LETTERS TO THE EDITOR

TABLE 1—Comparison of Race- and Age-Specific Abortion Ratios for US* and Eight-State§ Reporting Area, 1978

<table>
<thead>
<tr>
<th>Age ≤ 14</th>
<th>Age 15–17</th>
<th>Age 18–19</th>
<th>Age 12–19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>U.S.</td>
<td>Eight-State Area</td>
<td>U.S.</td>
</tr>
<tr>
<td>White</td>
<td>617</td>
<td>1362</td>
<td>665</td>
</tr>
<tr>
<td>Non-White</td>
<td>629</td>
<td>718</td>
<td>620</td>
</tr>
<tr>
<td>Black</td>
<td>670</td>
<td>736</td>
<td>731</td>
</tr>
<tr>
<td>Others</td>
<td>1438</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Derived from Ezzard, et al. Table 3.
§Derived from NCHS, Table A and Table 3.

Those calculated by Drs. Hale and Pickett:

1) Sources of Data—We used three national sources: annual numbers of legal abortions from the Alan Guttmacher Institute (AGI), age and race distributions from the Centers for Disease Control (CDC), and numbers of live births from the National Center for Health Statistics (NCHS). Hale and Pickett used data only from the eight selected states which reported abortions to NCHS. Perhaps they did not realize we used the same NCHS data from these states as a subset of our national data for 1978. Thus, some of the difference between our estimates and theirs is probably due to real variation in age-race abortion patterns for the US as a whole compared with patterns in the eight selected states. For example, nationally 33 per cent of abortions were obtained by women of Black and other races, compared with 26 per cent in the states used by Hale and Pickett. The racial percentages and abortion ratios vary even more when only teenagers are considered.

2) Age of Conception—Our abortion ratios were calculated by age of conception, whereas they used age at occurrence of the live birth or the abortion. Using age at conception is particularly important for teenagers because a teenager whose pregnancy results in birth is likely to be in an older age group by the time the birth actually occurs. We found our procedure reduced the ratio for the youngest teenagers more than the older teenagers, and reduced the ratio for White teenagers more than the corresponding ratio for Black and other teenagers.

We are not as concerned as Hale and Pickett about the effects of aggregating the Black and other racial categories. On a national level, Black women account for about 90 per cent of pregnancies in "non-White" teenagers. We did not include "unknown" races in the "other" category, nor did we use the terms "non-White" and "Black" interchangeably. We used the specific term "Black" only when referring to other articles which focused on Black teenagers.

Contrary to other vital registration data, induced abortions are not reported as completely as "survey" data. The AGI "survey" is designed to enumerate a census rather than a probability sample. For example, the AGI counted over 200,000 induced abortions performed in the eight states reporting abortions to the NCHS; only 176,000 procedures were reported by these states to the NCHS.

We agree with Hale and Pickett that abortions obtained by disadvantaged women are more completely reported than those obtained by the more advantaged. To the extent this reporting artifact differed in the national and the eight-state data sets, it could account for a portion of the discrepancy between their abortion ratios and ours. We believe our national estimates accurately reflect the trends in teenage abortion patterns between 1972 and 1978. After the 1973 Supreme Court decisions, teenagers of both races made increasing use of legal abortion, with the initial increases occurring faster among members of Black and other races than among Whites. This caused race-specific differences in abortion ratios to narrow; by 1978, these ratios were quite similar.

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REFERENCES


On the Usefulness and Ethics of Chemical Testing of Children


1) The article begins by asserting that, “In adolescents, denial or minimalization of cigarette smoking are probably common.” It seems that this untested assumption might be tested by...
the saliva procedure, presumably because of the unreliability of self-reporting of cigarette smoking. However, at the conclusion to the article, the authors inform us that the procedural data themselves are to be validated by “...self-report data...a method recognized as frequently inaccurate. Nevertheless, the self-report data presented are of particularly good quality due to the unique collection techniques outlined above, and described elsewhere as the ‘Bogus Pipeline’ method.” They began by saying that self-report data on prevalence are not valid, so they proposed saliva testing instead. At the end, they “validated” their saliva testing conclusions with self-reporting data. They cannot have it both ways. If the self-report data are valid enough to show the usefulness of the saliva test, why not simply go with the self-report?

2) Nowhere is there a glimmer that it might be unethical to use captive subject children in a study that requires them to impart information about their illegitimate behavior to “authority figures” through the device of a chemical test, when presumably they would not impart it freely otherwise. If their smoking behavior is something they do not want to tell officials about, by what right do the investigators wrest it from them? It is one thing for adults in a smoking-cessation group to opt for the test, quite another for it to be put upon a general population of children.

3) How could this procedure be used in the future? Its results detect only heavy smoking, and for population groups, it seems not to improve on self-reporting. Its value to health education outcomes is dubious: is each child to be routinely checked for compliance? Will we again see the familiar pattern of minorities and unfavored children subjected to the tests with institutional penalties dealt out on the basis of either positive results or refusal to participate? This could lead to testing of school children’s urine for alcohol, genital inspection for sexual activity, and other procedures limited only by the imagination of the “authority figures.” Health education needs to address the use of alcohol, tobacco, and sex, but, the method proposed by the authors is ethically questionable.

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Response by Dr. Luepker, et al.

The letter by Dr. Church raises questions about both the interpretation of the scientific data and the ethics of the measurement method presented in the article, “Saliva Thiocyanate: A Chemical Indicator of Cigarette Smoking in Adolescents.”

Regarding the scientific merits of this measure, we recognize, and discuss in the paper, the limitations of self-report data collected under standard conditions and in combination with the saliva thiocyanate methodology. The described measurement strategy combining self-report with saliva thiocyanate does result in substantially higher reported rates of smoking which are presumed to be much more reliable. We would refer to Table 6 in the article. Our position on the reliability and comparability of the reported rates of smoking using this measurement strategy have also been discussed elsewhere. The relative validity of self-reports versus biochemical measures has been considered in greater detail in another recent manuscript.

We share with the writer concerns over the protection of individuals in any scientific study and the potential for misuse of data collection or measurement tools. However, we have paid scrupulous attention to total disclosure of the procedures to both parents and the student subjects. While the “Bogus Pipeline” technique has been used elsewhere in a deceptive way, that is not our procedure. Some students and parents do elect the option not to participate and that wish is respected. The data collection was strictly guarded and confidentiality maintained by the utilization of code numbers and other well-known methods of protection.

Finally, there is the issue of potential uses of the methodology. Here the writer seeks to extend our work into flagrant abuse. Such misuse is possible on any information gained from or about individuals. Fortunately, our society has methods for safeguarding the rights of individuals yet maintaining the ability to collect information which has the potential for advancing the common good. This issue is particularly relevant in the public health field where understanding of patterns and trends in population diseases and health habits is crucial. While the rights of the individual should be protected as much as possible, the needs of society for the most accurate data for public health planning are also real and pressing. Our data indicate that the rights of the individuals can be protected while more accurate self-report data are collected. The measurement strategies we describe can accomplish both goals.

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REFERENCES