

individuals when, in effect, they were tested in 13 (10 before their publication [5] and 3 more by us for verification), a level that exceeds any research recommendations, including their own (7).

Next, they state, "Discarding means with inconsistent values is questionable[. . .]." It is difficult to imagine that contrasting responses to foods with reliable glycemic index/glycemic load values is a methodological flaw. The fact that predictive power improves with inclusion of foods eliciting unreliable responses suggests that either a property other than glycemic index is responsible or that only a subset of individuals are responsive to the property. Both options undermine the utility of the glycemic index concept.

Finally, Wolever and Brand-Miller recognize that "large between-subject variation of glycemic responses exists." This recognition is completely consistent with our findings and undermines the predictive value of the glycemic index classification of foods. The glycemic index rating is a property of a food, not a response of an individual. There would be no point in testing foods and publishing their glycemic index values, as these authors have done, nor creating diets based on this property if individual responses to their ingestion are highly variable.

In the larger picture, our findings do not argue against the potential health benefits of a low-glycemic index diet. The balanced inclusion of fruits, vegetables, nuts, legumes, and whole grains that comprise such a diet are wholesome and may aid weight management through mechanisms independent of their glycemic index rating.

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Standards of Medical Care in Diabetes

Response to position statement of the American Diabetes Association

I write in reference to the recently updated and circulated "Standards of Medical Care in Diabetes," in particular part II, "Screening for Diabetes," which were recently updated and published in the American Diabetes Association (ADA) 2006 Clinical Practice Recommendations (1). I would like to take issue with the use of the phrase "standards of medical care in diabetes," which is used to title all the individual components of these recently updated ADA guidelines. I think this phrase is unhelpful for both the health care community and the public at large, in that it strongly suggests that these guidelines are the definitive source to inform a "standard of care" for diabetes. Any deviation from the guideline may then be interpreted as "substandard care."

A number of these guideline recommendations cite a level of evidence "E" (i.e., based on "[e]xpert consensus or clinical experience"). In most taxonomies, this is considered the weakest level of evidence available. The U.S. Preventive Services Task Force (USPSTF), in their most recently circulated guidelines, assigns an "I" ("inconclusive") rating to whether asymptomatic individuals should be routinely screened for type 2 diabetes and a

"B" rating ("fair evidence that the services improve important health outcomes and concludes that benefits outweigh harms") to screening adults with hypertension or hyperlipidemia.

Given the importance of defining a standard of care for any disease management, I teach medical students that well-constructed guidelines developed by a nonpartisan group and based on a good level of evidence (such as the "B" rating by USPSTF) are the best informants of standard of care. Given the "I" rating by USPSTF, there clearly is room for clinical judgment when it comes to screening the general population. I respectfully suggest that it would be more helpful if the ADA guidelines, instead of being titled "Standard of Medical Care in Diabetes," were titled something like "ADA Consensus Panel Guidelines."

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Standards of Medical Care in Diabetes

Response to Power

We would like to thank Dr. Power for his letter (1) and allowing us to comment on the appropriateness of the title for our clinical practice guidelines, the evidence levels used in our guidelines, and specifically our recommendation regarding screening for type 2