June 3, 1971

Dr. Nanette Wenger
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Dear Nanette and Sam:

I am impressed with the completion of a very clear tabular material and abstract on the MI Care survey and will be happy to review your detailed text. The data are useful. As soon as you have it accepted for publication it might be worthwhile for efforts here to write an editorial on it, or abstract it for a European publication. Do you agree? Please let me know.

I wonder whether we might not consider looking at and labelling the .05 probability differences as well as the .01?

The abstract and the text might also give an indication of the proportion of each professional group, and of all U.S. doctors actually sampled. For example, this would give one of the better estimates available of AMI incidence if the 70,000 patients could be multiplied by the sampling factor.

"In the previous year" would be more accurate than "in the past year."

I recalled the earlier mean duration as 22 days.

I realize you cannot include everything in an abstract, but I would like to have mentioned diet fat restriction.

The sentence on chest pain and arrhythmias is ambiguous and I suggest you break it down.

I would say "highly significant differences (L01)" according to the type of practice were found to include:

The abbreviation ICU is not defined in the abstract, and is only used once--suggest the full term.

Prefer non-metropolitan than metro lingo.

". . . identifies areas of emphasis for physician education programs." It provides useful and properly sampled data on present practice in AMI in the USA.

I would suggest some sort of analysis to determine how biased are the responses, a phone interview with non-respondents? a comparison of first vs. second mailing responses, etc.

Table 6: Monitoring misppelled.

Table 7: What facility? put ICU.

Table 8: I don't know what might be called a progressive care facility and it must be defined either in text or in the legend. The same for progressive PA program.

I don't see any special reason to put the number of omitted responses on every table. The different totals can be explained once in the text.

Tables which do not add up to 100% should be explained (eg 16).

I question the validity of responses to the Table 17 question. Who would say he gave no advice, even if he didn't?

The abstract and text should indicate the percent of questionnaire response of each specialty group.

The porportion of physicians handling zero cases should be given and consideration made to excluding their other responses if they handled no case that year.

The range and distribution of responses is of great interest for some items of the continuous sort, such as the duration of hospitalization in days.

I am a little concerned now with the use of the term "mild." We should report just what we asked them, but I would prefer the term, usual uncomplicated cases I would hesitate to call a case with a very large infarction, with unknown eventual recovery, as "mild," even though he had an uneventful, uncomplicated course.

Many thanks,

Henry Blackburn, M.D.

HB/rs
Dictated from Geneva

c.c. Sam Castranova
H. Hellerstein