MICHAEL JOHN BARRY, MD: a conversation with the editor on shared decision making

Michael John Barry, MD, and William Clifford Roberts, MD

Michael Barry (*Figure*) was born on July 23, 1953, in Hartford, Connecticut, and grew up there. He graduated from Trinity College in 1975 and from the University of Connecticut School of Medicine in 1979. From there, he went to Strong Memorial Hospital in Rochester, New York, where he did his residency training in internal medicine. From 1983 through 1985 he was a research fellow in general internal medicine at the Massachusetts General Hospital (MGH), where he has remained since. From 1997 to 2008, he was chief of the general medical unit of the Department of Internal Medicine, where he was responsible for ensuring the career satisfaction and advancement of approximately 250 clinician-teachers. He became a full professor of medicine at Harvard Medical School in 2005.

His research efforts have focused on several different areas but most extensively on the epidemiology, natural history, and outcomes of prostate disease. The results of a number of his studies have had a worldwide impact on research and treatment. His research has led to the publication of over 130 articles,

nearly all in peer-reviewed medical journals. Although he has contributed considerably to our base of medical knowledge and to the training of houseofficers, Dr. Barry has always considered himself a “doctor first.”

In 2009, Dr. Barry became president of the nonprofit Informed Medical Decisions Foundation, transitioning from his previous role of chief medical editor. The foundation strives to improve the quality of medical decisions through better patient education and greater patient involvement, which has been a theme of his own research.

For his contributions, Dr. Barry has received numerous honors. He was named a Master of the American College of Physicians in 2009, served as president of the Society of General Internal Medicine from 2004 to 2005, and served as president of the Society for Medical Decision Making from 1996 to 1997; he has also received a number of teaching awards at the MGH, among other awards. Dr. Barry was a visiting professor of medicine at Baylor University Medical Center at Dallas (BUMC) on July 17, 2012, and I had the privilege of speaking with him for an hour thereafter.

William Clifford Roberts, MD (hereafter, Roberts): *Dr. Barry, your presentation this morning was excellent. Since we have limited time, could you summarize for the readers of the BUMC Proceedings the points you made in your presentation and also the points you hope to make at your noon presentation to the medical housestaff?*

Michael John Barry, MD (hereafter, Barry): Thank you for the opportunity to talk to your readers. I’m here representing the Informed Medical Decisions Foundation, which was founded over 20 years ago. It attempts to get patients more involved in their health care. The mission of the foundation is to inform and amplify the patient’s voice in health care decisions.

Figure. Dr. Michael Barry during the interview.

From the General Medicine Unit, Massachusetts General Hospital, and the Informed Medical Decisions Foundation, Boston, Massachusetts (Barry); and the Heart and Vascular Institute, Baylor University Medical Center at Dallas (Roberts).

Corresponding author: Michael J. Barry, MD, General Medicine Unit, Massachusetts General Hospital, 50 Staniford Street, 9th Floor, Boston, MA 02114 (e-mail: mbarry@partners.org).

Why do we need to do that? Informed consent, as we usually practice it, has problems. I illustrated the problem with the example of percutaneous coronary intervention (PCI), where about three quarters of patients who go through the procedure think they are doing it to reduce their risk of a heart attack or to live longer. Although there are other reasons to do it for stable angina pectoris, such as to reduce angina and improve function, PCI does not increase longevity or reduce the risk of myocardial infarction. Thus, patients undergoing these procedures don't really know why they are having them done. And that's not an isolated problem. Our foundation has been working with the University of Michigan on a nationwide study of the quality of medical decisions about surgery, screening tests, or lifelong medications and has found that patients often don't know the fundamental facts they should know before choosing these treatments. We think something needs to be done about that.

We also find that patients' preferences aren't being readily communicated to their clinicians, resulting in clinicians sometimes just assuming they know what their patients' preferences are. Without asking the patients, clinicians really cannot know their patients' preferences. I illustrated that principle with the example of early stage breast cancer treatment, where women have a choice between a mastectomy or a lumpectomy plus radiation. Both treatments have the same cancer mortality over time but obviously very different implications in terms of whether the breast is lost or not and whether 6 to 8 weeks of radiation is required. Also, there is a higher risk of breast cancer recurring in the breast if a total mastectomy is not done. Reasonable, informed women can make different decisions between those options. We found that when clinicians were asked what patients were worried about, for example, many clinicians thought the issue of keeping or losing the breast was the dominant issue on most women's minds. Actually, only about 7% of women said that was an important consideration. They were really interested in other issues.

We think there is a challenge to improve two-way communication of information when a medical decision must be made. Clinicians need to communicate more about patients' options and the outcome of those options, but patients need to communicate more of what they care about to their clinicians. There is this dual problem of patients often making decisions in the face of "avoidable ignorance"—facts that they could know but don't—as well as clinicians not accurately "diagnosing" patients' preferences. These communication problems underlie some of the wide geographic variations in medical practice that have been documented in the Dartmouth Atlas of Health Care.

What's the solution? It's an approach that many clinicians take to naturally. We call it "shared decision making." It's a process involving the clinician and the patient and whoever else they would like to invite in to help make the decisions; patients may include family members, and clinicians might invite a broader health care team. They begin by sharing information: the clinician sharing information about what the different options are and the outcomes of those options, and the patients sharing information of what they care about and

their preferences. They reach a decision together on the best course to implement and then go about doing it together. For some medical decisions, there is clearly one right thing to do, such as the use of beta-blockers or aspirin after a heart attack, antibiotics for bacterial meningitis, or repair of a fractured hip. But in fact for most things in medicine there is more than one way to skin the cat. Again, the breast cancer treatment decision is a good example. Elective hip or knee replacement would be another. And for stable angina, PCI would be another good example where medical therapy or PCI might both be reasonable choices. And the best way to approach that decision is with the shared decision-making process.

Decision aids are tools that can help make shared decision making practical in the busy world of day-to-day medical practice, where we have limited time to talk to patients. In the area I work in, prostate cancer screening and treatment, I can start at a higher-level conversation with the patient rather than having to start by explaining where the prostate is, that it is the "prostate" and not the "prostrate," and whether it's good for anything other than getting men into trouble, which most people have doubts about. I would rather use a decision aid to help get patients up to a certain level of knowledge about their problem. I can then use the limited time I have to try to help that person make the best decision about what to do given his values and preferences.

Just as there are meta-analyses of randomized trials of PCI, there are meta-analyses of randomized trials of shared decision making supported by patient decision aids. In the latest Cochrane review, there are 86 randomized trials of this strategy that show that the quality of medical decisions is improved. Patients are more knowledgeable and more interested in participating in their decisions, less conflicted, and more comfortable with their decisions. If they are on the fence, it helps get them off the fence. When patients are well informed, they often become a little more conservative than their clinicians about what they want to do. For example, there are 11 randomized trials in the Cochrane review that address major surgical decisions. Together those trials show that when patients are fully informed, there is about a 20% reduction in the rate of those surgical interventions. However, shared decision making isn't primarily about trying to do fewer procedures and tests. In fact, we found that when we did a randomized trial using a decision aid for men facing the choice of surgery for benign enlargement of the prostate gland, surgical rates dropped when patients were fully informed. When the same tool was used in the United Kingdom, where surgical rates were much lower than in the USA, the rates increased substantially.

We know there are dramatic geographic variations in treatments. One area may have a several-fold higher rate of an intervention than another area, sometimes even a neighboring area. It begs the question of what rate is right. How do you find out what rate is right? We think that educating patients and having them participate in the decisions is the right way to get to the right level of intervention for preference-sensitive conditions. Given all the evidence, the shared decision-making approach seems to be a better way for clinicians and patients to

work together to come up with the right decisions. But, how can shared decision making become the rule rather than the exception in day-to-day health care?

Our foundation is working with a network of demonstration sites around the country to try to insert shared decision making into the workflow of day-to-day care. These places include my own hospital, Massachusetts General Hospital in Boston, Dartmouth Hitchcock Medical Center, Group Health Cooperative in Washington State, the Oregon practice-based research network, Mercy Clinics in Iowa, and Stillwater Medical Group in Minnesota, among others. All of them are working to try to integrate shared decision making into day-to-day care. We are finding that we are able to replicate the findings in the randomized trials in these larger-scale implementations.

Many people are concerned that the approach of informing people and inviting them into decisions may be good for younger, well-educated patients but may not be suited for older patients with relatively little education. In contrast, we have found that the shared decision-making approach supported by decision aids has been received with great enthusiasm across the spectrum of age, gender, and educational level. We still have a lot to learn about tailoring materials to different races, cultures, and ethnicities, but all groups seem to be enthusiastic about being involved in their medical decisions.

We have been finding in our implementation sites that relatively few people still want the physician to make all the decisions. Most patients want to share the decisions with their clinician when there is more than one reasonable option to manage their condition. Patients usually will understand that their input is important to come to an optimal decision. There is a lot of enthusiasm out there for the approach of sharing the decision and for the use of decision support tools. We also have found that just as in the Cochrane review, if patients are wrestling with major surgical interventions (knee replacement, hip replacement, surgery for spinal stenosis, etc.), those who are unsure ahead of time tend to get off the fence in a more conservative direction. The impact of decision support for screening tests depends on the problem. With colorectal cancer screening, for example, if patients are well informed, those who are unsure about what to do beforehand tend to get off the fence in favor of screening, which is what the evidence supports. With prostate-specific antigen (PSA) testing, where the evidence is more mixed, the unsure ones tend to get off the fence in the direction of not screening. There are still plenty of well-informed patients who want to be screened for prostate cancer, and in my opinion they have a right to be as long as they are well informed about what they are doing. We have a strategy supported by 86 randomized trials. The real challenge is to figure out how to make it work in multiple clinical settings. It would be good to work with folks here at BUMC to help advance that knowledge.

Roberts: *What are you finding in regard to statin therapy—whether they should go on a statin or not or have the dose raised?*

Barry: Some decisions about statin therapy fall into the category of proven effective care. For example, for secondary prevention after a coronary event, the right answer is to get people on a statin and to keep them on it over time and deal

with any side effects that come up. For primary prevention, particularly in patients whose risk factor profile is favorable, the absolute benefits are smaller and they will often have the same risks of side effects as patients being treated in the secondary prevention setting. The risk and benefit balance is less clear with primary prevention; that is, it is preference-sensitive care. Making sure patients are fully informed about their absolute risks and what they'd gain from statin therapy is the key. There are risk calculators that can give patients a sense of "if I don't take a statin how likely is it that I will have a coronary heart disease event over the next 10 years?" Statins in general reduce that risk about 30%, but if the risk is 1% and I am reducing it to 0.67%, that is very different than if it's 12% and I'm reducing it to 9%. Getting a sense of the absolute risks and absolute benefits is a good first step. Then, having patients understand the potential side effects and the strategies for dealing with them comes next. Understanding a bit of the evidence about using a fixed dose of statin versus adjusting the statin dose to achieve a target cholesterol level is useful. Particularly in primary prevention, there is room for patients to think about statins as well as alternative interventions, such as aspirin. In secondary prevention, both those interventions are proven effective care. We should try to avoid the one-size-fits-all approach in medicine, instead tailoring treatment to patients' absolute risk and risk of side effects.

Roberts: *How do you handle the situation of the hypertensive patient who says that he doesn't want to go on any antihypertensive drugs?*

Barry: For severe hypertension, that is proven effective care. The absolute benefits of treatment are large and outweigh the potential side effects, particularly with the ability to change therapies until a regimen is found that minimizes if not eliminates side effects. I tell patients that there are so many different drugs available that, although there may be some trial and error involved, you can almost always find a good regimen with enough time and patience.

The challenge comes with the much larger number of people with mild hypertension. As with statins, knowing patients' overall risk profile, including their other risk factors, is very important in making the decision about drug treatment vs. lifestyle changes for milder degrees of hypertension. Once again, it's about trying to quantify the absolute benefit against the side effects. A low-risk person with mild hypertension may well decide to accept the small but finite risk of stroke or heart attack over time to avoid the potential side effects. Different people can make different decisions in that setting. Again, as the absolute benefits get greater based on their risk profiles and how high the blood pressure is, that makes less sense, and at a certain threshold it's reasonable to treat routinely.

Roberts: *You talked about both young and old patients benefiting from discussions of joint decision making. What about the older physicians who might get annoyed when a patient resists taking a recommended drug? Have you gotten any resistance to your message from older physicians compared to younger physicians?*

Barry: I'm not sure if older or younger makes a difference with physicians. Medicine historically has been pretty paternalistic. Making the transition to more of a partnership between

clinicians and patients to make better decisions comes naturally to many physicians. Many older physicians tell me that this is what they have always done. They appreciate that tools like decision aids can help them do it better and more efficiently. Ten years ago there was more pushback; comments such as “patients don’t want this and they will do better if I tell them what to do” are less frequent now. Today there are more comments such as “this makes great sense but I don’t have time, and the tools aren’t readily available.” The objections are becoming more logistic than conceptual. What we really need to do now is solve the logistical problems.

Roberts: *One of your publications in the British Journal of Urology International discussed why you decided not to have a PSA test. What was the reasoning there?*

Barry: The first Scandinavian randomized trial showed we can change the natural history of at least some prostate cancers by intervening with surgery. This trial randomized men with localized prostate cancer to radical prostatectomy or observation. These were men largely diagnosed the old-fashioned way: when a physician feels a nodule in the prostate gland or a transurethral resection for benign enlargement of the prostate shows cancer in the pathologic specimens. At up to 15 years of follow-up, there was about a 6% absolute decrease in the risk of dying of prostate cancer in that study. The number needed to treat—that is, the number of men who would have to have their prostate glands removed to prevent one death—was around 17. Whether a number needed to treat of 17 is large or small is in the eye of the beholder. I was asked to prepare that article considering whether the results of the Scandinavian trial would be enough for me to want a PSA test or not. It wasn’t.

We now have two large randomized trials of PSA screening that have conflicting results: the US trial showed no benefits, albeit there were methodologic issues such as contamination of the control group by a lot of PSA testing in usual care. The more informative trial from my perspective is the European trial, where there was much less background PSA testing and where PSA testing resulted in about one fewer prostate cancer death per 1000 men screened over 10 years. That seems like a small benefit to me. On the other hand, the risk of being diagnosed with prostate cancer was 70% higher with screening in the European trial, with the risk of overdiagnosis turning into overtreatment with resulting sexual problems and incontinence. Such evidence prompted the US Preventive Services Task Force to give PSA screening a grade D recommendation—saying we shouldn’t do it. The European trial shows that while the benefit is small, it is finite and statistically significant. I believe there are men—who are not mentally ill—who could look at that benefit and say that they were willing to accept the risks. It’s not a very good deal from my perspective, but I’m unwilling to take the option of the test away from patients when there is this tradeoff between risk and benefits.

The prostate cancer screening decision and the treatment decision when men are diagnosed with prostate cancer are good examples where shared decision making can be brought to bear. The way to resolve the PSA controversy is not on a population

basis but one man at a time, helping them as best we can to understand the tradeoffs involved.

Roberts: *I noticed that you are on the editorial board of one or two urology journals. How has that community responded to your thesis?*

Barry: I think my colleagues in urology have been very forward thinking about patient involvement. I was a part of the American Urological Association (AUA) guidelines panel on treatment of benign prostatic hyperplasia (BPH). I was one of the primary care physicians on the panel, but most were urologists. In some ways the guidelines we produced serve as a model for other shared decision-making guidelines. We suggested that the men with moderate to severe lower urinary tract symptoms should have the treatment options presented, namely watchful waiting, medication, and surgical treatment. That’s shared decision making in a nutshell. We’ve also recently done a study of men aged ≥ 65 years who made a decision about surgical treatment of prostate cancer and found that compared to other interventions (for example, for PCI) patients with prostate cancer were much more likely to be asked their opinion on how they should be treated. I think that all the controversy around PSA screening and prostate cancer treatment has resulted in many men getting a pretty good shared decision-making experience before treatment. I applaud my urologic colleagues for jumping on board this bandwagon, though there’s certainly more to accomplish.

Roberts: *What about the use of colonoscopy to hopefully prevent colorectal cancer?*

Barry: That’s a good example of where clinicians and patients may have different preferences. Most clinicians think colorectal cancer screening with colonoscopy makes great common sense. Although we do not have direct randomized trials on the effect of colonoscopy on colorectal cancer mortality, several trials of sigmoidoscopy show reduction in incidence and mortality from colorectal cancer. So, why not examine the whole colon rather than just the left side? Isn’t sigmoidoscopy just like examining the left breast in women rather than both? What about fecal occult blood testing? This test also has been shown to reduce colorectal cancer mortality in randomized trials. Most clinicians facing screening themselves do not like the hassle of doing fecal occult blood testing every year, whereas a colonoscopy, even with its small risk of perforation, can be done just once every 10 years. Although most clinicians consider doing a screening colonoscopy a no-brainer, many patients, particularly minorities, consider colonoscopy quite invasive. A recent randomized trial suggested that offering both screening tests rather than colonoscopy alone boosted screening rates from about 40% to about 70%.

Roberts: *How did you get into the prostate gland shared decision-making philosophy?*

Barry: Many people have asked that question. The two go hand-in-glove. I had come to Harvard Medical School and the Massachusetts General Hospital in the early 1980s interested in the preference-driven side of medicine and was looking for medical problems where patient preferences should have a major effect on decision making. It turned out that intervention for

BPH is a great example because the condition is rarely fatal and most of the morbidity is from bothersome lower urinary tract symptoms. The question was a simple one at that time (before the era of effective medical therapies): “Would you be willing to take the small but finite risk of a surgical intervention to reduce the frequency of your bothersome symptoms?” Who is best qualified to judge whether the symptoms are bothersome enough to merit taking the surgical risk than the patient? So, we began to study BPH. A mentor of mine, Jack Wenberg at Dartmouth, had been demonstrating remarkable variations in surgical rates from community to community. He showed me adjoining communities where the chance that a man would have his prostate out by the time he was 80 might be 15% in one community and 50% in the other. My initial reaction as a young investigator was to think there was “something in the water” that either accelerated or retarded prostate growth. Maybe we could find a biological explanation for why this was happening. The answer for that variation, however, was not in the lakes and streams but behind the closed doors in the physicians’ offices, namely different thresholds for recommending surgery or conservative management for the symptoms. Ultimately, these practice variations led to the very responsible AUA guidelines on BPH that recommended involving the patient in the decision. The PSA blood test led to a whole new set of controversies that we are still wrestling with. To involve the patient in making decisions about both prostate cancer screening and treatment still seems like the best approach to me.

Roberts: *Was anyone in your family a physician? How did you get interested in medicine?*

Barry: Both my parents were educators. There were no physicians in the family. In college I wanted to find a career where I could go home every day feeling I’d learned something, helped someone, and not been bored, and medicine seemed to fit the bill. I have no regrets because I still have those days every day.

Roberts: *Where is Trinity College?*

Barry: Hartford, Connecticut. There’s a more famous one in Dublin, but I stayed closer to home.

Roberts: *Did you live at home during college?*

Barry: No, I lived on campus although it was still quite convenient to go home to do laundry.

Roberts: *What did you major in?*

Barry: Biology.

Roberts: *Why did you go to Rochester, New York, for your residency?*

Barry: The University of Connecticut, where I had gone to medical school, was a relatively new medical school at that point. For a state resident there was a great economic advantage to go there. I was the oldest of four children. Although I was accepted at other more prestigious medical schools, the tuition in Connecticut couldn’t be beat. I think I got a fabulous medical school education. The decision to go to Rochester, New York, for residency was fairly ephemeral. I really liked the environment. It had a strong focus on general medicine, which appealed to me since I didn’t know what I wanted to do. I was interested in general medical training, and in retrospect it was a great decision for me. The role models in general medicine

were fantastic. I wound up deciding not to specialize but to stay in general medicine. The great thing about general medicine and primary care is that no problem is off limits, including prostate disease. There are so many interesting problems at the interface between general medicine and the specialties that they can provide a lifetime research agenda.

Roberts: *I’ve always thought that the general internist was the smartest physician.*

Barry: I don’t know about that. But it was my mentors at Rochester who said that liking all the specialties of medicine is a good thing, not simply a problem, and we’ve got a career for you.

Roberts: *How did you decide to go to MGH after your training in Rochester?*

Barry: I had done some research, both in medical school and in residency in Rochester, in the arena of outcomes research: work on radiation-related thyroid cancer in medical school and the outcomes of gastrointestinal bleeding in residency. I realized that I didn’t have the research skills to be able to become an independent investigator without additional training. I was interested in how clinicians and patients made decisions. Decision analytic skills were just coming to medicine, and there was real expertise in the area at Harvard and MGH. One of my mentors, Albert Mulley, who was my boss for many years, had the expertise in medical decision making that brought me to Harvard and MGH.

Roberts: *How does a general internist fit into the hierarchy at MGH? I saw that you have received a number of teaching awards, played a major role in teaching medical housestaff, and helped to choose houseofficers.*

Barry: I didn’t appreciate it before I came to MGH, but it has had a longstanding tradition of general medicine and primary care. It started with the leadership of Dr. John Stoeckle. MGH has a large primary care group within the Department of Medicine. It’s always provided me a terrific home. Many of our specialists really value their general medicine skills.

Roberts: *I noticed that you recently became a clinical professor of medicine rather than a professor of medicine. What is that all about?*

Barry: Three years ago I took a new job as president of the nonprofit Informed Medical Decisions Foundation, and that move meant I had to convert my full-time appointment at Harvard as professor to a part-time appointment as clinical professor. I don’t feel any different for having done it.

Roberts: *How much do you travel in this position?*

Barry: There is a fair amount of travel, but not a lot more than I did as an academic working primarily at MGH. There is a lot of international interest in this topic. I’ve gone to Europe a fair amount. The UK is particularly interested in shared decision making as a concept. I’ve been to China a couple of times. The Chinese Ministry of Health is very interested in involving patients in their decision making. I’ll be going to Australia soon. Many people have wondered if the idea of involving patients in their decisions is a parochial US idea. No. It’s a global movement. Two years ago we sponsored a Salzburg Seminar on shared decision making. People came from all over the world, including

clinicians, journalists, patient advocates, and patients themselves. The importance of involving patients seemed to resonate across all countries. The Salzburg Statement that was written by those participants is a succinct statement about the importance of informing and involving patients the world over in their care (see <http://us.cochrane.org/sites/us.cochrane.org/files/uploads/Ford,%20Peg%20-%20Salzburg-Statement-amended5.pdf>). Although the form of shared decision making may be somewhat different in each country, the approach is a global one.

Roberts: *When you are in Boston, what is your day-to-day life like? What time do you wake up in the morning, what time do you get to work, what time do you leave the hospital or office? What do you do at night from the time you get home until you go to bed?*

Barry: I'm a relatively early riser. I'm usually up by 5:30 AM and try to get into MGH by 7:00 AM. I still take care of a panel of primary care patients at MGH. We've been together a long time and I've gotten to know them and they know me, and I wouldn't want to step away from that. I think it also makes what I do more real in the informed medical decision making world. I start and end the day at MGH trying to make sure that all the patient issues are resolved. I have wonderful colleagues who help cover for me during the day if urgencies arise, so I spend the middle part of the day (8:00 to 5:00 or so) at the foundation and then finish up at MGH at night. I still have a pretty active research program and publish papers on both shared decision making and prostate diseases. I tend to go in on Saturday and catch up at both places. I have a nice niche, the clinical and research world at MGH and then my "day job" helping advance the cause of shared decision making through the foundation.

Roberts: *Where is the foundation located?*

Barry: It's on City Hall Plaza, about three blocks from MGH, so it's very convenient to get back and forth.

Roberts: *What time do you get home at night?*

Barry: It varies. I try to get to the gym about 3 days a week and I'm a late-in-the-day exerciser. I am most productive in the morning so I save exercise for late in the day and listen to books on tape and lose myself in them while exercising.

Roberts: *What kind of exercise are you talking about?*

Barry: Aerobic exercise mostly. I'm stressing the importance of stretching. I had a hamstring injury playing tennis last year. That's the exercise I like the best, though I'm not very good

at it. I tend to get home between 7:00 and 8:00 PM. I'll have dinner then.

Roberts: *Do you have children at home? How many children do you have?*

Barry: The two kids are grown. For a change of pace, I like to cook outside.

Roberts: *When you cook outside, do you cook cows, pigs, sheep, or goats?*

Barry: Sometimes dead mammals but I'm fond of fish and eggplant as well. My children are fond of saying only wimps go to bed at the hour I do, probably around 9:30 PM.

Roberts: *You get about 7 hours sleep?*

Barry: That sounds about right.

Roberts: *Do you have hobbies?*

Barry: I play tennis and exercise. I'm fond of books on tape while exercising. In my commute, which is about half hour each way, I've gotten addicted to college courses on tape, mainly lectures on history and literature. It's quite enjoyable. I had a grandfather who was a great fisherman and hunter. I've been away from it for a while but I have a fishing trip this weekend, the first in a long time. It's with one of my Rochester mentors, Paul Griner. I was the New England field archery junior champion in high school and have toyed with the idea of getting back into archery one day.

Roberts: *Did you play other sports in high school or college?*

Barry: No, archery was it.

Roberts: *How did you get into that sport?*

Barry: It was probably the sportsman thing through my grandfather. Field archery is a type of competitive archery that came out of the bow hunting culture. People usually think of Olympic-style archery, or Robin Hood pounding away at targets at a fixed distance. Field archers actually go around a golf course-like setting with targets at different distances and fire four arrows at each of 28 targets.

Roberts: *What do you hunt?*

Barry: I was a bird and rabbit hunter in my younger days.

Roberts: *Is there anything you would like to discuss that we haven't talked about?*

Barry: You've been pretty eclectic in your questions. I think I'll go with what I've said.

Roberts: *Dr. Barry, thank you for coming to BUMC and for sharing your knowledge with us.*