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Reviewer A

The authors aim to assess the acceptability and quality of information of a Decision-Aid Form (DAF) and the predictive value of its related care stratification on health outcome of cancer patients.

We would first thank all the reviewers for their helpful comments. We have tried to reply as precisely as possible to each major and minor comment. The text has been in a large part rewritten, especially *Methods, Results*, and *Discussion* sections. New subsections have been created. Our findings are more precisely discussed according to the literature, and 11 references have been added. We tried to reply concisely in order to respect as much as possible the number of words authorized. We hope that this revised version is now clear enough to diffuse our main messages, i.e., that 1) a Decision Aid-Form may be implemented in a French setting for cancer patients and could help to decrease the aggressiveness of care, but 2) that cultural factors still limit, at least in part, preparation for unanticipated clinical events and sharing of decisions with the patients.

In general, method section needs to be better described and detailed to ensure reproducibility.
Reply A.1: We agree that the method had to be better described. As required, the *Methods* section has been deeply revised and detailed. A new paragraph ("*Focus group*") has been created in the *Methods* section to describe the process of the multidisciplinary team.
Changes in the text: The *Methods* section has been improved, in particular with creation of new subsections: *Focus group* (see page 6, lines 108-116), and *Data collection* (see page 7, lines 132-144).

The sampling method applied to estimate the number of patients required to conduct the study need to be described in more details. Although 184 patients presented a DAF, only 30 has an acute event and were deeply investigated on the conducted research.
Reply A.2: We agree with the reviewer that this point had to be more detailed. A number of about 200 patients was expected to be included over the recruitment period. This number allows a satisfying absolute precision of at least 7 percent-points for estimates of proportions. Among the included patients, based on a pilot study, it was expected that about 15% would present with an acute event. The expected 30

patients with acute events would constitute a significant subgroup to allow dedicated additional analyses.
Changes in the text: the number of patients required is better explained in the *Methods* section, see page 5, lines 99-101 ("*A number of about 200 patients was…*").

For me, it was not clear the inclusion criteria (being transferred from the main site to the follow up unit) for achieve the first aim proposed, since the DAF was filled in the main site. Also, for the second aim, it was not clear what the outcome of interest in the study (According to the information on method subsection named "study design", it seems the acute medical event is one of the outcomes. But, on Results subsection named "Correlation between stratification of care and outcome" death until 6 months after GR2 admission is suggested as the outcome of interest).
Reply A.3: Inclusion criteria: The transfer from the main site to the follow-up unit was the first setting in which the DAF was evaluated, and therefore the only one in which the DAF was filled in for every patient when the study was performed. For this reason, we chose to study this condition of transfer (in "the best conditions"), before implementation in other situations. This is now explained in the text (See *Focus group*).
The aims (main and second goals) are now better explained in the *Methods* section. According to the reviewer's statement, our findings are described in the same order in the *Results* section (first, only patients with an acute even and then correlation between stratification of care and outcome in all included patients).
Changes in the text: we have modified our text as follows:
- See page 6, lines 113-116 The DAF was first tested in patients who were transferred from the main site of our hospital to the second one, a follow-up care unit (see also page 5, lines 94-96).
- Page 5, lines 102-107. The main goal of this study was to assess the acceptability and the degree of completeness of the DAF in daily practice. Additional aims were to assess 1) the prognostic value of the proposed stratification on the actual level of care delivered in the subset of patients with an acute event; 2) the correlation between stratification of care and outcome in the overall population.

According to the presented results, many DAF fields were not filled and the main reasons for this situation need to be discussed deeply.
Reply A.4: We agree with the reviewer that this point is the cornerstone of our study and needs to be discussed deeply. Several clarifications have been added in the *Discussion* section.
Changes in the text: we have modified our text as advised, see page 11, L 230-272. Six references have been added (20-25).

Additionally, I did not understand why the authors described care stratification results only for patients with an acute medical event, which represents a minor portion of the planned sample.

Reply A.5: We agree that this point is insufficiently explained, mainly in the *Methods* section, and that the legend of Figure 4 is confusing. Care stratification results were first described for patients with an acute medical event (according to therapeutic decisions), and then for all 206 patients included (according to the outcome, Figure 4).This point is now presented more clearly in the *Methods (Objectives)* section, and the legend of Figure 4 has been corrected ('*in case of acute event*' has been deleted):
Changes in the text: we have modified our text and the Figure legend as advised, see page 5 (lines 103-107) and Figure 4.

Finally, it seems the authors evaluated the predictive value of WHO/ECOG for death/survival and not the predictive value of care stratification according to what is described on Result subsection named "WHO/ECOG performance status".
Reply A.6: As required, the predictive value of care stratification for death/survival is better mentioned in the *Methods* section. In the *Results* section, there is a subsection named *Correlation between stratification of care and outcome*, as illustrated in the Figure 4.
Changes in the text: we have rewritten the sentence in the *Methods* section, see page 8, L 153-158 ("Stratification over the criteria of interest (level of care, ECOG performance status), when filled-in, was completed with log-rank test for equality of survival").

Data presentation on tables and figures need to be carefully revised, since in some of them it was not clear what subset of patients was included in the analysis and also the total is not hierarchically organized (for example, in the "Involvement of the interdisciplinary palliative care team presentation"). Specially, figure 4, has an inside title related to acute medical event patients, and in the description of the figure there is information of N=179.
Reply A.7: The title of Figure 4 is well: "Six-month survival curves according to the level of stratification of care (when recorded in the Decision-Aid Form, N=179)" This is now better explained in the text; the legend of Figure 4 has been corrected, as required.
The Involvement of the interdisciplinary palliative care team has been carefully cited at the end of the Field 2, as in the DAF. We hope that the reviewer will consider this presentation as adequate.
Changes in the text: the corrected sentence is "As shown by Kaplan-Meier survival curves of the 179 patients for which the stratification of care was well recorded in the ADF (Figure 4)" (see page 10, line 206).

As a minor point, the manuscript could benefit from revision by a native English speaker.
Two native English speakers (one English, one American) revised our original manuscript. The revised manuscript was also re-revised by a native English speaker

(who is also an American physician). We hope that this revised version and our reply will be considered as satisfactory.

Reviewer B

This is an important prospective examination of an advanced care planning tool (ADF) in a Comprehensive Cancer Center.

We would first thank all the reviewers for their helpful comments. We have tried to reply as precisely as possible to each major and minor comment. The text has been in a large part rewritten, especially *Methods, Results*, and *Discussion* sections. New subsections have been created. Our findings are more precisely discussed according to the literature, and 11 references have been added. We tried to reply concisely in order to respect as much as possible the number of words authorized. We hope that this revised version is now clear enough to diffuse our main messages, i.e., that 1) a Decision Aid-Form may be implemented in French settings for cancer patients and could help to decrease the aggressiveness of care, but 2) that cultural factors still limit, at least in part, preparation for unintended clinical events and sharing of decisions with the patients.

Methods: Could be more clearly described in primary paper (not in supplement if possible). The process by which pts were identified and followed would be helpful.
Reply B.1: We agree that the description of the process is an important issue in the methods. The method is now extensively described in the primary paper (and not in the additional material)
Changes in the text: we have modified our text as advised, see page 7 (lines 132-144). A new subsection (*Data collection*) has been created.

The Data Analysis section is not well delineated. I don't know what "an exhaustive list of 100% means" Is this an exhaustive list of all pts hospitalized between 1.20.17 and 5.17.17, an exhaustive list of all pts who completed the ADF, or something else?
Reply B.2: We agree that the sentence was unclear. We clarified the sentence in the text as follows:
Changes in the text: we have modified our text as advised, see page 7, lines 133-134 ("*A complete list of all patients transferred from GR1 to GR2 during the study period was obtained thanks to the hospital's medical data information system*").

Also the results mention an survival curve, but that is not described in the data analysis section of the primary manuscript.
Reply B.3: Survival curves are now better presented in the *Statistical analysis* subsection, as follows:
Changes in the text: we have modified our text as advised, see page 8, lines 154-158.

Results: In the results a brief description of the 206 pts included would be helpful. I see that they are described in the table, but it's not referred to in the results section. What cancer or other medical comorbid diagnoses did they have? I think this would help the reader understand the context of the findings.
Reply B.4: We agree that demographic data would be helpful for the reader. Unfortunately, data on comorbid diagnoses were not prospectively recorded. Data on the type of cancer were not recorded, but we include now in the *Results* section the hospital units where patients were hospitalized in GR1 before transfer.
Changes in the text: we completed demographics as much as possible, see page 8, lines 164-167.

Discussion: I think the discussion sufficiently highlights some of the limitations of the tool and its implementation. I think readers may be interested in the process by which the multidisciplinary team developed the ADF, this is an important contribution to the literature.
Reply 5: We agree with the reviewer that the process of our multidisciplinary team needs to be explained.
Changes in the text: a new subsection named *Focus group* has been created, see page 6, line 108.

Reviewer C

General comments
Thank you for submitting this paper which focuses in the use of a decision making aid/tool to inform the care of people diagnosed with cancer. This is an important topic and the paper makes for interesting reading. However, there are many several key elements of the paper that need to be rewritten so that there is clarity about bow the study was conducted and what it adds to what is known about this topic in general.

We would first thank all the reviewers for their helpful comments. We have tried to reply as precisely as possible to each major and minor comment. The text has been in a large part rewritten, especially *Methods, Results*, and *Discussion* sections. New subsections have been created. Our findings are more precisely discussed according to the literature, and 11 references have been added. We tried to reply concisely in order to respect as much as possible the number of words authorized. We hope that this revised version is now clear enough to diffuse our main messages, i.e., that 1) a Decision Aid-Form may be implemented in a French setting for cancer patients and could help to decrease the aggressiveness of care, but 2) that cultural factors still limit, at least in part, planning for unanticipated events and sharing of decisions with the patients.

Introduction

Page 2

Lines 53-54: This sentence needs to be revised as the statement that cancer is fatal in nearly 50% of patients requires more critical analysis. The mortality of people diagnosed with cancer depends on the type and stage of cancer that they have and this complexity needs to be conveyed in this sentence. Stating that cancer is fatal in nearly 50% of patients is an over simplification which is likely to create an inappropriate perception in the mind of the reader. This sentence also needs to be supported with a reference.

Reply C.1: We agree with this comment. Our sentence was awkward. A new sentence has been included and is now supported with a reference.

Changes in the text: we have modified our text as advised, see page 4, lines 60-62.

Lines 54-57: The sentence which begins ‘ In the absence of a contraindication in the patient's medical records, the maximum6 therapeutic commitment…‘ needs to be rephrased as the point that is being made is not clear.

Reply C.2: As rightly required, the sentence has been changed as follows (and is referenced):

Changes in the text: we have modified our text as advised, see page 4, lines 63-64.

Line 58-59: The sentence which begins needs to be rephrased to that it is clear who has to manage uncertainty about effectives in a traumatic emotional context.

Reply C.3: The sentence has been changed as follows:

Changes in the text: we have modified our text as advised, see page 4,line 66.

Line 71: The text which reads ‘this type of anticipated approach‘ needs to be rephrased so that it refers to an advance care planning approach to end of life care

Reply C.4: The sentence has been changed as follows:

Changes in the text: we have modified our text as advised, see page 4, line 76 (“*…regarding anticipated approaches to end of life care such as ACP and even EOL discussions*.”). We hope that was the idea of the reviewer.

Methods

Data analysis

Page 3: The data (statistical) analysis section is too short. The additional information about data/statistical analysis in the additional material needs to be included in the data analysis section. This is important as the manner in which data were analysed as a key aspect of the information which needs to be reported in the paper in a clear and concise manner that the reader can access straight away.

Reply C.5: As required, the information about data/statistical analysis has been included in the *Results* section, now in two parts (*Data collection; Statistical analysis*).

Changes in the text: we have modified the *Methods* section as advised, see pages 7-8, lines 132-159 (mainly line 145).

Results

Page 3

Line 123-124: The first sentence needs to be rephrased so that it is clear that one of the 207 eligible participants was excluded from this study.

Reply C.6: We agree with reviewer's comment. The sentence has been modified as follows:

Changes in the text: we have modified our text as advised, see page 8, line 163.

Discussion

There are many paragraphs in the discussion which restate the results and there is not enough discussion of the results of this study in relation to the evidence from wider literature. Therefore, I recommend that you revise the results so that the results from this study are stated clearly and concisely. The discussion can then be revised to compare and contrast the results of this study to the results of other studies of decision aids/tools. A detailed discussion which compares the results of this study to wider literature is important because it demonstrates the original contribution of this study to the reader and how it adds to what is known about the use of decision aids/tools in people diagnosed with cancer. I have give you a couple of examples of paragraphs that need to be rewritten, but the whole discussion needs to be rewritten so that it contains more critical analysis and synthesis,

Reply C.7: We would thank the reviewer for these very helpful comments, mainly about references and comparison with the wider literature available.

Changes in the text: Many parts of *Results* and *Discussion* section have been deeply modified (pages 11-12, lines 230-269), and 9 references have been added.

Page 5

Line 193: The text which reads 'shares several conceptual features' needs to be rephrased so that the conceptual features that are mentioned are clearly stated.

Reply C.8: The sentence has been modified and the paragraph deeply modified.

Changes in the text: we have modified our text as advised, see page 11, lines 235-241.

Line 194: The sentence which begins 'This tool' needs to be rephrased so that it is clear which tool is being referred to

Reply C.9: We agree that the phrase was unclear. The sentence has been also modified and the paragraph deeply modified.

Changes in the text: we have modified our text as advised, see page 11,lines 234-241.

Lines 199-213: There are several points about the manner in which the ADF completed, which in my opinion should be in the results. This paragraph needs to discuss how the manner in which elements of the ADF were completed are compared

to the evidence about the completion of other decision support tools/aids from other studies.

Reply C.10: The points about the manner in which the ADF completed are now described in the *Results* section (P8, L168-171). We agree that the discussion about the unsatisfactory completeness of the ADF needed to be improved, mainly the poor involvement of IPCT and the insufficient sharing of decisions with patients. The commentary has been modified as follows:

Changes in the text: we completely rewritten our text, mainly from line 242 to 273 (pages 11-12). Six references were added (20-25).

Page 5-6

Line 214-226: The points that are made in this paragraph need to be discussed in more detail in relation to wider literature.

Reply C.11: We agree also with the reviewer that this important issue needs to be discussed in more depth. Therefore, the end of the paragraph has been modified as follows, and 3 references have been added:

Changes in the text: we have modified our text as advised, see page 13, lines 280-286.

Appendices

Page 9

Figure 1: The first sentence which reads 'This "Aid to Decision-making Form" (ADF) is an help to grade care and do not constitute an irrevocable decision.' needs to be rephrased so that the point that is being made is clear.

Reply C.12: We agree that the sentence is unclear.

Changes in the text: we have modified our text as follows, see Figure 1: *The DAF is only an indicator and is a help to grade care in case of an acute event. The final decision remains a medical responsibility and is based on a case by case clinical judgment.*