board-certified dermatologist—they still must have additional specialized training or experience in pediatric dermatology to qualify for this subspecialty certification.

Harry J. Hurley, MD
John S. Strauss, MD
Executive Consultants
American Board of Dermatology
Detroit, Mich

In Reply: I appreciate the clarification.
Lynne Lamberg
JAMA Medical News & Perspectives

A Story About Suicide in the Arctic

To the Editor: In his A Piece of My Mind article entitled “Five Miles From Tomorrow,” Dr Shah1 describes an elderly Inuit man who was seen at our clinic, and who was said to end his life by walking into the ocean. I remember well Shah’s medical student rotation with us last year, and I enjoyed the week that we spent together. As his supervising physician during that week, I believe that his story deserves a response.

I appreciate Shah’s story for the questions it raises about respecting end-of-life wishes, whether or not they occur in the context of an intensive care unit or a remote arctic village. However, the subtleties and complexities of real-life medicine are better appreciated in case illustrations when they have some basis in reality. Shah’s article is presented as a true story, when in fact there is little truth about it. I can understand Shah wanting to change details to protect confidentiality. I can even understand his wanting to “tweak” his description of the events a little to make it a better story. But Shah’s story goes beyond such editorial adjustments: the events described in his story never happened.

There was no elder who came to us with a complaint of “uselessness” or with the intent of “saying good-bye.” There has never been a Siberian Yupik tradition that an elder “bids farewell to his family and walks over the frozen Arctic Ocean, never to return.” Shah’s story perpetuates a falsehood that has never been true among the Inuit of Alaska. Thiers is not “a culture that feels a man is only as valuable as the wisdom he imparts.” As in all Inuit cultures, the Siberian Yupik hold their elders in very high esteem—partly because of their role as reservoirs of cultural traditions and wisdom, but mostly just because they are the elders. They are intrinsically valued as indispensable members of the community. Nor is the arctic a “harsh land of limited resources” where such a tradition might evolve. To the Inuit, the land is bountiful and beautiful, an inextricable element of their cultural identity that has always provided what is needed for their survival.

Being fiction does not necessarily detract from the value of Shah’s story. As a piece of fiction, this is a nice story that offers an insightful reflection on our own cultural prejudices: when so much of a person’s status depends upon performance and achievements, suicide might become a reasonable option for uselessness. But an elder faced with such despair would be far more common within our own culture than he would among the Siberian Yupik.

Michael D. Swenson, MD, PhD
Norton Sound Health Corporation
Nome, Alaska


In Reply: Although I appreciated Dr Swenson’s teaching and clinical insights, his criticisms of the story bear little relation to the larger issues of cultural sensitivity and end-of-life care that the story addressed.

Swenson complains that the story is written as a first-person account; no such event took place during our week in the Arctic. However, this does not mean that such events do not occur in the village I was writing about. Several residents and patients in Nome related similar stories throughout my 5-week stay. As I wrote the story, I was aware of the need to condense events to present a formalized and palatable essay—one that would raise the pertinent issues of medicine and cultural context in a readable format. This was necessary to protect patient confidentiality and falls well within the limits of artistic license. Swenson himself acknowledges both these needs, stating he understands the need to alter events “. . . to make it a better story.” Thus, the ultimate purpose of the story was hopefully served, and the medical community can concentrate more on end-of-life issues and less on stylized writing.

No one doubts elders in the Yupik culture are held in high esteem by their peers. I purposely noted this in my story, which mentions the patient’s ability to impart mastered skills to others. However, being held in high regard by peers does not necessarily translate to feeling useful in a part of the world where living is extremely difficult. Such feelings have, I believe, led several older members of Inuit to take the actions I discussed.

Shetal I. Shah, MD
Durham, NC

Editor’s Note: At the time Dr Shah’s manuscript was accepted, the editors believed that the essay represented his actual experience. The author’s cover letter of submission states: “The story represents an experience I had an [sic] a visiting medical student in the remote village of Gambell, Alaska.”

RESEARCH LETTER

Relationship Between Asthma Prevalence and Income Among Canadians

To the Editor: Asthma is one of the most common chronic diseases in Canada,1 and it has been observed that Canadians with low incomes are at increased risk of asthma.2 Based on data from 17605 participants in the first cycle of the National Population Health Survey (NPHS) in 1994 through 1995, men and women with low incomes had 1.44- and 1.33-fold increases, respectively, in the prevalence of asthma compared with their coun-

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terparts with high incomes; however, there was no significant difference observed between middle- and high-income categories. A much larger sample size of the second cycle of NPHS allowed us to further explore whether the prevalence of asthma increases consistently with decreasing income.

Methods. We analyzed the cross-sectional data of the NPHS, conducted by Statistics Canada in the period 1996 through 1997. The design and execution of the survey have been detailed elsewhere. A total of 173032 respondents aged 12 years or older who responded to the question about asthma were included in this analysis. Respondents who answered the following question affirmatively were considered as having asthma: “Do you have asthma diagnosed by a health professional?”

Based on total household income adjusted for the number of household members, subjects were classified into 3 income categories: low (<$15000/y for 1 or 2 people; $10000-$14999 for 3 or 4 people; $15000-$29999 for 5 or more people), middle ($15000-$29999 for 1 or 2 people; $20000-$39999 for 3 or 4 people; $30000-$59999 for 5 or more people), and high ($30000-$59999 for 1 or 2 people; $40000-$79999 for 3 or 4 people; ≥$60000 for 5 or more people) (all currencies expressed in Canadian dollars). Other variables included in the analysis were sex, age, history of allergy, household size, and number of bedrooms. Point estimates were weighted according to the demographic profile of the Canadian population, and the Rao-Wu bootstrap method was used to estimate the standard errors of these estimates to take into account the complex survey design. Logistic regression models were used to evaluate the association between income adequacy and the prevalence of asthma after adjusting for covariates. Model parameters were estimated by the method of maximum likelihood, and were tested for significance using the Wald statistic.

Results. Of 84311 men and 88721 women 12 years of age or older, 5.7% (93% confidence interval [CI], 5.4%-6.0%) of men and 7.9% (95% CI, 7.5%-8.3%) of women reported having asthma. The prevalence of asthma was higher for the age group 12 through 24 years (10.5%) compared with other age groups (25-39 years, 6.6%; 40-54 years, 5.1%; 55-69 years, 5.6%; ≥70 years, 6.0%). The prevalence of asthma increased with decreasing household income in both men and women (Table). After adjusting for sex, age, history of allergy, household size, and number of bedrooms, individuals with low incomes had a higher risk of asthma while those with high incomes had a lower risk, compared with those having middle incomes. The results were consistent for men and women.

Comment. This analysis indicates that the risk of asthma increases with decreasing income adequacy in both sexes. We consider income adequacy, as measured at the household level, to be an indicator of familial resources and standard of living. There exist several mechanisms whereby income adequacy may influence asthma. Poor inner city housing may increase exposure to cockroach and mouse antigens. The prevalence of cigarette smoking is inversely related to income. Other unexplored possibilities include living in more polluted neighborhoods and differences in dietary habits. Our results suggest that asthma control and prevention programs should target lower income families to a greater extent than higher income families. However, it is not yet known if income is related to new development of asthma, exacerbations of preexisting asthma, or both.

Table. Relationship Between Income Adequacy and the Prevalence of Asthma Among Canadians Aged 12 or More Years*

<table>
<thead>
<tr>
<th>Income Adequacy</th>
<th>No. (%)</th>
<th>Asthma Cases</th>
<th>AOR† (95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>7586 (8.0)</td>
<td>529</td>
<td>1.30 (1.00-1.68)</td>
</tr>
<tr>
<td>Middle</td>
<td>19241 (6.0)</td>
<td>1241</td>
<td>Reference</td>
</tr>
<tr>
<td>High</td>
<td>38431 (5.1)</td>
<td>2242</td>
<td>0.74 (0.63-0.87)</td>
</tr>
<tr>
<td>Unknown</td>
<td>19053 (5.2)</td>
<td>1111</td>
<td>0.89 (0.76-1.05)</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>10761 (10.4)</td>
<td>1178</td>
<td>1.26 (1.08-1.47)</td>
</tr>
<tr>
<td>Middle</td>
<td>20938 (8.0)</td>
<td>1702</td>
<td>Reference</td>
</tr>
<tr>
<td>High</td>
<td>36495 (7.1)</td>
<td>2765</td>
<td>0.79 (0.70-0.91)</td>
</tr>
<tr>
<td>Unknown</td>
<td>20527 (7.4)</td>
<td>1579</td>
<td>0.97 (0.83-1.11)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18347 (9.4)</td>
<td>1707</td>
<td>1.27 (1.11-1.45)</td>
</tr>
<tr>
<td>Low</td>
<td>40179 (7.1)</td>
<td>2943</td>
<td>Reference</td>
</tr>
<tr>
<td>High</td>
<td>74926 (6.1)</td>
<td>5007</td>
<td>0.77 (0.69-0.86)</td>
</tr>
<tr>
<td>Unknown</td>
<td>39580 (6.4)</td>
<td>2690</td>
<td>0.93 (0.84-1.04)</td>
</tr>
</tbody>
</table>

* AOR indicates adjusted odds ratio; CI, confidence interval.
† Adjusted for sex, age, history of allergy, household size, and number of bedrooms.

CORRECTION

Incorrect Wording: In the Medicine and the Media article entitled “Violence in E-Rated Video Games” published in the August 1, 2001, issue of THE JOURNAL (2001; 286:591-598), there was an incorrect word in a sentence. On page 596, at the bottom of the first column, the part of the sentence that read “curb your desire” should have read “control your desire.”

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