Response to “Let’s Break Down the Barriers”

To the Editor:

We read with interest the letter from Ebell et al suggesting that the Society of Teachers of Family Medicine (STFM), the North American Primary Care Research Group (NAPCRG), and the American Academy of Family Physicians (AAFP) explore greater integration or merger of our organizations. The consolidation of some or all of our family medicine organizations has been suggested in the past, and various attempts to have our organizations better coordinate their activities have had varying degrees of success.

Over the past 5 years the four academic family medicine organizations—STFM, NAPCRG, the Association of Family Medicine Residency Directors (AFMRD), and the Association of Departments of Family Medicine (ADFM)—have worked toward a higher level of collaboration and coordination by forming the Council of Academic Family Medicine (CAFM), with liaisons from the AAFP and the American Board of Family Medicine. CAFM has enabled our organizations to be more nimble in our advocacy efforts, dealing with the rapidly changing landscape of health care reform and health manpower issues. CAFM has also had ongoing discussions regarding further consolidation of our organizations, but multiple barriers exist, reflecting in particular the differing cultures, structures, and perceived needs of our various memberships.

However, CAFM is committed to continuing to work to improve the coordination and, as possible, integration of the efforts of our organizations going forward. How this effort will evolve is difficult to predict, but during this period of change and opportunity, it is certain that our family medicine organizations must work together as a team for our patients, our communities, and our discipline.

Examples of the types of projects that CAFM task groups have been able to tackle include the development of a standardized curriculum for family medicine student clerkships, the development of joint recommendations for residency training guidelines for obstetrical care, and an examination of the important role of integrated mental and behavioral health care in the Patient-centered Medical Home. See Web site at http://www.academicfamilymedicine.org/. CAFM has also enabled our organizations to be more nimble in our advocacy efforts, dealing with the rapidly changing landscape of health care reform and health manpower issues. CAFM has also had ongoing discussions regarding further consolidation of our organizations, but multiple barriers exist, reflecting in particular the differing cultures, structures, and perceived needs of our various memberships.

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From the STFM Executive Committee:
W. Perry Dickinson, MD, President
Jeri Hepworth, PhD, President-Elect
Terrence Seyer, MD, Immediate Past-President
Richard Streiffer, MD, Secretary-Treasurer
Deborah Taylor, PhD, Senior Member-at-Large
Stacy Brungardt, CAE, Executive Director
CHC management rather than a true lack of leadership.

Certainly, medical schools and residencies need integrated education on the function, structure, management, and community health role of CHCs, with more practical exposure to CHCs. Some resources already exist to promote physician management of CHCs: fellowships (such as Georgetown’s Fellowship in Community Health Center Director Development), Primary Care Association (PCA) education and conferences (supported by the National Association of Community Health Centers [NACHC] and the Health Resources Services Administration (HRSA) and Area Health Education Center (AHEC) programs. These educational opportunities may be undersubscribed by physicians, leading to the perceived lack of support described by Markuns et al. Greater collaboration among physician training programs and CHCs is necessary to improve physician leadership in CHCs and maximize the potential of the CHC system.

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References
3. www.teachinghealthcenter.org/

Pharmaceutical Advertisements, Citations, and Trust

To the Editor:
The following letter to the editor regarding a pharmaceutical advertisement was submitted April 21, 2010, for publication in a respected American medical journal, the same journal that published the advertisement:

Recently I came across an advertisement for Aleve brand of naproxen that appeared in your journal.1 One of the claims made in the ad was this: “Ibuprofen may decrease the antiplatelet benefit of aspirin; ALEVE doesn’t impact the antiplatelet benefit in patients taking low-dose aspirin, according to a pharmacodynamic study.”

Now, if true, this could influence a lot of prescribing decisions. The reference cited for ibuprofen is Advil Labeling by Wyeth Consumer Healthcare, 2006. This assertion is further supported by a peer-reviewed study published in the New England Journal of Medicine that concludes: “Treatment with ibuprofen in patients with increased cardiovascular risk may limit the cardioprotective effects of aspirin.”2 No disagreement here.

However, my curiosity was aroused by the claim that naproxen was exempt from this interaction. To support ALEVE’s superiority, the ad offers one study, cited as Abstract 858, Arthritis Rheum 2007;56(9 suppl):s359. I sought to read this publication. I searched my usual handy sites: PubMed, Google Scholar, and our university’s library Web site. No luck.

I did, however, come across an editorial about coxibs written by the lead author, and here I learned of consultancies with Bayer, Merck, Novartis, Pfizer, and Sanofi.3 I went to the Web site listed on the ad: the Naproxen Clinical Data Center.4 Here I found a list of 12 publications relevant to naproxen. Among them was an article by Capone et al, which concludes: “Naproxen interfered with the inhibitory effect of aspirin on platelet COX-1 activity and function. This pharmacodynamic interaction might undermine the sustained inhibition of platelet COX-1 that is necessary for aspirin’s cardioprotective effects.”5 Interesting. Does this conclusion not contradict the claim in the ad?

Not listed on the Naproxen Clinical Data Center is a 2008 paper by Gladding et al that states: “In conclusion, ibuprofen, indomethacin, naproxen, and tiaprofenic acid all block the antiplatelet effect of aspirin.”6

Finally, near the end of the list of 12 citations, I found the elusive “Abstract 858.” Actually, it was a poster, presented at a 2007 meeting of the American College of Rheumatology.7 The authors of the poster reveal consultant and research support by Bayer (who makes ALEVE) and others. I was able to print out and study the poster, which concluded: “In the present study OTC doses of naproxen sodium 220 mg tid as well as acetaminophen 1,000 mg qid did not interfere with the antiplatelet effect of EC-ASA.”

Is a potentially practice-changing generalization being made from a study involving only 37 subjects and using low doses of naproxen? I wonder why a full report of this study does not seem to have been published. Can we really trust the assertion made in the advertisement that ALEVE doesn’t impact the antiplatelet benefit in patients taking low-dose aspirin?

Shouldn’t “ethical” drug manufacturers be presenting ads with credibility that stand up to a quick citation check? And what about the responsibility of medical journals that carry these ads and thereby lend some legitimacy? Do we need a citation checker for ads submitted to medical journals? And what is the role of the US Food and Drug Administration (FDA) in all of this?

On May 28, 2010, I received a rejection notice regarding my letter.

In June 2010, a report of this trial was finally published.8 The authors note the small sample size and open-label trial design as limitations. I still wonder if this small study justifies the claim in the ad,