use of the Delphi technique in palliative care research and focused on its application for  
35 palliative care tool development. However, to date, no attention has been given to its use for the  
36 development of good clinical practice in palliative care. The aim of this review is to  
37 systematically examine the application of the Delphi technique for the development of guidance  
38 for best practice in palliative care.  
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### 51 **Methods**

52 A qualitative and quantitative methodological systematic review<sup>23-26</sup> was undertaken to answer  
53 the review question "How is the Delphi technique being used for the development of guidance  
54 for best practice in palliative care?" **A particularity of a methodological systematic review is its  
55 focus on the studies' methodological features, instead of appraising the evidence on the  
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3 therapeutic effects of medical interventions.<sup>25</sup> Its purpose is to examine the quality of the study  
4 design, and the rigour of the conduct and reporting of the respective studies. We adopted this  
5 methodology to determine whether key components of the Delphi technique were adequately  
6 applied and featured in studies using the method for the development of best-practice-guidance  
7 in palliative care. The procedures for searching, identifying relevant publications, screening,  
8 appraising quality criteria and handling of data extraction were informed by the Centre for  
9 Reviews and Dissemination guidance for systematic reviews and the Preferred Reporting Items  
10 for Systematic Reviews and Meta-Analyses (PRISMA).<sup>27,28</sup>

### 19 **Search strategy**

20 The literature search was conducted using the databases PubMed, CINAHL; Web of Science,  
21 Academic Search Complete, and EMBASE between 15<sup>th</sup> and 22<sup>nd</sup> March 2015. For each  
22 database, a specific search strategy was constructed to ensure high precision and sensitivity  
23 (as an example, see Box 1 for the search strategy in PubMed). The main search was  
24 supplemented by publications identified through other sources during online retrieval of full text  
25 articles.  
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34 [insert Box 1 / search terms]  
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### 38 **Study selection**

39 All records were screened by title and abstract by SJ and were considered for full text analysis if  
40 they fulfilled the eligibility criteria (Box 2). No limits were set in terms of the publication date of  
41 the study. Any uncertainty was resolved through review by SGB and SP.  
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47 [insert Box 2 / criteria for eligibility]  
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### 51 **Data extraction**

52 Qualitative and quantitative data extraction was conducted by SJ using a structured form based  
53 on the principles of the Centre for Reviews and Dissemination guidance for systematic  
54 reviews.<sup>27</sup> Since no reporting criteria for Delphi studies exist to date, criteria were developed  
55 from key publications on the Delphi technique, and based on our own experience of conducting  
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Delphi studies.<sup>20,22,29</sup> We collected all data pertaining to the key methodological components of the Delphi process. Data extraction included details on (1) in- and exclusion criteria of the article; (2) the focus of the study; (3) the rationale for the use of the Delphi technique; (4) the overall study design; (5) the applied methods and the procedure; (6) data analysis; and (7) key outcomes of the consensus process. Finally, a quality assessment was undertaken to rate the rigour of the methodology and the transparency of reporting. The evaluation assessed whether the following elements were considered and transparently described: purpose of the study and rationale for using the Delphi technique; justification for the selection of experts; sound description of methodology including flow chart; clear definition of consensus; piloting of instruments; appropriate use of statistics; transparent reporting of results; adequate feedback and information of next survey round; discussion of limitations; and whether the conclusions drawn by the authors adequately reflected the process and the results of the Delphi study.

## Results

The search yielded 2,649 records. In addition, five records were identified through other sources (Figure 1). Of these, 35 papers published between 1997 and 2015 were identified as meeting the inclusion criteria and were eligible for in-depth analysis (Tables 1 a-c). These 35 papers pertained to 30 Delphi studies since for four of the studies<sup>30-38</sup>, more than one publication was identified. The n=30 Delphi studies will constitute our sample and will be referred to for further analysis. Eleven of these studies had an international scope; 14 a national scope with a (potential) international applicability; and five studies had an explicitly stated national or local scope, mostly conducted by within-country or local research teams.

[insert Figure 1 / PRISMA flow chart]

### *Focus and purpose of the studies*

The majority of the 30 studies focused on interventions in palliative care (n=16); two studies focused on specific conditions; five studies dealt with paediatric or neonatal palliative care; and seven studies concerned standards for palliative care delivery in specific settings or work fields (Tables 1 a-c). Half of the 16 intervention-focused studies (n=8) dealt with the pharmacological

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3 or non-pharmacological management of symptoms such as pain, dyspnoea, or depression.<sup>32-43</sup>  
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5 The remainder considered artificial nutrition or hydration (n=2)<sup>44,45</sup>, psychosocial or spiritual  
6 support (n=3)<sup>30,31,46,47</sup>, end-of-life decision making (n=1)<sup>48</sup>, palliative sedation (n=1)<sup>49</sup>, or  
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8 euthanasia and physician assisted suicide (n=1)<sup>50</sup>. Studies addressing specific conditions  
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10 focused on dementia<sup>51</sup> and multiple sclerosis.<sup>52</sup> Five studies aimed at developing guidance in  
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12 the field of paediatric or neonatal palliative care.<sup>53-57</sup> Of the studies concerning standards for  
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14 palliative care delivery in specific settings or work fields, five were in institutional settings  
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16 (hospital or nursing home<sup>58-62</sup>, one in primary care<sup>63</sup>, and one focusing on general conditions for  
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18 palliative care service delivery<sup>64</sup>.

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21 [insert Tables 1 a-c / Focus and purpose of the studies]  
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### 24 25 ***Rationale for the use of the Delphi technique***

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27 All but three studies (n=27) explicitly provided a rationale for using the Delphi technique. This  
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29 included a lack of published guidance, the appropriateness of the method when evidence is  
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31 needed to be drawn outside the gold standard RCTs, and the aim to build systematic  
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33 consensus in order to resolve uncertainty about a clinical question or a concept of care. Two  
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35 studies emphasised the qualitative nature of the Delphi technique and therefore considered it  
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37 particularly appropriate for clinical questions where quantitative methods are unlikely to yield  
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39 results that can be successfully implemented in practice.<sup>30,58</sup>

### 40 41 42 ***Study design and type of Delphi***

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44 Most studies (n=28) explicitly referred to undertaking a consensus Delphi study. In ten  
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46 publications, the term “modified Delphi technique” was used; only two of these specified what  
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48 exactly the modification entailed. In nine articles modifications were identified but not labelled as  
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50 such; for example, the use of intermediate face-to-face meetings between Delphi survey  
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52 rounds<sup>45</sup> or the involvement of different expert panels in the consensus process.<sup>59</sup>

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54 Of the 30 studies, 10 comprised the Delphi technique alone and 11 comprised a Delphi survey  
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56 plus additional elements such as a preparatory literature review or an evaluative assessment of  
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58 the guidelines during an expert workshop. In nine of the 30 studies, the Delphi technique formed  
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60 part of a larger piece of work with a more complex research design including multiple other

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3 stages such as subsequent field testing of a protocol, or a one-year follow-up to evaluate  
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5 implementation of a clinical guideline.  
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### 8 ***Selection of experts***

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10 The most prominent criteria for the identification and selection of experts were (1)  
11 representation of a particular profession or stakeholder group (n=24); (2) affiliation to a  
12 particular setting or work field (n=23); and (3) relevant clinical and / or academic expertise  
13 (n=20) (Table 2). Other criteria included membership of an organisation or professional board  
14 (n=11), being a recognised authority in the field (n=11), and geographical origin (n=13); with  
15 several studies paying particular attention to a balanced composition of the expert panel with  
16 representation from different regions and socio-economic backgrounds, or a relevant  
17 participation of experts from developing countries.<sup>32-34,43</sup>  
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### 27 ***Definition of consensus***

28 Most studies (n=25) reported a definition of consensus; five did not. Nearly all of them (n=22)  
29 had set an a priori criterion or cut-off (Table 2); one used a post-hoc criterion for exclusion of  
30 items if more than 10% of panellists rated a specific guideline as not important.<sup>62</sup>  
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33 For the majority of studies (n=25), consensus was conceptualised using statistical measures  
34 such as the percentage of ratings or the median value on a rating scale. The attainment of  
35 consensus based on statistical measures was operationalised depending on the rating scales  
36 employed in the study; the most prominent response formats were either a traditional 9-point  
37 scale (n=6) referring to the original RAND UCLA method<sup>32-34,45,47-49,60</sup> or a 5-point Likert  
38 scale<sup>35,36,42,46,51,53,61,62,64</sup>, but 6- / 7- / 10- or 11-point scales were also used.<sup>37,38,41,45,51,53,57,59,62</sup>  
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45 Some studies used a ranking (n=4)<sup>30,31,40,43,58</sup> or selection of items (n=3)<sup>39,52,63</sup> rather than a  
46 scale.  
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48 The cut-off for (non)consensus was mostly based on percentage of agreement (mainly 75 or  
49 80%), median score, or a combination of both (n=23) (Table 2). Three studies distinguished  
50 between different degrees of (dis)agreement and consensus, reporting combined parameters to  
51 define low, moderate, and high levels.<sup>42,51,64</sup> Two studies used a more procedural definition  
52 such as “stability of group response over successive rounds”<sup>30</sup>, or the cut-off for inclusion of  
53 items being based on a “natural break” in the overall score.<sup>58</sup>  
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### ***Number and purpose of rounds***

The number of rounds ranged from one to five, with the majority of the 30 studies reporting either two (n=14), or three (n=8) survey rounds. Only one survey round was reported in two studies.<sup>32-34,46</sup> In terms of duration, for most studies (n=19) no details were provided on the length of survey rounds or the overall process. Seven studies specified the duration of rounds ranging from 10 days to 10 weeks; and four studies provided details on the duration of the overall study process, ranging from two to 18 months.

The majority of studies (n=27) stated the purpose of the survey rounds (Table 3) which comprised: rating or evaluating statements (n=24); identifying issues or generating items (n=8); collecting qualitative responses or comments (n=7); ranking or prioritising items (n=6); reviewing or approving a (final) framework or document (n=5); and developing guiding principles or a draft document (n=4).

### ***Design of Delphi rounds***

Different ways of informing the first and subsequent Delphi rounds were used within the studies. Methods used to inform the first Delphi round included systematic or scoping literature reviews<sup>33,36,37,39,41,42,45,46,49,50,52,53,59,62-64</sup>; a synthesis of already existing guidelines<sup>41,42,44,55,56,60</sup>; the identification of relevant elements and priorities for best practice<sup>32,38,40,45,57,61,64</sup>; the development of a conceptual framework<sup>34,38,39,45,53,56,60,64</sup>; the drafting of statements or guidelines<sup>34,36,41,42,44,45,49-53,57,60-63</sup>; and information packages provided before the start of the first round in order to standardise the knowledge base of panellists.<sup>39,59,60</sup>

The studies in this review reported diverse strategies of processing results between survey rounds and feedback provided to inform the experts' judgements during the next survey round (Table 3). These included a statistical group response of quantitative parameters (n=11), a summary of qualitative comments (n=8), the inclusion of newly generated items (n=10), the modification of items (n=6), the selection or reduction of items (n=9), and the presentation of a document for review or approval (n=8). The reduction of items can both refer to items with (very) high agreement that were instantaneously accepted and therefore did not need further consideration in a subsequent survey round; or to items with (very) low agreement or relevance that were therefore entirely discarded from the list. The process of achieving consensus was not

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3 always visible; for example, eight studies did not detail how the synthesis of responses in one  
4 survey round was used to design the following round; for six studies, the design of the next  
5 survey round was either not reported or was unclear.  
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8 The role of the research team was identified in 25 of the analysed studies and included planning  
9 and managing of the overall study process and processing results to inform the next Delphi  
10 round. Sometimes this involved complex and difficult decisions such as managing persistent  
11 non-consensus<sup>51</sup>, or a conflict between the majority opinion on the best medical treatment and  
12 ethical concerns about this treatment<sup>42</sup> (p. 495).  
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### 17 18 19 **Key outcomes resulting from the studies**

20 The format of the guidance resulting from the Delphi studies varied and included elementary  
21 tables with the top ten criteria identified as relevant for the field in question<sup>30,31,57</sup>; detailed  
22 listings of key recommendations, and lists of recommended medicines (e.g.,<sup>32-34,43,63</sup>); and  
23 complex guidelines comprising several sections including an introduction, definitions, charts,  
24 and clinical algorithms (e.g.,<sup>45,46,49,51</sup>). Variation was also found with respect to the scope of the  
25 resulting guidance claimed by the authors, and the official or even binding character of the  
26 guideline, ranging from rather moderate narrative descriptions of the key aspects resulting from  
27 the Delphi study (e.g.,<sup>30,31,57</sup>) to intensely advocated guidelines with a high level of  
28 dissemination, often endorsed by one or more authorities in the field (e.g.,<sup>32-34,35,36,40,46,64</sup>).  
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### 40 **Quality assessment**

41 A quality assessment was undertaken with respect to the rigour of the conducted studies and  
42 the transparency of reporting (Table 2). While the majority of studies (n=24) fulfilled at least nine  
43 of the 12 predefined quality criteria, for a number of studies one or more of these criteria were  
44 not reported. A clear definition of consensus was not provided for five studies; for 9 studies, an  
45 appropriate discussion of potential limitations was not included; and only for five out of 30  
46 studies some sort of piloting of the survey instruments was reported. The methods were clearly  
47 described for 25 studies, but only six provided a flow chart illustrating the process. In cases  
48 where two articles were included about one study (n=4), the publications differed in terms of the  
49 transparency of reporting; variation was observed not only concerning the total number of  
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3 quality criteria met, but also with respect to which of the criteria were met in either of the two  
4 articles (Table 2).  
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## 8 **Discussion**

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10 This methodological systematic review identified considerable variation in the design and the  
11 reporting of process- and outcome parameters of studies using the Delphi technique to develop  
12 guidance for best practice in palliative care. **In the following, the main findings will be**  
13 **summarised and related to previous treatises on the Delphi technique, with a focus on (1) the**  
14 **rigour of the design and conduct of the analysed studies; (2) the quality of reporting; and (3) the**  
15 **dissemination politics for the resulting guidance. Subsequently, implications and**  
16 **recommendations for research will be discussed, and a standard for Conducting and REporting**  
17 **DElphi Studies (CREDES) will be proposed.**  
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## 27 **Summary of main findings**

### 28 ***The rigour of the design and conduct of Delphi studies***

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30 Across the studies assessed in this review, variation was found regarding the rigour of the  
31 design and the conduct of the Delphi process; this included the absence of a clear consensus  
32 criterion or a piloting of the survey instrument. Also, diverse interpretations were identified of  
33 what constitutes a “Delphi round” and which steps are conceived of as additional preparatory or  
34 concluding stages. Notably, for two studies only one survey round was reported while an  
35 iterative process with at least two rounds is characteristic of the Delphi technique and  
36 constitutes its distinguishing feature compared to a regular survey.  
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43 These findings reveal a lack of clarity and unanimity regarding the core elements of the Delphi  
44 process. This makes the studies vulnerable to bias and arbitrariness during data collection,  
45 analysis, and the interpretation of findings. Furthermore, it renders the Delphi technique  
46 susceptible to criticism as an undependable research method.  
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### 52 ***The quality of reporting***

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54 The identified variations in the level of detail in reporting make it difficult for the reader to  
55 appraise to quality of the study design, its conduct, and the resulting outcomes. For example,  
56 across the assessed studies, it was not always clear how the synthesis of responses in one  
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3 survey round was used to design the following round. A number of exemplary articles analysed  
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5 in this review illustrate how a sound and substantial reporting of essential parameters of the  
6  
7 applied Delphi technique is even possible with limited space (e.g., <sup>35,36,39,42,44,47-49,51-53,59,60,62-64</sup>);  
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9 these can serve as good examples of what is needed to allow the reader to make a judgment  
10  
11 about the rigour of the applied methods, the nature of the consensus building process, and the  
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13 quality of the resulting recommendations.

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15 This review also revealed inconsistencies in the nomenclature and discrepancies regarding the  
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17 terms used to describe the methods applied in the Delphi studies. For example, a  
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19 heterogeneous use of the term “modified Delphi” was observed. Although some authors have  
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21 treated the concept “modified Delphi” as a methodological variant on its own <sup>20,65</sup>, there is no  
22  
23 standard definition as to what a “modified Delphi” exactly entails. Since a range of  
24  
25 methodological variations do exist in the application of the Delphi technique, the use of the term  
26  
27 “modified” should be critically reconsidered – even more when used without further specification  
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29 or explanation. In addition, the reference against which the definition as “modified” is made  
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31 needs to be reassessed. Many studies in this review referred to early literature on the Delphi  
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33 technique; though some early works can still be considered as standard references, it needs to  
34  
35 be taken into account that the methodology has been further developed since its first usage.

### 36 ***Dissemination politics for guidelines resulting from Delphi studies***

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38 Across the analysed studies, the scope of the resulting guidance claimed by the authors varied.  
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40 Depending on the researchers’ scientific provenance and professional affiliation within the  
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42 palliative care research community, studies with only isolated reception were identified, while  
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44 others were intensely advocated with a high degree of dissemination activities and international  
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46 coverage. Some of these were used to inform political decision making or textbook knowledge,  
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48 and were lent credibility through endorsement by one or more authorities in the field, including  
49  
50 the World Health Organization. These findings emphasise the impact of Delphi studies on  
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52 knowledge production in palliative care and underline the importance of methodological rigour  
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54 and robustness of the results.  
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**Recommendations for conducting and reporting Delphi studies: CREDES**

Since clinical guidance in palliative care relies to a considerable extent on the Delphi technique, there is a need for consistency and quality both in the conduct and in the reporting of studies using this method.<sup>20,22,29</sup> This will constitute a prerequisite for acknowledgement of the method as a contribution to robust evidence, and for a higher appraisal of the value of expert judgement in evidence based medicine. Guidance has been proposed for enhancing rigour and transparent reporting of Delphi studies by authors from diverse disciplines;<sup>13,20-22,29</sup> however, clear recommendations on the conduct of Delphi studies and a generally accepted reporting standard for their publication in peer-reviewed journals to date are not available. We therefore propose recommendations concerning the rationale for the choice of the Delphi technique, its conduct, and the reporting of Delphi studies. Building on previous treatises,<sup>18,20,22,29</sup> and drawing on the findings from this review, a guide on minimal requirements was created for Conducting and REporting of DElphi Studies (CREDES) (Box 3). Like existing reporting standards for other types of research, such as CONSORT,<sup>66</sup> COREQ,<sup>67</sup> or PRISMA,<sup>28</sup> these can be used by researchers undertaking Delphi studies, by authors publishing them, and by reviewers and journal editors when evaluating the quality of the study design and the transparency of reporting. Since such a standard to date does not exist, CREDES may also be used for studies using the Delphi technique outside palliative care research.

[insert Box 3 / Conducting and REporting of DElphi Studies (CREDES)]

***Recommendations concerning the rationale for the use of the Delphi technique***

In line with Greenhalgh et al.<sup>2</sup>, we argue that there is a need for an alternative view of evidence based medicine which emphasises the value of expert judgement, including implicit or tacit knowledge, for example pertaining to clinical routines, that is not directly accessible through clinical trials. However, this implies that the choice of the Delphi technique as a method of systematically collating expert consultation and building consensus needs to be well justified. When choosing it for the development of good clinical practice in palliative care, two aspects need to be taken into account: (1) it is a heuristic device that relies on expert knowledge to negotiate a shared reality and to co-construct knowledge, rules, and recommendations; and (2) its outcomes can only be as reliable as the available evidence and the participating experts.



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<sup>13,68,69</sup> In consequence, it is important to keep in mind its constructivist nature when selecting the Delphi technique to answer a particular research question.<sup>68,70-72</sup>

### ***Recommendations for a sound and rigorous conduct of Delphi studies***

When properly employed, the Delphi technique has the potential to create an environment that will allow experts to arrive at justifiable, valid and credible solutions based on the best available evidence and their experiential expertise (Box 3).<sup>14,22</sup>

#### *Design, planning, and process*

Flexibility of the Delphi technique allows adaptation of the method to the requirements of the study.<sup>22</sup> However, this should be done systematically and rigorously, justified by a rationale and (whenever possible) a reference, to avoid arbitrariness. This includes systematic methodological decisions such as careful planning of the process and justification of potential modifications; as well as thorough development, review, and piloting of all relevant material used throughout the consensus process such as cues and questions, survey instruments, information and feedback provided to experts.

#### *Definition of consensus*

Ideally, an a priori criterion for consensus should be defined that is suitable for the purpose of the study and applicable for the research question. As Diamond et al.<sup>29</sup> concluded from their systematic review on operationalisations of consensus, the mere fact of conducting a Delphi study does not automatically imply consensus as its outcome. In the field of palliative care, perfect agreement may often not be realistic due to different values, world views, and ethical dilemmas concerning medical decision making. Therefore, the definition of consensus needs to include procedures to be followed when consensus is not reached after several iterations. This should be done in line with the envisaged scope of the resulting guidance, e.g. in terms of its geographical span (local, national, or international); the range of settings for which it is intended; or the applicability for one specific disease versus diverse conditions. The criteria for consensus should provide a clear and transparent guide for action how to proceed with certain items or topics in the next survey round – for example, delete them from the list, or refine them in order to attain higher consensus.<sup>29</sup> If an a priori definition of consensus is not realistic due to the

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3 explorative nature of the study, it should be identified and established by the research team in  
4 the course of the process.  
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#### 7 8 *Interpretation of results* 9

10 When interpreting the results of a Delphi study, it needs to be considered that consensus does  
11 not necessarily imply that the “correct” answer or judgement has been found.<sup>71</sup> The meaning of  
12 (non)consensus needs critical reflection; the value of stable disagreement must not be  
13 underestimated since it provides informative insights and highlights differences in perspectives  
14 regarding complex issues.<sup>70</sup>  
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#### 19 20 21 *Ensuring credibility and preventing bias* 22

23 It is the responsibility of the research team to allow the experts to arrive at valid and credible  
24 judgements. Research is often driven by an original interest of the principal investigator who is  
25 likely to have a determined position on a given topic; and the technique may force consensus  
26 while several individuals still maintain their different positions.<sup>20,68</sup> It is therefore important to  
27 make sure to refrain from directly or indirectly influencing the experts’ judgements.  
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#### 33 34 *Informational input* 35

36 Attention should be paid to how information will influence – and possibly bias - panellists’  
37 judgements. This includes information provided at the outset of the study, such as a synthesis  
38 of the available evidence; as well as the synthesis of experts’ responses provided as feedback  
39 to inform the next survey round. Piloting informational input is indispensable to examine its  
40 effect on experts’ judgements, preferably with selected candidates who are representative of the  
41 expert panel. Likewise, the survey instrument needs to be pilot-tested for the impact of cues and  
42 questions on the panellists’ responses. In addition, prevention of bias can entail a balanced  
43 composition of the core research group; entrusting an independent researcher with the main  
44 coordination of the consensus process; ensuring critical reflection of outcomes within the team;  
45 and having a final draft of the outcomes reviewed by an external board or authority before  
46 publication and dissemination.  
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### ***Recommendations for a transparent reporting of Delphi studies***

All methodological decisions throughout the Delphi process should be reported transparently to allow readers to understand the steps taken, the involvement of consensus building, and to judge the results obtained (Box 3).<sup>22,29</sup> This comprises a transparent description of the expert panel, the procedure, the attainment of consensus, as well as the impact of methodological limitations on the interpretation of results and the ensuing guidance for good practice in palliative care. The format of reporting should be thoroughly reflected; in addition to the resulting guidance on good clinical practice in palliative care (e.g., a clinical guideline or a white paper), the publication of an additional methodological paper or at least a study protocol should be considered to inform transparently on details of the study process (e.g.,<sup>51,64</sup>). A careful dissemination plan includes advocating the outcomes of the Delphi study by seeking professional endorsement and political support.<sup>14</sup> On an overarching level, clarity regarding the nomenclature and the terminology when reporting on Delphi studies should be attained. For example, the use of terms such as “round” or “modified Delphi study” should be clear and unambiguous. Therefore, agreement needs to be settled on essential elements of the Delphi technique, on the definition of its core features (e.g., what constitutes a “round”), as well as the necessary features to qualify a study as a “Delphi process”. This will lay the foundation for unambiguous reporting on the methodological features of a particular Delphi study, including possible modifications.

### **Strengths and limitations**

A particular feature of this review is its focus on research methodology. Since the credibility of scientific knowledge depends on the rigour of the underlying research, a systematic investigation of its methodology contributes to quality of health care and palliative care research. Robustness and credibility of the analysis was supported by a multi-professional team of international researchers.

A limitation of this review is that it was restricted to English language, and only considered original articles published in peer-reviewed journals whilst not including grey literature. Best-practice-guidance for palliative care with a national or local scope, or published outside the scientific databases, may therefore be underrepresented in the analysis. In addition, the consideration of grey literature – including the full clinical guidelines resulting from the Delphi

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3 studies or final project reports – may have allowed for extraction of more complete  
4 methodological details in order to inform the quality assessment performed as part of this  
5 review; in consequence, the rigour of the applied methods and the transparency of reporting  
6 may have been underestimated. However, several of the reviewed articles exemplified that  
7 essential information on the applied methods can be provided even with limited space.  
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11 The abovementioned limitations notwithstanding, the elaborated recommendations have the  
12 potential to improve the future conduct and reporting of Delphi studies and to facilitate the  
13 scientific review process of the resulting publications.  
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## 21 **Conclusions**

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23 The Delphi technique as a means of attaining expert consensus plays an important role for the  
24 development of guidance for good medical practice not only in the absence of sufficient  
25 published evidence from RCTs. The quality of the resulting recommendations largely depends  
26 on the rigour of the application and reporting of consensus processes. This methodological  
27 systematic review analysed the application of the Delphi technique for the development of best-  
28 practice guidance in palliative care with a particular focus on the quality of the study conduct  
29 and the transparency of reporting. In line with Hasson et al. and Diamond et al.,<sup>20,22,29</sup> we  
30 recommend a rigorous use of the technique including justification of details in the study design.  
31 Building on previous treatises,<sup>13,18,20,22,29</sup> a guide for the Conduct and Reporting of Delphi  
32 Studies (CREDES) was created to allow an appraisal of the methodological quality and the  
33 robustness of the resulting recommendations. Like existing standards for other types of  
34 research, this can be used by researchers, reviewers, and journal editors. Future research  
35 should aim for settling international agreement on the definition of essential elements of the  
36 Delphi technique, and on the nomenclature of its core features. **This will constitute a  
37 prerequisite for acknowledgement of the method as a contribution to robust evidence.**  
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## 55 **Authors' contribution**

56 SJ developed the research idea; the review question and the design, conducted the literature  
57 search, constructed the data extraction form, performed data extraction and analysis, and  
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3 drafted the manuscript. SP and SGB provided support with identifying the final review question,  
4 reviewed the data extraction form, critically reviewed selected papers for in- or exclusion, and  
5 provided expertise and advice with writing the manuscript. JB provided expertise and support  
6 with developing the search strategy for the different data bases and with doing the literature  
7 search. LR critically reviewed the manuscript for important intellectual content and contributed  
8 with expertise to the discussion of results. All authors provided critical comments on drafts of the  
9 manuscript and approved the final version.  
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#### 17 **Declaration of Conflicting Interests**

18 The Authors declare that there is no conflict of interest.  
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**Guidance on Conducting and Reporting DElphi Studies (CREDES) in palliative care –  
recommendations based on a methodological systematic review**

**Tables, Figures, and Boxes**

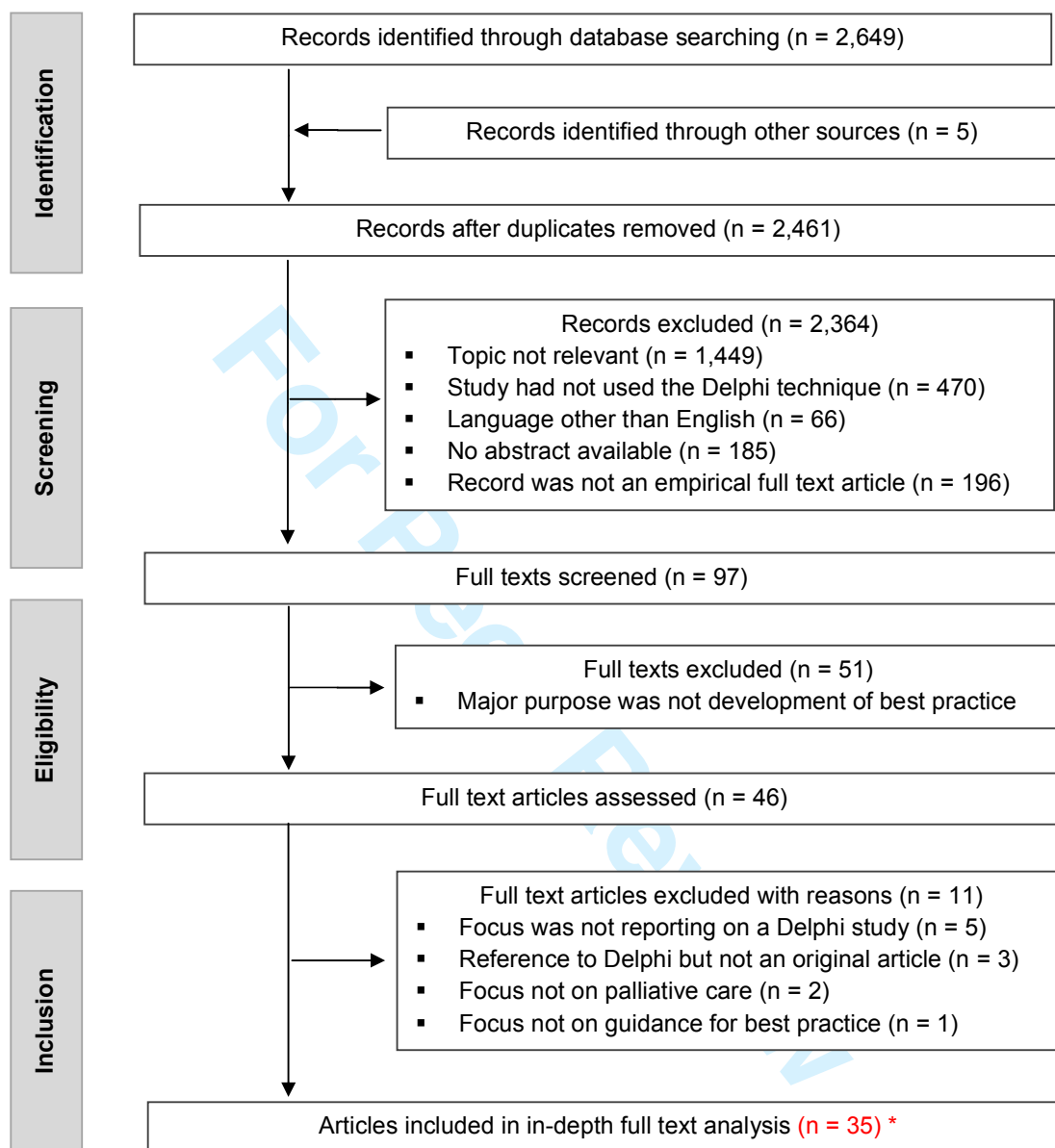
**Box 1 Search terms and search strategy in PubMed**

Search (((("Delphi Technique"[Mesh]) OR "Consensus"[Mesh]) OR (delphi OR consensus))) AND (((("Hospice and Palliative Care Nursing"[Mesh] OR "Palliative Medicine"[Mesh] OR "Palliative Care" [Mesh] OR "Hospice Care"[Mesh] OR "Terminal Care"[Mesh] OR "Hospices"[Mesh])) OR (hospice OR palliative OR "end of life"))

**Box 2 Criteria for eligibility**

|                            |   |
|----------------------------|---|
| <b>Topic</b>               | The focus of the study addresses a research question or issue in the field of palliative and / or hospice care  |
| <b>Purpose</b>             | The study aimed at improving patient care through identifying consensus-based components of best practice in palliative care and seeking to develop some sort of guidance about these, such as a list of best practices, a protocol, a standards, or a guideline  |
| <b>Language</b>            | English   |
| <b>Type of publication</b> | Full text article reporting on an empirical study (excluded: conference abstracts; papers referring to a Delphi study but not reporting the methodology)  |
| <b>Methodology</b>         | Delphi technique / modified Delphi technique (excluded: surveys or qualitative enquiries not fulfilling the criterion of an iterative process with at least two rounds; consensus procedures other than Delphi (conferences, nominal group technique, workshops)) |

Figure 1 – Flow diagram of the systematic literature search



\* These n = 35 articles pertain to n = 30 Delphi studies since for four studies, more than one article was identified.

**Table 1a** Projects focusing on best practice in the field of specific interventions

| Nr. | Author(s), year                     | Geographical scope   | Major topic   | Aim / purpose / expected outcome  | Guidance for best practice - content  | Guidance – format and product  |
|-----|-------------------------------------|--|---|---|---|--|
| 3.a | Bridgman et al., 1997 <sup>30</sup> | UK   | Family support for patients in need of palliative care in a hospital  | To identify (a) supportive nursing behaviours / the most helpful care in assisting families of palliative care patients to deal with the demands of the illness; and (b) difficulties nurses encounter in trying to meet the needs of these families, and factors against effective provision of family care in a hospital. | Categories for providing family-focused palliative care in hospital   | Two tables listing the 10 most important topics for providing family-focused care, and the 10 most important difficulties in providing that care; discussion with focus on the four most important aspects for each category, illustrating them with free text answers from the first Delphi round |
| 3.b | Bridgman et al., 1998 <sup>31</sup> | UK   | Family end-of-life support in hospital                                | To identify what nurses regarded as the most helpful way to provide care and assistance to the families of patients receiving palliative care, to help them deal with the illness and the difficulties nurses encounter.  |   |  |
| 6.a | De Lima et al., 2007 <sup>32</sup>  | Worldwide  | Symptom treatment / essential medicines in palliative care.           | To develop a list of essential medicines for palliative care, based on the recommendation from palliative care experts, taking into consideration the criteria of efficacy and safety.  | International Association for Hospice and Palliative Care (IAHPC) List of Essential Medicines for Palliative Care | Table listing 33 medications including details on formulation, indication, and reference to the World Health Organization (WHO) Essential Medicines Model List   |
| 6.b | De Lima, 2012 <sup>33</sup>         | Worldwide  | Symptom treatment / essential medicines in palliative care            | To develop a list of essential medicines for palliative care by expert consensus, facilitating provision of the best possible care for all those with advanced life threatening illness.  |   |  |
| 6.c | De Lima et al., 2007 <sup>34</sup>  | Worldwide  | Symptom treatment; essential medicines in palliative care             | To develop a list of essential medicines for palliative care, based on the consensus of international palliative care clinicians, following the criteria of efficacy and safety   |   |  |
| 8.  | Downar et al., 2010 <sup>48</sup>   | CAN  | Discussion of do-not-resuscitate (DNR) order and goals of care        | To develop content guidelines for physicians for the discussion of cardiopulmonary resuscitation (CPR) or "code status" and goals of care. To facilitate effective, informed, and ethically sound decision making.  | Guidelines for the discussion of cardiopulmonary resuscitation (CPR) and goals of care                            | A full list of consensus statements provided in the appendix of the paper (9 statements on timing, framing, offering a prognosis, etc.)  |
| 9.  | Dreesen et al., 2012 <sup>44</sup>  | Europe; study based in BE; 5 countries involved (BE, FR, DE, IT, ES) | Home parenteral nutrition for cancer patients                         | To identify key interventions to ensure high-quality home parenteral nutrition care for cancer patients and to rank/ to agree on main outcome indicators.<br>To investigate whether the resulting parameters differed from those suggested for the care of benign patients.   | Key interventions and outcome indicators for home parenteral nutrition for cancer patients                        | Table listing a set of 42 key interventions for good clinical practice in home parenteral nutrition; table with top ten quality of care outcome indicators   |
| 12. | Holmes et al., 2008 <sup>39</sup>   | USA  | Medication use in palliative care for patients with advanced dementia | To evaluate the feasibility of developing consensus recommendations for appropriate prescribing for patients with advanced dementia in whom palliation of symptoms is the primary goal, using a conceptual framework; and to determine the frequency of inappropriate medication use.                                       | Recommendations for appropriate medication use for persons with advanced dementia in need of palliative care      | Table providing a full final list of medications according to their level of appropriateness (always / sometimes / rarely / never appropriate; no consensus).  |
| 13. | Hudson et al., 2012 <sup>46</sup>   | AUS / international  | Family caregivers.  | To develop clinical practice guidelines for multidisciplinary health care professionals and clinical services commonly involved in caring for adult patients receiving palliative care to guide the provision psychosocial and bereavement support of family caregivers of palliative care patients.                        | Guidelines for the psychosocial and bereavement support of family care givers of palliative care patients         | Two tables, one listing 14 principles for family caregiver support and one with a summary of 20 guideline statements comprising four parts; complete guidelines available online   |

|       |  |  |   |   |   |   |
|-------|--|--|---|---|---|---|
| 15.   | Lindqvist et al., 2013 <sup>40</sup>           | International; 9 participating countries: AR, DE, IT, NZ, SI, SE, CH, NL, UK | Essential medicines / medical symptom treatment in palliative care    | To explore the degree of consensus about appropriate pharmacological treatment for common symptoms in the last days of life for patients with cancer, among physicians working in specialist palliative care  | Essential drugs for quality care of the dying   | Four classes of essential drugs that should be available for all patients in the last days of life  |
| 16a.  | Mahler et al., 2010 <sup>35</sup>              | USA; worldwide   | Symptom management; dyspnoea; advanced lung or heart disease          | To provide consensus statements on effective relief of dyspnoea to address the problem that patients with advanced lung or heart disease are not being treated consistently and effectively for the relief of dyspnoea.   | American College of Chest Physicians (ACCP) consensus statement on the management of dyspnoea in patients with advanced lung or heart disease                       | List of 20 ACCP consensus statements, covering five domains, with additional explanation in the text body of the article.   |
| 16b.  | Mahler et al., 2010 <sup>36</sup>              | USA / international  | Symptom management; dyspnoea; advanced lung or heart disease          | To develop a consensus statement on the management of dyspnoea in patients with advanced lung or heart disease; to influence clinical practice and to provide suggestions for consistent and effective treatment of dyspnoea in patients with advanced lung or heart disease. |   |   |
| 18.   | Morita et al., 2005 <sup>49</sup>              | JP   | Palliative sedation   | To construct a clinical guideline for palliative sedation therapy to help clinicians adequately perform sedation and ensure better quality care for terminally ill patients.  | Clinical guideline for palliative sedation therapy  | Extensive and detailed guideline comprising four sections with narrative guidance, four diagrams for clinical application (algorithms), and two tables listing standard treatments for symptoms and sedatives used in palliative sedation therapy |
| 19.   | Morita et al., 2007 <sup>45</sup>              | JP   | Artificial hydration therapy for adult patients with incurable cancer | Establishing a clinical guideline with recommendations on best practice for artificial hydration therapy that can contribute to patient well-being, and to improve quality of life, dying, and death by clarifying best practice for Japan.                                   | Clinical guideline for artificial hydration therapy for terminally ill patients with cancer   | Extensive and detailed guideline including a conceptual framework (flow chart), a list of 14 general recommendations, and nine sections of specific recommendations for practice of artificial hydration therapy in diverse conditions            |
| 20.   | Onwuteaka-Philipsen et al., 2001 <sup>50</sup> | NL / international   | Euthanasia and physician-assisted suicide                             | To develop a protocol for consultation of another physician for euthanasia. To make it easier for general practitioners to find an independent and knowledgeable consultant, but also to professionalise consultation and to ensure uniformity.                               | Protocol for consultation of another physician in case of euthanasia and assisted suicide   | Four boxes listing necessary and recommended guidelines for consultation addressing independence, expertise, tasks, and judgement of the consultant   |
| 21.   | Pigni et al., 2010 <sup>41</sup>               | International, Europe  | Symptom management; opioid treatment for cancer pain                  | To critically revise and update the EAPC recommendations on cancer pain management.<br>To have valid evidence-based guidelines for the improvement of cancer pain management.   | European guidelines on the use of opioids for cancer pain   | Table listing 22 key topics to be further analysed for good clinical practice by means of systematic reviews to assess current evidence   |
| 22.a. | Rayner et al., 2011 <sup>37</sup>              | International, Europe  | Symptom management / depression in palliative cancer care             | To produce a European evidence-based clinical guideline on the management of depression in patients receiving palliative care to inform practice, establish policy, promote European consensus and ultimately improve patient outcomes.                                       | Evidence-based European guidelines on the management of depression in palliative cancer care (European Palliative Care Research Collaborative depression guideline) | Guideline with three main sections: (1) prevention; (2) detection, diagnosis and assessment; and (3) treatment. Summary of the final key recommendations including an explanation, references, and the quality of evidence / strength of          |
| 22.b. | Rayner et al., 2011 <sup>38</sup>              | International, Europe  | Symptom management; depression in palliative                          | To inform the development of best practice recommendations for the European Palliative Care Research Collaborative clinical practice  |   |   |



|     |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|
|     |   |   | care  | guideline on managing depression in palliative care.  |   | recommendation based on GRADE   |
| 27. | van der Maaden et al., 2014 <sup>42</sup> | NL, USA, CAN, UK, IT, DE, CH, CZ <sup>1</sup> | Symptom relief for patients with pneumonia and dementia | To develop a practice guideline for a structured and consensus-based approach for optimal symptom relief and comfort specifically for patients with pneumonia in patients with dementia in nursing homes.   | Practice guideline for optimal symptom relief for patients with pneumonia and dementia in nursing homes | Practice guideline consisting of an introduction, a checklist of symptoms and the core guidelines   |
| 29. | Vermandere et al., 2013 <sup>47</sup>     | BE, NL  | Spiritual care in palliative home care                  | To develop a consensus-based framework of the main elements of spiritual care within the context of palliative home care.   | Framework for spirituality in palliative home care  | Table listing nine domains with 14 core elements of spiritual care within the context of palliative home care                                       |
| 30. | Vignaroli et al., 2012 <sup>43</sup>      | International                                 | Pain management with opioids in adults                  | To develop an opioid essential prescription package (OEPP) to be used when initiating a prescription for the control of moderate to severe chronic pain, that would ensure that opioids are better tolerated by patients and therefore lead to more sustained improvements in pain control. | International Hospice and Palliative Care Association (IAHPC) opioid essential prescription package     | Table listing the opioid essential prescription package including details on drug class, recommended medicine, routes of administration, and dosage |

**Table 1b Projects focusing on specific conditions**

| Nr. | Author(s), year                          | Geographical scope         | Major topic  | Aim / purpose / expected outcome  | Guidance for best practice - content  | Guidance – format and product  |
|-----|--|----------------------------|--|---|---|--|
| 25. | Strupp et al., 2014 <sup>52</sup>        | DE                         | Specialised palliative care integration for patients with MS | Analysis of when and why specialised palliative care integration for patients with multiple sclerosis would be beneficial by examining health care professionals' attitudes                           | Guidance on integration of palliative care for severely affected patients with multiple sclerosis | Table listing possible criteria for integrating specialist palliative care in multiple sclerosis, completed by explanations in the text  |
| 28. | van der Steen et al., 2014 <sup>51</sup> | Europe-wide; international | Palliative care for people with dementia                     | To define optimal palliative care in dementia as distinct from palliative care for other patient groups. Definition of domains and provision of guidance on palliative care for people with dementia. | White Paper defining optimal palliative care in older people with dementia                        | Box listing 11 core domains of optimal palliative care for people with dementia, with a set of 57 recommendations and a figure on goals of care in the course of disease progression; final version including explanatory text available as online supplementary Annex |

<sup>1</sup> Dutch focus, therefore some of the decisions were adjusted to the Dutch experts / context. Certain recommendations should be re-evaluated in other countries because when literature and consensus were lacking, we prioritised the situation in the Netherlands.

**Table 1c Projects focusing on paediatric palliative care**

| Nr. | Author(s), year                     | Geographical scope                       | Major topic  | Aim / purpose / expected outcome   | Guidance for best practice - content  | Guidance – format and product   |
|-----|-------------------------------------|--|--|--|---|---|
| 1.  | Bradford et al., 2014 <sup>53</sup> | AUS                                      | Paediatric palliative care                                 | To define the components and principles of an early paediatric palliative care consultation (i.e., not end of life); to develop a published framework from expert consensus.   | Framework of components and principles of a paediatric palliative care consultation   | Algorithm / flow chart  |
| 4.  | Carter et al., 2001 <sup>54</sup>   | Medical College of Georgia, Augusta, USA | Neonatal intensive care                                    | To develop a clinical practice guideline for providing comfort care to newborns with life-limiting conditions for the neonatal intensive care unit, with the following purposes: to be (1) practical, (2) family-centred, (3) respectful of the infant patient, and (4) educational.                         | Comfort / palliative care guidelines for neonatal practice  | Guidelines comprising three sections (purpose, newborns for whom the guidelines are appropriate, and 17 guideline statements)   |
| 5.  | Catlin et al., 2002 <sup>55</sup>   | USA                                      | Neonatal palliative care                                   | To create a palliative care protocol for newborns, delineating the needs of patients, families, and staff necessary to provide a pain-free, dignified, family- and staff-supported death for newborns who cannot benefit from intensive, life-extending, technological support.                              | Neonatal end-of-life protocol   | Detailed narrative guideline comprising 14 sections / domains with an introduction and bullet points providing guidance for practice  |
| 10. | Finlay et al., 2008 <sup>56</sup>   | UK                                       | Paediatric palliative care / psychosocial end-of-life care | To develop a "best practice framework" to improve child and family engagement in the planning process at the end of life and to aid communication and decision making with parents and children.   | Best practice "lifetime" framework for planning for the end of life for children with a non-malignant life-limiting condition | A "3x3 framework" addressing plans and actions for the child, the family, and extra-familial others during three different stages in the disease trajectory before death, acute event/at death, and after death |
| 17. | Mendes et al., 2013 <sup>57</sup>   | PT                                       | Neonatal palliative care                                   | To develop a new programme for better end-of-life care for infants and their families in Portugal.<br>Specific objectives: (1) to identify the main areas for the protocol; (2) to build consensus; and (3) to elaborate a protocol for neonatal palliative care that could be used in the Portuguese NICUs. | Protocol for neonatal palliative care   | Detailed narrative guidance for neonatal palliative and end of life care comprising seven areas of practice   |

**Table 1d Projects focusing on standards for palliative care delivery in specific settings or work fields**

| Nr. | Author(s), year                    | Geographical scope | Major topic  | Aim / purpose / expected outcome   | Guidance for best practice - content  | Guidance – format and product   |
|-----|------------------------------------|--------------------|--|--|---|---|
| 2.  | Bradley et al., 2009 <sup>58</sup> | USA                | Palliative care in a surgical intensive care unit (SICU) | To formulate patient-specific guidelines for identifying patients most in need of palliative care consultation in the SICU; clinically relevant "triggers" that can be used in the SICU to identify those patients who can benefit from palliative care involvement. | Guidelines to identify patients who would benefit from palliative care services in the SICU | Table with 10 criteria to identify patients in a SICU setting in need for a palliative care consult |
| 7.  | De Lima et                         | Worldwide          | Primary palliative care;                                 | To identify the essential practices in primary palliative care that could  | International Association for Hospice   | Table listing 62 consented and  |

|     |   |                              |  |   |  |  |
|-----|---|------------------------------|--|---|--|--|
|     | al., 2012 <sup>63</sup>                   |                              | essential components for optimal pc provision                            | be provided by physicians, nurses, and nurse aides working at the primary care level and providing guidance on practices aimed at meeting the most prevalent needs of palliative care patients and their families.  | and Palliative Care (IAHPC) List of Essential Practices in Palliative Care                     | approved essential practices in palliative care, subdivided in four categories addressing physical and psychological care needs, care planning, and communication  |
| 11. | Hawryluck et al., 2002 <sup>59</sup>      | CAN                          | Palliative care and palliative sedation in the intensive care unit (ICU) | To develop consensus guidelines on the administration of analgesia and sedation in dying intensive care unit patients that help distinguish palliative care from euthanasia, decrease confusion and anxiety regarding the use of opioids and sedatives, and that consider the unique challenges encountered when palliating dying ICU patients. | Guidelines on analgesia and sedation in dying ICU patients                                     | Four tables with guidance for practice listing 16 consensus statements addressing general aspects of palliative care in an ICU setting, management of pain and suffering, ways of improving palliative care in the ICU, and areas of controversy |
| 14. | Jünger et al., 2012 <sup>64</sup>         | International scope / Europe | General concepts and principles of palliative care delivery              | To provide an empirical basis for a common understanding of palliative care delivery in Europe; to provide guidance and recommendations for service providers, stakeholders, and policy makers  | White Paper on standards and norms for hospice and palliative care in Europe                   | Figure with key dimensions for the development of norms for palliative care in Europe; reference to full text of White Paper   |
| 23. | Sasahara et al., 2009 <sup>60</sup>       | JP                           | Hospital palliative care consultation teams for cancer patients          | To develop a hospital-based palliative care consultation team standard / to standardize the role of palliative care consultation teams, providing guidance on minimum standards for new palliative care consultation teams.   | Standard for hospital-based palliative care consultation teams                                 | Detailed guideline comprising four sections with specific recommendations for practice   |
| 24. | Sprung et al., 2014 <sup>61</sup>         | Worldwide                    | End-of-life care for the critically ill in intensive care (adults)       | To develop worldwide professional consensus for key end-of-life practices and to determine the extent of worldwide consensus / lack of consensus on end-of-life practices.  | Principles of end-of-life care for the critically ill  | Extensive and detailed table listing 22 specific recommendations for worldwide end-of-life practice in intensive care units  |
| 26. | Temkin-Greener et al., 2015 <sup>62</sup> | USA                          | Palliative care in nursing homes   | To achieve consensus on guidance for palliative care teams in nursing homes, based on the guidelines developed by the National Consensus Project.   | Palliative care practice guidelines and standards for nursing-home based palliative care teams | Table listing 17 practice guidelines in 7 domains of care  |

Table 2 Selection of experts, definition of consensus, and quality of reporting

| Author(s), year                           | Transparency and quality of reporting |                      |  |                              |            |                               |                           |                                  |  |                       |                           |                         | Selection criteria expert panel |                      |                                      |                    |                      | Definition of consensus   |  |
|---|---------------------------------------|----------------------|--|------------------------------|------------|-------------------------------|---------------------------|----------------------------------|--|-----------------------|---------------------------|-------------------------|---------------------------------|----------------------|--------------------------------------|--------------------|----------------------|---|--|
|   | Purpose well defined                  | Rationale for Delphi | Selection of experts clearly justified | Clear description of methods | Flow chart | Clear definition of consensus | Pilot test of instruments | Transparent reporting of results | Data analysis clearly justified and reported | Information of rounds | Discussion of limitations | Adequacy of conclusions | Member of organisation          | Recognised authority | Relevant clinical academic expertise | Geographical scope | Setting / work field |   | Profession / stakeholder   |
| Bradford et al., 2014 <sup>53</sup>       | ✓                                     | ✓                    | ✓                                      | ✓                            | ✓          | ✓                             |                           | ✓                                | ✓  | ✓                     | ✓                         | ✓                       | ✓                               |                      |                                      |                    | ✓                    | ✓   | ≥ 80% of panellists (strongly) agree                                       |
| Bradley et al., 2009 <sup>58</sup>        | ✓                                     | ✓                    | ✓                                      | ✓                            |            | ✓                             |                           | ✓                                | ✓  | ✓                     | ✓                         | ✓                       | ✓                               |                      | ✓                                    | ✓                  | ✓                    |   | Cut-off for inclusion of items based on a "natural break" in overall score |
| Bridgman et al., 1997 <sup>30</sup>       | ✓                                     | ✓                    |  |                              |            | ✓                             |                           |                                  |  |                       | ✓                         |                         |                                 |                      |                                      |                    | ✓                    | ✓   | Stability of group response on an item over successive rounds              |
| Bridgman et al., 1998 <sup>31</sup>       | ✓                                     | ✓                    | ✓                                      | ✓                            |            |                               |                           | ✓                                | ✓  | ✓                     |                           | ✓                       |                                 |                      | ✓                                    |                    | ✓                    | ✓   | /  |
| Carter et al., 2001 <sup>54</sup>         | ✓                                     | ✓                    | ✓                                      |                              |            |                               |                           |                                  |  |                       | ✓                         |                         | ✓                               |                      |                                      |                    | ✓                    | ✓   | /  |
| Catlin et al., 2002 <sup>55</sup>         | ✓                                     | ✓                    | ✓                                      |                              |            |                               |                           |                                  |  |                       |                           | ✓                       | ✓                               |                      |                                      |                    | ✓                    | ✓   | /  |
| De Lima et al. (#485), 2007 <sup>34</sup> | ✓                                     |                      |  |                              |            | ✓                             |                           |                                  |  | n/a                   |                           |                         |                                 |                      |                                      | ✓                  | ✓                    | 1-3 (9-point scale) not safe/effective; 7-9 very safe and effective         |  |
| De Lima et al., 2007 <sup>32</sup>        | ✓                                     |                      |  |                              |            | ✓                             |                           |                                  |  | n/a                   |                           |                         |                                 |                      |                                      | ✓                  | ✓                    | ≥ 50% rating score ≥ 7 on a 9-point scale for both safety and efficacy      |  |
| De Lima, 2012 <sup>33</sup>               | ✓                                     |                      |  |                              | ✓          | ✓                             |                           |                                  |  | n/a                   |                           |                         |                                 |                      | ✓                                    | ✓                  | ✓                    | 1-3 (9-point scale) not safe/effective; 7-9 very safe and effective         |  |
| De Lima et al., 2012 <sup>63</sup>        | ✓                                     |                      | ✓                                      | ✓                            |            | ✓                             |                           | ✓                                |  |                       |                           |                         |                                 |                      |                                      | ✓                  | ✓                    | ≥ 80% of panellists rating a practice as "essential"                        |  |
| Downar et al., 2010 <sup>48</sup>         | ✓                                     | ✓                    |  | ✓                            |            | ✓                             |                           | ✓                                | ✓  | ✓                     | ✓                         | ✓                       |                                 |                      | ✓                                    |                    | ✓                    | 70% of panellists rating of ≥ 7 on a 9-point scale                          |  |
| Dreesen et al., 2012 <sup>44</sup>        | ✓                                     | ✓                    | ✓                                      | ✓                            |            | ✓                             |                           | ✓                                | ✓  | ✓                     | ✓                         | ✓                       | ✓                               |                      | ✓                                    | ✓                  | ✓                    | Median >5 (6-point scale); 75% rated intervention as (strongly) contributes |  |



|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sasahara et al., 2009 <sup>60</sup>       | ✓ |   | ✓ | ✓ |   | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Median ≥ 8 (9-point-scale) + difference between min and max rating ≤ 4 <sup>5</sup>                               |
| Sprung et al., 2014 <sup>61</sup>         | ✓ |   | ✓ | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |   | ✓ | ✓ | ✓ | ≥ 80% of panellists (strongly) agree with statement (4 / 5 on a 5-point-scale)                                    |
| Strupp et al., 2014 <sup>52</sup>         | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |   |   | ✓ |   | ✓ | ✓ | ≥ 75% of panellists agree on a statement (yes / no responses)   |
| Temkin-Greener et al., 2015 <sup>62</sup> | ✓ | ✓ | ✓ | ✓ |   |   |   | ✓ | ✓ | ✓ | ✓ | ✓ |   |   | ✓ |   | ✓ | ✓ | No a priori criteria for agreement; disagreement: ≥ 10% ratings of a guideline as not (at all) important          |
| van der Maaden et al., 2014 <sup>42</sup> | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ |   |   |   |   | ✓ | ✓ | Detailed parameters for strong / moderate consensus <sup>6</sup> and a compromise option "I can live with it"     |
| van der Steen et al., 2014 <sup>51</sup>  | ✓ | ✓ | ✓ | ✓ |   | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ | Detailed parameters for importance rating and for high / moderate / low agreement on recommendations <sup>7</sup> |
| Vermandere et al., 2013 <sup>47</sup>     | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ | Median ≥ 8 (9-point-scale); ≥ 30% ratings 1-3 and 8-9 = disagreement <sup>8</sup>                                 |
| Vignaroli et al., 2012 <sup>43</sup>      | ✓ |   | ✓ | ✓ |   | ✓ |   | ✓ | ✓ | ✓ | ✓ | ✓ |   |   | ✓ |   | ✓ | ✓ | ≥ 75% of panellists ranking a medication as safe and effective <sup>9</sup>                                       |

<sup>5</sup> If panellists rated a statement as less than 6 they were asked to give the reason.

<sup>6</sup> Median 4 or 5, IQR ≤ 2 → Moderate consensus on agreement with statement; Median 1 or 2, IQR ≤ 2 → Moderate consensus on disagreement with statement; Median 4 or 5, IQR ≤ 1 → Strong consensus on agreement with statement; Median 1 or 2, IQR ≤ 1 → Strong consensus on disagreement with statement; Median 1 / 2 / 4 / 5; IQR > 2; Median 3; no IQR → No consensus

<sup>7</sup> Importance rating of domains: mean score ≥ 8; elimination of items scoring ≤ 6; recommendations: high, or very high agreement based on measures of central tendencies and dispersion = full consensus; very high agreement → Median = 5, IQR = 0 and ≥ 80% scoring a 4 or 5; high agreement → median = 5, IQR ≤ 1, ≥ 80% scoring of 4 or 5; moderate agreement → Median 4-5, IQR ≤ 2, ≥ 60% scoring of 4 or 5; low agreement (no consensus) → Median 4-5, IQR ≤ 2 or ≥ 60% scoring of 4 or 5. Items with Medians between 2 and 4 were rejected; full consensus on very high disagreement → Median = 1, IQR = 0, ≥ 80% scoring 1 or 2.

<sup>8</sup> To ensure that views of stakeholder groups were equally represented, the scores were weighed since physicians were overrepresented.

<sup>9</sup> Medications rated lower than 15% after the first round were dropped from the list.

Table 3 Characteristics of the Delphi procedure

| Author(s), year                           | Purpose and number of Delphi rounds <sup>1</sup> |                                 |  |                                      |   |  |                                   |                  | Feedback and design of next round(s) <sup>2</sup> |                                 |   |                       |   |   |
|---|--|---------------------------------|--|--------------------------------------|---|--|-----------------------------------|------------------|---|---------------------------------|---|-----------------------|---|---|
|   | Identification of issues; generation of items    | Development of a draft document | Rating / evaluation of statements / document | Ranking / selection / prioritisation | Qualitative responses / comments / feedback | Review / approval of (final) framework | Not reported / not entirely clear | Number of rounds | Statistical group response                        | Summary of qualitative comments | Inclusion of items newly generated / added by experts | Modification of items | Selection / reduction of items <sup>3</sup> | Presentation of final document for approval |
| Bradford et al., 2014 <sup>53</sup>       |  | ✓                               | ✓  |                                      |   | ✓                                      |                                   | 5                |   |                                 | ✓   |                       | ✓   |   |
| Bradley et al., 2009 <sup>58</sup>        |  |                                 |  | ✓                                    |   | ✓                                      |                                   | 3                |   | ✓                               | ✓   |                       | ✓   | ✓   |
| Bridgman et al., 1997 <sup>30</sup>       | ✓  |                                 |  | ✓                                    |   | ✓                                      |                                   | 3                |   | ✓                               | ✓   |                       |   | ✓   |
| Bridgman et al., 1998 <sup>31</sup>       | ✓  |                                 |  | ✓                                    |   | ✓                                      |                                   | 3                |   | ✓                               | ✓   |                       | ✓   |   |
| Carter et al., 2001 <sup>54</sup>         | ✓  | ✓                               | ✓  |                                      |   |  | ✓                                 | /                |   |                                 |   |                       |   | ✓   |
| Catlin et al., 2002 <sup>55</sup>         |  |                                 |  |                                      |   |  | ✓                                 | 4                |   |                                 |   |                       | ✓   | ✓   |
| De Lima et al. (#485), 2007 <sup>34</sup> |  |                                 | ✓  |                                      |   |  |                                   | 1                |   |                                 | ✓ <sup>4</sup>  |                       | ✓ <sup>4</sup>                              |   |
| De Lima et al., 2007 <sup>32</sup>        |  |                                 | ✓  |                                      |   |  |                                   | 1                |   |                                 | ✓ <sup>4</sup>  |                       | ✓ <sup>4</sup>                              |   |
| De Lima, 2012 <sup>33</sup>               |  |                                 | ✓  |                                      |   |  |                                   | 1                |   |                                 | ✓ <sup>4</sup>  |                       | ✓ <sup>4</sup>                              |   |
| De Lima et al., 2012 <sup>63</sup>        |  |                                 | ✓  |                                      |   |  |                                   | 3                | ✓   |                                 |   |                       | ✓   |   |
| Downar et al., 2010 <sup>48</sup>         | ✓  |                                 | ✓  |                                      |   |  |                                   | 2                |   | ✓                               |   |                       |   |   |
| Dreesen et al., 2012 <sup>44</sup>        | ✓  |                                 | ✓  | ✓                                    | ✓   |  |                                   | 2                | ✓   |                                 | ✓   |                       |   |   |
| Finlay et al., 2008 <sup>56</sup>         |  |                                 |  |                                      |   |  | ✓                                 | /                |   |                                 |   |                       |   | ✓   |
| Hawryluck et al., 2002 <sup>59</sup>      | ✓  |                                 | ✓  |                                      | ✓   |  |                                   | 3                | ✓   | ✓                               | ✓   |                       | ✓   |   |
| Holmes et al., 2008 <sup>39</sup>         |  |                                 | ✓  |                                      |   |  |                                   | 3                | ✓   |                                 |   |                       |   |   |
| Hudson et al., 2012 <sup>46</sup>         |  |                                 | ✓  |                                      | ✓   |  |                                   | 1                |   |                                 |   |                       |   |   |
| Jünger et al., 2012 <sup>64</sup>         |  |                                 | ✓  |                                      | ✓   |  |                                   | 2                |   |                                 |   | ✓                     |   | ✓   |

|  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|--|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Lindqvist et al., 2013 <sup>40</sup>           | ✓ |   |   | ✓ |   |   |   | 2 |   |   | ✓ |   |   |   |
| Mahler et al., 2010 <sup>36</sup>              |   |   | ✓ |   |   |   |   | 2 |   |   |   |   |   |   |
| Mahler et al., 2010 <sup>35</sup>              |   |   | ✓ |   |   |   |   | 2 |   |   |   | ✓ |   |   |
| Mendes et al., 2013 <sup>57</sup>              | ✓ |   | ✓ |   |   |   |   | 3 | ✓ |   |   | ✓ | ✓ |   |
| Morita et al., 2005 <sup>49</sup>              |   |   | ✓ |   |   |   |   | 3 | ✓ |   |   |   |   |   |
| Morita et al., 2007 <sup>45</sup>              |   |   | ✓ |   |   |   |   | 3 |   |   |   |   |   |   |
| Onwuteaka-Philipsen et al., 2001 <sup>50</sup> |   |   | ✓ |   | ✓ | ✓ |   | 2 |   |   | ✓ |   |   |   |
| Pigni et al., 2010 <sup>41</sup>               |   |   | ✓ |   |   |   |   | 2 | ✓ |   |   |   | ✓ |   |
| Rayner et al., 2011 <sup>37</sup>              |   |   | ✓ |   |   |   |   | 2 | ✓ | ✓ |   |   |   |   |
| Rayner et al., 2011 <sup>38</sup>              |   |   | ✓ |   |   |   |   | 2 | ✓ | ✓ | ✓ |   |   |   |
| Sasahara et al., 2009 <sup>60</sup>            |   |   | ✓ |   |   |   |   | 2 |   |   |   | ✓ | ✓ | ✓ |
| Sprung et al., 2014 <sup>61</sup>              |   |   | ✓ |   |   |   |   | 2 |   | ✓ |   | ✓ |   |   |
| Strupp et al., 2014 <sup>52</sup>              |   |   |   |   |   |   | ✓ | 2 |   |   |   |   |   |   |
| Temkin-Greener et al., 2015 <sup>62</sup>      |   |   | ✓ |   |   |   |   | 2 |   |   |   |   |   |   |
| van der Maaden et al., 2014 <sup>42</sup>      |   | ✓ | ✓ |   | ✓ |   |   | 5 | ✓ |   |   | ✓ | ✓ |   |
| van der Steen et al., 2014 <sup>51</sup>       |   | ✓ | ✓ | ✓ |   | ✓ |   | 5 | ✓ | ✓ |   | ✓ | ✓ | ✓ |
| Vermandere et al., 2013 <sup>47</sup>          |   |   | ✓ |   |   |   |   | 2 |   | ✓ | ✓ |   | ✓ |   |
| Vignaroli et al., 2012 <sup>43</sup>           | ✓ |   | ✓ | ✓ | ✓ |   |   | 2 | ✓ |   |   |   | ✓ |   |

<sup>1</sup> This refers to aspects that were explicitly reported as elements of one or more survey rounds. The development of a draft document in some studies was seen as preparatory step before the start of the actual "Delphi process".

<sup>2</sup> This refers to aspects that were explicitly reported in the respective publication as elements of the feedback provided – while more general descriptions (or missing mention) in other publications may imply these features as well.

<sup>3</sup> This can either refer to items with (very) high agreement so that these could be instantaneously accepted and no further consideration was warranted in a subsequent survey round; or to items with (very) low agreement or relevance that were therefore entirely discarded from the list.

<sup>4</sup> In this study only one round was referred to as "Delphi process" while there were still details provided on the nature of feedback and the design of the subsequent stages.



**Box 3 Recommendations for the Conducting and Reporting of DELphi Studies (CREDES)****Rationale for the choice of the Delphi technique**

1. *Justification:* The choice of the Delphi technique as a method of systematically collating expert consultation and building consensus needs to be well justified. When selecting the method to answer a particular research question, it is important to keep in mind its constructivist nature.

**Planning and design**

2. *Planning and process:* The Delphi technique is a flexible method and can be adjusted to the respective research aims and purposes. Any modifications should be justified by a rationale and be applied systematically and rigorously.
3. *Definition of consensus:* Unless not reasonable due to the explorative nature of the study, an a-priori criterion for consensus should be defined. This includes a clear and transparent guide for action on (a) how to proceed with certain items or topics in the next survey round; (b) the required threshold to terminate the Delphi process; and (c) procedures to be followed when consensus is (not) reached after one or more iterations.

**Study conduct**

4. *Informational input:* All material provided to the expert panel at the outset of the project and throughout the Delphi process should be carefully reviewed and piloted in advance in order to examine the effect on experts' judgements and to prevent bias.
5. *Prevention of bias:* Researchers need to take measures to avoid directly or indirectly influencing the experts' judgements. If one or more members of the research team have a conflict of interest, entrusting an independent researcher with the main coordination of the Delphi study is advisable.
6. *Interpretation and processing of results:* Consensus does not necessarily imply the "correct" answer or judgement; (non)consensus and stable disagreement provide informative insights and highlight differences in perspectives concerning the topic in question.
7. *External validation:* It is recommended to have the final draft of the resulting guidance on best practice in palliative care reviewed and approved by an external board or authority before publication and dissemination.

**Reporting**

8. *Purpose and rationale:* The purpose of the study should be clearly defined and demonstrate the appropriateness of the use of the Delphi technique as a method to achieve the research aim. A rationale for the choice of the Delphi technique as the most suitable method needs to be provided.
9. *Expert panel:* Criteria for the selection of experts and transparent information on recruitment of the expert panel, socio-demographic details including information on expertise regarding the topic in question, (non)response, and response rates over the ongoing iterations should be reported.
10. *Description of the methods:* The methods employed need to be comprehensible; this includes information on preparatory steps (How was available evidence on the topic in question synthesised?); piloting of material and survey instruments; design of the survey instrument(s); the number and design of survey rounds; methods of data analysis; processing and synthesis of experts' responses to inform the subsequent survey round; and methodological decisions taken by the research team throughout the process.
11. *Procedure:* Flow chart to illustrate the stages of the Delphi process, including a preparatory phase, the actual "Delphi rounds", interim steps of data processing and analysis, and concluding steps.
12. *Definition and attainment of consensus:* It needs to be comprehensible to the reader how consensus was achieved throughout the process, including strategies to deal with non-consensus.
13. *Results:* Reporting of results for each round separately is highly advisable in order to make the evolving of consensus over the rounds transparent. This includes figures showing the average group response, changes between rounds, as well as any modifications of the survey instrument such as deletion, addition, or modification of survey items based on previous rounds.
14. *Discussion of limitations:* Reporting should include a critical reflection of potential limitations and their impact of the resulting guidance.
15. *Adequacy of conclusions:* The conclusions should adequately reflect the outcomes of the Delphi study with a view to the scope and applicability of the resulting practice guidance.
16. *Publication and dissemination:* The resulting guidance on good practice in palliative care should be clearly identifiable from the publication, including recommendations for transfer into practice and implementation. If the publication does not allow for a detailed presentation of either the resulting practice guidance, or the methodological features of the applied Delphi technique, or both, reference to a more detailed presentation elsewhere should be made (e.g., availability of the full guideline from the authors or online; publication of a separate paper reporting on methodological details and particularities of the process (e.g., persistent disagreement and controversy on certain issues)). A dissemination plan should include endorsement of the guidance by professional associations and healthcare authorities to facilitate implementation.