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Title	Surgeon decision-making about referral for adjuvant therapy for persons with non-small-cell lung, breast, or colorectal cancer: a qualitative study
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Reviewer 1	Dr. Lorraine M Elit
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General comments (author response in bold)	Thank you for the opportunity to review this manuscript on the surgeons' decision making about referral of cancer patients for adjuvant therapy. This paper is well written and clearly presents the reason for the study, the novelty of the work, the study process, the results and the implications of these results. My questions for the authors are as follows: 1) Is it possible to include the study guide and probes in the publication? **Response:** Absolutely. We have included the Interview Guide with our response to be included as an online appendix to the manuscript. **Change to manuscript:** The Interview Guide is included in our resubmission, to be included as an online appendix. 2) Is it possible to provide more demographic information on the participants ie., teaching vs community hospital practice; cases per year in the domain of interest; years in practice; gender; geographic distance of the practice from the cancer centre ect? **Response:** We appreciate this comment and the value of this information. Due to the small number of surgeons in Nova Scotia, we believe presenting detailed demographic information might potentially compromise our ability to preserve anonymity to the greatest extent that we can (see our response to Comment 1.1 above). As indicated in the manuscript, 59% of our participants practiced in a community hospital and 83% were male. We have also added years of practice, using the following groupings: <5 years, 5-15 years, 16+. **Changes to manuscript:** We have added the following statement to the Results section (pg. 8 of the revised manuscript): … and 24%, 28%, and 48% practiced for <5, 5-15, 16+ years, respectively. 3) What percent of the interviews were face-to-face? **Response:** Eleven (38%) of the interviews were face-to-face. **Change to manuscript:** We have added the following statement to the Results section (pg. 8 of revised manuscript): … 38% were face-to-face. 4) Was there any triangulation of results ie., using a pre-interview questionnaire? **Response:** No, there was no formal triangulation of results with another data collection method, such as a pre (or post) interview questionnaire. As stated in the manuscript, all participants were provided a summary of the preliminary findings (including main categories, relationships amongst categories, and illustrative quotations) and invited to provide feedback. No participants provided feedback to disconfirm the findings or to suggest revisions. Rather, four participants responded that the findings appropriately captured and presented their experiences and re-confirmed several categories they felt particularly important (specifically, knowledge of local standards of care, consultation with colleagues, and navigating patient logistics). **Change to manuscript:** No change to manuscript. 5) I found the Line 6 on Pg 11 odd. In reading the quotes I did not sense that the surgeons DISTRUSTED the oncologists' knowledge. Rather it appeared that the surgeons felt the oncologists had knowledge in another domain separate from the surgeons' and only a consult would provide the patient with this input. Maybe the phrasing of "surgeons' trust in oncologists' knowledge and expertise" could be altered to reflect surgeon's respect for the oncologists knowledge. **Response:** We thank the Reviewer for this comment. It was not our intent to imply that the surgeons distrusted the oncologists' knowledge. Rather, our finding reflects what the Reviewer suggests: that surgeons did feel that oncologists had knowledge in another domain, separate from their particular knowledge, that would benefit the patient. Thus, "surgeons' trust in oncologists' knowledge and expertise" really does reflect respect for the oncologists' knowledge versus a distrust of their knowledge/expertise. **Change to manuscript:** We have changed the phrase (pg. 11 of revised manuscript) from: … surgeons' trust in oncologists' knowledge and expertise … to … surgeons' respect for oncologists' knowledge and expertise …
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General comments (author response in bold)	Main concerns: 1) The second objective is inappropriate – 'to identify potential strategies to promote referral' – given the qualitative nature of the study. The identified strategies in Table 3 and comments in the discussion result from subjective interpretation of the data by the authors. This could be included in the discussion but should not be considered a major objective of the current work and has no place being referenced in the results. **Response:** Please see our response to Comment 1.3 above. While we did explicitly ask surgeons their views on potential strategies, we recognize this doesn't fit within the current manuscript. **Change to manuscript:** We have omitted this objective from the revised manuscript (Abstract and Introduction section) as well as Table 3 in the Results section. 2) It is not clear how the seven identified factors or themes were organized into the sections 'clinical encounter', 'mediating factors', and 'outer context'. Could not all the factors be considered mediating? This should be better explained. **Response:** We thank the Reviewer for this important comment. While the development and confirmation of categories was described in the initial manuscript (and has been expanded in this revised version; see Comment 1.6 above), the organization of findings was not made explicit. Both the phrasing and organization of categories was an iterative process that occurred through regular review, discussion, and questioning of emerging findings. Once the seven key factors/categories were confirmed, the specific organization of these factors – into 'sections' titled clinical encounter, mediating factors, and outer context – was discussed and questioned amongst the research team and repeatedly revised/refined until team members felt the final organization adequately captured/reflected the findings. This process involved several full-team meetings, email communications, as well as ongoing meetings of the two researchers who coded and categorized the data (and who were much "closer" to the data than the other members of the research team). These two researchers took the team's feedback, went back to the data, held discussions amongst themselves, revised/refined the findings as needed (e.g., phrasing and organization), and then held another discussion (meeting or email) with the full team to confirm or refine the organization further. Essentially, as the categories emerged, it became evident from the data there were two "core" categories that influenced the decision-making process. These core categories (indications/contraindications for therapy, patient beliefs and preference) were central to the decision itself, occurring during the clinical encounter (and thus are very proximal to the decisional event). At the same time, surgeons discussed and reflected on a number of factors, which they perceived were outside of or external to the clinical encounter, that sway or affect their referral decisions. After iterative discussion, the research team chose to organize these categories together and term them mediating factors, which were considered distal in influence compared to the core categories. Most surgeons also discussed numerous practice/system issues that had less of a direct influence on decision-making but that they must deal with during and/or after making a decision. They described these issues as always being present and as part of the context or system in which they practice and make decisions. We chose to organize the two categories that reflect these issues together as part of the outer context. **Changes to manuscript:** We have expanded the Data Analysis sub-section (pg. 7 of the revised manuscript) to include more detail around confirmation of categories and theoretical saturation (in response to Comment 1.6 above) as well as the phrasing and organization of categories. 3) In the results when reviewing the influence of the seven identified factors, the authors use the phrase 'with the magnitude of influence depending on their decisional proximity'. Given this is a qualitative study, how did the authors determine magnitude – was it the subjective interpretation of results by the authors? **Response:** We thank the Reviewer for this comment. The 'magnitude of influence' was indeed an interpretation of the qualitative data and not a concept that we quantified in any way. **Change to manuscript:** We have changed the word "magnitude" to "degree" to minimize any confusion around quantifying an actual strength of association (pg. 8 of revised manuscript). Minor comments: 1) Introduction – surgeons are often the gatekeepers for solid tumours such as the three diagnoses included in this paper. The phrase in the introduction that 'surgeons are the main gatekeepers to the organized cancer system' is too general and thus likely inaccurate. **Response:** We agree with the Reviewer that this comment is general and have thus revised it to make it more specific and accurate. **Change to manuscript:** We have changed the statement from: Since surgeons are the main gatekeeper to the organized cancer system, … to For solid tumours, surgeons are the main gatekeepers to adjuvant therapy services. 2) Related to 1) above, the phrase 'organized cancer system' is not well explained in the introduction and thus confusing. **Response:** We thank the Reviewer for this comment and agree this phrase was not well explained in the Introduction. We have revised this phrase in the revised manuscript. **Change to manuscript:** We have changed the phrase from:

	… organized cancer system, … to … adjuvant therapy services.