Peer Review File

Article information: https://dx.doi.org/10.21037/gpm-23-16

Reviewer A

Comment 1: Thank you for submitting this article for publication. Whilst I feel it is generally well written I think that there are a couple of discussion points missing that would add value and I have one question for clarification. On lines 186 and 188 you comment about reading levels but these grade levels are not known internationally, please also provide the average age of this grade for understanding.

Reply 1: Thank you for this comment. We have clarified the average age of the grade levels in the text.

Changes in the text:
Lines 186-189
Students in these grades are typically 11-13 years old. The grade level of PEMs from professional urologic and urogynecologic societies for POP materials has been estimated on average to be a twelfth-grade level, the last year of secondary school when students are about 18 years old (24).

Comment 2: You have not made any comment about education for patients whose native language is not the same as the country they are living in and the issues around providing appropriate information that is accessible for all eg those with language barriers, intellectual deficit, unable to read etc. The discussion could also be enriched with consideration of the role of other health care professionals / patient carers and family members in pre op assessment and education.

Reply 2: Regarding patients whose native languages are not the same, this point is very well taken. We have included a discussion point about this.

Changes in the text:
Lines 193-195:
Patients who do not speak the native language of the country they live in are also frequently seen in practice and must be considered. Communication can be improved with these patients by having access to reliable and accurate translation services and PEMs written in multiple languages in the office.

Reviewer B

Comment 1: Please revise line 80.

Reply 1: Thank you for your comments. Line 80 has been removed

Comment 2: One may argue that it is difficult to assess/estimate health literacy of patient. There is no objective measure of this.

Reply 2: This point is well taken. Given the retrospective nature of the study, and that most providers likely do not use a validated metric to estimate their patients' health literacy, this was the only way to obtain an estimate of patient health literacy. However, we agree that the provider's assessment is subject to bias.

Comment 3: It would be a good follow up study to assess patient perception on this and what they prefer in terms of education preoperatively. The bias of providers is a limitation. It is difficult to judge if patients are also able

to grasp or understand all the information if a huge gamut of information is thrown at them at once. An important question may be to include the number of pre operative counselling session prior to surgical treatment. Especially this POP is a quality-of-life surgery rather than oncological where time is of the essence.

Reply 3: Thank you for this thoughtful comment. The number of pre-operative counseling sessions prior to surgery would be an interesting question to study. We agree that the next steps from this study would be to obtain the patient perception on patient education, and this is mentioned in our conclusion.

Comment 4: Furthermore, providers may assume they are using simple language, but have a recollection bias and patients may not feel the same way.

Reply 4: We have included a statement about the potential for recall bias by the providers.

Changes in the text:
Lines 222-223:
In addition, recall bias may have caused providers to report they discussed certain complications and used communication techniques when they did not.