Author's response to reviews

Title: How to engage Type-2 diabetic patients in their own health management? Implications for clinical practice

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Author's response to reviews:

We are very grateful to have been given the opportunity to revise our manuscript for BMC Public Health.

We thank the referees for their comments to strengthen the presentation of our work. We have modified the text to respond to all the issues and have elaborated on the changes below.

Referee: 1

Comment 1: The paper includes a number of interesting and provocative observations that would be of value to the field. However, their current framing vis a vis concepts of engagement is somewhat confusing. Revision in this aspect of the paper would, I believe, improve it considerably.

Response 1: Thank you very much for your suggestion, we clarified our perspective towards the concept of engagement, its features and its value for improving the healthcare. We deepened the explanation of the concept of patient engagement in the discussion section.

Comment 2: Engagement as the authors use it is intended to capture more than just behavioral management, adherence, and clinical status, but also to encompass the affective and quality-of-life as well as other dimensions that comprise a more holistic characterization of patients’ response to their diabetes and its treatment. The present paper, however, little description of engagement but rather details patients’ problems with “lack of knowledge,” “behavioral disorganization,” and “emotional burden” across spheres of diet, physical activity, treatment/medication, and doctor-patient relationships. As such, the paper documents problems in engagement more than a clear model of what engagement is. The two are surely related, but not the same. As a result, some of the conclusions drawn do not really follow from the paper. For example, the assertion (p. 20) that emotional and cognitive domains “in our findings, appear to be crucial in understanding patient availability and capacity to engage in self care” really does not follow from the current findings. This is because those
findings do not present clear depictions of engagement from which its essential characteristics might be identified. Instead, they present problems patients note in these areas. Based on these criticisms, I would recommend that the authors recast somewhat their observations. Rather than looking to their data to build a model of engagement, they can assert the model they have in mind, that is one that includes emotional, cognitive and other dimensions. As they cite, there is much basis for such a model in the literature, so their bringing these perspectives together in a comprehensive model of engagement would not be speculative or groundless. Then, they could show how their qualitative observations indicate problems in the several domains and dimensions of engagement that their model poses.

Response 2: You raise a very valid point. Per your advice, we added further details in the results (see paragraph entitled “Experiential dimensions of (dis)engagement” in order to better ground into the data our model of engagement. Moreover in the discussion section we explained better our model and we drown conclusions by better clarifying the link between results and conclusions.

Comment 3: Further they might show how their model of engagement might be helpful in organizing and integrating the problems patients articulate into a more useful framework than just a collection of complaints. That is, they might show how the model of engagement helps organize and guide responses to diverse problems patients note with their diabetes. This I believe would be a substantial contribution and of interest to the field.

Response 3: Thank you for providing this idea, we shown the possible implications for the clinical practice within the discussion section. We clarified how our model may guide tailored intervention to address the diverse problems happening in the different phases of then patient illness experience.

Comment 4: The task of patients was quite effortful, including daily diaries for a week. How were patients recruited and, perhaps, reimbursed for this?

Response 4: We deeply described the recruitment process in the method section (see the paragraph “Participants”).

Comment 5: The description of coding and data analysis does not mention how translation from Italian to English was managed and where that took place along the path of data gathering, consolidation, coding, and reporting. Given the importance of idiom in the kinds of issues patients addressed, the approach and placement of translation within the analyses needs to be described.

Response 5: We agree with this point and we added information on the topic in the data analysis section.

Comment 6: The text on p. 8 indicates that participants were “diagnosed with type-2 diabetes in treatment within 18 months of being enrolled in the study.” I am not quite sure of the meaning here, but interpreted this as indicating that the data gathering took place within 18 months of the time patients had been diagnosed and entered into treatment. However, later in the same paragraph, the
text indicates that “13 patients had been treated with insulin for at least 2 years.”

Response 6: Thank you for this advice, we corrected the text. All the patients involved in the study had to be in treatment for at least two years (see method section, paragraph “Participants”).

Referee:2

Comment 1: I think authors should be the process of patient’s recruitment clearer, because this will help readers to decide whether or not these results were representative of common Type 2 diabetes patients. I did not understand whether they recruited from out-of-hospital patients at hospital or the population. Furthermore, how did you choose the final 29 diabetes patients for the study? What was this response rates?

Response 1: Thank you for this comment, we added the required details about recruitment in the “Participants” section. # The response rate was 100%

Comment 2: To interpret findings, background of patients is essential. If possible, more information should be added into the table, especially regarding social factors: educational levels, income, living status (alone, or not), working status, and social support.

Response 2: Thank you for the suggestion, we added details in the table 2 (living status, educational status, work condition).

Comment 3: In analysis, you used the N-Vivo software for this qualitative approach. Please explain briefly what the software did.

Response 3: Explanation about N-vivo features were added in the Data analysis paragraph

Comment 4: L4, Page 2, should be a small letter of “Diabetes”. The same mistake was found elsewhere.

Response 4: Thank you for the comment, we addressed this point in the text

Comment 5: For HbA1c values, please add the unit “%” in the text.

Response 5: Thank you for the comment, we addressed this point in the text