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

Version: 2 Date: 25 March 2006

Reviewer: James Gill

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.
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.

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.
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. 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.

<table>
<thead>
<tr>
<th>Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)</th>
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<tbody>
<tr>
<td>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”?</td>
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<td>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.</td>
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<td>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.</td>
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Discretionary Revisions (which the author can choose to ignore)

<table>
<thead>
<tr>
<th>What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions</th>
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<tbody>
<tr>
<td>Level of interest: An article of limited interest</td>
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<tr>
<td>Quality of written English: Needs some language corrections before being published</td>
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<tr>
<td>Statistical review: No</td>
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<tr>
<td>Declaration of competing interests:</td>
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<tr>
<td>I declare that I have no competing interests</td>
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