Letters to the Editor

Letters to the Editor will be reviewed and are published as space permits. By submitting a Letter to the Editor, the author gives permission for its publication in the Journal. Letters should not duplicate material being published or submitted elsewhere. Those referring to a recent Journal article should be received within 3 months of the article's appearance. The Editors reserve the right to edit and abridge and to publish responses. Submit three copies. Both text and references must be typed double-spaced. Text is limited to 400 words and fewer than 10 references.

Reprints can be ordered through the author whose address is listed at the end of the letter.

The Prevalence of Smoking among Physicians in Japan

I read with great interest the March 1993 Journal article by Hensrud and Sprafka. The authors commented on smoking among physicians in Europe but not in Japan. A number of reports indicate high rates of smoking among the general male populations in Asian countries. A survey conducted by Japan Tobacco Inc. in 1990 found that the prevalence of smoking was 60.5% among men and 14.3% among women; in other words, about 26.5 million men and 6.7 million women in Japan smoke.[2] In 1989 we conducted a survey of the smoking habits and attitudes toward smoking among the members of the Japan Society of Chest Diseases and found that 24.8% were current smokers, 39.4% were former smokers, and 35.9% had never smoked.[3] The prevalence of smoking was lower than for physicians in general in Japan (which is estimated to be 39%[4]), and much lower than for the general male population.

Health professionals have an important role in anti-smoking campaigns. I hope that thoracic physicians in Japan will make every effort to reduce the high smoking prevalence among Japanese men. □

Hiroshi Kawane, MD, FCCP

Requests for reprints should be sent to Hiroshi Kawane, MD, FCCP, Department of Medicine, Kawasaki Medical School, Kurashiki City, Okayama, Japan.

References

1. Hensrud D, Sprafka J. The smoking habits of Minnesota physicians. *Am J Public Health.* 1993;83:415–417.
2. Kawane H. The influence of the US tobacco industry in foreign markets. *N Engl J Med.* 1991;325:815.
3. Kawane H, Soejima R. Smoking among members of the Japan Society of Chest Diseases. *Nippon Kyobu Shikkan Gakkai Zasshi.* 1991;29:182–185.
4. Kawane H. Tobacco smoking in Japan. *Can Med Assoc J.* 1986;135:971.

Risk of HIV Infection among Army Reserve Components Physicians

Regarding occupational human immunodeficiency virus (HIV) transmission to physicians, little information is available based on prospective studies. Until studies evaluating exposures on an individual basis can be completed, available populations should be evaluated to obtain approximate risk estimates. The US Army Reserve Components provide an opportunity for evaluating infection incidence among a population of physicians working in the civilian community. Since the last report,[1] additional members have been tested, and many more person-years of follow-up have accrued.

Methods of testing and data collection have been presented elsewhere.[1] This report reflects all tests conducted between October 1985 and December 1991 that have been matched with personnel files from June of each year from 1986 to 1991.

This report addresses only physicians, who were assigned area of concentration identifiers based on the physician's training and experience.[2] Exposure categories were determined based on duty areas of concentration. It was assumed that members with particular areas of concentration work in those occupations in their civilian practices.

The physicians' potential exposure to blood categories were based on a combination of Kelley et al.[3] and Centers for Disease Control and Prevention[4] groupings and include maximum, moderate, and minimum exposure. The specialties in the maximum category have a substantial surgical component and a likelihood of exposure to blood in uncontrolled or not-well-controlled environments (e.g., emergency rooms). Those in the moderate category also have a substantial surgical component, but generally in the more controlled environment of a clinic or operating room. Those in the minimal exposure group would have limited surgical or other exposure to blood. The areas of concentration in each category are presented in the Appendix.

Members with an initial negative HIV test followed by one or more subsequent tests were included in this study. Follow-up time started with the initial negative test, and it terminated with the first positive test for seroconverters and the last negative test for all others. Incidence density of infection was defined as the number of seroconversions per 1000 person-years of follow-up. The 95% confidence interval (95% CI) was based on the Poisson distribution.

A total of 2018 men and 198 women were followed for 5926 person-years of fol-

TABLE 1—Physicians in the Army Reserve Components: Person-Years of Follow-Up, by Potential Exposure to Blood Category

Potential Exposure	No. Followed	Total Person-Years of Follow-Up	Incidence Density	Poisson 95% CI[a]
Maximum	739	1923	0.0	0, 1.9
Moderate	719	1970	0.0	0, 1.9
Minimum	758	2033	0.0	0, 1.8

[a]Poisson 95% confidence interval for the incidence density of infection (per 1000 person-years of follow-up).

low-up. No seroconversions were observed. Table 1 shows the person-years of follow-up by exposure group, with the 95% CI for the incidence density of infection.

Physicians who know or suspect they are infected may avoid testing or leave the Reserve Components altogether, but it is not possible to determine if this actually occurs. The low risk of seroconversion among Reserve Components physicians is consistent with other findings of low seroprevalence among physicians and surgeons.[5,6] □

David N. Cowan, PhD
John F. Brundage, MD, MPH
Robin S. Pomerantz, MS
Z. Frank Wann, MS
Richard N. Miller, MD, MPH

David N. Cowan, Robin S. Pomerantz, and Z. Frank Wann are with SRA Technologies, Inc., Alexandria, Va. Dr Cowan, John F. Brundage, and Richard N. Miller are with the Division of Preventive Medicine, Walter Reed Army Institute of Research, Washington, DC.

Requests for reprints should be sent to David N. Cowan, PhD, SRA Technologies, Inc., 4700 King St, Suite 300, Alexandria, VA 22302.

References

1. Cowan DN, Brundage JF, Pomerantz RS, Miller RN, Burke DS. HIV infection among members of the US Army Reserve Components with medical and health occupations. *JAMA.* 1991;265:2826–2830.
2. *Commissioned Officer Classification System.* Washington, DC: Department of the Army, Headquarters; October 31, 1989. Army Regulation 611-101.
3. Kelley PW, Miller RN, Pomerantz RS, Wann F, Brundage JF, Burke DS. Human immunodeficiency virus seropositivity among members of the active duty U.S. Army: 1985–89. *Am J Public Health.* 1990; 80:405–410.
4. *Request for Proposals 200-91-0933(P), Seroprevalence Survey of Human Immunodeficiency Virus Infection in Surgeons.* Atlanta, Ga: Centers for Disease Control; April 16, 1991.
5. Henderson DK, Fahey BJ, Willy M, et al. Risk for occupational transmission of human immunodeficiency virus type 1 (HIV-1) associated with clinical exposures. A prospective evaluation. *Ann Intern Med.* 1990; 113:740–746.
6. Tokars JI, Chamberland ME, Schable CA, et al. A survey of occupational blood contact and HIV infection among orthopedic surgeons. *JAMA.* 1992;268:489–494.

APPENDIX—Medical Corps' Areas of Concentration for Each Category of Potential Exposure to Blood and Body Fluids

- Maximum exposure: Obstetrician/gynecologist (60J); general surgeon (61J); thoracic surgeon (61K); orthopedic surgeon (61M); emergency physician (62A).
- Moderate exposure: Urologist (60K); ophthalmologist (60S); otolaryngologist (60T); plastic surgeon (61L); pathologist (61U); peripheral vascular surgeon (61W); neurosurgeon (61Z); field surgeon (62B).
- Minimum exposure: All medical corps areas of concentration not listed above.

Misuse of Pediatric Emergency Services and Fathers' Employment Status

Excessive use of nonappointment emergency services characterizes inner-city health care for children as well as for adults.[1–3] In a survey of 99 children from 91 families that was conducted at the Pediatric Acute Care Center, Kings County Hospital, Brooklyn, NY, we confirmed the observations of Grumbach, Keane, and Bindman[1] that a lack of health insurance for the poor directs patients to inner-city emergency rooms for nonemergency care. However, we found that families with fathers living at home had unique characteristics influencing their use of the emergency room.

A contemporary social concern is to maintain the integrity of inner-city families, under the assumption that the children will benefit from the presence of the father.[4,5] In our survey, fathers who remained in the home were likely to be employed, thus providing a positive role model for their children; however, the presence of an employed father in the home was associated with a perceived "misuse" of the health care system concomitant to the family's lack of health care insurance (which for the poor and near poor is Medicaid).

Our data show that having an employed father is associated with the father's living at home [odds ratios (OR) = 5.86, 95% confidence intervals (CI) = 1.93, 18.5], and families with a father at home are less likely to have Medicaid than either private health insurance (usually from stable jobs with good benefits) (OR = 0.115, 95% CI = 0.026, 0.482) or no insurance (OR = 0.241, 95% CI = 0.068, 0.823). Because none of the 16 families with a father in the home—who received income from work but no health insurance—brought their children to the Pediatric Acute Care Center for a true emergency, it was not possible to construct an odds ratio. Chi square with Yates correction (4.91) was significant ($P < .05$). These findings suggest that, within this population sample, health insurance is not available for intact families attempting to support themselves and that, although the families' income from work is low, it is still too high for them to qualify for Medicaid support.

The data support the observation that "the poor are not dysfunctional operators in a limited resource base but are highly adaptive actors in an essentially dysfunctional economic system. Poverty creates a powerful environment which shapes people's responses to social situations."[6,7] To deprive families with working fathers who live at home of health care insurance is to contribute to the social instability of inner-city communities by providing a counter-incentive for families to remain intact and fathers to be employed. The positive influence of an effective health care system on the well-being of inner-city family life should not be ignored. □

Robert Karp, MD

Request for reprints should be sent to Robert Karp, MD, Kings County Hospital Center, 451 Clarkson Ave, Brooklyn, NY 11203.

References

1. Grumbach K, Keane D, Bindman A. Primary care and public emergency department overcrowding. *Am J Public Health.* 1993;83:372–378.