PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Professional roles and relationships during the Coronavirus disease 2019 pandemic: A qualitative study among US clinicians
AUTHORS	Butler, Catherine; Wong, Susan P. Y.; Vig, Elizabeth; Neely, Claire; O'Hare, Ann

VERSION 1 – REVIEW

REVIEWER	Iwan A. Meynaar, MD, PhD Intensive Car Unit, HagaZiekenhuis, The Hague, The Netherlands
REVIEW RETURNED	19-Dec-2020

GENERAL COMMENTS	Butler et al have done a qualitative study on perception and experiences of clinicians caring for patients with pandemic COVID-19. The manuscript is written clearly and concisely. Methods are adequate, although I must admit that I am no expert at qualitative research. The research question is answered fully. The authors conclude that clinicians caring for COVID-19 patients during the pandemic experienced disruption, constructive adaptation and estrangement. As a researcher but also as a clinician who cared for patients with COVID-19 and as a manager who helped to set up mental support for clinicians, I can say without doubt or hesitation that the results of this study are very well recognizable for me and for my colleagues and deserve immediate publication.

REVIEWER	Elizabeth Chuang Montefiore Medical Center, USA
REVIEW RETURNED	31-Jan-2021

GENERAL COMMENTS	This manuscript has significant strengths. This is a large qualitative study including a variety of front line clinicians and leadership in US hospitals facing the initial period of the COVID-19 pandemic. The findings are clearly presented and the methodology adheres to COREQ guidelines. The findings and conclusions are valuable to those in leadership positions in acute care hospitals responding to the ongoing COVID-19 crisis and will be valuable to inform approaches to future crises, particularly with respect to fostering collaboration and trust. I have only two minor comments. 1. Is it possible to stratify responses according to the clinical situation faced by the respondents in April and May of 2020? The experience is likely to be very different for respondents who did or did not face resource scarcity and did or did not work in hospitals

	using triage strategies. Different challenges faced those who were immersed in a surge versus those whose daily work was disrupted by preparations for a surge but who did not experience one as is alluded to in quote #55. This would be more useful contextualizing information than the deaths per 100,000 population presented in Table 1. Can you instead present proportion of respondents who worked in a hospital that implemented triage strategies or that experienced patient load above normal operating capacity? Can you say anything about differences in responses between subjects facing these different circumstances? 2. I'm surprised that issues around increased family obligations (e.g. disrupted childcare, increased family caregiving responsibilities) did not emerge under Theme 1, blurred boundaries between work and home life. Were there any responses to that effect?

REVIEWER	Philip A. Cola, PhD Case Western Reserve University Cleveland, Ohio 44106 United States
REVIEW RETURNED	01-Feb-2021

GENERAL COMMENTS	Most importantly, the authors need to be congratulated for doing this large amount of important work in a short period of time. It is very important to capture the lived experiences of physicians, nurses and healthcare leaders during the pandemic and to be able to do so at the initial height of the pandemic is laudable. The manuscript contains a great deal of information and evidence to support the emergent findings and this has great potential to be strong. The objective that starts the manuscript appears to be actionable and manageable, but as you go on there might have been benefit to articulating a research question such as: How and to what extent have clinician roles (including leadership roles) and relationships been impacted by the pandemic? The leadership aspect is not covered directly by the objective that is stated currently in the paper. How many leaders were interviewed in the sample of 61? We know how many physicians and nurses, but not how many of them in particular had leadership roles. It appears that those with leadership roles were still "active clinicians", but how many either changed roles from leadership back to practitioner or even vice versa if applicable. It is very important to study the leadership aspects on clinicians during a pandemic, but it was not clear at the outset that such was part of the objective. Therefore, a more specific research question would have helped guide the reader. The research method, in general, seems reasonable. The inclusion of the qualitative research checklist is strong. However, the methods could be augmented even more if there were some additional details regarding a constant comparative methodological approach (see Corbin & Strauss, 1998; Charmaz, 2014). The method employed here appears to be a constant comparative method, but that is not explicitly stated, (i.e., we reviewed the first three manuscripts then the fourth comparing it to the first three and so on and so forth). This is important especially

	based on the reference to a grounded theory approach per Birks & Mills 2015 which would imply a comparative method. It is unclear, as to why, the dual rating of all transcripts ended at 30 and then a different and single author continued with the analyses of the remaining 31 transcripts. Theoretical saturation usually helps determine the sample size when employing a constant comparative method. Therefore, to have the 61 interviews and say that saturation was met during the coding process and then we changed the coding process for the remaining 31 would require additional explanation. This sample size for this type of qualitative study is strong and I think the paper would be strengthened had all transcripts been reviewed and coded as the interviews were still being conducted and then agreed upon saturation reached with additional interviews taking place thereafter to be more confident in the saturation. Was there any inter-rater reliability conducted between the first two coders of the first 30 transcripts? Additionally, then of the 30 transcripts with the remaining 31 transcripts post theoretical saturation? It is understood that other authors then combed the transcripts for strong quotations, but how about for congruence of the emergent sense of the main themes? Were the ones that were initially coded by two people actually the first 30 transcripts or perhaps I am just assuming that was the case? Perhaps the paper should include in the title something about "in Academic Medical Centers" as that is where the vast majority of the sample was working or at least in large health systems. It is not solely about the general physicians roles and responsibilities as the paper does not really cover community based settings or settings in rural parts of the country or even perhaps in disadvantaged areas. Therefore, some qualification upfront as to where this is most generalizable would be helpful. Also, most of the sample is white and it was surprising to see that out of 61 people interviewed only two were black. Generally, the findings are strong, important and relevant. These types of findings need to be disseminated and understood. Disruption is critically important, but then there is the finding about demands on leaders and how some trust in leaders was eroded as they were not clearly understanding the role of the clinician, but were not all participants clinicians? Again, how many of these individuals had dual roles in clinical care and leadership and what was the change or shift in those roles during the pandemic? This would be very helpful to understand better. Constructive adaptation was clearly something that emerged if you read through the quotes and the senate of collaboration was necessary, but then in the conclusions that is replaced with teamwork and those two things are different unless more specifically defined. Was collaboration needed (findings) or teamwork (discussion). How are they similar and how are they different? It appears that inter professional power differentials could be important during these times of crisis that is seemingly directly related to leadership. Those findings are juxtaposed and not integrated and that would benefit from additional integrations.

	Perhaps for each emergent theme the definition of the finding needs to be the next sentence under the headings of each finding. This would clarify more clearly how you interpreted and defined what emerged from the data. In the discussion, emphasis is placed on teamwork and collaboration and that is likely very true to these lived experiences. However, there is really not a key definition to these terms and their similarities and differences. Even if you look specifically at the large number of quotations at the end of the paper in the tables the terms teamwork or team and collaboration are not used often so it is not clear why such emerged overwhelmingly as the main discussion point. I am not arguing that such is not the most important conclusion here, but rather just trying to track the evidence in a very specific and clear way. This is a strong paper that with some additional clarifications and information related to the aforementioned comments should be accepted.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Dr. IA Meynaar, Intensive Care Unit, Reinier de Graaf Hospital

Comments to the Author:
Butler et al have done a qualitative study on perception and experiences of clinicians caring for patients with pandemic COVID-19. The manuscript is written clearly and concisely. Methods are adequate, although I must admit that I am no expert at qualitative research. The research question is answered fully. The authors conclude that clinicians caring for COVID-19 patients during the pandemic experienced disruption, constructive adaptation and estrangement.

As a researcher but also as a clinician who cared for patients with COVID-19 and as a manager who helped to set up mental support for clinicians, I can say without doubt or hesitation that the results of this study are very well recognizable for me and for my colleagues and deserve immediate publication.
It is reassuring to us that our findings resonate with the reviewer and we than thank the reviewer for taking the time to reflect on our work.

Reviewer: 2
Dr. Elizabeth Chuang, Yeshiva University Albert Einstein College of Medicine

Comments to the Author:
This manuscript has significant strengths. This is a large qualitative study including a variety of front line clinicians and leadership in US hospitals facing the initial period of the COVID-19 pandemic. The findings are clearly presented and the methodology adheres to COREQ guidelines. The findings and conclusions are valuable to those in leadership positions in acute care hospitals responding to the ongoing COVID-19 crisis and will be valuable to inform approaches to future crises, particularly with respect to fostering collaboration and trust.
We appreciate the reviewer's thoughtful read.

I have only two minor comments.

1. Is it possible to stratify responses according to the clinical situation faced by the respondents in April and May of 2020? The experience is likely to be very different for respondents who did or did not face resource scarcity and did or did not work in hospitals using triage strategies. Different challenges faced those who were immersed in a surge versus those whose daily work was disrupted by preparations for a surge but who did not experience one as is alluded to in quote #55. This would be more useful contextualizing information than the deaths per 100,000 population presented in Table 1. Can you instead present proportion of respondents who worked in a hospital that implemented triage strategies or that experienced patient load above normal operating capacity? Can you say anything about differences in responses between subjects facing these different circumstances?
We agree that experiences likely varied by clinical setting. To our knowledge none of the participants in this study were practicing at institutions that had explicitly declared crisis capacity. Unfortunately, we did not collect information on institutional or clinician workload or COVID-19 burden at the time of interview. We also found that many clinicians reflected on experience in a range of settings with evolving case load over time, so the COVID-19 burden at the time of the interview may not have reflected the content of these interviews.

2. I'm surprised that issues around increased family obligations (e.g. disrupted childcare, increased family caregiving responsibilities) did not emerge under Theme 1, blurred boundaries between work and home life. Were there any responses to that effect?
These issues did emerge in our analyses and we agree they are important and have included relevant text and quotations in the revised manuscript (Results, Theme 1, sub-theme 1, line 7-8).

Reviewer: 3
Dr. Philip Cola, Case Western Reserve University

Comments to the Author:
Most importantly, the authors need to be congratulated for doing this large amount of important work in a short period of time. It is very important to capture the lived experiences of physicians, nurses and healthcare leaders during the pandemic and to be able to do so at the initial height of the pandemic is laudable.

The manuscript contains a great deal of information and evidence to support the emergent findings and this has great potential to be strong. The objective that starts the manuscript appears to be actionable and manageable, but as you go on there might have been benefit to articulating a research question such as: How and to what extent have clinician roles (including leadership roles) and relationships been impacted by the pandemic?
We agree now articulate our research goal more clearly (Introduction, paragraph 2, line 7-8).

The leadership aspect is not covered directly by the objective that is stated currently in the paper. How many leaders were interviewed in the sample of 61? We know how many physicians and nurses, but not how many of them in particular had leadership roles. It appears that those with leadership roles were still "active clinicians", but how many either changed roles from leadership back to practitioner or even vice versa if applicable.
While some of those interviewed were selected because of their leadership roles, we did not systematically ask all participants whether they were serving in a leadership role (or roles). We also now clarify that we sampled for clinicians involved in institutional planning for the pandemic, who may have had formal or informal leadership roles. (Methods, paragraph 2, line 5-6)

It is very important to study the leadership aspects on clinicians during a pandemic, but it was not clear at the outset that such was part of the objective. Therefore, a more specific research question would have helped guide the reader.

In the revised manuscript, we have clarified that we studied roles and relationships related to both clinical and leadership responsibilities. (Introduction, para 2, line 7-8)

The research method, in general, seems reasonable. The inclusion of the qualitative research checklist is strong. However, the methods could be augmented even more if there were some additional details regarding a constant comparative methodological approach (see Corbin & Strauss, 1998; Charmaz, 2014). The method employed here appears to be a constant comparative method, but that is not explicitly stated, (i.e., we reviewed the first three manuscripts then the fourth comparing it to the first three and so on and so forth). This is important especially based on the reference to a grounded theory approach per Birks & Mills 2015 which would imply a comparative method.
We agree with the reviewer that our methodologic approach is largely consistent with constant comparison, and now give a more detailed account of this approach. (Methods, paragraph 4)
Because we were required to adapt this methodology by over-recruiting early in the study rather than following the constant comparison methodology precisely and relying exclusively on analysis to guide purposive recruitment, we prefer to not use the term ‘constant comparison’, but agree that we were guided by Charmaz, and now add a reference. (Constructing grounded theory, Chapter 3: Coding in Grounded Theory Practice, 2006)

It is unclear, as to why, the dual rating of all transcripts ended at 30 and then a different and single author continued with the analyses of the remaining 31 transcripts. Theoretical saturation usually helps determine the sample size when employing a constant comparative method. Therefore, to have the 61 interviews and say that saturation was met during the coding process and then we changed the coding process for the remaining 31 would require additional explanation. This sample size for this type of qualitative study is strong and I think the paper would be strengthened had all transcripts been reviewed and coded as the interviews were still being conducted and then agreed upon saturation reached with additional interviews taking place thereafter to be more confident in the saturation.
Because we were unsure of the course of the pandemic at the time that we were conducting the study—that is, we thought it might not last long--we prioritized collecting interviews over analysis and ultimately interviewed many more clinicians than needed to reach saturation. We now clarify that both analysts coded 30 interview transcripts sampled purposively across a range of dates and clinical contexts throughout the interview period until reaching saturation, after which one of the analysts coded the remaining 31 transcripts to confirm congruence with emergent themes and select additional exemplar quotations. (Methods, para 3, line 10-12)

Was there any inter-rater reliability conducted between the first two coders of the first 30 transcripts? Additionally, then of the 30 transcripts with the remaining 31 transcripts post theoretical saturation? It is understood that other authors then combed the transcripts for strong quotations, but how about for congruence of the emergent sense of the main themes? Were the ones that were initially coded by two people actually the first 30 transcripts or perhaps I am just assuming that was the case?
We now clarify that both analysts independently coded 30 transcripts sampled across a range of interview dates and met multiple times to discuss emerging themes and come to consensus. One of these analysts then coded the remaining transcripts to confirm congruence with emergent themes and select exemplar quotations. Two other authors reviewed draft manuscript tables that included exemplar quotations selected by the two analysts and helped to refine the thematic schema but did not review interview transcripts. (Methods, paragraph 4)

Perhaps the paper should include in the title something about "in Academic Medical Centers" as that is where the vast majority of the sample was working or at least in large health systems. It is not solely about the general physicians roles and responsibilities as the paper does not really cover community based settings or settings in rural parts of the country or even perhaps in disadvantaged areas. Therefore, some qualification upfront as to where this is most generalizable would be helpful. Also, most of the sample is white and it was surprising to see that out of 61 people interviewed only

two were black.
We agree and include information about these relevant participant demographic characteristics in the abstract. Because we intentionally included clinicians practicing in rural and non-academic settings, we prefer not to include a reference to academic medical centers in the title, but do now mention this imbalance in recruitment as a potential limitation (discussion, paragraph 5).

Generally, the findings are strong, important and relevant. These types of findings need to be disseminated and understood.
Thank you.

Disruption is critically important, but then there is the finding about demands on leaders and how some trust in leaders was eroded as they were not clearly understanding the role of the clinician, but were not all participants clinicians? Again, how many of these individuals had dual roles in clinical care and leadership and what was the change or shift in those roles during the pandemic? This would be very helpful to understand better.
We did intentionally recruit clinicians with leadership roles and now articulate this more clearly (Methods, Paragraph 2, Line 5). However, we did not recruit non-clinical members of hospital leadership, nor did we systematically ascertain participants' leadership roles. Thus, we are unable to provide a detailed characterization of participants' leadership roles, particularly because our sense is that these roles could be informal and dynamic. Some clinicians commented on their experience with non-clinician administrators (but these non-clinician administrators were not study participants). We have clarified what we think may have been a confusing statement in the results by emphasizing the distinction that participants made between clinician leaders and non-clinician administrators. (Theme 3, sub-theme 4, line 4-7)

Constructive adaptation was clearly something that emerged if you read through the quotes and the senate of collaboration was necessary, but then in the conclusions that is replaced with teamwork and those two things are different unless more specifically defined. Was collaboration needed (findings) or teamwork (discussion). How are they similar and how are they different?
We agree that these terms were used somewhat interchangeably in the earlier version of our manuscript. We now articulate more clearly that our findings highlight the importance of teamwork, including--but not limited to--collaboration. In the revised manuscript, we reference other aspects of teamwork including mutual respect and shared goals among colleagues and include references to the broader literature on the role of teamwork in health care.

It appears that inter professional power differentials could be important during these times of crisis that is seemingly directly related to leadership. Those findings are juxtaposed and not integrated and that would benefit from additional integrations.
We now specifically cite the importance of recognizing and addressing pre-existing power differentials and personal tensions when usual practices are disrupted in emergency situations. (Discussion, paragraph 4) We also emphasize the value of collaborative rather than top-down approaches to leadership. (Discussion paragraph 3)

Perhaps for each emergent theme the definition of the finding needs to be the next sentence under the headings of each finding. This would clarify more clearly how you interpreted and defined what emerged from the data.
We now include a summary sentence introducing each theme.

In the discussion, emphasis is placed on teamwork and collaboration and that is likely very true to these lived experiences. However, there is really not a key definition to these terms and their similarities and differences. Even if you look specifically at the large number of quotations at the end of the paper in the tables the terms teamwork or team and collaboration are not used often so it is not

clear why such emerged overwhelmingly as the main discussion point. I am not arguing that such is not the most important conclusion here, but rather just trying to track the evidence in a very specific and clear way.
The reviewer is correct that study participants did not make frequent mention of either of these terms. Rather, we used these terms in describing our interpretation of interview transcripts. In response to the reviewer concern, we have re-reviewed our discussion of these concepts and the relevant exemplar quotations on which these are based and do feel that our interpretation is well grounded in and supported by the quotations.

This is a strong paper that with some additional clarifications and information related to the aforementioned comments should be accepted.
We appreciate the thorough and constructive review.

VERSION 2 – REVIEW

REVIEWER	Elizabeth Chuang Albert Einstein College of Medicine/Montefiore Medical Center
REVIEW RETURNED	22-Feb-2021

GENERAL COMMENTS	As I stated in my previous review, this is a very strong paper with important implications. My minor comments have been addressed and I have no further questions.

REVIEWER	Philip A. Cola, PhD Case Western Reserve University United States
REVIEW RETURNED	27-Feb-2021

GENERAL COMMENTS	The changes in the revised manuscript appear to be direct responses to previous comments. Also, there are additional edits to the text and the writing. Generally, all appear to be in good order to proceed with publication of the manuscript. The change in the title from "thematic analyses" to "qualitative study" is technically more accurate. The objective is clearly stated in the abstract and again toward the end of the introduction, but it is not in the form of a research question. That is likely acceptable, but the review form asks about the research question twice. Technically there is not a question, but rather the objective is "the impact of the pandemic on clinicians" and then there is an added portion now regarding "the impact on clinicians going forward". The latter addition does not match with the abstract and should be included in the abstract. The introduction and methods section remain brief per journal guidelines and sufficiently set the hook and background for the study and describe in adequate detail what was done including the sample, the data collection, and analyses. It would be interesting to know how many different participants contributed to the 81 quotations provided to support the findings. I still do not believe that this is clear (i.e., of the 60 participants are there quotations from all of them or the vast majority of them?). Also, it is not clear how many of the 60 participants had leadership responsibilities. It is clear that leadership is not the over riding premise of this paper. However, since two of the findings deal with leadership it might be

	good to know of the 60 interviewed what was the number that were known to have leadership responsibilities of the total sample. Otherwise, the introduction and the sample are deemed appropriate to meet the study objectives at this point. The results section makes up the majority of the paper as it discusses 3 emergent themes and 10 sub-themes within those main themes. The flow of the results are clear and the editing has improved the flow further. Extensive data tables are provided by theme with 81 quotations included from a wide array of participants. This is the strength of the paper and extensive. The organization of the quote tables is good and easy to follow thought it might be possible to support the findings with even slightly few quotations. I am a firm believer in supporting the emergent findings in qualitative research with quotations, but on average there are approximately 8 quotations provided per sub-theme. Now if there is some justification that the extensive numbers of quotes were provided to be more inclusive of all participants than this could answer the question posed above in the methods section around number of participants quoted in the paper. The goal is to have a very wide variety of the N=60 providing evidence or support for the findings. Also, for the one sub-theme (under Theme 1. Disruption) termed "demand on leaders" it would be good to know how many clinicians in the sample had leadership roles as part of their overall role (see comment in methods section above). Without knowing this the validity and reliability of this finding is not congruent with the other findings that are clearly emergent findings for the clinician role and not the leader or manager role per the study objective. Finally, for the sub-theme in Theme 3 around "mistrust in leadership", that is clearly around being a clinician, but if some of these people were clinicians and leaders too (as would be indicated by the sub-theme in Theme 1 referenced above) then would this have to be presented more clearly for the mistrust finding. Perhaps again, knowing the number of people in the sample with leadership roles would help clarify this overall. Otherwise the results match and flow well out of the objective of the paper and are congruent with the methodology used to conduct the study. The results are supported by the emergent data in a clear manner. The conclusions flow well from the objective, method and findings and draw practical conclusions for clinicians during a sever time of disruption which is valuable for both the clinician, but for healthcare administrators as well, to under stand. References are relatively current and complete. Overall, the timeliness of this work and the extensive work to interview and code these data in real time during the pandemic is to be applauded. Well done.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2
Dr. Elizabeth Chuang, Yeshiva University Albert Einstein College of Medicine

Comments to the Author:
As I stated in my previous review, this is a very strong paper with important implications. My minor comments have been addressed and I have no further questions.

> Thank you for your review.

Reviewer: 3
Dr. Philip Cola, Case Western Reserve University

Comments to the Author:

The changes in the revised manuscript appear to be direct responses to previous comments. Also, there are additional edits to the text and the writing. Generally, all appear to be in good order to proceed with publication of the manuscript.

The change in the title from "thematic analyses" to "qualitative study" is technically more accurate.

The objective is clearly stated in the abstract and again toward the end of the introduction, but it is not in the form of a research question. That is likely acceptable, but the review form asks about the research question twice. Technically there is not a question, but rather the objective is "the impact of the pandemic on clinicians" and then there is an added portion now regarding "the impact on clinicians going forward". The latter addition does not match with the abstract and should be included in the abstract.

> We now explicitly include our research question in the abstract: “How has the pandemic impacted US clinicians’ professional roles and relationships?” We now clarify that although not an explicit goal of the project, our hope in designing this study was that our findings would offer insights that could help support clinicians moving forward. (Introduction, paragraph 2, Line 5-6)

The introduction and methods section remain brief per journal guidelines and sufficiently set the hook and background for the study and describe in adequate detail what was done including the sample, the data collection, and analyses. It would be interesting to know how many different participants contributed to the 81 quotations provided to support the findings. I still do not believe that this is clear (i.e., of the 60 participants are there quotations from all of them or the vast majority of them?).

> We now mention that exemplar quotations came from 39 participants. (Results, paragraph 2, line 4) We have also included a unique identifier in the second column of Tables 2-4 so that readers can see when quotations came from the same individual.

Also, it is not clear how many of the 60 participants had leadership responsibilities. It is clear that leadership is not the over riding premise of this paper. However, since two of the findings deal with leadership it might be good to know of the 60 interviewed what was the number that were known to have leadership responsibilities of the total sample. Otherwise, the introduction and the sample are deemed appropriate to meet the study objectives at this point.

> We now include information on the number of participants who mentioned titles that included the terms: chief, head, manager, leader, and/or director when asked to describe their clinical and leadership roles during the pandemic. However, we note that this might not include minor or informal leadership roles. (Methods paragraph 3, line 16-19; Discussion paragraph 5, line 7-9)

The results section makes up the majority of the paper as it discusses 3 emergent themes and 10 sub-themes within those main themes. The flow of the results are clear and the editing has improved the flow further. Extensive data tables are provided by theme with 81 quotations included from a wide array of participants. This is the strength of the paper and extensive. The organization of the quote tables is good and easy to follow thought it might be possible to support the findings with even slightly few quotations. I am a firm believer in supporting the emergent findings in qualitative research with quotations, but on average there are approximately 8 quotations provided per sub-theme. Now if there is some justification that the extensive numbers of quotes were provided to be more inclusive of all participants than this could answer the question posed above in the methods section around number of participants quoted in the paper. The goal is to have a very wide variety of the N=60 providing evidence or support for the findings.

> We appreciate the supportive comments. We strongly prefer to retain the exemplar quotations selected in order to do justice to the complex experiences and breadth of perspectives of study participants. This approach also allows us to include quotations for a higher proportion of participants. Unless the reviewer feels strongly, we prefer to retain the selected quotations.

Also, for the one sub-theme (under Theme 1. Disruption) termed "demand on leaders" it would be good to know how many clinicians in the sample had leadership roles as part of their overall role (see comment in methods section above). Without knowing this the validity and reliability of this finding is not congruent with the other findings that are clearly emergent findings for the clinician role and not the leader or manager role per the study objective.

> As described above, we now include information on the number of clinicians who mentioned leadership roles.

Finally, for the sub-theme in Theme 3 around "mistrust in leadership", that is clearly around being a clinician, but if some of these people were clinicians and leaders too (as would be indicated by the sub-theme in Theme 1 referenced above) then would this have to be presented more clearly for the mistrust finding. Perhaps again, knowing the number of people in the sample with leadership roles would help clarify this overall.

> We are unable to sub-divide the group of participants as leaders versus non-leaders as many of those interviewed had multiple different roles. We agree that additional work exploring the unique experience of leaders or non-leaders would add to the literature.

Otherwise the results match and flow well out of the objective of the paper and are congruent with the methodology used to conduct the study. The results are supported by the emergent data in a clear manner.

The conclusions flow well from the objective, method and findings and draw practical conclusions for clinicians during a sever time of disruption which is valuable for both the clinician, but for healthcare administrators as well, to understand.

References are relatively current and complete.

Overall, the timeliness of this work and the extensive work to interview and code these data in real time during the pandemic is to be applauded. Well done.

> Thank you again for your excellent input, careful review, and supportive comments.