Despite demographic changes in the past quarter century, Wisconsin and the Midwest retain a vital rural and small town culture and population. In an important contribution to the conversation about the future of clinical research, Strasburger points out how federal and foundation research funds flow disproportionately to urban centers (Meeting the research infrastructure needs of micropolitan and rural communities. *WMJ.* 108:3;133-138). She points out that the lack of research infrastructure deprives rural and micropolitan communities of the benefits of research conducted on their issues, but also deprives those communities of the economic and intellectual resources that would help them thrive in the wired world of the future. There are fewer and fewer reasons not to have a robust research agenda, federally and state funded, in the non-metropolitan areas of the state.

Patient safety and avoidance of medical errors have been prominent in the public eye for almost a decade since the first Institute of Medicine report on the subject. The drive to decrease medical error has brought hospitals, clinics, and health professionals of all types together, which is in itself a good thing. But physicians are at the center of the systems and our behavior and attitudes are essential for any improvement to occur. The MEMO study is a national project that has examined 2 issues: physician morale and workplace environment and how they might adversely affect patient outcomes. Manwell and colleagues (Physician perspectives on quality and error in the outpatient setting. *WMJ.* 108:3;139-144) share data from interviews of primary care clinicians about making errors in their practices. More importantly, they list what would improve care in the primary care office, which, if adopted, would not only decrease errors but do so with a more satisfied primary care workforce.

Rabago and colleagues (The prescribing patterns of Wisconsin family physicians surrounding saline nasal irrigation for upper respiratory conditions. *WMJ.* 108:3;145-150) confirm that nasal irrigation has established itself as a standard of care by family physicians for upper respiratory illness in Wisconsin. What was considered an alternative method of treatment is now mainstream. Good research with hard outcomes showing patient improvement with nasal irrigation can decrease the use of antibiotics, with all of their adverse personal and environmental effects. That, one would say, is real progress, and a triumph of science and an open mind, not to mention reducing the cost of care to individuals and the public. Multiply those savings times millions of upper respiratory infections each year and, as they say, it could add up to real money.

Havelena and colleagues (Factors associated with the seasonality of blood lead levels among preschool Wisconsin children. *WMJ.* 108:3;151-155) confirm that all regions of the state, not just high density urban areas, show higher blood lead levels in children at the end of the summer than the end of the winter. They describe a variety of possible environmental influences that would affect those levels. They don’t report on the prevalence of toxic levels in the screened population or discuss the larger issue of whether the policy of screening all children set out by the Wisconsin Division of Public Health still makes sense in light of the lack of such a recommendation from the United States Preventive Services Task Force of the US Public Health Service. As someone who spent time during my internship 40 years ago running chelation therapy for lead toxic children in Chicago, I realize that lead screening is a longstanding public health issue. But policy change often lags behind changes in society and science. It might be time to consider focusing on high risk screening for children in the state.

The article by Bradley (Emergency contraception and practitioner rights of conscience—a review of current legal standards in Wisconsin. *WMJ.* 108:3;156-160) about legal protection for Catholic or other objecting physicians in
the use of emergency contraception elaborates on the conflicts of conscience that such physicians may feel. Bradley focuses on the protections in Wisconsin law for physicians who refuse to provide emergency contraception. In the April 2009 *Journal*, Buchanan reviewed the likely rescinding of the Bush administration regulation by President Obama within the next few months. This will not change the Wisconsin statute. But the larger question, of course, is not what is or is not the Catholic “position” but what is the professional responsibility of physicians to their patients. No one believes in coercing or punishing physicians to act against their personal beliefs. But meeting patient needs is our overarching responsibility, and if we have personal moral belief that would preclude legal care, most would feel that our obligation is to follow the American College of Obstetricians and Gynecologists recommendations for emergency contraception and transfer the patient to a physician who can act on the patient’s behalf. The coming over-the-counter availability of Plan B® for emergency contraception only sidesteps the discussion of professionalism and patient-centered care. This disagreement is unlikely to be settled any time soon.

References


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