

PEER REVIEW HISTORY

BMJ Paediatrics Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Title: Exposure and attitudes to adolescent health amongst Paediatric trainees in Northern Ireland: a mixed methods study
AUTHORS	Mullen, Stephen; Stevenson, Mike; O'Donoghue, Dara

VERSION 1 – REVIEW

REVIEWER	Reviewer name: Peter Flom Institution and Country: Peter Flom Consulting, USA Competing interests: None
REVIEW RETURNED	13-Aug-2019

GENERAL COMMENTS	<p>I confine my remarks to statistical aspects of this paper. However, it could use a thorough editing for word use, consistency and general grammar.</p> <p>The statistics were quite simple, but this is appropriate. I do have some comments:</p> <ol style="list-style-type: none">1. The age group 10-19 seems ludicrously large. The authors can't fix that, but they should comment on it. I would imagine that most 10 year olds are seen by pediatricians, while most 19 year olds are seen by general practitioners.2. Of the 107 people, many did not respond. On p. 8 the authors say 66 responded but in table 2, N = 59. Which is correct? And, how were the respondents different from non respondents? This could well be a biased sample.3. On p 7, the authors should say what analysis was done.4. Table 2 - you can remove the N's from the table and put them in a footnote, as all were 59. You can also remove the ** as you have listed exact p values5. The line at the top of p. 14 doesn't really mean much "2nd highest mortality ..." of whom exactly? There seem to be 4 groups of "under 19s". 2nd of 4 is not very high. What was the actual rate? I am guessing it is very low.
-------------------------	--

REVIEWER	Reviewer name: David James Institution and Country: University Hospital Southampton NHS FT, UK Competing interests: None
REVIEW RETURNED	11-Sep-2019

GENERAL COMMENTS	Thank you for giving me the chance to review the paper. It is interesting and highly relevant to the current climate and fits in with the expanding agenda of increasing training in adolescent medicine. There are however a few minor issues to address before
-------------------------	--

	<p>publication:•</p> <ul style="list-style-type: none"> • There are quite few typos running through the piece, particularly the frequent use of the word "adolescences" which I think is mainly in place of adolescents, compiled v complied in the methods - focus group section, • HEADSS is now generally referred to as HEEADSSS to include eating and safety • Intro – it might be worth mentioning the move towards 10-24 as an international definition • I feel that there needs to be a bit of work with Table 1.I found it a little difficult to understand initially as from the text I was expecting it to be all about differences between age groups but it starts with particular clinical situations ie mental or sexual health (I assume these are just in the adolescent age range or are they at any age?). <p>I wonder if there is the chance to split it into two - firstly the attention grabbing one about differences between neonates, children, adolescents and adults and then a second one for the specific conditions?.</p> <ul style="list-style-type: none"> • There is an interesting point to bring out that if I have read it right. They rate prior teaching better in neonates and paedes and this is where they have better confidence/self assessed skill and knowledge. However there is not a direct relation between prior teaching and these when correlation was looked for overall. Could this be expanded on? The relation between confidence and perceived skill and knowledge is predictable as they are essentially asking very similar thing but it is surprising that perceived prior teaching is not significant correlated to these... • Are the comparisons for knowledge, confidence and skill between the age ranges stat sig? • Discussion – mortality stat seems wrong from the reference given(highest under 19 – do they mean 15-19?) <p>I look forward to these areas being addressed and would support its publication in this circumstance</p>
--	--

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

I confine my remarks to statistical aspects of this paper. However, it could use a thorough editing for word use, consistency and general grammar.

Actioned

The statistics were quite simple, but this is appropriate. I do have some comments:

1. The age group 10-19 seems ludicrously large. The authors can't fix that, but they should comment on it. I would imagine that most 10 year olds are seen by pediatricians, while most 19 year olds are seen by general practitioners.

Addressed in introduction

2, Of the 107 people, many did not respond. On p. 8 the authors say 66 responded but in table 2, N = 59. Which is correct? And, how were the respondents different from non respondents? This could well be a biased sample.

We have made this clearer in the text

3, On p 7, the authors should say what analysis was done.

Inserted in methods

4. Table 2 - you can remove the N's from the table and put them in a footnote, as all were 59. You can also remove the ** as you have listed exact p values

Actioned

5. The line at the top of p. 14 doesn't really mean much "2nd highest mortality ..." of whom exactly? There seem to be 4 groups of "under 19s". 2nd of 4 is not very high. What was the actual rate? I am guessing it is very low.

Actioned in discussion

Reviewer: 2

Comments to the Author

Thank you for giving me the chance to review the paper. It is interesting and highly relevant to the current climate and fits in with the expanding agenda of increasing training in adolescent medicine.

There are however a few minor issues to address before publication:•

- There are quite few typos running through the piece, particularly the frequent use of the word "adolescences" which I think is mainly in place of adolescents, compiled v complied in the methods - focus group section,

Actioned

- HEADSS is now generally referred to as HEEADSSS to include eating and safety

Actioned

- Intro – it might be worth mentioning the move towards 10-24 as an international definition

Inserted in discussion

- I feel that there needs to be a bit of work with Table 1. I found it a little difficult to understand initially as from the text I was expecting it to be all about differences between age groups but it starts with particular clinical situations ie mental or sexual health (I assume these are just in the adolescent age range or are they at any age?).

I wonder if there is the chance to split it into two - firstly the attention grabbing one about differences between neonates, children, adolescents and adults and then a second one for the specific conditions?.

Table split into two.

- There is an interesting point to bring out that if I have read it right. They rate prior teaching better in neonates and paedS and this is where they have better confidence/self assessed skill and knowledge. However there is not a direct relation between prior teaching and these when correlation was looked for overall. Could this be expanded on?

The relation between confidence and perceived skill and knowledge is predictable as they are essentially asking very similar thing but it is surprising that perceived prior teaching is not significant correlated to these...

- Are the comparisons for knowledge, confidence and skill between the age ranges stat sig?

This has been made clearer

- Discussion – mortality stat seems wrong from the reference given(highest under 19 – do they mean 15-19?)

Altered

I look forward to these areas being addressed and would support its publication in this circumstance