Reviewer's report

Title: Accept or refuse? Factors influencing the decision-making of transplant surgeons who are offered a pancreas: results of a qualitative study

Version: 1 Date: 23 May 2013

Reviewer: Randall S Sung

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Major Compulsory Revisions
1. It would be useful to describe the number of pancreas transplants done by the participating centers, how many surgeons in each center performed them, and the experience of the surgeons.

2. On page three, it should be clarified what the definitions of offered, discarded, and withdrawn signify. I assume that withdrawn from the allocation process means not recovered. I find a 71% frequency of discard to be extremely high, and it is easy to mix this up with not used. For example, in the US about 30% of pancreases are discarded (recovered but not transplanted) but 60% of pancreases are not recovered from donors of other organs.

3. It would be helpful to present more data about how the medical criteria were identified. How is their relative importance determined? Can the importance be weighted?

Minor Essential Revisions
None

Discretionary Revisions
1. One concept that should be emphasized is that the implications for allocation efficiency are more profound if the issues affect the post-recovery phase compared to the pre-recovery or initial offer phase. Thus, variations in acceptance behavior based on medical criteria ought to have a much smaller impact (just need to find another more permissive center/surgeon further down the list) than finding a center to accept a pancreas that is already out and judged to be unsuitable, because you are now fighting CIT, possibly distance, and another team having recovered the pancreas.

2. While better training for donor surgeons may be indicated, the issue may be as much one of perceived expertise as actual expertise, which may be more difficult to remedy. This seems to be implied in the figure but might be made more explicit in the text. Additional measure to address this might be:
   a. Require that the accepting center send their own team or designate a surrogate surgeon as a condition of acceptance.
   b. Use of visual communication tools to provide information about the pancreas so that it is no longer acceptable for the center to require that they “personally inspect” the pancreas at their center.
3. The issue of variation in acceptance by medical criteria is an interesting one. Two important considerations are 1) whether there is variation by center only or by individual surgeons within a center; 2) whether there is inconsistent behavior by individuals from donor to donor. It would be a difficult sell (and may not be medically beneficial) to advocate universal acceptance algorithms, and even more difficult to achieve in practice. It would not be unreasonable to expect that centers or surgeons create their own criteria/algorithms, and to receive feedback about how consistently they follow them.

4. There is a suggestion that absolute rule out criteria and criteria that take other factors into consideration are mutually exclusive, which is not the case. Nearly all center/surgeons are likely to have both. For donor age, for example, it would not be unusual in the US to have a hard cutoff of 50 and a relative upper level of 40-50 where other factors are also carefully considered.

5. If possible, I would elaborate on why the surgeons thought P-PASS was not useful.

6. I think that most experts would view the practice of incorporating need, waitlist size, and the value of the alternative donor into acceptance decisions as a reasonable one. However, this would probably depend on the specifics, and whether the practice is evidence-based.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

Nothing to declare