PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Frequency and Format of Clinical Trial Results Dissemination to Patients: A Survey of authors of trials indexed in PubMed
AUTHORS	Schroter, Sara; Price, Amy; Malički, Mario; Richards, Tessa; Clarke, Mike

VERSION 1 - REVIEW

REVIEWER	Richard L Kravitz UC Davis Division of General Medicine, USA
REVIEW RETURNED	13-Jul-2019

GENERAL COMMENTS	This paper reports upon a thoughtful, carefully conducted survey of first authors of clinical trials from 2014 and 2015, asking about their current practices with respect to dissemination of research results to a) participating patients and b) other non-scientific stakeholders, particularly patients with the condition under study. The study should be of substantial interest to the research community and possibly to patient groups as well, but I do have two general comments and a methodological note. First, there seems to be insufficient attention to the possibility that dissemination to participants and patient stakeholders could be harmful. As some of the survey respondents imply, just because organized bodies declare a practice to be "ethical" or "unethical" does not make it so. We know, for example, that findings from scientific studies are easily amplified, distorted, and misunderstood as they are passed from investigators to journals to university public affairs offices to the press, and increasingly, to social media. Furthermore, as one of the participants also suggests, a single study is rarely enough to justify a change in practice. It is certainly not implausible that a requirement to "disseminate" to participants or to patient groups could promote misinformation, hype, and actual patient harm. Addressing this possibility deserves more than a sentence or two in the Discussion. The authors seem to advocate for mandatory enforcement by institutions and regulatory bodies and funders. They should carefully consider the unintended consequences. Relatedly, if there is an ethical imperative to share meaningful results with patients (for reasons beyond simply satisfying patients' curiosity, which may be reason enough), some studies are likely more meaningful than others. For example, among the many randomized trials analyzed some undoubtedly examined outcomes that are important to patients (mortality, quality of life) whereas others may have focused on proxy outcomes such as biomarkers and/or mechanisms of disease. The imperative to disseminate is surely greater for the first kind of study than the second. The manuscript would be improved if the authors were able to perform

	an analysis stratified according to whether a study examined patient-oriented outcomes. In terms of Methods (and the corresponding LImitations section in the Discussion), the response rate of roughly 30% is good for this kind of survey, but that doesn't make it "good." While technically a problem with generalizability, the problem goes deeper than that: the actual results are likely biased because respondents to this kind of survey are probably more likely to disseminate results to patients than non-respondents. At this point, there are two ways the authors could deal with this problem (aside from handwaving and saying that "the reported results likely overestimate dissemination.") One is to do a "wave analysis," asking whether results for respondents who responded in the first wave were different than for the second or third wave. The other approach is sensitivity analysis: what if the non-respondents were 20% less likely to disseminate than their responding peers? What if 40% less likely?

REVIEWER	Dr Rossella Salandra University of Bath School of Management UK
REVIEW RETURNED	13-Aug-2019

GENERAL COMMENTS	Dear Authors, Thank you for the opportunity to review your manuscript ‘Frequency and Format of Clinical Trial Results Disseminated to Patients: A Survey of authors of trials’. 1. Is the research question or study objective clearly defined? Yes, it is clear that the study aim is to investigate the frequency and format of results dissemination to trial participants and patient groups. Accordingly, the title could be revised from ‘Frequency and Format of Clinical Trial Results Disseminated to Patients: A Survey of authors of trials’ to ‘Frequency and Format of Clinical Trial Results Dissemination to Patients: A Survey of authors of trials’ 2. Is the abstract accurate, balanced and complete? Mostly so. Some sentences are not as clear as they could be, and some figures may need double checking. For example: • ‘Questionnaire emailed to authors of 19,824 trials’. The manuscript and Figure1 suggest that respondents are 19,321? • ‘Among the 1818, 498 authors (27%) reported having disseminated results to participants, 238 (13%) planned to do so, 600 (33%) did not plan to, 176 (10%) were unsure, and 256 (14%) indicated “other” or did not answer.’ These add up to 1768 as opposed to 1818. Based on the manuscript, should the last category include 306 respondents? • ‘314 (17%) of funders suggested dissemination to trial participants, 252 (14%) to patient groups; 333 (18%) ethical review boards suggested dissemination to trial participants, 148 (8%) to patient groups.’ .Should this be ‘of ethical review boards'? Also, since the

	question was directed to the survey respondents (as opposed to the founders themselves), would it be useful to clarify that 'founders reportedly suggested'? • 'Fewer than half the respondents had disseminated, or planned to disseminate, to participants and only half of those in language tailored to them'. This sentence is not as clear as it could be, for example it is not fully clear what 'half of those' refers to? 3. Is the study design appropriate to answer the research question? Yes. 4. Are the methods described sufficiently to allow the study to be repeated? Yes. 5. Are research ethics (e.g. participant consent, ethics approval) addressed appropriately? Yes. 6. Are the outcomes clearly defined? Yes. 7. If statistics are used are they appropriate and described fully? Yes. 8. Are the references up-to-date and appropriate? Yes. 9. Do the results address the research question or objective? Yes. 10. Are they presented clearly? Yes. One potential development could be to cross tabulate the results to show how results dissemination varies based on the respondents' characteristics captured in the survey (e.g., respondent' work and clinical experience, or funding source). 11. Are the discussion and conclusions justified by the results Yes. For clarity, study implications could be more tightly aligned to the results (e.g., the findings on the perceived barriers to dissemination). For example: what would the recommendation be regarding overcoming difficulties in reaching patients (e.g. disseminating in a different language)? One option could be to take the barriers one by one and discuss the relative implications / recommendations for practice, training and so forth. 12. Are the study limitations discussed adequately? Yes. 13. Is the supplementary reporting complete (e.g. trial registration;

	funding details; CONSORT, STROBE or PRISMA checklist)? Yes. 14. To the best of your knowledge is the paper free from concerns over publication ethics (e.g. plagiarism, redundant publication, undeclared conflicts of interest)? Yes. 15. Is the standard of written English acceptable for publication? Yes. However, some sentences are not as clear as they could be. For example: • Page 4 line 52: 'We did not exclude authors of published protocols'. This sentence is not as clear as it could be. Perhaps it may be useful to remove the double negative ('not excluded')? • Page 6 line 50: 'Among the 1818 trials, 906 authors (50%) reported that trial participants were asked if they wanted to receive the study results'. Although it is clear that there is a 1:1 mapping between trials and authors, the manuscript sometimes makes reference to authors, sometime to trials. For clarity, would it be useful to choose one of the two and use it consistently thought-out the manuscript? • Page 10 lines 5-8. 'Our study shows that two-fifths of clinical trialists had disseminated to trial participants (or planned to) up to two years after publishing their study. Of these, half of the trialists shared documents prepared specifically for lay readers'. 'Of these' appear to refer to the 498+238=736 authors that have disseminated or are planning to do so. However, the statement that 'half of the trialists have shared document prepared for lay readers' would be correct if referring to those who have disseminated (252/498=51%). Would it be useful to rephrase to avoid confusion? Good luck and all the best with the project!

REVIEWER	Marjorie Mau University of Hawai'i at Mānoa, John A. Burns School of Medicine Department of Native Hawaiian Health 677 Ala Moana Blvd, Ste 1016-B Honolulu, HI 96813
REVIEW RETURNED	19-Aug-2019

GENERAL COMMENTS	Interesting manuscript undertaken to better understand the practice of disseminating research findings to enrolled patients, participants and the broader public. The activity of disseminating research results to participants is an important topic to the entire research enterprise and yet it receives very little traction by the funders, academic institutions or to many institutional review boards. Thus, this paper does fill an important gap in our knowledge and does so in such a way as to capture this type of information by surveying the researchers themselves. Unfortunately, there are some important weaknesses that would, in my opinion, improve the manuscript. 1) The major weakness is the low response rate to the survey. It would be helpful to know if there are any differences between the authors that responded and the

	non-responders. Was there a difference by country? Type of clinical trial? (i.e. cancer trial, heart, etc.) Or size of the trial? (i.e. number of participants). Could this be fleshed out in a better way? This would enable the reader to determine bias. 2) A clear definition of a clinical trial would be useful - there may be multiple definitions depending on the funder (NIH, industry, foundation etc.). 3) Interpretation of the results and the conclusions require a more balanced approach in my opinion with more discussion of the potential for responders' bias given that only 16% responded. BMJ Open Reviewer Critiques Rationale for the study was largely based on benefits of dessiminating research results from human clinical trials to participants/patients or the public. The authors proposed to understand the perspectives of authors of published clinical trials as to the frequency of disseminating results to participants/patients and if so – how dissemination was carried out. This paper does fill a gap in our understanding on clinical trial dissemination to patients/participants and the public at large. Strengths – • Relatively large survey results from authors of clinical trials published in 2014-2015 and retrieved through PubMed. • Use of a newly developed survey instrument aimed at determining the frequency and format of how clinical trial results were dessiminated to patients/participants/public. Weaknesses – • Low response rate of authors to this survey. (16%) • No description of the Responders vs. Non-responders to their survey. • No verification – it would have enhanced the study results if there was a verification process for at least a smaller random sample of the the clinical trials. • NO parametrics of the new survey are mentioned in the paper which would have been helpful in terms of validity and reliability. Suggestions: Overall important paper in terms of advancing the science of translating research findings into to clinical practice. However, there are a number of major concerns about low response rate of eligible authors and a new survey that was utilized without a sense of its parametric properties. Suggestions for improving the paper are listed below: 1) Major revision suggestions: • Provide reliability scores for survey instrument and reliability testing which would improve the interpretation of the results. • Were there any missing items on the survey results? How was that handled? • Comparison between the authors that responded versus those who were non-responders. This will aid the reader in terms of sample bias. • Provide more blance interpretation of the results such as the potential downside – if any to patients/participants receiving clinical trial results. (e.g. unecessary clinical work-up or treatment., etc.)

	2) Minor revision questions: • Was there a difference in the results based on the funder? NIH, industry, foundation, no funding. • What about type of clinical trial – Cardiovascular vs. Cancer, etc. Or based on the outcomes (i.e. re-hospitalization vs. Behavioral outcomes) • Why was the period of 2014-2015 selected? How does this time period vs. another time period compare??

VERSION 1 – AUTHOR RESPONSE

Comment	Response	Description of the location of all revisions that have been made (clean version)
Reviewer 1		
This paper reports upon a thoughtful, carefully conducted survey of first authors of clinical trials from 2014 and 2015, asking about their current practices with respect to dissemination of research results to a) participating patients and b) other non-scientific stakeholders, particularly patients with the condition under study. The study should be of substantial interest to the research community and possibly to patient groups as well, but I do have two general comments and a methodological note. First, there seems to be insufficient attention to the possibility that dissemination to participants and patient stakeholders could be harmful. As some of the survey respondents imply, just because organized bodies declare a practice to be "ethical" or "unethical" does not make it so. We know, for example, that findings	We have revised the Discussion section to address the fact that dissemination could lead to harm.	Discussion p10-12

from scientific studies are easily amplified, distorted, and misunderstood as they are passed from investigators to journals to university public affairs offices to the press, and increasingly, to social media. Furthermore, as one of the participants also suggests, a single study is rarely enough to justify a change in practice. It is certainly not implausible that a requirement to "disseminate" to participants or to patient groups could promote misinformation, hype, and actual patient harm. Addressing this possibility deserves more than a sentence or two in the Discussion. The authors seem to advocate for mandatory enforcement by institutions and regulatory bodies and funders. They should carefully consider the unintended consequences.		
Relatedly, if there is an ethical imperative to share meaningful results with patients (for reasons beyond simply satisfying patients' curiosity, which may be reason enough), some studies are likely more meaningful than others. For example, among the many randomized trials analyzed some undoubtedly examined outcomes that are important to patients (mortality, quality of life) whereas others may have focused on proxy outcomes such as biomarkers and/or mechanisms of disease. The imperative to disseminate is surely greater for the first kind of study than the	We agree that some study results may be of more interest and relevance to some patients, and that (as suggested by the reviewer) these might reflect the outcomes analysed, but they might also reflect the setting (e.g. trials done with critically ill patients in critical care compared to those in people seeking advice from a GP). However, we feel that trial participants themselves are best placed to decide if something is of importance, interest or relevance to them, not us or trialists. Some patients may be interested in receiving all results even those with proxy outcomes or those that will not help them make decisions in the future. We also feel that one of the purposes of informing participants of the findings of their trial is to acknowledge their participation and to help with their awareness of research and its importance. With this in mind, considering the amount of work involved in coding and stratifying our results on the basis of patient-oriented outcomes (or, for example, trial settings) and the difficulty of knowing what such analysis would actually mean, we do not feel that doing this would add to the primary focus of	No changes.

second. The manuscript would be improved if the authors were able to perform an analysis stratified according to whether a study examined patient-oriented outcomes.	our paper.	
In terms of Methods (and the corresponding LImitations section in the Discussion), the response rate of roughly 30% is good for this kind of survey, but that doesn't make it "good." While technically a problem with generalizability, the problem goes deeper than that: the actual results are likely biased because respondents to this kind of survey are probably more likely to disseminate results to patients than non-respondents. At this point, there are two ways the authors could deal with this problem (aside from handwaving and saying that "the reported results likely overestimate dissemination.") One is to do a "wave analysis," asking whether results for respondents who responded in the first wave were different than for the second or third wave. The other approach is sensitivity analysis: what if the non-respondents were 20% less likely to disseminate than their responding peers? What if 40% less likely?	We have followed the advice to conduct a sensitivity analysis. It is difficult to know what values to use for sensitivity analysis, so we have calculated it using the values suggested by the reviewer. We have added the following to the results section: "As we received a low response rate for the survey and those who did not respond may have been less likely to have disseminated we report some sensitivity analysis: if non-responders were 20% less likely to have disseminated (or have plans to disseminate) than responders, then the overall proportion who have disseminated (or have plans to) would be 21% (4137/19321) and if non-responders were 40% less likely it would be 5% (898/19321)."	Results p7
Reviewer 2		
1. Is the research question or study objective clearly defined? Yes, it is clear that the study aim is to investigate the frequency and format of results	We have changed the title to: Frequency and Format of Clinical Trial Results Dissemination to Patients: A Survey of authors of trials indexed in PubMed	Title

dissemination to trial participants and patient groups. Accordingly, the title could be revised from 'Frequency and Format of Clinical Trial Results Disseminated to Patients: A Survey of authors of trials' to 'Frequency and Format of Clinical Trial Results Dissemination to Patients: A Survey of authors of trials'		
2. Is the abstract accurate, balanced and complete? Mostly so. Some sentences are not as clear as they could be, and some figures may need double checking. For example: • 'Questionnaire emailed to authors of 19,824 trials'. The manuscript and Figure1 suggest that respondents are 19,321?	We have revised this to: "Questionnaire emailed to 19,321 authors trials; 3127 responses received (16%)."	Abstract
• 'Among the 1818, 498 authors (27%) reported having disseminated results to participants, 238 (13%) planned to do so, 600 (33%) did not plan to, 176 (10%) were unsure, and 256 (14%) indicated "other" or did not answer.' These add up to 1768 as opposed to 1818. Based on the manuscript, should the last category include 306 respondents?	We have revised this to: "Among the 1818, 498 authors (27%) reported having disseminated results to participants, 238 (13%) planned to do so, 600 (33%) did not plan to, 176 (10%) were unsure, and 306 (17%) indicated "other" or did not answer."	Abstract
• '314 (17%) of funders suggested dissemination to trial participants, 252 (14%) to patient groups; 333 (18%) ethical review boards suggested dissemination to trial participants, 148 (8%) to patient groups.' .Should	We have revised this to: "Relatively few of the 1818 authors reported dissemination was suggested by institutional bodies: 314 (17%) of funders reportedly suggested dissemination to trial participants, 252 (14%) to patient groups; 333 (18%) of ethical review boards reportedly suggested dissemination to trial participants, 148 (8%) to patient groups. Authors described many barriers	Abstract

this be 'of ethical review boards'? Also, since the question was directed to the survey respondents (as opposed to the founders themselves), would it be useful to clarify that 'founders reportedly suggested'?	to dissemination."	
• 'Fewer than half the respondents had disseminated, or planned to disseminate, to participants and only half of those in language tailored to them'. This sentence is not as clear as it could be, for example it is not fully clear what 'half of those' refers to?	We have revised this to: "Fewer than half the respondents had disseminated to participants (or planned to) and only half of those who had disseminated shared lay reports."	Abstract
3. Is the study design appropriate to answer the research question? Yes.	No change required.	NA
4. Are the methods described sufficiently to allow the study to be repeated? Yes.	No change required.	NA
5. Are research ethics (e.g. participant consent, ethics approval) addressed appropriately? Yes.	No change required.	NA
6. Are the outcomes clearly defined? Yes.	No change required.	NA
7. If statistics are used are they appropriate and described fully? Yes.	No change required.	NA
8. Are the references up-to-date and appropriate? Yes.	No change required.	NA

9. Do the results address the research question or objective? Yes.	No change required.	NA
10. Are they presented clearly? Yes. One potential development could be to cross tabulate the results to show how results dissemination varies based on the respondents' characteristics captured in the survey (e.g., respondent' work and clinical experience, or funding source).	We feel that this suggestion would significantly add to the length of the paper and was not something we planned to do. We collected the characteristics simply to describe the sample who had responded (Table 1) not to look at subgroups.	No changes.
11. Are the discussion and conclusions justified by the results Yes. For clarity, study implications could be more tightly aligned to the results (e.g., the findings on the perceived barriers to dissemination). For example: what would the recommendation be regarding overcoming difficulties in reaching patients (e.g. disseminating in a different language)? One option could be to take the barriers one by one and discuss the relative implications / recommendations for practice, training and so forth.	Respondents reported numerous perceived or actual barriers to dissemination and it would significantly increase the length of the paper if we were to take each in turn and address the implications of each, the training required and to make recommendations. We feel that the key barriers are addressed in the implications section but we are unable to address the more study-specific issues such as how to reach patient groups other than by encouraging ethics committees to scrutinise and advise when and how to reach patients for individual studies.	No changes.
12. Are the study limitations discussed adequately? Yes.	No change required.	NA
13. Is the supplementary reporting complete (e.g. trial registration; funding details; CONSORT, STROBE or PRISMA checklist)?	No change required.	NA

Yes.		
14. To the best of your knowledge is the paper free from concerns over publication ethics (e.g. plagiarism, redundant publication, undeclared conflicts of interest)? Yes.	No change required.	NA
• 15. Is the standard of written English acceptable for publication? Yes. However, some sentences are not as clear as they could be. For example: • Page 4 line 52: 'We did not exclude authors of published protocols'. This sentence is not as clear as it could be. Perhaps it may be useful to remove the double negative ('not excluded')?	We have rephrased this to: "We included authors of published protocols because protocols are not categorised/indexed in PubMed in a way that would allow them to be easily identified."	Methods p5
• Page 6 line 50: 'Among the 1818 trials, 906 authors (50%) reported that trial participants were asked if they wanted to receive the study results'. Although it is clear that there is a 1:1 mapping between trials and authors, the manuscript sometimes makes reference to authors, sometime to trials. For clarity, would it be useful to choose one of the two and use it consistently thought-out the manuscript?	We have revised this throughout the paper.	Throughout the paper.
• Page 10 lines 5-8. 'Our study shows that two-fifths of clinical trialists had disseminated to trial participants (or planned to) up to two years after publishing their study. Of these, half of the trialists shared documents	We have revised this to make it clearer: "Our study shows that two-fifths of clinical trialists had disseminated results to trial participants (or planned to) up to two years after publishing their study. Half of those who had (or planned to) disseminate shared documents prepared specifically for lay readers and a quarter shared both these and those written for	Discussion section paragraph 1, p10

prepared specifically for lay readers'. 'Of these' appear to refer to the 498+238=736 authors that have disseminated or are planning to do so. However, the statement that 'half of the trialists have shared document prepared for lay readers' would be correct if referring to those who have disseminated (252/498=51%). Would it be useful to rephrase to avoid confusion?	an academic/clinical audienc.."	
Reviewer 3		
… Unfortunately, there are some important weaknesses that would, in my opinion, improve the manuscript. 1) The major weakness is the low response rate to the survey. It would be helpful to know if there are any differences between the authors that responded and the non-responders. Was there a difference by country? Type of clinical trial? (i.e. cancer trial, heart, etc.) Or size of the trial? (i.e. number of participants). Could this be fleshed out in a better way? This would enable the reader to determine bias.	Whilst the response rate is low, this is typical of surveys with researchers and doctors. We did however achieve a large and varied sample. We recognise that there may be non-response bias but it is not possible to conduct a meaningful comparison of responders and non-responders using the variables suggested. The survey was sent to over 19,000 authors and to extract data about the countries in which the studies were conducted and size of trials would be a significant undertaking as this extraction cannot be automated. Also, with such a broad number of included trials it would be hard to place the studies into meaningful subtypes.	No changes.
2) A clear definition of a clinical trial would be useful - there may be multiple definitions depending on the funder (NIH, industry, foundation etc.).	We agree that there are multiple definitions of clinical trials. We included all articles indexed in PubMed with an article type categorised as clinical trial. We describe this in the methods section under the sampling and search strategy heading. This website contains more details of the definition: https://www.ncbi.nlm.nih.gov/books/NBK222768/	NA
3) Interpretation of the results and the conclusions require a more balanced approach in my opinion with more discussion of the potential for responders' bias given	We have added some more details to the Discussion under the section on study strengths and limitations. "Whilst the response rate is similar to other surveys conducted with researchers[27, 28] and we generated a large and varied sample, the	Discussion section, p10-11 Study strengths and limitations

that only 16% responded.	generalisability of the results may be compromised by the low response rate. We do not know if responders differed from non-responders in terms of the characteristics of the trials, the authors, or the funding received; it is possible that those who responded were more likely to have disseminated than those who did not."	
Weaknesses – 1) Low response rate of authors to this survey. (16%) 2) No description of the Responders vs. Non-responders to their survey. 3) No verification – it would have enhanced the study results if there was a verification process for at least a smaller random sample of the the clinical trials. 4) NO parametrics of the new survey are mentioned in the paper which would have been helpful in terms of validity and reliability	1) See comments above 2) See comments above 3) Verifying if authors actually disseminated ie doing what they said they did is beyond the scope of the design of this study. We do already acknowledge in the article summary on p3 that "A survey can only report what authors said they did, not what they actually did in practice". Also, the fact that such a high proportion indicated they didn't disseminate suggests that authors have responded truthfully. 4) It is not relevant to evaluate the reliability and validity of a survey like this which is only collecting descriptive information and is not measuring constructs. The survey was piloted before use with potential users to ensure the questions were clear.	No changes.
Suggestions: Overall important paper in terms of advancing the science of translating research findings into to clinical practice. However, there are a number of major concerns about low response rate of eligible authors and a new survey that was utilized without a sense of its parametric properties. Suggestions for improving the paper are listed below: 1) Major revision suggestions: a) Provide reliability scores for survey instrument and reliability testing which would	a) As the survey questions were never meant to represent a construct or a scale, reliability testing is not needed. b) There was missing data and where this occurred it is either reported in the results section or is clear in the tables of results.eg see footnotes to Tables 1,3,4,&5. c) See comments above. d) We have built this into the revised Discussion section.	d) Discussion p10-12

improve the interpretation of the results. b) Were there any missing items on the survey results? How was that handled? c) Comparison between the authors that responded versus those who were non-responders. This will aid the reader in terms of sample bias. d) Provide more blance interpretation of the results such as the potential downside – if any to patients/participants receiving clinical trial results. (e.g. unecessary clinical work-up or treatment., etc.)		
2) Minor revision questions: a) Was there a difference in the results based on the funder? NIH, industry, foundation, no funding. b) What about type of clinical trial – Cardiovascular vs. Cancer, etc. Or based on the outcomes (i.e. re-hospitalization vs. Behavioral outcomes) c) Why was the period of 2014-2015 selected? How does this time period vs. another time period compare??	a) and b) We did not set out to look at subgroups such as these but rather to take a snapshot of dissemination practice across all disciplines and funding types. As such any proposed analyses like these are adhoc. It would be challenging to categorise our broad sample into meaningful types of trial or outcomes and it would be a significant amount of work to do so as this data was not captured as part of the survey and would need to be coded manually. c) We conducted the survey in January 2016 and sampled trials published in the previous 2 years (2014&2015). Whilst there may be differences if we sampled another time period this was not the objective of the study. This could be done as further research.	No changes.

VERSION 2 – REVIEW

REVIEWER	Rossella Salandra School of Management University of Bath
REVIEW RETURNED	30-Sep-2019

GENERAL COMMENTS	The authors have tackled all the issues highlighted during the previous submission.

REVIEWER	Marjorie Mau University of Hawai‘i John A. Burns School of Medicine Dept. of Native Hawaiian Health USA
REVIEW RETURNED	27-Sep-2019

GENERAL COMMENTS	Authors have adequately addressed the concerns raised by reviewers. Changes to the manuscript are acceptable and I recommend that the paper be accepted at this point.