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Title	**A survey on buprenorphine practice and attitudes in 22 Canadian emergency physician groups**
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Reviewer 1	Dr. Aaron Johnston
Institution	British Columbia
General comments (author response in bold)	Overall: This is an important study, well written and potentially interesting to a broad audience. The data collection technique has lead to a much more robust response than is typical for this type of survey and I thank the authors for explaining their survey methodology in significant detail. Issues 1. Pointing out that the study may not generalize to small or rural departments. a. A critique of the paper is that it presents itself as a pan-Canadian cross section, but in reality it has not captured date from smaller hospitals or rural hospitals. The paper emphasizes the importance of addictions trained ancillary staff and physician training in OAT, which may be less likely to occur in smaller and rural hospitals. The papers inclusion criteria of EDs that have at least 30K annual visits and the practice setting differentiation of >or> 100K (page 16 line 30) probably allow some differentiation of urban vs. small urban, but specifically do not capture smaller and rural hospitals. b. Overall I think it would strengthen the paper to actively point out that data from small hospitals and rural hospitals is not included and that inferences about this population cannot be made (since this would be an interesting study to repeat with that population, and if it is pointed out perhaps a rural researcher may take it up). This could be added to discussion or limitations. [Editor's note: suggest that this be addressed in the Limitations.] **This concern has now been incorporated into limitations.** 2. Page 4 Line 40 and reference 29: You are referencing 6600 Canadian Emergency Physicians, a number estimated from page 41 of the CWG Future EM Final Report. In the final report this number includes FRCP-EM and CCFP-EM certified physicians (3536) and CCFP certified physicians who indicated an interest in EM on their renewal (2924). The CWG had only a 9% response rate from the latter group, who were more concentrated in smaller communities and hospitals. Your study restricted data collection to hospitals with greater than 30K annual visits and only captured 15 CCFP or other trained physicians, which is likely more reflective of a more urban setting. Since there may be urban/rural differences in OAT initiation in the ED your denominator may not be the 6600 since that includes rural departments, which I don't think you are sampling and which may be different. **Thank you for raising this important point about both the nominator and**

	denominator of our sampling frame. This has been added to the limitations. 3. Possible data loss? a. Page 4 Line 15-23: "The online survey could not be completed more than once from the same IP address." Did this prevent participants from completing the survey from Emergency Department based computers if another department member had already done so? b. "If multiple partially complete online surveys existed for the same IP address, the most complete version was retained for analysis." Is this an issue for multiple department members completing the survey from computers in their ED's or hospitals? Is there any chance of data loss here? It surprises me that you had more paper responses than online responses (this might indicate the potential for IP address-based data loss)? **The process for administering the survey is now explained in greater detail and provides the necessary background for understanding why we had a greater number of paper responses. (paper first at group meetings the follow up with online surveys for those not present at meeting). A few groups went directly to online. We have also clarified the handling of incomplete online data from the same IP address in the methods: if incomplete responses from the same IP address had identical demographic information, only the most complete version was kept. If demographic information was different, both incomplete responses were retained.**
Reviewer 2	Dr. Ka Wai Cheung
Institution	Vancouver General Hospital
General comments (author response in bold)	This is an important paper. Congratulations on completing this important survey, and outlining important next steps. Please see further comments below. Thank you! 1. Page 2 a. Line 25- Would you be able to clarify and give some statistics on how much OAT can reduce overdose and all-cause mortality from OUD? Relative risk reduction now provided, but additional background data kept very brief with overall word count in mind. b. Line 27 - for patients who survive an overdose who have a 5-15% one-year mortality rate, I am assuming that this only includes patients not started on OAT? **These mortality rates mostly stem from administrative database studies, which did not measure whether subjects were on or off OAT during the one-year follow-up post overdose.** c. Line 28- "survival increases with longer periods of OAT". Is this statement redundant? Longer treatment correlates with longer survival? Maybe instead state that ongoing therapy is necessary to prevent relapse? **This has been clarified. There is a dose response for duration on OAT and**

	survival. d. Line 32 Maybe change "ED BUP programs have been implemented in various locations" to "multiple ED BUP programs have been implemented" Changed to active voice e. Line 38. Change "North America" to "Canada" **Done** 2. Page 6 a. Line 26. Partial paper and online surveys were included "if they" provided "answers to" demographic questions and at least one other question "was" answered. **The sentence has been edited to make agreement between subject and verb clearer.** 3. Page 9 a. Line 8. Would recommend removing the "82% response rate" as there were sites that withdrew and one site had low participation and was excluded. **The meaning of "response rate" has been clarified in both the first paragraphs of the results and the interpretation sections.** 4. Interpretation - a. Why did 3 EDs withdraw from study and why was there low participation in the one other? [Editor's note: This should be addressed in the Limitations subsection.] **Reasons for withdrawal are now specified in Results. Implications are now mentioned in Limitations.** b. Interesting that more than 60% had prescribed BUP and yet more than 30% thought that "there is little that I can do to help PWUD" Thoughts on this? **Agreed. The 60+% represents those prescribing BUP at least once. Some of those physicians may have felt that there was not much they could do for PWUD and not become routine prescribers. Only about 25% were regular (at least once a month) BUP prescribers.** c. I am not sure that the summary of results adds too much to the paper. The earlier results section highlights the findings nicely. [Editor's note: a brief summary of results in the first paragraph of the Interpretation is part of the CMAJ Open template as some readers may go directly there, rather than reading the Results section. Please retain.] **This section was retained to conform with CMAJ Open template.**

	d. Explanation of findings- I do not think this section necessarily explains findings as much as puts the finding in the context of previous research. Perhaps more thought can be put in to actually explaining the findings. **We have added an extra paragraph in the Interpretation Section that focuses on explaining the findings.** e. Limitations i. Page 11 Line 4. We chose sites based "on" a minimum annual volume. **This sentence has been revised quite extensively to respond to other comments on the limitations section.** ii. Page 11 Line 4. Why was this minimum annual volume included in the inclusion criteria? **Because of the implementation focus of the survey and of our CRISM project overall, we recruited group leads who were likely to act on the survey results. Because resources limited the number of groups we could recruit, we recruited medium and large volume EDs, where any intervention stemming from the survey would be likely to reach more patients.** iii. Should also include limitation that this is survey data. Physicians who indicate that they may be willing to start BUP on a survey may not actually be willing in clinical practice. Conversely, physicians who think they may not be ready to start on a survey may be willing to in clinical practice. **Some of the potential biases of self-reported survey data are now included in limitations.** 5. Table 2. a. Was there any further clarification on what ordering BUP once per month means? Once per month over the last 3 months? 6 months? 12 months? **The question did not specify a specific time frame. Based on ease of recall, we assumed respondents would answer based on their most recent practice pattern.** b. Consider including the results under "availability of the following resources" in Table 2 in the actual earlier Results section. I think these are important findings. **Some additional data from Table 2 has now been included in the Results Section.** 6. With respect to CHERRIES reporting (and recognizing that this was a paper and online survey), was there any data collected on view rates, recruitment rates, completion rates? Also, there was no mention of whether or not cookies were used. **The online survey was viewed 291 times with a completion of rate of 66.7%. 28 surveys with no responses or with demographic responses only were considered blank. 2 incomplete surveys were duplicates and not counted. 63 surveys were incomplete but contained sufficient information to be included**

	in the analysis. 4 incomplete surveys and 5 complete surveys were excluded from a site with low participation. 189 complete surveys were included.