

**TABLE 1—Cause-Specific Death Ratios (%) in Florida Correctional Institutions: 1987 through 1992**

Cause of Death	1987 (n = 75)	1988 (n = 83)	1989 (n = 97)	1990 (n = 93)	1991 (n = 123)	1992 (n = 130)
AIDS	34.7	38.6	41.1	42.7	48.0	52.3
Cardiac arrest	18.7	15.7	13.7	16.7	18.7	13.1
Cancer	13.3	22.9	21.1	20.8	16.3	13.1
Neurological	4.0	1.2	0	4.1	2.4	3.1
Meningitis	0	0	0	2.1	0	0.7
Respiratory	1.3	2.4	3.2	1.0	2.4	3.1
Asthma	2.7	1.2	1.1	0	0	2.3
Tuberculosis	1.3	0	0	0	0.8	0
Hepatic-related	0	4.8	5.3	5.2	2.4	3.8
Renal failure	0	2.4	1.1	0	0	0
Septicemia	4.0	0	2.1	0	0.8	0
Vascular	1.3	0	3.2	0	0	0
Postoperation complications	0	2.4	1.1	0	0	0
Bleeding	1.3	0	0	0	0	0
Diabetes complications	0	0	0	0	2.4	0
Gastrointestinal disease	0	0	0	0	0	2.3
Suicide	8.0	2.4	4.2	2.1	2.4	4.6
Accidents	2.7	1.2	2.1	2.1	3.3	1.5
Homicide	6.8	4.8	1.1	3.1	1.6	0

Note. These percentages are based on the number of deaths each year that occurred in Florida's major institutions and that were subject to mortality review by the Bureau of Health Services, Florida Department of Corrections.

Source. Ratios are based on data from the Florida Department of Corrections Health Services, Quality Management Program, 1993.

for study period = 601). In 1987, AIDS was clearly the major cause of death. The percentage of deaths from AIDS was higher than those for all other causes, and it was about twice as high as the percentage for cardiovascular diseases and about three times that for cancer deaths.

AIDS remained the major cause of death throughout the study's 5-year period. Moreover, the data show a systematic increase in AIDS-related deaths, compared with all other causes or groups of causes. In 1992, the ratio of AIDS-related deaths was about four times as high as those for cardiovascular diseases and for cancer deaths. The ratios for most of the other natural causes of death remained relatively constant over the 5-year period, except for some fluctuation in cancer mortality. The data also illustrate that prison AIDS deaths were concentrated among young Black men (not shown in the table).

It is obvious from this study that AIDS education is necessary for inmates. Also, there is an urgent need for state and city government and prison administrators to review their policies on AIDS among prisoners. □

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## The Reliability of Cigarette Consumption Reports by Spousal Proxies

In smoking and passive smoking studies, information on the exposures is often provided by proxy respondents. Previous studies have shown a moderate agreement ranging from 53% to 69% between subjects and their spouses or other relatives as proxies on daily cigarette consumption.<sup>1</sup> Spouses are relatively reliable informants on smoking status and the age at which the subject started smoking.<sup>2</sup> One study reported that proxy wives appeared to overestimate the amount that their husbands smoke.<sup>3</sup> There is lack of clear evidence about the reliability of smoking information provided by proxy husbands.

We studied 1998 residents aged 18 to 74 years, representing 86% of the eligible population in the town of Humboldt, Saskatchewan, in 1993. Among the participants, there were 638 spouse pairs. A self-administered questionnaire was delivered to each subject's home. Questions covered information about current daily cigarette consumption of both the subjects and their spouses. Of the 638 pairs, 13 wives and 10 husbands did not complete a question about their spouses' total daily cigarette consumption. An agreement to within five cigarettes a day was calculated between subjects and spousal proxies after excluding pairs with missing data. The agreement between husband subjects and wife proxies was 92.8% and that between wife subjects and husband proxies was 93.0%, each with an estimated kappa value of 0.73 (Table 1). The proxy information seems unbiased.

Compared with previous studies,<sup>1</sup> our data showed greater agreement between subjects and spousal proxies on daily cigarette consumption. An important reason for improved agreement could be that subjects completed the questionnaire at home, where they could have consulted with their spouses if they wanted. In addition, the prevalence of current smoking was low in this population, 19% among the population aged 18 to 74 years and 14% among married couples, comparable to the smoking prevalence in the general Canadian population for this ethnic group.<sup>4</sup> There was greater agreement on nonsmoking than on smoking consumption.

In studies of passive smoking and children's health, parents are frequently

**TABLE 1—Daily Cigarette Consumption Reported by Subjects and Spousal Proxies: Number of Spousal Pairs (n = 638) in Agreement**

Consumption Reported by Subject	Consumption Reported by Spousal Proxy							Total
	None	1-5	6-10	11-15	16-20	21-25	25+	
<b>Husband</b>								
None	529	1		1				531
1-5	5	6	2		1			14
6-10	2	1	6					9
11-15	1		7	9	2			19
16-20			2	3	9	4	1	19
21-25					1	17	2	20
25+			1			8	4	13
<b>Total</b>	<b>537</b>	<b>8</b>	<b>18</b>	<b>13</b>	<b>13</b>	<b>29</b>	<b>7</b>	<b>625<sup>a</sup></b>
<b>Wife</b>								
None	536	1						537
1-5	3	9	2					14
6-10	1	5	13	7	1			27
11-15	1	1	5	12	2	1	1	23
16-20				1	7	5	1	14
21-25				1	1	6	1	9
25+			1		2		1	4
<b>Total</b>	<b>541</b>	<b>16</b>	<b>21</b>	<b>21</b>	<b>13</b>	<b>12</b>	<b>4</b>	<b>628<sup>a</sup></b>

<sup>a</sup>Thirteen wives and ten husbands did not complete a question about their spouses' total daily cigarette consumption.

asked to provide information about parental smoking history. It has been documented that maternal smoking has a larger effect on the respiratory health of their children than does paternal smoking.<sup>5</sup> There is a conjecture that in studies using self-administered questionnaires, which are more likely to be completed by mothers than fathers, smoking data are more accurate for mothers (self-reported) than for fathers (reported by spouses).<sup>6</sup> Our study suggests that husbands and wives provide equally reliable information on cigarette consumption for their spouses if self-administered questionnaires are completed at home. Also, in our case, reporting bias on spousal daily cigarette consumption is minimal. □

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**Is Public Health Credentialing Necessary?**

Credentialing is an increasingly common response to perceived problems in establishing or maintaining standards of performance for professional and technical occupations.<sup>1</sup> Arguments for public

health credentialing have identified two concerns: the establishment of a minimal common base of knowledge for all public health workers and the development of public health leadership. These are legitimate concerns, but is credentialing the most cost-effective and equitable approach to addressing them?

*The Future of Public Health's* paradigm of the public health function at the local level suggested the need to redefine (or, perhaps more appropriately, update and upgrade) the knowledge base, skills, and competencies of public health practitioners.<sup>2</sup> Many would agree that public health workers should have a generic knowledge base that includes some fundamentals of epidemiology, biostatistics, and population-based primary prevention. However, the multidisciplinary nature of the public health field of practice complicates this task. Moreover, the professional work force in local public health largely comprises persons who already hold public and/or private credentials (e.g., nurses, physicians, sanitarians, nutritionists, and health educators).

Credentials become institutionalized in job criteria and, in public employment, in civil-service job classifications. These standards are slow to change and are difficult to keep current with changing and expanding knowledge and technology. Who would have thought, 20 years ago, that computer literacy would become essential to efficient operations in every management environment? Credentialing tends to increase the cost of services provided by persons holding the credential, even if the credential is voluntary rather than mandatory, as in state licensure. The public interest will be served only to the extent that the increased cost of services is offset by increases in the quality or cost-effectiveness of the services provided by the credentialed person.

Cross-disciplinary training and skill upgrading are occurring in the public health workforce without the imposition of a credentialing framework. For example, with financial and technical assistance from the Centers for Disease Control and Prevention, many states are conducting innovative training programs for state and local public health workers. These programs offer tremendous potential for individual and group learning in the work site, with practical applications to community problems and issues. On the national level, the Public Health Leadership Program is an example of leadership development that has greater flexibility and lower start-up costs than