

## Peer Review File

Article Information: <http://dx.doi.org/10.21037/apm-20-2094>

	<b>Reviewer A Comments</b>	<b>Responses to Reviewer B's Comments</b>
1	Page 2, line 56: "Poor quality medical decision making"- please reword or define. This is vague.	This language has been changed to "preference sensitive decisions made by surrogates". This is the language used to describe medical decisions such as artificial nutrition after stroke in the literature. Citations have been included.
2	Page 2, line 75: In the brief description of the 2 patients, age and comorbid conditions should be included.	The patients' ages were already present; however, comorbid conditions have been added.
3	Page 2, line 83: please add a brief description of what the larger study was. If possible, also include a reference for the methodology that was done here where coding and themes were identified by the study team. How bias was accounted for.	The methods have been changed to reflect that no parent study was published. The original intended parent study was not published because there were not enough subjects enrolled to draw meaningful conclusions that were generalizable. The original study data collection was stopped because the authors needed to change direction in the study due to a grant being accepted. This case study is a result of the preliminary data that was collected which was expanded upon for the purpose of the case study.
4	Page 3, line 94: please add a brief sentence regarding why there were 2 neurologists in Patient A while only 1 in patient B.	This sentence has been added.
5	Overall, it would help to have a better visualization of the conversation from the neurologist. It would seem that the perception in patient A's surrogate came from her without insight of what the neurologist actually said verbatim, that was deemed "judgemental". Although I understand that this manuscript wanted to depict the complexity of decision making, I still would want to see an objective process of evaluation of the assessment. I also think the discussion needs more substance in terms of what are the available literature for instance with regards to palliative care involvement and neurologically devastated patients? Should they be having meetings with the family without the primary team? What is the effect of culture on PEG placement?	The authors have addressed this comment in two parts: 1. Direct quotes from the neurology team have been added which help provide a better visualization of the conversation between the neurologist and helps clarify why the patient felt judged.  2. While the authors appreciate the reviewer's suggestion about adding information to the discussion about who should be involved in family meetings and the culture of PEG placement, the authors believe that this may be outside the scope of the case study as the mention of family meetings was removed. Additionally, in order to make this change, the authors would need additional word space which we do not have if we are to meet the journal's word requirements and make other essential revisions.
6	No comment – this was blank	The comments skipped from 5 to 7
7	Was the palliative care specialist involved in the case study?	Palliative care was not interviewed for this case study; however, comments from palliative care clinical notes have been added to provide additional insight into the issues with medical

		decision making the patients in this case study faced.
	<b>Reviewer B Comments</b>	<b>Responses to Reviewer B's Comments</b>
1	The authors describe a process to derive themes in the methods. However, the explanation of the cases are quite descriptive and I don't see any clear summary of the major themes that were obtained through the thematic analysis.	This comment is almost identical to comment #3 from Reviewer A. The authors have addressed both comments and the explanation of how we addressed this comment is under comment #3 from Reviewer A.
2	The patients themselves do not offer any perspectives in this case series due to severe impairment. The authors should comment on this gap and how it might affect the themes that are obtained through interviews and the decision-making process.	In the discussion, the authors have added a comment which addresses the challenge of patients not being able to assert their preferences and values about PEG tube and the challenges this raises.
3	There should be a comment on how differences in timing for PEG may impact on decision-making. In the US, median time to placement is 7 days, whereas in Canada it is closer to 14-21 days (NG is kept in for longer to allow recovery before decision is made). Faster placement times are often driven by institutional pressures and culture and may affect decision-making. This rapid pressure to decide on PEG seems to have occurred in both cases. As a follow-up question, were patients/surrogates offered a choice to wait for recovery while using NG before considering PEG?	The authors have added to the discussion the point that the surrogates experienced pressure to place a feeding tube and that this may have affected decision making. The authors did not discuss the differences in feeding tube placement timing between countries and institutions as there is simply not space to make these points.
4	In case A, there is a comment about the surrogate receiving conflicting information. However it's not clear why conflicting information was provided. Was this a difference in opinion about prognosis, opinions about goals of care, or perspectives on utility of PEG?	An explanation has been added. The neurology team had a more optimistic prognosis than the palliative care team about the patient's recovery.
5	In the methods it states the "most likely" outcome was explored but this was not mentioned for the individual cases (only best and worst, as far as I could tell).	The reviewer is correct that the most likely outcomes was not made explicit in the manuscript. This has been changed. We added quotes and explicitly name the most likely outcome.
6	The idea of a "trial of PEG" should be further explored (more than what is mentioned in the introduction). Is this a legitimate ethical option to provide, given that removal of PEG for palliation once placed is rarely undertaken? (ie. placing PEG is typically a one-way street). Did this come up in the cases?	The idea of a trial peg did not come up in either case; however, the manuscript has been updated to add that palliative care offered the patient's family the option of stopping tube feeds multiple times throughout his prolonged hospitalization. Additionally, the manuscript does discuss in the idea of a trial peg being appropriate from the prospective of an internal medicine physician who believed it might be appropriate, but it was not discussed with the patient's family because they did not believe it would improve the patient's quality of life.
7	One factor that can impact decision-making (and thus result in differing decisions for patient with similar stroke severity), is baseline function. What were the	The patient's baseline characteristics have been added. The baseline characteristics were not a factor in decision making as in both cases, the

	patients' baseline cognitive and functional status and did this impact decision-making?	families stated that they believed the patient's would not return to baseline.
8	The authors discuss that a multidisciplinary meeting would have been useful in these instances. How does this specifically apply to the cases? For example, for patient 1 it seems the decision was made quite rapidly after extubation – was a multidisciplinary meeting planned in this case, and if so why did it not occur? For patient 2, I would be surprised if there was not at least one (or multiple) meetings throughout their very prolonged hospital stay.	The authors believe that the best way to address this comment is to remove the statement about multidisciplinary meetings. The statement does not add to the discussion in a meaningful way and in fact seems to raise more questions that the authors do not have the space to address in this manuscript given the word limit. Thus, the statement about multidisciplinary meetings has been removed from the manuscript.
9	The palliative care team was consulted in both instances but their perspectives into case B are not made clear to the reader.	This comment is similar to comment #7 from Reviewer A, as such this comment has been addressed above.
10	What is the reason for patient B's incredibly long hospital stay (148 days) between the first and second discharge to rehabilitation? Why were they discharged to a rehabilitation facility rather than long-term care if not able to speak or walk after 148 days?	The patient was initially discharged to rehab on his first discharge and was subsequently discharged to a SNF. This has been made clear in the manuscript.
11	First paragraph: "affecting" should be "affected" or "impaired"	This has been corrected to "affected"
12	No need to capitalize Middle Cerebral Artery in the first instance	This has been corrected
13	For completion please state whether patient B received thrombectomy	This has been added
14	There is an error in Patient A flowchart – death was stated in the paper to be on Day 16, not Day 8. Also, palliative is misspelled in both flowcharts.	This has been corrected.
15	The running title should somehow reference PEG/nutrition.	The running title has been changed to "PEG Tube Decisions after Severe Stroke"