### Supplemental Table 1: Areas of agreement between participants: men with low grade prostate cancer and physicians

| Topic                          | Shared perspectives | Physicians                                                                 | Men diagnosed with prostate cancer                                                                 |
|-------------------------------|---------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| **Active Surveillance defined** | For low grade/low risk disease | • It’s a small tumor, it doesn’t tend to behave in an aggressive fashion. We can avoid the side effects without compromising the survival because we are following closely and willing to intervene if that changes.  
• It is really about deferring treatment until the time it is necessary: it is active and not about doing nothing.  
• It’s really a program of following a patient closely with the intent to intervene when cure remains a possibility. | • it’s a slow thing and it’s not aggressive at all.  
• I guess I am on the mild side…and it grows so slowly other things are more apt to have an impact.  
• The doctor said my cancer was too trivial, too small, too insignificant for surgery…he put me on active surveillance.  
• My first reaction to the concept [AS] …that’s really doing nothing…he laid it all out…and as I researched it…it is doing something. It’s actually monitoring in a quite regular basis. I got comfortable with that.  
• If I could go another 10 years without an operation, I’d feel good about that, about not having one. I’m 67 now.  
• I was more or less on [the idea that] the less aggressive form of action would be better for me right now…postpone as long as we can. 57 is too young to go under the knife.  
• I don’t want to go into [surgery] just yet. It could be a slow developing cancer; I think most prostate cancers are. And people can live a healthier lifestyle and die of other old age and illness than this. So, I’ll take that chance right now. |
|                               | About doing some active |                                                                           |                                                                                                  |
|                               | Postponing treatment until it is required |                                                                           |                                                                                                  |
| **The benefits of active surveillance** | Close monitoring so that action can be taken if there is a change in disease status | • In addition to avoiding the morbidity of management of the modality of treatment, it still gives us the ability to…in patients that are potentially curable, the ability of monitor them and treat those who require treatment when the time comes, avoiding treatment in the majority of others…it will never be clinically significant.  
• Patients understand that, they understand that we would change [what we do] according to the follow-up. Because if we wouldn’t change our attitude during the follow-up then why would we follow-up?  
• The aim is to preserve quality of life, to defer urinary incontinence, sexual dysfunction, issues with treatments and hopefully, have the same good outcome at the end of the day. | • It didn’t seem bad. We decided we are going to watch it and if something happens then we can do something.  
• I felt I could probably live with it if I could be able to visit frequently with him [doctor] and he could follow me. If there was a suspicious or sudden changes in my health, we could consider radiation then, or whatever else.  
• It’s not about doing nothing, It’s doing something. You are monitoring and going to catch it in time if it gets bigger, I will have time to act.  
• The person [who goes on active surveillance] wants to know, if I go on this regime of just testing very often, am I at risk? Will it get past the threshold of danger, you know, before we find out?…having time to act if something begins to change, is there time to act? That’s critical. That’s what makes action surveillance safe for us.  
• Avoiding treatment side effects |
| Key factor in deciding that active surveillance is the best approach for an individual. | Disease factor is key factor in decision |
|---|---|
| Overall better for men...men who do not really need the treatment do not have to undergo the treatment and suffer the consequences. | The approach of choice when there is little disease, low PSA/Gleason scores, no symptoms. |
| | There are some cancers that will probably not do anything to the individual. |
| | It's the knowledge that there's a very high probability that they will be able to live their life without any clinically relevant disease. |
| | I have no symptoms...it is a very small cancer. It’s not aggressive. So I decided that was the course for me. I would take active surveillance |
| | A very, very modest amount of cancer showed up in the biopsy. So that's the major factor in my decision [to do AS]. |
| | If ever this thing goes over to the surrounding tissue, it could be the organs, it could be the bone, or whatever, than I think you've got to take a different approach...maybe to the surgery part of it. |
| | If the test shows it's progressing, let's go for the end result...I mean surgery. I mean, let's not procrastinate at that point. |

| Comfort on active surveillance. | Men can be comfortable if there is close monitoring and no change in disease status |
|---|---|
| | They are very happy not to be treated, 'cause you are offering a treatment that is morbid, potentially morbid versus...just being, staying as they are with a few appointments and maybe an unpleasant biopsy down the road. |
| | Patients accept it very well...but I insist that they do biopsies because things could change eventually. |
| | The men are going to be coming back for follow-ups and I lay out the criteria we are going to use to know there is a change in the situation, what is less aggressive and less threatening, and what will lead to intervention. |
| | Most patient initially, I would say, are surprised by the option of not treating. But once you explain carefully the plan of action, the goals, and the follow-up, and the role of intervention. I would say most of the time everyone proceeds. |
| | As long as it’s [cancer] just sitting there not doing anything, it doesn’t bother me. But I would be very worried if it wasn’t being monitored. |
| | There doesn’t seem to be any compelling reason to take more active measures at this point. But we will constantly watch what is happening...maintain surveillance. |
| | I was reassured that some of these indicators can remain fairly stable for a long time. |
| | I am comfortable with my decision [to follow AS]. I can live with it. But I am aware, you know, things could get worse and something happen in the future...so the monitoring is a good thing. |
| | I opted to go that way [AS] with the hope that I would continue being seen by Dr [specialist] once or twice a year. |
| | I know I am being watched closely. If you weren’t paying attention and watching, you wouldn’t catch it in time. It could sneak up on you. |
| | We say we are monitoring it. We monitor the situation. It’s not major currently. |
| Key factor in deciding to stop active surveillance and pursuing treatment | Change in disease status is a key factor |
|---|---|
| • I think being comfortable because you are doing something…with the PSA…you have more numbers over time and mine have been consistent. So I am relatively comfortable. |
| • Doing the PSAs. And the biopsies It’s staying on top, monitoring, and if anything changes to the point where something else needs to be done that can happen quickly. |
| • Key factor in deciding to stop active surveillance and pursuing treatment |
| • If you follow the patient, and you read biopsy, and of course the…biopsy changes, well, that’s a…trigger point. |
| • We observe actively, until it’s time, if that time comes, if the disease becomes very active, then we provide regular treatment at that time. |
| • The criteria I would use for triggering an intervention would be, mostly biopsy…and significantly more aggressive cancer. |
| • If the test is showing that it’s progressing, let’s go for the surgery. Let’s not procrastinate. |
| • I can always change my mind if the situation changes. |
| • If things get really serious, OK, I will do something, but now I am just going to hold off. |
| • It’s been 7 years and I feel fine…as long as my numbers are good, my exams are good, I am going to stay on active surveillance. |
| • If I was ever going to have another biopsy, and there were shown major changes in the amount of cancer in the biopsy bits, and if the doctor suggested that well maybe we should consider an operation, I mean that is the kind of information you want to hear to help you make a decision on it. |
| • If I visit the doctor and if I get a blood test that shows very little change in the PSA and the doctor says it doesn’t seem to have gotten enlarged at all, then I’d be comfortable on active surveillance. |
| • I guess if your PSA suddenly became elevated and your Gleason scores were out of whack…then you might even get a second opinion…do something different |