In This Issue

Disease Registries, Patients, and Offices: How We Ask Questions About Health

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This issue of the Wisconsin Medical Journal contains a rich mix of information, ranging from access to primary care, through disparities in birth outcomes and cancer, to how we judge obesity in practice populations. Like most research, however, the way that information is gathered affects the usefulness of study outcomes to our practices and teaching.

Both the study by Jones and colleagues1 and by Klein and colleagues2 look at the prevalence of cancer in populations. Jones's study uses cancer data from the state cancer registry to look at how the rates of cancer in African Americans and whites in Wisconsin have changed over 2 decades. Their results give some reason for optimism, as well as concern, going forward. Both African Americans and whites have had a decrease in the burden of cancer over the study period. In some cases, African Americans had a greater decrease in cancer prevalence than whites. But on the whole, disparities persist and, as the authors mention, should alert clinicians to use active surveillance for cancer in all populations with an emphasis on both community education and improving access to screening for African Americans and other high risk populations.

But medical care is not the only issue that affects cancer, and we need to look more deeply at many other social determinants of health as well.

Klein and colleagues use one of the most important longitudinal population databases in this country, the Beaver Dam Eye Study, to see if a combination of patient self-report and cancer registry can reflect a more accurate and comprehensive understanding of the prevalence of cancer in a population. They found that patients were able to report personal cancers, without in most cases the specificity of hospital tumor registries, but that patients also added cancers that the registry did not include. Databases have flaws that are well recognized by public health educators. This study should stimulate cancer investigators to understand that an accurate measure of the health of a population can often be known only by asking the patients themselves.

Thomson and Baisch3 discovered the realities of primary care access in Milwaukee by having researchers act like patients and call clinics and offices to inquire about appointments. Their results highlight how access limited by both location and availability will negatively affect creating patient-centered medical homes, particularly in low income neighborhoods. The discontinuity and increased costs inherent in urgent care and emergency departments may, in great part, be due to the “primary care deserts” that exist in cities after 5 PM. Without policies and clinical facilities that meet patient needs, everything else will suffer. The solution is more accessible, community- and neighborhood-based offices with longer hours, not bigger emergency departments.

Salm Ward and colleagues,4 again, use a publicly available data set but couple it with data on social determinants of health such as educational level and income to ask whether improving socioeconomic status (SES) would have a positive effect on high-risk births. These data were also combined with census track and mapping data to look at what parts of the city might be the most important to focus on. While women from higher SES groups had fewer adverse birth outcomes for both African American and white women, the middle SES groups showed improvement in whites and not blacks. This study raises a number of issues that require the “on-the-ground” research represented in some of the studies in this issue—like interviews about perceptions, access, and many other factors that affect birth outcomes. Raising income seems to help but not in the linear fashion we might expect, and only deeper level research will help understand why.

Smith and colleagues5 inquired from primary care offices whether an office-based screening tool for obesity changed their use of...
BMI measures. Many physicians increased their use of BMI measures but not all. More surprisingly, physicians continue to rely on “eyeballing” patients as a way of assessing obesity, which, while not quantitative, might work, as long as it is entered into the patient’s problem list.

All the articles in this issue address the “what” questions about health issues much better than the “why.” Since researchers use a wide variety of methods to answer their questions, readers might read the abstract, the discussion AND the methods sections before acting on the results. And good research, as is represented in this issue, should alert us of the shortcomings of the work and what data is needed to make conclusions stronger and more useful for action.

References
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