ADMap - Kottke

Mayo Clinic

Rochester, Minnesota 55905 Telephone 507 284-2511

Department of Health Sciences Research
Section of Clinical Epidemiology

March 11, 1988

Reply to Jaffe done

Henry Blackburn, M.D.
Professor and Chairman
Division of Epidemiology
School of Public Health
University of Minnesota
611 Beacon Street S.E.
Minneapolis, Minnesota 55455

Dear Henry:

I have two additional favors to ask of your. I would ask you to respond to the Academic Credentials Committee of Mayo when they write to you about giving me academic rank. The letter that you sent to the Clinic when they were considering hiring me would be perfectly appropriate if you just changed the words in the right place from hiring to academic status.

The second would be to write a letter to Fred Heydrick, Ph.D., Chief, Clinical Trials and Training Review Section, Westwood Building, Room 548, Bethesda, Maryland 20892. I am going to submit a preventive cardiology academic award on behalf of the Mayo Clinic. Your letter should arrive at NHLBI before April 1.

We will have the standard introduction to the concept of risk factors in the medical school but the major thrust of our effort will be to integrate preventive cardiology into the mainstream of clinical practice here at Mayo. For example, I have proposed that any patient who is admitted to the cardiovascular service in the hospital and has used tobacco in the previous two months automatically receive a smoking cessation consultation. Mayo has effectively used medical protocols to increase the efficiency of care and decrease the cost of care. Therefore, the concept is not unknown here and there is a nidus of support for this type of practice. The overwhelming problem with preventive cardiology is that it is of low acuity but eventually the risk factors kill the patient. It is constantly being juxtaposed to problems of high acuity but little overall impact to the patient. Unfortunately, physicians focus on the acuity of a problem rather than the overall impact on the patient's life. Patients do the same. Therefore, we need to have physicians make a decision at the board table that these problems will be treated and that we will not rely on the day to day activity of the physician to initiate treatment.

Jerry Gau, Bruce Kottke, Bob Frye and others have been extremely supportive with my efforts down here, much of this being due to your long friendship and interaction with the clinicians at Mayo. Plans are going ahead for a freestanding health promotion center. I think that over the next five to ten years we have a true opportunity to develop a model that implies that the physician just does not sleep as well at night if he or she has not offered treatment for cardiovascular disease risk factors.

Thanks once again for your ongoing, continued, and unfaultering support. It has been most valuable and appreciated.

Yours truly,

Thomas E. Kottke, M.D.
Senior Associate Consultant

TEK: kme

corresp- Kottke

UNIVERSITY OF MINNESOTA
TWIN CITIES

Division of Epidemiology
School of Public Health
Stadium Gate 27
611 Beacon Street S.E.
Minneapolis, Minnesota 55455
(612) 624-5400

September 7, 1988

918 NW

Dr Tom Kottke
200 First Street NW
Rochester, MN 55905

Dear Tom:

Thanks for your 20th of June letter that I've been carrying around on travels. It looks like it will be a while before I get around to putting my ideas down on the benefit/cost effectiveness issue. I would like to have you start on it if you would like to, since your primary interest appears to be at the level of the individual consequences.

I would explore how the econonmic models are inadequate in dealing with the "macrosocial" implications. I think they're way off base there, as you think they're off base in terms of the value of the individual. Between us we should stimulate some discussion.

My criticism will also go toward the inadequacy of their concepts and models to assess the social benefit and the cost savings of preventive strategies that operate across the full age range and life span and that interact to reduce or augmentdisease rates. And, of course, if we remain with the simplistic ideas that people are socially and economically unproductive after age 65, we make it impossible to move forward with more rational models.

Since I am no expert I would be orienting my comments in the form of questions. How can we do better to model and predict and to measure cost benefit and cost effectiveness, etc?

Thanks for your tip on Mary Ann Pentz. I agree she's impressive. We've just closed our search for a "senior behavioral scientist". We're now thinking now in terms of a second position in cancer epidemiology and a second position in infectious disease to bolster our very promising beginnings there.

Cordially,

Henry Blackburn, MD
Professor and Director

/tmw