75.4 for white men)\(^6\) in the same year—more than 3 years less than for Japanese men in Japan. The assertion that “differences in infant mortality are largely a function of the prevalence of low birth weight . . . race is the most significant factor”\(^7\) is also incorrect. Removing all births to African American mothers (to minimize the effects of race) does not substantially change the poor ranking of the United States on infant mortality.\(^7\)

Barbara Starfield, MD, MPH
bstarfield@jhsphs.edu
Johns Hopkins School of Public Health
Sharon D. Morris, MLS
Sheridan Libraries
Milton S. Eisenhower Library
Johns Hopkins University
Baltimore, Md


In Reply: Goodman et al\(^1\) explain that outcomes such as life expectancy and infant mortality are a function of many factors besides medical care. Important variables include diet, social status, social stability, wealth, and risk-taking behavior—as well as genetic endowment. Additionally, they argue that the health of US residents is not poorer than that of people who live under single-payer health systems. Their argument is buttressed by extensive references to official statistics and the medical literature, which cannot be cited in a brief book review or letter.

Median life expectancy at birth for members of the European Union is 81.2 years for women and 75.1 years for men,\(^2\) compared with 80.1 years and 74.7 years, respectively, for US non-Hispanic whites.\(^3\) Median life expectancy at age 65 years, perhaps a better reflection of medical care, is 19.2 years for women and 15.7 years for men in the European Union, compared with 19.2 years and 16.3 years for US women and men, respectively, for all ethnic groups combined.\(^2\)

Lacking data about Japanese Americans, Dr Starfield and Ms Morris compare life expectancy in men in Japan (78.4 years) to overall life expectancy for American men (74.8 years). A more appropriate comparison is to life expectancy in Asian American men (80.9 years).\(^3\) More recent data than those cited by Goodman et al indicate that Japanese American men living in Hawaii were outliving their Japanese counterparts.\(^4\)

Goodman et al state that higher US infant mortality is partly explained by a higher frequency of low birth weight and that incidence of low birth weight is nearly twice as high in African Americans. The reference of Arias et al\(^5\) cited by Starfield and Morris corroborates both statements. Birth weight-specific perinatal mortality in the United States compares very favorably with that in Norway and Japan. The actual reported mortality rates in 1980-1982 were, per 1000 live births, 10.8 for Japanese infants, 10.5 for Norwegian infants, 11.1 for white US infants, and 19.8 for black US infants. However, using US race and birth weight–specific rates, infant mortality would have been 7.9 for US whites and 6.5 for blacks had the US birth-weight profile been like that of Japan, and 6.8 for whites and 6.6 for blacks had the profile been like that of Norway.\(^6\)

A single-payer health care financing system would not remedy the multifactorial causes of death.

Jane M. Orient, MD
jorient@ mindspring.com
Association of American Physicians and Surgeons
Tucson, Ariz


CORRECTIONS

Editing Error: In the 10th paragraph of the Medical News & Perspectives article “The Gut Yields Clues to Obesity, Therapies” published in the May 11, 2005, issue of JAMA (2005;293:2200-2201), the figures given for weight loss due to drug therapy were incorrect. The correct amount is 2 to 10 kg (4.4 to 22 lb).

Incorrect Author Name: In the Research Letter entitled “Respiratory Illness as a Reaction to Tropical Algal Blooms Occurring in a Temperate Climate” published in the June 1, 2005, issue of JAMA (2005;293:2599-2600), an author’s name was incorrectly spelled. The name should be Nicolet Gentilioni Silver, MD.

Acknowledgment Omitted: In the Original Contribution entitled “Multidrug Resistance Among Persons With Tuberculosis in California, 1994-2003” published in the June 8, 2005, issue of JAMA (2005;293:2732-2739), the acknowledgment was incomplete. The authors also thank Sarah Royce, MD, MPH, of the TB Control Branch in California for her contributions.