PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

Title (Provisional)

Preferred labels and language to improve communication about lesions at low risk of progressing to cancer: Qualitative interviews with patients and physicians

Authors

Lyons, Mavis S; Baker, Clara; Chaput, Genevieve; Finelli, Antonio; Kupets, Rachel; Look Hong, Nicole J; Wright, Frances C; Gagliardi, Anna R

VERSION 1 - REVIEW

Reviewer	**1**
Name	**Nickel, Brooke**
Affiliation	**University of Sydney, School of Public Health**
Date	**29-Oct-2024**
COI	**None**

This qualitative study with low-risk cancer patients and physicians aimed to explore views about existing and alternative labels and language for low-risk lesions, and also knowledge that could inform improved communication about low-risk cancer lesions. While there has been a number of both hypothetical quantitative studies looking at this issue as well as a few qualitative studies with both patients and physicians, this study extends that knowledge with patients from additional cancers that to my knowledge have not been explored qualitatively. Further the approach for selecting these cancers is unique as these cancers underwent label changes. The paper is therefore, important however I have a few comments and suggestions which I believe will help to strengthen the manuscript.

- The Abstract could be improved for detail in a few places including the specific aim is not clear from just reading the abstract and just stating “Pan-Canada”. Also, suggest adding actual n and not just % in results. Check punctuation.

- In the Introduction I think it would be valuable to include a bit of background on the hypothetical quantitative studies (RCTs and DCEs) that have been conducted on testing low risk cancer labels including for prostate, thyroid and breast (DCIS). This data gives precedent to the research question and study. Also, there has been a number of reviews done in this area as well and a few studies not cited with both patients and physicians in thyroid cancer (including by Nickel and Jensen) that would be worth noting up front.

- The themes feel fairly superficial and read more like topic summaries rather than providing meaningful insights. If someone only reads them and not the actual data, it is hard to understand what actual 'themes' came out of the data. More descriptive theme headings are needed. Also, consider ensuring that deep insights are provided within the themes and not just a summary of what was found.

- Also, in the Results consider removing some of the identifiers in the quotes. From an international perspective only really age, sex and cancer needed for patients and sex, physician type and cancer

- It is interesting that there were no real differences found by cancer type as prostate cancer is a lot more known to be overdiagnosed and overtreated. Can the authors comment any further on this?

- Given the diverse and limited sample size for both patient and physicians across each cancer type and locations, can findings be generalised? One comment from one patient or physicians should not have raised a particular theme or point to draw any major conclusions.

- While I really liked the suggested accommodating tactics presented, how do we get past the inherent bias and change habit of physicians in order to implement these approaches? How can these tactics be actually implemented into practice given limited time and resources physicians already face?

- Again, in the discussion previous qualitative research with physicians in thyroid cancer found similar findings and should be referred to. Framing of the specific cancers could be highlighted and discussion around how findings might related to other cancers more likely to be overdiagnosed and overtreated therefore warranting a change in nomenclature would be welcomed.

Reviewer	**2**
Name	**Santos-Silva, Alan Roger**
Affiliation	**Universidade Estadual de Campinas**
Date	**07-Nov-2024**
COI	**None**

The study raises an interesting and relevant discussion about the terms used by physicians when discussing low-risk lesion diagnoses with patients. However, I believe the study needs to further explore some topics that were not clearly developed throughout the article:

The present study mentions the need for Patient-Centered Care (page 12, lines 47 to 53). This concept has already been discussed in the literature, and there are a series of elements associated with it (https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559). It may be worthwhile to add this to the discussion on page 13, lines 47-49.

Transparency in the communication process is one of the elements for Patient-Centered Care. Although the use of the word "cancer" can generate anxiety and hinder the patient's understanding of their illness, as discussed in the present article, recent studies indicate that patients prefer to receive clear information about their diagnosis. This includes straightforward discussions about a cancer diagnosis or the risks of developing cancer, even when the probabilities are low. Furthermore, research suggests that the greater challenge lies not in the use of a particular word but in how healthcare professionals communicate bad news to patients. Well-established communication protocols, such as the SPIKES protocol, exist to assist in this process. With this in mind, I recommend that the authors incorporate the importance of these protocols throughout the text and emphasize how they can enhance professionals' abilities to engage in challenging conversations with patients.

Alves CGB, Ribeiro ACP, Brandão TB, et al. Patient's perceptions of oral and oropharyngeal cancer diagnosis disclosure: communication aspects based on SPIKES protocol. Oral Surg Oral Med Oral Pathol Oral Radiol. 2023;135(4):518-529. doi:10.1016/j.oooo.2022.12.008.

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000;5(4):302-11. doi: 10.1634/theoncologist.5-4-302.

The example on page 4, lines 34 to 36, illustrates the previous comment. The lack of technique and preparation to discuss challenging topics, such as cancer or the possibility of its development, can cause anxiety and confusion. However, studies show that appropriate communication significantly enhances patient adherence to treatment and increases their autonomy in making health decisions. In this context, on page 10, lines 49-50, beyond the terminology used, are physicians prepared to discuss these terms with patients? Is the issue more about the choice of wording or the manner in which it is presented to the patient?

Zachariae R, Pedersen CG, Jensen AB, Ehrnrooth E, Rossen PB, von der Maase H. Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. Br J Cancer. 2003 Mar; 88(5):658-665. doi:10.1038/sj.bjc.6600798.

Sobczak K, Leoniuk K, Janaszczyk A. Delivering bad news: Patient‘s perspective and opinions. Patient Prefer Adherence. 2018 Aug; 12:2397-2404. doi:10.2147/PPA.S183106.

Page 8, lines 10 to 17: This passage reinforces the need to reevaluate whether the issue pertains to the terminology used or the manner in which this information is presented to the patient. It further emphasizes the importance of communication protocols to guide how this information should be delivered.

In the Materials and Methods section, it is stated that the patients included in the study self-reported a diagnosis of a low-risk lesion. Did you request any documentation, such as a medical report or histopathological report, to verify the patient's claims? If so, please include this information in the article.

Did the researchers contact the same number of doctors from each specialty? If so, please include the information in the article.

It would be valuable to assess whether the physicians who participated in the study have undergone any form of training in delivering bad news, and to determine if there is a difference in their approach compared to other physicians in discussing the topics addressed in this research.

Page 14, lines 12 and 13: Recent studies show that there is no significant difference in psychological distress whether bad news is disclosed by telephone or in person. What matters is how the news is delivered, rather than the modality of disclosure. I suggest adding this point to the discussion.

Reference: Mueller J, Beck K, Loretz N, et al. The Disclosure of Bad News Over the Phone vs. in Person and its Association with Psychological Distress: a Systematic Review and Meta-Analysis. J Gen Intern Med. 2023;38(16):3589-3603. doi:10.1007/s11606-023-08323-z.

The collected data is very interesting, but the tables are cluttered with too much information, making it difficult to discern the main message. I suggest reviewing the tables and reorganizing them to highlight the key information in a more straightforward manner. Additional data can be included in the additional file, as is already being done with other supplementary information.

VERSION 1 - AUTHOR RESPONSE

REVIEWER #1 (Brooke Nickel)

Comment	Response
This qualitative study with low-risk cancer patients and physicians aimed to explore views about existing and alternative labels and language for low-risk lesions, and also knowledge that could inform improved communication about low-risk cancer lesions. While there has been a number of both hypothetical quantitative studies looking at this issue as	Thank you

well as a few qualitative studies with both patients and physicians, this study extends that knowledge with patients from additional cancers that to my knowledge have not been explored qualitatively. Further the approach for selecting these cancers is unique as these cancers underwent label changes. The paper is therefore, important however I have a few comments and suggestions which I believe will help to strengthen the manuscript.	
The Abstract could be improved for detail in a few places including the specific aim is not clear from just reading the abstract and just stating "Pan-Canada". Also, suggest adding actual n and not just % in results. Check punctuation	Given the journal-imposed restriction on Abstract word limit and journal allowance for phrases rather than full sentences, we added some detail to the Abstract: edited the Objectives, added n in addition to percent, and clarified a few details. We believe that punctuation is accurate but are happy for in-house editors to correct as needed.
In the Introduction I think it would be valuable to include a bit of background on the hypothetical quantitative studies (RCTs and DCEs) that have been conducted on testing low risk cancer labels including for prostate, thyroid and breast (DCIS). This data gives precedent to the research question and study. Also, there has been a number of reviews done in this area as well and a few studies not cited with both patients and physicians in thyroid cancer (including by Nickel and Jensen) that would be worth noting up front	We purposefully chose to justify this study by making the following points in the Introduction: (1) low risk lesions prompt confusion and anxiety due to poor communication; (2) modifying labels may be one way to improve communication along with other strategies; and (3) given lack of insight on rationale for communication preferences, we interviewed key informants about how to improve communication. Then, in the Discussion, we contextualized the findings of this study by referring to prior research including two prior studies by this reviewer relevant to DCIS (#29, #30) and a recent review by Lyons et al. (# 31 published in 2024) that included the other studies referred to by this reviewer pertaining to prostate and thyroid cancer, as follows: – Nickel B, Barratt A, Copp T, Moynihan R, McCaffery K. Words do matter: a systematic review on how different terminology for the same condition influences management preferences. BMJ Open 2017;7:e014129. – Nickel B, Semsarian C, Moynihan R, et al. Public perceptions of changing the terminology for low-risk thyroid cancer: a qualitative focus group study. BMJ Open. 2019;9(2):e025820. Published 2019 Feb 5. – Nickel B, Barratt A, McGeechan K, et al. Effect of a Change in Papillary Thyroid Cancer Terminology on Anxiety Levels and Treatment Preferences: A Randomized Crossover Trial. JAMA Otolaryngol Head Neck Surg. 2018;144(10):867-874. – Nickel B, Brito JP, Barratt A, Jordan S, Moynihan R, McCaffery K. Clinicians' Views on Management and

	Terminology for Papillary Thyroid Microcarcinoma: A Qualitative Study. Thyroid. 2017;27(5):661-671. Given that the 2024 Lyons review included the studies recommended by this reviewer, we do not feel that we need to provide details for all studies included in that review, and maintain the conclusion that, unlike any prior studies that only examined labels, our study elaborated on rationale for preferences on labels across three categories of labels (abnormal, precursor-to-cancer, cancer), and also identified accompanying language and other strategies that can improve communication.
The themes feel fairly superficial and read more like topic summaries rather than providing meaningful insights. If someone only reads them and not the actual data, it is hard to understand what actual 'themes' came out of the data. More descriptive theme headings are needed. Also, consider ensuring that deep insights are provided within the themes and not just a summary of what was found.	We employed very rigorous methods and reported results in a detailed, analytic way that is far from "superficial". One, there are many different approaches to qualitative research, which influences the nature of the results and how they are reported. Methods-Approach states that we employed qualitative description, which is a way to summarize straight-forward accounts; hence, interview themes represent concrete views and experiences, which may not resemble conceptual themes that are more likely to emerge from qualitative approaches such as grounded theory technique. We already comprehensively and thoroughly reported those findings in detailed Additional Files that included all themes and quotes, summary tables in the manuscript that included themes and exemplar quotes, and the text of the Results. Two, to more thoroughly analyze the findings in a thematic manner, we mapped interview results to Communication Accommodation Theory (CAT), which transformed the concrete views that emerged from interviews into a higher-level, more conceptual understanding of similarities and differences in the views, preferences and recommendations of patients and physicians. In doing so, we referred to CAT components, which more thematically organizes and reports the straightforward results. Three, because we used CAT to organize and interpret findings, and report the relationship between results, we employed language that reflects the components of CAT. Therefore, we referred to conflicting initial orientation and divergent psychological accommodation between patients and physicians, but alignment between patients and physicians on accommodating tactics in the categories of approximation, interpretability, interpersonal control, discourse management and emotional expression. These are the key findings, which are reported in text in Results, Communication Accommodation section, and graphically in Figure 1.

	However, to address this concern and clarify to readers what was done, we made the following changes in Methods: Methods, Approach This approach [referring to qualitative description] is widely used in health services research as a way to gather and summarize explicit information on challenges and possible solutions. We then mapped those concrete ideas to theory as a way to generate deeper meaning. Methods, Data Analysis We used thematic analysis and constant comparison to inductively identify, expand or merge themes reflecting explicit patient and physician views about labels, language and other strategies to improve communication in transcripts of recorded interviews… We already justified use of CAT and explained its components. To that paragraph, we added: We mapped themes that emerged from initial content analysis onto CAT domains, resulting in higher-level themes reflecting CAT domains.
Also, in the Results consider removing some of the identifiers in the quotes. From an international perspective only really age, sex and cancer needed for patients and sex, physician type and cancer	Please see response to editor's request. We modified all identifiers in text, tables and Additional Files
It is interesting that there were no real differences found by cancer type as prostate cancer is a lot more known to be overdiagnosed and overtreated. Can the authors comment any further on this?	We can only report the explicit findings: patients and physicians held differing expectations (initial orientation) and values/approaches (psychological accommodation) for communication, but largely agreed on the strategies needed to improve communication. This was true for each of cervix, bladder and prostate cancer. However, to address this comment, in Discussion, implications paragraph, we added: Discordance in patient and physician expectations (initial orientation) and values/approaches (psychological accommodation) for communication was common across bladder, cervix and prostate cancer contexts. This may not be surprising given prior research showing that physicians lacked insight on satisfaction with communication during consultations with patients who had different types of cancer [35].
Given the diverse and limited sample size for both patient and physicians across each cancer type and locations, can findings be generalised? One	In the Discussion limitations paragraph, we had already acknowledged limitations in generalizability as follows: We acknowledge several limitations. As volunteers, patient and physician views may be biased. In particular, patients unhappy with communication may have agreed to participate. The

comment from one patient or physicians should not have raised a particular theme or point to draw any major conclusions.	results may not be transferrable to patients with other types of low-risk lesions or the physicians who care for them. This work took place in Canada; hence, the results may not be relevant to patients or physicians in other jurisdictions with differing healthcare systems. And we had also recommended further research to confirm these findings: However, further research is needed to assess how best to implement these strategies, and if and how these strategies improve communication about low-risk cancer and related outcomes. However, to address this concern, in the Discussion limitations paragraph, we added: In keeping with the nature of a qualitative study, we interviewed a small number of patients and physicians for each of bladder, cervix and prostate low-risk lesions. Hence, the results may not be broadly generalizable or transferrable to patients with other types of low-risk lesions or the physicians who care for them.
While I really liked the suggested accommodating tactics presented, how do we get past the inherent bias and change habit of physicians in order to implement these approaches? How can these tactics be actually implemented into practice given limited time and resources physicians already face?	In the Discussion, we had already noted several concrete approaches to implement the results and further research on implementation strategies or tools that might improve communication. Beyond the following numerous suggestions already included in the Discussion, we cannot further comment because we did not study which of these approaches might be most successful. – Nomenclature agencies could update their decision-making process to be more patient-centred by considering evidence of patient preferences, such as that generated in this study, and/or engaging patients in their meetings. – Doing so may yield labels that are both meaningful to patients and accepted by physicians. – Then, professional societies could encourage use of the updated nomenclature among members. – A multi-disciplinary approach is another way to address the information needs of patients with low-risk cancer to overcome the limitations of imposed visit length. In this model of care, the treating physician might initially disclose the diagnosis and treatment options to patients, and other types of healthcare professionals such as nurse practitioners or social workers could further discuss the implications with patients to address their questions and concerns. – Further research is needed to assess how best to implement these strategies [referring to accommodating tactics], and if and how these strategies improve communication about low-risk cancer and related outcomes.

	– Further research is needed to thoroughly examine the potential benefits and harms of this and other strategies, particularly to suit the nuances of different patient languages and cultures. – Future research should develop tools that help physicians or other team members to assess whether a person has understood risk-based discussion, as prior research demonstrated that physician perceptions of patient beliefs significantly differed from patients' actual beliefs and aligned more closely to their own beliefs [42]; and informational resources to which physicians could refer patients, as existing resources may not distinguish low-risk lesions from invasive cancer [43].
Again, in the discussion previous qualitative research with physicians in thyroid cancer found similar findings and should be referred to. Framing of the specific cancers could be highlighted and discussion around how findings might related to other cancers more likely to be overdiagnosed and overtreated therefore warranting a change in nomenclature would be welcomed.	Please see above response to this issue. In the Discussion, we contextualized the findings of this study by referring to prior research including two prior studies by this reviewer relevant to DCIS (#29, #30) and a recent review by Lyons et al. (# 31 published in 2024) that included the other studies referred to by this reviewer pertaining to prostate and thyroid cancer: – Nickel B, Barratt A, Copp T, Moynihan R, McCaffery K. Words do matter: a systematic review on how different terminology for the same condition influences management preferences. BMJ Open 2017;7:e014129. – Nickel B, Semsarian C, Moynihan R, et al. Public perceptions of changing the terminology for low-risk thyroid cancer: a qualitative focus group study. BMJ Open. 2019;9(2):e025820. Published 2019 Feb 5. – Nickel B, Barratt A, McGeechan K, et al. Effect of a Change in Papillary Thyroid Cancer Terminology on Anxiety Levels and Treatment Preferences: A Randomized Crossover Trial. JAMA Otolaryngol Head Neck Surg. 2018;144(10):867-874. – Nickel B, Brito JP, Barratt A, Jordan S, Moynihan R, McCaffery K. Clinicians' Views on Management and Terminology for Papillary Thyroid Microcarcinoma: A Qualitative Study. Thyroid. 2017;27(5):661-671. Given that the 2024 Lyons review included the studies by, and recommended by this reviewer, we do not feel that we need to provide details for all studies included in that review, which would duplicate that review, and is beyond the scope of the current study.

REVIEWER #1 (Alan Roger Santos-Silva)

Comment	Response
The study raises an interesting and relevant discussion about the terms used by physicians when discussing low-risk lesion diagnoses with patients.	Thank you!
The present study mentions the need for Patient-Centered Care (page 12, lines 47 to 53). This concept has already been discussed in the literature, and there are a series of elements associated with it	We mention a patient-centred approach in two locations in the Discussion: 1/

(https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559). It may be worthwhile to add this to the discussion on page 13, lines 47-49.	Nomenclature agencies could update their decision-making process to be more patient-centred by considering evidence of patient preferences, such as that generated in this study, and/or engaging patients in their meetings. 2/ This research identified 16 strategies to improve patient-physician communication about low-risk lesions regardless of labels used. Such guidance could benefit physicians given documented lack of training in person-centred care and in discussing a cancer diagnosis, which contributes to emotional exhaustion and burnout [36,37]. We mentioned patient-centred care as a potential benefit that may be achieved if nomenclature agencies and physicians implemented these findings. So the emphasis is on implementing the labels, language and other strategies that emerged from this research, and not on the concept of patient-centred care. However, to address this request, we added the following just before the conclusions: Overall, endorsement and adoption of the labels, language and other strategies that emerged from this research by nomenclature agencies, professional societies and physicians may lead to enhanced person-centred cancer care, which refers to an approach that engages patients by fostering a healing relationship, exchanging information, exploring emotions, managing uncertainty, sharing decisions and supporting self-management [44,45], resulting in numerous proven experiential and clinical benefits for patients [46,47]. Note that we did not cite the reference provided by this reviewer, which appears to be a brief commentary article rather than

	empirical research. Instead, we referred to landmark work that established the components of person-centred care in the context of cancer (McCormack) and other notable reviews: 44. Constand MK, MacDermid JC, Dal Bello-Haas V, et al. Scoping review of patient-centered care approaches in healthcare. BMC Health Serv Res 2014;14:271. 45. McCormack LA, Treiman L, Rupert D, et al. Measuring patient-centered communication in cancer care: a literature review and the development of a systematic approach. Soc Sci Med 2011;72:1085-95. 46. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open 2013;3:1-18. 47. Rathert C, Wyrwich MD, Boren SA. Patient-centered care and outcomes: a systematic review of the literature. Med Care Res Rev 2013;70:351-79.
Transparency in the communication process is one of the elements for Patient-Centered Care. Although the use of the word "cancer" can generate anxiety and hinder the patient's understanding of their illness, as discussed in the present article, recent studies indicate that patients prefer to receive clear information about their diagnosis. This includes straightforward discussions about a cancer diagnosis or the risks of developing cancer, even when the probabilities are low. Furthermore, research suggests that the greater challenge lies not in the use of a particular word but in how healthcare professionals communicate bad news to patients. Well-established communication protocols, such as the SPIKES protocol, exist to assist in this process. With this in mind, I recommend that the authors incorporate the importance of these protocols throughout the text and emphasize how they can enhance professionals' abilities to engage in challenging conversations with patients. – Alves CGB, Ribeiro ACP, Brandão TB, et al. Patient's perceptions of oral and oropharyngeal cancer diagnosis disclosure: communication aspects based on SPIKES protocol. Oral Surg Oral Med Oral Pathol Oral Radiol. 2023;135(4):518-529. doi:10.1016/j.oooo.2022.12.008. – Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to	We fully agree with the idea in this comment that labels alone are not the only solution to improving patient-provider communication about a cancer diagnosis. We had already acknowledged this in the Introduction ("Thus, even if nomenclature omitted cancer-related terms (e.g. explicit use of "cancer" or labels synonymous to or suggestive of cancer such as neoplasia), there may still be a need for accompanying language or other communication strategies that better explain the meaning or implications of low-risk lesions to affected persons.") and in Discussion ("All labels prompted confusion and anxiety among patients," and "In contrast to prior calls for changes in nomenclature as the sole approach to improving communication [19], this study generated detailed insight

the patient with cancer. Oncologist. 2000;5(4):302-11. doi: 10.1634/theoncologist.5-4-302.	on how by: identifying three categories of labels, comparing perceived benefits and harms of different labels between patients and physicians to identify key areas of discord; and revealing language and other strategies to improve communication regardless of label.”) We appreciate the references to SPIKES. This instrument does not appear to have been validated, and is remarkably similar to the components of person-centred cancer care elucidated by McCormack. However, to address this request, we incorporated SPIKES in Discussion, paragraph two, as follows: This study contributes to gaps in prior research on cancer communication, which largely focused on how to deliver unfavourable news to those with late-stage or aggressive cancers [26-28]. Little prior research examined preferences for, or the impact of labels for discussing low-risk lesions despite the existence of tools such as SPIKES, a six-step protocol for delivering bad news [29]. While SPIKES recommends using lay language rather than technical terms, avoiding excessive bluntness such as stating you have cancer and need immediate treatment, and giving information in small chunks with periodic assessment of comprehension, it does not specify labels, language or other strategies that could assist physicians in achieving these recommendations [29].
The example on page 4, lines 34 to 36, illustrates the previous comment. The lack of technique and preparation to discuss challenging topics, such as cancer or the possibility of its development, can cause anxiety and confusion. However, studies show that appropriate communication significantly enhances patient adherence to treatment and increases their autonomy in making health decisions. In this context, on page 10, lines 49-50,	As noted above, we agree that labels alone cannot improve communication about a low-risk cancer diagnosis, as explicitly stated in both the Introduction and Discussion; the Results itemize language and other strategies that can help physicians communicate

beyond the terminology used, are physicians prepared to discuss these terms with patients? Is the issue more about the choice of wording or the manner in which it is presented to the patient? Zachariae R, Pedersen CG, Jensen AB, Ehrnrooth E, Rossen PB, von der Maase H. Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. Br J Cancer. 2003 Mar; 88(5):658-665. doi:10.1038/sj.bjc.6600798. Sobczak K, Leoniuk K, Janaszczyk A. Delivering bad news: Patient's perspective and opinions. Patient Prefer Adherence. 2018 Aug; 12:2397-2404. doi:10.2147/PPA.S183106.	with patients; and in the Discussion, we have identified numerous additional approaches (beyond SPIKES) that may help physicians to communicate with patients, as follows. Therefore, we have fully addressed this issue. – This research identified 16 strategies to improve patient-physician communication about low-risk lesions regardless of labels used. ***And the Results section of our manuscript plus Table 4 and Table 5 lists those approaches, which include language and other strategies*** – A multi-disciplinary approach is another way to address the information needs of patients with low-risk cancer to overcome the limitations of imposed visit length. In this model of care, the treating physician might initially disclose the diagnosis and treatment options to patients, and other types of healthcare professionals such as nurse practitioners or social workers could further discuss the implications with patients to address their questions and concerns. – Future research should develop tools that help physicians or other team members to assess whether a person has understood risk-based discussion, as prior research demonstrated that physician perceptions of patient beliefs significantly differed from patients' actual beliefs and aligned more closely to their own beliefs [43]; and informational resources to which physicians could refer patients, as existing resources may not distinguish low-risk lesions from invasive cancer [44].
Page 8, lines 10 to 17: This passage reinforces the need to reevaluate whether the issue pertains to the terminology	We don't have a version of the manuscript that specifies line

used or the manner in which this information is presented to the patient. It further emphasizes the importance of communication protocols to guide how this information should be delivered.	numbers, so we are not sure which passage this refers to. However, the idea in this comment is similar to the above two comments, which we have addressed.
In the Materials and Methods section, it is stated that the patients included in the study self-reported a diagnosis of a low-risk lesion. Did you request any documentation, such as a medical report or histopathological report, to verify the patient's claims? If so, please include this information in the article.	We did not, and now note this in the Discussion, limitations paragraph, as follows: We did not verify patient's self-reported claims of having been diagnosed with a low-risk cervical, bladder or prostate lesion; however, even if their lesion was higher grade, views about labels, language and other strategies to improve communication are likely relevant.
Did the researchers contact the same number of doctors from each specialty? If so, please include the information in the article.	In Methods, Sampling & Recruitment, we had already noted: We recruited participants through [*30 updated to 263] charitable (e.g. Canadian Cancer Society), advocacy (e.g. Bladder Cancer Canada), professional (e.g. Canadian Association of Surgical Oncology) and support (e.g. Gilda's Club) organizations that agreed to share a study information sheet with clients or members by email instructing interested persons to contact the study coordinator. We also identified [*specified 467] physicians of various specialties that see patients with bladder, cervical or prostate lesions on the web sites of Canadian medical schools. Because organizations shared study invitation with their members and networks on our behalf, it is impossible to establish an exact denominator of how many patients and physicians we contacted, but it was a LOT because recruiting for qualitative research is getting more and more challenging. Throughout the recruitment process, we continuously revisited numbers, and focused recruitment efforts on under-represented sub-groups. For example, despite best efforts and outreach via numerous

	organizations, we were only able to recruit 3 family physicians. To address this issue, in Methods, Sampling & Recruitment, we added: It is not possible to establish the reach of these organizations and individuals, thus we cannot specify the precise number of people invited to participate, but intense recruitment efforts likely reached hundreds of patients and physicians.
It would be valuable to assess whether the physicians who participated in the study have undergone any form of training in delivering bad news, and to determine if there is a difference in their approach compared to other physicians in discussing the topics addressed in this research.	We asked participants to identify rationale for label preferences plus other language and strategies that could improve communication. Factor that influence physician behaviour, such as bad-news training or skill, was beyond the scope of this study and we did not ask physicians to provide this information. Given that the study has concluded and funding depleted, this is not something we can now undertake. However, in the future, researchers may wish to build on this study by identifying physician-specific factors that influence communication.
Page 14, lines 12 and 13: Recent studies show that there is no significant difference in psychological distress whether bad news is disclosed by telephone or in person. What matters is how the news is delivered, rather than the modality of disclosure. I suggest adding this point to the discussion. Reference: Mueller J, Beck K, Loretz N, et al. The Disclosure of Bad News Over the Phone vs. in Person and its Association with Psychological Distress: a Systematic Review and Meta-Analysis. J Gen Intern Med. 2023;38(16):3589-3603. doi:10.1007/s11606-023-08323-z.	In the Discussion, we already cited evidence from the United States and Norway that cancer patients want to learn of their diagnosis in person. The systematic review cited by this reviewer appears to be recent and rigorously conducted; however, this reviewer also recommended we mention SPIKES, which refers to giving bad news in a comfortable, private setting among many other strategies that are likely better achieved in person rather than by telephone. While conveying a cancer diagnosis in person or by telephone is not the focus of this work, to address this request, we added the following to Discussion: Prior research suggests that patients in the United States and in Norway preferred learning of a cancer diagnosis in person [38,39,40], yet a more recent review found that

	patients experience the same level of distress regardless of whether they receive bad news in person or by telephone, suggesting that perhaps the way the news is delivered is more important than setting [41]. This finding underscores the importance of the labels, language and other strategies identified in this study, which can inform the way news is delivered regardless of mode.
The collected data is very interesting, but the tables are cluttered with too much information, making it difficult to discern the main message. I suggest reviewing the tables and reorganizing them to highlight the key information in a more straightforward manner. Additional data can be included in the additional file, as is already being done with other supplementary information.	We revisiting the content of tables, which are essential to the written discussion of Results and summarize the far more detailed online-only Additional Files, and considered how to simplify them. Table 2 In qualitative research, it is important to highlight themes with select quotes (in addition to additional online-only supplemental files providing the entirety of the data), and to compare views between different groups of participants. Given that Table 2 includes select quotes from both patients and physicians, and is not overly lengthy, we did not adjust Table 2. Table 3 Extensively revised by merging rows to only three for each of the three types of lesions; however, as is required in qualitative research, we compared patient and physician comments for each of benefits and harms Table 4 The table shows participant views for each of the language options and other strategies recommended. It is not terribly lengthy, simple in format, and as is required in qualitative research, compares the views of different groups. Therefore, we did not make any changes. Table 5

	Again, the table compared patient and physician views on the most important approaches for improving communication and is only one page in length, so we did not make any changes.

VERSION 2 - REVIEW

Reviewer	**1**
Name	**Nickel, Brooke**
Affiliation	**University of Sydney, School of Public Health**
Date	**24-Nov-2024**
COI	

The authors have adequately addressed and/or justified all of my previous comments and concerns. While I would still prefer that the overarching themes in main text of the manuscript be more descriptive, as I believe this would add an overall richness to the data, if the authors don't agree then that is fine - the rest of the manuscript is improved.

Reviewer	**2**
Name	**Santos-Silva, Alan Roger**
Affiliation	**Universidade Estadual de Campinas**
Date	**09-Dec-2024**
COI	

The authors have thoroughly addressed all of my comments and recommendations.