Author's response to reviews

Title: Type 2 diabetes clinical practice guidelines do not have a major impact on family doctors self-reported care of their patients

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Author's response to reviews: see over
Authors' response to reviewers.

Title: Family doctors’ knowledge and self-reported care of the type 2 diabetes patients in comparison to the clinical practice guideline: cross-sectional study

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Author's response to reviews: see over

First of all, we would like to thank the reviewers for their contribution and comments. They were very helpful in improving the manuscript.

Reviewer's report
Title:
Type 2 diabetes clinical practice guidelines do not have a major impact on family doctors self-reported care of their patients
2 25 March 2006 Version: Date:
Shlomo Vinker Reviewer:
Reviewer's report:
General
The issue of utilization of clinical guidelines in the usual every day practice is a very important one. Although I am not sure that this research is really representative of the common practice in Estonia due to the low response rate and the unclear method of the questionnaire. It is actually an attitudes survey and a real performance one, an issue that should be clarify in the aim of the study and in the discussion. It is well known that there may be a great discrepancy between “declarations” and performance. The English and grammar through all the manuscript should be improved

We totally agree that we are not assessing physicians’ actual performance but self reported knowledge and awareness. According to Cabana’s findings the doctor-related barriers in adherence to guidelines knowledge is the first factor in behaviour changing model „knowledge-attitude-behaviour“. We rephrased the title and the aim of the study.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Introduction
The introduction is too long and should be shorten, for example the part “The incidence of cardiovascular mortality ..” to the end of the paragraph is irrelevant and can be removed. The part on the changing policy of treatment in Estonia also should be shorten.
Suggested changes in introduction have been done.

Methods
It is not clear if the authors used open or close questions in their survey. It is critical especially in parts of recommendations in the guidelines (for example if it is a close questionnaire, there should be some wrong answers.
Statistical analysis: The authors should make power analysis, as in the results section they found many of their statistical tests “not significant” the reason may be a too small sample size.

For guideline availability, usage of yes/ no answers were required. Questions expecting blood glucose values were open questions.
In the part of recommendations in the guideline all the aspects needed to perform within certain time were stated and respondents had to choose the right frequency, or answer “I do not consider it necessary. “Wrong” question was about performance of chest X-ray. But as there were no statistically significant correlations in proportion of doctors choosing this test as necessary for diabetes patients, we did not describe it.
There was not enough data available from the literature, to prognose the results in Estonia.

Results
The results section should be shorten and the authors should try to minimize duplication between the text, tables and figures (for example table 3 and figure 1, etc.)
Page 9 1st paragraph – as the number of diabetic patients in every clinic is only an estimate and the number 300 seems a “round” one and an extreme you should use “median” instead of mean. I did not find through all the results section the use of statistical tests out of simple descriptive (frequencies). You should for example made a comparison between the adherence with different recommendations to see if the difference is significant.
I would also recommend to make a score of adherence with for each physician and to look for a correlation between his or her background characteristics and the score using logistic regression.
The result section was shortened, as the part describing the doctors’ statements of treatment goals were omitted because those questions were not in accordance with guideline but extra added to the questionnaire by the researchers. We have decided to reflect only the aspects that are in accordance with guideline. Therefore Figure 2 is extracted as well.
In previous table 1 the glucose values were presented when doctors decide start medication but on the figure the division of the doctors’ is seen.
The mean of the number of diabetes patients is used and the table 2 was removed.
We calculated the score for adherence, and tried to clarify it. In the statistical analysis we made all possible comparisons with independent variables, as well with physicians having different adherence scores. Scales were made for doctors starting treatment at the different levels of fasting glucose (fig 1) and comparisons were made but all results were statistically insignificant.

Discussion
The discussion is too long. For example the second paragraph in page 11 is irrelevant (the manuscript is dealing on the guidelines and the prevalence of DM is not the main issue to start the discussion)
It was changed and shortened.
The disposal of guidelines as well as the provision of diabetes care are both according to the declaration of the physician and not the actual situation. Results are presented as doctors’ self-reported data.
You should pay attention in the literature review and the comparison with your finding if the results are from “attitude surveys” or from actual performance. Comparisons with actual performance studies were extracted.

Reviewer’s report
Type 2 diabetes clinical practice guidelines do not have a major impact on family doctors self-reported care of their patients
2 25 March 2006 Version: Date:
James Gill Reviewer:
Reviewer’s report:
General
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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
1. The major issue is that I think the title does not really reflect what the study shows. The title
and purpose statement says that the study examines the impact of guidelines. However, the
way the study is set up, I do not think it is really able to do that. The study does not look at
behavior for physicians who did vs. did not receive the guidelines; nor does it examine
behavior before and after the guidelines were disseminated. Rather it looks at behavior at a
point in time for all physicians who were exposed to the guidelines. That may still be an
interesting study, as it looks at physician behavior in comparison to the guidelines. But it
does not really look at the impact of the guidelines.
This important remark has been taken into account. Changes have been made.
The authors do have an independent variable which they describe as “having the guidelines
at your disposal.” However, I do not think that indicates exposure to the guideline. When
physicians who say that they do not have the guideline at their disposal, that does not
necessarily mean that they were not exposed to the guideline. They may have read the
guideline in depth and incorporated its principles into their practice, but then may have
discarded the guideline. One may argue that “having the guideline at your disposal” is an
indicator of being continuously exposed to the guidelines. However, this is also not
necessarily true, since different physicians may interpret “at your disposal” very differently.
Some may have the guideline in the chart, so they are always looking at it. Some may have
it in a file cabinet and rarely or never look at it. So the variable of “at your disposal” does not
seem to me to be a good proxy of exposure to the guideline.
This misunderstanding is probably due the language usage. In 2000, copy of the guideline
on paper was delivered to all members of Estonian Family Medicine Society. And we asked
whether they still have the guideline available. When the study was carried out the Estonian
guideline was not available on the Web. We changed the term “disposal” with “available”.
Guideline has quite exact recommendations; we do not think they are always known by heart.
Guideline availability as a variable has used in different studies before as well (Wolff M,
Ward M)
2.
One aspect that makes interpretation difficult is that we don’t know all of what the Estonian guidelines for diabetes recommend.
Reading between the lines, it appears that some recommendations are quite different from US guidelines. For example, it says on page 9 “More than half of the doctors made a decision to start treatment with medications on FBG above 7 mmol/l, while a few made this decision at FBG values below 6.0 mmol/l/". This makes me think that the Estonian guidelines recommend treatment based on fasting blood sugar rather than HgbA1c. If so, this is different from US guidelines, which recommend treatment primarily based on HgbA1c levels.

Estonian diabetes guideline was mainly adapted from European Diabetes Policy Group (IDF) guideline (the reference is given). In the guideline both, HbAc1 and the fasting blood glucose are given as possible alternatives. The explanation is added to method section.

Another example on page 9 is the reference to “absence of ketones and absence of glucosuria”. Again, this makes me think that these goals are recommended by the guidelines; if so, this differs from US guidelines. If not, the interpretation of the results would differ greatly.

Those aspects were not driven from the guideline but were asked in the questionnaire. To present only aspects from guideline, this block of questions and results was omitted.
The guidelines for frequency of testing seem clearer, although it is unusual that this is articulated only in the figures and not in the text. So overall, it is important to state what the Estonian guidelines are, so the reader can determine if the respondents are in line or not. If the guidelines differ from US or other national guidelines, that may be OK, although the implications of this for generalizibility are important and should be discussed.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
1. One minor issue with regard to the results in table 4 and figures 3 and 4. The authors interpret whether physicians generally do tests more or less often than the guidelines recommend. For most tests this is very clear, since there is a discrete time period recommended (e.g., every 3 months or annually). However, for blood pressure the recommendation is “every visit”. So it is unclear how the responses were compared; i.e., if the response was “every 3 months”, is this more or less or the same as “every visit”? It is all right when the blood pressure is measured within the three months, but there exist a proportion of patients visiting doctors even more often than once in three months. This option was given to them. But of course some biases can remain defining the frequency.
2. There are several places in the manuscript where the wording is difficult to interpret. I suspect much of this is due to differences in language or word usage. For example, on page 6 it talks about “year of graduation from the medical faculty”. I suspect this means what year they graduated from medical school, but not sure. On page 9 it says “how many of their diabetes patients were compensated”. I suspect this means how many were controlled, but not certain.

Suggestions were accepted.
3. There are also some examples of grammatical errors or oddities, which again I suspect are due to language or translation issues. For example: “It is evident that part of Estonian FDs does not have” does not seem grammatically correct. I suspect most of this can be corrected in the editing process.

English editing has been done.
Discretionary Revisions (which the author can choose to ignore)
Unable to decide on acceptance or rejection until the authors have responded to the What next?:
major compulsory revisions
An article of limited interest Level of interest:
Needs some language corrections before being published Quality of written English:
No Statistical review:
Declaration of competing interests:
I declare that I have no competing interests