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.

To the Editor:

I read with interest the editorial in a recent issue of CHEST (March 2008)4 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 unrestricted 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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Reference

1 Tobin MJ. Counterpoint: evidence-based medicine lacks a sound scientific base. Chest 2008; 133:1071–1074

References

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Estimating Mean Pulmonary Artery Pressure From Systolic Pressure

A Caveat?

To the Editor:

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

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