DESCRIPTIVE INDEX OF MORTALITY STUDIES FROM SELECTED SOURCES, 1951-1995 pdf

1: Singer, Richard B. [WorldCat Identities]

Two extra volumes of A Descriptive Index of Mortality Studies from Selected Sources, and one extra volume of Medical Risks: Compend of Mortality and Morbidity, containing no annotations or inscriptions, were removed from the collection and added to the.

Disclaimer Injury-related mortality in South Africa: Correspondence to Richard Matzopoulos email: Bulletin of the World Health Organization ; They are not nationally representative, since they are only available for two of nine provinces, and use mortuary registers rather than postmortem reports. Under the Inquests Act of , 8 postmortem investigations are a statutory requirement for all deaths that are not clearly from natural causes. This is a potentially useful alternative source of data on injury-related mortality. Here, we use postmortem records to provide a more accurate cause-specific profile of injury-related mortality in South Africa for the year This enables comparison with data from several sources including official statistics, the national survey of female homicides 9 and global burden of disease estimates. The study was commissioned by the South African Medical Research Council as part of its second national burden of disease study. Data were obtained from postmortem reports and ancillary documentation, including police reports and hospital records. A multistage stratified cluster sample was drawn for eight provinces, using mortuaries as the primary sampling unit. All records for the Western Cape were obtained from the Provincial Injury Mortality Surveillance System 11 to complete the national sample. We assessed whether each death was from natural, external or undetermined cause. To account for the selection probabilities of mortuaries within survey strata, we applied analysis weights. Cases with unknown-age were proportionally redistributed to all other ages using a scaling factor. Field workers used a mobile phone based questionnaire to collect demographic information from the postmortem report, including age, sex and race of the deceased. Postmortem and police reports categorize individuals by the races black, coloured, Asian and white, and we kept those categories when conducting the study. We also recorded whether each death was related to a legal intervention, occurred in custody or if there was evidence of sexual assault. The mortuary death register number and the death notification number were collected as identifiers for follow-up to resolve data capture errors. The data captured on the mobile phone questionnaire application Mobenzi Researcher, Cape Town, South Africa were submitted to a central web-based platform. The project manager and biostatistician conducted quality checks while data were collected and resolved any data quality problems with the national level coordinator. Further details are available from corresponding author. The discrepancy arose from invalid entries that had been included in the sampling frame â€” such as deaths that occurred before â€” and a small number of cases not recorded in mortuary registers or lacking records. Cause of death recorded by mortuaries, South Africa, Note: The age-standardized mortality rate from all external causes in South Africa in was The mortality rate among males Homicide was the leading apparent manner of death, accounting for The male homicide rate The male-to-female ratio of homicide 6 male deaths per female death was higher than for any other apparent manner of death. This was due to the particularly high rate ratios for three major external causes of death that were attributed to homicide: The suicide rate of Males were again over represented and overall there were five male suicides for every female suicide. Transport-related injuries accounted for more than one-third of all external causes of death Most of the transport-related deaths were due to road traffic injuries, which represented Pedestrian deaths accounted for Drivers and passengers accounted for The other major causes of unintentional injuries included burns, drowning and falls. The male-to-female mortality ratios were lower for accidental than for intentional injuries. For a small subset of deaths from external causes 4. This was most common among deaths arising from the ingestion of poisonous substances including drugs , deaths from fires, burns and hot substances, and instances where decomposed bodies, bones or skeletons were found. Male and female deaths by injury categories, South Africa, Note: Gunshot injuries were a leading cause across several categories, accounting for deaths, equivalent to Of these, were homicides, were suicides, 48 were

unintentional and 87 were deaths of undetermined intent. For all injuries and for homicide, metro mortality rates were notably higher than for non-metro areas. This finding was consistent when the data were stratified by sex and age. For road traffic fatalities, there were 3. The age pattern for homicide was similar across metro and non-metro areas, albeit with the metro rates being noticeably higher in all but the youngest age category. Homicide rates were highest among teenagers and young adults in the 15â€”29 years age group in metro areas, and the 30â€”44 years age group in non-metro areas. Within age strata, the differences between metro and non-metro areas were not significant except for teenagers and young adults 15â€”29 years age group among whom metro homicide rates were significantly higher, subjecting them to twice the risk of their non-metro counterparts. Suicide rates by age followed a similar pattern to homicide rates. The metro and non-metro homicide and suicide patterns by race were inconsistent. People categorized as coloured experienced the highest homicide risk overall. Homicide rates among people categorized as black were highest in metro areas; conversely, among people categorized as white, the highest rates were found in non-metro areas. Homicide, suicide and road-traffic injury mortality rates by race in metro and non-metro areas, South Africa, Note: The categories for race are those used in postmortem and police reports in South Africa. Road traffic mortality rates were higher in non-metro areas for people categorized as black, children and the elderly. Homicide ranked highest for five provinces: Injury-related mortality rates by province, South Africa, Note: Discussion This study provides a comprehensive profile of injury-related mortality in South Africa in the year and provides cause-specific rates that are not available from other sources. Vital registration data suggest that there has been an overall decrease in external causes of death from to , 14 â€” 16 but the reasons are unclear. Previously, the first South African burden of disease study 2 provided the only detailed national estimates by age and sex for major causes of injury. This is consistent with national police statistics 18 and retrospective national surveys of female homicides that also indicate a decrease. The exceptionally high homicide rate among males has been noted previously, 2 but the male-to-female ratio has increased since indicating that the decrease in male homicide has not kept pace with the greater decline among females. After taking into account the overall decrease, the pattern of homicides by age group was similar to that in the year Suicide remains an important contributor to injury-related mortality, although our study does suggest a decrease in the female suicide rate from an estimated 6. Analysis by age shows a slight decrease, compared to estimates, among adults younger than 44 years, which is offset by an increase among older adults. As has been shown previously, 21 higher suicide rates were associated with increasing socioeconomic status, which was consistent across metro and non-metro areas. Traffic authorities reported a slight increase in deaths related to road traffic injuries. If the homicide rate continues to decline, deaths from road-traffic injury are on course to become the leading cause of injury-related mortality. Limpopo, Mpumalanga and the North West Province. At a national level, the prominence of pedestrian fatalities is of particular concern as it suggests that the strategy to improve road safety has not met the needs of vulnerable road users. Pedestrian safety relies on reduced exposure to risk through improved safety infrastructure and the provision of alternative transport modes for vulnerable road users, as behavioural modifications to reduce the risk of crash involvement and severity in the event of a collision are not easily attained. Contrary to the conventional discourse that violence is more concentrated in areas of poverty and deprivation, 25 , 26 our study reveals that peopled categorized as coloured who are, on average, more affluent than black people , 27 have comparable rates of homicide to black people. This is due to the relatively high rates of homicide among people categorized as coloured in non-metro areas, especially in the Western and Northern Cape. These two provinces have high levels of violence and of alcohol-related harm. Metro homicide rates were higher among racial categories that are, on average, poorer. Closer inspection reveals potential inaccuracies from the modelling process and the triangulation of inherently limited data sources that may have affected the earlier estimates. A previous study recognized the urban bias of mortuary-based surveillance data 2 as well as the poor distinction between deaths of undetermined cause i. Our data confirm the incompleteness and misclassification of vital registration data from the Department of Home Affairs, which codes as R99 i. We have demonstrated the feasibility and utility

of using mortuary-based data to provide timely, accurate and representative injury-related mortality information to monitor major injury trends and to identify at-risk groups. The study provides empirical evidence of the extent of misclassification and underreporting that compromises the evaluation of violence and injury prevention efforts. Comparison with several official sources and secondary analyses that rely on these sources suggests that mortuary data can improve estimates of mortality from external causes, and complement national and global burden of disease estimates. We are grateful to the National and Provincial Health Departments for allowing access to their facilities and provincial Forensic Pathology Services FPS for their assistance during fieldwork. This work was funded by the South African Medical Research Council, which paid the salaries of the research personnel involved in the study as well as the fieldwork costs.

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2: Principles of Epidemiology: Glossary|Self-Study Course SS|CDC

Richard B Singer. Filter your search Descriptive Index of Mortality Studies from Selected Sources, Richard B Singer. 01 Oct Book. Notify me.

Department of Labor, gather detailed information about the labor market experiences and other aspects of the lives of six groups of men and women. The first set of surveys, initiated in , consisted of four cohorts. These four groups are referred to as the "older men," "mature women," "young men," and "young women" cohorts of the NLS, and are known collectively as the "original cohorts. The NLSY97 Cohort is a longitudinal project that follows the lives of a sample of American youth born between ; 8, respondents were ages when first interviewed in " Documentation can be downloaded from the Cohorts section of the website. The samples drawn from aged Medicare beneficiary enrollment files are nationally representative of both community and institutional residents. The , , and NLTCS are designed to measure the point prevalence of chronic 90 days or more disability in the U. Some documentation is available for free download, however, a login is required to access the data contained in these surveys. The sample includes a main cross-section of 9, households plus an oversampling of blacks, Puerto Ricans, Mexican Americans, single-parent families, families with step-children, cohabiting couples and recently married persons. The subset included "a mid-to-later life sample of main respondents 45 and older with no focal children, and a parent sample made up of main respondents and their young adult focal children. The weights have been readjusted. A description of the files is available at the HRS website https: To access the documentation for the files can be found at: Survey data were collected from the original respondents or their parents in , , , and and a selected sibling in and Users must register for the data before acquiring it. Selected data raw or SAS data sets or descriptive statistics can be accessed. Download options are available. Users must login before using the system. Wonder also hosts many bibliographic databases. Users must login at the main site before accessing data. It assigns uniform codes across the samples. Users can pick geographies, variables, sample sizes, and cases. Output can be accessed in raw or compressed form, with a customized codebook and SPSS data definition statements. Note that free registration is required to use the extraction system. Users can pick both geographies and variables. Download, as well as mapping options are available. The previous version of the American Factfinder site, with access to Census data, is no longer available. Summary or detailed data is available from as early as to projections as late as In addition, static or "active" population pyramids are available. Users can aggregate selected countries into chosen regions. Countries can be ranked by population for any year from IDB can also be downloaded and used locally on the PC. Microdata are standardized and become part of the database. Researchers in member countries have access to this data, after registration. Available datasets and documentation can be found at the site. Its aim is to "construct a databank containing Labour Force Surveys from the early nineties from countries with quite different labour market structures. The LES team has harmonised and standardised the micro data from the labour force surveys in order to facilitate comparative research. The "User Information" section provides links to available electronic documentation needed to set up program statements.

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3: Descriptive Epidemiology

Descriptive Index of Mortality Studies from Selected Sources - (1) Descriptive Index of Mortality Studies from Selected Sources - (2.

Descriptive Epidemiology Introduction The image above illustrates the ten essential functions of public health. Epidemiology plays a particularly important role for three of the functions: The 10 Essential Public Health Services describe the public health activities that all communities should undertake. Public health systems should Monitor health status to identify and solve community health problems. Diagnose and investigate health problems and health hazards in the community. Inform, educate, and empower people about health issues. Mobilize community partnerships and action to identify and solve health problems. Develop policies and plans that support individual and community health efforts. Enforce laws and regulations that protect health and ensure safety. Link people to needed personal health services and assure the provision of health care when otherwise unavailable. Assure competent public and personal health care workforce. Evaluate effectiveness, accessibility, and quality of personal and population-based health services. Research for new insights and innovative solutions to health problems. Disease surveillance systems and health data sources provide the raw information necessary to monitor trends in health and disease. Descriptive epidemiology provides a way of organizing and analyzing these data in order to understand variations in disease frequency geographically and over time, and how disease or health varies among people based on a host of personal characteristics person, place, and time. This makes it possible to identify trends in health and disease and also provides a means of planning resources for populations. In addition, descriptive epidemiology is important for generating hypotheses possible explanations about the determinants of health and disease. By generating hypotheses, descriptive epidemiology also provides the starting point for analytic epidemiology, which formally tests associations between potential determinants and health or disease outcomes. Specific tasks of descriptive epidemiology are the following: Monitoring and reporting on the health status and health related behaviors in populations Identifying emerging health problems Alerting us to potential threats from bioterrorism Establishing public health priorities for a population Evaluating the effectiveness of intervention programs and Exploring potential associations between "risk factors" and health outcomes in order to generate hypotheses about the determinants of disease. Learning Objectives After successfully completing this unit, the student will be able to: Explain the role of descriptive studies for identifying problems and establishing hypotheses. Identify case reports and case series and explain their uses and their limitations. Describe the design features of an ecologic study and discuss their strengths and weaknesses. Explain the concept of ecologic fallacy both in general and in the context of a study. Identify the strengths and limitations of an ecologic study. Describe the design features of a cross-sectional study and describe their uses, strengths, and limitations. These characteristics are carefully considered when a disease outbreak occurs, because they provide important clues regarding the source of the outbreak. Hypotheses about the determinants of disease arise from considering the characteristics of person, place, and time and looking for differences, similarities, and correlations. Consider the following examples: There are also substantial differences in genetics and diet. Perhaps these factors are related to stomach cancer. If the frequency of disease varies in relation to some factor, then that factor may be a cause of the disease. Descriptive epidemiology provides a way of organizing and analyzing data on health and disease in order to understand variations in disease frequency geographically and over time and how disease varies among people based on a host of personal characteristics person, place, and time. Epidemiology had its origins in the desire to understand the determinants of acute infectious diseases, but its methods and applicability have expanded to include chronic diseases as well. Descriptive Epidemiology for Infectious Disease Outbreaks Outbreaks generally come to the attention of state or local health departments in one of two ways: Requirements for reporting infectious diseases in Massachusetts are described in CMR Clues About the Source of an Outbreak of Infectious Disease When an outbreak occurs,

one of the first things that should be considered is what is known about that particular disease. How can the disease be transmitted? In what settings is it commonly found? What is the incubation period? There are many good summaries available online. With this background information in mind, the initial task is to begin to characterize the cases in terms of personal characteristics, location, and time when did they become ill and where might they have been exposed given the incubation period for that disease. In sense, we are looking for the common element that explains why all of these people became ill. What do they have in common? Demographic information is always relevant, e. In the beginning of an investigation a small number of cases will be interviewed to look for some common link. These are referred to as "hypothesis-generating interviews. What did these victims have in common? Where did they do their grocery shopping? What restaurants had they gone to in the past month or so? Had they been exposed to other people who had been ill? Other characteristics will be more specific to the disease under investigation and the setting of the outbreak. For example, if you were investigating an outbreak of hepatitis B, you should consider the usual high-risk exposures for that infection, such as intravenous drug use, sexual contacts, and health care employment. Of course, with an outbreak of foodborne illness such as hepatitis A , it would be important to ask many questions about possible food exposures. Where do you generally eat your meals? Do you ever eat at restaurants or obtain foods from sources outside the home? Hypothesis generating interviews may quickly reveal some commonalities that provide clues about the possible sources. A simple and useful technique for looking at geographic patterns is to plot, on a "spot map" of the area, where the affected people live, work, or may have been exposed. A spot map of cases may show clusters or patterns that reflect water supplies, wind currents, or proximity to a restaurant or grocery store. In there was an epidemic of cholera in the Broad Street area of London. John Snow determined the residence or place of business of the victims and plotted them on a street map the stacked black disks on the map below. He noted that the cases were clustered around the Broad Street community pump. It was also noteworthy that there were large numbers of workers in a local workhouse and a brewery, but none of these workers were affected - the workhouse and brewery each had their own well. On a spot map within a hospital, nursing home, or other such facility, clustering usually indicates either a focal source or person-to-person spread, while the scattering of cases throughout a facility is more consistent with a common source such as a dining hall. In studying an outbreak of surgical wound infections in a hospital, we might plot cases by operating room, recovery room, and ward room to look for clustering. The epidemic curve for an outbreak of hepatitis A is shown in the illustration below. Begriming in late April, the number of new cases rises to a peak of twelve new cases reported on May 12, and then the number of new cases gradually drops back to zero by May Knowing that the incubation period for hepatitis A averages about days, the investigators concluded that this was a point source epidemic because the cluster of new cases all occurred within the span of a single incubation period see explanation on the next page. This, in conjunction with other information, provided important clues that helped shape their hypotheses about the source of the outbreak. Person, Place, and Time The shape of the curve in relation to the incubation period for a particular disease can give clues about the source. There are three basic types of epidemic curve. Point source outbreaks epidemics involve a common source, such as contaminated food or an infected food handler, and all the exposures tend to occur in a relatively brief period. Consequently, point source outbreaks tend to have epidemic curves with a rapid increase in cases followed by a somewhat slower decline, and all of the cases tend to fall within one incubation period. The graph above from a hepatitis outbreak is an example of a point source epidemic. The incubation period for hepatitis ranges from days, with an average of about days. In a point source epidemic of hepatitis A you would expect the rise and fall of new cases to occur within about a 30 day span of time, which is what is seen in the graph below. Continuous common source epidemics may also rise to a peak and then fall, but the cases do not all occur within the span of a single incubation period. This implies that there is an ongoing source of contamination. The down slope of the curve may be very sharp if the common source is removed or gradual if the outbreak is allowed to exhaust itself. The epidemic curve below is from the cholera outbreak in the Broad Street area of London in that was investigated by Dr. Cholera has an incubation period

of days, and even though residents began to flee when the outbreak erupted, you can see that this outbreak lasted for more than a single incubation period. This suggests an ongoing source of infection, in this case the Broad Street pump. Propagated or progressive source epidemic. The epidemic curve shown below is from an outbreak of measles that began with a single index case who infected a number of other individuals. The incubation period for measles averages 10 days with a range of days. One or more of the people infected in the initial wave infected a group of people who become the second wave of infection. So here transmission is person-to-person, rather than from a common source. Propagated epidemic curves usually have a series of successively larger peaks, which are one incubation period apart. The successive waves tend to involve more and more people, until the pool of susceptible people is exhausted or control measures are implemented. This is an ideal example, however; in reality, most of these epidemics do not produce the classic pattern. For some outbreaks the descriptive information is all that is needed to figure out the source, and control measures can be undertaken rapidly. When this occurs, it is necessary to test the hypotheses by conducting an analytical study, i. This means collecting data and analyzing it in order to identify the source. After the hepatitis outbreak in Marshfield, DPH conducted a case-control study. After an outbreak of Giardia in Milton, MA, a retrospective cohort study was conducted. So, the descriptive studies that generate hypotheses are essential. Use the graph below to answer this "Quiz Me.

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4: Welcome to Joyce's website!

This book is a collection of mortality abstracts based on recent follow-up studies on the results of health disorders from the abstracts and articles appearing recently in the Journal of Insurance Medicine.

Abstract Background While many studies have examined differences between body mass index BMI categories in terms of mortality risk and health-related quality of life HRQL , little is known about the effect of body weight on health expectancy. HALE at age 20 follows these same associations and is significantly lower for class 1 obesity in women. Proportion of life spent in nonoptimal health and decomposition of HALE demonstrate progressively higher losses of healthy life associated with lowered HRQL for BMI categories in excess of normal weight. Conclusions Although being in the overweight category for adults may be associated with a gain in life expectancy as compared to normal weight adults, overweight individuals also experience a higher proportion of these years of life in poorer health. Due to the descriptive nature of this study, further research is needed to explore the causal mechanisms which explain these results, including the important differences we observed between sexes and within obesity subcategories. Overweight, Obesity, Underweight, Body mass index, Life expectancy, Health expectancy, Mortality, Health-related quality of life Background As rates of overweight and obesity continue to climb in Canada and many other developed countries, curbing and reducing these rates has become a long-term goal for public health practitioners in these countries [1]. Underweight adults are also at risk for negative health consequences including elevated mortality [2]. Health expectancy measures such as health-adjusted life expectancy HALE combine life expectancy LE with a measure of health-related quality of life HRQL or disability to create an indicator for assessing the combined effects of health and mortality, which is expressed in an intuitive measure similar to that of life expectancy [3]. Furthermore, in populations where life expectancy is increasing, health expectancies can be used to monitor whether the proportion of life spent in health is increasing compression of morbidity or decreasing expansion of morbidity due to a particular health problem such as insufficient or excess body weight [4]. Certain associations have been demonstrated between the body weight categories of underweight, overweight, and obese including its two subcategories: Recent national population-based studies in Canada and the United States [2 , 5 , 6] have demonstrated that being in the underweight or severely obese BMI category is associated with an increased risk of mortality amongst adults in the general population when compared to their peers in the normal weight BMI category These same studies also demonstrated a decreased risk of mortality for those in the overweight category when compared to those in the normal weight category: Other studies have demonstrated an increased risk of mortality with overweight and lower levels of obesity. However, these studies tended to be based either on more restricted populations that exclude older adults, as well as certain socio-economic status and ethnic groups which may have a greater number of competing mortality risks as compared to the general population [8 - 10]. Additionally, some of these study populations consist of less-recent cohorts [11 , 12] where follow-up occurred during time periods when mortality risk for excess weight may have been greater [6]. When the effects of BMI on health-related quality of life are observed, the literature for population-level studies [13 - 15] generally demonstrate that for women, there is a consistent decrease in HRQL across excess weight categories. The two studies [14 , 15] which addressed underweight demonstrated that this weight category is associated with lower HRQL in both sexes, although this association appears to be age-dependent for women [14]. While these studies provide insight into health losses due to premature mortality and reduced HRQL, there are a limited number of studies that examine how BMI impacts on both of these two measures in the form of health expectancy. Four studies have examined health expectancy for multiple BMI categories [16 - 19]. When stratified by sex, the estimates for health expectancy in these studies range from small gains for overweight women and negligible losses for men in the excess weight categories, to considerable loss of health expectancy for overweight women and obese men and women. Several of these studies have one or more limitations which make it difficult to assess health

expectancy results by BMI category at the population level. Another of these studies [19] based its relative risks for obesity-related morbidity and mortality on studies using populations other than the study population, which may lead to biased estimates [20]. In addition, none of these studies presented complete health expectancy results by obesity subgroup i. Health expectancy for those in the underweight category has also not been explored to date. In both surveys, the samples are weighted to be representative of the Canadian population. The methodology of these surveys has been described in detail elsewhere [21 , 22] and are briefly summarized here. We used eight cycles of the data covering the period from to Mortality follow-up occurred regardless of response status, and thus there is little loss to follow-up with mortality as the studied end point. The survey includes self-reported height and weight as well as information about health status and health determinants. Data are available from and, since , are collected on an ongoing basis. Prior to , data collection occurred every two years over a month period. In order to reduce the variability in our estimates, we combined the first three CCHS cycles, which span the years â€" The sample size generated by combining these three cycles for BMI prevalence estimation was ,, with an age range of 20 to The household-level response rate was between Two different methods are recommended for combining data from different survey cycles: The choice of approach is based, amongst other things, on the degree to which the parameter being measured remains constant between cycles. The age-sex-specific BMI prevalences were estimated based on the separate approach, in which a simple average of estimates from each CCHS cycle being combined is calculated. Since the age-sex-specific Health Utilities Index HRQL measure explained in more detail below estimates were more stable across cycles, the pooled approach was used in which the microdata from each cycle are combined into a single sample. The CCDSS is a national collaborative network of provincial and territorial chronic disease surveillance systems that collect administrative health care data [24]. The CCDSS data include death and population counts by sex and five-year age groups and health information such as the prevalence and incidence of selected chronic diseases. Total mortality rates were estimated from CCDSS data for the period of â€" by sex and five-year age groups. Ethical approval was not required as this study was based on analysis of secondary data and no experimental research on humans was carried out. A sensitivity analysis was performed to evaluate the impact of using self-reported BMI as compared to BMI corrected for self-report bias [25]. HUI is a preference-based measure that defines health states according to eight attributes vision, hearing, speech, ambulation, dexterity, emotion, cognition, and pain , with five or six levels ranging from normal to severely limited functioning for each. Single attribute utility scores range from 0. The eight attributes are combined into a single score using the multi-attribute utility function: The overall scores on the HUI range from From a societal perspective, some health states are considered worse than death, and consequently are assigned negative scores. Details are described elsewhere [28] on how the utility scores are derived from preference scores for individual attributes. A discrete-time proportional hazard model using a complementary log-log function clog-log was used to estimate HR. The model was adjusted by BMI category, sex, and age group. The linearity assumption was supported and goodness of fit was confirmed using the Hosmer-Lemeshow test. By taking into account BMI prevalence by sex and five-year age group and the relative risk of dying for each BMI category relative to the normal weight category by sex and for two age groups, the age-specific mortality rates for the total Canadian population were partitioned into mortality rates by BMI class, sex, and five-year age group. The formulae used to determine mortality rates are available in an Additional file 1 to this article. This method has been demonstrated to be an unbiased and consistent estimator of health expectancy [32].

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5: How to Prepare a Life Expectancy Report for an SPECIAL REPORT

Descriptive and Analytic Studies Descriptive Studies. Characterize who, where, or when in relation to Mortality rate = / 24,

This type of graph is useful for identifying medians and quartiles and other percentiles. D death-to-case ratio the number of deaths attributed to a particular disease, injury, or other health condition during a specified period, divided by the number of new cases of that disease, injury, or condition identified during the same period. For a rate, the denominator is usually the midinterval population. In statistics, the frequency and pattern of the values or categories of a variable. E effect the result of a cause. Usually, the cases are presumed to have a common cause or to be related to one another in some way see also outbreak. Analytic epidemiology uses comparison groups to provide baseline or expected values so that associations between exposures and outcomes can be quantified and hypotheses about the cause of the problem can be tested see also study, analytic. F false-negative a negative test result for a person who actually has the condition similarly, a person who has the disease perhaps mild or variant but who does not fit the case definition, or a patient or outbreak not detected by a surveillance system. Similarly, a person who does not have the disease but who nonetheless fits the case definition, or a patient or outbreak erroneously identified by a surveillance system. Data points are plotted at the midpoints of the intervals and are connected with straight lines. G geometric mean see mean, geometric. H health a state of complete physical, mental, and social well-being and not merely the absence of disease or other infirmity. Data from these systems are used to learn about health status, health care, provision and use of services, and the impact of services and programs on health. The class intervals of the variable are grouped on a linear scale on the horizontal axis, and the class frequencies are grouped on the vertical axis. Columns are drawn so that their bases equal the class intervals i. The alternative is adopted if the null hypothesis see also hypothesis, null proves implausible. The null hypothesis is used in conjunction with statistical testing. I immunity, active resistance developed in response to an antigen i. Herd immunity is based on having a substantial number of immune persons, thereby reducing the likelihood that an infected person will come in contact with a susceptible one among human populations, also called community immunity. Incidence rate is calculated as the number of new cases over a specified period divided either by the average population usually mid-period or by the cumulative person-time the population was at risk.

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6: Epidemiology for Public Health Pratice: Table of Contents

The study population consisted of registered nurses working in selected medical college hospitals and government hospitals of Udupi and Mangalore districts. Descriptive survey design was used to.

Singer, MD The purpose of this methodology article is to describe a suitable format for a legally acceptable report on the life expectancy of the principal in a tort case that is being advocated or defended by an attorney. Life insurance medical directors and underwriters are clearly skilled and experienced in mortality risk classification for life insurance. However, the judicial system is accustomed to measuring excess mortality only in terms of reduced life expectancy. The analyst preparing the report must convert the excess mortality into a figure for reduced life expectancy and compare this with the life expectancy of persons matched by age, sex and race in the latest Decennial US Life Tables. This process is different from the life insurance underwriting process. A life table projected to age must be constructed as an essential part of the report, and the entire process must be presented clearly and convincingly. There are good reasons why the excess death rate EDR should be used as the index of excess mortality in constructing the life table, in preference to the mortality ratio MR , which is used most of the time in life insurance risk classification. All of these considerations are discussed in this article, which is based on a sample of 40 cases handled by the author, a retired life insurance medical director. Life expectancy, excess mortality, life table, tort cases, judicial system. March 12, Accepted: August 18, Methodology Article N5 cians board certified in the specialty involved. As all American Academy of Insurance Medicine AAIM members know, most physicians, no matter what their medical expertise and experience in their specialty, have no expertise in mortality risk appraisal. There are exceptions, in those interested in followup studies, clinical trials and clinical decision-making, but as far as I know they constitute a small minority. Providing an expert opinion on life expectancy represents an opportunity for life insurance medical directors to utilize their skill in medicine and mortality risk appraisal to render a valuable service to attorneys in providing a truly expert opinion BACKGROUND In the 15 years that I have been involved, the court system personnel attorneys, their staff and judges all have employed life expectancy as their index of reduced survival in assessing damages in tort cases. I believe this practice goes back a century or more. Life expectancy is usually derived from population life tables. However, attorneys and the courts recognize that many injuries and medical conditions are associated with excess mortality and reduced life expectancy. However, the preparation of a good report is a very different procedure from rating a life insurance application, as I will explain in this article. If desired, the corresponding age can also be transferred from the reference table. In column 3, the decimal EDR is inserted in the top row of the age sequence for EDR generally a quinquennial interval, except for the last, which is carried to age The same EDR is copied into the remaining years of the sequence. All EDR values that are tailored to the individual case must be calculated in advance and inserted into the appropriate attained age intervals. In column 4, also an insertion, the projected annual mortality rate of the group at increased risk is derived from the data in columns 2 and 3: This is done in accordance with the formula method of Microsoft Excel, or whatever spreadsheet program is utilized. The arbitrary number of A decimal place is carried for reference when survivors become very few because of attrition by death. Deaths d are shown in column 6. They are derived as the product of projected q and Cohort: Deaths during a year of attained age must be subtracted from the Cohort to obtain the number of survivors alive at the start of the next year of attained age: Cohort61 5 Cohort60 2 d60 5 This attrition is the basis of linking the life table calculations for one year of age with those for the next year. L in column 7 and T in column 8 are auxiliary variables needed for the life table calculation of life expectancy. L is the average number exposed to risk during the full year of attained age or the number at risk at the midpoint of the year, approximated as: L 5 Cohort 2 0. T is the sum total of all values of L from the current year through age I should mention that virtually all of the life tables for my mortality articles are prepared with a pocket calculator, because they are short tables. However, the average life expectancy table is over 50 lines starting

age about 55, with annual data through age It would be too time consuming to attempt this calculation process by hand. But, it can be done in less than an hour with a spreadsheet program, which can be readily constructed by any reader familiar with computerized spreadsheets. The life expectancy chosen for this article, shown in Table 2, in which the decimal EDR values are those derived for the fictitious case example created for this article. The columns are numbered numerically from the left, as I explain the derivation of the variable in each column. Age, in the left hand column 1, is for the last birthday and starts with age used as the starting age in the report. All attained ages from the starting age to age the highest shown in the Decennial US Life Tables must have data calculated to make the most accurate calculation of life expectancy. Life Table for Mr. ABC, WM age The calculation for this is: Instead, successive values are still displayed, decreasing from 1. The reason for this is that 16 decimal places are carried for arithmetical calculations in the memory of the computer but not displayed in the table, for which only one decimal place has been selected for these variables. However, this is subject to modification if the hours prove to be insufficient. For this case, you receive two thick loose-leaf volumes of the complete medical records from outpatient clinics, hospital admissions and test procedures at units of the Department of Veterans Affairs DVA. The case involves a veteran, Mr. ABC, who had 4 years of Army service. Unfortunately during recovery, he had a mucous plug obstructing his trachea, which produced anoxia and irreversible brain damage before it was discovered and aspirated. ABC was adjudged to be brain dead and assisted ventilation was discontinued at the request of the family. You have several inches of medical records to review. You will pay special attention to the discharge summaries, important records of the hospital admissions, which are almost always typed and therefore easily legible, and the chief source of medical information pertinent to your assessment of life expectancy. Outpatient records are generally handwritten and often illegible. In this case, however, there is a history of borderline and increasing blood pressures, culminating in a hospital admission 5 years prior to death with diagnosis of definite hypertension. Antihypertensive drugs were prescribed and ABC was followed in the clinic with many blood pressures recorded. As a conscientious reviewer, you accordingly review the outpatient records page by page and record all the blood pressure readings in your notes, so that you can arrive at an average under recent treatment. The attorney is charged with defense of a suit against the United States for wrongful death of a veteran due to complications following an operation at a Veterans Hospital. Before the operation, the veteran had at least 3 mortality risk factors: The attorney probes your qualifications and ascertains your fee schedule and availability, if needed, to make a deposition in your home city and to testify in trial at a US District Court, usually in a distant city. He asks for your curriculum vitae, and if he is satisfied with your qualifications he calls you again, and requests you to make a report after you have reviewed the medical records. Customarily, you are requested to make a preliminary estimate of the life expectancy after you have reviewed the records. Then you call the attorney and discuss your estimate, so that he may confirm the preparation of the report or rarely to ask you to stop further work on the case. It sometimes happens that a case may be settled before you have written the report. For important information in your notes, you should record the page number, so you can refer back for details in writing your report. In the case of ABC, your review confirms the 3 common, significant risk factors as described by the attorney with no other significant ones, past or recent. You prepare a worksheet to record each of these and your source data for EDR by age and duration. A subject-classified source for follow-up studies is in a recently published bibliographic index. I have seldom needed to do a literature search if time was available to make one. The best source, of course, is the Build Study. Table D63 should be used, because it gives excess mortality by duration for men with and without minor impairments, and excess mortality, even by MR, increases with duration of follow-up. However, it may be calculated from the MR and expected mortality rates given in a table on page 9, as shown below, for men aged 40â€” Labile readings about this level were confirmed on admission and as the blood pressure was monitored thereafter. Various studies were normal, including heart size by chest x-ray, electrocardiogram, urinalysis, echocardiogram, renal function and other studies. ABC was started on antihypertensive medication, discharged, and followed in the hypertension clinic. In all, 34 readings were

recorded over the next 5 years. For excess mortality, you consult the separate results summarized in a article in the Journal of Insurance Medicine,9 not the combined standard and substandard results of the Blood Pressure Study. ABC should be in the substandard experience of Table 3 of the cited article men aged 40â€”69 , because of the history of hypertension and current readings being under treatment. I prefer to use the very large American Cancer Society year follow-up of smokers and nonsmokers as developed in Abstract in the Medical Risks monograph. These rates are given for quinquennial attained age groups from 40â€”44 through 85â€”89, and they increase progressively with age. These differences, which I consider to be a good estimate of excess mortality in men smoking a pack or more per day are: Since the average covers a period of 5 years since diagnosis at age 55, we should use the experience from 5 to 22 years for attained ages 60 and up: Attained age EDR 60â€”64 7 65â€”69 10 Summary of Qualifications I insert this paragraph to circumvent the need for the reader to consult a separate document. This should emphasize your expertise in medical risk appraisal and the use of life table methodology. These two paragraphs usually take up the first page. Age Smoking Obesity High BP Total EDR 60â€”64 13 10 7 30 65â€”69 19 25 11 55 70â€”64 29 42 20 91 75â€”79 38 42 20 This is a chronological account of the medical history of the case, based on your notes and reference to the original records for details when needed. You will probably have some reorganizing to do because the records are seldom in completely chronological order, and sometimes duplicates are included. You may have to request records that appear to be missing. Preparing a clear chronological history is a challenge, but it is necessary for the next step. The organization I use is intended to be complete, logical and clear to the attorneys on both sides, any mediator, and the judge, if the case comes to trial. Your objective is to clarify the concepts of excess mortality, EDR, and their application to the life table method of calculating life expectancy. I use the following order of presentation. Mortality Risk Factors Dating the assessment of risk factors is based on your judgment after discussion with the attorney. The date may not be the latest available, including the date of death, if death is involved. It might be before a diagnosis is made or a major operation is carried out. In this section, you list the risk factors, cite the source you select for EDR data in each one, describe the study very briefly, and give the EDR values by duration, converted to attained age.

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7: Center for Demography of Health and Aging

A subject-classified source for follow-up studies is in a recently published bibliographic index.4 You should be familiar with mortality articles in recent issues of the Journal of Insurance Medicine.

Estey in three increments: May , July , and January Accession The greater part of the Correspondence Series has been arranged chronologically, and the remainder arranged alphabetically. The other five series in the collection are arranged alphabetically. Richard and his older brother, Edgar A. Richard graduated in after advancing two grade levels. Upon his return to the United States in the winter of , Richard entered the University of Pennsylvania, where over the next eight and one half years he earned three degrees: He followed his graduation from Medical School by serving a two-year rotating internship at the Hospital of the University of Pennsylvania. In the National Research Council awarded Singer one of its prestigious fellowships. He used it to conduct research at Harvard University in acid-base balance in human blood. At Harvard, Singer worked under the direction of Dr. His research was eventually interrupted by World War II. Singer continued in the Naval Reserve until when he retired with the rank of captain. He remained with the firm until his retirement in It was at New England Mutual Life that Singer began his studies on the analysis of excess mortality follow-up studies â€" which he would continue after his retirement. Singer married Margaret Henson in and they had three children â€" Elizabeth, Permelia, and Richard. They lived there until , when they retired to York, Me. Richard Bunker Singer passed away on February 19, Margaret Henson Singer died eleven weeks after her husband, on May 11, The collection has been organized into seven series: The Correspondence Series predominantly consists of letters sent to Dr. Singer throughout his life, with copies of outgoing correspondence starting around Singer to his family. The bulk of letters are from family members, and covers such topics as summer camp in New England, trips to Cape May, NJ, service during World War II, and his career as a medical researcher. Letters from his brother Edgar A. Also of note are two letters from Dr. Ravdin in and ; and letters from his classmate John Joyce Sayen who served in the 20th General Hospital and later collaborated with him in medical research. The Personal Series documents Dr. Singers education, travels, affiliations, U. Navy service, and other aspects of his life not related to his career. The Research Series contains material from Dr. Works By contains drafts and final versions of Dr. The Photographs Series contains images of Dr. Singer, as well as a number of images taken by him during his trips to Europe and Cape May. Most photographs appear to have been taken by Singer and show images around the base â€" particularly the medical department. The images from Dr. The Awards Series contain a number of plaques which Dr. Singer received throughout his career. Of note for researchers interested in Cape May, NJ the collection has a number of images of the resort town from the s through the s. This includes scenes of the Baltimore Inn, the boardwalk including a Mummers parade , the beach, sailing scenes, and images of the old NAS Cape May hanger. In the correspondence series there are also a number of post cards from Cape May â€" including ones from the World War II period. When the Singer family vacationed in Cape May they regularly stayed at the Baltimore Inn, as such the collection contains correspondence from the hotel.

8: Results for Richard-B-Singer | Book Depository

Background. While many studies have examined differences between body mass index (BMI) categories in terms of mortality risk and health-related quality of life (HRQL), little is known about the effect of body weight on health expectancy.

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