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Title	Assessing the impact of an internal medicine nocturnist service on quality of care among patients with cancer at a large Canadian teaching hospital: a quality improvement study
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Reviewer 1	Lawrence A. Haber
Institution	School Medicine, University of California San Francisco, San Francisco, Calif.
General comments (author response in bold)	- Can you include who supervises the two admitting first year residents — was there a senior resident or attending available (on site or off)? As this doesn't seem to be included in the nocturnist duties. **We have added description of the supervisory process as suggested. They are supervised by an in-house second-year resident and a home-call attending physician.** (Methods, Setting, paragraph 2 (page 3) - If the nocturnist is not involved in supervising overnight residents, how can residents comment on issues pertaining to impact on autonomy or education, etc? **Though not directly supervising residents, the primary function of the nocturnist was to offload clinical work. We believe this would enhance residents' focus on existing patients without the need to cross-cover. Overnight senior resident call had become somewhat of a rite of passage in our hospital, and we were concerned that the offloading of clinical volume to the nocturnist may affect residents' ability to manage large patient volumes.** - Did all the residents emailed/ surveyed actually participate in overnight work? **Yes, all residents emailed participated in overnight call.** - Was the survey not performed until June-Dec 2019 (when the nocturnist program started in July 2018) due to the ramp up phase? **The delay in survey performance was as a result of ramp-up activities, survey design and ethics waiver acquisition, and delays due to obtaining permission from educational leadership to survey trainees. This applied mainly to the resident surveys. The surveyed faculty have variable amounts of clinical time and a one-year period ensured that most would have potentially been exposed to the effects of the nocturnist. We have clarified the intentional delay of one year in the methods section.** Methods, Design, Surveys (page 5) - May benefit from being more explicit at start of methods or at end of introduction section that the manuscript will cover two areas 1) patient outcomes and resident census levels based on EHR data and 2) resident and staff perceptions of care based on survey data. Two related, but separate angles on the nocturnist implementation- how do providers feel about nocturnist presence and how does it affect patient care. **This is an excellent suggestion, and we have made this clarification explicit in the introduction.** Introduction, paragraph 3 (page 3) - May make sense to present patient outcome data first, as ultimately probably more important objective measure and I believe the data comes temporally before the survey data.

	This is an excellent suggestion and we have changed the presentation order in the abstract, methods, and results. - Why 24 faculty surveyed when 30 physicians participated as nocturnist faculty- or are the survey respondents a completely different faculty group (daytime only)? **Please see our Response to Query 11, above.** - Were qualitative/ narrative responses coded in any way for analysis (as there are statements made regarding their content and themes)? **Please see our response to 9b, above.** - It seems that some residents who were not IM were surveyed. Can the authors comment on why? **In our CTUs, the complement of residents typically includes 1-2 "off service" first-year residents who are part of a program other than internal medicine (e.g. Psychiatry, neurology, etc.). They are treated nearly identically to first-year internal medicine residents with respect to call and work. We have clarified this in the Interpretation section.** (Interpretation, paragraph 2 (page 11)) - Conclusion may overstate the findings. While interesting findings and contributes to our understanding of the impact of overnight hospitalists, I would be hesitant to say that the small total sample size of the surveyed respondents as well as the largely negligible patient outcome measures make a compelling case for implementation nationally. **Thank you for this suggestion. We have amended some of the wording to reduce such overstatement.** - Slightly tricky as a quality argument, as likely costs a lot of money to the institution for no change in patient outcomes (save for code status documentation, which could probably be increased through cheaper means). Reminds me somewhat of literature on comanagement, in that the outcomes may not be better, but the perception of those involved in the care is. **This is an insightful point, and likely what we are seeing. The code status documentation was chosen as a tangible representation of at least one aspect of admission quality, but institutionally this program is costly. Despite this, the perception from virtually all involved is that there is significant improvement and 'going back to the old way' would be challenging. This seems similar to prior literature from the US.**
Reviewer 2	Anju Anand
Institution	Division of Respirology, St Michaels Hospital, Toronto, Ont.
General comments (author response in bold)	I appreciate the low survey response rate is acknowledged in the limitation section for residents. (only 29% responded). There was no mention of how this could have been higher- eg were email reminders sent. Was the one email at end of rotation all that was done? Did they try to contact residents with a paper survey or allot time at the end of rotation to complete email version of survey. I would be interested to see why response rate is so low. **We have clarified some of the reasons for the low response rate in our limitations section.** (Interpretation, limitations (page 12))