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dissemination and use in practice presents a dilemma to all health practitioners. Some of the sources that physicians indicate they use routinely for drug information such as company representatives and journals may cut down on lag time but limitations exist. Representatives provide only FDA approved information and the emphasis is on their company's products. Journals are useful sources for new studies or information on new products but may be inefficient for retrieving unless some kind of filing system is maintained.

The practitioner should consider selection of some sources which provide quick, concise, unbiased evaluations of new drugs and information on changes in drug use. Two established examples are the *FDA Drug Bulletin* and *The Medical Letter*. The practitioner can also identify resources available in the particular location such as the availability of medical library services, drug information and poison centers. Such services can be valuable when the immediately available resources do not solve the problem and a quick answer is needed. It is wise to evaluate the capability of such services before their use is needed.

The general family practitioner needs to be aware of other drug information resources besides the PDR. Such resources might

include selection of other drug information references which are updated more frequently and provide information beyond the package insert. Support services such as drug information centers are probably available to many physicians but are not utilized because the benefits of such services remain unrecognized. In assessing information needs, the area of drug information should be evaluated separately. Physicians should make a conscious effort to develop an awareness of available resources and select those that best meet their individual needs.

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## Practical Aspects of Presenting Information to Practicing Physicians

Charles H. Pierce, M.D., Ph.D., F.C.P.

**T**HE American College of Clinical Pharmacology has been committed to educational goals since its inception. Most of this commitment has been directed to the un-

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dergraduate and graduate levels of medical and pharmacy education. Thus students, interns, and residents have benefitted from the expertise of those who consider themselves clinical pharmacologists. This turn of events is expected since most of the activity and advances in our knowledge about drugs occurs in the setting of academe or, at

least, is aired at professional scientific meetings. It is now clear that clinical pharmacologists play a very important role in education at the undergraduate and graduate levels. It is less clear what role clinical pharmacologists play at the post-graduate level.

The influence of clinical pharmacology and clinical pharmacy on the practicing physician is potentially tremendous if only because of numbers. Practicing physicians represent a vast sea when compared to the small pool of undergraduates and recent graduates. Tremendous also because the use of drugs, in general, by the practitioner reflects a real need for assistance. The continuing medical education needs of these physicians is underlined by the explosive increase in CME accredited institutions from 1970 to 1980 (from 72 to 2,026).<sup>1</sup> Despite this increase in the course offerings many physicians find many of them a waste of time and give as a primary reason that they are read to.<sup>2</sup>

One way for clinical pharmacology to exert a positive influence upon the way drugs are used is to become active in the continuing medical education movement by either inserting ourselves in programs or by organizing our own. However we go about it, the important point is to promote rational therapeutics based upon sound basic principles but to do it in a way that is eminently practical and useful. This last point needs emphasizing as it is one thing to present information and data to one's peers but quite a different matter to present the same basic information and same conclusions to a group of family physicians. It is clear that the difference is not the level but rather how practical and useful is the information. Failure at this point has been seen as one of the major problems facing continuing medical education today.<sup>3</sup>

Most CME courses are sponsored by academic institutions wherein the criterion for advancement is "scholarly productivity," as measured by publication in "referred journals and books". Only rarely is one's

teaching ability part of the promotion process. CME courses must in part account for differences among physicians with regard to the means by which the more knowledgeable clinicians acquire information. Courses offering a variety of means such as lectures, panel discussion, case presentations, group workshops, audiovisual material and even individual instructing will probably have a greater impact than any one of these approaches alone.

The most successful presentations to general practitioners will be those which assist him in interpreting that which he is reading at the scientific level so that he may use this information to solve clinical problems. The practicing physician is keen to keep up with all of the advances but often lacks the background to understand the abbreviations and jargon the "scientist" uses as he explains a mechanism of action or the latest research data. If the presenter will keep in mind that the last physiology, biochemistry or pharmacology course that his audience may have had was five, ten or even 20 years ago he will think twice before spending half of his time on structural formulas or metabolic pathways.

There are some general points about presentations to practicing physicians which might be kept in mind:

1. Short, to-the-point talks which are orientated to patient problems with practical and useful information will be appreciated far more than even the most scholarly lecture reviewing everyone's data.
2. Talks should be well organized as the points flow logically. This will help you stay well within the time given and help you to drop irrelevant information.
3. Slides should be kept simple and readable and in an appropriate number for the length of the talk. If the slides are complex and cannot be easily read from the back of the room the speaker will immediately lose the audience. Data slides should be in the minority.

4. To read a paper to an audience of general physicians represents passive learning at its worst. A paper read is usually resented.<sup>2</sup>

5. Transmitting information by lecture fosters to passive learning. A good presentation coupled with reinforcing material in the form of a handout is considered the most effective way to present information. Time should be taken to write out the essence of a talk beforehand perhaps making the points differently, and including copies of most of the slides. Remember, a syllabus is not an

outline and does not contain the statements "... will be presented" or "... will be discussed."

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## What the Practicing Family Physician Needs

William J. Kane, M.D.

**T**HIS paper will discuss the needs of the practicing family physician with regard to pharmacotherapeutics. I am assuming that my comments may be applied not only to the family physician but also to the general internist and the general pediatrician. In preparing this paper, I was forced to face the reality that what I believe the family physician needs may be very different from what the family physician really wants and will accept. I prepared this paper as a family physician who is a graduate of a family medicine residency program, has practiced in a small community for 20 months, and has been the director of a family medicine residency program for the past six years. For several years I have been concerned about the medical profession's willingness to utilize new drugs and treatments which add little to already established regimens. I have recently also come to appreciate the extensive informa-

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tion available in the area of pharmacotherapeutics and have had the good fortune for the past two years of working closely with faculty qualified in this area.

I congratulate the American College of Clinical Pharmacology for this symposium and other efforts which are aimed at improving the skills of the practicing physician. The importance and scope of ambulatory care makes such efforts mandatory. Most of your time and effort is devoted to activities in our medical centers. As you move more toward specialization in pharmacology, it is impressive to remember that it is in the ambulatory area where most prescriptions are written, where most people are seen, most drug cost incurred, and where the most potential for harmful side effects exists. I hope that you will not be caught in the isolation of much of academe but will increase your efforts to become aware of the needs of the practicing family physician. I believe the role of the clinical pharmacologist and the Pharm. D. must be expanded, and brought into the community