Peer Review Report

Review Report on Aftercare provision for bereaved relatives following euthanasia or physician-assisted suicide: a cross-sectional questionnaire study among physicians

Original Article, Int J Public Health

Reviewer: Reviewer 1
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EVALUATION

Q 1 **Please summarize the main findings of the study.**

This study demonstrates that most physicians (including GP's, clinical specialists and elderly care physicians) have aftercare conversations with bereaved relatives after a completed EAS-trajectory. General practitioners have these conversations more often than clinical specialists working in hospitals. Furthermore, these conversations are more often provided to relatives that were a cohabiting partner of the patient compared to other types of relatives. When aftercare conversations were conducted, topics addressed were the proceedings of the EAS-trajectory, the emotional experience of the relatives during the trajectory and their wellbeing at the time of the aftercare conversation.

Q 2 **Please highlight the limitations and strengths.**

This article increases our understanding of the provision of aftercare to bereaved relatives after an EAS-trajectory which is an under-researched topic. It is very complete, well written and generally has a clear structure. The presentation of findings on discussed topics during the aftercare conversations is somewhat limited in scope. Lastly, the sample was rather small and consisted mostly of general practitioners, limiting the generalizability of results, especially to other disciplines.

Q 3 **Please provide your detailed review report to the authors. The editors prefer to receive your review structured in major and minor comments. Please consider in your review the methods (statistical methods valid and correctly applied (e.g. sample size, choice of test), is the study replicable based on the method description?), results, data interpretation and references. If there are any objective errors, or if the conclusions are not supported, you should detail your concerns.**

Major comments:

1. I believe the results section 'Topics after conversations' (Lines 161-198) to be in need of improvement. Please find below some of my thoughts.
a) When reading this section it seems to me that physicians let themselves be guided by the needs of the relatives. In almost all quotes it becomes clear that the physician provided relatives the opportunity to ask any remaining questions and to share their experiences. This is not reflected upon in the results section, yet it is addressed in the discussion section (line 263-264). Please also see comment 1e) on whether it might be valuable to reflect on purpose of the conversation as well, besides the addressed topics.
b) In table 2 and in line 163 the second topic concerns 'Emotional experience of relatives regarding the EAS trajectory'. However, when elaborated on in line 174, this section and the accompanying quotes just concern the emotional experience during the performance of the EAS.
c) I don't quite see how the topic on emotional experiences is different from 'looking back at the trajectory' as the emotional experience is inevitably part of the trajectory. Could it be that the first topic is phrased a little too broadly? Maybe the first topic addresses the practical components and the second topic the emotional experience? If so, the authors may need to make this distinction clearer by using different phrasing and selecting different quotes to better demonstrate this contrast.
d) The connection between the sentence in line 181 and the quote that follows is not very clear. It states that physicians themselves shared how they experienced the EAS but the quote shows that it was the relatives that mentioned the physician's tension during the EAS.
e) I'm wondering whether the 'other' topics addressed in lines 195-206 don't belong in one of the other topic categories. Expressing gratitude might be a part of looking back at the trajectory, or the emotional experience of relatives. And I'd say the final decision of the euthanasia review committee is part of looking back at the trajectory as well. Wrapping up the trajectory and saying goodbye might be a purpose of the conversations rather than a topic. Such purposes might also be valuable to reflect on in this section.
2. Quite a few statements are made in the discussion section without referring to literature. Please find below some, but not all, examples:
a) Lines 225-229
b) Lines 242-244

c) Lines 254-255 (see for example https://pubmed.ncbi.nlm.nih.gov/34695567/ for barriers for in-hospital bereavement services).

Minor comments:

General
1. To my knowledge, the term 'aftercare' is not commonly used in the context of care for bereaved relatives. A Pubmed-search with 'aftercare' and 'bereave*' in Title/Abstract only yields 29 results. In lines 41 and 42 the authors use the more commonly used term 'bereavement care'. I am wondering why the authors have chosen to use the term 'aftercare' throughout the article and whether either 'bereavement care' or 'follow-up' may be a better alternative.
2. It isn't quite clear to me what was aimed at with the third question on aftercare. In the text (line 117) it is formulated as 'If yes, did this lead to the provision of/referral to additional care.' I understand the interest in the occurrence of referral, but what is meant exactly with 'provision of additional care'? If more than one aftercare conversation was provided that would become clear in the first question with the answer option 'Yes, multiple times'.
Furthermore, in the supplemental material it is formulated as 'If yes, did this lead to the provision of care', adding to my confusion. Could the authors clarify this?

Abstract
3. Line 12: It would be informative to add which types of physicians were included.

Introduction
4. Structure of introduction: I believe the structure of the introduction can be somewhat improved. More specifically, I believe the sentences "A mortaliy follow-back (…) and 93% (the Netherlands))" (lines 44-47) to be more fitting in the fourth paragraph (lines 58-66). The findings regarding provided bereavement care in general by GP's can be connected to knowledge on provided bereavement care in the context of EAS. Especially since there seems to be differences here. Furthermore, the third paragraph (lines 49-56) on experiences of grief and possible needs when bereaved after EAS can smoothly follow line 44 ("(…) available bereavement services").
5. Lines 28-29: the sentence isn't clear due to the combination of 'also' and 'compared to'.
6. Line 42: 'Such standard' should be 'Such standards'
7. Line 64-65: I would advise restructuring the sentence somewhat to '(…) that while bereavement care is integral to palliative care according to the WHO definition (…)'.
8. Line 68: The authors state that it is unknown how many and which physicians provide aftercare, but I do not believe the current study provides answers to (just) these issues exactly. My suggestion would be to change the phrasing somewhat. For example: "it is unknown to what extent and in which cases aftercare is provided to bereaved relatives and what such aftercare entails exactly."

Methods
9. Lines 77-81: I believe most of the information in this sentence to belong in the section 'Data collection'. I suggest just mentioning here that the study was conducted among GP's, clinical specialists and elderly care physicians and possibly add why was chosen for these three types of physicians. Furthermore, it would be informative to add information on why the number of invited physicians (1100, 1000, 400) differed for each type of physician.
10. Line 79: I assume the elderly care physicians worked in nursing homes, but I would suggest making this explicit as 'elderly care physician' is a unique profession in the Netherlands and may therefore be unknown to readers with other nationalities.
11. Lines 90-98: Information on the response is actually a result rather than part of the methods. I would suggest incorporating this information at the beginning of the results section.
12. Line 111: I would advise moving this sentence 'physicians only completed one case in part c' to line 107 after 'and 3) another condition.' as it would help the reader to understand what follows.

Results
13. Line 148: I don't believe SCEN physician is a well-known term to all nationalities. In Table 1 it is explained, but if it is remained in the main text I believe it would be more fitting to explain it in the main text. Another option is to not mention it in the main text.

Discussion
14. Line 214-215: It is stated here that no other case-specific characteristics were found to be associated with the provision of aftercare. However, one of the findings is that a cohabiting partner is more likely to receive aftercare. Please add this information in this first summarizing paragraph.
15. Lines 221-225 are repetition of the previous paragraph (especially if the authors incorporate my previous comment).
16. Lines 237: The authors state that bereaved relatives frequently share the same GP. I am wondering whether this is truly the case. Did they find any literature to support this claim? I can imagine this to be the case when the relative is a cohabiting partner (although there are probably many

cases as well where this isn't the case), but not so much when it is an adult child of the patient. Considering the high proportion of GP's in this study, this may also explain why cohabiting partners more often receive aftercare.
17. Lines 254-257: I believe this part, starting at 'although most physicians provide aftercare' to be a very important notion. The authors may want to consider dedicating a separate paragraph to this notion. Furthermore, I'm wondering whether a reflection on the high proportion of GP's may be a valuable addition here (or elsewhere). As mentioned by the authors based on existing literature (Pender et al), GPs often provide aftercare. As shown in this study, clinical specialists do this less often. Possible the percentage of aftercare provided would be lower if more clinical specialists or possibly more other types of physicians than GP's were included?
18. Line 260-261: it is suggested here that grief and mental well-being are two different things, but I'd say they are connected. In line 187 in the results section the topic of grief is even part of the topic category 'mental wellbeing'.
19. Lines 259-275: I found it interesting to read in the results section on topics during aftercare that information about grief or bereavement services is barely mentioned, while in the introduction this is mentioned as an important part of bereavement care (line 44). A reflection on this by the authors would be valuable in the discussion section.
20. Lines 265-266: A conclusion is drawn here starting with 'Consequently', but I don't quite see the connection with the preceding sentences. From the preceding sentence I gather that it is important that physicians realize that providing information about grief should not be the sole purpose of aftercare. It is currently unclear what this has to do with the need for aftercare to extend beyond relatives at high risk of psychological problems.
21. Line 259-275: the authors state in this paragraph that aftercare should not only focus on grief. To what extent is this currently the case? It is mentioned in line 260 that research frequently emphasizes grief, but that is based on a study specifically about grief counselling with therapists. I believe this to be different from aftercare provided by healthcare professionals that were involved in the patient's illness trajectory and I find it hard to believe that these healthcare professionals only focus on grief, especially since the results of the current study show that grief is not one of the main topics addressed during aftercare conversations. In my view, this might even imply that healthcare professionals should be more aware of the value of providing some information about grief and bereavement services, as many guidelines advise this.
22. Lines 277-286: A limitation that may be added is that based on this study we don't know why a quarter of relatives did not receive aftercare. Furthermore, the large proportion of GP's might make the results less generalizable to other types of physicians. The suggestion for future research may be made more specific, as some elements of what the authors suggest is already addressed in their own study (what aftercare looks like, what it entails). A more specific suggestion may be a qualitative research design to gain a deeper understanding of aftercare after EAS which also includes the perspective of the relatives.

Conclusion
23. Line 293: I don't quite see how the statement here is connected to the results of this study as in this study no distinction is made in the extent to which relatives belonged to the at risk population. The same goes for the abstract.

PLEASE COMMENT

Q 4 Is the title appropriate, concise, attractive?

The title clearly conveys the content of the article. However, the authors may want to consider omitting 'in the Netherlands' from the title as this may limit readership (https://www.researchgate.net/publication/308002451_The_effect_of_a_country's_name_in_the_title_of_a_publication_on_its_visibility_and_citability) and lead to bias in research evaluation (https://journals.sagepub.com/doi/10.1177/19485506211024036).

Q 5 Are the keywords appropriate?

The authors have provided 'medical aid in dying' as a keyword. I would suggest making this more consistent with the article's content and using 'Euthanasia' and 'Physician-assisted suicide' as keywords instead. Furthermore, no keyword is provided that entails the notion of supporting bereaved relatives. The authors may consider adding 'aftercare' or 'bereavement care' as a keyword.

Q 6 Is the English language of sufficient quality?

Yes

Q 7 Is the quality of the figures and tables satisfactory?

Yes.

Q 8 Does the reference list cover the relevant literature adequately and in an unbiased manner?)

The reference list appears unbiased, but more literature may be included in the discussion section (see major comment 2).

QUALITY ASSESSMENT

Q 9	Originality	
Q 10	Rigor	
Q 11	Significance to the field	
Q 12	Interest to a general audience	
Q 13	Quality of the writing	
Q 14	Overall scientific quality of the study	

REVISION LEVEL

Q 15 Please make a recommendation based on your comments:

Minor revisions.