PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (**http://bmjopen.bmj.com/site/about/resources/checklist.pdf**) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	How is the Medical Assistance in Dying (MAID) process carried out in Nova Scotia, Canada? A qualitative process model flowchart study
AUTHORS	Crumley, Ellen; Kelly, Scarlett; Young, Joel; Phinney, Nicole; McCarthy, John; Gubitz, Gordon

VERSION 1 – REVIEW

REVIEWER	Beuthin, Rosanne University of Victoria
REVIEW RETURNED	19-Jan-2021

GENERAL COMMENTS	Thank you for this detailed report. It will indeed provide current and historic insight into the various ways in which assisted dying has been enacted in practice in one province in Canada. I am being very granular here, and offer suggestions for edits that I believe will add clarity and accuracy. Thank you again for the commitment to improving end of life care through research. pg 3, line 14. the proposed C-7 changes if successful will include "advance consent" and not "advance directives" as stated here. (The possibility for adv. directives will be explored in another upcoming review along with age and mental illness.) pg 3, line 31 is inaccurate; MAiD is very unique in that is holds both assisted suicide (oral) and the administered IV (euthanasia). To day that these 8 jurisdictions have MAID is incorrect. For example, in the US, the only option is oral. pg 3, line 46; extend the sentence to read: "yet the number of physicians and NPs that provide it is not growing in all areas." (the numbers are definitely growing in many areas.) pg 3, line 48: I am not sure this is accurate, that we lack best practice guidelines. For example, CAMAP has created and distributed very cohesive practice guidelines specific to MAiD. pg 4, line 39: data collection. You use the acronym MAA here and again on page 7 but maybe need to define it. You use MNN here and again on page 5, and define on page 5, but maybe define here. pg 5, line 25: i might suggest a change regarding conscientous objection.... I find it is best to not judge or lock people into a position, so prefer to not say X is a C. objector", but rather "If the clinician has a conscientious objection..." as I have found this shifts over time. pg 5 line 30; "the MNN contacts the patient" (not contacts with?) pg 5, line 41: not clear, that finding assessors takes time due to the small # of providers...", as they are 2 different groups are they not? Please explain.

	pg 6, line 23: you state that the process is finished if the 2nd and 3rd assessors find them ineligible. Maybe say finished in the NSHA. As a patient can travel to another province, or even out of country to be assessed and for care. pg 6, line 40: can be waived for 2 reasons, imminent lose of capacity or imminent death. pg 6, line 55: I am curious, why would 2 - 5 pharmacists be required? I can understand the double check. pg 7, line 22: I wonder if you might change the word "comfortable" to describe the nurse, and change this to say or add "competent." The vascular access knowledge required and multiple other skills speak to quality care (beyond comfortable). pg 7, line 54: might it be more accurate to say "if a patient does not have the capacity to consent to MAiD..." as opposed to request at this stage. pg 8, line 14: I am startled to read that security transfer a body. I have not ever heard of this. pg 8, line 36: I appreciate that each province is unique in many ways, but I am surprised to hear that the returned drugs are disposed of, especially given concerns about shortages even before covid. (they are not disposed of in BC). pg 9, line 21: might you say that NS could learn from other provinces, for example, Manitoba. (it is just that each province has such varied approaches, and Manitoba's model has problems given its regional approach). pg 9, line 42: you refer to research your study builds on, but ref #12 is a news article so maybe not appropriate as a ref. here. pg 10, line 10: under future research, I wonder if you might consider that researchers going forward explore how a more patient centred model/approach/lens would be of benefit. I fear that we are becoming very medicalized. pg 10, line 25: i am wondering if you can conclude that sustainability is in question due to the hours required. Many procedures require clinical hours. I wonder if a conclusion might shine a light on the ethics of so much unpaid work, and i think this would impact sustainability as providers will stop. If you only link sustainability to cost, I think there is a counter narrative to that - some reports have looked at overall system savings generated by assisted deaths. It becomes ethical, why are cost and effort not compensated? I am sorry if too detailed, offered for consideration. All the best with your continued research!

REVIEWER	Thorne, Sally University of British Columbia, Nursing
REVIEW RETURNED	24-Jan-2021

GENERAL COMMENTS	This manuscript represents an original, important, and timely piece of scholarship that will be of considerable interest to the community of clinicians, planners and scholars in the field of assisted dying. The Canadian context is undergoing considerable legislative change, and reflects an evolving landscape. Nevertheless, an indepth understanding of what the legislative framework implies in terms of actual work within the interprofessional health care team, and the points at which disruptions or delays can influence those processes, will be an important frame of reference as this process evolves. The study design is solid and effectively described, and the entire report is well written. Tables and graphics are effectively used to

	augment the narrative text and provide further depth. Among those tables I am least comfortable with the Table 2 (Professionals' quotes about their MAiD role and tasks), which provides exemplars of raw interview data selected to illustrate ideas deriving from different professional contexts. As a qualitative researcher, I see possible themes and angles within that set of selected data that are not yet considered within the narrative summary in the main text. I appreciate, however, that in the limits of publishing length, it is often difficult to do justice to interview exemplars as they pertain to the question at hand. Thus this may be a stylistic option that works appropriately in this context. I find a minor disconnect between the title ("How is the Medical Assistance in Dying (MAiD) process carried out? A qualitative process model flowchart study") and the focus of the study within one province. As the authors point out, there are provincial variations in process steps across Canadian provinces, and similarly between nations that deliver some form of MAiD. I suggest consideration of contextualizing the location of this study more explicitly within the title (&/or abstract/introduction), this making it clear throughout that it reflects one context in considerable detail, thereby creating a process description that may be informative to understanding the complexity of processes within other contexts. I do believe that this report, offered with this level of detail, will be of considerable interest, but where the impression is that it is designed to describe the more generalized approach across jurisdictions, it would be more subject to critique. So I encourage some critical reflection on how best to ensure that readers do not misinterpret the intended purpose, by making it more explicit that this exact flowchart reflects insights deriving from one jurisdiction in action. Finally, I note a few very minor editorial suggestions: p. 6 line 20 – I believe this is the first mention of NSH, so would require the long version before the acronym makes sense to all readers. Also, will Dying with Dignity be recognizable by an international audience? If not, may require an explanation (eg a "national human-rights charity focused on end-of-life options") p. 6 line 27 – suggest avoiding gender-specific language in relation to health care roles. p. 29 – there appears to be a 'note to self' on the COREQ table (sex vs gender) that should be corrected prior to publication. And I agree that it is likely sex you are identifying (rather than gender). Also note that you are using the term "researcher" to refer to only two members of your research team. If this is to be made available to readers as supplementary material, for the purposes of clarity, I would suggest modifying this to read "interviewer" so that it makes sense why you have focused on these two researchers only. Thank you for the opportunity to review this excellent manuscript. I look forward to seeing it in publication.

REVIEWER	Freeman, Laurie Univ Windsor, Faculty of Nursing
REVIEW RETURNED	07-Feb-2021

GENERAL COMMENTS	Please share my comments in the body of this manuscript with the Authors. I feel this article could really contribute to MAiD in

	Canada and think it is a interesting way to do it. However, for a qualitative study it is lacking some very important ways to report the findings. It says Results when it fact it is Findings. If they re-write it and incorporate suggestions it will be a good article that others can look to for assistance when providing MAiD and possible pit falls. Some concluding statements are not supported (e.g. costs of doing the provision of MAiD). - The reviewer provided a marked copy with additional comments. Please contact the publisher for full details.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Dr. Rosanne Beuthin, University of Victoria, Vancouver Island Health Authority

Comments to the Author:
Thank you for this detailed report. It will indeed provide current and historic insight into the various ways in which assisted dying has been enacted in practice in one province in Canada.
I am being very granular here, and offer suggestions for edits that I believe will add clarity and accuracy. Thank you again for the commitment to improving end of life care through research.

Comment: pg 3, line 14. the proposed C-7 changes if successful will include "advance consent" and not "advance directives" as stated here. (The possibility for adv. directives will be explored in another upcoming review along with age and mental illness.)

- This has been revised to read: “Canada’s MAiD criteria is currently being debated and the legislation may be expanding: advance consent for those who will lose capacity may be included and the “reasonably foreseeable” death requirement may be removed”

Comment: pg 3, line 31 is inaccurate; MAiD is very unique in that is holds both assisted suicide (oral) and the administered IV (euthanasia). To day that these 8 jurisdictions have MAID is incorrect. For example, in the US, the only option is oral.

- This has been revised to read: “The 8 jurisdictions that have assisted suicide and/or euthanasia, Australia (some states recently legalized assisted suicide and euthanasia), Belgium, Canada, Colombia, Luxembourg, The Netherlands, Switzerland, and 8 states in the United States”

Comment: pg 3, line 46; extend the sentence to read: "yet the number of physicians and NPs that provide it is not growing in all areas."   (the numbers are definitely growing in many areas.)

- This has been revised to read: “yet the number of physicians and nurse practitioners (NP) that provide it is not growing in NS”

Comment: pg 3, line 48: I am not sure this is accurate, that we lack best practice guidelines. For example, CAMAP has created and distributed very cohesive practice guidelines specific to MAiD.

- This has been revised to read “National best practice guidelines and training are available”

Comment: pg 4, line 39: data collection. You use the acronym MAA here and again on page 7 but

maybe need to define it. You use MNN here and again on page 5, and define on page 5, but maybe define here.

- This has been revised to read: “As JM is the Medical Affairs Advisor (MAA), NP is the MAiD Nurse Navigator (MNN),”

Comment: pg 5, line 25: i might suggest a change regarding conscientous objection.... I find it is best to not judge or lock people into a position, so prefer to not say X is a C. objector", but rather "If the clinician has a conscientious objection..." as I have found this shifts over time.

- This has been revised to read: “If the clinician has a conscientious objection”

Comment: pg 5 line 30; "the MNN contacts the patient" (not contacts with?)

- This has been revised to read: “the MNN contacts the patient”

Comment: pg 5, line 41: not clear, that finding assessors takes time due to the small # of providers...", as they are 2 different groups are they not? Please explain.

- This has been clarified to read “Finding assessors may take time due to the small number of NS clinicians who participate in MAiD, their lack of time and/or their inability to travel.”. There are more assessors than MAiD providers, however, as we indicate in the following sentence, some assessors only assess their own patients.

Comment: pg 6, line 23: you state that the process is finished if the 2nd and 3rd assessors find them ineligible. Maybe say finished in the NSHA. As a patient can travel to another province, or even out of country to be assessed and for care.

- This has been clarified to read: “If the second and third assessors indicate the patient is ineligible for MAiD, the process is finished in NS. Although it is more rare, some patients may go to another province or country to be assessed for assisted dying or euthanasia eligibility.”

Comment: pg 6, line 40: can be waived for 2 reasons, imminent lose of capacity or imminent death.

- This has been revised to read: “The 10-day waiting period can be waived for patients about to lose capacity or their imminent death and MAiD will be provided before the 10 days have passed.”

Comment: pg 6, line 55: I am curious, why would 2 - 5 pharmacists be required? I can understand the double check.

- This has been clarified: “Two to five pharmacists fill the PPO and double-check the two sets of medications according to their protocol [51] because: pharmacists change shifts (i.e., the MAiD PPO may be partially filled when the shift changes), MAiD PPO are filled when: pharmacists have additional time (i.e., another pharmacist may take over the PPO if the other pharmacist is busy), because there are numerous checks on the MAiD medications and NS pharmacy technicians cannot fill the MAiD PPO.”

Comment: pg 7, line 22: I wonder if you might change the word "comfortable" to describe the nurse, and change this to say or add "competent." The vascular access knowledge required and multiple other skills speak to quality care (beyond comfortable).

- This has been clarified: “A VON nurse manager will find a nurse who does not have a conscientious objection.”

Comment: pg 7, line 54: might it be more accurate to say "if a patient does not have the capacity to consent to MAiD..." as opposed to request at this stage.

- This has been revised to read: “If a patient does not have the capacity to consent to MAiD, the procedure does not occur, although this may change with the revised legislation.”

Comment: pg 8, line 14: I am startled to read that security transfer a body. I have not ever heard of this.

- This has been clarified: “Ward staff follow the protocols for post-mortem care and, although this may not be the usual process in many organizations, may contact security to transfer the body to the morgue.”

Comment: pg 8, line 36: I appreciate that each province is unique in many ways, but I am surprised to hear that the returned drugs are disposed of, especially given concerns about shortages even before covid. (they are not disposed of in BC).

- We clarified this with the pharmacists interviewed and added more details to the article: “The pharmacy disposes of the used MAiD medications. Some hospital pharmacies store and re-use the backup medications if they have not left their premises. Other pharmacies discard both sets of medications as they do not know how and where the medications were stored, what conditions they were exposed to, who they might have come into contact with, etc.”

Comment: pg 9, line 21: might you say that NS could learn from other provinces, for example, Manitoba. (it is just that each province has such varied approaches, and Manitoba's model has problems given its regional approach).

- This has been clarified “NS could learn from other provinces, including Manitoba where a single MAiD team serves the entire province”

Comment: pg 9, line 42: you refer to research your study builds on, but ref #12 is a news article so maybe not appropriate as a ref. here.

- We have added the studies this work builds on: [3-6, 26-28, 30-32, 34, 48, 57]

Comment: pg 10, line 10: under future research, I wonder if you might consider that researchers going forward explore how a more patient centred model/approach/lens would be of benefit. I fear that we are becoming very medicalized.

- We added the sentence “As many jurisdictions are integrating patient-centered care, MAiD administrators should consider the value of incorporating this approach.”

Comment: pg 10, line 25: i am wondering if you can conclude that sustainability is in question due to the hours required. Many procedures require clinical hours. I wonder if a conclusion might shine a light on the ethics of so much unpaid work, and i think this would impact sustainability as providers will stop. If you only link sustainability to cost, I think there is a counter narrative to that - some reports have looked at overall system savings generated by assisted deaths. It becomes ethical, why are cost and effort not compensated?

- This has been revised to: “There are serious questions about this model’s sustainability due to potential for burnout and clinicians ceasing to provide MAiD since the model relies on them working additional (uncompensated) hours on evenings and weekends. Issues could also be raised about the ethics of sustaining a volunteer model which depends on unpaid work, personal time and inefficient workflow. The Nova Scotia College of Pharmacists should consider allowing pharmacy technicians to help prepare MAiD medications as pharmacists also spend significant time preparing and checking MAiD PPO.”

Reviewer: 2
Dr. Sally Thorne, University of British Columbia

Comments to the Author:

This manuscript represents an original, important, and timely piece of scholarship that will be of considerable interest to the community of clinicians, planners and scholars in the field of assisted dying. The Canadian context is undergoing considerable legislative change, and reflects an evolving landscape. Nevertheless, an indepth understanding of what the legislative framework implies in terms of actual work within the interprofessional health care team, and the points at which disruptions or delays can influence those processes, will be an important frame of reference as this process evolves.

Comment: The study design is solid and effectively described, and the entire report is well written. Tables and graphics are effectively used to augment the narrative text and provide further depth. Among those tables I am least comfortable with the Table 2 (Professionals' quotes about their MAiD role and tasks), which provides exemplars of raw interview data selected to illustrate ideas deriving from different professional contexts. As a qualitative researcher, I see possible themes and angles within that set of selected data that are not yet considered within the narrative summary in the main text. I appreciate, however, that in the limits of publishing length, it is often difficult to do justice to interview exemplars as they pertain to the question at hand. Thus this may be a stylistic option that works appropriately in this context.

- Yes this was a publishing length issue. For table 2, we added themes, moved some quotes into the text (also requested by Reviewer 3) and expanded some quotes (highlighted in the table). We are also working on a separate article where we are qualitatively analyzing and theming the interview transcripts.

Comment: I find a minor disconnect between the title ("How is the Medical Assistance in Dying (MAiD) process carried out? A qualitative process model flowchart study") and the focus of the study within one province. As the authors point out, there are provincial variations in process steps across Canadian provinces, and similarly between nations that deliver some form of MAiD. I suggest consideration of contextualizing the location of this study more explicitly within the title (&/or abstract/introduction), this making it clear throughout that it reflects one context in considerable detail, thereby creating a process description that may be informative to understanding the complexity of processes within other contexts. I do believe that this report, offered with this level of detail, will be of considerable interest, but where the impression is that it is designed to describe the more generalized approach across jurisdictions, it would be more subject to critique. So I encourage some critical reflection on how best to ensure that readers do not misinterpret the intended purpose, by making it more explicit that this exact flowchart reflects insights deriving from one jurisdiction in action.

We have added Nova Scotia, Canada to the article's title and the abstract. We added NS throughout the article, in the conclusion and to the figure title to clarify that this study is in one Canadian province.

Finally, I note a few very minor editorial suggestions:

Comment: p. 6 line 20 – I believe this is the first mention of NSH, so would require the long version before the acronym makes sense to all readers.

- Nova Scotia Health and NSH acronym and have been clarified to read: "the Nova Scotia Health (NSH)"

Comment: p. 6 line 20 – Also, will Dying with Dignity be recognizable by an international audience? If not, may require an explanation (eg a "national human-rights charity focused on end-of-life options")

- This has been added “Dying with Dignity (DWD), a “national human-rights charity committed to improving quality of dying, [and] protecting end-of-life rights”,[]”

Comment: p. 6 line 27 – suggest avoiding gender-specific language in relation to health care roles.

- This has been changed to: “If the MNN does not receive a referral, they will follow-up with the clinician.”

Comment: p. 29 – there appears to be a ‘note to self’ on the COREQ table (sex vs gender) that should be corrected prior to publication. And I agree that it is likely sex you are identifying (rather than gender). Also note that you are using the term “researcher” to refer to only two members of your research team. If this is to be made available to readers as supplementary material, for the purposes of clarity, I would suggest modifying this to read “interviewer” so that it makes sense why you have focused on these two researchers only.

- This has been clarified:
- Interviewers:
- ETC is a woman (gender)
- JY is a man (gender)

Reviewer: 3
Dr. Laurie Freeman, Univ Windsor, University of Windsor

Comments to the Author: See file attached.

Comment: Please share my comments in the body of this manuscript with the Authors. I feel this article could really contribute to MAiD in Canada and think it is a interesting way to do it. However, for a qualitative study it is lacking some very important ways to report the findings. It says Results when it fact it is Findings. If they re-write it and incorporate suggestions it will be a good article that others can look to for assistance when providing MAiD and possible pit falls. Some concluding statements are not supported (e.g., costs of doing the provision of MAiD).

Comment: Abstract – objectives. I think you need to start with that this is in Canada. We are truly the only ones that call it MAiD adding it in lower under setting is a bit late

- This has been clarified: “1. To create a flowchart process model of how medical assistance in dying (MAiD) occurs in Nova Scotia (NS), Canada and, 2. To detail how NS healthcare professionals are involved at each stage of MAiD.”

Comment: Abstract – participants. Give the N and then break it down initially when I read this I thought well that is a really small sample

- This is changed to: “Thirty-two interviewees self-selected to participate (12 physicians, 3 nurse practitioners, 6 nurses, 6 pharmacists and 5 healthcare administrators and advocates).”

Comment: Abstract – conclusion. I'd like to see a statement above regarding this uncompensated cost so this conclusion flows more readily from your results

- This has been added “Some physicians and nurse practitioners provide MAiD for free as they cannot be reimbursed or find it too difficult to be reimbursed.”

Comment: strengths and limitations. in Canada needs to be added in

- This has been done: “Our novel flowchart process model of medical assistance in dying in Nova Scotia, Canada outlines professionals’ roles and activities, the points at which they are involved and where delays/stops can occur.
- Our findings from Nova Scotia, Canada provide an opportunity for other jurisdictions to learn how medical assistance in dying works as well as compare and contrast their model.
- As this study occurred in one Canadian province, Nova Scotia, it does not enable us to generalize the findings to other provinces or internationally.”

Comment: Introduction: four years is a very short time in medicine, you need to comment on the latest poll that took place on this topic and how it is up for debate and change. Canada’s MAiD criteria expanding (1st paragraph). may be, not can yet.

- This has been added “Canada’s MAiD criteria is currently being debated and the legislation may be expanding: advance consent for those who will lose capacity may be included and the “reasonably foreseeable” death requirement may be removed [11, 12, 13, 14]. The latest national poll found Canadians support advance consent (82%) and removing “reasonably foreseeable” (71%) [Ipsos poll].”

Comment: scattershot mess quote. this was from 2017 many policies and processes have been finalized in Ontario. You need to indicate that in the past there were issues. My understanding as a HCP that is not the case now. This is very misleading.

- This now reads “In 2017 when the MAiD process was first being set up, the press described it in the provinces of Ontario and Nova Scotia (NS), respectively, as:
  “an ad hoc, scattershot mess. Policies were hammered out in email chains and over casual conversations” [9]

  “We have a small set of providers, but we can't possibly keep up with the patient demand” [10].”

Comment: line 18, p. 4. The objectives… in what?

- This has been added: “The objectives of this study are to create a flowchart process model of how MAiD occurs and detail where and how healthcare professionals are involved in NS’s process.”

Comment: 8 jurisdictions. again they do not call it MAiD that is a Canadian term, it may be Assisted Death or Assisted Suicide, clear this up for the readers

- “The 8 jurisdictions that have assisted suicide and/or euthanasia, Australia (some states recently legalized assisted suicide and euthanasia), Belgium, Canada, Colombia, Luxembourg, The Netherlands, Switzerland, and 8 states in the United States”

Comment: “adequate information to evaluate and improve the service”. really why not?

- This has been clarified “collect descriptive statistics about number of deaths, gender, etc. However, additional data is needed to evaluate and improve the service (e.g., feedback from providers, patients and families, analyses of the process including its policy, functionality, efficiency, effectiveness, impacts and sustainability, etc.) [].”

Comment: “Knowing how MAiD occurs”. the process involved in the provision of MAiD in Canada would be a better choice of words

- This is changed to “The process involved in the provision of MAiD in one province”

Comment: “the number of physicians and nurse practitioners (NP) that provide it is not growing [39].” this is an opinion piece , what are the stats on this , just specific to your area would be fine. I do not support sweeping generalizations as fact

- This has been clarified for NS only: “yet the number of physicians and nurse practitioners (NP) that provide it is not growing in NS”

Comment: “Recruitment continued until no new information was found”. data saturation occured?

- we removed the sentence “Recruitment continued until no new information was found” as the data collection section already stated: “To achieve saturation, data was collected until no new information about the process was found.”

Comment: “The data were collected using a semi-structured, pre-tested interview guide in-person in a private location, by telephone or Microsoft Teams”. by whom? Were their trained research assistants?

- This has been clarified: “ETC collected data from 29 participants using a semi-structured, pre-tested interview guide in-person in a private location, by telephone or Microsoft Teams® [see Additional file 1]. JY, a medical student, was trained by ETC and conducted 3 of the interviews under her supervision.”

Comment: “Interviewers probed responses”. not sure that this means?

- This has been clarified: “Interviewers probed participants’ responses by asking follow-up questions”

Comment: “can be delayed or stop”. grammar

- This has been clarified: “may stop or be delayed”

Comment: Steps 1-5. I would use your data that you collected to support all of these steps... e.g according to physicians "...." on the other hand NP's say "..." RN's participate by xyz "..." and so forth do this for all of these sections then discuss how you developed the flow charts. As this stands it looks like you speculate on what is done

- We have done this for all sections.

Comment: “understand the patient's goals”. seeks to... no one can truly understand how another things or feels

- We have clarified: “and seeks to understand the patient's goals”

Comment: “Anytime, patients may decide”. At

- At has been added: "At any time, patients may decide"

Comment: "If the clinician the patient visited will not". initially ?

- This is changed to "If the clinician the patient initially visited will not"

Comment: discussion paragraph 1. yes but are they getting paid and is part of a regular work week?f not why not also what does the literature say about healthcare professionals participation in assisted death in other countries is this the same there?

- This has been clarified: whether they get paid and/or do MAiD in their work week differs according to their profession and/or what's written in their contract (e.g., some NPs have MAiD in their contract, others do not; some physicians do not have billing set up with the province, consider it too complicated and they provide MAiD for free)
- For comparison, we added: "Some clinicians are reimbursed, while others are not (e.g., depending on their contract, some NP cannot be reimbursed for MAiD and must participate outside working hours; some physicians provide MAiD for free outside working hours). To compare, Oregon pays for assisted suicide for terminally ill people with low income but does not specify who pays the physician for participating (e.g., insurance companies).[65, 66] As well, physicians in the Netherlands are compensated by the patient's insurance company but Belgian physicians do not receive compensation.[67]"
- We could not find information on compensation for nurses, pharmacists and health administrators in other countries

Comment: table 2. see my comments above add these in to support your statements and then use the rest as added support in chart form.

- This has been done.

VERSION 2 – REVIEW

REVIEWER	Beuthin, Rosanne University of Victoria
REVIEW RETURNED	01-Apr-2021

GENERAL COMMENTS	I had the opportunity to review the original draft in January, and now this revised version. I find the manuscript to be improved and note that finer points have been clarified, which adds rigor. Thank you for pursuing this research and for publishing. The findings will contribute to building a strong foundation as we in Canada continue to learn and adapt processes now and over time. And will be of great interest to other countries as well. Sincere thanks!

REVIEWER	Thorne, Sally University of British Columbia, Nursing
REVIEW RETURNED	04-Apr-2021

GENERAL COMMENTS	Happy to accept the revised version. Thanks for your careful attention to the original review comments from three reviewers with somewhat different types of suggestions. I believe that the revised version is coherent, interesting, and will be of great interest to the field.

REVIEWER	Freeman, Laurie Univ Windsor, Faculty of Nursing
REVIEW RETURNED	22-Apr-2021

GENERAL COMMENTS	Overall comment : This study remains a very important subject and suitable for publication in this journal. It is substantially improved from the initial version. Suggesting a few minor changes for consideration prior to it being published see below. Page 1-Line 7-Medical Assistance in Dying acronym is MAiD. Page 4-Line 21-22- Finish this sentence (e.g. to be changed in the current law or some such thing) Page 5-Line 28- In general REB's do not 'approve' research studies they provide 'clearance' Table 2- some of the chosen quotes were hard to understand as written, maybe consider shortening them or removing some of words for example- And facilitating the actual procedure of coordinating the … the healthcare. Page 11-Line 10-15- a set timeline for completion would clarify why a follow up re-assessment is necessary when the provision of MAiD is delayed Line 19 &23 are redundant- consider combining to eliminate the issue Page 11-12 - Lines 52-4 as written are very confusing to the reader -rewrite for clarity, e.g. the process of filling the order for the MAiD PPO is time consuming, shift changes or … may occur delaying how quickly etc. then in line 17 Given that the time to fill … pharmacists report Page 11-42- get rid of the – and use the word 'for' add an s to patient Page 12- line 25- syntax error get rid of and Page 15 line 45 syntax error Page 16- line 17 why do nurses want to meet the day before expand on this unfinished thought

VERSION 2 – AUTHOR RESPONSE

Reviewer 3

Page 1-Line 7-Medical Assistance in Dying acronym is MAiD.
Response: This has been changed

Table 2- some of the chosen quotes were hard to understand as written, maybe consider shortening them or removing some of words for example - And facilitating the actual procedure of coordinating the … the healthcare.
Response: As this is a qualitative paper, our aim is to keep the quotes in the person's original words. Longer quotes also provide contextual information, which can be helpful for readers. Aside from the quote above, it is unclear which other quotes the reviewer would like us to change. Keeping in mind that using a large number of ellipses in a quote to remove extra words can make it confusing and more difficult to read than leaving the original format, we went through the table and shortened some of the longer quotes.

Page 4-Line 21-22- Finish this sentence (e.g. to be changed in the current law or some such thing)
Response: This has been changed to "The latest national poll found Canadians support advance consent (82%) and removing "reasonably foreseeable" (71%) in the legislation"

Page 5-Line 28- In general REB's do not 'approve' research studies they provide 'clearance'

Response: this word has not been changed as the word approve is used on the BMJ Open Authors website. Please see the heading “Peer review of study protocols” on https://bmjopen.bmj.com/pages/authors/

Page 11-Line 10-15- a set timeline for completion would clarify why a follow up re-assessment is necessary when the provision of MAiD is delayed
Response: There is no set timeline for MAID in NS, the timing is up to the patient. We revised these sentences to “Sometimes, neither assessor provides MAID, the patient decides to wait, the original assessors are not available or the patient requests MAID during a busy time (e.g., summer or December). If MAID is delayed for a significant amount of time or another provider is needed, the MNN helps find a provider to re-assess the patient to ensure they still meet MAID criteria.”.

Page 11 Line 19 &23 are redundant- consider combining to eliminate the issue
Response: Line 19 has been removed.

Page 11-12 - Lines 52-4 as written are very confusing to the reader -rewrite for clarity, e.g. the process of filling the order for the MAiD PPO is time consuming, shift changes or … may occur delaying how quickly etc. then in line 17 Given that the time to fill … pharmacists report Page lines 11-42- get rid of the – and use the word ‘for’ add an s to patient
Response: We have revised lines 52-4 to read “Two to five pharmacists fill the MAID PPO which is time-consuming for several reasons: shift changes (i.e., the MAID PPO may be partially filled when the shift changes), MAID PPO are filled in-between regular work (i.e., another pharmacist may take over the PPO if the other one is busy) and the two sets of medications need to be double-checked according to pharmacy protocol. [51] Because NS pharmacy technicians cannot fill the MAID PPO, this results in additional work for NS pharmacists: [quote]”.
For the second comment, we cannot find a dash in line 42 on pages 11 and 12 and thus cannot make this change (e.g., the comment reads “Page lines 11-42” which could be page 11 line 42 or another page lines 11-42). Given that these two comments were written together, we assumed there are referring to page 11-12.

Page 12- line 25- syntax error get rid of and
Response: We could not find the additional and in this place in the manuscript.

Page 15 line 45 syntax error
Response: It is unclear what this refers to but we removed the colon so the sentence reads “The clinician documents the procedure and sends the MNN information including people present, medications given and dose, times the medication was pushed, time of death and notes about the procedure and/or family difficulties.”

Page 16- line 17 why do nurses want to meet the day before expand on this unfinished thought
Response: We have revised the sentence to read “Along with offering support, inserting the IVs and documenting the process, our nurses want to meet patients and their supports before the day of MAID to get to know the person having MAID and in case there are family issues”.