

An Epidemiology to Give Visibility to the Invisible

Una epidemiología para dar visibilidad a los invisibles

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It is not easy to propose a commentary to the article of Macchia et al., (1) who through classical data, as the elaboration of the information contained in the vital statistics of a country, offers a perspective which -beyond the apparently obvious clinical and public health meaning of the term “premature”- is quite innovative, even in the frame of international literature. The novelty is to document the possibility and with that the obligation of converting epidemiology -of individuals and not only of diseases- from a descriptive tool of known or at least suspected realities (usually marginal for the clinic and cosmetic for policies) into a strong diagnosis which points out accurate and urgent interventions, and imposes the need of a joint responsibility of the two components of society represented on the authors’ panel (academia and public institutions).

The other difficulty of a commentary is the risk of redundancy with respect to the clarity and originality of the discussion that, throughout its reflections and bibliographic references, can fully confront the challenges, doctrinally and formally recognized as priorities, although destined to an operative limbo, both in the literature and in the international policies. The world built around the recent “sustainable development goals” (SDG) is the most obvious model of the concrete risk of dissociation between the “ideology” of global description and the effective right to a public health tailored to its needs. (2)

The commentary can at this point be simply limited to an exercise that emphasizes words. Perhaps, to begin with, by inviting to read a very recent “special article”, (3) that specifically in its conclusions seems to be the commentary to Macchia et al.’s, proposal (1) and with that the acknowledgement-recommendation of its relevance and anticipatory power.

The first group of words matches those selected as key words by the authors. All refer to realities, knowledge, very “hard” indicators. Together they constitute the real “evidence” that should guide the path of medicine: vital statistics are more informative than the inclusion/exclusion/success criteria adopted by clinical trials, because they place all the people, as

groups and individuals, in their contexts of time and space. Health inequalities and socioeconomic factors are the strongest and most efficient outcome determinants. However, none of these keywords that define evidence-based medicine (EBM) is a normal part of medical and social assistance records of daily health-care, not even in the cardiovascular sector, where the weight and relevance of the scenarios represented by the same words are specifically visible and translated into concrete actions.

The keywords that follow seem positioned at the opposite end of those mentioned above: “513 departments of Argentina”. The apparent irrelevance of the administrative and geographical notation, which defines the map and specificity of the study design without explicit clinical echoes, is indeed an essential magnifying glass. It reveals a conceptual and operational priority, essential at a time that speaks obsessively of power and supremacy, at the level of knowledge production, global statistics and the use of “big data” explored with the many versions of data mining transformed into predictive-prognostic models. Individuals and populations (which constitute the concrete denominator of the first keyword block) live, meet and express their own needs and expectations in every department -and in a different way in each of them- of the specific country which is Argentina. The epidemiology which is closest to the clinic is not that at the service, pretending to give credibility, to models built with the same logic and the same objectives as the economic and financial statistics, which necessarily “withdraw” people and lives who have local, not global rights, attributable, not promising.

The comparison of the differences, similarities and community histories, allow translating into a professional, political and social dialogue on how global wishful-thinking to decline mortality can be explained not in average results [which, as Macchia et al. document, hide the history of the increasing relative inequality compared to overall results indicating reductions], but in the capacity to effectively take charge of premature deaths: those undue deaths, which are

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not only, or mainly, indicators of care deficiencies, but of the daily, silent abuse, which is occasionally mentioned, as descriptive variable, of the human right to a life with dignity.

The third block of keywords is that which only includes apparently only and/or mainly technical terms: ecological model, assessment rates, inclusive considerations, linear gradient, and thresholds.

The message, or rather, the proposal very well supported with "obvious" data from tables and their comments does not match an academic recommendation to study/learn/work with sophisticated statistical techniques. Technical terms qualify in fact a culture and strategies.

It is said that the possibility-necessity of inclusive, ecological views, that tell integrated stories of people and their contexts, not only produce diagnoses and order prescriptions: today, they should and may be considered essential.

To understand and assume the responsibility of cardiovascular priorities with technologies that allow representing individual and collective stories is a radical breakthrough, which reaches the clinical management of individual cases, as well as the planning/management oriented to issues and/or populations. Macchia et al.'s (1) proposal, is not formulated as a study conclusion to give the idea that the study itself is interesting-relevant. It is proposed as a real, though different, stage of translational medicine. The classic passage, from bench to bed, is transferred in the exchange, not occasional and bidirectional, between

assistance and life. The key words of this epidemiology, which customizes general knowledge-threshold, linear gradient, change over time, context variables....-are not different from those learned and used in common language to qualify the looks (with images and biomolecular markers) produced by more or less digitalized predictive diagnostic technologies.

The challenge presented is cultural, and certainly more political than technical: liberating, not occupying more the time of a growing number of professionals who are interested in producing -according to not overly distant effectiveness criteria - practices that correspond to acknowledging prevention and the differences that truncate and prevent life.

Conflicts of interest

None declared.

(See authors' conflicts of interest forms in the website/Supplementary material).

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