Author’s response to reviews

Title: Exploring how patients understand and assess their diabetes control

Authors:

Anjali Gopalan (Anjali.Gopalan@kp.org)
Katherine Kellom (kellomk@email.chop.edu)
Kevin McDonough (kevinh.mcd@gmail.com)
Marilyn Schapira (mschap@mail.upenn.edu)

Version: 1 Date: 28 Aug 2018

Author’s response to reviews:

Dr. Koltowska-Haggstrom,

We thank you for your careful review of our manuscript. We have addressed each of your comments and summarize our responses below. We include the lines in the revised manuscript where each comment has been addressed. We are including both an annotated and clean version of the revised manuscript. We hope you feel this revised version is worthy of peer-review and consideration for publication in BMC Endocrine Disorders.

Please feel free to contact me directly with any additional questions or concerns.

Sincerely,

Anjali Gopalan
1. In the abstract the result section (lines 10-11) indicates that HbA1c was the only information used to assess diabetes, but the conclusions (lines 17-18) mention more types of information. Please, clarify

The original sentence stated that “HbA1c was only one type of information used…”. This may have been misread or misinterpreted as “HbA1c was the only type…”. To avoid this confusion, we have changed the text to read “HbA1c was one of several types of information participants used…”

Lines 10-11

2. Please specify whether only oral informed consent was collected (lines 55, 318-319)

We collected oral consent only to protect participants’ privacy as a signed document would have been the only link between interview subjects and the interview transcripts. We have clarified this in the text.

Lines 55-56

3. Please define “convenience sample” (line 58)

We intended "convenience sample" to describe that we recruited from people who were waiting for appointments with a doctor, and we conducted the interviews before or after their appointment. We did not specifically contact people to come in to the office for these interviews. We have attempted to make this clear in the manuscript.

Lines 60-62

4. The fact that the first interviews were supervised implies bias see my comment (lines 65-66).

We agree that the supervision of these first interviews could introduce bias. However, we had to balance this potential bias with the need to appropriately train KM (an undergraduate research assistant) to conduct the interviews. We have noted this as a limitation in the manuscript.

Lines 308-312
5. Why Sharon vs. John test was performed after participants have heard HbA1C definition (lines 76-77). We do not know their knowledge before having heard the definition. This is the main methodological concern. I don’t think it can be corrected now, but at least should be discussed.

Assessing baseline HbA1c understanding among interview participants was not the goal of this exercise. Past work has documented poor understanding of the HbA1c. Our goal for the Sharon vs. John test was to assess whether participants who were provided with a basic description of the HbA1c value were able to comprehend and apply this information to a situation. We have clarified this goal in the manuscript.

Lines 85-88

6. Suggest adding the diagram depicting the data management process (line 89)

We have added a figure to provide an overview of the data analysis process.

See Figure 1, Line 476

7. AG supervised first interviews and coded and classified the data. Did she deal also with the transcripts she observed? Potential for bias. Lines 89-91

AG did code these interviews. This was unavoidable given a tight budget and no other available study staff. However, we feel that the number of interviews completed, the use of a structured script, coding by two individuals, and the input from the remainder of the study team during the analysis process, helped to mitigate this potential bias. We have added additional details to the Methods section and have noted this as a limitation in the manuscript.

Lines 94-108 and 308-312

8. The missing information on type of diabetes is also a concern; the authors discuss this limitation, but why this basic information was not collected?

In our clinical experience, many patients with diabetes are not entirely sure what type of diabetes that have. Further, for some patients, the distinction between type 1 and type 2 diabetes is not black and white, and without testing (e.g., insulin autoantibodies, c-peptide), even providers may not accurately know the type of diabetes, but rather make assumptions based on age and comorbidities (i.e., obesity). While we acknowledge this as a limitation in the manuscript, we
feel that understanding of diabetes control is a universal concern for people with diabetes, regardless of type.

Lines 315-319

9. Information on how participants reported their knowledge on HbA1c is missing and definitely should be included. See my comment line 112

This information is now included in greater detail in Section 3.2

Lines 195-203

10. Data in section 3.1 are reported in far too general way – see my specific comments

We have added these missing details.

Lines 113-249

11. Demographics of the study population should be discussed vs the population of patients with diabetes in West Philadelphia (lines 289-290)

We have added this information to the manuscript.

Lines 304-306

12. The conclusions need to be re-considered and re-written so they are based on your results, not as general statements suitable for discussion, but not conclusions. Of course, you can finish with general statement and application to patient management but this must be based on the study results

We have edited this section based on this thoughtful feedback.

Lines 321-330

13. Table 1 comments
   a. Years repeated in table
b. Race and education categories

a. We have corrected this error

b. We changed the race/ethnicity categories to be 3 mutually exclusive categories: Black, White, and Multiple. For education, we moved the person who gave 2 responses into the higher (i.e., more educated) of the two response categories.

Line 436