Reviewer's report

Title: Training of family medicine and internal medicine residents in the US in implementing clinical practice guidelines: a survey study

Version: 1 **Date:** 22 September 2008

Reviewer: Trudy van der Weijden

Reviewer's report:

General

This is a relevant study. Not much is known about how to best influence medical doctors early in their career in their knowledge about and attitude towards clinical practice guidelines (CPGs). Sensitisation to CPGs from the moment of starting with medical decision making in real patient consultations will probably stimulate awareness, attitude and adherence to CPGs.

Major Compulsory Revisions

It's not clear what you mean by teaching CPGs. I can think of at least different scopes:

1) Teaching on CPGs as end-product, just on knowledge of it's content.

2) Or teaching about the development process of CPGs, including EBM critical appraisal skills and AGREE-perspective.

3) Or teaching on how to integrate CPGs in medical decision making, in other words on consciously adhering or not-adhering to CPG recommendations. In the medical decision making during a real time consultation one tries to apply / translate a guideline to a unique individual. Given this it is clear that 100% adherence is wrong (cookbook medicine), but what than are benchmarks for "good" adherence?

4) Or teaching residents on the place of CPGs in quality circles with feedback on each other's performance with the CPGs as indicator for best practices?

It becomes somewhat clear only after having viewed the supplemented questionnaire. How often did the respondents make use of the option "other?".

The authors could reflect somewhat more on the design:

- You did a great job in keeping the survey very short and apparently feasible for respondents. Despite this only a low to moderate response was reached. Why did you choose for this large sample of a national survey, inviting all 839 directors of educational programs? Telephone interviews of a purposeful sample combined with a critical analysis of the curricula documents would probably have generated more in-depth results. And you are over-powered, regarding e.g. an odds ratio 0.99 being significant with p=0.022. (or OR 1.05 with p=0.019, OR 1.08 p=0.041). This is significant, but does not seem very relevant.

- The literature was reviewed to develop the questionnaire. Would some qualitative pre-survey work (by e.g. in-depth interviews with some program directors) not have been more valuable in ensuring that your questionnaire is relevant?

Minor essentials revisions

In the introduction I miss the underpinning of the relevance of your research question. What is the reason for the suboptimal implementation of CPGs by residents. Is it indeed attributable to suboptimal training? See also the 3rd paragraph on page 11, where you state that role modelling is the main reason for low adherence, and apparently not so much training.

In the discussion the authors could reflect more on the possible aspects that can be taught to medical residents. What is your idea on goals that have high priority, on page 10, 3rd paragraph?

In the last sentence of your discussion you plea for exploration of the influence of training residents in implementing CPGs on future behaviour. Okay, interesting of course, but what really interests me is what would be your outcome. Is it just adherence to guidelines (scoring on quality indicators), or is it the level of integrating guidelines in medical decision making (how often did they “use” the guidelines, meaning consciously adhering or not-adhering to guideline recommendations)?

Discretionary revisions

In the results section it appears that the most frequently reported evaluation was auditing of residents’ adherence. This evokes further questions: was it absolute adherence (0 – 100%), including the use of norms or benchmarks to the recommendations, or relative adherence compared to peers?

The potential solutions mentioned in the discussion on page 11 seem to be based more on opinion than on evidence or research findings.

IMG = international medical graduate. Confusing use of this acronym. It’s not mentioned in your list of abbreviations. Why is this variable used anyway? What was your hypothesis in using the <25% international medical graduates as an independent variable in the logistic models? There is no reflection in the discussion whatsoever on these IMGs.

page 8: Conducting objective assessment was inversely ASSOCIATED with ……..

What is a “Jeopardy-like” game?

We preferably use 95% CI for the Odds Ratios instead of p-values.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.