

with the higher value should be used for subsequent measurements.¹

Several studies have compared blood-pressure measurements in the two arms. Almost all have reported differences. In one of the largest studies, involving 400 subjects and using simultaneous measurements with oscillometric devices, there were clinically important differences of more than 10 mm Hg in systolic blood pressure between the arms in 20% of subjects and differences of more than 10 mm Hg in diastolic blood pressure between the arms in 11% of subjects.² Such data underscore the importance of measuring blood pressure in both arms initially, not only to prevent the misdiagnosis of hypertension but also to detect coarctation of the aorta, arterial obstruction in the arm,³ congenital heart disease, and unilateral neurologic and musculoskeletal abnormalities.⁴

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THE AUTHORS REPLY: The purpose of our Video in Clinical Medicine was to provide instruction in

the proper technique for measuring blood pressure, which is critically important for the accurate staging and treatment of hypertension. Once these basic techniques are mastered, they can be generalized to a variety of clinical settings. Time and space limitations prevented us from addressing some points that may be relevant to blood-pressure evaluation, including those cited by Terentes-Printzios et al. and Dudeja and Dudeja. Nonetheless, these special circumstances still require adherence to the techniques demonstrated in the video.

We agree with Terentes-Printzios et al. that measuring blood pressure in patients who are in the standing position may identify persons with an orthostatic fall in blood pressure. Such a measurement would be particularly appropriate in patients with clinical conditions or risk factors that predispose them to orthostatic hypotension. Dudeja and Dudeja note that measuring blood pressure in both arms at an initial visit helps to uncover large differences in blood pressure between the arms. This finding may justify the preferential use of one arm (the one with the higher reading) for future blood-pressure measurements. We agree that this step may be appropriate. However, it is unclear whether blood-pressure differences between the arms are reproducible over time or whether they indicate intrinsic intraindividual variations in blood pressure.

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Developing Unbiased Diagnostic and Treatment Guidelines in Psychiatry

TO THE EDITOR: In 1984, the *Journal* was one of the first medical journals to establish a policy requiring disclosure of financial interests for all authors of research articles. During the past 25 years, all medical specialties have been grappling with how best to manage conflicts of interest. Today, the field of psychiatry is perceived to have suffered a unique "crisis of credibility" with respect to the

growing influence of pharmaceutical companies on organized psychiatry.¹

The reaction of the organization that is increasingly in question, the American Psychiatric Association (APA), has ranged from calling for greater transparency — mandating that all members of task forces that produce its diagnostic guidelines (i.e., the *Diagnostic and Statistical Manual of Mental*

Disorders [DSM]) complete financial-disclosure statements — to labeling critics' concerns about conflicts of interest as a "well documented anti-medication bias."² However, it is clear that transparency alone is not enough of a safeguard: approximately 68% of the members of the DSM-V task force reported having industry ties, which represents a relative increase of 20% over the proportion of DSM-IV task-force members with such ties. Also, of the 137 DSM-V panel members who have posted disclosure statements, 77 (56%) have reported having industry ties, such as holding stock in pharmaceutical companies, serving as consultants to industry, or serving on company boards³ — no improvement over the 56% of DSM-IV members who were found to have such industry relationships.⁴ If financial conflicts of interest are not reduced, private-sponsor bias in research will be exacerbated.

Moreover, both disclosure requirements and specific policies about the management of existing conflicts of interest are missing in the APA's clinical practice guidelines. This is an especially important omission because these guidelines are seen by many as the standard for evidence-based medicine in clinical psychiatry. The APA is in the process of revising both its diagnostic guidelines and some of its most influential clinical practice guidelines (e.g., for bipolar disorder and major depressive disorder). Thus, it would be both timely and prudent for the APA to take this opportunity to address the gaps in existing policies regarding transparency and the management of conflicts of interest. For example, unrestricted research grants were excluded from disclosure require-

ments, and currently, there are no policies for managing indirect financial ties, such as industry funds that are pooled and given to academic departments, hospitals, and medical schools. To strengthen its current conflict-of-interest policy and monitor the process for the development of unbiased diagnostic and treatment guidelines, the APA will need to substantially free itself from its extensive financial ties to pharmaceutical companies.

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Dr. Bursztajn reports serving as a consultant to physicians and institutions seeking to craft conflict-of-interest policies and providing expert legal advice to both plaintiffs and defendants in cases involving product liability and the determination of competency to consent to neuropsychopharmaceutical treatment. No other potential conflict of interest relevant to this letter was reported.

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