board-certified dermatologist—they still must have addi-
tional specialized training or experience in pediatric derma-
tology to qualify for this subspecialty certification.
Harry J. Hurley, MD
John S. Strauss, MD
Executive Consultants
American Board of Dermatology
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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 medi-
cal 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 re-
specting end-of-life wishes, whether or not they occur in the
context of an intensive care unit or a remote arctic village. How-
ever, 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 want-
ing to change details to protect confidentiality. I can even un-
derstand 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 “use-
lessness” or with the intent of “saying good-bye.” There has
never been a Siberian Yupik tradition that an elder “bids fare-
well 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. Theirs 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 ele-
ment 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 cul-
tural context in a readable format. This was necessary to pro-
tect 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 hope-
fully 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 oth-
ers. However, being held in high regard by peers does not nec-
essarily 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 be-
lieved that the essay represented his actual experience. The author’s cover letter
of submission states: “The story represents an experience I had as [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 dis-
eases 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, respec-
tively, 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; $39999 for 3 or 4 people; $30000-$59999 for 5 or more 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.

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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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