AMWA

Indiana Chapter Newsletter

May 2017

American Medical Writers Association Indiana Chapter

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Coming Attractions

November 1-4, 2017
AMWA Medical Writing & Communication Conference
Walt Disney World Swan and Dolphin Resort
Lake Buena Vista, FL 32830

Links

AMWA

AMWA LinkedIn AMWA Twitter AMWA Facebook

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Global English Blog

Health Care Brand Journalism Blog

WilliamsTown Communication Blog

Please let us hear your voice!

Let us know if there is anything we can do to help you benefit professionally from your AMWA membership. Volunteering to help our chapter or national association is a great way to have fun while meeting some wonderful people, improving yourself and the profession, and becoming and being the leader you were meant to be. Join our LinkedIn group, come to the chapter events, or click on the name of a chapter officer or committee chair above to join the conversation about medical communication and our chapter.

Contents

Find updates to chapter and community events on our Web site

Cover

Find AMWA members near you by searching the AMWA member directory by city.
This map of the locations of our 80 chapter members was created with BatchGeo.

A Brief Look at the History of Health Literacy

Helen Osborne, MEd, OTR/L (helen@healthliteracy.com)

It's wonderful to see so much interest in health literacy these days. This is a dramatic shift from when I started doing this work more than 20 years ago. Then few had ever heard the term "health literacy," much less knew what to do about it. Now clinicians, public health specialists, health educators, medical writers, researchers, librarians, policy makers, community leaders, and many others worldwide are working hard to help patients and the public better understand health information.

Curious about when health literacy started and how it's grown over the years, I posted a query on the *Health Literacy Discussion List*. Here is a brief look at just that, with information from the online discussion along with my own recollection. Done with the intention to be succinct, all errors and omissions are mine.

1974. The first mention of the term "health literacy" was in a monograph by SK Simonds, *Health Education as Social Policy*, published the next year in Proceedings of the Will Rogers Conference on Health Education. Health literacy is framed within the context of social policy.

1980s. Leonard and Cecilia Doak (whom many consider the founders of health literacy as we know it today) studied the reading skills of hospitalized patients. The Doaks, along with Jane Root, co-authored the landmark book, *Teaching Patients with Low Literacy Skills*, first published in 1985. Listen to a Health Literacy Out Loud (HLOL) podcast interview with the Doaks, *Len & Ceci Doak Discuss Health Literacy's Past, Present, and Future (HLOL #13)*.

Many consider Leonard and Cecilia Doake to be the founders of health literacy

Early 1990s. Inspired by the work of Dr. Harold Freeman (then, President of the American Cancer Society), Wendy Mettger and others at the National Cancer Institute and the AMC Cancer Research Center created the National Work Group on Cancer and

Literacy. This brought together experts from diverse fields--many who still research, practice, teach, and continue as health literacy leaders today.

Mid 1990s. Others got involved in health literacy issues and initiatives. They not only included physicians and other clinicians but also literacy practitioners, teachers, researchers, health communicators, patient educators, medical librarians, disability professionals, and social justice and environmental activists. The lay public, including new readers (adults learning to read) also became active in health literacy.

Late 1990s. Health literacy gained worldwide attention. Leaders included Irving Groopman and Linda Shohet of Canada, Donald Nutbeam of Australia, and Ilona Kickbush of Germany. Health Literacy Month, a worldwide awareness-raising event, was started by Helen Osborne in 1999. Learn more here.

Early 2000s. Interest in health literacy quickly grows, thanks in part to the Institute of Medicine's 2004 report, *Health Literacy: A Prescription to End Confusion*. The American Medical Association Foundation also championed health literacy and created an educational toolkit with the powerful video, "You Can't Tell by Looking." Around this time, the pharmaceutical company Pfizer got involved. One of their efforts was hosting an annual conference. As I recall they combined the terms "health" and "literacy" to describe the field we know today.

Around 2010. Dr. Howard Koh (then Undersecretary of US Health and Human Services Department) said health literacy reached a "tipping point." He cited milestones including the *US Plain Language Writing Act*, HHS's *National Action Plan to Improve Health Literacy*, and the national ACA/Health Care Reform Act. Listen to the HLOL podcast, *Dr. Howard Koh, Assistant Secretary for HHS, Talks About Boosting Health Literacy to Move Beyond the Cycle of Costly Crisis Care (HLOL #77)*.

Health literacy reached a "tipping point" around 2010

Large-scale health literacy efforts are underway

2017, and beyond. Exciting, large-scale, health literacy efforts are underway. These include formation of the *International Health Literacy Association*, start of a *Journal of Health Literacy*, and efforts toward creating a health literacy certification program. There now are thousands of health literacy research articles, hundreds of health literacy programs, numerous health literacy coalitions, and too-many-to-count health literacy conferences, initiatives, and innovations taking place across US and around the world. I encourage medical writers to join in.

Helen Osborne is president of Health Literacy Consulting, founder of Health Literacy Month, and producer/host of the podcast series Health Literacy Out Loud. She is also the author of AMWA's award-winning book, Health Literacy from A to Z: Practical Ways to Communicate Your Health Message, Second Edition. Ms. Osborne is a long-time member of AMWA and its New England chapter.

Thinking About Taking the BELS Exam?

Nicola Parry, DVM, MSc,DipACVP, ELS
(nicola@parrymedicalwriting.com**)**

Ever thought about taking the Board of Editors in the Life Sciences (BELS) certifying exam? I'd like to share some of my thoughts and experiences about the exam.

If you're unfamiliar with BELS as an organization or want to learn more about its exam application process and what topics the exam tests, please visit their recently revamped website.

Why Take the BELS Exam?

Although everyone has their own reason for wanting to become BELS-certified, the BELS website outlines three objectives of their examination program:

To establish a standard of proficiency for editing in the life sciences;

To provide qualified manuscript editors in the life sciences a way to demonstrate their editorial proficiency; and

To provide employers and clients of manuscript editors in the life sciences a way to identify proficient editors

For me, it also provided a continuing education focus. Because I'm self-employed, I no longer receive annual performance evaluations. However, I do like to focus on "something" each year, whether it's continuing education- or business-related. Having some goals for the year certainly contributes to the feeling that I'm running a serious business.

Preparing for the BELS exam allowed me to revisit all those rules of writing, grammar, and punctuation that we, as writers and editors, use every day—mostly without even consciously thinking about them. My preparation helped to remind me of those rules and the reasoning behind them, and thus improve how I use them in my everyday work.

How and what should I study?

If you're thinking of taking the exam, the *Certification Study Guide* on the BELS website is an extremely helpful start. It stresses that your daily work as an editor is your best preparation. Having taken the exam, I definitely agree. I'm a veterinarian, so my science background also helped, especially with some of the random science-based questions on my exam.

The guide also details exactly what the exam aims to test, and lists a dozen or so reference books you might find helpful as you prepare for the exam. But, you don't have to read them all to pass the exam. In fact, although I've acquired many of these books since taking the exam, the only one I had at the time was the *AMA Manual of Style: A Guide for Authors and Editors*. I found this great to use as a focus for my studying—especially Section 2 (Style), which

The *Certification Study Guide* is an extremely helpful start

covers topics including grammar, punctuation, plurals, capitalization, correct and preferred usage, and non-English words.

Some other materials I found most helpful as I prepared for the BELS exam were my *AMWA Essential Skills Workbooks*. I'd previously earned the certificate, so I dragged out my workbooks, re-read them, and re-read them again. The workbooks on basic grammar, punctuation, and sentence structure were especially useful.

The BELS study guide also includes 22 sample exam questions, and these are very representative of what you'll find on the exam. Some are "short and sweet"—maybe just asking you to define a scientific term. However, others require you to evaluate a paragraph of text and answer multiple questions about it.

Other sources of exam-style questions that you might find useful as you prepare for the exam:

Style quizzes on the *AMA Manual of Style* website

Quizzes on *AMA Style Insider*, the official blog of the *AMA Manual of Style*

Quizzes in the *AMWA Essential Skills Workbooks*:

End-of-chapter quizzes in each workbook (answers provided in the books)

The final quiz you need to complete and submit for the certificate (answers unknown)

The worst bit was making sure I worked through the test at the right speed

What's it like taking the exam?

If you're like me, it's been many years since you had to sit at a desk for a few hours under examination conditions. That was taxing enough. However, for me, the worst bit was making sure I worked through the test booklet at just the right speed. Because the

questions range in structure and length, you can fly through the brief ones. However, the longer, paragraph-based questions slow you down. I still remember one set of questions based on a paragraph of text about 15-20 lines long. I must've read that text at least 3 times before my brain processed any of it! My tactic was to skip over questions if I found myself obsessively dwelling on them. I hate leaving things unanswered, but I found this to be the best way to manage the time during the exam. I knew that excessive dwelling on one question would just increase the odds of me not finishing the exam. So, I just skipped over several and went back to them at the end.

The exam contains some questions on publishing ethics

For many questions, it was easy to eliminate two potential answer choices, but then tougher to choose which of the remaining two was "most correct"—especially under the time pressure.

The exam contains some questions on publishing ethics. I remember they raised issues of things such as copyright, patient involvement in human clinical trials, and sharing of unpublished work between editors.

Although I don't recall ever having read about some of the specific issues raised in the questions on my test, because of my experience writing and editing scientific manuscripts and my 13 years working in research and academia, I could answer some of these questions using a "common knowledge" approach. For others, I could make an educated guess. In general, though, Section 1 (Preparing an Article for Publication) in the AMA Manual of Style is helpful as a source of information to help you tackle these types of questions.

Although the exam doesn't set out to test your mathematical skills, you will come across questions that require you to double-check some basic calculations, just as you might do in someone's scientific manuscript. Although you should be able to work through the calculations without a calculator, most people prefer to use one for speed and accuracy.

I recommend taking along your own calculator. The proctors will have some for you to borrow, but maybe not enough for every candidate, depending on the number of candidates. So, you may have to wait your turn to use one, and that could be frustrating if you're strapped for time and the minutes are ticking by. You won't be able to use your smartphone's calculator, either—I bought myself a $10 old-school calculator (just a basic one) from Staples for the occasion.

The exam contains questions about statistics—for example, about definitions of statistical terms, and what statistical measures best estimate central tendency under different circumstances.

The exam contains questions about statistics and data presentation

It also contains questions about data presentation. These might include how best to represent different types and amounts of data; why certain tables are better than others in some circumstances; terminology that applies to tables ("stub", etc.); and how you'd arrange data in a table according to what data are most important; etc.

Even though the exam also doesn't aim to specifically test your scientific or medical knowledge, if you have a science or medical background, it will serve you well. And my exam did contain a few short questions that required scientific knowledge to correctly answer them. One required me to select the correct definition of "pH"; others required me to select a unit of measure that was most like another unit (such as the gray and the pascal).

People often ask whether the exam is hard. Having thought about this for a while, I think "hard" might just be the wrong adjective to use. If you're accustomed to editing, and you know your rules of grammar, etc, I doubt you'll find the actual exam material difficult, especially if you have a science background.

But, as with any exam, it's the time crunch that can be toughest to conquer. I remember sitting at home one Sunday morning, enjoying my coffee while working through the 22 sample questions in the BELS Study Guide. No problem! And I

didn't feel rushed. However, teleport yourself to your real exam, and all bets are off!

The exam itself lasts 2 hours and 45 minutes and consists of about 100 multiple choice questions (the exact number varies with each test). The pass mark is 65%. However, the marks allocated to different questions are weighted differently, so there's no specific number of questions you need to answer correctly to be sure of passing.

I emerged from the exam having no clue as to whether I'd passed it. I've come across some folk who've said they came out feeling sure they'd passed, but since the questions are weighted differently, it's difficult to know how you've done. Maybe if you finish with plenty of time to spare, you can flick back through your answers to gain a sense of how many you feel sure are correct. I remember having only about 7 minutes to spare, though, which wasn't nearly enough time for me to check through the entire exam again. Don't forget, too, that the exam is different each time. Just because someone of similar ability to you said they finished with 30 minutes to spare, don't expect your experience to be the same if you decide to take the exam.

The exam lasts 2 hours and 45 minutes and consists of about 100 multiple choice questions

Final thoughts

I think BELS does a great job of putting together the certification exam. Even though the exam involves only multiple choice questions, it uses paragraphs of text in a very constructive manner that allows for testing of a candidate's editing competence and performance.

The AMWA annual meeting typically hosts one or two BELS exam-related roundtables, so keep an eye out for them if the moons align in such a way that you're pondering the exam at around the same time the meeting takes place. In particular, Leslie Neistadt (BELS Registrar) usually hosts, So, You're Going to Take the BELS Exam... I attended this one & found it useful. Leslie is very helpful and is happy to discuss the exam procedure in depth.

If you're used to editing scientific or medical manuscripts, you'll be an ideal candidate

Overall, though, I'll stress again that if you're used to editing scientific or medical manuscripts, you'll be an ideal candidate for the exam, and it won't surprise you. You don't have to have a scientific or medical background to succeed, either—I know plenty of medical writers and editors without any scientific or medical background who are BELS-certified. However, if you have worked as a scientist or clinician, that can only go in your favor.

So, I hope this inspires some of you to consider taking the BELS exam! In addition to adding to your credibility as an editor, BELS certification also allows you to become a member of the organization and to network with other fellow editors. BELS members can also serve as volunteers for the organization and this is something I enjoy doing.

I encourage you to check out the BELS website, especially if you're thinking of taking the exam. If you're already BELS-certified, please encourage your editor friends and colleagues to also consider pursuing certification; or, if you have some time to spare, why not think about volunteering for the organization?

Nicola Parry is a veterinary pathologist and freelance medical writer in Lafayette, IN.

A Primary Care Physician's Look at Attention-Deficit/Hyperactivity Disorder

Christina Santangelo, MD (csanta1219@gmail.com)

One of my biggest challenges as a general pediatrician is to build and lead teams. I didn't learn that skill in medical school. But I

can't accurately diagnose, evaluate, and treat some common diseases without it.

Consider attention-deficit/hyperactivity disorder (ADHD). Diagnosis and treatment of most cases is not straightforward. Left untreated, this common, chronic, and incurable neuropsychiatric disease robs an afflicted child of self-esteem, healthy relationships, and ability to perform well in school. It disrupts the child's family and can harm the child's future adult life.

Guidelines for the primary care physician from the American Academy of Pediatrics (AAP) help. They recommend using the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th edition*) to diagnose ADHD. Of 9 symptoms listed for both inattention and hyperactivity, a child diagnosed as having ADHD must have 6 symptoms that interfere significantly with the child's quality of life for about 6 months, observed in at least 2 environments. Behavioral therapy is typically the first line of treatment for both preschool- and elementary school-age children. If moderate to severe impairment persists, the child is treated with an FDA-approved stimulant.

But those guidelines are not enough. My time with a child is limited to a series of 15-minute monthly office visits. In addition to my own observations, I need the eyes, ears, and hands of the child's parents, teachers, and (often) psychologist. An important part of my job is to help this team understand the child, each other, and how to help the child.

To do that, I have to know my team. In filling out a child's history or DSM 5 checklist, some parents and teachers know how to properly evaluate a child with ADHD and know appropriate age-specific behaviors, others do not. I standardize my team's reports of a child's behavior by trying to account for cultural, educational, and socioeconomic influences that can lead to differences in perception. Doing so helps me distinguish affliction by ADHD from affliction by other psychiatric (eg, severe anxiety), medical, or social conditions that mimic ADHD.

One of my biggest challenges is to build and lead teams

Guidelines for the primary care physician recommend using the DSM-5 to diagnose ADHD

I need to educate my team

I also need to educate my team, sometimes outside of office hours, on how to help the child. I might help a school develop an individualized education plan (a written document developed for a child receiving special education) for a patient or I might observe and assess the quality of behavioral therapy given in the home or school. I explain to busy parents of a child needing a stimulant that it can take months to find the optimum dose that minimizes side effects and maximizes efficacy. During that time of dose titration, I help the child's parents and teachers adjust the child's behavioral therapy to match the child's changing behavior.

Building and leading these teams is not easy. My reward is seeing the result of our efforts—children with a better chance of leading a happy life.

Dr. Santangelo is a board-certified pediatrician affiliated with Riley Hospital For Children in Indianapolis.

An Introduction to Epidemiological Terms

Tammie L. Nelson, MPH, CPH (TNelson@MarionHealth.org)

Epidemiologists study the cause, effect, distribution, pattern, and control of population health and disease. Many specialized terms are used and sometimes misinterpreted. With that in mind, this article focuses on epidemiological terms most commonly encountered.

Surveillance & Investigation

Medical surveillance is the monitoring of a potentially exposed individual to detect disease early. Two related terms are often confused. **Quarantine** separates an individual or group from the

general population until it is known whether an infection has occurred. **Isolation** is a type of quarantine that separates those known to be infected from those not infected to prevent secondary transmission of disease.

Public health surveillance is systematic collection, analysis, and dissemination of public health data to maintain vital records and immunization history and to monitor patterns of injury and disease. One form of public health surveillance is **sentinel surveillance**, in which a network of pre-selected clinicians (i.e., emergency departments, primary care providers) agrees to test for, and report all diagnoses of, a specific notifiable condition. This is often used by public health agencies to identify severity and trends during flu season.

Injury or Disease

Infectious disease is caused by agents that replicate in their host and cause disease. The most common agents are bacteria, viruses, and fungi; however, protozoa and helminths (worms) are also considered infectious agents. **Communicable disease** is an infection that can pass from one person or animal to another. **Chronic disease** lasts at least three months (i.e., type 2 diabetes and obesity). The **incubation** (infectious disease) or **latency** (chronic disease) **period** of a disease is the time between exposure and disease onset when only subclinical changes occur.

Pathogenicity is a property of an infectious agent that determines the proportion of individuals that become ill following infection. Measures of pathogenicity include **attack rate** (the proportion of individuals infected among those exposed) and **secondary attack rate** (the proportion of individuals infected among those in contact with infected individuals during the incubation period).

Virulence is the proportion of individuals who become severely ill or die after becoming infected.

An **epidemic**, or **outbreak**, occurs when disease or injury occurs at a higher than expected rate in a given area. Use of the term varies by condition. A flu outbreak might not be declared until thousands are diagnosed; whereas, one small pox diagnosis is an outbreak. A **pandemic** is an epidemic affecting a large proportion of the population over a wide geographic area.

Active immunity is resistance to an infection developed in response to an antigen. This can follow vaccination against, or infection with, an infectious agent (e.g., measles). In comparison, **passive immunity** is acquired from an external source such as antibodies passed from mother to infant (transplacentally or in breast milk) or by administration of immune globulin.

Herd immunity is group resistance to an infection based on the proportion of group members resistant to infection. For instance, pertussis vaccination of a high proportion of residents helps to prevent outbreaks of the disease among those too young to be vaccinated.

Measures of Risk

Relative risk (RR) compares risk between groups. RR could be used to determine risk of HIV by gender. Often confused with RR, the **odds ratio (OR)** compares occurrence of injury or disease among groups in a sample of the population with known exposure status.

Incidence is the number of new diagnoses made during a set time in a population. Incidence is often reported as a rate of occurrences per 100,000 residents per year.

Prevalence is the number of individuals in a population who have a particular injury or disease at a specific point in time. Prevalence is often expressed in terms of the number of affected per 100,000 residents.

Morbidity is injury or disease in a population.

Mortality is death in a population. Mortality rates can be calculated for a specific injury or disease over a set time. One example would be the number of lung cancer deaths per 100,000 Indiana residents during 2016. Mortality is usually reported per 100,000 in adults and per 1,000 live births in infants.

Years of life lost (YLL) is a measure of years of life lost due to premature death in a population. It is calculated by summing differences between life expectancy and age of death of individuals who died earlier than expected due to injury or disease.

Years lost due to disability (YLD) is a measure of the impact of disability in a population. It is calculated by summing the number of years lived with a disability, weighted by specific injury or disease.

Disability-adjusted life year (DALY) is a measure of the overall burden of an injury or disease in a population in terms of years of healthy life lost. It is calculated as: YLL+YLD=DALY.

Conclusion

This article barely scratches the surface of the epidemiological vernacular. If you encounter a term that you need to understand better, you can look it up in the Centers for Disease Control and Prevention's epidemiological glossary.

Tammie Nelson is an epidemiologist and manages the Epidemiology Department at the Marion County Health Department in Indianapolis.

Report: 2017 AMWA Indiana Chapter Conference

David Caldwell, PhD (davidccaldwell@att.net)

Our chapter celebrated medical communication on April 21 & 22 with our annual conference in downtown Indianapolis. Thirty seven participants from 6 states (IL, IN, KY, MI, OH, WI) enhanced their careers with a full measure of education and networking.

Networking

We met old and new friends for a festive dinner on Friday evening at Tavern on South. Chapter members Ellen Stoltzfus, PhD (associate director of medical writing & scientific services, *JK Medical Communications*) and Laura Town (owner, *WilliamsTown Communications*) narrated their journeys to and through medical communication especially for those new to the field.

Conversations continued on Saturday over breakfast and lunch at the Columbia Club as members of different chapters learned from each other and exchanged ideas on how to improve our professional experience.

Esther Asplund (chapter president and owner of *Hoosier Medical Communication Services*) concluded the conference by leading our first annual chapter membership meeting. Esther summarized the state of our chapter and participants suggested insightful ways to refresh our chapter.

Esther Brooks-Asplund, PhD

Education

Participants learned more about our profession from true experts during five career enhancing open sessions briefly summarized here. Photos by William Pietrzak, PhD.

STATE OF HEALTHCARE AND LIFE SCIENCES IN INDIANA AND OPPORTUNITIES FOR MEDICAL COMMUNICATORS
Moderator: Esther Asplund, PhD (*Hoosier Medical Communication Services*)
Panelists: Brian Stemme, BS (*BioCrossroads*), Michael Church, MA (*inVentiv Health*), Karen Heraty, ELS (*Eli Lilly & Co.*), and Lisa Lenahan, BS (*Roche Diagnostics*)

Panelists (l to r): Karen Heraty, ELS; Lisa Lenahan, BS; Michael Church, MA; Brian Stemme, BS

Panelists described how the profession of medical communication fits into Indiana's life sciences industry, ranked among the top 5 in the United States by the Biotechnology Innovation Organization. The discussion included tips on what interviewers look for in a job candidate, a summary of which companies practice which kinds of medical communication, mention of Indiana's formal educational opportunities for medical communicators, and a list of ways medical communicators can network within Indiana's life sciences community.

CLINICAL EVALUATION REPORTS FOR THE MEDICAL DEVICE INDUSTRY: WHAT YOU NEED TO KNOW
William S. Pietrzak, PhD (*Musculoskeletal Publication & Analysis, Inc.*)

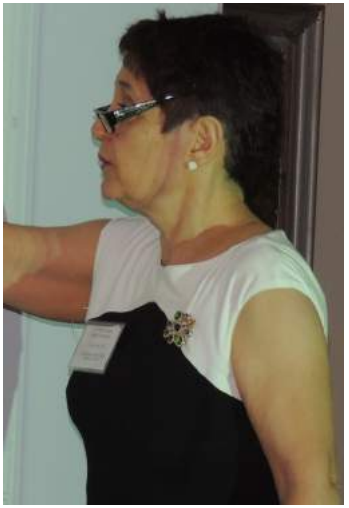
Summary co-authored by Bill Pietrzak.
A medical device sold in the European Union must be labeled with the CE Mark. The Mark notifies businesses and

consumers that the device has an acceptable benefit/risk profile and meets clinical safety and performance standards set by the *Medical Device Directive*. A Notified Body evaluates evidence for that assertion, provided in a Clinical Evaluation Report (CER) satisfying MedDev 2.7/1 Rev 4, before it approves of placing the Mark on the device. In his entertaining presentation (punctuated with slides from, and short quizzes about, popular movies), Bill explained the CE Marking process and did a deep dive into how to write an effective CER.

CLINICAL PHARMACOLOGY AND BIOPHARMACEUTICS, KEY CONCEPTS AND CONTRIBUTIONS TO MARKETING APPLICATIONS
Lisa Toth, BS (*Eli Lilly & Co.*)

Make it easy for your regulatory reviewer to say yes to your request to market a drug or biologic. Tell the reviewer a compelling story about the development of the product. While describing what interests a reviewer, Lisa Toth offered helpful advice on how to become familiar with the product, to interview the players in the story, and to lead a team in crafting a well written story.

WORD TIPS AND TRICKS YOU CAN USE NOW
Teresa Keller, MA (*Ivy Tech*)



Microsoft Word, a standard tool of our trade, has several time-saving features that can make our lives easier and our products more consistent. Teresa Keller's lively presentation pointed out and demonstrated features especially useful to medical writers such as styles, autocorrect, restricted editing, templates, and the legal blackline option for comparing documents.

THE PATIENT-AUDIENCE USHERS IN A NEW PARADIGM FOR MEDICAL COMMUNICATIONS
Leigh Anne Naas, BA (*Eli Lilly & Co.*)

What if our health care system were all about the individual patient? Leigh Anne Naas described why and how the Learning Health System is trying to make that happen by connecting people and organizations in an efficient patient-focused medical communication network. As one example, Ms. Naas described the role that social media plays in this effort and reviewed some of the skills social media professionals need.

Thank You

To all conference participants: THANK YOU for making this conference a success!

Our deep gratitude goes to all of the open session speakers who donated their travel, time, and exceptional talent to our conference.

We sincerely thank our energetic Education Committee members for the many hours of personal time they donated during the last year to organizing this conference: Elaine Lipscomb, PhD (chair); Esther Asplund, PhD; Dana Blue, MS; Lana Dominguez, ELS; and William Pietrzak, PhD.

Special thanks to: Laura Town for once again hosting the conference at the Columbia Club; Ellen Stoltzfus, PhD, and Laura for their presentations at Tavern on South; William Pietrzak, PhD for photographing the conference; and Eric Metcalf, BJ, MPH, for publicizing the conference.

Education Committee (l to r): Dana Blue, MS; Lana Dominguez, ELS; Elaine Lipscomb, PhD; Esther Asplund, PhD; William Pietrzak, PhD

Trends and Opportunities for Medical Communicators

AMWA in Orlando | November 1 - 4, 2017

Supersaver rates available now through June 30.