**Author's response to reviews**

**Title:** How the stigma of low literacy can impair patient-professional spoken interactions and affect health: insights from a qualitative investigation

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**Version:** 2  **Date:** 12 June 2013

**Author's response to reviews:** see over
Dear Editor

How the stigma of low literacy can impair patient-professional spoken interactions and affect health: insights from a qualitative investigation

Thank you for considering the above manuscript and for the reviewers’ comments.

We have made the requested changes to the abstract, provided more detailed description of the authors’ contributions and consulted the RATS checklist to ensure adherence to the criteria. We now submit a revised manuscript in which we have been careful to address the reviewers’ comments (as detailed below).

We hope you like the revision, and we look forward to hearing from you

Yours faithfully,

Dr Phyllis Easton
Health Intelligence Manager
Response to reviewers’ comments

Referee 1 Graham Kramer

Minor essential revisions:

The long sentence in the first paragraph of the results has been restructured

Discretionary revisions:

A section on implications for further research has been added

Referee 2 Michael Gionfriddo

Discretionary revisions:

1. The paragraph describing the collection of basic demographic information has been expanded. Racial information was not collected, as we considered it not to be relevant in this study which focused on people with English as a first language (the hidden population). Furthermore, Dundee has a very small minority ethnic population and while those who do not have English as a second language may require health literacy support through interpretation and translation services, this was not the focus of the present study. We have now explained this in the revised manuscript.

2. The group did not all have the same set of literacy difficulties. A description of the varying levels of ability was included in the first paragraph under ‘Participants and recruitment’ and has now been expanded.

3. A description of the Dundee population has been added to the ‘Setting’ section.

4. The interview guide and focus group guide are now included as Tables 1 and 3. Under ‘Data gathering’ we have added that the key issues in the interview guide were those identified in the literature and that additional topics were added after initial analysis of transcripts.

5. A brief explanation of why we chose Framework Analysis has been added under in the Analysis section.

6. The coding framework of key themes and concepts has been added as Table 4.

7. We have used the RATS checklist to ensure that the revised manuscript adheres to the guidelines

Referee 3 Jennifer Ridgeway

Major compulsory revisions:

1. The objective does not include reference to stigma because this was not a determined objective at the start of the study. While we acknowledged in the introduction that stigma associated with low literacy contributed to creating and maintaining the ‘hidden population’ we were interested in, we did not anticipate the extent of its significance. In the initial analysis, it became clear that stigma featured strongly in patient-provider interactions and in people’s abilities to seek help or improve their health literacy. The aspects of health included in the objectives have now been clarified, and our editing of the methods and results sections should now make the sequence and logic of what we did much clearer.

2. We have expanded the background section with more detail on definitions of health literacy and on associations with health reported in the literature, including causal pathways. We attempted to add an
explanation of the findings for references 24 and 25 but because these are very small (one qualitative study with 8 participants) or very narrowly focused (one qualitative study focused on the completion of HIV medication adherence questionnaires) we judged that the additional material distorted the emphasis in this section. We have therefore decided to omit the additional detail and preserve the statement that the experiences of people with low literacy themselves have been largely neglected. An introductory paragraph on current NHS policy has been added.

3. More detail has been added to the ‘Methods’ section as requested. The types of literacy difficulties experienced by participants are described at the beginning of the Results section.

4. We have restructured the results section to improve the flow, and have taken care to include additional explanation of the links between issues of interest.

Discretionary revisions:

1. The interview guide and focus group guide are now included as Tables 1 and 3

2. We have developed the ‘strengths and weaknesses’ section of the Discussion with more careful reflections on the ways that participants who had accessed adult learning may have been more empowered than others and the possibility that our recruitment strategy could potentially have led to limitations in the findings. We highlight that this population remained mainly hidden in healthcare contexts. We have not added more suggestions about future research research ideally including people who have not accessed learning to the manuscript as it would be difficult to find a way of recruiting such participants. Many existing studies have included literacy assessment and identified a range of literacy levels; however, these are mainly cross-sectional and quantitative and are also likely to have a low response rate among those with the lowest levels of literacy.

3. As noted above (Major compulsory revisions point 4), we have restructured the results section, including some additional explanation of the links between issues of interest. The ‘Low literacy and social-psychological wellbeing’ section has been moved and includes general social behaviours leading on to indicate that these findings relate to health status itself rather than the mediating factors.

4. The reasons for the choice of individual interviews followed by focus groups have been added under ‘Design’

5. The Analysis section has been reworked and the process explained in simpler language.

6. Our strong preference is to summarise findings that are very consistent with issues that have been identified previously, and to focus our findings section on the more original insights that have emerged from our study. We have explained and justified this in the section of the Results headed ‘Difficulties with written communication’. We have, however, now added references to other material that documents evidence of problems with the use of written text in health care provision, including our (accessible) summary report to the funders of this study and the PhD thesis from which we have developed this paper.

7. We have added suggestions and references for implementation of universal precautions and Teach-back techniques

8. The tables have been reformatted