Grading Improves Transparency and Quality

To the Editor:

The objection of Dr. Tobin to evidence-based medicine in a recent issue of CHEST (May 2008)1,2 seems to focus on the grading of recommendations. As Deputy Editor of a popular clinical resource, I have personally graded > 100 recommendations using the Grading Recommendations Assessment, Development, and Evaluation (GRADE) system and feel well qualified to comment on its benefits.3

Grading improves transparency by conveying the following for each recommendation: (1) the quality of the related evidence; (2) the author’s confidence that the benefits of the intervention outweigh the potential harms; and (3) the likelihood that informed patients would choose the intervention. No longer can authors make recommendations that fail to reveal the quality of the related evidence or the strength of the author’s belief. The transparency of recommendations is arguably as important as that of potential conflicts of interest, although the latter is more widely accepted.

The same information can be conveyed without grading, of course, but additional text is required. This causes clutter, redundancy, and monotony, which may distract and delay the reader. Ultimately, the quality of the review or guidelines suffers.

An additional benefit of grading is that authors, editors, and peer reviewers focus more on recommendations that are graded. One can argue whether this is appropriate, but the observation is undeniable. The added attention results in clearer recommendations that are easier for readers to apply to clinical practice.

I have heard many arguments against grading. Common among all arguments are misunderstandings of the purpose of grading and the GRADE system. In time, I firmly believe the entire medical community will appreciate the many advantages of grading recommendations.

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My wife has an investment account that is independently managed and may include stock in health-care-related companies at any given time (not a mutual fund). I am a Deputy Editor for Pulmonary, Critical Care, and Sleep Medicine at UpToDate, which uses the GRADE system to grade recommendations. I have been invited to join the GRADE working group. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/misc/reprints.shtml).4

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REFERENCES

1 Tobin MJ. Counterpoint: evidence-based medicine lacks a sound scientific base [editorial]. Chest 2008; 133:1076–1077

2 Tobin MJ. Rebuttal from Dr. Tobin [editorial]. Chest 2008; 133:1076–1077


The Chaos of War

To the Editor:

Soldier recruits marching toward the enemy feel the uncertainty and fear of the upcoming conflict. However, bolstered by their youthful zeal and patriotism, fortified by their training and conditioning, and mesmerized by their faith and knowledge that others believe in the ultimate truth of their cause, they march into the chaos of war. Watching the recruits marching into the unknown, seasoned veterans of conflicts recognize the sincere optimism those recruits exude and the naiveté in their expectations.

A physician’s wars are different. One soldier fights the emotional and biological enemies of one person at a time. Once our battle is engaged with the enemy, chaos often ensues. Like a real war, the planning, the terrain, the tactics, the objectives, and the definition of success change as the battle progresses. Knowledge of successful strategies and techniques is very important, but an ability to adapt to the evolving conflict is essential for success. For the physician, care is a continually changing process.

Evidence-based medicine, if it were ideal, would make sense of the chaos of our medical conflicts with disease, make our battle plans easier, make success more certain, and greatly lessen the daily stress of our (physicians’) lives. Alas, it does not. The physician recruits with their strong beliefs are able to act without doubt. The veterans, battered by years of changing medical opinions and reversals of standard practices, reassess their decisions and problems each time they are encountered, and wonder whether each decision is correct as they decipher hundreds of facts using their years of experience, fitting the details into the case at hand.

As a medical war veteran of 30 years, I salute Dr. Tobin’s eloquent essay on the current set of emperor’s clothes that many in the medical community are worshiping.

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The author has reported to the ACCP that no significant conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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Response

To the Editor:

I thank Drs. Hooper and Wilson for their comments on my article.1 I concur completely with Dr. Hooper’s sentiments.

Dr. Wilson links conflicts that arise through a physician’s relationship with industry and a physician’s scientific interest in a topic (so-called academic conflict of interest). These issues have been conflated recently by physicians who have financial conflicts. The two are completely different. A financial conflict is not a necessary requirement for doing science; it is also a voluntary choice. An academic interest is axiomatic to doing science; without it, one cannot develop expertise in a topic.

I compliment UpToDate in its performance as a powerful learning resource for physicians in training and in practice. I am proud to have been (continuously) a coauthor with Dr. Jubran of four chapters in UpToDate from the time it launched its “Pulmonary and Critical Care” section in 1996. In June 2006, Dr. Jubran and I were informed that UpToDate would add evidence-based medicine (EBM) grades to our chapters. We contacted UpToDate about this matter.

We learned that UpToDate was not the party that initiated contact with the EBM movement. Instead, UpToDate was contacted by a member of the EBM team at McMaster in 2001. UpToDate was told that it was not sufficiently evidence based, and that UpToDate needed to become more evidence based. Following repeated consultation with Dr. Guyatt, UpToDate introduced EBM grading throughout its site. The consequences of introduction of EBM grading are illuminating.

The manner in which Dr. Jubran and I wrote and revised our UpToDate chapters has not changed since 1996. We strove to base each sentence on the soundest of science. We learned, however, that our chapters were deemed “not evidence based” if they did not include EBM grades. As soon as EBM grades were applied, the very same chapters were classified as “evidence based.”

It is important to recognize what evidence based means in this context. We are not talking about the epistemologic soundness of a study. Instead, evaluation of new research is being reduced to a sound bite: the application of an EBM grade. This step, however, has the bonus that it is eminently marketable.

It is apposite that Dr. Wilson, as Deputy Editor of UpToDate, raises financial conflicts of interest, and emphasizes the importance of being transparent about them. In the footnote of his “Point-Counterpoint” article,2 Dr. Guyatt wrote: “The authors benefit in various ways, most nonfinancial, from the successful dissemination of EBM concepts and resources.” The same month, Dr. Guyatt wrote in a British Medical Journal article that “GHG [Gordon H. Guyatt] acts as a consultant to UpToDate; his work includes helping UpToDate in their use of GRADE [Grading of Recommendations Assessment, Development, and Evaluation].”3

UpToDate has been very generous in payments to Dr. Jubran and myself as authors. It is important that readers of UpToDate, CHEST, and other publications that carry EBM GRADE-related material be provided with full details of any (and all) financial transactions between the publishers and EBM GRADE consultants.

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In 2007, the author received $1,044.22 for contributions to UpToDate. The author does not receive financial support for writing, advising, or consulting on EBM or grading, or from pharmaceutical, biotechnology or medical device companies. The author receives royalties for two books on critical care published by McGraw Hill.

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Estimating Mean Pulmonary Artery Pressure From Systolic Pressure

A Caveat?

To the Editor:

I read with interest the editorial in a recent issue of CHEST (March 2008) regarding mean pulmonary arterial pressure measurements made from systolic pulmonary artery pressure. This interesting concept that mean pulmonary pressure is predictable from the systolic pulmonary arterial pressure seems to fail in at least one situation. An infant with an unrestrictive ventricular septal defect with low pulmonary vascular resistance and high pulmonary blood flow, and another infant with high pulmonary vascular resistance and low blood flow both could have same systolic pressure, but different diastolic pressures and different mean pulmonary arterial pressures, as hitherto calculated. In other words, the mean recorded pressures of 90/20 and 90/50 mm Hg are different. Perhaps, the compliance in a hyperkinetic, volume-loaded, fully recruited vasculature system and an obliterator pulmonary vasculature with fixed vascular resistance behave differently from the lung with normal physiology under varying circumstances. Of course, within the given system, the mean pressure may be largely driven by systolic pressure, as documented by the authors.

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The author has reported to the ACCP that no significant conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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1 Chemla D, Harve P. Estimation of mean pulmonary artery pressure simple than expected. Chest 2008; 133:592–593