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September 14, 1993

TO: Al Oberman

FROM: Henry Blackburn HB (by)

RE: Executive Summary 9/13

The Introduction/Preamble is really beginning to get chopped up now since it has been composed by so many people. I have made even more new suggestions.

I am not particularly happy with the use of the terms "population-based" and "community-based" "approaches". We usually use those terms in referring to sampling of some sort. For the strategies we are talking about are the public health and broader strategies (of the WHO policy on prevention, etc.), the correct terms, I believe, are "population approach" and "community approach" and/or "public health approach". Population-based is true, of course, but I believe it has a more familiar and limited connotation: a strict sample of a community.

I am a bit surprised to see the term "case finding or clinical approach" which I don't believe was either mine or Jerry's. We have always referred this to the "high risk, medical approach". Case-finding connotes a public health screening activity and I don't think we are referring to that, but rather identification of high risk people and their management in the medical system. I always thought "high risk medical approach" or strategy covered that adequately, and would like to hear justifications for entering this new term "case-finding, clinical approach". Thanks.

The concept of "prevalence of risk factors" continues to enter into our writing. I had hoped I had made a convincing argument that we not speak of prevalence of risk factors which suggests there is such a thing as an absence of risk factors, but rather to deal with elevated risk factors, etc. in a continuum of risk.

I really don't understand in the long first paragraph prevention itself being viewed as a "continuum or a series of stages" and that the greatest impact (import?) on health occurs at "the initial stage". Disease occurs in a series of stages and prevention may be viewed as acting on a continuum of disease stages and the greater benefit may be obtained at earlier stages, though this is debatable, depending on the economic model versus the social one. The term which people have thrown out from time to time is "prevention of elevated risk factors, in the first place". I can't fight against use of elevated risk factors "themselves" as in the current draft.

The Introduction is now unrecognizable as being from my or your hand or Jerry's hand. I think we must avoid such hyperbole as "tremendous strides". I guess I prefer, except for the few edits I am proposing in the draft faxed you 9/13, that we leave these issues to our excellent editor to try to make all this flow a little better.

I am comfortable with saying that "patients are often inadequately treated to reduce risk factors or prevent future events". I am <u>not</u> comfortable saying that "patients are often not given" drugs that would reduce these events. But I seem to be bogging down and I think we should leave the next draft to our editor and then see how we like the penultimate draft.

I have found a couple of clear redundancies in your excellent list of 5-year accomplishments and have sought to edit some of the narrative.