

Supplementary file: Examples from the interviews:

<p>Medical reasons</p>	<p><i>“Lately, I had a patient suffering from cystinosis. In his case I said: he belongs to us because it is a paediatric condition which asks for special treatment. In contrast, I am seeing a patient with M. Fabry – a condition which usually leads to CKD5 during adulthood. That patient however went into end-stage age 16. In his case I will not offer extension as this is an adult disease and the adult nephrologist will be better able to care for him.”</i></p> <p><i>“If they are still living with their parents, the situation won’t change much except for them seeing an adult nephrologist. It’s more about the parents and the social environment rather than the patient and the disability, really. The disability won’t change with or without postponing the transfer.”</i></p> <p><i>“The key-question is: will the patient benefit from staying in paediatric care! I have an 18 year-old patient of a single mother. The girl needs qualified neurological care as well. Her neuro-paediatrician now told them that she cannot see the girl any longer, so the family is looking for a new neurologist. Now, if at the same time we would withdraw as well and transfer her to an adult nephrologist, we would provoke a critical situation.”</i></p>
<p>Social factors</p>	<p><i>“At school everything is familiar. Teachers and pupils know about the patient’s condition and related needs and are considerate. Most problems really start after leaving school!”</i></p> <p><i>“Some really have difficulties finding a job. It is not easy to find a training placement when a chronic condition is limiting your choices, your abilities, and your options.”</i></p> <p><i>“Sometimes there are too many critical life-events at a time. One of our patients is 18 but not yet mature. His parents are about to get divorced, and everything is running out of the rudder. If we transferred him, this would not end well...”</i></p> <p><i>“Some kids have difficulties at home, parents who are not sufficiently competent to support them. In those cases we try to organise help from the youth welfare office for example to provide them with chances...which does help...sometimes...”</i></p> <p><i>“There are some patients with difficult social background. But we train them to be self-responsible and independent. And in the end they are doing better than those kids who have been pampered all the time, those kids whose parents do anything and everything for them all the time. I remember one girl who was always on her own, who – despite her disease – had to look after her siblings. And she did well. She was very able, because she had to be!”</i></p>
<p>Individual aspects</p>	<p><i>“The patient must be able to independently and autonomously talk to the doctors. He needs to have a certain level of maturity and show medical and emotional stability. This is of utmost importance: that the patient is in a generally stable situation.”</i></p>

	<p><i>“Patients with lacking compliance have an increased risk for rejection. If there is no professional support available, let’s say at least a local psychotherapist to facilitate coping.... In those cases extending paediatric care is essential.”</i></p> <p><i>“When our patients are of age, usually they are not yet mature. [...]They are still in school or in training; they are all living at home with their parents looking after them. And they are looked after just like 14 year-old healthy kids. So transfer age 18 years is simply made up out of air. [...]And the key question is: how does the patient compare to a healthy child.”</i></p>
Structural aspects	<p><i>“In fact we apply for extension in almost all cases. And if it’s medical reasons, like complex physical conditions, it’s generally accepted. However, if we name psychosocial reasons...this is really difficult.”</i></p> <p><i>“Unfortunately, we had to transfer patients due to a lack of resources. There are cases we transferred for capacity reasons although we agreed it would have been better to keep them here.”</i></p>