Author's response to reviews

Title: Self-monitoring of blood glucose in Black Caribbean and South Asian Canadians with non-insulin treated Type 2 diabetes mellitus: A qualitative study of patients’ perspectives

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Author's response to reviews: see over
BioMed Central Editorial

Thank you for giving us the opportunity to revise and resubmit our manuscript. We have tried to address the reviewers' comments, and provided justification to where we disagree. In this document, we present the reviewer's comments followed by our responses and changes made to the manuscript. We have used blue text to indicate changes in the manuscript.

Regards,
Enza Gucciardi

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Reviewer’s report

Reviewer: Elizabeth Beverly

**Major Compulsory Revisions:**

(1) Conclusion, Paragraph 1: The authors need to discuss how the findings of this study inform future research. More specifically, the authors should describe plans for their future research that build on these findings.

We agree with the reviewer's comment and have ended a sentence describing future research in our conclusion section. Please see page 17 in blue text in the manuscript.

"Further research is needed to corroborate our findings and to give voice to ethnic populations with a disproportionate burden of diabetes on their perspective of self-management issues and the value they place on SMBG in their diabetes management."

**Discretionary Revisions:**

(2) Abstract, Conclusion Paragraph: The authors introduce cost as an important barrier identified by the participants; however, barriers (i.e., cost) were not discussed in the Results paragraph.

Our results section does make reference to cost as a barrier. See page 9, the 2nd paragraph and page 10, the 1st paragraph. See bolded text.

All participants identified barriers that may inhibit regular SMBG use. Five were noted most often: negative emotional responses to unexpected blood glucose readings, **cost**, pricking pain, burden of SMBG, and lack of self-discipline/motivation.
Second, the cost of lancets and strips inhibited most participants from regular SMBG. Compared to Caribbean participants, South Asian participants were more vocal about these costs (see Table 3, Theme 3, SAW10). A few participants reported that to reduce the cost, they reused lancets which made lancing their skin much more painful (see Table 3, Theme 3, CW1).

(3) The Conclusion section of the Abstract (as well as the Manuscript) should not introduce new information but rather provide an interpretation of what the findings mean in the larger context of the problem/issue.

Because there is no specific reference to this new information being introduced, we feel we cannot address this comment or make any modifications. Perhaps the reviewer was referring to cost as a barrier that she thought we didn’t address in the results section, but we did discuss in our conclusion (both in the abstract and manuscript). As addressed above, this discussion was based on our findings. Please advise of further modifications if necessary.

(4) Methods, Data Collection, Paragraph 1: The methods would benefit from inclusion of additional information regarding the interview process. Did the same researcher conduct all of the interviews? Was the interviewer trained in qualitative interviewing? How were the interview questions developed?

In the methods section, under data collection, on page 5, we included that the interview questions were developed by the research team. It is already mentioned in the manuscript that the questions were based on the concepts of the Health Belief Model. We also added that two interviewers were used for all interviews and were trained in qualitative interviewing by the principle investigator. Please see page 5 of the manuscript for additional text in blue.

(5) Results, Theme One, Paragraph 1: The authors should consider including a quotation in this paragraph or Table 3 illustrating the participants’ perceived susceptibility for future diabetes-related complications. The only quotation included from this theme reflected one participants’ lack of perceived severity for diabetes and its complications.

As suggested by the reviewer, we have included a quote reflecting participants’ perceived severity of their diabetes. Please see Table 3 on page 25 and the inclusion of the quote from CW3 on page 8 under Theme One.

(6) Results, Themes 4 & 5: The fourth and fifth theme titles are too brief and far-reaching. The authors should consider more descriptive titles that explain the findings (e.g., Cues to action --> Factors supporting/impeding SMBG or Perceived support for SMBG).

We appreciate the reviewers comment; however, these theme titles are based on the concepts of the Health Belief Model. Our questions and analysis (organization of codes) were based on these concepts and feel we need to preserve the original conception and title of the themes that we explored as directed by our research objectives.
(7) Limitations, Paragraph 1: The authors should address the issue of selection bias and social desirability as limitations to the qualitative study.

In our limitation section we tried to address the reviewer’s comment. Please see text below. Modified text is in blue below and in the manuscript on page 16.

“Another limitation is our recruiting method as we recruited participants from two different cultural groups from different diabetes education programs and health centres. These centres could have different quality levels of patient care and services, which in turn could have influenced study participants’ views and practice of SMBG, and hence a potential selection bias based on centre recruitment. The fact that most participants describe SMBG as a valuable self-management tool can potentially be due to wanting to respond in a socially desirable manner. It is important to note that our interviewers clearly stated this information is confidential and their health care provider will not have access to this information.”

(8) Discussion, Paragraphs 5 & 6: In paragraphs 5 & 6, the authors refer to findings from two participants and one participant respectively. In light of the small sample size and the hypothesis-generating nature of qualitative research, the authors should be careful to not reach beyond the scope of their data. These findings are too preliminary to draw any strong conclusions about SMBG in Black Caribbean and South Asian adults.

We agree with the reviewer and added a sentence in our limitation section on page 16, 1st paragraph that reads:

“Nevertheless, discussions that are based on two or less participant quotes are too preliminary to draw strong conclusions.”

(9) Conclusion, Paragraph 1: The authors state that the findings show similar themes emerging from Black Caribbean and South Asian adults compared to other studies with predominantly White adults. However, the next sentence calls attention to observed differences across gender and culture. What are these differences? The authors need to clearly describe these differences in greater detail.

We have provided some clarification to the reviewer’s comment on page 16, paragraph 1 under the conclusion section. These two issues are already discussed in greater detail in our results and discussion section. Please see modified text below.

“However, differences in self-blame and social support with regards to the practice of SMBG were observed across gender and culture that should be noted to better support self-management.”
Reviewer’s report

Reviewer: Terence Babwah

Major

(1) The patient group was very small with only 6 patients each from each ethnic group selected. It represented a limited patient population in a specific part of Canada.

*We have noted this limitation in our limitation section on page 16, first paragraph. However, qualitative research is the generation of themes based on peoples’ experiences and thoughts, and data saturation is a more important concept that sample size in qualitative research. These ethnic populations are also prevalent in other parts of the world, for example in the United States and the United Kingdom.*

(2) The references to this paper do not include the latest papers in this field e.g. Malanda et al 2012 answered many questions posed here.

*We thank the reviewer for acknowledging this reference, which we have read and now referenced. However, we feel our work is contributing to the gaps this Cochrane review identifies, for instance, exploration of the psychological impact of SMBG and its impact on diabetes specific quality of life and well-being. We would also like to mention that this review was based on randomized clinical trials, which excludes research that explores and documents the experiences and voices of patients who are living with diabetes.*

(3) Almost all systematic reviews or meta analyses studies now show very limited uses of SMBG, then really why do this study?

*We have recognized and referenced the limited uses of SMBG found in systematic reviews and meta-analysis studies in the background section of the manuscript on page 3. However, we also argue in the background section of the manuscript on page 4 that given the patient’s role in their own self-management, the patient’s voice is needed to help make appropriate clinical practice guidelines and policy decisions for this self-management tool. Changes to the 2013 Canadian clinical practice guidelines which have reviewed the current literature in this area still recommend the use of SMBG for people with diabetes not using insulin but prescription is individualized. We believe it is a rash and premature opinion to state that there are very limited uses for SMBG in diabetes self-management.*

(4) As it deals with minority groups in a specific location then this study may be of interest to a regional or local journal rather than an international journal.

*See response in comment (1).*